ST. VINCENT CHARITY MEDICAL CENTER

A Ministry of the Sisters of Charity Health System

COMMUNITY HEALTH NEEDS ASSESSMENT

IMPLEMENTATION STRATEGY 2020–2022

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INTRODUCTION

St. Vincent Charity Medical Center is a ministry of the Sisters of Charity Health System. Located in the Central neighborhood, one of Cleveland's most economically disadvantaged areas, St. Vincent Charity is the City's only faith-based, acute-care teaching hospital, caring for the community since 1865. Faithful to the philosophy and heritage of the Sisters of Charity of St. Augustine, St. Vincent Charity is committed to the healing mission of Jesus, serving with a deep respect for the dignity and value of all persons, practicing with quality care, a dedication to the poor and a commitment to education.

St. Vincent Charity is renowned for its practices in specialty care: including Behavioral Health and Addiction Medicine (Rosary Hall), the Spine and Orthopedic Institute, the Center for Bariatric Surgery and the Health Literacy Institute. Additionally, St. Vincent Charity provides comprehensive services in emergency medicine, primary care, wound care, pain management, radiology, occupational health, pulmonary medicine and oncology. St. Vincent Charity also operates one of only two 24/7 psychiatric emergency departments in the State of Ohio and has the largest dedicated hospital-based detox facility in Northeast Ohio.

In continuing the history of caring for the community St. Vincent Charity believes that assessing the needs of the community and developing strategies to improve health are an integral part of its mission. St. Vincent Charity recognizes that health is significantly affected by social determinants, which play a key role in accessing care and achieving good health.

In 2019 St. Vincent Charity was part of a collaborative effort to develop a comprehensive Community Health Needs Assessment (CHNA). In addition to St. Vincent Charity, the CHNA Steering Committee included Better Health Partnership, Case Western Reserve University School of Medicine, Cleveland Clinic, the Cleveland Department of Public Health, the Cuyahoga County Board of Health, the Health Improvement Partnership – Cuyahoga (HIP-Cuyahoga), The MetroHealth System, PolicyBridge, Southwest General Health Center, The Center for Health Affairs, United Way of Greater Cleveland and University Hospitals. This approach provided for a robust, inclusive evaluation of the health of residents in Cuyahoga County and laid the framework for collaboration to address health needs and align with the Ohio State Health Assessment (SHA).

The top health needs in the CHNA were identified through input from community voice, community stakeholders, hospitals and public health. This input, along with primary and secondary data, gave a complete picture of the health of Cuyahoga County residents. Since health encompasses not only physical wellbeing, social determinants including safety, housing, education, employment, insurance, food insecurity, etc. were also assessed. A prioritization process including hospitals, the CHNA Steering Committee, and community health workers determined the top health priorities through weighted voting.

The following health priorities were chosen:
– Chronic Disease
– Community Conditions
– Mental Health and Addiction
– Eliminating Structural Racism*
– Enhancing Trust and Trustworthiness across Sectors, People, Communities*

*These are long-term, cross-cutting strategies that will be integrated into each of the other priority areas identified. An intentional plan to address these fundamental contributors to the health of both individuals and populations within Cuyahoga County will be created.

The CHNA was approved by the St. Vincent Charity Medical Center Board of Directors on October 2, 2019. A CHNA is conducted at least once every three years and an implementation strategy is adopted to address the health needs of the community.

INTRODUCTION *(continued)*

The CHNA, compliant with the IRS requirements of Treas. Reg. §1.501(r) Section 501(r) and Ohio Revised Code (ORC) 3701.981 provides the underlying framework for the Implementation Strategy (IS). The IS defines how the hospital intends to address the community health needs, the anticipated impact of the initiatives, resources committed by the hospital, and collaboration with other organizations to reach improved outcomes. The IS addresses the priority health needs identified in the CHNA that the hospital determines to be part of its mission. The IS will be adapted if necessary based on emerging needs of the community as well as the evolving collaborative efforts focused on the aligned strategies. St. Vincent Charity will be working in collaboration with other organizations, hospitals, health departments and the community on aligned strategies in order to more effectively address health and inequities.

In accordance with ORC 3701.981 the board of health and tax-exempt hospitals must collaborate on community health assessments (CHA) and community health improvement plans (CHIP) by October 2020. The regulation also mandates that hospitals must align the CHNA and IS with the Ohio SHA and the Ohio State Health Improvement Plan (SHIP). The IS will address the identified health priorities and align with the 2019 SHA and 2017-2019 SHIP. (See Appendix 1)

MISSION, VISION, VALUES

MISSION

St. Vincent Charity Mission: In the spirit of the Sisters of Charity of St. Augustine, the St. Vincent Charity Medical Center family is dedicated to the healing ministry of Jesus. As caregivers we serve with a deep respect for the dignity and value of all persons, we are focused on quality care, dedicated to the poor
and committed to continuing education.

OUR VISION

St. Vincent Charity Medical Center, with the commitment of its caregivers and physicians, will be a leading model for healthcare delivery in Northeast Ohio based on its faith-based mission, dedication to education, commitment to the communities it serves, excellence in the patient experience it provides, focus on surgical services, and partnerships with physicians and other constituencies.

OUR VALUES

Respect: We serve in an atmosphere of mutual respect and fairness, treating each person with reverence and dignity that recognizes each individual's contribution.

Integrity: We hold ourselves accountable for our actions and are honest and ethical in all our dealings.

Quality: We are committed to continuous improvement of our services to better each life as if it were our own.

Teamwork: We celebrate the opportunity to come together as caregivers in an inclusive workplace where diversity and open communication are valued.

2019 COMMUNITY HEALTH NEEDS ASSESSMENT OBSERVATIONS

The 2019 Cuyahoga County CHNA is a 176-page report that consists of primary and secondary data for Cuyahoga County. St. Vincent Charity partnered with other hospitals and local health departments to develop the CHNA using a county-level definition of community which allowed for a comprehensive assessment of the health needs of the community. The shift to a county-level definition allows the hospitals to more readily collaborate with public health and other key stakeholders for both community health assessments and equity – grounded health improvement planning. This innovative, collaborative approach enables larger scale collective impact on previously intractable problems resulting in health inequities across the region. Each of the hospitals partnering on the CHNA had the majority of their patient discharges from Cuyahoga County.

The following data and themes are key findings from the CHNA that deepened understanding of the current health needs and health inequities in Cuyahoga County and support the priorities and strategies found in this IS. The full CHNA report can be found at: **https://www.stvincentcharity.com/media/1525/2019-chna-final.pdf**

1. A tremendous wealth of community assets and health care resources exist in Cuyahoga County, yet stark inequities in health are experienced by its residents.
    a. The conditions that shape health (commonly referred to as the social and environmental determinants of health) – such as financial resources, access to healthy food, and safe and affordable housing, to name a few – are not spread equitably, resulting in significant differences in health outcomes, such as disease severity, life expectancy and infant mortality. These differences are shaped by long-standing systems and structures that impact the conditions in which residents live, work, learn and play.
2. Current differences in health outcomes across various neighborhoods within Cuyahoga County are the direct result of systems, structures, and policies, such as redlining that over many decades have limited opportunities and impacted health for residents of color in those communities.
    a. The 2019 Cuyahoga County CHNA represents a new era in working across boundaries to build on community strengths to address the most pressing and challenging determinants of health for all who live, learn, work and play in Cuyahoga County.
    b. Significant work to enhance trust and trustworthiness across sectors, people and communities is necessary to ensure all Cuyahoga County residents have an equal opportunity to achieve their fullest potential.
    c. Structural racism was identified as the underlying issue that globally affects health which must be addressed in order to impact inequity and improve health outcomes.
3. The strongest indicator we have of health status is poverty. The 2019 Cuyahoga County CHNA identified several inequities in access to care and health outcomes based on socioeconomic status:
    a. One-third (33%) of City of Cleveland residents lived below the poverty line in 2017, compared to 18.0% of county residents, as a whole.
    b. Cuyahoga County families with incomes below $25,000 have higher rates of children diagnosed with asthma (27.3%) compared to those with incomes above $25,000 (13.7%) according to survey results.

2019 COMMUNITY HEALTH NEEDS ASSESSMENT OBSERVATIONS *(continued)*

4. There are several priority health and safety concerns for Cuyahoga County and there are several reasons for this designation. They may be conditions where Cuyahoga County appears to compare unfavorably to its peer counties, they may be conditions that can be minimized or prevented via effective programming, or they may have been selected because they impact certain population groups in our county at particularly high frequency. For all of these, Cuyahoga County compares unfavorably to national benchmark goals in the following areas:
   a. Cuyahoga County's mortality rate from cardiovascular disease was higher (204.4 per 100,000) than for the state (186.2) and the U.S. overall (165.0). African Americans had the highest cardiovascular mortality rate among all racial/ethnic groups in Cuyahoga County overall (254.8).
   b. Among survey respondents, 12.7% of Cuyahoga County adults have been told by a medical professional that they have diabetes. Rates are significantly higher among Black non-Hispanic residents (25.8%) compared to White non-Hispanic residents (7.7%).
   c. Cuyahoga County's suicide rate is 12.1, exceeding the national benchmark of 10.2 (per 100,000). In surveys, county residents report an average of 3.7 poor mental health days per month. The homicide rates within Cuyahoga County (14.2) and the City of Cleveland (28.3) are significantly higher than the national benchmark of 5.5 (per 100,000).
   d. The number of unintentional opioid deaths in 2017 was high in Ohio overall (39.2 per 100,000) and in Cuyahoga County (37.8). In the City of Cleveland, the rate of unintentional opioid deaths was nearly twice as high (72.5) as in the county overall. The rate of unintentional opioid deaths in the City of Cleveland is five times that of the U.S. overall (14.5).
   e. Transportation was mentioned by social service agency participants and community residents at separate focus groups as a concern that impacts access to jobs, health care, school and ability to socialize. In particular, community residents highlighted the lack of access to public transportation. One-fifth of all Cuyahoga County households located in a food desert do not have a vehicle.
5. Diseases of the circulatory system (15.2%) and diseases of the respiratory system (9.6%) were the most common reasons Cuyahoga County residents were hospitalized in 2017. The most common ambulatory care sensitive (ACS) conditions for Cuyahoga County residents in 2017 were chronic obstructive pulmonary disease (3.2%), congestive heart failure (1.8%) and diabetes (1.7%).

PRIORITY HEALTH NEEDS

The process of prioritizing the top health needs for the IS involved several layers. First, the data subcommittee identified 16 critical health issues using all sources from the CHNA. (See Appendix 2)

CHNA Steering Committee members agreed to use the following six criteria to guide the selection of priority health needs:

1) Magnitude of the Problem
How many people are affected?

2) Severity of the Problem
How likely is it to limit length and quality of life?

3) Inequity/Social Determinants of Health
Does it affect some populations more than others?

4) Magnitude of Health Disparity
How much of each population group is affected and are there differences?

5) Priorities Determined by Community
How highly was the health topic rated by community stakeholders or residents?

6) SHA/SHIP Alignment
Does it align with health priorities in the SHIP

CHNA Steering Committee members came to consensus on using the following weighting process for voting:

- **20% community voice**
  – Community stakeholders (10%) vote cast by United Way of Greater Cleveland
  – Community residents (10%) vote cast by community health workers
- **40% hospitals**
  – Southwest General Health Center (10%)
  – St. Vincent Charity Medical Center (10%)
  – MetroHealth (10%)
  – University Hospitals (10%)
- **40% local health departments**
  – Cleveland Department of Health (20%)
  – Cuyahoga County Board of Health (20%)

Voting was informed by the selection criteria and information gathered from three community meetings (two residents' meetings and one meeting of social service agencies).

At the August 8, 2019 voting meeting, CHNA Steering Committee members, community health workers, and hospital community outreach staff gathered to vote on the top 3-5 health priorities. Five health priorities were chosen that will guide the focus of the IS. There is strong alignment between the selected health priorities (shown below) and SHIP priorities:

- Eliminating structural racism*
- Enhancing trust and trustworthiness across sectors, people, communities*

  ➔ between hospital/public health systems and residents

  ➔ between clinicians and patients

  ➔ between social service agencies/community stakeholders and hospitals
- Addressing community conditions, such as reducing poverty and its effects, including transportation and homicides/violence/safety
- Enhancing mental health and reducing substance abuse
- Reducing chronic illness and its effects

* Eliminating structural racism and enhancing trust on multiple levels are long-term, crosscutting strategies that will be integrated into each of the other priority areas through an intentional plan to address these fundamental contributors to the health of both individuals and populations within Cuyahoga County. A comprehensive plan to eliminate structural racism has been part of the Cuyahoga County Community Health Improvement Plan, operationalized by HIP-Cuyahoga since 2015. This early work, in conjunction with the priority to enhance trust on multiple levels within the community, will serve as a foundation for the IS.

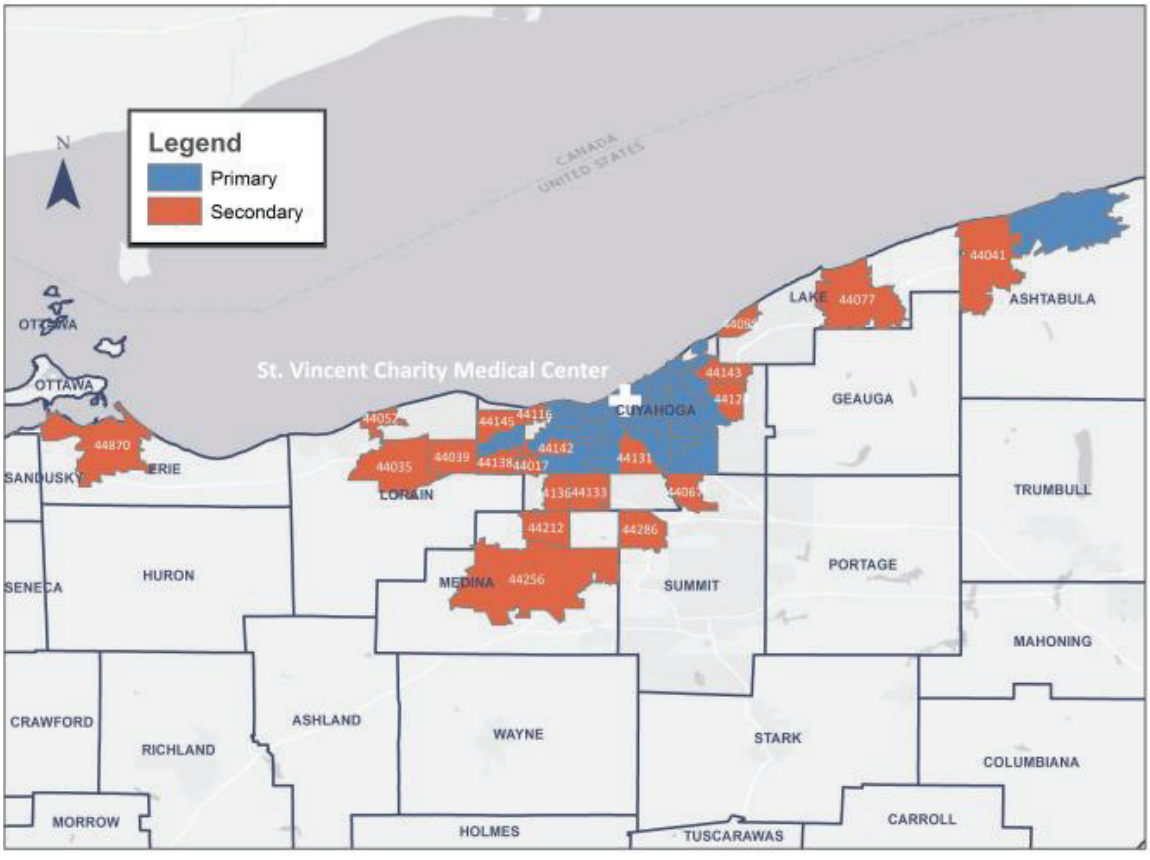
The 2017-2019 SHIP identifies community conditions, mental health and addiction, and chronic disease as key priority areas, thus providing excellent alignment with the chosen health priorities. Furthermore, the SHIP employs an equity-grounded overarching approach for all identified priorities, thus interfacing well with the equity approach identified above with the goal of eliminating structural racism.

PRIORITY HEALTH NEEDS *(continued)*

The St. Vincent Charity Community Benefit Committee, an interdisciplinary group, that includes representatives from Behavioral Health, External and Government Affairs, Quality, HealthCare Center, Mission Outreach, Diabetes Education, and Primary Care met on January 17, 2020 to review the top five health priorities, determine alignment with the mission of the hospital and discuss strategies. There was consensus on addressing the five identified health priorities of reducing chronic disease, addressing community conditions, enhancing mental health and reducing substance abuse along with the crosscutting strategies of eliminating structural racism and enhancing trust. St. Vincent Charity will work collaboratively with multiple stakeholders on the aligned strategies of eliminating structural racism and addressing community conditions.

COMMUNITY SERVED BY ST. VINCENT CHARITY MEDICAL CENTER

Cuyahoga County is one of Ohio's largest counties in terms of population. It sits within Northeast Ohio with a northern border of Lake Erie. It includes the City of Cleveland and 58 suburban communities. Two local public health departments and multiple hospitals are located within the county. In 2017, St. Vincent Charity had 8,286 discharged patients. Of those, 6,604 were in Cuyahoga County representing 79.7% of all discharges. Mental and behavioral disorders accounted for 3,582 discharges, 43.2%, a higher percentage of total discharges for this disorder than all other hospitals in Cuyahoga County.



Prepared By: The Center for Health Affairs, June 2016

STRATEGIES TO ADDRESS THE PRIORITY HEALTH NEEDS

The following goals, anticipated outcomes, indictors and strategies are specific to Cuyahoga County.

Note: This symbol will be used to designate when a priority, indicator or strategy align with the 2017-2019 SHIP.

PRIORITY HEALTH NEED: REDUCING CHRONIC DISEASE AND ITS EFFECTS

DIABETES

GOAL

Reduce the percent of adults who have been diagnosed with diabetes

ANTICIPATED OUTCOMES

1. Maintain or reduce the percent of adults 20 and older who have ever been diagnosed with Diabetes by December 2022 (Source: Healthy Northeast Ohio (CDC))
2. Maintain or reduce the percent of adults 20 and older who are obese according to the Body Mass Index by December 2022 (Source: Healthy Northeast Ohio (CDC))

INDICATORS

1. Percent of adults 20 and older who have ever been diagnosed with Diabetes (Source: Healthy Northeast Ohio (CDC) Baseline: 9.3% in 2016)
2. Percent of adults 20 and older who are obese according to the Body Mass Index (BMI ≥30 is obese) (Source: Healthy Northeast Ohio (CDC) Baseline 30.2% in 2016)

STRATEGY

- Reach people in high risk zip codes for pre-diabetes and diabetes management.
- Provide outreach into the community to increase knowledge of pre-diabetes, diabetes and modifiable risk factors.
- Increase support for those living with pre-diabetes and diabetes focused on healthy eating.

ACTION STEPS

- Increase pre-diabetes and diabetes self-management education including individual and group visits for people in high risk zip codes.

  – Address barriers to access and attendance for both medical and educational pre-diabetes and diabetes management services.
- Deliver targeted outreach into the community to increase knowledge of pre-diabetes, diabetes and modifiable risk factors.

  – Identify locations to engage the community where they work, play and pray.

  – Provide consistent health screenings in the community.

  – Develop a diabetes prevention program utilizing Community Health Workers addressing the social determinants of health.
- Offer programs to provide diabetes support outside of medical and educational visits.

  – Six diabetes support group meetings each year

  – Ohio State University (OSU) Extension “Dining with Diabetes,” a four class series, offered at least yearly

COLLABORATING PARTNERS

Cleveland State University (CSU), Ohio State University Extension, Greater Cleveland Food Bank, Hunger Network, St. Vincent Charity Community Advisory Board

STRATEGIES TO ADDRESS THE PRIORITY HEALTH NEEDS *(continued)*

PRIORITY HEALTH NEED: REDUCING CHRONIC DISEASE AND ITS EFFECTS

CARDIOVASCULAR DISEASE

GOAL

Reduce the percent of adults who have ever been diagnosed with coronary heart disease

ANTICIPATED OUTCOMES

1. Maintain or reduce the age-adjusted death rate due to coronary heart disease by December 2022 (Source: Healthy Northeast Ohio (CDC)
2. Maintain or reduce the mortality rate for cardiovascular disease by December 2022 (Source: Cuyahoga County Board of Health Vital Statistics (2019 CHNA)

INDICATORS

1. Age-adjusted death rate due to coronary heart disease (Source: Healthy Northeast Ohio (CDC) Baseline: 114.8 per 100,000 from 2015-2017)
2. Mortality rate for cardiovascular disease (Source: Cuyahoga County Board of Health Vital Stats (2019 CHNA) 204.4 per 100,000 for Cuyahoga; 246.3 per 100,000 for Cleveland in 2017)

STRATEGY

- Reach people in high risk zip codes for hypertension and cardiovascular disease management.
- Provide outreach into the community to increase knowledge of cardiovascular disease and modifiable risk factors.

ACTION STEPS

- Deliver targeted outreach into the community to increase knowledge of cardiovascular disease, hypertension and modifiable risk factors.

  – Identify locations to engage the community where they work, play and pray.

  – Provide consistent health screenings in the community.
- Continue the Coumadin Clinic to ensure patients receive appropriate management of medicine to prevent complications
- Pharmacy to explore the possibility of starting a heart failure clinic
- Inpatient and outpatient medication therapy management to ensure patients understand their medicine regimen

COLLABORATING PARTNERS

St. Vincent Charity Community Advisory Board, Greater Cleveland Food Bank and American Heart Association

STRATEGIES TO ADDRESS THE PRIORITY HEALTH NEEDS *(continued)*

PRIORITY HEALTH NEED: ADDRESSING COMMUNITY CONDITIONS

POVERTY/TRANSPORTATION/ SAFETY (HOMICIDE/VIOLENCE)

GOAL

Arrest the upward trend of poverty

ANTICIPATED OUTCOMES

1. Maintain the downward trend of people living below the poverty level through December 2022 (Source: Healthy Northeast Ohio (American Community Survey))
2. Maintain the downward trend of the percentage of people under the age of 18 living below the federal poverty level through December 2022 (Source: Healthy Northeast Ohio (American Community Survey))
3. Maintain the downward trend of the violent crime rate through December 2022 (Source: Healthy Northeast Ohio (Ohio Department of Public Safety, Office of Criminal Justice Services))

INDICATORS

1. Percentage of households with annual incomes below the federal poverty level (Source: Healthy Northeast Ohio (American Community Survey) Baseline: 18.3%, 2013-2017)
2. Percentage of people under the age of 18 living below the federal poverty level (Source: Healthy Northeast Ohio (American Community Survey) Baseline: 26.9%, 2013-2017)
3. Percentage of the population who experienced food insecurity at some point during the year (Source: Healthy Northeast Ohio (Feeding America) Baseline: 18.4%, 2013-2017)
4. Percentage of the population unemployed (Source: U.S. Census Bureau. American Community Survey, 2016, 1 Year Estimates, Table S2301 and B23001 Cleveland & Cuyahoga Health Data Matters Baseline: Cuyahoga 7.61%, Cleveland 13.9%, Ohio 5.7%)
5. Percentage of the population without health insurance (Source: U.S. Census Bureau. American Community Survey, 2016, 1 Year Estimates, Table S2701 and B27001 Cleveland & Cuyahoga Health Data Matters Baseline Cuyahoga 4.9%, Cleveland 7.4%, Ohio 5.6%)
6. Total violent crime rate per 100,000 population (crimes including murder, nonnegligent manslaughter, rape, robbery, and aggravated assault) (Source: Healthy Northeast Ohio (Ohio Department of Public Safety, Office of Criminal Justice Services) Baseline: 637.5 per 100,000, 2017)
7. Homicide rate per 100,000 population (Source: Cuyahoga County Board of Health Vital Stats (2019 CHNA Baseline: 14.2 in Cuyahoga and 28.3 in Cleveland, 2017)

STRATEGY

- Address the social determinants of health to improve physical and mental wellbeing.

ACTION STEPS

POVERTY

Continue the Medical Legal Partnership

- "Medical-legal partnerships (MLPs) integrate the unique expertise of lawyers into health care settings to help clinicians, case managers, and social workers address structural problems at the root of so many health inequities . . . . [MLPs leverage] legal services and expertise to advance individual and population health."[1]
- Two Legal Aid Society of Cleveland attorneys manage the St. Vincent Charity patient referrals related to civil legal needs. The types of cases handled include public benefits, housing, family, individual rights, consumer law, and more. Referrals come from social workers, nurses, physicians, counselors, case managers, chaplains, and other sources.

[1] https://medical-legalpartnership.org/

STRATEGIES TO ADDRESS THE PRIORITY HEALTH NEEDS *(continued)*

PRIORITY HEALTH NEED: ADDRESSING COMMUNITY CONDITIONS

POVERTY/TRANSPORTATION/ SAFETY (HOMICIDE/VIOLENCE)

ACTION STEPS

POVERTY *(continued)*

Development of a tailored patient Street Card

- Through the Medical-Legal Partnership between The Legal Aid Society of Cleveland and St. Vincent Charity, attorneys, patient advocates and social workers are creating targeted brochures to provide to patients that include the following topics:
  1. Applying for public benefits: food assistance, Medicaid, cash assistance, social security, how to get a photo ID or birth certificate, a safe place to get mail
  2. Housing search and application assistance
  3. Finding shelter
  4. Community resources
- These brochures are being written with vulnerable populations in mind, in particular for patients with mental health diagnoses and homeless individuals and families. The topics were selected after the Legal Aid attorneys were consistently seeing the same issues from St. Vincent Charity patients and seeing the difficulty patients had in navigating the traditional Street Card.

Continue to grow the reach and depth of work through the Health Literacy Institute.

- Study the effect of teach back technique on patient knowledge.
- Expand the number of trainings for hospital caregivers and health care providers in the community.

Expand the use of the food insecurity screening and improve access to healthy food for patients.

- Increase the use of the food insecurity two question screener which assesses for adequate quantity and quality of food at all times for a household.
- Streamline the process for linking food insecure patients to resources.

TRANSPORTATION

Potential expansion of Lyft service

- Non-emergency medical transportation is provided to patients using on-demand Lyft transportation. Rides are scheduled by caregivers as needed for patients attending outpatient chemical dependency treatment and appointments, diabetes education events, and patient discharges when other transportation is not available.
- In the future, Lyft may be used to transport patients to previously scheduled medical appointments.

Improve access and knowledge of reliable transportation options for patients

- Address transportation barriers such as knowledge of available options.
- Work with current hospital partners to maintain reliable rides for patients and address any barriers to access.
- Continue to assess the need for transportation and assist patients with scheduling rides to and from medical appointments.

STRATEGIES TO ADDRESS THE PRIORITY HEALTH NEEDS *(continued)*

PRIORITY HEALTH NEED: ADDRESSING COMMUNITY CONDITIONS

POVERTY/TRANSPORTATION/ SAFETY (HOMICIDE/VIOLENCE)

ACTION STEPS

SAFETY

Improve public safety through collaboration and caregiver education

- Cleveland Homicide Review Commission
  –Participation in the Cleveland Homicide Review Commission, an initiative through the Cleveland Division of Police to reduce the number of homicides. The commission is charged with creating innovative and effective responses and prevention strategies, prevention/intervention resources and strategic problem-solving analysis to better understand the problem.
- Human Trafficking Initiative
  –Membership in the Cleveland Collaborative to End Human Trafficking to effectively assess, respond, and care for minors and adults of human trafficking.
  –Caregiver training at least annually concerning identifying those at risk, linkage to resources and steps to protect the patient.
  –Develop a formal Human Trafficking policy and procedure.
- Photovoice Project
  –The Resilient Youth Program, facilitated by St. Vincent Charity, is part of the Photovoice Project.
  –The photovoice project involves youth in both the Central and Clark-Fulton neighborhoods. The project aims are to explore the perceptions of children and youth related to how their health and well-being are shaped by the neighborhood environment. An identified focus area is safety.

COLLABORATING PARTNERS

Legal Aid Society of Cleveland, Ohio Health Literacy Partnership, Greater Cleveland Food Bank, Hunger Network, Elite Transportation, Lyft, Cleveland Division of Police, Collaborative to End Human Trafficking, Resilient Youth Program

STRATEGIES TO ADDRESS THE PRIORITY HEALTH NEEDS *(continued)*

PRIORITY HEALTH NEED: ENHANCING MENTAL HEALTH AND REDUCING SUBSTANCE USE

MENTAL HEALTH/SUICIDE, OPIOID/ SUBSTANCE USE DISORDERS

GOALS

1. Reduce the number of overdose deaths
2. Reduce the number of suicide deaths

ANTICIPATED OUTCOMES

1. Reduce the number of deaths due to unintentional drug overdoses per 100,000 population by December 2022 (Source: Cuyahoga County Board of Health Vital Statistics (2019 CHNA)
2. Reduce the number of unintentional opioid-related deaths per 100,000 by December 2022 (Source: Cuyahoga County Board of Health/Cuyahoga County Medical Examiner's Office (2019 CHNA)
3. Reduce the total number of overdose deaths by December 2022 (Source: Cuyahoga County Medical Examiner's Office)
4. Reduce the age-adjusted death rate due to suicide by December 2022 (Source: Healthy Northeast Ohio (CDC))

INDICATORS

1. Number of deaths due to unintentional drug overdoses per 100,000 population (Source: Cuyahoga County Board of Health Vital Statistics (2019 CHNA (Baseline: 44.1 2015-2016)
2. Number of unintentional opioid-related deaths per 100,000 population (Source: Cuyahoga County Board of Health/Cuyahoga County Medical Examiner's Office (2019 CHNA) Baseline: 37.8 in Cuyahoga; 72.5 in Cleveland in 2017)
3. Reduce the total number of overdose deaths (most common drugs – heroin, cocaine, carfentanil, fentanyl, all opioids) (Source: Cuyahoga County Medical Examiner's Office Baseline: 632 deaths in 2019)
4. Age-adjusted death rate due to suicide (Source: Healthy Northeast Ohio (CDC) Baseline: 12.3 per 100,000 population 2015-2107)

STRATEGY

- Improve access to mental health services through expanded capacity and integrated care
- Institute patient screening in primary care to promote early identification of those in need of behavioral health services

ACTION STEPS

Integrated Care Model

- Planning for an integrated care pilot began in April 2019. Integrated care combines behavioral health care and primary care in one setting. It is a team-based, person-centered approach to care for individuals.
- Working with the National Council for Behavioral Health, St. Vincent Charity is drafting its business plan, staffing model, and partnership strategy.

Partial Hospitalization Program

- Added a chemical dependency focused partial hospitalization program (PHP) in 2019 with plans to expand capacity over the next two years.

On-demand Access

- Expanding hours to meet the needs of patients for on-demand access to chemical dependency services, including inpatient detoxification.
- Rosary Hall intake department will expand its hours to provide 24/7 intake and scheduling for chemical dependency treatment.

Screening, Brief Intervention, and Referral to Treatment (SBIRT)

- An evidence-based practice to early identification of substance use and behavioral health needs.
- Initial rollout will begin in the medical clinic of the HealthCare Center for all new and existing patients followed by all inpatient medical-surgical admissions, followed by all emergency department arrivals, and so on. Social workers and likely a peer counselor will be hired to drive care management for patients who agree to receive further services following positive screening results.
- Screening tools will be used to identify alcohol and drug use/abuse, anxiety, depression, and trauma.

COLLABORATIVE PARTNERS

ADAMHS Board of Cuyahoga County, Cuyahoga County Board of Health, National Council for Behavioral Health

STRATEGIES TO ADDRESS THE PRIORITY HEALTH NEEDS *(continued)*

PRIORITY HEALTH NEED: ENHANCING TRUST AND TRUSTWORTHINESS

TRUST AND TRUSTWORTHINESS

GOALS

1. Strengthen the relationship between the community and St. Vincent Charity in order to better address health needs.
2. Identify appropriate assessment tools and measurements of trust for future community surveys.
3. Include a question(s) on existing St. Vincent Charity program evaluation forms to assess the patient perception of trustworthiness.

ANTICIPATED OUTCOMES AND INDICATORS

1. **Long term:** Identify a valid and reliable assessment tool and benchmarks to measure trust and community involvement in initiative planning. Arnstein's Ladder of Citizen Participation is a potential tool to gauge the inclusion of community voice in decision making processes.
2. **Short term:** Establish a baseline measurement by adding a question(s) to existing St. Vincent Charity program evaluation forms regarding the perception of trustworthiness of the hospital by patients.

STRATEGY

- Assess and build trust within the community
  - ➔ between hospital/public health systems and residents
  - ➔ between clinicians and patients
  - ➔ between social service agencies/ community stakeholders and hospitals

ACTION STEPS

- Creation of the St. Vincent Charity Community Advisory Board (CAB) to serve as a link between St. Vincent Charity and the community. The CAB will serve to establish and facilitate an ongoing dialogue to rebuild and enhance the relationship between the hospital and community in an effort to inform the hospital's plans/programs to meet community needs.
- Opportunities for engagement of medical residents and caregivers in the community through the Reverse Ride Along. The Reverse Ride Along sponsored by the Sisters of Charity Foundation is a community based initiative intent on building networks of trust and collaboration between social servants and the constituents they serve. The discussions focus on health/health care with a strong emphasis on the social determinants of health.
- Collaboration with the CHNA Steering Committee to identify assessment tools and questions to evaluate the perception of trustworthiness.

COLLABORATING PARTNERS

St. Vincent Charity Community Advisory Board, Sisters of Charity Foundation, CHNA Steering Committee

EMERGING ALIGNED STRATEGIES

In addition to the individual strategies that each stakeholder is developing to address the identified health priorities, several emerging initiatives are underway that will allow stakeholders to work collaboratively on what are being described as "aligned strategies." These aligned strategies will complement the individual strategies underway and bolster the impact that all stakeholders can have to make a deeper impact on addressing the five identified priorities. Furthermore, these strategies demonstrate the progress that local health departments and hospitals have made to align not just their assessments but also their strategies as described in guidance developed by the Ohio Department of Health. The aligned strategies that have been selected in Cuyahoga County align with state population health efforts to address cross-cutting, upstream factors that impact health as described in the 2017-2019 SHIP.

Gaining consensus among all stakeholders was critical when determining which aligned strategies to work on collaboratively and a multi-step process was developed to achieve this which brought together hospitals, public health departments, community residents and other organizations. Goal statements tied to the five identified health priorities were created. Potential aligned strategies tied to the goal statements were developed by stakeholders and several rounds of voting determined which aligned strategies stakeholders were most interested in pursuing, the number of aligned strategies that should be developed (1 to 3) and the type of organizational resources that could be committed to supporting the development of these strategies. The results of this consensus building process yielded the following two aligned strategies – tied to goal statements and identified priorities – that will be developed from 2020-2022:

PRIORITY: ELIMINATING STRUCTURAL RACISM

GOAL

Develop a cross-sector systems change model to eliminate structural racism as a social determinant of health for Cuyahoga County.

STRATEGY

Co-create a systems model for change to eliminate structural racism using the Robert Wood Johnson Foundation/Public Health National Center for Innovations grant as a first step.

OBJECTIVE

By June 2022, develop short, intermediate and long-term action steps to affect structural racism in Cuyahoga County. Identified action steps will include community-generated ideas on multiple levels, from the neighborhood to organizational, policy, and systems change levels.

ANTICIPATED OUTCOMES

A collaboratively-developed systems change model focused on systems change and cross-sector alignment to address structural racism in Cuyahoga County.

ACTION STEPS

- Develop a community core modeling building team to develop and facilitate the group modeling building sessions and community meetings.
- Employ equity-grounded participatory group model building (GMB) using community-based system dynamics (CBSD) to create a systems change model to eliminate structural racism for Cuyahoga County. Community partners who have engaged in the selection of the aligned strategy will be included in the group model building work.
- Identify systems interventions that address structural racism and lack of trust through the systems model.
- Determine measures/indicators to help track progress.

EMERGING ALIGNED STRATEGIES *(continued)*

PRIORITY HEALTH NEED: ADDRESSING COMMUNITY CONDITIONS

GOAL

Increase shared responsibility to create healthy communities and environments to enable people to live to their full potential.

STRATEGY

Develop multi-organization partnership to better link social service resources and community through IT and on-the-ground strategies.

OBJECTIVE

Patients and community residents are better connected to community-based resources that can help address their social needs. By June 2022, there will be an established community-wide process and IT infrastructure for linking social needs of community members/patients with community-based organizations.

ANTICIPATED OUTCOME

Dedicated network of decision-makers tasked with identifying and implementing innovative solutions to link Cuyahoga County families to resources addressing social determinants of health; with the long-term expectation of a renewed system of care delivery that has a seamless connection between various health care providers.

ACTION STEPS

- Convene stakeholders to determine specific new strategies to better link community with social services (i.e. such as a community calendar, etc.)
- Increase access to important health and wellness resources through either the Healthy Northeast Ohio website or the development of a mobile application.
- Use learnings from the Data Across Sectors for Health mentorship with 2-1-1 San Diego to inform the development of a shared learning platform.

LONG-TERM COMPREHENSIVE COMMUNITY ENGAGEMENT STRATEGY

In addition, while not identified through the consensus-building process as one of the two aligned strategies, one of the other vitally important elements is to develop a long-term, comprehensive community engagement strategy that begins in 2020 and creates multiple levels of engagement in every part of the assessment and improvement planning process. This will continue to be developed in 2020 and will involve a robust network of community residents and all community health improvement planning organizational partners.

HEALTH NEEDS NOT BEING ADDRESSED IN THE IMPLEMENTATION STRATEGY

The CHNA highlighted the top 16 health needs identified by residents of Cuyahoga County using a comprehensive assessment of data, interviews, and focus groups. After the prioritization process there were 5 health priorities with subcategories (i.e. Chronic Disease – Diabetes and Cardiovascular disease) chosen for the IS. The following health needs from the initial 16 identified are not being specifically addressed in the IS for the following reasons. Appendix 3 provides a list of programs/services in the community to address the 5 health priorities.

Tobacco use is being addressed by the health departments with the Tobacco 21 initiative. Multiple cities in Cuyahoga County, including Cleveland, have passed ordinances prohibiting the sale of tobacco, tobacco-related products and alternative delivery devices to anyone under the age of 21. The Cuyahoga County Board of Health provides monitoring and inspections for permits to businesses to sell tobacco products. Tobacco use is addressed by Respiratory Therapy for inpatients who screen positive for tobacco use and for outpatients in the Lung Cancer Screening Clinic through education and goal setting. All outpatient areas of the hospital provide patient counseling and educational resources for smoking cessation.

Lack of physical activity is being addressed by multiple community organizations including the Cuyahoga County Board of Health through Creating Healthy Communities focused on policy, systems, and environmental changes within the community, schools, and the workplace. Physical activity is addressed in clinical areas of the hospital through patient education and outpatient Cardiac Rehabilitation services.

Flu vaccine rates are addressed by the health departments who track influenza and vaccination rates and also provide Immunization Clinics to residents. St. Vincent Charity addresses prevention of influenza for all caregivers and patients by offering vaccination for all who are appropriate.

Childhood asthma is being addressed by Better Health Partnership through its work with primary care to connect families to resources in the community and mapping to identify neighborhoods with high rates of asthma to inform programming. The Cleveland Department of Public Health, MetroHealth System, and the non-profit Environmental Health Watch are working on the project “Engaging the Community in New Approaches to Healthy Housing,” targeting neighborhoods where residents have high rates of asthma, lead poisoning and COPD. The project includes inspections and home assessments, identifying families at risk, mapping areas likely to pose significant health hazards and expanding on the asthma prevention program with home visits to high-risk patients in these neighborhoods. Childhood asthma is not being addressed by St. Vincent Charity as it does not serve the pediatric population.

Infant mortality is being addressed by multiple community partners. The Cleveland Department of Public Health coordinates MomsFirst to provide mothers and fathers with education, home visits and care coordination. First Year Cleveland is focused on reducing racial inequities, addressing extreme prematurity and eliminating sleep-related infant deaths through gathering data, aligning programs and coordinating systems. Infant mortality is not being addressed by St. Vincent Charity as it does not offer Obstetric or Pediatric services.

Lead poisoning is addressed by the Cuyahoga County Board of Health’s Lead Poisoning Prevention Program providing environmental assessments, free home repairs, blood lead testing and case management for children with elevated levels. The Cleveland Department of Public Health also has a Lead Safe Living program to help residents find resources. Lead poisoning is an issue that mainly affects the pediatric population, which St. Vincent Charity does not serve.

COLLABORATORS

2019 CHNA Steering Committee

Assim Alabdulkader, MD, MPH, Preventive Medicine Resident, Case Western Reserve University and University Hospitals

Terry Allan, Cuyahoga County Board of Health

Leslie Andrews, St. Vincent Charity Medical Center

Elyse Bierut, University Hospitals

Debbie Borowske, Southwest General Health Center

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Patricia Cirillo, PhD, Cypress Research Group

Karen Cook, MetroHealth

Kirstin Craciun, The Center for Health Affairs – Co-Chair

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Elizabeth Fiordalis, Cleveland Clinic

Merle Gordon, Cleveland Department of Public Health

Heidi Gullett, MD, MPH, Case Western Reserve University School of Medicine – Co-Chair

Martha Halko, Cuyahoga County Board of Health

Chris Kippes, Cuyahoga County Board of Health

Candice Kortyka, The Center for Health Affairs

Jonathan Lever, Better Health Partnership

Benjamin Miladin, United Way of Greater Cleveland

Frances Mills, Cleveland Department of Public Health

Adam Nation, Cleveland Department of Public Health

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Patricia Terstenyak, The Center for Health Affairs

St. Vincent Charity Community Benefit Committee

Leslie Andrews, Diabetes Education

Kaitlyn Cannone, Behavioral Health

Dr. Gregory Hall, MD

Orlando Howard, Rosary Hall

Cathy Kopinsky, Mission Outreach

Fonda McClain, HealthCare Center

Louise Motley, Health Care Navigator

Maureen Nagg, Marketing

Thom Olmstead, External Affairs

Ben Silver, Quality

Julie Terlizzi, HealthCare Center

St. Vincent Charity Community Advisory Board
St. Vincent Charity Caregivers:

Leslie Andrews, Certified Diabetes Educator

Marijo Atkinson, Patient Advocate

Mike Biscaro, Psy.D., ABPP (Forensic)
Chief, Behavioral Health

Jody Blessing, Nurse Director, Cardiovascular Services; Acting CNO

Sr. Miriam Erb, VP, Mission & Ministry

Cathy Kopinsky, Project Coordinator, Mission Outreach

Carrie Lang, Project Coordinator, External Affairs

Anne Messer, Patient Advocate

Jan Murphy, President & CEO

Thom Olmstead, Director, External Affairs

Shannan Ritchie, COO

Adnan Tahir, MD, Chief Clinical Officer

COLLABORATORS *(continued)*

Community Organizations:

Roderick H. Adams, Jr., Senior Warden,
St. Andrew's Episcopal Church

Yolanda Armstrong, President/CEO,
Friendly Inn Settlement, Inc.

Erika Bell, Community Relations Manager,
Tri-C, Metro Campus

Lydia Bert, Center Director, MetroHealth

Joylyn Billy, Outreach Coordinator, St. John A.M.E.

Joe Black, Promise Engagement Manager,
Promise Neighborhood

Beverly Burgess, External Affairs Specialist,
Care Alliance

Councilwoman Phyllis Cleveland, Ward 5 City Council

Delores Collins, Executive Director, A Vision of Change

Kelly Gibbs, Principal, Marion-Sterling School

Dawn Glasco, Community Engagement Coordinator,
Promise Neighborhood

Delores Gray, Resident Council President,
Cedar High Rise

Gregory Hall, MD, Director, Urban Health, CSU/NEOMED

Rick Kemm, Executive Director, May Dugan Center

Mark Lammon, Executive Director, Campus District, Inc.

Bill Myers, Manager, Central Recreation Center

Scott Osiecki, CEO, ADAMHS Board of Cuyahoga County

Veronica Robinson, Promise Ambassador, Promise
Neighborhood, Executive Director, Hand & Hand Inc.,
Committee Chair, Cuyahoga County Office of ReEntry

Fredy Robles, Chief Program Officer, Catholic Charities

Monica Rudzinski, Branch Manager, Cleveland Public
Library, Sterling Branch

Commander Dorothy Todd, Cleveland Police
Third District

Julius Warfield, Pastor, St. Phillips Church

Andrea Wasdovich-Duffner, Director,
Project H.O.P.E. of Cleveland

The following public health partners informed the creation of an aligned strategy:

Terry Allan, Cuyahoga County Board of Health

Romona Brazile, Cuyahoga County Board of Health

Merle Gordon, Cleveland Department of Public Health

Dr. Heidi Gullett, Case Western Reserve School of
Medicine / HIP-Cuyahoga

Martha Halko, Cuyahoga County Board of Health

Frances Mills, Cleveland Department of Public Health

Nichelle Shaw, Cuyahoga County Board of Health

Adam Nation, Cleveland Department of Public Health

The following community stakeholders participated in facilitated discussions that yielded the two aligned strategies:

Marilyn Burns, Community Resident

Delores Collins, A Vision of Change

Sara Continenza, Food Strong

Reverend Earnest Fields,
Calvary Hill Church of God in Christ

Cheryl Johnson, Community Resident

Tracy McArthur, PQRST Center

Alexander Robertson, Recess Cleveland

Barbara Wilcher, Neighbor-to-Neighbor Facilitator /
Community Resident

COLLABORATORS *(continued)*

Hospitals

Leslie Andrews, St. Vincent Charity Medical Center

Jacque Bailey, Cleveland Clinic

Nazleen Bharmal, Cleveland Clinic

Elyse Bierut, University Hospitals

Pam Brys, University Hospitals

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Chesley Cheatham, University Hospitals

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Karen Cook, MetroHealth

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Mary Kiczek, University Hospitals

Candace LaRochelle, University Hospitals

Rasheeda Larkin, Cleveland Clinic

Cheryl O'Malley, Southwest General Health Center

Thom Olmstead, St. Vincent Charity Medical Center

Danielle Price, University Hospitals

Philip Rowland-Seymour, University Hospitals

Colletta Somrack, University Hospitals

Jennifer Walker, University Hospitals
Rainbow Babies & Children's Hospital

Kathy Wesolowski, University Hospitals
Rainbow Babies & Children's Hospital

Chantel Wilcox, Cleveland Clinic

Other

Greg Brown, Policy Bridge

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QUALIFICATIONS OF CONSULTING CONTRIBUTORS

The process to develop this IS was facilitated by Kirstin Craciun, Director of Community Outreach, The Center for Health Affairs and Dr. Heidi Gullett, MD, MPH, Case Western Reserve University School of Medicine.

The report was written by Leslie Andrews, Diabetes Coordinator, St. Vincent Charity Medical Center and Kirstin Craciun with input from Thom Olmstead, Director of External Affairs, Danielle Price, Director, Community Engagement, University Hospitals and Dr. Heidi Gullett.

The Center for Health Affairs, Cleveland, Ohio

The Center for Health Affairs is the leading advocate for Northeast Ohio hospitals. With a rich history as the Northeast Ohio hospital association, dating back to 1916, The Center serves as the collective voice of 36 hospitals spanning nine counties.

The Center recognizes the importance of analyzing the top health needs in each community while ensuring hospitals are compliant with IRS regulations governing nonprofit hospitals. Since 2010, The Center has helped hospitals fulfill the CHNA requirements contained within the Affordable Care Act. More recently, The Center has helped hospitals coordinate their community health planning efforts with those of public health departments to ensure alignment with state population health guidance. Beyond helping hospitals with the completion of timely CHNA reports, The Center spearheads the Northeast Ohio CHNA Roundtable, which brings member hospitals and other essential stakeholders together to spur opportunities for shared learning and collaboration in the region.

The Center's contribution to the 2020-2022 Implementation Strategies for the Cuyahoga Community Health Partners - included meeting facilitation, writing report narrative and project management - was led by The Center's community outreach director, supported by the Member Services project manager and overseen by The Center's senior vice president of member services.

More information about The Center for Health Affairs and its involvement in CHNAs can be found at www.chanet.org.

Heidi Gullett, MD, MPH, Associate Professor of Family Medicine, Inaugural Appointee of the Charles Kent Smith, MD and Patricia Hughes Moore, MD Professorship in Medical Student Education in Family Medicine. Dr. Gullett is dually board-certified in Preventive Medicine and Family Medicine and maintains a robust clinical practice at Neighborhood Family Practice on Cleveland's west side.

Dr. Gullett is involved in medical education, teaches medical students and Family and Preventive Medicine residents is a leader of the Block 1 first-year curriculum and are Associate Program Director for the Public Health/ General Preventive Medicine residency.

For the past four years, Dr. Gullett has been embedded as the School of Medicine population health liaison at the Cuyahoga County Board of Health. Her responsibilities include building partnerships between public health and clinical care in an effort to achieve health equity through community health improvement. She also serves as co-chair of the Health Improvement Partnership-Cuyahoga (HIP-Cuyahoga), a large cross sector community health improvement consortium.

Her research, supported by a career development award from the American Cancer Society, heavily focuses on cancer prevention and helping people move out of poverty. Dr. Gullett is passionate about the realization of equity through authentic long-term partnerships and collective impact.

CONTACT FOR INFORMATION

For more information, questions or to obtain a copy of the Community Health Needs Assessment or Implementation Strategy please contact:

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To access the Community Health Needs Assessment or Implementation Strategy please visit the links below:

2019 Community Health Needs Assessment
https://www.stvincentcharity.com/media/1525/ 2019-chna-final.pdf

2020 – 2022 Implementation Strategy
https://www.stvincentcharity.com/about/community-benefit/

APPENDIX 1

Ohio 2017-2019 state health improvement plan (SHIP)

Overall health outcomes

- ⬆ Health status
- ⬇ Premature death

3 priority topics

Mental health and addiction	Chronic disease	Maternal and infant health

10 priority outcomes

⬇ Depression	⬇ Heart disease	⬇ Preterm births
⬇ Suicide	⬇ Diabetes	⬇ Low birth weight
⬇ Drug dependency/ abuse	⬇ Child asthma	⬇ Infant mortality
⬇ Drug overdose deaths		

Equity: Priority populations for each outcome above

Cross-cutting outcomes and strategies

The SHIP addresses the 10 priority outcomes through cross-cutting factors that impact all 3 priority topics

Cross-cutting factors	Strategies to promote:
Social determinants of health	Student success Economic vitality Housing affordability and quality
Public health system, prevention and health behaviors	Tobacco prevention and cessation Active living Healthy eating Violence-free communities Population health infrastructure
Healthcare system and access	Access to quality health care Comprehensive primary care
Equity	Strategies likely to decrease disparities for priority populations

2 The SHIP includes outcome indicators and evidence-based strategies for each cross-cutting factor.

APPENDIX 1 *(continued)*

The 2019 State Health Assessment (SHA) for Ohio illustrates the overall health and wellbeing of residents.

The SHA was developed with input from Ohioans through forums, online surveys, the advisory committee and steering committee.

Key findings include:
- A 1.1 year drop in life expectancy from 77.6 years in 2010 to 76.5 years in 2017.
- Life expectancy disparities for those who are African American (72.8), have lower income, disabilities or live in Appalachian counties.
- A need to address cross-cutting factors including access to mental health care, income, unemployment, transportation, racism, tobacco use, physical activity, adverse childhood experiences, lead poisoning and access to dental care.
- Mental health and addiction, chronic disease and maternal and infant health remain significant challenges.

Top Priorities
- Mental Health and addiction
- Chronic disease
- Maternal and infant health

Cross-cutting factors
- Poverty
- Transportation
- Physical activity and nutrition
- Access to care

Next steps include the development of the 2020-2022 State Health Improvement Plan including priorities, objectives and evidence-base strategies for multiple sectors in and outside the realm of health.

APPENDIX 2

COMMUNITY HEALTH PRIORITIES

Top Health Needs

Community voice, community stakeholder, hospital, and secondary data in the 2019 Cuyahoga County CHNA helped paint a picture of the health status of Cuyahoga County residents and areas that should be the focus of improvement. The list that follows illustrates the 16 health issues that were identified by the data subcommittee upon reviewing all data sources that comprised the 2019 Cuyahoga County CHNA. These issues were then further prioritized using a highly participatory collaborative process to identify the five highest priority issues to be addressed in the 2020-2022 Implementation Strategy / Community Health Improvement Plan.

Overarching
- Trust
- Structural racism

Quality of Life
- Poverty
- Food insecurity
- Transportation
- Homicide / violence / safety

Health Behaviors
- Tobacco use
- Lack of physical activity
- Flu vaccine rates

Chronic Disease
- Cardiovascular disease
- Childhood asthma
- Diabetes

Mental Health and Addiction
- Mental health / suicide
- Opioids / substance use disorders

Maternal / Child Health
- Infant mortality
- Lead poisoning

Many of the top health and safety concerns for Cuyahoga County were selected based on Cuyahoga County comparing unfavorably to the state and national benchmarks, such as cardiovascular disease and homicide / violent crime rates. Some of the top health needs were chosen because certain population groups in Cuyahoga County experience these conditions at high rates, such as higher rates of infant mortality among Black, non-Hispanic individuals, for example. Poverty was selected given that many inequities in access to care and health outcomes are based on socioeconomic status.

APPENDIX 3

INVENTORY OF CURRENT STAKEHOLDER-SPECIFIC PROGRAMS THAT RELATE TO THE 5 PRIORITIES

2019 CHNA Priorities	*Strategy/Program*	*CCBH*	*CDPH*	*Metro*	*St. Vincent*	*SWGH*	*UH*
Overarching Priorities							
Structural Racism*	Creating Healthy Communities Program - Supermarket Access	X					
	Maternal and Child Health Program	X	X				
	Racial and Ethnic Approaches to Community Health	X	X				
	EDI Training in Internal Workforce Development		X				
	Annual Internal Cultural Competence Training		X		X	X	
	Race, Ethnicity and Language		X	X			
	All policies and procedures do not discriminate on race, sex, religion				X	X	
	Health Scholars						X
	Trauma Informed Care/Bias education		X				X
	Centering Pregnancy						X
Trust**	Breast and Cervical Cancer Prevention Program	X					X
	Creating Healthy Communities Program - Supermarket Access	X					
	Lead Safe Cleveland Coalition Membership		X				
	Gain Health Literacy Champion Designation		X				
	Collection of Client/Patient Satisfaction Data		X				
	Institute for H.O.P.E.			X			
	EcoDistrict			X			
	Buckeye Community Resource Center			X			
	Reverse Ride Along through the Sister of Charity Foundation for caregivers/medical residents. Community based initiative to build trust and collaboration between medical professionals and the community they serve				X		
	Community Advisory Board				X	X	
	Health Navigator				X	X	
	24/7 hot-line to connect community members to critical care nurse and NPs					X	
	Web-based social media platform to educate individuals on the programs at SW-Working with local communities to help bridge the gaps in care and education					X	
	Multiple support groups for HF, CA, Mental Health					X	
	Educational talks, support groups, connection				X	X	X

APPENDIX 3 *(continued)*

INVENTORY OF CURRENT STAKEHOLDER-SPECIFIC PROGRAMS THAT RELATE TO THE 5 PRIORITIES

2019 CHNA Priorities	*Strategy/Program*	*CCBH*	*CDPH*	*Metro*	*St. Vincent*	*SWGH*	*UH*
Community Conditions							
Poverty	Racial and Ethnic Approaches to Community Health	X	X				
	Ryan White HIV/AIDs Part A	X					
	Healthy Homes Program	X	X				
	Creating Healthy Communities Program	X					
	Monthly Mobile Food Pantry		X				
	Open Table			X			
	Medical-Financial Partnership (with ESOP)			X			
	Resilient Youth Program at Cleveland Central Recreation						
	Financial Counseling				X	X	
	Medical Legal Partnership				X		
	Food Insecurity Screener with links to resources				X		
	Medication assistant program for patients with cancer					X	
	Transportation for those who need rides to appointments					X	
	Free screenings -basic health					X	
	Youth Summer Lunch Program						X
	Education on financial assistance programs						X
	Step Up to UH						X
	Health Scholars Internship & Beachwood Medical Academy						X
	Food for Life Market						X
	Meals on Wheels program						X
	Community resource fair: Breakfast with Santa						X
	Rainbow Connects, SDOH screening and support services						X
	Dental van						X
Homicide/Violence/Safety	Continue to convene the Healthy Cleveland Initiative Violence Prevention Committee		X				
	Violence Interrupters (via NOTS - Northern Ohio Trauma Systems)			X			
	Trauma Recovery Center			X			
	Center for Community Health Resilience			X			
	Healing Circles (Faith-based Outreach)			X			
	Mental health support groups		X			X	
	Community nurse education					X	
	Working with local high schools for prevention education					X	
	Violence Interrupters						X
	Cleveland Collaborative to End Human Trafficking				X		
	Resilient Youth Photo Voice Project				X		
	Stop the Bleed						X

APPENDIX 3 *(continued)*

INVENTORY OF CURRENT STAKEHOLDER-SPECIFIC PROGRAMS THAT RELATE TO THE 5 PRIORITIES

2019 CHNA Priorities	*Strategy/Program*	*CCBH*	*CDPH*	*Metro*	*St. Vincent*	*SWGH*	*UH*
Transportation	Racial and Ethnic Approaches to Community Health	X					
	Ryan White HIV/Aids Part A	X					
	Safe Routes to School	X	X				
	Bus Tickets for Outpatient/Inpatient				X		
	Lyft services for hospital discharge and outpatient programs				X	X	
	Elite Transportation for outpatient services				X		
	Transportation program that provides rides within our taxing district to and from appointments					X	
	Bus passes					X	X
Chronic Disease							
Cardiovascular Disease	Creating Healthy Communities Program	X					
	Racial and Ethnic Approaches to Community Health	X	X				
	Farm to School	X					
	Ohio Healthy Program	X					
	Early Ages Healthy Stages Coalition	X					
	Tobacco 21	X	X				
	Collect and report neighborhood level data on heart disease incidence and mortality		X				
	Smoking cessation		X	X		X	
	Community-Clinical Linkages (via BHP)			X			
	Community Health Screenings/Education				X		
	Medication Therapy Management in Outpatient Pharmacy				X	X	
	Coumadin Clinic				X	X	
	Stroke Prevention Screening					X	
	Tobacco Screening				X	X	
	Central Community Healthy Group - residents promoting healthy eating, stroke education and disease prevention at neighborhood events				X		
	Chronic care clinic that provides care for those individuals who need extra assistance-TCM-CCM program with RN and Pharmacist					X	
	Telemedicine for our HF and COPD patients-Healthy eating programs-Healthy Heart, Grey Maters, Circulation Circuit-Full cardiovascular screenings					X	
	Transitional nurse program that will go into the patients home after D/C from the hospital-Navigator role for Chronic Care Services					X	
	Health education and screenings (includes cancer / Seidman's new mobile health unit)					X	X
	Nutrition outreach program at Dave's teaching kitchen						X
	School and community-based career/health education					X	X

APPENDIX 3 *(continued)*

INVENTORY OF CURRENT STAKEHOLDER-SPECIFIC PROGRAMS THAT RELATE TO THE 5 PRIORITIES

2019 CHNA Priorities	*Strategy/Program*	*CCBH*	*CDPH*	*Metro*	*St. Vincent*	*SWGH*	*UH*
Diabetes	Collect and report neighborhood level data on diabetes incidence and mortality		X				
	VIDA!			X			
	Food As Medicine			X			
	Diabetes Self-Management			X		X	
	Fresh Produce Distribution		X	X			
	Diabetes Inpatient/Outpatient Education Program				X	X	
	Diabetes Support Group				X	X	
	Political Advocacy through the American Association of Diabetes Care and Education Specialists –Ohio Board and Northeast Ohio Chapter				X		
	Community Health Screenings/Education				X	X	
	Foot screenings by Podiatry through Project H.O.P.E.				X		
	Free screening for patients to detect diabetes					X	
	Community nurses education					X	
	Comprehensive wound care program					X	
	Screenings					X	X
Mental Health / Addiction							
Suicide	Mental Health - EAHS - Social Emotional Health - ACE's	X	X				
	School Health Program/SAFE (Students Are Free to Express)			X			
	Comprehensive inpatient and outpatient services					X	
	Strongsville & Columbia Station high school education programs					X	
Substance/Opioid Use Disorder	Cuyahoga County Overdose Data to Action (OD2A) Initiative	X					
	CenterPoint (Outpatient Treatment Groups)		X				
	Project Dawn (Narcan / Opioid Education)		X				
	Office of Opioid Safety - multiple programs			X			
	Project DAWN (Deaths Avoided with Naloxone)		X	X			
	Psychiatric Emergency Department				X		
	Rosary Hall/ Rosary Hall Lyft Program				X		
	Addiction Education Family Sessions				X	X	
	Hospital wide Screening Brief Intervention and Referral to Treatment (SBIRT)				X		
	Tele-psychiatry Pilot				X		
	Partial Hospitalization Program				X		
	Breakthru program - Participating in Safe Passages Program					X	
	Comprehensive inpatient and outpatient services including adolescents - intake/Assessment team in the ED					X	

APPENDIX 3 *(continued)*

INVENTORY OF CURRENT STAKEHOLDER-SPECIFIC PROGRAMS THAT RELATE TO THE 5 PRIORITIES

2019 CHNA Priorities	*Strategy/Program*	*CCBH*	*CDPH*	*Metro*	*St. Vincent*	*SWGH*	*UH*
	ED adopted guidelines for prescribing opioids-no replacement for lost prescriptions-Ohio automated RX reporting system					X	
	Education and awareness of opiate abuse		X				X
	Awareness of non-pharmacological pain management						X
	UH MOMS (Maternal Opiate Medical Support)						X
	Northeast Ohio Hospital Opioid Consortium			X	X		X
Other Mental Health	Mom Power (Group parenting / mental health intervention)						X
	Stress reduction classes: Mindfulness, acupuncture, massage, music therapy						X

***Structural Racism: Racial bias across and within society. The cumulative and compounded effects of a range of factors such as public policies, institutional practices, cultural representations, and other norms that work in various, often reinforcing ways to maintain racial inequity**

****Trust**
→ between Hospital/Public Health Systems and Residents
→ between Clinicians and Patients
→ between Social Service Agencies / Community Stakeholders and Hospitals