ST. VINCENT CHARITY
MEDICAL CENTER

A Ministry of the Sisters of Charity Health System

COMMUNITY HEALTH NEEDS ASSESSMENT

2013-2016 Implementation Plan

Table of Contents

Executive Summary Page 3

Partners Page 6

Strategic Planning Model Page 7

Needs Assessment & Priorities Pages 8-10

Strategy #1 Decrease the number of adults who are overweight or obese Pages 11-15

Strategy #2 Increase access and awareness to substance abuse and mental health services Pages 16-24

Strategy #3 Increase health care access Pages 25-32

Measuring Outcomes & Contact Information Page 33

Executive Summary

For nearly 150 years, St. Vincent Charity Medical Center has been committed to serving the needs of the community by extending the healing mission of Jesus. Inspired by the example of our founders, the Sisters of Charity of St. Augustine (CSA), we have a legacy of identifying and serving the unmet needs of the community.

One of the tools we use today to assist in that effort is the Community Health Needs Assessment (CHNA). The Cuyahoga County Health Partners, comprised of member hospitals and healthcare providers of the Center for Health Affairs, came together to commission the 2012 Cuyahoga Community Health Needs Assessment. This comprehensive survey tool identified specific health needs in the community.

Based on data gathered from this unique county-wide collaboration, the St. Vincent Charity Medical Center Community Benefit Planning Committee met over a period of months to define priority health issues that the hospital will address. This process allows us to focus our resources toward prevention, education, wellness and outreach that will have the greatest impact on the community we serve.

This report identifies the community health needs served by St. Vincent Charity Medical Center as well as the hospital's ability to impact those needs. This process and document ensure that St. Vincent Charity Medical Center is in accordance with the Internal Revenue Service and the Patient Protection and Affordable Care Act of 2010.

Mission and Values

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 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.

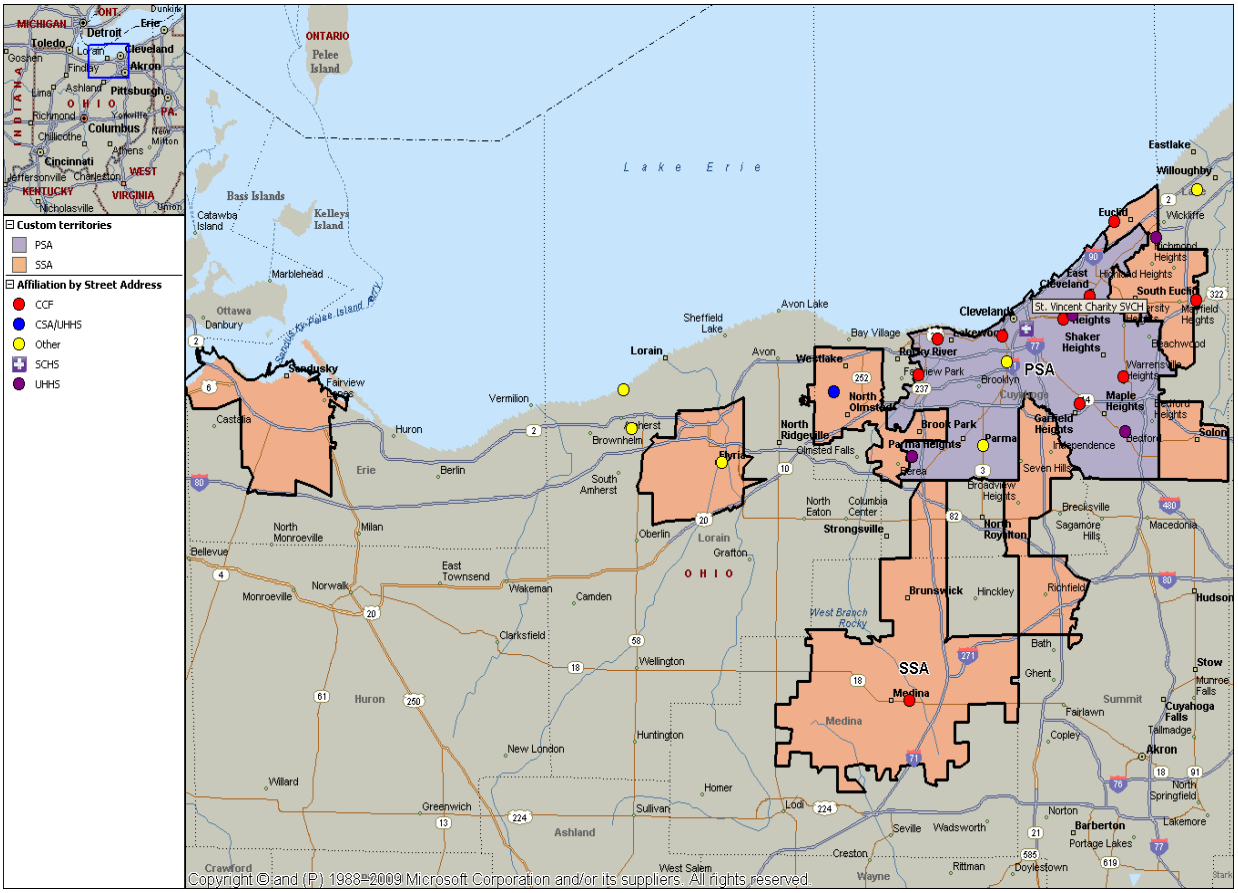
Quality
We are committed to continuous improvement of our services to better each life as if it were our own.

Team Work
We celebrate the opportunity to come together as Caregivers in an inclusive workplace where diversity and open communication are valued.

CEO Statement on Diversity and Inclusion

Diversity and inclusion is a much broader concept than numbers and ratios. It's bringing to the table individuals with the broadest range of ideas, perspectives, cultural views and experiences to create a stronger, more dynamic organization.

Primary and Secondary Service Areas



PSA = ZIP Codes from which the hospital draws 75 percent of its inpatients
SSA = ZIP Codes from which the hospital draws the next 15 percent of its

Strategies

Priority Health Issues for St. Vincent Charity Medical Center
1. Decrease the number of adults who are overweight or obese
2. Increase access and awareness to substance abuse and mental health services
3. Increase health care access

Target Impact Areas:

To decrease adult weight control issues, St. Vincent Charity Medical Center will focus on the following target impact areas: 1) Promote healthy living 2) Increase consumption of fruits and vegetables, and 3) Increase opportunities for physical activity.

To increase awareness of substance abuse and mental health issues, St. Vincent Charity Medical Center will focus on the following target impact areas: 1) Increase education and screening 2) Implement a pain management program, and 3) Initiate the feasibility study of a geriatric psychiatry unit.

To increase health care access, St. Vincent Charity Medical Center will focus on the following target impact areas: 1) Increase patient advocacy, 2) Decrease hospital readmissions.

Strategies, continued

Action Steps:

To work toward **decreasing adult weight control issues**, the following action steps are recommended: 1) Increase healthier food options for staff, patients and visitors at St. Vincent Charity Medical Center 2) Increase awareness and availability of healthy food in the community, 3) Develop a medically supervised weight loss program, and 4) Develop an employee wellness program for St. Vincent Charity Medical Center.

To work toward **increasing access and awareness to substance abuse and mental health services,** the following actions steps are recommended: 1) Increase education of physicians and primary care providers on substance abuse and mental health issues, 2) Increase the number of ER physicians and primary care providers who screen for alcohol and drug abuse, 3) Increase the number of ER physicians and primary care providers who screen for depression and mental health issues, 4) Implement a pain management program, and 5) Initiate a feasibility study of creating an expanded geriatric psychiatry unit.

To work toward **increasing health care access,** the following actions steps are recommended: 1) Increase patient advocacy and decrease patient readmissions through use of patient navigator, 2) Increase the overall health and wellness of the Hispanic Community, 3) Increase coordination of services with Federally Qualified Health Centers (FQHC), and 4) Increase patient success at home.

Partners

Acknowledgements

St. Vincent Charity Medical Center wishes to acknowledge the numerous contributions of the following partners and stakeholders.

St. Vincent Charity Medical Center Community Benefit Planning Committee Members:

David F. Perse, MD-President and CEO, St. Vincent Charity Medical Center
Joan Ross- Chief Operating Officer, St. Vincent Charity Medical Center
John Rusnaczyk- Chief Financial Officer, St. Vincent Charity Medical Center
Susan Howell – Chief Nursing Officer, St. Vincent Charity Medical Center
Beverly Lozar- Vice President, Professional and Support Services, St. Vincent Charity Medical Center
Sister Mary Ann Mozser, CPPS- Vice President, Mission and Ministry, St. Vincent Charity Medical Center
Wendy Hoke- Senior Director of Marketing and Communications, St. Vincent Charity Medical Center
Ted Monczewski, Director of Human Resources, St. Vincent Charity Medical Center
Carol Johlin, Director of Behavioral Health, St. Vincent Charity Medical Center
Orlando S. Howard- Clinical Manager Rosary Hall, St. Vincent Charity Medical Center
Helen Dumski- Director Center for Bariatric Surgery, St. Vincent Charity Medical Center
Robin Bachman- Assistant Vice President, Government Affairs & Public Policy, Sisters of Charity Health System
Cathy Kopinsky- Mission Outreach, St. Vincent Charity Medical Center
Lisa Triska- Health Care Navigator, St. Vincent Charity Medical Center
Leslie Andrews, RN, BS, MPA, Diabetes Coordinator, St. Vincent Charity Medical Center

The data used to support the strategies in this plan is derived from the 2012 Cuyahoga County Community Health Needs Assessment, led and supported by the Center for Health Affairs.

This strategic planning process was facilitated by Britney Ward, MPH, Assistant Director of Health Planning, and Michelle Von Lehmden, Health Assessment Coordinator, both from the Hospital Council of Northwest Ohio.

About the Hospital Council of Northwest Ohio

The Hospital Council of Northwest Ohio has been in existence since 1972. HCNO has 24 full members and 9 Affiliate/Associate members. The Council is a member-driven organization that represents and advocates on behalf of its member hospitals and health systems and provides collaborative opportunities to enhance the health status of the citizens of Northwest Ohio. HCNO helps counties to create, build or enhance coalitions to work collaboratively on the health assessment process.

Strategic Planning Model

Beginning in February 2013, the St. Vincent Charity Medical Center Community Benefit Planning Committee formally met five (5) times and completed the following planning steps:

1. ***Choosing Priorities***—Use of quantitative and qualitative data to prioritize target impact areas

2. ***Ranking Priorities***—Ranking the health problems based on magnitude, seriousness of consequences, and feasibility of correcting

3. ***Resource Assessment***—Determine existing programs, services, and activities in the community that address the priority target impact areas and look at the number of programs that address each outcome, geographic area served, prevention programs, and interventions

4. ***Gap Analysis***—Determine existing discrepancies between community needs and viable community resources to address local priorities; Identify strengths, weaknesses, and evaluation strategies; and Strategic Action Identification

5. ***Best Practice***—Review of best practices and proven strategies, Evidence Continuum, and Feasibility Continuum

6. ***Draft Plan***—Review of all steps taken; Action step recommendations based on one or more the following: Enhancing existing efforts, Implementing new programs or services, Building infrastructure, Implementing evidence based practices, and Feasibility of implementation

Needs Assessment

The Community Benefit Planning Committee reviewed the 2012 Cuyahoga County Health Assessment. Each member completed an "Identifying Key Issues and Concerns" worksheet. The following table is the group's results.

What are the most significant <u>ADULT</u> health issues or concerns identified in the 2012 assessment report?

Key Issue or Concern	% of Population Most at Risk	Age Group Most at Risk	Gender Most at Risk
1. <u>Cardiovascular Health</u>			
High Blood Pressure	38% of total county population 49% of African American Population	Ages 65+ (59%)	Males (46%)
High Blood Cholesterol	38% of total population **43% of St. Vincent's primary service area**	Ages 65+ (68%)	Males (46%)
2. <u>Weight Control Issues</u>			
Obesity	24% of total county population obese/43% overweight **27% of St. Vincent's primary service area** 37% of African American population	Ages 30-64 (30%) Income <25K (31%)	Females (25%)
Diabetes	9% of total county population **10% of St. Vincent's primary service area** 17% of African American Population	Ages 65+ (14%)	Males & Females
3. <u>Women's Health Issues</u>			
***2006-2008 female age - adjusted breast cancer mortality rate was higher than the state. (26.2%)**			
***2006-2008 female age - adjusted uterine cancer mortality rate was higher than the state. (6.6%)**			
Mammograms	38% Mammogram in past year	Income <25K (34%)	Females
Pap Smears	45% Had pap smear in past year	Income <25K (30%)	Females

Key Issue or Concern	% of Population Most at Risk	Age Group Most at Risk	Gender Most at Risk
4. <u>Mental Health Issues</u>			
Depression	10% of total county population depressed 17% of African American Population	Income <25K (20%)	Females (12%)
4. <u>Substance Abuse Issues</u>			
Binge Drinking	42% of drinkers binged in past month	Income <25K (51%)	Males (49%)
Drinking and driving	11% of total population		Males (15%)
Medication misuse	9% of total population	Income <25K (11%)	Males & Females
6. <u>Healthcare Access</u>			
Transportation Issues	No car 6% No driver's license 4% Unable to afford gas 3% Limited public transportation 3%		Males & Females
Did not get a prescription filled from doctor	Didn't think they needed it 11% Could not afford it 8% No insurance 5% Took less than prescribed 4%		Males & Females

Priorities Chosen

The St. Vincent Charity Medical Center Community Planning Committee completed an exercise where they ranked the key issues based on the **magnitude of the issue**, **seriousness of the consequence**, and the **feasibility of correcting the issue**. A total score was given to each priority. The max score was 30. All committee members' scores were combined and then average numbers were produced. Based off these parameters, the group decided to focus on the following three issues: weight control, substance abuse/mental health and healthcare access. The results were sent out to the full committee for approval.

The rankings were as follows:

1. Cardiovascular Health (25)
2. Weight Control Issues (24.4)
3. Substance Abuse Issues (22.4)
4. Health Care Access (22.1)
5. Mental Health (21.4)
6. Women's Health (19.7)

Priorities Handled by Other Providers

The Committee's decision not to focus on the other priorities identified—cardiovascular health and women's health—was based on the availability of those services elsewhere. Women's Health Services are a focus at the three largest hospitals surrounding our campus—Cleveland Clinic, MetroHealth and University Hospitals. There are also a number of neighborhood clinics and practices that cater to women's health. Similarly, cardiovascular health is addressed by the three main hospitals surrounding our campus. However, we will address some aspects of cardiovascular health through our focus on weight control issues since high blood pressure, and high blood cholesterol are co-morbidities of obesity.

Strategy #1: Decrease the number of adults who are overweight or obese
Obesity indicators

67% of Cuyahoga County adults were overweight or obese based on Body Mass Index (BMI). 71% of adults in St. Vincent Charity Medical Center's primary service were overweight or obese based on BMI.

Weight Status

The 2012 Cuyahoga County Health Assessment indicates that 43% of adults were overweight and 24% were obese based on Body Mass Index (BMI). The 2011 BRFSS reported that 30% of Ohio and 28% of U.S. adults were obese and 36% of Ohio and 36% of U.S. adults were overweight.

44% of adults in St. Vincent Charity Medical Center's primary service area were overweight and 27% were obese.

Nutrition

In 2012, 6% of adults were eating 5 or more servings of fruits and vegetables per day. 90% were eating between 1 and 4 servings per day. The American Cancer Society recommends that adults eat 5-9 servings of fruits and vegetables per day to reduce the risk of cancer and to maintain good health. The 2009 BRFSS reported that only 21% of Ohio adults and 23% nationwide were eating the recommended number of servings of fruits and vegetables.

Cuyahoga County adults got their fruits and vegetables from the following places: large grocery store (63%), local grocery store (56%), Farmer's Market (36%), restaurants (4%), corner store (2%), food pantry (1%), and other places (9%).

Cuyahoga County adults reported the following reasons they choose the types of food they eat: taste (66%), healthiness of food (62%), cost (58%), enjoyment (54%), availability (41%), ease of preparation (35%), food that they are used to (32%), calorie content (26%), what their spouse prefers (25%), time (23%), what their child prefers (13%), health care provider's advice (5%), and other (5%).

Physical Activity

In Cuyahoga County, 60% of adults were engaging in some type of exercise or physical activity for at least 30 minutes 3 or more days per week. 35% of adults were exercising 5 or more days per week. One-fifth (20%) of adults were not participating in any physical activity in the past week, including those who were unable to exercise.

Reasons for not exercising included: too tired (22%), laziness (21%), time (20%), pain/discomfort (11%), weather (9%), chose not to exercise (9%), could not afford a gym membership (5%), no childcare (2%), did not know what activity to do (2%), safety (2%), no walking/biking trails (1%), no gym available (1%), doctor advised them not to exercise (1%), no sidewalks (<1%), and other (4%).

The CDC recommends that adults participate in moderate exercise for at least 2 hours and 30 minutes every week or vigorous exercise for at least 1 hour and 15 minutes every week. Whether participating in moderate or vigorous exercise, CDC also recommends muscle-strengthening activities that work all major muscle groups on 2 or more days per week (*Source: CDC, Physical Activity for Everyone*)

Strategy #1: Decrease the number of adults who are overweight or obese
Obesity indicators

2012 Adult Comparisons	Cuyahoga County 2012	Ohio 2011	U.S. 2011
Obese	24%	30%	28%
Overweight	43%	36%	36%

2012 Cuyahoga County Health Assessment Summary Chart for St. Vincent Charity Medical Center Service Area

Adult Variables	Primary Service Area (n=395)	Secondary Service Area (n=94)	Cuyahoga County 2012	Ohio 2011	US 2011
Weight Status					
Overweight by BMI (25.0-29.9)	44%	40%	43%	36%	36%
Obese by BMI (30+)	27%	24%	24%	30%	28%

Strategy #1: Decrease the number of adults who are overweight or obese Resource Assessment				
Program/Strategy/ Service	**Responsible Agency**	**Population(s) Served**	**Continuum of Care** (prevention, early intervention, or treatment)	**Evidence of Effectiveness**
Center for Bariatric Surgery	St. Vincent Charity Medical Center	Adults	Treatment	Evidence based
Diabetes Self - Management/Education	St. Vincent Charity Medical Center	Adults	Early Intervention	Evidence based
Healthy Kids Healthy Weight	University Hospitals Rainbow Babies & Children's Hospital	Adolescents-Teens	Early Intervention/Treatment	Evidence based
Meal Replacements	Parma	Adults	Treatment	Results are tracked
Chronic Disease/ Diabetes Self-Management Program	Fairhill Center	Adults	Early Intervention	Evidence based
Community Gardens	Multiple locations	All ages	Prevention/Early Intervention/Treatment	Best practice
Weight Watchers	Weight Watchers (Multiple sites)	Ages 10+	Prevention/Treatment	Evidence based
Jenny Craig	Jenny Craig	All ages	Prevention/Treatment	Results are tracked
Local Fitness Centers, Gyms & Classes	Multiple locations throughout Cuyahoga County	All ages	Prevention/Early Intervention/Treatment	None
Optifast	Multiple Locations	Adults	Treatment	Evidence based
Garden Boyz Farmer's Market	Sisters of Charity Health System	All	Prevention/Early Intervention	None
HIP-C (Health Improvement Partnership- Cuyahoga) Focusing on improving nutrition and physical activity	Cuyahoga County Health Department	All ages	Prevention/Early Intervention	None
Prevention Research Center for Healthy Neighborhoods (addresses lifestyle barriers to health)	Case Western Reserve University	All ages	Prevention/Early Intervention	Outcomes monitored

Strategy #1: Decrease the number of adults who are overweight or obese
Gaps & Potential Strategies

Gaps	Potential Strategies
Healthier food options within the hospital to serve patients, visitors and staff	• Create a group to look at parameters for food options (partner with Metz and US Foods) • Begin looking at healthy food initiatives (OHA) • Initiate an employee survey • Look at what other local hospitals have done to increase healthier food options
Lack of awareness and availability of healthy food	• Create a community garden at the hospital (triangle space) • Expand awareness of the Building Health Communities Garden Boyz fruit and vegetable stand • Partner with OSU Extension to bring nutrition, healthy eating classes at the hospital • Create kiosk/resource center in cafeteria to empower community and visitors to healthy eating and access to healthy foods • Expand awareness of local community markets through Grow Ohio food access guide
Lack of funds to purchase health food	• Partner with the Prevention Resource Center at Case Western Reserve University • Partner with Food Policy Coalition and Healthy Eating Active Living to improve access to healthy food • Expand awareness of ability to use SNAP at farmer's markets/ community markets
Medically supervised weight loss programs	• Identify which health care providers are using full, partial, or no meal replacements • Recruit physicians/physician's assistant/nurse practitioner/exercise physiologist/ dietician that are interested in weight loss • Develop a program/model that could be expanded into primary care/physician's offices • Increase opportunities for physicians and office staff to increase education on nutrition and weight loss
Reducing sedentary behavior and increasing exercise	• Expand the Pre-gym prep program (orientation on gym equipment) • Partner with Cleveland State for gym access (for hospital employees) • Support groups
An exercise component for diabetes education	• Partner with local gym • Partner with cardiac rehab
Employee wellness program	• Partnership with CSU for employee gym membership • Screenings and testing to obtain baseline data (not punitive)

Best Practices

The following programs and policies have been reviewed and have proven strategies to **reduce obesity in adults**:

1. **Weight Watchers—**Weight Watchers has been the gold standard for successful weight loss programs. Among the reasons for Weight Watchers' longevity, the program is based on science and addresses the dieter's lifestyle as a whole. Weight Watchers has always focused on long-term weight management and a commitment to an overall healthy lifestyle. The program is based on four basic principles: eating smarter, moving more, getting support, and developing better habits. For more information go to http://www.weightwatchers.com.

2. **Diet Therapy—**Current dietary recommendations continue to focus on the low-calorie, low-fat diet, with intake of 800 to 1500 kcal of energy per day. Caloric reduction in the range of 500 to 1000 kcal less than the usual intake is appropriate. This will allow for approximately 1 to 2 pounds of weight loss per week. For more information go to http://www.mypyramid.gov/.

3. **Exercise program—**The CDC recommends 60 minutes of physical activity for at least 5 days a week. Encourage people to make lifestyle changes such as taking the stairs, parking farther away, playing with their kids, etc. Small bouts of physical activity all day long can account to 60 minutes easily. It does not have to be a full hour of exercising in a gym. For more information go to http://www.mypyramidtracker.gov/.

4. **Health Insurance Incentives & Penalties—**The number of employers offering financial rewards for participating in wellness programs rose by 50 percent from 2009 to 2011. In 2012, four out of five companies plan to offer some type of financial health incentive. The use of penalties among employers more than doubled from 2009 to 2011, rising from 8 percent to 19 percent. It could double again next year when 38 percent of companies plan to have penalties in place. Requiring smokers to pay a higher portion of the health insurance premium is among the most common penalties. A provision in the federal health care reform law will let employers offer greater incentives for participating in wellness programs starting in 2014. The 2010 Patient Protection and Affordable Care Act boosts the threshold for premium incentives to 30 percent of total premium per person and, in cases approved by federal health and labor officials, up to 50 percent in 2014. Employer programs often reward employees who exercise, lose weight or participate in disease management programs.. For instance, an employer might offer a $500 health insurance premium discount to everyone and rescind the reward for employees who choose not to participate in the care management program.

5. **Community Gardens**: A community garden is any piece of land that is gardened or cultivated by a group of people. Community gardens are generally owned by local governments or not-for-profit groups. Supporting community gardens may include the means to establish gardens (e.g., tax incentives, land banking, zoning regulation changes) or ongoing assistance through free services such as water or waste disposal.

   Expected Beneficial Outcomes
   - Increased accessibility of fruit & vegetables
   - Increased consumption of fruit & vegetables
   - Increased physical activity for gardeners
   - Increased availability of healthy foods in food deserts

For more information go to http://www.countyhealthrankings.org/policies/community-gardens

Strategy #2: Increase Access & Awareness to Substance Abuse & Mental Health Services
Mental Health & Substance Abuse Indicators

In 2012, the health assessment results indicated that 24% of all Cuyahoga County adults had five or more alcoholic drinks (for males) or four or more drinks (for females) on an occasion in the last month and would be considered binge drinkers.

Adult Alcohol Consumption

In 2012, nearly three-fifths (59%) of the Cuyahoga County adults had at least one alcoholic drink in the past month, increasing to 67% of those under the age of 30 and those with incomes more than $25,000. The 2011 BRFSS reported current drinker prevalence rates of 56% for Ohio and 57% for the U.S.

Nearly one-fifth (18%) adults were considered frequent drinkers (drank on an average of three or more days per week).

Of those who drank, Cuyahoga County adults drank 2.9 drinks on average, increasing to 3.7 drinks for males.

One in four (24%) Cuyahoga County adults had five or more alcoholic drinks (for males) or 4 or more drinks (for females) on an occasion in the last month and would be considered binge drinkers by definition. The 2011 BRFSS reported binge drinking rates of 20% for Ohio and 18% for the U.S.

42% of current drinkers reported they had at least one episode of binge drinking in the past month.

Cuyahoga County adults experienced the following: drank more than they expected (10%), spent a lot of time drinking (2%), gave up other activities to drink (2%), drank more to get the same effect (1%), tried to quit or cut down but could not (1%), continued to drink despite problems caused by drinking (1%), and drank to ease withdrawal symptoms (1%).

3% of Cuyahoga County adults have used a program or service to help with alcohol or other drug problems for either themselves or a loved one. Reasons for not using such a program included: had not thought of it (4%), did not know how to find a program (1%), stigma of seeking alcohol services (1%), did not want to miss work (1%), could not afford to go (1%), fear (1%), transportation (<1%), and other reasons (1%). 90% of adults indicated they did not need a program or service to help with alcohol or other drug problems.

11% of adults reported driving after having perhaps too much to drink, increasing to 15% of males.

2012 Adult Comparisons	Cuyahoga County 2012	Ohio 2011	U.S. 2011
Drank alcohol at least once in past month	59%	56%	57%
Binge drinker (drank 5 or more drinks for males and 4 or more for females on an occasion)	24%	20%	18%

2012 Cuyahoga County Health Assessment Summary Chart for St. Vincent Charity Medical Center Service Area

Adult Variables	Primary Service Area (n=395)	Secondary Service Area (n=94)	Cuyahoga County 2012	Ohio 2011	US 2011
Alcohol Consumption					
Had at least one alcoholic beverage in past month	54%	67%	59%	56%	57%
Had driven a car after having too much to drink in past month	10%	15%	11%	NA	NA

N/A- Not available

In 2012, 9% of Cuyahoga County adults had used marijuana during the past 6 months. 9% of adults had used medication not prescribed for them or took more than prescribed to feel good or high and/or more active or alert during the past 6 months.

Adult Drug Use

9% of Cuyahoga County adults had used marijuana in the past 6 months, increasing to 13% of those with incomes less than $25,000.

When asked about their frequency of marijuana and other recreational drugs in the past six months, 9% of Cuyahoga County adults who used drugs did so almost every day, and 32% did so less than once a month.

4% of Cuyahoga County adults reported using other recreational drugs such as cocaine, heroin, LSD, inhalants, and methamphetamines.

9% of adults had used medication not prescribed for them or they took more than prescribed to feel good or high and/or more active or alert during the past 6 months, increasing to 10% of those ages 30-64 and 11% with incomes more than $25,000.

When asked about their frequency of medication misuse in the past six months, 33% of Cuyahoga County adults who used these drugs did so almost every day, and 44% did so less than once a month.

Strategy #2: Increase Access & Awareness to Substance Abuse & Mental Health Services
Mental Health & Substance Abuse Indicators, continued

In 2012, the health assessment results indicate that 2% of Cuyahoga County adults considered attempting suicide. 10% felt so sad or hopeless nearly every day for two or more weeks that they stopped doing usual activities.

Adult Mental Health

2% of Cuyahoga County adults considered attempting suicide in the past year.

10% of adults felt so sad or hopeless nearly every day for two or more weeks in a row that they stopped doing usual activities. Increasing to 17% of African Americans and 20% of adults with incomes less than $25,000.

In the past year, Cuyahoga County adults were diagnosed with or treated for the following mental health issues: an anxiety disorder (9%), a mood disorder (7%), a psychotic disorder (1%), and some other mental health disorder (1%). 11% indicated they had taken medication for one or more mental health issue.

Mental Health Access

12% of Cuyahoga County adults reported they had used a depression or anxiety program for themselves or a loved one.

Reasons for not using such a program included: could not afford to go (6%), co-pay/deductible too high (5%), had not thought of it (5%), did not know how to find a program (4%), stigma of seeking mental health services (3%), did not feel the services they had received were good (3%), other priorities (3%), fear (3%), transportation (2%), could not get to the clinic/office (1%), and other reasons (1%).

Strategy #2: Increase Access & Awareness to Substance Abuse & Mental Health Services
Resource Assessment

Program/Strategy/ Service	Responsible Agency	Population(s) Served	Continuum of Care (prevention, early intervention, or treatment)	Evidence of Effectiveness
Rosary Hall (Intensive outpatient, inpatient detox)	St. Vincent Charity Medical Center	Adults	Treatment	Data is tracked
Inpatient psych units, psychiatric emergency room,	St. Vincent Charity Medical Center	Adults	Treatment	
Substance Abuse & Mental Health Services (Inpatient, outpatient, behavioral health, mental health and prevention)	Catholic Charities Services of Cuyahoga County	Adults	Prevention/ Treatment	Data is tracked
Substance Abuse Services (Residential-outpatient, childcare family services, and transitional housing)	Hitchcock Center for Women	Women	Treatment	Data is tracked
Project Hope (Outpatient- residential, intensive outpatient)	Hispanic UMADAOP	Adult Men (Casa Alma) Adult Women (Casa Maria)	Treatment	Data is tracked
Substance Abuse Education and information dissemination	Cleveland UMADAOP	Adults and Children	Prevention	Data is tracked
Drug Court	City of Cleveland	Adults	Early Intervention/ Treatment	Data is tracked
Substance Abuse Education, referrals, and mental health outpatient treatment	Center for Families And Children	Adults and Children	Prevention/Early Intervention/ Treatment	Data is tracked
Substance Abuse Assessment, Counseling, outpatient-residential)	Community Assessment and Treatment Services (CATS)	Adults-treatment Children-counseling	Prevention/Early Intervention/ Treatment	Data is tracked
TASC (Case management, assessment, counseling)	Court of Common Pleas Corrections Planning Board	Adults	Early Intervention	Data is tracked
Community Re-Entry Program (substance abuse and mental health)	Lutheran Metropolitan Ministry	Adults	Early Intervention	Data is tracked

Strategy #2: Increase Access & Awareness to Substance Abuse & Mental Health Services
Resource Assessment

Program/Strategy/ Service	Responsible Agency	Population(s) Served	Continuum of Care (prevention, early intervention, or treatment)	Evidence of Effectiveness
Counseling and mediation services	Moore Counseling and Mediation, Inc	Adults	Prevention/Early Intervention/ Treatment	Data is tracked
Substance abuse assessment, case management, crisis intervention, and outpatient behavioral health services	Murtis Taylor Human Services System	Adults and Children	Prevention/Early Intervention	Data is tracked
Substance abuse assessment, case management, counseling and outpatient treatment	New Directions	Children	Prevention/Early Intervention/ Treatment	Data is tracked
Youth mentoring and treatment Programs	Northern Ohio Recovery Association	Adults and Children	Prevention/Early Intervention/ Treatment	Data is tracked
Substance abuse counseling and treatment	ORCA House	Adults	Treatment	Data is tracked
Mental health and substance abuse assessment, counseling and treatment	Recovery Resources	All ages	Prevention/Early Intervention/ Treatment	Data is tracked
Substance abuse assessment and education	Salvation Army	Adults	Prevention/Early Intervention/ Treatment	Data is tracked
Substance abuse outpatient treatment	Stella Maris	Adults	Treatment	Data is tracked
211 First Call for Help	United Way	All ages	Prevention	Data is tracked
Support groups and education	NAMI of Greater Cleveland	All ages	Prevention	Data is tracked
Inpatient behavioral health services	Northcoast Behavioral Healthcare	Uninsured Adults	Treatment	Data is tracked
Psychiatric probate court	Cuyahoga County Probate Court	Adults	Intervention	Participants tracked
Free Clinic (chemical dependency intensive outpatient treatment	Free Medical Clinic of Greater Cleveland	Uninsured all ages	Treatment	Data is tracked
Metro Health Medical Center (psychiatric services)	MetroHealth	All ages	Treatment	Data is tracked
Mental health assessment, counseling, crisis intervention and substance abuse treatment	Bridgeway, Inc	Adults	Prevention/Early Intervention/ Treatment	Data is tracked
Health and wellness advocacy	Connections	Adults and children	Prevention/Early Intervention/ Treatment	Data is tracked
Mental health residential services, counseling, and assessment	Jewish Family Service Association	Adults and Children	Prevention/Early Intervention/ Treatment	Data is tracked

Strategy #2: Increase Access & Awareness to Substance Abuse & Mental Health Services
Resource Assessment

Program/Strategy/ Service	Responsible Agency	Population(s) Served	Continuum of Care (prevention, early intervention, or treatment)	Evidence of Effectiveness
Mental health assessment, support and employment services	Magnolia Clubhouse	Adults	Prevention/Early Intervention	Data is tracked
Mental health assessment, crisis intervention and employment services	Mental Health Services for the Homeless, Inc.	Homeless Adults and Children	Prevention/Early Intervention/ Treatment	Data is tracked
Mental health assessment, crisis intervention and employment services	Signature Health	Adults	Prevention/Early Intervention/ Treatment	Data is tracked
Mental health services	Visiting Nurses Association	Adults and Children	Prevention/Early Intervention/ Treatment	Data is tracked
Mental health assessment, counseling, partial hospitalization and prevention services	Windsor-Laurelwood Center for Behavioral Medicine	Adults and Children	Prevention/Early Intervention/ Treatment	Data is tracked
Substance abuse services	A New Beginning	Adults	Treatment	Data is tracked
Substance abuse services	Cleveland Treatment Center	Adults	Treatment	Data is tracked
Substance abuse services	Community Action Against Addiction	Adults	Treatment	Data is tracked
Substance abuse services	Edna Abuse for Women	Adults (females only)	Treatment	Data is tracked
Substance abuse services	Ed Keating Center	Adults (males only)	Treatment	Data is tracked
Substance abuse services	Freedom House	Adults (females only)	Treatment	Data is tracked

Strategy #2: Increase Access & Awareness to Substance Abuse & Mental Health Services Gaps & Potential Strategies

Gaps	Potential Strategies
Geriatric Psych floor	• Initiate a feasibility study of creating a geriatric psych floor
Lack of pain management information/abuse of prescription medication	• Pain management program • Increase opportunities for physicians and office staff to increase education on chronic pain • Strategies to deal with addicts seeking medications
Increase education of primary care providers on substance abuse and mental health issues	• Develop a program/model that could be expanded into primary care/physician's offices • Increase opportunities for physicians and office staff to increase education on substance abuse and mental health
Access to outpatient counseling and psychiatric services	• Partner with Psychological and Behavioral Consultants to open outpatient psychiatric office in Sisters of Charity Health System Building • Provide intensive outpatient, partial hospitalization and tradition outpatient visits for primarily geriatric patients • Expand psychiatric staff by three physicians • Provide opportunities for expanded intake services
Access and availability of affordable medication for patients with mental health issues	• No strategies identified

Strategy #2: Increase Access & Awareness to Substance Abuse & Mental Health Services Best Practices

Best Practices

The following programs and policies have been reviewed and have proven strategies to **increase access and awareness to substance abuse and mental health services.**

1. **PHQ-9:** The PHQ-9 is the nine item depression scale of the Patient Health Questionnaire. The PHQ-9 is a powerful tool for assisting primary care clinicians in diagnosing depression as well as selecting and monitoring treatment. The primary care clinician and/or office staff should discuss with the patient the reasons for completing the questionnaire and how to fill it out. After the patient has completed the PHQ-9 questionnaire, it is scored by the primary care clinician or office staff.
   There are two components of the PHQ-9:

   - Assessing symptoms and functional impairment to make a tentative depression diagnosis, and
   - Deriving a severity score to help select and monitor treatment

   The PHQ-9 is based directly on the diagnostic criteria for major depressive disorder in the Diagnostic and Statistical Manual Fourth Edition (DSM-IV).

For more information go to:
http://www.depression-primarycare.org/clinicians/toolkits/materials/forms/phq9/

Through proven and promising best practices, effective programs will be better able to help achieve the Healthy People 2020 Mental Health and Mental Disorders Objectives to improve mental health through prevention and ensure access to appropriate, quality mental health services.
Healthy People 2020 goals include:

- Reduce the suicide rate
- Reduce suicide attempts by adolescents
- Reduce the proportion of adults aged 18 and older who experience major depressive episodes (MDEs)
- Increase the proportion of primary care facilities that provide mental health treatment onsite or by paid referral
- Increase the proportion of persons with serious mental illness (SMI) that are employed
- Increase the proportion of adults aged 18 years and older with serious mental illness who receive treatment
- Increase the proportion of adults aged 18 years and older with major depressive episodes (MDEs) who receive treatment
- Increase the proportion of primary care physicians who screen adults aged 19 years and older for depression during office visits
- Increase the proportion of homeless adults with mental health problems who receive mental health services

The following evidence-based community interventions come from the Guide to Community Preventive Services, Centers for Disease Control and Prevention (CDC) and help to meet the Healthy People 2020 Objectives: Collaborative care for the management of depressive disorders is a multicomponent, healthcare system-level intervention that uses case managers to link primary care providers, patients, and mental health specialists. This collaboration is designed to:

1. Improve the routine screening and diagnosis of depressive disorders
2. Increase provider use of evidence-based protocols for the proactive management of diagnosed depressive disorders
3. Improve clinical and community support for active patient engagement in treatment goal setting and self-management

The following programs have been reviewed and have proven strategies to **address alcohol abuse related issues in adults**:

2. **Motivational Interviewing (MI)—**MI is a goal-directed, client-centered counseling style for eliciting behavioral change by helping clients to explore and resolve ambivalence. MI has been applied to a wide range of problem behaviors related to alcohol and substance abuse as well as health promotion, medical treatment adherence, and mental health issues. The MI counseling style generally includes the following elements:

- Establishing rapport with the client and listening reflectively.
- Asking open-ended questions to explore the client's own motivations for change.

- Affirming the client's change-related statements and efforts.
- Eliciting recognition of the gap between current behavior and desired life goals.
- Asking permission before providing information or advice.
- Responding to resistance without direct confrontation. (Resistance is used as a feedback signal to the therapist to adjust the approach.)
- Encouraging the client's self-efficacy for change.
- Developing an action plan to which the client is willing to commit.

For more information go to http://www.motivationalinterview.org

3. **Project ASSERT**- Project ASSERT (Alcohol and Substance Abuse Services, Education, and Referral to Treatment) is a screening, brief intervention, and referral to treatment (SBIRT) model designed for use in health clinics or emergency departments (EDs). Project ASSERT targets three groups:

    1. Out-of-treatment adults who are visiting a walk-in health clinic for routine medical care and have a positive screening result for cocaine and/or opiate use. Project ASSERT aims to reduce or eliminate their cocaine and/or opiate use through interaction with peer educators (substance abuse outreach workers who are in recovery themselves for cocaine and/or opiate use and/or are licensed alcohol and drug counselors).
    2. Adolescents and young adults who are visiting a pediatric ED for acute care and have a positive screening result for marijuana use. Project ASSERT aims to reduce or eliminate their marijuana use through interaction with peer educators (adults who are under the age of 25 and, often, college educated).
    3. Adults who are visiting an ED for acute care and have a positive screening result for high-risk and/or dependent alcohol use. Project ASSERT aims to motivate patients to reduce or eliminate their unhealthy use through collaboration with ED staff members (physicians, nurses, nurse practitioners, social workers, or emergency medical technicians).

    On average, Project ASSERT is delivered in 15 minutes, although more time may be needed, depending on the severity of the patient's substance use problem and associated treatment referral needs. The face-to-face component of the intervention is completed during the course of medical care, while the patient is waiting for the doctor, laboratory results, or medications.

    For more information go to: http://www.nrepp.samhsa.gov/ViewIntervention.aspx?id=222

Strategy #3 Increase Health Care Access
Health Care Access Indicators

The 2012 Health Assessment project identified that 5% of Cuyahoga County adults were using a hospital emergency room as their usual place of health care. More than half (57%) of adults reported that they had a particular doctor or healthcare professional they go to for routine medical care.

Health Care Access

In 2012, more than three-fifths (62%) of Cuyahoga County adults visited a doctor for a routine checkup in the past year, increasing to 79% of those over the age of 65.

More than half (57%) of Cuyahoga County adults reported they had one particular doctor or healthcare professional they go to for routine medical care, decreasing to 48% of those with incomes less than $25,000. 21% of adults had more than one particular doctor or healthcare professional they go to for routine medical care, and 21% did not have one at all.

Reasons for not having a usual source of medical care included: two or more usual places (23%), no insurance/could not afford insurance (21%), had not needed a doctor (19%), previous doctor unavailable/moved (12%), did not know where to go (4%), did not like/trust/believe in doctors (3%), and other reasons (14%).

5% of Cuyahoga County adults used a hospital emergency room as their usual place of health care, increasing to 8% of those with incomes less than $25,000.

22% of Cuyahoga County adults had visited the emergency room 1-2 times in the past year and 5% had been there more than 2 times.

Cuyahoga County adults had the following transportation problems when they needed health care: no car (6%), no driver's license (4%), could not afford gas (3%), limited public transportation available or accessible (3%), no car insurance (2%), disabled (2%), car did not work (1%), no public transportation available or accessible (<1%), and other car issues/expenses (3%).

Just over one-third (34%) of Cuyahoga County adults did not get medical care in the past year for the following reasons: care not needed (14%), cost/no insurance (13%), too long to wait for an appointment (2%), office was not open when they could get there (1%), no transportation (1%), too long to wait in the waiting room (<1%), and other reasons (2%). 66% of adults indicated they received all of the medical care they needed.

The following might prevent Cuyahoga County adults from seeing a doctor if they were sick, injured, or needed some kind of health care: cost (34%), hours not convenient (16%), difficult to get an appointment (15%), worried they might find something wrong (8%), frightened of the procedure or doctor (6%), could not get time off work (5%), difficult to find/no transportation (3%), do not trust or believe doctors (2%), and some other reason (4%).

Cuyahoga County adults did not receive the following major care or preventive care due to cost: medications (8%), mammogram (7%), weight-loss program (6%), pap smear (6%), colonoscopy (5%),

mental health (5%), surgery (3%), immunizations (3%), smoking cessation (3%), family planning (2%), PSA test (1%), and alcohol and drug treatment (1%).

During the past year, adults did not get a prescription from their doctor filled because: they did not think they needed it (11%), they could not afford to pay the out-of-pocket expenses (8%), they had no insurance (5%), they stretched their prescription by taking less than prescribed (4%), there was no generic equivalent of what was prescribed (3%), their deductibles were too high (3%), their co-pays were too high (3%), they had a high health savings account (HSA) deductible (2%), their premiums were too high (2%), they opted out of prescription coverage because they could not afford it (1%), they were taking too many medications (1%), and
transportation (1%). 74% of adults reported having all of their prescriptions filled.

2012 Cuyahoga County Health Assessment Summary Chart for St. Vincent Charity Medical Center Service Area

Adult Variables	Primary Service Area (n=395)	Secondary Service Area (n=94)	Cuyahoga County 2012	Ohio 2011	US 2011
Weight Status					
Has health care coverage	86%	90%	87%	86%	82%
Had visited a doctor for a routine checkup in the past year	63%	53%	62%	N/A	N/A
Usually seek treatment at a private doctor's office	62%	70%	66%	N/A	N/A
Usually seek treatment at a hospital emergency room	7%	3%	5%	N/A	N/A
Usually seek treatment at an urgent care center	4%	6%	4%	N/A	N/A
Do not have one particular place they seek treatment	4%	2%	4%	N/A	N/A

Strategy #3: Increase Health Care Access
Resource Assessment

Program/Strategy/ Service	Responsible Agency	Population(s) Served	Continuum of Care (prevention, early intervention, or treatment)	Evidence of Effectiveness
Connecting uninsured adults to care using a provider network	Cuyahoga Health Access Partnership	Adults (ages 19-64) living under 200% Federal Poverty Level and beyond	Early Intervention	Outcomes monitored Annual evaluation
Transportation for inpatient and outpatient treatment	St. Vincent Charity's Mission and Ministry Office	Both inpatient and outpatient, needs based	Early Intervention	Evidence based
Transportation	St. Vincent Charity Medical Center, Operations	Needs based Hospital outpatient Patients within 10 miles	Early Intervention	Evidence based
Patient navigation	St. Vincent Charity Medical Center and its medical group	Needs based Hospital and medical Home patients	Prevention/Early Intervention/ Treatment	Evidence based
Breast health advocate	St. Vincent Charity Medical Center and University Hospitals	African American women, ages 18-80	Prevention/Early Intervention/ Treatment	Outcomes monitored
Patient advocates Ombudsman for patients, links patients to services	St. Vincent Charity Medical Center	Emergency Room Clients	Treatment	Outcomes monitored
Patient Representative	St. Vincent Charity Medical Center	Ombudsman for inpatients	Treatment	Outcomes monitored
Social Services including health care access with 1:1 counseling	Ohio Benefit Bank	Needs based for all Ohio residents	Prevention	Outcomes monitored State funded
Health screening at food and clothing distribution day	St. Vincent Charity Medical Center	Adults in need of food, social services and health services	Prevention/Early Intervention/	Outcomes monitored
Health Eating Active Living (HEAL)/Cleveland Central Promise Neighborhood	Sisters of Charity Foundation of Cleveland	SVCMC provides health screenings and links patients to needed health services and social services	Prevention/Early Intervention/ Treatment	
Health Care Center Uninsured patient payment assistance program	St. Vincent Charity Medical Center	Uninsured	Prevention/Early Intervention/ Treatment	Outcomes monitored
Uninsured patient payment assistance program	Shaker Medical Campus and St. Luke's Dental Clinic	Uninsured	Prevention/Early Intervention/ Treatment	Outcomes monitored
Federally Qualified Health Center (F.Q.H.C) Medical, dental and supportive services	Care Alliance Health Centers	Sliding fee scale based on income (Medicaid, Medicare and some private insurance)	Prevention/Early Intervention/ Treatment	Outcomes monitored
Case Dental Program	Case Dental School	Adults and Children	Prevention/Early Intervention/ Treatment	Outcomes monitored

Strategy #3: Increase Health Care Access
Resource Assessment

Program/Strategy/ Service	Responsible Agency	Population(s) Served	Continuum of Care (prevention, early intervention, or treatment)	Evidence of Effectiveness
Non-profit community health center	Neighborhood Family Practice	All ages (accepts Medicaid, HMO's, insurance, Medicare, and sliding fee scale for uninsured)	Prevention/Early Intervention/ Treatment	Outcomes monitored
North East Ohio Neighborhood Health Services, Inc. (NEON)	North East Ohio Neighborhood Health Services, Inc. NEON	Multiple locations in the Greater Cleveland Area (Medicare, Medicaid, insurance and sliding fee scale)	Prevention/Early Intervention/ Treatment	Outcomes are monitored
Faith-based free clinic	North Coast Health Ministry	Uninsured (Western Cuyahoga County and Eastern Lorain County)	Prevention/Early Intervention/ Treatment	Outcomes are monitored
Free Clinic (Medical care, dental care, specialty care, counseling, HIV/AIDS services	The Free Medical Clinic of Greater Cleveland	Uninsured	Prevention/Early Intervention/ Treatment	Outcomes are monitored
Medical Center and Dental Clinic	Metro Health Medical Center	Multi-specialty services for residents of Greater Cleveland area	Prevention/Early Intervention/ Treatment	Outcomes are monitored
Cash assistance, nutrition assistance, Medicaid/Healthy Start, childcare assistance program	Cuyahoga County Employment & Family Services	Adults	Prevention/Early Intervention/ Treatment	Outcomes monitored
Housing assistance, employment services, counseling, Moms First Program, Strong Start Program, food and clothing distribution	May Dugan Center	Adults and Children	Prevention/Early Intervention/ Treatment	Outcomes are monitored
Prescription Assistance	St. Vincent Charity Medical Center	Patient assistance to link with pharmaceutical patient assistance programs	Treatment	Outcomes monitored
Heart Failure Program	St. Vincent Charity Medical Center	In-patients with heart failure are provided education, linked to appropriate care and services	Treatment	Outcomes monitored
211 First Call for Help	United Way	All Residents	Prevention/Early Intervention	Outcomes monitored

Strategy #3: Increase Health Care Access

Resource Assessment

Program/Strategy/ Service	Responsible Agency	Population(s) Served	Continuum of Care (prevention, early intervention, or treatment)	Evidence of Effectiveness
Comprehensive Social Services	Catholic Charities Health and Human Services	Northeast Ohio	Prevention/Early Intervention/ Treatment	Outcomes are monitored
Coordinated network of Information	Catholic Community Connection	Northeast Ohio	Prevention/Early Intervention/ Treatment	Outcomes are monitored Services are regularly evaluated
Joseph's Home	Sisters of Charity Health System	Homeless men ages 18+ with acute or temporary medical problems	Early Intervention/ Treatment	Outcomes monitored
Building Healthy Communities	Sisters of Charity Health System	Adults and Children	Prevention/Early Intervention	Outcomes monitored
Medical Services for Uninsured/Underinsured	Care Alliance	Uninsured/Underinsured Homeless	Prevention/Early Intervention/ Treatment	Outcomes monitored
Medical Services	Faith Baptist Community Center	Uninsured/Underinsured	Prevention/Early Intervention/ Treatment	Outcomes monitored
Dental Hygiene Clinic	Tri-C Cuyahoga Community College	Adults and Children	Prevention/Early Intervention/ Treatment	Outcomes are monitored
Cuyahoga Health Access Partnership (CHAP)	Cuyahoga Health Access Partnership (CHAP)	Uninsured	Prevention/Early Intervention/ Treatment	Outcomes monitored

Strategy #3: Increase Health Care Access
Gaps & Potential Strategies

Gaps	Potential Strategies
Connecting patients with resources/patient re-admissions	• Defining roles of health care navigator position • Collect data on the impact of the health care navigator (what does a typical case load look like?) • Expand health care navigator position • Decrease patient re-admissions (discharge task force) • Increase patient advocacy • Continue focus on hospital-wide health literacy
Connections with Hispanic Community	• Re-engage local Hispanic pastors (luncheon) • Create a Hispanic outreach coordinator (increase ability to serve Hispanic population • Partner with Hispanic Health Committee
Transportation	• No strategies identified
Increasing patient success at home	• Research other agencies that do patient "home visits" and possibly partner with them • Look for grants/other funding opportunities to do more work out in the community with patients at home (i.e. dieticians, filling prescriptions etc.) • Develop a community navigator/health advocate position
Increase coordination with FQHC's	• Collaborate with FQHC administrators to gain information and coordinate efforts (Luncheon) • Partner with FQHC's to apply for funding • Use participation in Cuyahoga Health Access Partnership (CHAP) to deepen relationships with FQHC's • Capitalize CHAP's access work by hosting CHAP enrollment opportunities for public • Include CHAP content on St. Vincent intranet • Work together to fill the gaps of services that they aren't able to provide
Leverage relationships to meet unmet needs and support systemic change	• Work of St. Vincent Charity Mission and Ministry office • St. Vincent Charity Medical Center board of Directors • Engagement with elected and community leaders • Support Sisters of Charity Health System mission-focused advocacy to increase health coverage through national, state and local public policy

Strategy #3: Increase Health Care Access
Best Practices

Best Practices
The following programs and policies have been reviewed and have proven strategies to **increase health care access:**

1. **Federally Qualified Health Centers** (FQHCs): Federally qualified health centers (FQHCs) are public and private non-profit health care organizations that receive federal funding under Section 330 of the Public Health Service Act. Governed by a community board, FQHCs deliver comprehensive care to uninsured, underinsured, and vulnerable patients regardless of ability to pay. FQHCs are located in high need communities in urban and rural areas and are often called Community Health Centers

   Expected Beneficial Outcomes:
   - Increased access to care
   - Improved health outcomes

   Evidence of Effectiveness
   - There is strong evidence that Federally Qualified Health Centers (FQHCs) increase access to primary care and improve health outcomes for their patients.
   - FQHCs have been shown to perform as well as or better than non-safety net providers
   - FQHCs may also improve access to oral health care.
   - By serving the uninsured, underinsured, and other vulnerable patients, FQHCs reduce disparities in access to care.
   - Investments in CHCs have been shown to reduce costs for local health care systems and provide economic benefits for surrounding communities

   Impact on Disparities:
   Likely to decrease disparities

   For more information go to: http://www.countyhealthrankings.org/policies/federally-qualified-health-centers-fqhcs

2. **Systems Navigators and Integration (E.g., Patient Navigators):** Patient navigators provide culturally sensitive assistance and care-coordination, guiding patients through available medical, insurance, and social support systems. These programs seek to reduce racial, ethnic, and economic disparities in access to care and disease outcomes.

   Expected Beneficial Outcomes:
   - Increased use of preventive services
   - Increased cancer screening
   - Improved birth outcomes
   - Improved maternal health

Evidence of Effectiveness

- There is strong evidence that patient navigator programs improve cancer screenings, especially for breast cancer. Additional evidence is needed to confirm effects for programs focused on other health outcomes.

Impact on Disparities:
Likely to decrease disparities

For more information go to: http://www.countyhealthrankings.org/policies/federally-qualified-health-centers-fqhcs

3. **Expand Use of Community Health Workers (CHW):** Community health workers (CHW), sometimes called lay health workers, serve a variety of functions, including: providing outreach, education, referral and follow-up, case management, advocacy and home visiting services. They may work autonomously or as part of a multi-disciplinary team; training varies widely with intended role and location. CHW services are often targeted at women who are at high risk for poor birth outcomes.

Expected Beneficial Outcomes

- Increased patient knowledge
- Increased access to care
- Increased use of preventive services
- Improved health behaviors

Evidence of Effectiveness

- There is some evidence that CHWs improve patient knowledge and access to health care, especially for minority women and individuals with low incomes.
- CHWs have been shown to improve access to care for patients that my not otherwise receive care.
- CHWs appear as effective as, and sometimes more effective than, alternate approaches to disease prevention, asthma management, efforts to improve colorectal cancer screening, chronic disease management, and maternal and child health.

Impact on Disparities:
Likely to decrease disparities

For more information go to: http://www.countyhealthrankings.org/policies/expand-use-community-health-workers-chw

Progress and Measuring Outcomes

The progress of meeting the priorities will be monitored with measurable indicators identified by the St. Vincent Charity Medical Center Community Benefit Planning Committee. The individuals that are working on action steps will meet on an as needed basis. The full community benefit committee will meet quarterly to report out the progress. A marketing committee will be formed to disseminate the strategic plan to the community. Action steps, responsible person/agency and timelines will be reviewed at the end of each year by the committee. Edits and revisions will be made accordingly.

Contact Us

For more information about any of the, programs or services described in this report, please contact:

Wendy Hoke
Senior Director of Marketing and Communications
St. Vincent Charity Medical Center
Office: 216-363-7440
Wendy.hoke@stvincentcharity.com