2016 IMPLEMENTATION PLAN




This Implementation Plan was approved by the University Hospitals Board of Directors on March 15, 2016

University Hospitals
Case Medical Center

INTRODUCTION

University Hospitals Cleveland Medical Center, dba University Hospitals Case Medical Center (the "Hospital") conducted a community health needs assessment (a "CHNA") of the geographic areas served by the Hospital pursuant to the requirements of Section 501(r) of the Internal Revenue Code ("Section 501(r)").[1] The CHNA findings were published on the Hospital's website in December 2015 (the "2015 CHNA"). This CHNA was adopted by the UH Board of Directors on September 24, 2015.

This is the second UH Case Medical Center CHNA in response to federal government regulation. The 2015 UH Case Medical Center CHNA served as the foundation for developing an implementation strategy to address those needs that (a) the Hospital determines it is able to meet in whole or in part; (b) are otherwise part of its mission; and (c) are not met (or are not adequately met) by other programs and services in the Hospital's service area. This implementation strategy ("Strategy"), also required by Section 501(r), documents the Hospital's efforts to address the community health needs identified in 2015 CHNA.

The Strategy identifies the means through which the Hospital plans to address a number of the needs that are consistent with the Hospital's charitable mission during 2016 through 2018 as part of its community benefit programs. Beyond the programs discussed in the Strategy, the Hospital is addressing many of these needs simply by providing care to all, regardless of their ability to pay, every day.

The Hospital anticipates the strategies may change and therefore a flexible approach is best suited for the development of its response to the 2015 CHNA. For example, certain community health needs may become more pronounced and require changes to the initiatives identified by the Hospital in the Strategy. During 2016 through 2018, other community organizations may address certain needs, indicating that the Hospital's strategies should be refocused on alternative community health needs or assume a different focus on the needs identified in the 2015 CHNA. In addition, changes may be warranted by the publication of final regulations.

The Strategy includes the following additional information:

1. Hospital Mission Statement
2. Community Served by the Hospital
3. Observations from the 2015 CHNA
4. Priority Community Health Needs
5. Implementation Strategies – 2013 Through 2015
6. Needs Beyond the Hospital's Mission or Service Programs
7. Implementation Strategy Development Collaborators

HOSPITAL MISSION STATEMENT

As a wholly owned subsidiary of University Hospitals Health System, Inc. ("University Hospitals" or "UH"), the Hospital is committed to supporting the UH mission, "To Heal. To Teach. To Discover." (the "Mission"), by providing a wide range of community benefits including clinical services, medical education and research. UH is an integrated delivery system and thus can provide benefits by coordinating within and among its various entities (the "UH System").

COMMUNITY SERVED BY THE HOSPITAL

The community served by the Hospital is defined based on the geographic origins of the Hospital's inpatients. The Primary Service Area ("PSA") is the geographic area from which the majority of the Hospital's patients originate. The Secondary Service Area ("SSA") is where an additional population of the Hospital's inpatients reside. The PSA is comprised of eight counties in Ohio: Ashtabula, Cuyahoga, Geauga, Lake, Lorain, Medina, Portage and Summit. The SSA is comprised of another seven Ohio counties: Ashland, Erie, Huron, Mahoning, Stark, Trumbull and Wayne.

In 2013, the Hospital's PSA included about 2,868,000 persons and its SSA included a population of approximately 1,119,000 persons for a total service area population of approximately 4 million. With approximately 1.2 million residents, Cuyahoga County accounted for nearly 32% of the Hospital's PSA population. In 2013, approximately 42% of the Hospital's inpatients originated from the PSA. Cuyahoga County accounted for approximately 71% of the Hospital's discharges in 2013.[2]

[1] *The Patient Protection and Affordable Care Act (Pub. L. 111-148) added section 501(r) to the Internal Revenue Code, which imposes new requirements on nonprofit hospitals in order to qualify for an exemption under Section 501(c)(3), and adding new reporting requirements for such hospitals under Section 6033(b) of the Internal Revenue Code.*

UH Case Medical Center followed the 2013 Proposed Regulations, published by the Treasury Department and IRS on April 5, 2013, in the Federal Register (REG-106499-12, 2013-21 I.R.B. 1111, [78 FR 20523]), in accordance with Notice 2014-2 that confirms that hospital organizations can rely on proposed regulations under section 501(r) of the Internal Revenue Code issued on June 26, 2012, and April 5, 2013, pending the publication of final regulations or other applicable guidance. The final rule entitled "Additional Requirements for Charitable Hospitals; Community Health Needs Assessments for Charitable Hospitals"; Requirement of a Section 4959 Excise Tax Return and Time for Filing the Return, was published by the IRS on December 31, 2014, and requires compliance after December 29, 2015.

[2] *Ohio Hospital Association Data, 2013.*

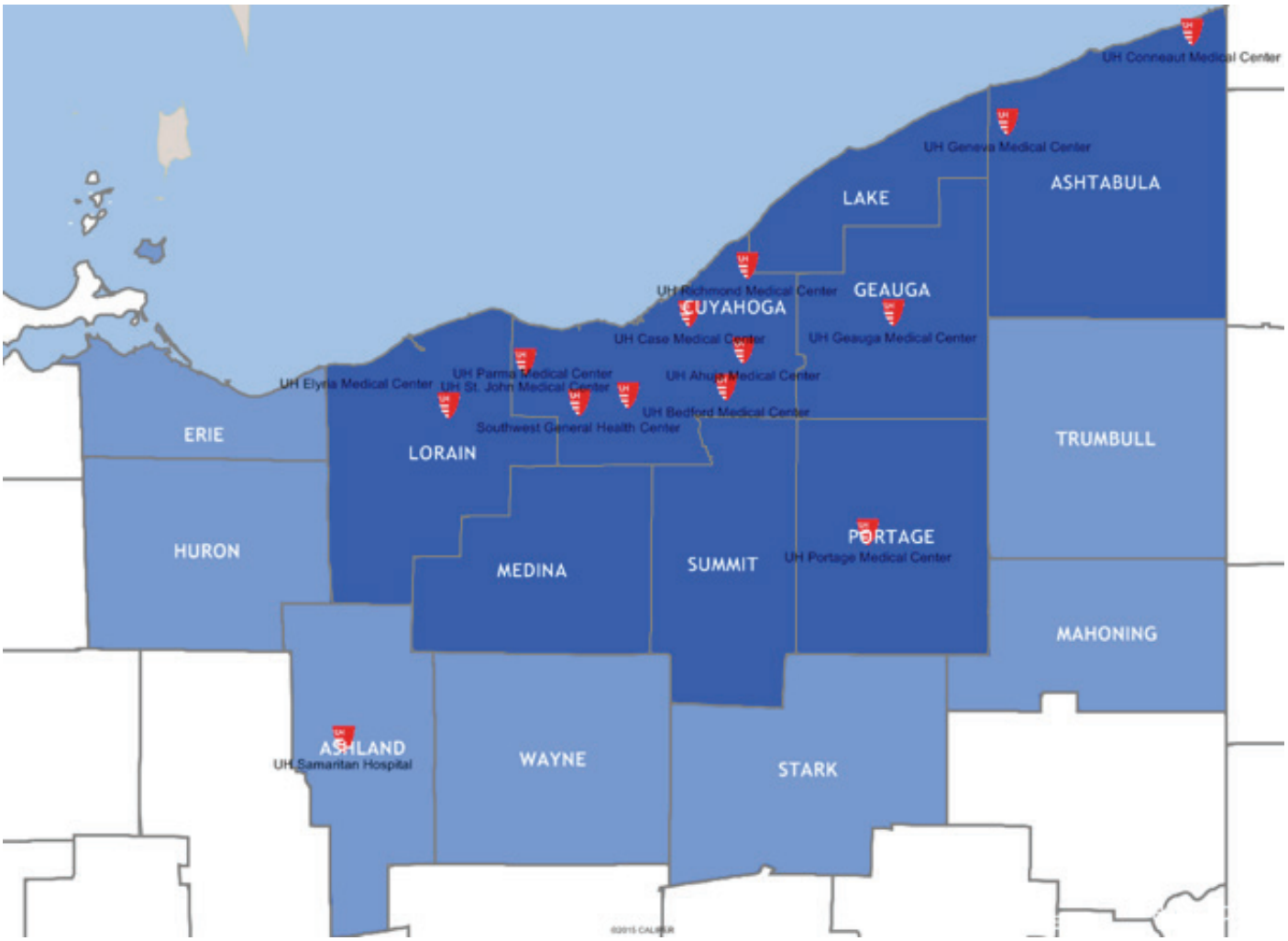


FIGURE 1: DEPICTS THE HOSPITAL'S PSA AND SSA. IT ALSO SHOWS THE LOCATION OF THE HOSPITAL AS WELL AS THE OTHER HOSPITALS IN THE AREA THAT ARE A PART OF THE UH SYSTEM.

OBSERVATIONS FROM 2015 CHNA

- For UH Case Medical Center's market areas the proportion of those ages 65 and over increased during the first half of this decade. This trend is expected to continue and is significant in that the use of health care increases exponentially with age, especially after age 65.
- Five counties in our primary service areas have higher poverty rates than the national and state averages. Portage and Cuyahoga counties had higher rates of people living below the poverty level than state averages in 2013. In Cuyahoga County in 2013 almost one in five residents (18.1%) lived under the poverty line. The proportion of residents living in poverty in Cuyahoga County increased by 1.4% from 2011 to 2013.
- The Hospital's PSA is more racially diverse than the SSA. In 2013, 17% of the PSA population was African-American compared to 8% in the SSA. African-American communities are most prevalent in the areas directly surrounding the Hospital. The proportion of non-White residents of Cuyahoga County increased by 1% from 2010 to 2013 and increased by 0.8% during that time frame in Summit County.
- Obesity (35% in Cleveland vs. 28% nationally) and smoking (36% of Cleveland adults vs. 17% nationally) rates are higher in Cleveland, as compared to state and national averages.
- About 12% of the Hospital's 2013 discharges were found to be ambulatory care sensitive (i.e., potentially preventable if patients were accessing primary care resources at optimal rates). The most prevalent diagnosis associated with ambulatory care sensitive cases was Congestive Heart Failure (primary diagnosis for 2.9% of inpatients in 2013). Hypertension and Diabetes, while rarely a primary diagnosis for hospitalizations in 2013, were a secondary diagnosis for 42.2% and 22.6% of the inpatients, respectively. These comorbidities were much more common among those hospitalized at UH Case Medical Center in 2013 than in the general population.
- Infant mortality is above average in Cuyahoga County and is much higher (three times higher) among Blacks than Whites.
- Cuyahoga County has 6% higher cancer death rates (all cancers combined) than the U.S. overall.

Additional information regarding the Hospital's PSA and SSA is included in the 2015 CHNA.

PRIORITY HEALTH NEEDS

Poor health status can result if a complex interaction of challenging social, economic, environmental and behavioral factors, combined with a lack of access to care, is present. Addressing the more common "root" causes of poor community health can serve to improve a community's quality of life and to reduce mortality and morbidity. Figure 2 (below) describes the community health needs identified through the 2015 CHNA as priorities.[4] Those needs that the Hospital plans to help address during 2016 through 2018, at least in part, are noted.

All gaps which relate to health identified in the 2015 CHNA are addressed, in one way or another, by UH Case Medical Center. However, herein we pinpoint those issues for which the Hospital is in the best position to impact the greatest number of community members with the greatest level of need. Below we repeat all health issues identified by the 2015 CHNA and denote those issues which UH Case Medical Center will proactively address in its 2016 – 2018 CHNA Implementation Strategy. Those denoted as 'no' are and will continue to be addressed by numerous programs offered by the Hospital. Those denoted as 'yes' are the areas toward which new and/or additional Hospital resources will dedicated from 2016 to 2018.

[4] *Health needs can also be found in the Hospital's 2015 CHNA.*

FIGURE 2: COMMUNITY HEALTH NEEDS IDENTIFIED IN 2015 CHNA

Priority Health Issues	Plan to Address
Health Disparities	
Equity	No
Poverty	No
Education	No
Unemployment	No
Aging population	No
Violence/Safety	No
Infant Mortality	Yes
Access Barriers	
Cost of Care	No
Transportation Barriers	No
Poor Access to Mental Health/Primary Care	No
High ED Utilization	Yes
Health Literacy	No
Lack of Resources	No
Lifestyle Barriers	
Obesity	No
Nutrition	No
Smoking	Yes
Physical Activity	No
Chronic Disease Conditions	
Cancer	Yes
Diabetes	No
Heart Diseases	Yes
Respiratory Disease	No
Mental Illness	No

Through implementing the above strategies, the Hospital anticipates the following improvements in community health:
1) Positive impact on the reduction of **cardiovascular disease**.
2) Positive impact on the **reduction of infant mortality** and improved infant health.
3) Reduced **inappropriate Emergency Room** use.
4) Positive impact on the **reduction of cancer mortality rates**, focusing on lung, colon, breast and cervical cancers. Coincident with this will be a positive impact on rates of **tobacco use**.

IMPLEMENTATION STRATEGIES – 2016 THROUGH 2018

The Hospital, through its Mission, has a strong tradition of meeting community health needs through its provision of ongoing community benefit programs and services. The Hospital will continue this commitment through the strategic initiatives set forth below that focus primarily on the four high-priority health needs as well as other selected needs identified in the 2015 CHNA.

The Hospital has provided community benefit programs for many years and will continue to provide such programs. Not all programs provided by the Hospital that benefit the health of patients in the Hospital's PSA and SSA are discussed in the Strategy. Further, given changes in health care, the strategies may change, and new programs may be added or programs may be eliminated during the 2016 – 2018 period.

Strategic Initiatives:

1. Reduce rates of cardiovascular disease.

a. The Heart Failure Program, started in 2013, in the University Hospitals Case Medical Center's Douglas Moore Clinic has become an integral part of the health care services **provided to underserved populations** in Cleveland. The Douglas Moore Clinic has been designated as being in a primary care Health Professional Shortage Area (HPSA ID 13999939C1). The Douglas Moore Clinic Heart Failure Program has had an enormous impact on the underserved population of Cleveland:

i. Facilitated heart failure care by embedding heart failure services within the Douglas Moore Clinic location. The Heart Failure Program routinely sees over 100 patients a month, of which 15 – 20 are new referrals from Douglas Moore Family Practice physicians.

ii. Provided guideline- and evidence-based care, including the appropriate identification of refractory heart failure patients for advanced therapies, including heart transplantation or mechanical circulatory assistance (i.e., heart pump).

iii. Promoted continuity of care for heart failure patients (who have the highest re-admission rates in U.S. and at the UH practice). Developed an initiative, in partnership with Internal Medicine Practice team and the UH Harrington Heart & Vascular Institute, to successfully reduce heart failure readmissions by providing disease and dietary education and by improving compliance of this challenging patient group.

iv. The partnership between the Cardiology/Heart Failure team and Internal Medicine Practice team at Douglas Moore Clinic has been successful in reducing heart failure readmissions by providing disease, drug, and dietary education, thereby improving patient compliance. We reduced hospital re-admissions by scheduling shorter interval follow-up office visits and frequent phone calls as well as home visits by nurses and health coaches to provide patient education, review complex medical regiments, and monitor daily weight. This intensive program is now standard practice within the Douglas Moore Clinic and is responsible for improving health outcomes, quality of life and patient satisfaction for more than 1,200 patients to date.

v. The Douglas Moore Clinic is staffed by Internal Medicine residents and attending physicians. It aims to increase the proportion of physicians who integrate preventive primary care with chronic and primary care of cardiac patients.

Goal: Reduce the hospitalization rates and mortality for identified cardiac patients within the Hospital's PSA, with a strong focus on those historically underserved.

Objective: To increase the number of adults among underserved populations in the PSA who are receiving medical care, patient lifestyle and dietary education, and ongoing health monitoring for their cardiovascular disease.

Evaluation Measures: Number of patients seen each month; hospitalization rates for Clinic patients; re-hospitalization rates for cardiac patients.

b. The UH Harrington Heart & Vascular Institute plans to:

i. Offer community nutrition classes.

ii. Offer free educational sessions on cardiovascular health in a variety of community settings.

iii. Offer free community screenings, including a combination of body mass index, body fat analysis, blood pressure, heart attack risk assessments and other cardiovascular screenings at multiple community venues.

c. The UH Neurological Institute will address vascular disease to prevent stroke through good cardiovascular health and plans to:

i. Offer free health screenings and educational talks for the general public.

ii. Offer free health and wellness events tailored to help individuals manage specific disorders.

iii. Offer "Know Your Numbers" events, which provide free stroke risk assessments to community members.

iv. Continue serving low-income populations through a neurological resident rotation at the Free Medical Clinic of Greater Cleveland.

Goal: Increase health literacy for cardiovascular patients and community members.

Objective: Provide outreach to community members to improve awareness and understanding of cardiac health issues.

Evaluation Measures: Improved early detection of cardiovascular disease among patients who seek care at the Douglas Moore Clinic, UH Harrington Heart & Vascular Institute, UH Neurological Institute and other UH affiliated care providers; decreased incidence of cardiovascular disease in the general population; improved death rates for cardiac disease in the community; decreased incidence of stroke in the general population; improved death rates from stroke in the general population.

2. Reduce infant mortality and improve infant health.

Below we describe several programs which aim to reduce infant mortality and improve infant health. While the specific goals of each of the programs are somewhat different, the over-arching goal is to reduce infant mortality within the Hospital's PSA.

a. The Centering Pregnancy Program ("CPP"), a joint program between UH MacDonald Women's Hospital and UH Rainbow Babies & Children's Hospital will work to improve neonatal outcomes through an innovative program that provides education, outreach, and coordination of health care and social services for **low income mothers**.

i. Prenatal Care

Goal: Continue and expand the Centering Pregnancy Program, a joint effort between UH MacDonald Women's Hospital and UH Rainbow Babies & Children's Hospital that provides a groundbreaking group approach to prenatal care that empowers at-risk expectant mothers by encouraging responsibility and accountability for their own health. The group dynamic helps reduce stress and depression among new young mothers who are often alone or isolated during pregnancy and afterward, while the program educates participants about breast feeding and safe sleep and helps provide essential services during pregnancy for improved neonatal outcomes.

Objective(s): Increase in number of centering pregnancy sessions offered, increase in number of women participating, improved sense of self efficacy and increased knowledge about safe infant care practices among participating women, greater number of prenatal care visits attended compared to women not participating in the program.

Evaluation measures: Tracking of number of at-risk women participating in the Centering Pregnancy program, average age and parity of women participating, average number of Centering sessions attended, average number of prenatal care appointments attended; collection of data on birth outcomes (gestational age, birth weight, days in hospital) for comparison with a random selection of similar women who do not participate in the Centering program, comparison of pre/post survey data for participating women that measures knowledge of infant care and development, understanding of safe sleep practices, and feelings of self-efficacy and perceived social support.

b. Work to identify and address unsafe sleep environments in high risk communities by continuing to roll out and expand an educational program for **first responders** to address high rates of sleep related morbidity and mortality in our region.

Goal: Continue and expand UH Rainbow Babies & Children's Hospital's Direct On Scene Education (DOSE) program that trains first responders to assess infant sleeping environments while in the home, take steps to make corrections, and educate parents about the basics of infant safe sleep. In the event there is not a safe place for the baby to sleep, first responders can refer families to the Cuyahoga County Board of Health to receive a portable safe sleep space.

Objective(s): Increase in number of training sessions, increase in number of first responders trained, increase in number of police and fire departments involved in training, increase in perceived self-efficacy and intention to act among individuals trained.

Evaluation measures: Tracking of number of training sessions held, number and type of first responders (police, fire, EMS) trained, number of municipalities taking advantage of training, and number of referrals to the Cuyahoga County Board of Health and number of portable cribs distributed as a result of referrals; feedback from individuals completing training regarding increases in knowledge, perceived importance of safe sleep issues, and intention of putting training into action.

c. Increase the availability of safe sleep spaces for low income families by reaching **at risk families prior to hospital discharge** in order to protect vulnerable infants by identifying families who are lacking safe sleep spaces for their infants and providing a safe portable crib that supports the benefits of room sharing without the risks of bed sharing.

Goal: Implement a new project designed as a collaboration between social workers in UH Rainbow Babies & Children's Hospital's Neonatal Intensive Care Unit (NICU) and NICU step down units and the staff of the Rainbow Injury Prevention Center. Social workers will assess safe sleep plans with parents prior to their infants' discharge and identify families who lack a safe sleep space for their babies. The Rainbow Injury Prevention Center will supply social workers with gift certificates redeemable for a Pack 'n Play portable crib from the Rainbow Safety Store.

Objective(s): Rollout of the new program according to schedule, training of NICU and NICU step down social workers on safe sleep issues and assessment techniques, establishment of consistent pattern of referrals to the program, convey the importance of the safe sleep issue to parents.

Evaluation measures: Tracking of stages of program launch, number of social workers trained, number of vouchers distributed, and number of vouchers redeemed.

d. To address the high rates of sleep related infant morbidity and mortality among low income families in the Greater Cleveland community by providing safe sleep education and outreach to **patient families and community physicians who provide primary care services to at risk families.**

Goal: Continue to post and distribute safe sleep educational materials (window clings, posters, and parent handouts) in UH Rainbow Babies & Children's Hospital departments that see large numbers of parents of infants (ambulatory clinic, pediatric emergency department, etc.) and expand the program through distribution of educational materials to practicing UH Rainbow Babies & Children's Hospital pediatricians throughout the community.

Objective(s): Increase in number of pediatric practices and pediatric services within UH Rainbow Babies & Children's Hospital who display or distribute safe sleep information for families of infants; increase in number of community pediatric practices who display or distribute safe sleep information for at risk families.

Evaluation measures: Tracking of number of materials distributed, number of hospital departments and number of community pediatricians reached who display/share information routinely with patients, estimation of number of families exposed to safe sleep messages through these sites.

e. Improve screening of patients for safe sleep habits through **training of all pediatric providers** in the Rainbow Care Connection Network. Providers will be trained to screen all babies from birth to six months of age for safe sleep habits and provide education to caregivers not practicing safe sleep habits.

Goal: Primary care pediatrician routinely screening for safe sleep habits in babies.

Objective(s): Increase training of clinicians performing safe sleep screening for babies.

Evaluation measures: Number of clinicians performing safe sleep screening and percentage of their patients for which safe sleep screening is documented.

3. Reduce inappropriate emergency room use.

Inappropriate use of the Emergency Department is a result of lack of access (financial, geographic, transportation, cultural) to primary care. The actions outlined below are designed to identify those in need of a primary care medical relationship and create a path to primary care. All of the programs described below seek to proactively identify patients who present to the Emergency Department with a nonemergent issue or proactively seek patients with chronic conditions that have historically been associated with high levels of inappropriate emergency room use.

a. Continue use of the Medical Access Clinic – a clinic that is run in conjunction with the Department of Emergency Medicine that will treat nonemergent patients in a clinic setting after they have been triaged and medically screened to meet EMTALA regulations in the emergency department. The Medical Access Clinic is staffed by Nurse Practitioners and Family Medicine physicians and provides care for these patients and then provides a link for them to primary care. The clinic sees an average of 4,000 patients per year and 97% of them have not returned to the CEM for nonemergent visits. They are also provided education on how to manage their medical conditions and access to care.

b. Provide and promote patient participation in primary care through primary care clinics at the Hospital, including the Family Medicine Clinic and Douglas Moore Clinic, and the UH Otis Moss Jr. Health Center located in Cleveland's urban east side, to better meet the needs of the growing number of uninsured and

underinsured patients in the area as well as the recent large influx of uninsured and Medicaid-covered patients who previously received care at a now closed inner-city hospital. These facilities, along with UH Rainbow Babies & Children's Hospital, the Rainbow Ambulatory Practice Clinic and UH MacDonald Hospital Women's Health Center, are health professional shortage area (HPSA) designated facilities on the Hospital campus.

c. Continue efforts through the Douglas Moore Clinic, which provides resident education in the provision of primary care and chronic disease management in a collaborative multidisciplinary environment, and the UH Otis Moss Jr. Health Center, which promotes and provides family-centered care. Primary care is available to pediatric and adult patients. Obstetrical and other services are also provided at the center. In addition, UH Otis Moss Jr. Health Center provides numerous free community outreach health screening events, educational programs on topics such as teen violence and self-esteem, parenting, nutritional education and other topics to residents in low-income areas. Patients who are hospitalized or who come to the emergency room and do not have primary care providers are linked to these clinics to promote better health care and preventative services.

d. Offer classes at the UH Otis Moss Jr. Health Center to the public on chronic disease management to teach people how to take charge and become more active participants in their health and wellness. In addition, sessions have been held to improve health literacy about how to appropriately seek health care and help people make more informed decisions when seeking care.

e. Continue efforts by the Hospital's patient access staff, which is highly effective at reducing inappropriate emergency department usage by enrolling patients in government programs such as Medicaid, State Children's Health Insurance Program or the UH Hospital Financial Assistance Program.

f. Provide care coordination for sickle cell anemia services when a need is identified during an emergency room visit or elsewhere in UH practice.

g. Continue fast-track programs that support patients with chronic disease through the use of immediate clinic access and on-call registered nurse and physician support teams for programs such as solid organ transplant, heart failure, pulmonary hypertension, special immunology, bone marrow transplant and other oncology teams. This immediate and dedicated support permits patients to access professional advice and health care in a timely manner, thus avoiding unnecessary emergency room use.

h. Deploy two teams from the Hospital House Calls Program consisting of physicians and nurse practitioners to provide continuity and acute home care for more than 200 Medicare and Medicaid dually eligible seniors in urban neighborhoods.

i. Encourage and enable Family Medicine physician faculty to volunteer at the Free Medical Clinic of Greater Cleveland that provides care to the uninsured in a primary care setting, thus reducing unnecessary visits to the emergency room.

j. Implement and evaluate a newly funded program at the Hunger Network food pantry locations and other nontraditional locations to provide health education about care options and disease management.

Goal: Reduce rates of inappropriate use of the re-direct patients to the Medical Access clinic for care; Emergency Department.

Objective(s): Identify those who present to the Emergency Department with non-emergent diagnoses; determine reason for use of Emergency Department instead of other community resources for primary care; re-direct patients to the Medical Access clinic for care; initiate process to link patient to community-based primary care; seek patients in the community who, because of life stage or health status, are likely to over-use the emergency department and provide case management or links to primary care.

Evaluation measures: Number of adult and pediatric patients who present to the Emergency Department as a nonemergent case.

4. Addressing high cancer mortality rates (and high tobacco use rates)

i. Increase Early Detection Initiatives

In addition to providing high quality care across the health continuum, it is a goal for UH Seidman Cancer Center to address gaps in early detection and screening measures. Data collected from the CHNA revealed that patients in our community access routine health screenings, more specifically cancer screenings, at low rates (less than half of adults have received a pap smear, mammogram, or prostrate screening within the previous year). Evidence continues to show that screening measures can detect disease at earlier rates thus providing patients with less aggressive treatment options and better health outcomes.

Goal: Improve cancer patient outcome through increased early detection.

Objective: Increase early detection rates by promoting the importance of screening, decreasing barriers to screening, and maximizing access to screening in under-served areas of the community.

Evaluated Outcomes: Proportion of cancers which are detected at earlier (I & II) stages; reduce cancer death rates.

UH Seidman Cancer Center has a history of providing low or no-cost cancer screenings to the community. **Our strategy to address this priority is to increase the amount of screenings we can provide to residents of our service area.** We also understand the importance of collaborating with other health institutions to pool resources and cast a wider net of services to the community.

- The Breen Breast Center located inside UH Seidman Cancer Center has been a grant recipient of Susan G. Komen Foundation for over a decade. That grant funds Project TEMPLE (Teaching, Educating, Mentoring, Preventing, Learning, Empowering) a community-based breast health education program aimed at educating and connecting women in low-socioeconomic and underserved areas with breast health services. To date, we have provided education to over 10,000 women over the past decade. It is our intention to seek additional funding from local and national funders to continue to provide breast health services to this population.
- The free Saturday Breast Exam provides a no-cost mammography program for uninsured women.
- The Mobile Mammography Project implemented by the UH Seidman Cancer Center outreach staff in collaboration with schools, churches and health centers to provide screening mammograms at a community site, at no cost to women without insurance.
- We will collaborate with our UH Digestive Health Institute to continue and increase the amounts of free colonoscopy screenings during the month of March. Our community outreach department is a part of a system-wide initiative to promote March as Colorectal Health Awareness Month. Beginning in 2016, we will utilize an inflatable colon in targeted areas to increase awareness and add a visual to reinforce the very important messaging of getting a colonoscopy.
- Cervical Cancer prevention and HPV vaccinations have emerged as an area of concern for our community. We have partnered with other institutions to increase the messaging surrounding this cancer. In the fall of 2015 we assisted in a back-to-school health fair sponsored by the City of Cleveland and made available HPV vaccines to 75 students. To capitalize on the momentum of the event, we have agreed to continue to partner with The Cleveland Clinic, MetroHealth System, The City of Cleveland Department of Health and The Cleveland Metropolitan School district to allow these students and any other interested students to receive their second and third doses of the vaccine at multiple clinics free of charge. We will track the participants using a software to which organizations have access to increase compliance and adherence to the vaccination schedule. The vaccination event will be held every year.
- Lung Cancer rates disproportionately affect Clevelanders, especially in the African-American Community. Incidences indicate that African Americans in Cleveland have an incidence rate approximately 37% higher than the national average (15 county incidence from OCISS 2008 – 2012). We want to respond to this trend by marketing low dose CT screenings to the community. UH Seidman Cancer Center has added lung cancer awareness presentations to the cadre of cancer health education that is provided by the Office of Community Outreach.
- UH Seidman Cancer Center identified that the number of prostrate screenings obtained by those eligible is lower in our population than compared to the state and national numbers. Only 36% of eligible residents obtained PSA screening in the past year. We have started to address this by securing free screenings provided by our clinicians in the Genitourinary Service. To continue in that vein, in the spring of 2016 we have partnered with CMHA (Cuyahoga County Metropolitan Housing Authority) and Fans for the Cure to provide a community event with our physicians to learn about prostate health and the importance of screenings. Participants who are living in public housing and are uninsured will have the option to be navigated to PSA appointments and connected with medical services free of charge.

ii. Recognize and Create Strategies to Reduce Barriers to Care

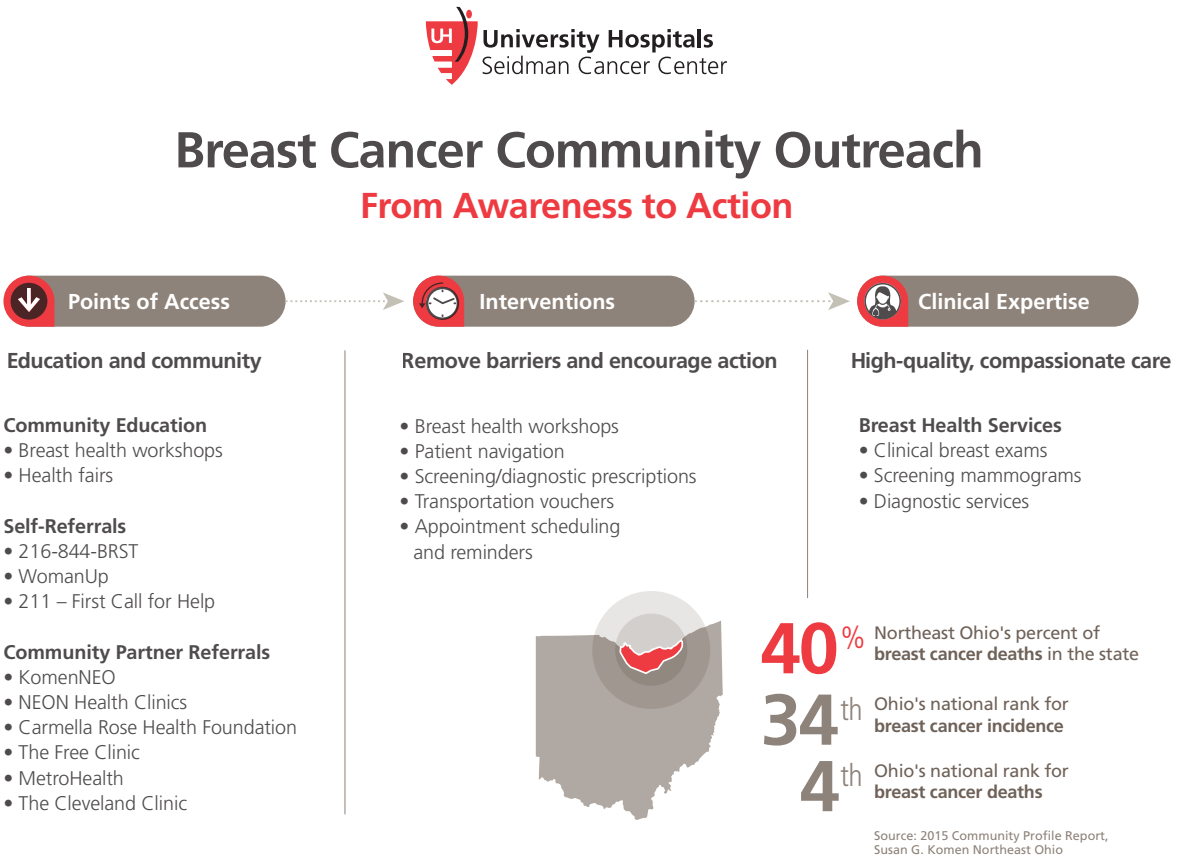
Goal: Improve cancer patient outcomes through improved community-based care.

Objective: Improve cancer patient outcomes through improved case management/navigation.

Evaluated Outcomes: Increase post-diagnosis life-span; reduce complication rates among cancer patients in case management/navigation program.

Using methods created in our breast cancer outreach programs, we want to implement a model of navigation for all cancers that we treat to assist patients through the continuum of care. We anticipate this intervention as a way to remove barriers identified by our patients. We have put in multiple touch points to connect so patients will experience the health care system seamlessly. There are also opportunities for health care providers to engage with one another to share best practices.

FIGURE 3: EXAMPLE OF CANCER OUTREACH MATERIALS FOR CLINICAL PROFESSIONALS



iii. Advocate and Provide Resources in Efforts of Reducing Tobacco Use

Goal: Reduce incidence of tobacco-related diseases.

Objective: Reduce tobacco use in community via 1) advocacy on policy known to reduce tobacco use and 2) increased access to smoking cessation programs for existing smokers.

Evaluated Outcomes: Increase number of smokers who begin participation in a smoking cessation program; proportion of program participants who complete a smoking cessation program; proportion of adults who are tobacco users; reduced tobacco-related cancer rates; reduced respiratory disease rates.

Tobacco use, arguably more than any other factor, is associated with a cancer diagnosis. Rates of smoking in our catchment area are double the national average. UH Seidman Cancer Center considers this to be a major factor in poor health and plans to address it over the next three years and beyond. We will work with our UH Harrington Heart & Vascular Institute to connect patients who identify as using tobacco to a comprehensive smoking cessation program. This program takes a multifaceted approach to cessation by using various methods to treat the tobacco user. Participants have access to smoking cessation counseling, nicotine replacement therapy, behavior change and coping skills to help kick the habit.

We will address tobacco use in the community by advocating for more stringent legislation surrounding tobacco sales. Members from the Office of Community Outreach are on committees at the city level (Healthy Cleveland Breathe Free Committee) that petitioned city government to pass a law prohibiting the sale of tobacco to those under the age of 21.

This committee has also been a part of a movement to get more businesses to hire smoke free candidates or create smoke-free policies.

iv. Create a Health Literate Environment throughout the Cancer Center

Goal: Increase health literacy among cancer patients.

Objective: Improve patient compliance through improved health literacy achieved through properly delivered and timely communications with patients.

Evaluated Outcomes: Improve patient outcomes.

Health literacy is the ability to obtain, process and act on health care information. Patients are inundated with materials in any hospital system, especially when dealing with a chronic disease such as cancer. It is a goal of UH Seidman Cancer Center that patients are given the appropriate amount of information at the appropriate time and in a manner in which they can understand.

The Office of Patient and Public Education has established guidelines for creating and disseminating patient education materials. Nurse educators employ various methods for ensuring that the materials are written below an 8th grade reading level. By using health literacy software, user testing, and the assistance of patient and family advisors, over 300 high-quality and properly-timed patient information sheets ranging from symptom management to psychosocial coping skills will be shared with patients and families during their treatment.

This process has been identified as a best practice by industry leaders in cancer patient education. A subsequent manuscript has been accepted to a peer reviewed oncology journal detailing the creation and evaluation of a plain language website and smartphone application for cancer clinical trials information. This innovative approach to health literacy has made complex clinical trial jargon less difficult and more user friendly.

Monitoring Implementation

UH Seidman Cancer Center will use members from the institution's cancer and other committees to monitor and evaluate the progress of each priority. Members are from various disciplines and disease site areas.

We anticipate that each priority will have successes and setbacks during implementation. The taskforce is charged with making sure each priority maintains momentum and tracks funds dispensed to manage programs. This will safeguard the integrity and quality of the work being done to complete the identified priority.

Strategies to Address Future Health Needs

UH Seidman Cancer Center is committed to making the necessary enhancements to address our health needs. We will strive to accurately measure each priority and share progress systemically. We plan to evaluate the effectiveness of each strategy each year to ensure that we are impacting the needs of the community. UH Seidman Cancer Center will also be stewards of valuable community resources and approach each priority through the lens of the community. If we consistently make advancement in each priority, it is our hope that will be reflected in the next CHNA.

NEEDS BEYOND THE HOSPITAL'S MISSION OR SERVICE PROGRAMS

No hospital facility can address all of the health needs present in its community. The Hospital is committed to adhering to its Mission and remaining financially healthy so that it can continue to enhance its clinical, teaching and research activities and to provide a wide range of community benefits. The Strategy therefore does not address the following community health needs identified in the 2015 CHNA in an aggressive or comprehensive way. With the understanding that many things are associated with good and/or poor health, The Hospital does collaborate with those in the community who are focusing on these issues.

Other Needs Not In Current Plan, But Otherwise Addressed by Hospital Programs

Numerous community health needs were identified in the Hospital's 2015 CHNA. The current plan most aggressively and comprehensively addresses four of those issues, as described above. Those issues were chosen based on the number of community members impacted and the Hospital being in the best position to have a positive impact on those issues. The issues which were not chosen to be a focus of this plan were therefore those where the Hospital is not in a position to have a significant positive impact and/or others are known to be focusing on that issue.

That being said, in addition to the aforementioned Strategic Initiatives outlined in detail in this Plan, the Hospital will either begin or continue to provide other community benefit programs responsive to the health needs identified in the 2015 CHNA. These may include, but are not limited to, health education programs, screenings, support groups and other community health improvement services; medical research; education for physicians, nurses and allied health professionals; and access to care through the UH Hospital Financial Assistance Program. Some of these were identified in the 2015 CHNA and are described below.

Health Issues Identified in 2015 CHNA	Efforts By Hospital To Address Issue
• Equity • Aging Population • Access Barriers • Cost of Care • Poor Access to Primary Care • Lack of Resources	**Health Equity:** UH Case Medical Center has begun compiling quality analytics on our inpatient and outpatient data to analyze our health outcomes by looking at metrics such as of race, ethnicity or primary language. We are also focusing on areas where major health disparities exist to reduce disparities in areas such as cancer, heart disease, and infant mortality. **Lack of Affordable and Accessible Care:** The Hospital offers financial assistance to those who qualify through the UH Hospital Financial Assistance Program. **Lack of Affordable and Accessible Prescription Medications:** The Hospital currently plans to continue addressing the lack of accessible and affordable prescription medications through direct patient counseling and education. The Hospital provides prescription medications at reduced or no cost through its Bolwell Pharmacy to those who qualify through the UH Hospital Financial Assistance Program. The Hospital is a registered safety-net hospital in the federal 340B Pharmaceutical Drug Access Program which provides discounts to qualifying hospitals on covered outpatient medications and are then provided to patients at a reduced cost. **Cost of Care:** The Hospital, working with the UH System and other third-party organizations, advocates at the local, state and federal levels of government to support appropriate health and human service agencies and programs to assure that critical health access and prevention programs remain strong. The Hospital and the UH System provide financial contributions to other nonprofit community benefit organizations to support the community at large in addressing community health needs.
• Health Literacy	**Health Literacy:** The Hospital provides extensive health education to meet community needs, including but not limited to, cardiovascular health, cancer prevention, nutrition, stroke awareness, diabetes, sexually transmitted disease and other health education topics.
• Poor Access to Mental Health Care • Mental Illness	**Poor Mental and Behavioral Health Status and Lack of Services:** Comprehensive evaluation, diagnosis and treatment of psychiatric illness for adults and children (both inpatient and outpatient) is offered through the Hospital's Department of Psychiatry.

Health Issues Identified in 2015 CHNA	Efforts By Hospital To Address Issue
• Lifestyle Barriers • Obesity • Nutrition • Physical Activity • Diabetes	**Prevalent Diet- and Exercise-Related Conditions:** The Hospital provides health education on nutrition and healthy eating, including the Body and Soul Program, working with local churches to help educate community members in low-income neighborhoods on the importance of proper nutrition and cancer prevention. UH continues to run the Be Well Program with the Hunger Network to provide health screening and education to people using these feeding centers.
• Violence/Safety	**Poor Community Safety:** The Hospital, through the UH Emergency Medical Services Institute (the "Institute"), and in collaboration with emergency squads in 71 Northeast Ohio communities, provides the public with advanced emergency care that helps save lives. The Institute provides education and training to first responder squads in nine counties. The 2,000 classes the Institute offers each year reach 18,000 emergency workers – paramedics, emergency medical technicians, fire chiefs and others. The Institute also makes medical equipment such as EKG machines available and trains squads in its use. In 2015, UH Case Medical Center started a Level I Trauma Center to meet the needs of the immediate community and of the region it serves.

Health Issues Identified in 2015 CHNA	Efforts By Hospital To Address Issue
• Unemployment • Poverty	**High Rates of Unemployment and Financial Hardship:** By supporting leading-edge supplier diversity models and area minority- and female-owned contractors, University Hospitals has built a diverse supply chain that, in turn, has added jobs to the Northeast Ohio region. Previously, through the UH Vision 2010 strategic capital plan, which included building a freestanding cancer hospital, renovating and expanding UH Case Medical Center's adult and pediatric centers for emergency medicine, and renovating the Neonatal Intensive Care Unit on the Hospital's campus, University Hospitals contributed to the stimulation of the local economy. UH has invested in training a diverse workforce for tomorrow through high school and apprenticeship programs in construction trades. University Hospitals provides funding support for the Evergreen Cooperative in urban Cleveland, which hires local workers at a living wage. Evergreen is located in the Greater University Circle area and hires local residents that are under and unemployed to work in one of three cooperatives: the Evergreen Laundry – UH is a major vendor to this company to provide a growing portion of our laundry/linen service; the Evergreen Energy Solutions – UH contracts with this company to do lighting/solar and other energy efficient installations across our health care system; and the Green City Growers – the region's largest under glass hydroponic greenhouse providing the vast supply of lettuce and herbs for our food service. UH also supports the NewBridge Center for the Arts and Technology. NewBridge provides unemployed adults with training in health care fields that are in demand, such as phlebotomy and pharmacy technician work, so that they are employable at UH and other health care institutions. UH also continues to work with Towards Employment and Neighborhood Connections to provide the nationally recognized Step UP to UH program that works with under and unemployed adults in the Greater University Circle area surrounding UH Case Medical Center to get them into entry level jobs. This program works to identify residents in the surrounding neighborhoods who with additional soft skills training, assistance with job interviewing and application assistance can be successful at UH. The program also includes a job coach to work with the new UH employee for a significant period to assure on-boarding and job retention is the best it can be. Additionally, UH Case Medical Center offers programs such as Bridge to your Future and Pathway to PCA to provide low wage incumbent workers with the resources and supports to earn a GED, attend college readiness classes and assist in developing career pathways to help employees move to higher wage positions.

Health Issues Identified in 2015 CHNA	Efforts By Hospital To Address Issue
• Education	**Low Educational Achievement:** This identified need is primarily addressed by the Cleveland Metropolitan School District and the State of Ohio Department of Education; however, the Hospital works with the Cleveland School of Science and Medicine at John Hay High School in its Journey Program. This program provides special opportunities for select students of excellence with an interest in science and math by integrating new educational events into their curriculum. During an additional 40 classroom hours, student participants shadow staff at UH Case Medical Center. University Hospitals has committed $1 million over five years to the NewBridge Center for Arts and Technology to educate unemployed adults as pharmacy technicians and phlebotomists.
• Transportation Barriers	**Lack of Transportation to Health Services:** The Hospital does not have a transportation program; however, on occasion the Hospital will assist patients with transportation to the Hospital consistent with federal regulatory guidelines.

Community benefits programming has been identified as a system wide initiative that will be used in crafting opportunities to positively affect health outcomes. We see this implementation strategy as a fluid and flexible approach to our community health concerns. Continuing to partner with the community, and focus on issues critical to our service area will keep us dedicated to our mission: To Heal. To Teach. To Discover.

IMPLEMENTATION STRATEGY DEVELOPMENT COLLABORATORS

In developing this implementation strategy, the Hospital collaborated with the following hospitals owned and/or operated by University Hospitals:

- UH Ahuja Medical Center
- UH Bedford Medical Center, a campus of UH Regional Hospitals
- UH Conneaut Medical Center
- UH Elyria Medical Center
- UH Geauga Medical Center
- UH Geneva Medical Center
- UH Parma Medical Center
- UH Portage Medical Center
- UH Rainbow Babies & Children's Hospital
- UH Richmond Medical Center, a campus of UH Regional Hospitals
- UH St. John Medical Center
- UH Samaritan Medical Center
- UH Avon Rehabilitation Hospital
- UH Rehabilitation Hospital (Beachwood)

Among the nation's leading academic medical centers, University Hospitals Case Medical Center is the primary affiliate of Case Western Reserve University School of Medicine, a nationally recognized leader in medical research and education.

The Strategy will be implemented in collaboration with other entities including, but not limited to:

- American Cancer Society
- American Heart Association
- American Liver Foundation
- Case Western Reserve University
- Crohn's and Colitis Foundation
- City of Cleveland Department of Public Health
- Cuyahoga County Board of Health
- Federally Qualified Health Centers
- The Gathering Place
- Hunger Network of Greater Cleveland
- March of Dimes
- State of Ohio/Department of Health
- Susan G. Komen Foundation
- Greater University Circle partnering organizations

UH Case Medical Center is a 1,032-bed tertiary medical center specializing in adult and pediatric medical and surgical specialties. It is also the primary affiliate of Case Western Reserve University School of Medicine. This academic medical center is the central campus of University Hospitals and includes UH MacDonald Women's Hospital, the only women's hospital in the state of Ohio, UH Rainbow Babies & Children's Hospital, a nationally ranked pediatric hospital, and UH Seidman Cancer Center, the only freestanding cancer hospital in northern Ohio.

2016 IMPLEMENTATION PLAN




This Implementation Plan was approved by the University Hospitals Board of Directors on March 15, 2016

University Hospitals

Rainbow Babies & Children's Hospital

INTRODUCTION

University Hospitals Rainbow Babies & Children's Hospital (the "Hospital") conducted a community health needs assessment (a "CHNA") of the geographic areas served by the Hospital pursuant to the requirements of Section 501(r) of the Internal Revenue Code ("Section 501(r)"). The CHNA findings were published on the Hospital's website in January 2016 (the "2015 CHNA"). This CHNA was adopted by the UH Board of Directors on September 24, 2015.[1]

This is the second UH Rainbow Babies & Children's Hospital CHNA in response to the federal government regulation.[2] The 2015 UH Rainbow Babies & Children's Hospital CHNA served as the foundation for developing an implementation strategy to address those needs that (a) the Hospital determines it is able to meet in whole or in part; (b) are otherwise part of its mission; and (c) are not met (or are not adequately met) by other programs and services in the Hospital's service area. This implementation strategy ("Strategy"), also required by Section 501(r), documents the Hospital's efforts to address the community health needs identified in the 2015 CHNA.

The Strategy identifies the means through which the Hospital plans to address a number of the needs that are consistent with the Hospital's charitable mission during 2016 through 2018 as part of its community benefit programs. Beyond the programs discussed in this Strategy, the Hospital is addressing many of these needs simply by providing care to all, regardless of their ability to pay, every day.

The 2015 CHNA list of health needs was compiled based on the variety of data assessed throughout the report. For example, issues like diabetes and obesity were found prevalently throughout the data sets; including in hospital discharge data, Hospital Council of Northwest Ohio Community Health Needs Assessment Data, and qualitative data collected through focus groups, surveys and public health interviews. Health needs were categorized into three primary categories, which encompassed a broader list of specific, related needs. To prioritize these health needs, a process was developed that included input from hospital leaders who work closely with the community and have an in-depth understanding of community needs. After reviewing the primary and secondary data analysis for the UH Rainbow Babies & Children's Hospital service area, a team of leaders from the hospital assembled to determine priority health needs. The team met in July 2015 and together determined a set of specific criteria with which to identify priority health needs. These criteria included: (1) magnitude of the problem, (2) alignment of the problem with organizational strengths and priorities, (3) impact of the problem on vulnerable populations, (4) existing resources addressing the problem, and (5) ability to measure outcomes related to implementation efforts. Feedback from external community leaders, as described in the Qualitative Data Analysis section of this report, was a driving factor in this prioritization process as well.

From this list, UH Rainbow Babies & Children's Hospital has prioritized three primary categories of health needs for this CHNA:

1. Lack of Access to Primary Care

2. Lack of Access to Dental Care

3. High Rates of Infant Mortality

The team determined that it would be best to focus on three primary priorities in order to devote resources to them in a meaningful way, rather than to spread resources too thin over a broader list of priorities. These priorities align with the priorities addressed in UH Rainbow Babies & Children's Hospital's 2012 Implementation Strategy. Because UH Rainbow Babies & Children's Hospital cares for children, the adult health needs identified through this CHNA are not directly prioritized. Within the primary categories of prioritized child and youth health needs fall several additional health issues identified through this CHNA. As such, these additional health issues will serve as second tier priorities for UH Rainbow Babies & Children's Hospital.

The Hospital anticipates the strategies may change and therefore, a flexible approach is best suited for the development of its response to the 2015 CHNA. For example, certain community health needs may become more pronounced and require changes to the initiatives identified by the Hospital in the Strategy. During 2016 through 2018, other community organizations may address certain needs, indicating that the Hospital's strategies should be refocused on alternative community health needs or assume a different focus on the needs identified in the 2015 CHNA. In addition, changes may be warranted by the publication of final regulations.

[1] *The Patient Protection and Affordable Care Act (Pub. L. 111-148) added section 501(r) to the Internal Revenue Code, which imposes new requirements on nonprofit hospitals in order to qualify for an exemption under Section 501(c)(3), and adding new reporting requirements for such hospitals under Section 6033(b) of the Internal Revenue Code.*

[2] *UH Rainbow Babies & Children's Hospital followed the 2013 Proposed Regulations, published by the Treasury Department and IRS on April 5, 2013, in the Federal Register (REG-106499-12, 2013-21 I.R.B. 1111, [78 FR 20523]), in accordance with Notice 2014-2 that confirms that hospital organizations can rely on proposed regulations under section 501(r) of the Internal Revenue Code issued on June 26, 2012, and April 5, 2013, pending the publication of final regulations or other applicable guidance. The final rule entitled "Additional Requirements for Charitable Hospitals; Community Health Needs Assessments for Charitable Hospitals"; Requirement of a Section 4959 Excise Tax Return and Time for Filing the Return, was published by the IRS on December 31, 2014, and requires compliance after December 29, 2015.*

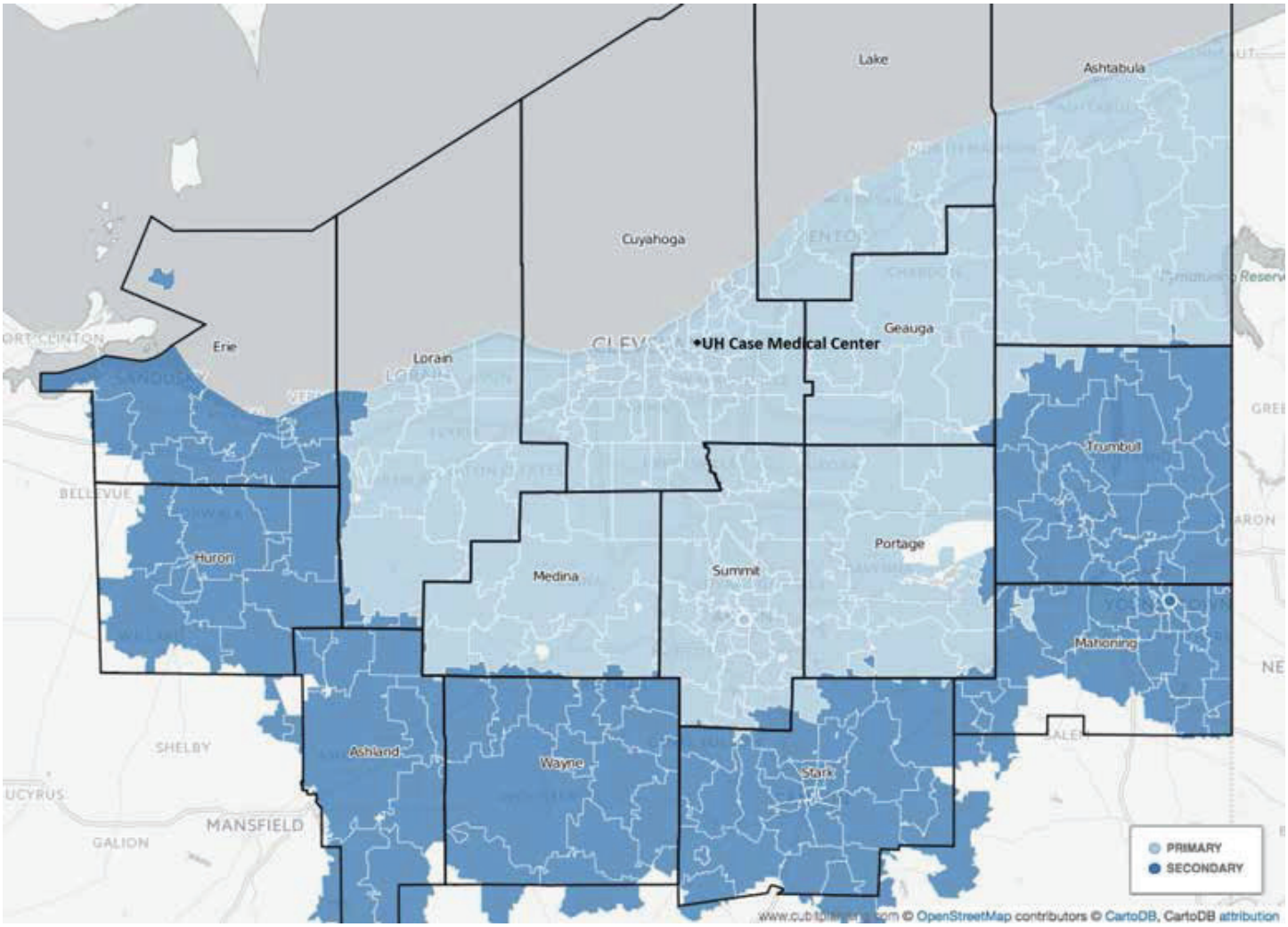
HOSPITAL MISSION STATEMENT

As part of University Hospitals Case Medical Center, a wholly owned subsidiary of University Hospitals Health System, Inc. ("University Hospitals" or "UH"), the Hospital is committed to supporting UH's mission, "To Heal. To Teach. To Discover." (the "Mission"), by providing a wide range of community benefits including clinical services, medical education and research. UH is an integrated delivery system and thus can provide benefits by coordinating within and among its various entities (the "UH System").

COMMUNITY SERVED BY THE HOSPITAL

The community served by the Hospital is defined based on the geographic origins of the Hospital's inpatients. The Primary Service Area ("PSA") is the geographic area from which the majority of the Hospital's patients originate. The Secondary Service Area ("SSA") is where an additional population of the Hospital's inpatients reside. The PSA is comprised of eight Ohio counties: Ashtabula, Cuyahoga, Geauga, Lake, Lorain, Medina, Portage and Summit. The SSA is comprised of another seven Ohio counties: Ashland, Erie, Huron, Mahoning, Stark, Trumbull and Wayne. UH Rainbow Babies & Children's Hospital's market areas lie within 15 counties in Northeast Ohio, with the strong majority of 2013 discharges (95.4%) being residents of the hospital's primary market area, which includes all of Ashtabula, Cuyahoga, Geauga, Lake, Lorain, Medina, Portage and Summit counties. In terms of population, UH Rainbow Babies & Children's Hospital's largest county in its market area is Cuyahoga, which contains 31.7% of the population within the hospital's market area. The hospital had 8,958 discharges in 2013. Of those discharges, 60.4% were residents of Cuyahoga County. Lorain County was home to 11.2% of UH Rainbow Babies & Children's Hospital's discharges in 2013. In 2014, UH Rainbow Babies & Children's Hospital had 31,457 visits to the emergency room; 98.2% were residents from the hospital's primary market area, and 0.8% were residents from its secondary market area. Only 1% of emergency room visits were from patients residing outside of the hospital's market area.

FIGURE 1: UH RAINBOW BABIES & CHILDREN'S HOSPITAL MARKET AREAS



OBSERVATIONS FROM 2015 CHNA

The 2015 CHNA highlighted the lack of access to primary care for many pediatric patients who live within the Medical Center's market areas in that 37.6% of inpatients in 2013 were 'ambulatory care sensitive cases' ('ACS'), or those hospitalizations which have a higher probability of being avoided through adequate primary care. Lack of Access to Primary Care includes two broader subcategories of health needs: (1) disease issues and (2) youth risk behaviors. The focus of UH Rainbow Babies & Children's Hospital's new model of primary care – centered on an integration of women's and children's primary care services in a new community-based health center – will lead to efforts to positively influence issues related to childhood obesity, mental illness, diabetes and asthma and increase access to resources related to critical health issues. Each of those medical conditions were identified as being among the more common primary or secondary diagnoses of inpatients in 2013.

With the construction of the new UH Rainbow Center for Women & Children in a densely populated urban neighborhood of Cleveland during 2016/2017, we will create a new home for our pediatric practice and women's health clinics designed with a focus on increasing access to care, creating continuity of services, and linking patients with the resources they need to address social determinants of health. We currently achieve greater than 40,000 patient visits per year in these clinics, and care for primarily Medicaid insured patients and families. This focus on primary care access will also drive a focus on many youth risk behaviors through a variety of educational opportunities.

Lack of access to dental care is closely connected with access to primary care and as such, it is important to tie these two priority health needs together. Efforts to influence high rates of infant mortality are largely connected to social services to address the social determinants of health. It is anticipated that efforts to address infant mortality will include efforts that will drive change around the vulnerable population conditions identified in this CHNA (e.g., workforce programs to address the increases in unemployment rates).

PRIORITY HEALTH NEEDS

(Lists yes/no, whether or not hospital plans to address each health need within the overall scope of the top three priorities)

The list that follows describes the priority health issues identified through the 2015 CHNA.

Priority Health Issues	Plan to Address
Vulnerable Population Conditions	
Increase in non-White populations	No
Increase in poverty rates	No
Increase in children living in poverty	No
Increase in unemployment	No
Adult health needs that influence children and youth	
Lack of access to primary care	Yes
– Due to transportation	Yes
– Due to cost	Yes
Prenatal care	Yes
Adult risk behaviors	
– Smoking	No
– Drug abuse	No
– Alcohol abuse	No
– Gun ownership	No

Priority Health Issues	Plan to Address
Child and youth health needs	
High infant mortality rates (especially among Black population)	Yes
Asthma	Yes*
Diabetes	Yes*
Obesity	Yes*
Mental illness	Yes
Lack of access to primary care	Yes
Lack of access to dental care	Yes
Violence	No
Youth risk behaviors	
– Seatbelt use	Yes*
– Alcohol consumption	Yes*
– Drinking/driving	Yes*
– Smoking	No
– Drug use	No
– Soft drink consumption	Yes*
– Gun access	No
– Sexual activity/no birth control	Yes*

*These will be addressed under the umbrella of improved access to primary care.

DESCRIBE HOW HOSPITAL PLANS TO ADDRESS A SIGNIFICANT HEALTH NEED

The Hospital, through its Mission, has a strong tradition of meeting community health needs through its provision of ongoing community benefit programs and services. The Hospital will continue this commitment through the strategic initiatives set forth below that focus primarily on the three high-priority health needs identified in the 2015 CHNA. The Hospital has provided community benefit programs for many years and will continue to provide such programs. Not all programs provided by the Hospital that benefit the health of pediatric patients in the Hospital's PSA and SSA are discussed in the Strategy. For example, UH Rainbow Babies & Children's Hospital has several initiatives in place to reduce the acute care needs of children diagnosed with asthma, including the creation of asthma "toolkits" for use by clinicians in primary care practices and emergency departments to aid in the provision of care and reduce likelihood of hospital admissions or readmissions. Further, given changes in health care, the strategies may change, and new programs may be added or programs may be eliminated during the 2016 – 2018 period.

A. Strategies to address lack of access to quality primary care

A1. The UH RAINBOW CARE CONNECTION and RAINBOW PRIMARY CARE INSTITUTE will continue to work to link patients identified as not having a medical home with pediatric primary care providers, hospitals, and managed care organizations to drive change and achieve better care, better health, and lower costs.

Goals: The UH Rainbow Care Connection will improve the health care delivery system for all pediatric patients and improve child health overall by using the Physician Extension Team (PET) model to:

- Improve quality of outpatient care for children
- Increase access to physicians
- Improve access to pediatric behavioral health services
- Decrease unnecessary emergency visits and hospitalizations
- Improve health and functionality of children with complex chronic conditions

Objective(s): Increase number of patients without a primary care provider receiving primary care within the Rainbow Care Connection Physician Network. Other objectives include increasing the number of same-day appointments slots in network, reducing the number of children with overdue well-check visits, increasing the hours of acute care access through after-hours and weekend clinics, increasing the number of patients receiving behavioral health services (including navigation), expanding the network's capacity for accepting new Medicaid beneficiaries, and expanding the number of primary pediatric care providers in low SES regions of our PSA and SSA.

Evaluation measures: Number of Medicaid beneficiaries receiving annual well-child visits, number of Medicaid beneficiaries enrolled within the Rainbow Care Connection Network, number of patients receiving behavioral health navigation services, number of children with medical complexity receiving case management, Emergency Department visits rates (annual visits per 1,000 members), number of primary care providers in PSA and SSA.

A2. UH Rainbow Babies & Children's Hospital will continue its innovative TELEHEALTH programs to improve access for children to receive medical care and treatment. All patients' families have access to a 24/7 telephone triage service with a nurse/doctor team with three options:

- Traditional nurse telephone triage
- Prescriptive therapy based on pre-approved standing orders to treat mild pediatric illnesses
- Physician-level evaluation when necessary

Goal: To improve access for children to receive medical consults and care instructions for non-emergent conditions or questions thereby decreasing the number of office and ED visits, and increasing capacity in offices to provide preventive and well-child care.

Objective(s): Increased use of the telehealth service for non-emergent conditions or questions and concomitant decrease in pediatric ED visits for non-emergent issues.

Evaluation measures: Number of telehealth consults, percentage of patients presenting to the Marcy R. Horvitz Pediatric Emergency Center for avoidable visits.

A3. UH Rainbow Babies & Children's Hospital will continue to develop and expand its INTEGRATED BEHAVIORAL HEALTH ACCESS AND MANAGEMENT program. Offerings include in-office psychiatric social worker assessments and treatment recommendations, education and practice facilitation for in-office behavioral health screening and disease management, behavioral health navigation services linking patients to appropriate community behavioral health services, assistance in navigating waiting lists for mental health services, and ED crisis intervention services.

Goal: To improve identification and management of patients with behavioral health needs, increase access to behavioral health services for patients within the community, improve functionality and appropriate utilization of inpatient pediatric psychiatric services.

Objective(s): Increased number of patients receiving integrated behavioral health services, increased number of UH affiliated clinicians trained in and performing behavioral health screenings in the office, increased number of physicians trained in behavioral health illness management, increased functionality of patients accessing integrated behavioral health services, and decreased hospitalization to patients presenting to the Marcy R. Horvitz Pediatric Emergency Center with behavioral health diagnoses.

Evaluation measures: Number of patients accessing integrated behavioral health services, number of clinicians routinely administering screening tests in practice, number of clinicians trained in behavioral health disease management, increase in six month functionality utilizing a standardized assessment tool, percent of children hospitalized from the Marcy R. Horvitz Pediatric Emergency Center after presenting with a behavioral health diagnosis.

A4. Improve children's health through the implementation of a HEALTH LEADS program for screening and management of SOCIAL DETERMINANTS that impact a patient's health.

Goal: Implement a Health Leads program that makes it easier for low income families to maintain primary care relationships by screening for social determinants of health and addressing barriers to care and psychosocial needs that impact health and well-being. Primary care physicians will assess social barriers to health – such as housing, utilities, and transportation needs – during routine appointments and provide referrals to the onsite Health Leads coordinator, who will help connect patient families with resources.

Objective(s): Implementation of the Health Leads program, physician education to promote understanding of the program and prompt referrals, increase in the number of Health Leads referrals and consultations over the program's first year.

Evaluation measures: Hiring and training of Health Leads staff, education of physicians, implementation of program according to established timeline, tracking of physician referrals and Health Leads consultations to demonstrate continued program growth over time.

B. Strategies to address lack of access to dental care

B1. Continue the growth of UH RAINBOW BABIES & CHILDREN'S HOSPITAL'S IRVING AND JEANNE TAPPER DENTAL CENTER, a hospital-based pediatric dental center which serves an approximately 85% Medicaid patient base. The Tapper Dental Center removes barriers to dental health for low income and special needs children by providing an easily accessible source of preventive and complex dental services for all children, training the next generation of pediatric dental professionals, and serving as Northeast Ohio's only source of specialized dental care for patients with acute or chronic health problems, including children with special health needs.

Goal: To continue to provide much needed services to Greater Cleveland's low income and special health care needs populations, to increase the number of low income children accessing services at UH Rainbow Babies & Children's Hospital's Tapper Dental Center, and to promote careers in areas lacking access to dental care for dental students.

Measurable objective(s) and indicators of success: Increase in overall number of children accessing Tapper's pediatric preventive dental health services, maintaining a proportion of 80% or more Medicaid patients; increase in the number of low income children receiving complex dental health services at Tapper following referral from UH Rainbow Babies & Children's Hospital's Ronald McDonald Care Mobile; increase in number of children with special health care needs receiving preventive or complex care at Tapper; outreach to dental students training at UH Rainbow Babies & Children's Hospital's Tapper Dental Center to promote careers serving low income urban or rural populations lacking access to dental care.

Evaluation measures: Tracking of patient numbers at UH Rainbow Babies & Children's Hospital's Tapper Dental Center, with stratification by service provided, public or private insurer, and source of referral; tracking of proportion of patients who receive routine preventive services (with a preventive visit every 6 months) indicating they have established a 'dental home' at Tapper, tracking of number of children with special health care needs (including special medical conditions like epilepsy, spinal cord injuries, bleeding disorders or craniofacial anomalies, and developmental disabilities including behavioral problems, cognitive deficits, or autism) who receive routine or complex care at Tapper, and tracking of outreach and education efforts for dental students training at Tapper that promote a career serving families in areas with decreased access to dental care.

B2. Continue to bring dental care directly to children who need it most through UH RAINBOW BABIES & CHILDREN'S HOSPITAL'S RONALD MCDONALD CARE MOBILE, a 42-foot-long mobile dental clinic. The Care Mobile travels throughout Northeast Ohio to provide much needed dental care to children ages 3 to 12 in underserved populations, many of whom get their first glimpse of a dentist's chair through this service. Tooth decay is the most common chronic childhood disease in America. One in every 5 children aged 5 to 11 have at least one untreated decayed tooth. It's a problem that overwhelmingly effects children from low income families, who are less likely to receive regular dental care. More than 51 million school hours are lost each year to dental-related illness in the U.S.

Goal: To continue to reach underserved children throughout a 14 county area to provide preventive care and routine treatment of dental caries and other issues, to increase the number of children reached each year, and to increase referrals to UH Rainbow Babies & Children's Hospital's Tapper Dental Clinic for complex needs and to aid children in establishing a dental home.

Objective(s): Continue to reach underserved children throughout a 14 county area to provide preventive care, sealants, fluoride treatment, and treatment of dental caries; increase the number of schools, Head Starts, and public health agencies reached each year; increase the number of low income children reached each year who do not have a regular source of preventive dental care; and increase referrals to UH Rainbow Babies & Children's Hospital's Tapper Dental Clinic for patients with complex needs that cannot be treated on the mobile dental unit.

Evaluation measures: Tracking of number of schools, Head Starts and other public health agencies visited each year; tracking of services performed; tracking of percentage of children receiving free or reduced cost lunches at each school visited as a proxy for low income; tracking of number of referrals made to UH Rainbow Babies & Children's Hospital's Tapper Dental Center for complex care or ongoing preventive care; cross referencing of referrals with Tapper Dental Center records to determine the number of families who follow up on referrals and get children needed complex care; and tracking of the number of families who indicate on Care Mobile intake forms that their children have not received any routine preventive dental treatment within the past year.

B3. Implementation of a RAINBOW CARE CONNECTION FLOURIDE VARNISH strategy to reduce dental caries in very young children, particularly those with the following risk factors: low socio-economic backgrounds (children on Medicaid), premature birth, insufficient sources of dietary fluoride, high carbohydrate diets, caretakers who transmit decay-causing bacteria to their children via their saliva, areas of tooth decalcification, reduced salivary flow, and poor oral hygiene. Pediatric care providers will apply fluoride varnish to children 1 to 3 years old as soon as the first teeth have erupted.

Goal: Continue efforts of primary care providers in the Rainbow Care Connection pediatric ACO to ensure that young patients (aged 1 to 3 years) from low socioeconomic homes and at greatest risk of dental caries receive a fluoride varnish treatment.

Objective(s): Increase in number of children 1 to 3 years old who receive fluoride varnish. Since varnish is most effective if applied two to four times a year, work to attain that goal.

Evaluation measures: Tracking of number of children who receive at least one varnish application per year in their first three years. Tracking of number of children who have a dentist visit per year.

C. Strategies to address high rates of infant mortality

C1. To improve neonatal outcomes through an innovative program, CENTERING PREGNANCY, that provides education, outreach, and coordination of healthcare and social services for low income mothers.

Goal: Continue and expand the Centering Pregnancy Program, a joint effort between UH MacDonald Women's Hospital and UH Rainbow Babies & Children's Hospital that provides a groundbreaking group approach to prenatal care that empowers at-risk expectant mothers by encouraging responsibility and accountability for their own health. The group dynamic helps reduce stress and depression among new young mothers who are often alone or isolated during pregnancy and afterward, while the program educates participants about breast feeding and safe sleep and helps provide essential services during pregnancy for improved neonatal outcomes.

Objective(s): Increase in number of centering pregnancy sessions offered, increase in number of women participating, improved sense of self efficacy and increased knowledge about safe infant care practices among participating women, greater number of prenatal care visits attended compared to women not participating in the program.

Evaluation measures: Tracking of number of women participating in the Centering Pregnancy program, average age and parity of women participating, average number of Centering sessions attended, average number of prenatal care appointments attended; collection of data on birth outcomes (gestational age, birth weight, days in hospital) for comparison with a random selection of similar women who do not participate in the Centering program, comparison of pre/post survey data for participating women that measures knowledge of infant care and development, feelings of self efficacy and perceived social support.

C2. Work to IDENTIFY AND ADDRESS UNSAFE SLEEP ENVIRONMENTS IN HIGH RISK COMMUNITIES by continuing to roll out and expand an educational program for first responders to address high rates of sleep related morbidity and mortality in our region.

Goal: Continue and expand UH Rainbow Babies & Children's Hospital's Direct On Scene Education (DOSE) program that trains first responders to assess infant sleeping environments while in the home, take steps to make corrections, and educate parents about the basics of infant safe sleep. In the event there is not a safe place for the baby to sleep, first responders can refer families to the Cuyahoga County Board of Health to receive a portable safe sleep space.

Objective(s): Increase in number of training sessions, increase in number of first responders trained, increase in number of police and fire departments involved in training, increase in perceived self efficacy and intention to act among individuals trained.

Evaluation measures: Tracking of number of training sessions held, number and type of first responders (police, fire, EMS) trained, number of municipalities taking advantage of training, and number of referrals to the Cuyahoga County Board of Health and number of portable cribs distributed as a result of referrals; feedback from individuals completing training regarding increases in knowledge, perceived importance of safe sleep issues, and intention of putting training into action.

C3. INCREASE THE AVAILABILITY OF SAFE SLEEP SPACES FOR LOW INCOME FAMILIES by reaching at risk families prior to hospital discharge in order to protect vulnerable infants by identifying families who are lacking safe sleep spaces for their infants and providing a safe portable crib that supports the benefits of room sharing without the risks of bed sharing.

Goal: Implement a new project designed as a collaboration between social workers in UH Rainbow Babies & Children's Hospital's Quentin & Elisabeth Alexander Level IIIc Neonatal Intensive Care Unit (NICU) and NICU step down units and the staff of the Rainbow Injury Prevention Center. Social workers will assess safe sleep plans with parents prior to their infants' discharge and identify families who lack a safe sleep space for their babies. The Rainbow Injury Prevention Center will supply social workers with gift certificates redeemable for a Pack 'n Play portable crib from the Rainbow Safety Store.

Objective(s): Rollout of the new program according to schedule, training of NICU and NICU step down social workers on safe sleep issues and assessment techniques, establishment of consistent pattern of referrals to the program, level of success in conveying the importance of the safe sleep issue to parents, as measured by the number of vouchers for a free Pack 'n Play redeemed.

Evaluation measures: Tracking of stages of program launch, number of social workers trained, number of vouchers distributed, and number of vouchers redeemed.

C4. To address the high rates of sleep related infant morbidity and mortality among low income families in the Greater Cleveland community by providing SAFE SLEEP EDUCATION AND OUTREACH TO PATIENT FAMILIES AND COMMUNITY PHYSICIANS who provide primary care services to at risk families.

Goal: Continue to post and distribute safe sleep educational materials (window clings, posters, and parent handouts) in UH Rainbow Babies & Children's Hospital departments that see large numbers of parents of infants (ambulatory clinic, pediatric emergency department, etc.) and expand the program through distribution of educational materials to practicing UH Rainbow Babies & Children's Hospital pediatricians throughout the community.

Objective(s): Increase in number of pediatric practices and pediatric services within UH Rainbow Babies & Children's Hospital who display or distribute safe sleep information for families of infants; increase in number of community pediatric practices who display or distribute safe sleep information for at risk families.

Evaluation measures: Tracking of number of materials distributed, number of hospital departments and number of community pediatricians reached, estimation of number of families exposed to safe sleep messages through these sites.

C5. Improve SCREENING OF PATIENTS FOR SAFE SLEEP HABITS through training of all pediatric providers in the Rainbow Care Connection Network. Providers will be trained to screen all babies from birth to six months of age for safe sleep habits and provide education to caregivers not practicing safe sleep habits.

Goal: Primary care pediatrician routine screening for safe sleep habits in babies.

Objective(s): Number of clinicians performing safe sleep screening for babies.

Evaluation measures: Number of clinicians performing safe sleep screening and percentage of their patients for which safe sleep screening is documented.

DESCRIBE WHY HOSPITAL IS NOT ADDRESSING A SIGNIFICANT HEALTH NEED

No hospital facility can address all of the health needs present in its community. The Hospital is committed to adhering to its Mission and remaining financially healthy so that it can continue to enhance its clinical, teaching and research activities and to provide a wide range of community benefits. The Strategy does not address the following community health needs identified in the 2015 CHNA:

High Rates of Poverty, Unemployment and Financial Hardship: While the Hospital is a significant employer within its PSA, unemployment and financial hardship are not a part of the Hospital's Mission.

Lack of Transportation to Health Services: The Hospital does not have a transportation program; however, on occasion the Hospital will assist patients with transportation to the Hospital consistent with federal regulatory guidelines.

High Rates of Adult Smoking: The Hospital provides a free smoking cessation program for its employees who desire to stop smoking; it does not have a smoking cessation program targeting youth in the community.

Prevalent Adult Alcohol and Drug Use: A number of community organizations address youth drug abuse prevention and treatment, including Catholic Charities Chemical Dependency Services, the Covenant, New Directions, Northern Ohio Recovery Association and Recovery Resources.

Adult Gun ownership and Child Gun Access: UH Rainbow Babies & Children's Hospital's primary and emergency care providers are trained to assess safety in the home environment – including gun ownership and storage – as part of their standard practices. Because of the highly politicized nature of the firearm debate in America, UH Rainbow Babies & Children's Hospital does not address gun ownership directly; however, education on safe storage practices, access to free or reduced cost gun trigger locks, and prompts for parents to ask about the presence and storage of firearms in homes where their children spend time are part of the ongoing activities of the Rainbow Injury Prevention Center.

Child and Youth Violence: UH Rainbow Babies & Children's Hospital's Level I Pediatric Trauma Center provides the highest level of care to injured children and adolescents injured and staff are trained to recognize and provide behavioral health referrals to youth who have been the victims of violence or who have witnessed violence. UH Rainbow Babies & Children's Hospital supports the efforts

of community organizations that address child and youth violence and the Hospital recognizes that these individuals and agencies are better positioned to provide meaningful messages from culturally relevant messengers.

Youth Smoking and Drug Use: A number of community organizations address youth drug abuse prevention and treatment, including Catholic Charities Chemical Dependency Services, the Covenant, New Directions, Northern Ohio Recovery Association and Recovery Resources. Law enforcement agencies throughout the region provide a drug abuse resistance education (DARE) curriculum for students and UH Rainbow Babies & Children's Hospital supports those efforts through our law enforcement partnerships as lead agency for the Greater Cleveland Safe Communities Coalition.

IMPLEMENTATION STRATEGY COLLABORATORS

The Strategy will be implemented in collaboration with other entities including, but not limited to:

UH Case Medical Center

UH Ahuja Medical Center

UH Avon Rehabilitation Hospital

UH Bedford Medical Center, a campus of UH Regional Hospitals

UH Conneaut Medical Center

UH Elyria Medical Center

UH Geauga Medical Center

UH Geneva Medical Center

UH Parma Medical Center

UH Portage Medical Center

UH Rehabilitation Hospital (Beachwood)

UH St. John Medical Center, a Catholic hospital

UH Samaritan Medical Center

Southwest General Health Center, a joint-venture of University Hospitals

City of Cleveland

Cuyahoga County

Municipalities within the PSA

Cleveland Metropolitan School District

School Districts within the PSA and SSA

Fire and EMS Departments within the PSA and SSA

Ohio Department of Health

Cuyahoga County Board of Health

City of Cleveland Department of Health

Greater University Circle Community Health Initiative

Health Districts within the PSA and SSA

HIP-Cuyahoga

Safe Communities Coalition

Voices for Ohio's Children

Grant-making organizations

Oral Health America/Smiles Across America

Ronald McDonalds House Charities of Northeastern Ohio

Centers for Families & Children

Among the nation's leading academic medical centers, University Hospitals Case Medical Center is the primary affiliate of Case Western Reserve University School of Medicine, a nationally recognized leader in medical research and education.

2016 IMPLEMENTATION PLAN




This Implementation Plan was approved by the University Hospitals Board of Directors on March 15, 2016

University Hospitals
Ahuja Medical Center

INTRODUCTION

University Hospitals Ahuja Medical Center ("Hospital") conducted a community health needs assessment ("CHNA") of the geographic areas served by the Hospital pursuant to the requirements of Section 501(r) of the Internal Revenue Code ("Section 501(r)"). The CHNA findings were published on the Hospital's website in December 2015. This CHNA was adopted by the UH Board of Directors on September 24, 2015.[1]

This is the second UH Ahuja Medical Center CHNA in response to Federal government regulation.[2] The 2015 UH Ahuja Medical Center CHNA will serve as a foundation for developing an implementation strategy to address those needs (a) the hospital determines it is able to meet in whole or in part; (b) are otherwise part of its mission; and (c) are not met (or are not adequately met) by other programs and services in the hospital's service area.

UH Ahuja Medical Center is located in the Chagrin Highlands area in the city of Beachwood in Cuyahoga County, Ohio. UH Ahuja Medical Center's market areas lie within five counties in Northeast Ohio. These include 27 municipalities (nine in its primary market area, 13 in its secondary market area, and five in its tertiary market area) and includes: Geauga, Lake, Cuyahoga, Summit and Portage counties.

The strategies herein identify the means through which the Hospital plans to address a number of the needs that are consistent with the Hospital's charitable mission during 2016 through 2018 as part of its community benefit programs. Beyond the programs discussed in the Strategy, the Hospital is addressing a number of these needs simply by providing care to all, regardless of their ability to pay, every day.

The Hospital anticipates the strategies may change and therefore, a flexible approach is best suited for the development of its response to the 2015 CHNA. For example, certain community health needs may become more pronounced and require changes to the initiatives identified by the Hospital in the Strategy.

UH Ahuja Medical Center will be focusing on expanding services related to chronic conditions including **diabetes**, **cardiovascular disease** and **respiratory disease**. These three health needs were chosen due to their higher than average prevalence in our patient population and their strong association with high hospitalization rates and the need for patient education, disease management and compliance. We believe expanded education, screenings and awareness of these three disease states will have the greatest impact on the communities we now serve.

OVERVIEW OF THE STRATEGY

The Strategy includes the following information:

1. Hospital Mission Statement
2. Community Served by the Hospital
3. Observations for the CHNA
4. Priority Community Health Needs
5. Implementation Strategies: 2016 through 2018
6. Implementation Strategy Development Collaborators
7. Needs the Hospital Will Not Address

HOSPITAL MISSION STATEMENT

As a wholly owned subsidiary of University Hospitals Health System, Inc. (University Hospitals or UH), the Hospital is committed to supporting the UH mission, "To Heal. To Teach. To Discover." (the "Mission"), by providing a wide range of community benefits including clinical services, medical education and research. UH is an integrated delivery system and thus can provide benefits by coordinating within and among its various entities ("UH System").

COMMUNITIES SERVED BY THE HOSPITAL

The communities served by the Hospital are defined based on the geographic origins of the Hospital's inpatients. The Primary Service Area (PSA) is the geographic area from which the majority of the Hospital's patients originate. The Secondary Service Area (SSA) is where an additional population of the Hospital's inpatients reside. The PSA is comprised of three ZIP codes in Cuyahoga and Summit counties in Ohio. The SSA is comprised of five ZIP codes, also in Cuyahoga and Summit counties. In 2013, the PSA and SSA were home to approximately 187,023 persons. In 2013, more than 82% of the Hospital's inpatients lived in the specified ZIP codes.

[1] *The Patient Protection and Affordable Care Act (Pub. L. 111-148) added section 501(r) to the Internal Revenue Code, which imposes new requirements on nonprofit hospitals in order to qualify for an exemption under Section 501(c)(3), and adding new reporting requirements for such hospitals under Section 6033(b) of the Internal Revenue Code.*

[2] *UH Ahuja Medical Center followed the 2013 Proposed Regulations, published by the Treasury Department and IRS on April 5, 2013, in the Federal Register (REG-106499-12, 2013-21 I.R.B. 1111, [78 FR 20523]), in accordance with Notice 2014-2 that confirms that hospital organizations can rely on proposed regulations under section 501(r) of the Internal Revenue Code issued on June 26, 2012, and April 5, 2013, pending the publication of final regulations or other applicable guidance. The final rule entitled "Additional Requirements for Charitable Hospitals; Community Health Needs Assessments for Charitable Hospitals"; Requirement of a Section 4959 Excise Tax Return and Time for Filing the Return, was published by the IRS on December 31, 2014, and requires compliance after December 29, 2015.*

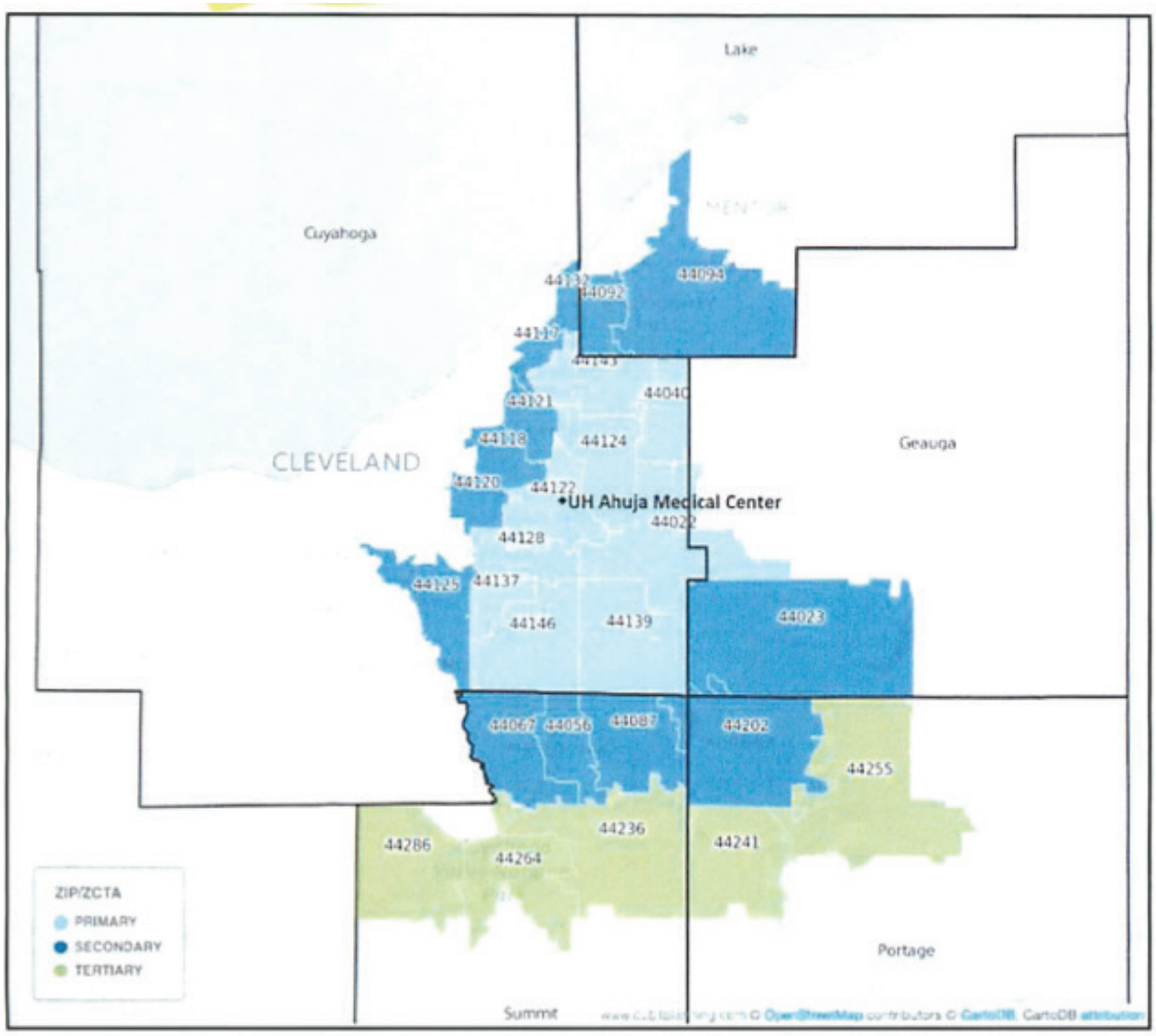


FIGURE 1 (ABOVE) DEPICTS THE HOSPITAL'S PSA AND SSA.

OBSERVATIONS FROM 2015 CHNA (2010 – 2013 DATA)

Key points from CHNA	UH Ahuja Medical Center Programs Related to the Implementation strategy
5.7% of adult patients discharged in 2013 had a primary diagnosis of congestive heart failure.	**Heart Health Day, Beachwood High School Medical Academy, New Leaf Program; Warrensville Middle School, " Medical Big Tent," Health Matters** presentations; quarterly and monthly, healthy cooking demonstrations, **Age Well Be Well senior** initiatives, **Building Life-Saving Communities**; Mayors' initiative, screenings and health fairs
32.1% of adult patients discharged in 2013 had a secondary diagnosis of congestive heart failure, which was far more common among older (age 40+) discharges.	**Heart Health Day**, Beachwood High School Medical Academy, **New Leaf Program**; Warrensville Middle School, **Health Matters** presentations; quarterly and monthly, healthy cooking demonstrations, Age Well Be Well senior initiatives, **Building Life-Saving Communities**; Mayors' initiative, screenings and health fairs
52% of discharged patients had a secondary diagnosis of hypertension.	Heart Disease strategies to address this health condition through the strategies listed above
29.8% of discharged patients were diabetic. The diabetes mortality rate in Cuyahoga County is higher than average when compared to peer counties.	Expansion of accredited Diabetes Center "**Medical Big Tent**," one-on-one nutrition counseling and diabetes education classes, annual Diabetes Health Fair to include A1C screening
26.4% of those hospitalized at UH Ahuja Medical Center in 2013 were obese or morbidly obese which is often a component of chronic disease.	Often linked to diabetes, heart disease and respiratory disease, obesity will be addressed through the strategies listed above. **Smoothies for Seniors** program will be a partnership with Ohio Dept. of Aging. To enhance overall health, provide access to Primary Care physicians that will order/instruct on diet and lifestyle changes.
Cancer is the leading cause of death for adults in Cuyahoga County and is higher than average when compared to peer counties.	Often linked to most chronic poor health statuses, cancer will be addressed through the strategies listed above and cancer screenings at community events

Additional observations from the 2015 CHNA:

- In 2013, 22.7% of discharges were Ambulatory Care Sensitive ("ACS") cases with three primary diagnoses: congestive heart failure (5.7%), bacterial pneumonia (4.8%) and chronic obstructive pulmonary disease (2.2%). ACS cases are those that are presumed to be avoidable if patients receive high-quality primary care. A high proportion of ACS cases in a community signal a shortage of adequate primary care providers.
- **Cuyahoga and Summit counties, like their neighboring counties, are growing older, on average**. In 2013, the proportion of senior citizens increased by 0.4 percentage points in Cuyahoga County and 0.9 percentage points in Summit County. Given that the use of health care increases substantially with age, especially after age 65, the aging of the population will have significant impact on the demand for health care in regions where the proportion of older citizens is increasing.
- UH Ahuja Medical Center's market area is becoming more racially diverse. Cuyahoga County is majority White, but the percentage of the population that is White decreased by 1% from 2010 to 2013. Black is the dominant minority race in Cuyahoga County (29.7% of the total population). Summit County is also majority White, but that majority percentage decreased by 0.8% from 2010 to 2013.
- **Poverty levels in the Hospital's market area are increasing.** The average (median) income decreased by 4.6% in Cuyahoga County and 2% in Summit County from 2010 to 2013.
- Of all discharges in 2013, 73% were Medicare patients and 9% were Medicaid patients.

PRIORITY HEALTH NEEDS IDENTIFIED IN CHNA

Health Disparities: Aging Population, Unemployment, Poverty

Access Barriers: Cost of Care, Lack of Primary Care Providers, Access to Transportation

Lifestyle Barriers: Obesity, Substance abuse (drug/alcohol/tobacco), Violence

Chronic Disease Conditions: Heart Disease, Respiratory Diseases, Diabetes, Alzheimer's, Cancer and Mental illness

Poor health status can result if a complex interaction of challenging social, economic, environmental and behavioral factors, combined with a lack of access to care, is present. Addressing the more common "root" causes of poor community health can serve to improve a community's quality of life and to reduce mortality and morbidity. This team decided to select three chronic disease conditions as the hospital's primary priorities for this CHNA implementation plan of 2016 – 2018.

1. Diabetes

2. Cardiovascular disease

3. Respiratory disease

The table below describes the community health needs identified through the 2015 CHNA as priorities. Those needs that the Hospital plans to proactively address during 2016 through 2018 are noted. However, the Hospital will continue to offer several programs, either alone or in collaboration with others, which address numerous community health needs. Those are also briefly described below.

HEALTH DISPARITIES	PLAN TO ADDRESS
Aging Population	No
High Rate of Poverty	No
High Rate of Unemployment	No
Infant Mortality/Premature Births	No
ACCESS BARRIERS	**PLAN TO ADDRESS**
High Cost of Care	No
Access to Primary Care Providers	No
LIFESTYLE BARRIERS	**PLAN TO ADDRESS**
Obesity	No
Substance Abuse (tobacco, drugs, alcohol)	No
Violence	No
CHRONIC DISEASE CONDITIONS	**PLAN TO ADDRESS**
Cardiovascular Disease	Yes
Respiratory Diseases	Yes
Diabetes	Yes
Kidney Disease	No
Alzheimer's	No
Gonorrhea	No
Mental Health	No
– Older Adult Depression	No
– Mental Illness	No

IMPLEMENTATION STRATEGIES: 2016 THROUGH 2018. To address the following significant health needs: Heart Disease, Respiratory Disease and Diabetes

The Hospital, through its Mission, has a strong tradition of meeting community health needs through its provision of ongoing community benefit programs and services. The Hospital will continue this commitment through the strategic initiatives set forth below that focus primarily on high-priority health needs.

Goals & Objectives:

UH Ahuja Medical Center's efforts on all of the three priority health issues will have the following overall long-term **goals**:

- Increased community member knowledge and understanding of these chronic conditions
- Increased awareness levels of local services available to help them avoid or treat these conditions
- Increased detection of disease in participants that may not have been identified without the screening programs
- Reduced readmission and mortality due to chronic disease.

Likewise, all of the programs aimed at the three priority health issues will share the following **objectives**:

- All plans have the overarching goal of serving a disease-specific population – a group that is susceptible to chronic disease due to lack of health education, lack of access to care and financial considerations
- Encourage compliance by making expert care available close to home
- Encourage compliance by increasing awareness of available medical and community resources and financial counseling services, to make care affordable for those with financial limitations
- Develop relationships with community physicians, the UH Primary Care Institute physicians, extended care facilities, community and faith-based nonprofit organizations and public health departments to extend care management, community outreach and health education services into the community
- Establish tracking mechanisms and metric goals for those individuals in the community who participate in our various programs to ensure programs are helping us reach our goals
- Monitor ongoing progress of all programming and implementation strategies

UH Ahuja Medical Center will launch the "**Medical Big Tent**" (Figure 2 below) in 2016 to serve chronic disease populations. The Tent will address the three primary chronic diseases stated in our CHNA 2015: **Cardiovascular, Respiratory and Diabetes diseases**. Under the Tent will offer all the community, social, disease-specific, medical and self-help resources a patient or member of this population will need to enhance their knowledge on how to best manage their chronic disease. A full-day event will offer a comprehensive evaluation of their disease and resource needs. They will work with the clinicians to create an individualized Care plan to manage their disease.

The overall goal of the Medical Big Tent is to eliminate fragmentation of service delivery that can interfere with the development of and compliance with a comprehensive plan to manage the disease.

FIGURE 2: "MEDICAL BIG TENT" MODEL FOR COORDINATED CHRONIC CARE

EDUCATION & SELF CARE	OUTREACH & NETWORKING	MEDICAL CARE	SUPPORT
SUPPORT GROUPS & ASSOCIATIONS	PRIMARY CARE PROVIDERS	PRIMARY CARE	DISEASE SPECIFIC ORGANIZATIONS
PRIMARY CARE PROVIDERS	EMERGENCY ROOMS	SPECIALIST REFERRALS	HOME CARE
HOSPITALS	HEALTH CLINICS/CENTERS	MEDICAL HOME	SENIOR CENTERS
CARE MANAGEMENT	COMMUNITY GROUPS	COMMUNITY BENEFIT	INSURANCE RESOURCES
			COUNTY/CITY PROGRAMS

CARDIOVASCULAR DISEASE

Actions:

- Education through monthly educational seminars (Health Matters).
- Host and/or participate in regular health fairs with a focus on heart health.
- Expand screening programs including Coronary Artery Disease risk assessments.
- Increase community awareness of services available and local physician specialists.
- Increase education on CPR/AED to community, employers and high school seniors (3,000 individuals trained in 2015).
- Annual Family Health & Safety Day to offer comprehensive screenings related to heart health.
- Participation in system annual Heart Day events.
- Creating a "Medical Big Tent."

Evaluated Outcomes:

- Decreased hospitalization rates and length-of-stay for hospitalizations of those with cardiovascular disease (as measured by inpatient data).
- Proportion of discharged patients with a referral to a specialist.
- Steadily increasing participation rates for community members in outreach programs, especially by those who are at risk (lower socioeconomic status, previously hospitalized patients, those with the high priority chronic diseases).

RESPIRATORY DISEASES

Actions:

- Education through monthly educational seminars (Health Matters).
- Host annual respiratory wellness event with spirometry screenings and physician specialist presentations.
- Increase community awareness of services available and local physician specialists.
- Annual Family Health & Safety Day to offer comprehensive screenings related to respiratory health.
- Annual Lung Cancer Screening.
- Creating "Medical Big Tent" for Respiratory Diseases.

Evaluated Outcomes:

- Decreased smoking rates among youth and adult population. Tobacco use is the leading cause of respiratory disease and will be the cornerstone of the prevention strategy.
- Decreased hospitalizations rates and length-of-stay for hospitalization of those with respiratory disease (as measured by inpatient data).
- Proportion of discharged patients with a referral to a specialist.
- Steadily increasing participation rates for community members in outreach programs, especially by those who are at risk (lower socioeconomic status, previously hospitalized patients, those with the high priority chronic diseases).

DIABETES

Actions:

- Education through monthly educational seminars (Health Matters).
- Continue to promote the accredited Diabetes Center, which offers blood sugar monitoring and annual screenings; access to education classes specific to diabetes; one-on-one support and counseling; and access to dietitians, pharmacists and physician specialists.
- Host an annual "Medical Big Tent," with A1C glucose testing, physician presentations, nutrition counseling and community resource specialist to combat diabetes.
- Annual Family Health & Safety Day to offer comprehensive screenings related to diabetes.

Evaluated Outcomes:

- Decreased hospitalization rates and length-of-stay for hospitalizations of those with diabetes (as measured by inpatient data). This would be achieved through improved compliance and disease self-management of diabetic patients (which are numerous – approximately 10% of the adult population has diabetes).
- Proportion of discharged patients with a referral to a specialist.
- Steadily increasing participation rates for community members in outreach programs, especially by those who are at risk (lower socioeconomic status, previously hospitalized patients, those with the high priority chronic diseases).

Commitment of programs and resources:

- UH Ahuja Medical Center is committed to providing the financial support needed to recruit, hire and retain physician specialists in these fields.
- "Medical Big Tent" to be established. Post-discharge care is vital to disease management.
- Education and support groups will be formed to provide ongoing education and support in an effort to enhance overall health and decrease unnecessary hospital readmissions.

Other Community-Based Initiatives

UH Ahuja Medical Center recognizes that there are several overarching issues that relate to the community's wellness, but that the Hospital is not in a position to significantly impact. However, the Hospital does offer programs to indirectly impact those issues:

A. Improve access to care: Provide access to health care services through the **UH Hospital Financial Assistance Program**.

B. Continue the primary and specialty physician education series "**UH Health Matters**" to provide access and meet community needs in **geographic areas where these physicians are limited**.

C. Increase outreach, improve preventive health, encourage healthy habits, improve parenting skills and enhance safety standards through the **UH Ahuja Medical Center Health Matters Initiative**, which encompasses the Hospital's entire community outreach program quarterly and monthly education programs through screenings, presentations, health fairs and community events with local organizations and other nonprofit agencies.

D. Continue pediatric and young-adult health education on disease prevention and safety;

1. Beachwood High School Medical Academy
2. New Leaf Program Warrensville Middle School

E. The Hospital, through the **UH Emergency Medical Services Institute** (the "Institute"), collaborates with emergency squads in the community to provide the public with advanced emergency care that helps save lives. Through the Institute, the Hospital provides education and training to first responders, including paramedics, emergency medical technicians, fire chiefs and others. The Hospital also provides traffic and other safety education to the community, area businesses and schools.

Who Will UH Ahuja Medical Center collaborate with to ensure success:

- UH Institutes
- UH Center for Lifelong Health (Age Well Be Well members is an independent network of facilities that support seniors in UH Ahuja Medical Center's primary and secondary markets)
- Local and civic leaders in the community
- EMS Institute and Providers
- Cuyahoga County Board of Health
- American Diabetes Association
- American Heart Association
- American Cancer Society
- American Red Cross
- Ohio Department of Aging

WHY HOSPITAL IS NOT ADDRESSING A SIGNIFICANT HEALTH NEED

No hospital facility can address all of the health needs present in its community to the fullest. The Hospital is committed to adhering to its Mission and remaining financially healthy so that it can continue to enhance its clinical, teaching and research activities and to provide a wide range of community benefits. The Strategy utilizes community resources to meet several community health needs address. It is with that collaboration that needs can be met.

CHNA PRIORITY HEALTH NEEDS NOT ADDRESSED IN 2016 – 2018 PLANS

HEALTH DISPARITIES	Reason Issue Not Directly Addressed in Current Plan
• Aging Population	A majority of UH Ahuja Medical Center's 2013 inpatient population were senior citizens. Therefore its current focus is and will continue to be on the acute care of older patients. In addition, the Hospital's outreach programs (for example, the no-cost Age Well Be Well membership) focus on the growing need for preventative health services for seniors.
• High Rate of Poverty • High Rate of Unemployment	Economic conditions within the market areas of the Hospital are outside its locus of control. However, the Hospital does address the cost of care as a barrier to access of care through its Financial Assistance Program which provides financial assistance to those who received care, are low-income and uninsured.
• Infant Mortality/Premature Births	This community health issue is being addressed by First Year Cleveland, a public-private initiative among local governments and hospitals, including University Hospitals Systems. This comprehensive multi-year initiative, beginning in 2016, will harness the needed resources to reduce the higher-than-average infant mortality rates in Cuyahoga County.
ACCESS BARRIERS	**Reason Issue Not Directly Addressed in Current Plan**
• High Cost of Care	The Hospital addresses the cost of care as a barrier to access of care for some through its Financial Assistance Program which provides financial assistance to those who received care, are low-income and uninsured.
• Access to Primary Care Providers	The shortage of primary care physicians is widespread and is being addressed at the state level.
LIFESTYLE BARRIERS	**Reason Issue Not Directly Addressed in Current Plan**
• Obesity	Several outreach programs conducted by the Hospital address obesity, being overweight, and lack of fitness. And, because of its strong tie to diabetes, obesity is addressed through all efforts (described above) aimed at reducing diabetes in the community.
• Substance Abuse (tobacco, drugs, alcohol)	While the Hospital has not adopted this community health need as a priority in its 2016 – 2018 Plan, it does provide treatment services to the community through the system-wide UH Connor Integrative Health Network. The Hospital also participates in the Mayors' Initiative, a community-based effort focused on wellness. Hospital inpatients who are diagnosed with a substance abuse issue receive proper referrals to community-based programs.
• Violence	The Hospital is not involved in programs aimed at reducing community violence levels. This is not within the hospital staff's area of expertise.
CHRONIC DISEASES	**Reason Issue Not Directly Addressed in Current Plan**
• Kidney Disease	Kidney disease is strongly associated with chronic hypertension. Hypertension is addressed through the Hospital's outreach programs (health fairs, etc.) for early detection of chronic disease symptoms.

CHNA PRIORITY HEALTH NEEDS NOT ADDRESSED IN 2016 – 2018 PLANS

CHRONIC DISEASES	Reason Issue Not Directly Addressed in Current Plan
• Alzheimer's	The Hospital does not provide long-term inpatient services for Alzheimer's Disease.
• Gonorrhea	The Cleveland Department of Health monitors gonorrhea rates for the region and manages public health initiatives aimed at reducing the rising rates of gonorrhea.
• Mental Health – Older Adult Depression – Mental Illness	The Hospital does not maintain a psychiatric unit or psychiatric emergency room. However, inpatients identified with depression or other mental illness are referred to community-based health care professionals.

IMPLEMENTATION STRATEGY COLLABORATORS

In developing this implementation strategy, the Hospital collaborated with the following hospitals owned and/or operated by University Hospitals:

- UH Case Medical Center
- UH Bedford Medical Center, a campus of UH Regional Hospitals
- UH Conneaut Medical Center
- UH Elyria Medical Center
- UH Geauga Medical Center
- UH Geneva Medical Center
- UH Parma Medical Center
- UH Portage Medical Center
- UH Rainbow Babies & Children's Hospital
- UH Richmond Medical Center, a campus of UH Regional Hospitals
- UH St. John Medical Center, a Catholic hospital
- UH Samaritan Medical Center
- Southwest General Health Center, a joint-venture of University Hospital

A. Planned Collaborations with Other Organizations

The Strategy will be implemented in collaboration with other entities including, but not limited to:

- Ohio Department on Aging
- Cuyahoga County Department of Job and Family Services
- Cuyahoga County Board of Health
- Bellefaire JC
- Warrensville Heights YMCA
- American Diabetes Association
- Diabetes Partnership of Cleveland
- American Heart Association
- Cuyahoga County Health Care Council/ Joint Advisory Committee
- Health Improvement partnership – Cuyahoga Universal Health Care Action Network
- Local Municipalities in the primary service area
- Local schools, libraries and community centers in the primary service area
- Susan G. Komen Foundation
- Greater University Circle partnering organizations

UH Ahuja Medical Center – the first new stand-alone hospital in Cuyahoga County in 30 years – opened its doors in 2011. The 53-acre health care campus in Beachwood, Ohio, features a 144-bed hospital and a 60,000-square-feet outpatient medical building. The hospital offers an array of inpatient and outpatient medical and surgical services including adult and pediatric emergency 24/7, pediatric outpatient surgery, intensive care services, and traditional, minimally invasive and robot-assisted surgery.

Among the nation's leading academic medical centers, University Hospitals Case Medical Center is the primary affiliate of Case Western Reserve University School of Medicine, a nationally recognized leader in medical research and education.

2016 IMPLEMENTATION PLAN




This Implementation Plan was approved by the University Hospitals Board of Directors on March 15, 2016

University Hospitals
Geauga Medical Center

INTRODUCTION

University Hospitals Geauga Medical Center (the "Hospital") conducted a community health needs assessment (a CHNA") that was adopted by the UH Board of Directors on September 24, 2015.[1] CHNAs seek to identify priority health needs and access issues for particular areas and populations.

This is the second UH Geauga Medical Center CHNA in response to federal government regulation. The 2015 UH Geauga Medical Center CHNA served as the foundation for developing an implementation strategy to address those needs that (a) the Hospital determines it is able to meet in whole or in part; (b) are otherwise part of its mission; and (c) are not met (or are not adequately met) by other programs and services in the Hospital's service area. This implementation strategy ("Strategy"), also required by Section 501(r), documents the Hospital's efforts to address the community health needs identified in the 2015 CHNA.

The strategy identifies the means through which the Hospital plans to address a number of the needs that are consistent with the Hospital's charitable mission during 2016 through 2018 as part of its community benefit programs. Beyond these programs, the Hospital is addressing some of these needs simply by providing care to all, regardless of their ability to pay, every day.

The Hospital anticipates the strategies may change and therefore, a flexible approach is best suited for the development of its response to the 2015 CHNA. For example, certain community health needs may become more pronounced and require changes to the initiatives identified by the Hospital in the Strategy. During 2016 through 2018, other community organizations may address certain needs, indicating that the Hospital's strategies should be refocused on alternative community health needs or assume a different focus on the needs identified in the 2015 CHNA.

OVERVIEW OF THE STRATEGY

The Strategy includes the following information:

1. Hospital Mission Statement
2. Community Served by the Hospital
3. Observations from the 2015 CHNA
4. Priority Community Health Needs
5. Implementation Strategy
6. Needs the Hospital Will Not Address
7. Implementation Strategy Collaborators

HOSPITAL MISSION STATEMENT

As a wholly owned subsidiary of University Hospitals Health System, Inc. ("University Hospitals" or "UH"), the Hospital is committed to supporting the UH mission, "To Heal. To Teach. To Discover." (the "Mission"), by providing a wide range of community benefits including clinical services, medical education and research. UH is an integrated delivery system and thus can provide benefits by coordinating within and among its various entities ("UH System").

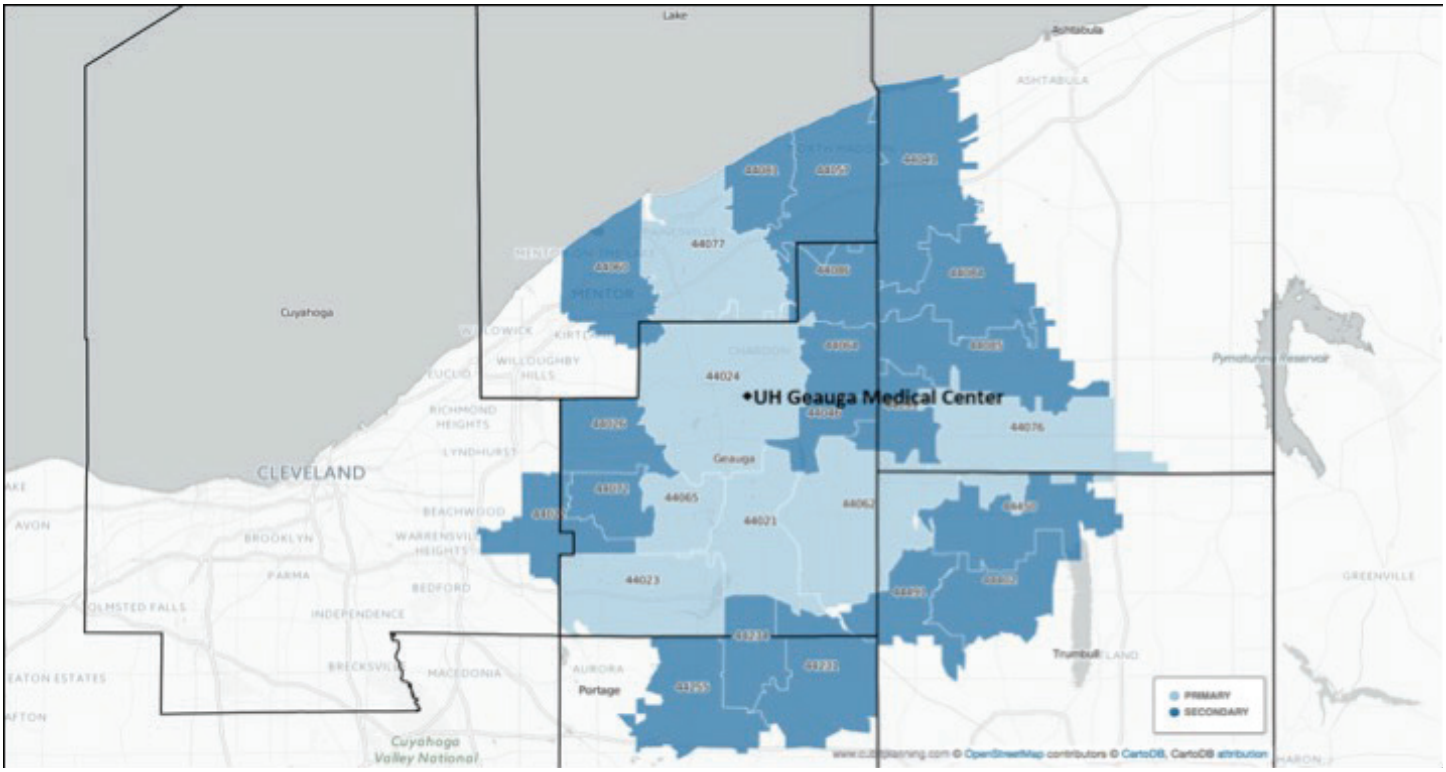
COMMUNITY SERVED BY THE HOSPITAL

The community served by the Hospital is defined based on the geographic origins of the Hospital's inpatients. The Primary Service Area (" PSA") is the geographic area from which the majority of the Hospital's patients originate. The Secondary Service Area ("SSA") is where an additional population of the Hospital's inpatients reside. The PSA is comprised of seven ZIP codes in Ashtabula, Geauga and Lake counties in Ohio. The SSA is comprised of 20 ZIP codes in Ashtabula, Cuyahoga, Geauga, Lake, Portage and Trumbull counties. In 2013, the PSA and SSA were home to approximately 306,932 persons, almost all of whom live in Ashtabula, Geauga and Lake counties. In 2013, more than 76% of the Hospital's inpatients lived in the specified ZIP codes.

[1] *The Patient Protection and Affordable Care Act (Pub. L. 111-148) added section 501(r) to the Internal Revenue Code, which imposes new requirements on nonprofit hospitals in order to qualify for an exemption under Section 501(c)(3), and adding new reporting requirements for such hospitals under Section 6033(b) of the Internal Revenue Code.*

UH Geauga Medical Center followed the 2013 Proposed Regulations, published by the Treasury Department and IRS on April 5, 2013, in the Federal Register (REG-106499-12, 2013-21 I.R.B. 1111, [78 FR 20523]), in accordance with Notice 2014-2 that confirms that hospital organizations can rely on proposed regulations under section 501(r) of the Internal Revenue Code issued on June 26, 2012, and April 5, 2013, pending the publication of final regulations or other applicable guidance. The final rule entitled "Additional Requirements for Charitable Hospitals; Community Health Needs Assessments for Charitable Hospitals"; Requirement of a Section 4959 Excise Tax Return and Time for Filing the Return, was published by the IRS on December 31, 2014, and requires compliance after December 29, 2015.

FIGURE 1 DEPICTS THE HOSPITAL'S PSA AND SSA.



OBSERVATIONS FROM 2015 CHNA (2010 – 2013 DATA)

Key points from CHNA	Relate to the Implementation Strategy
16.8% of discharges were Ambulatory Care Sensitive (CHF was the most common 3.9%)	• Heart Health Day annually (free screenings, presentations and hospital employees available to discuss services) • Health Matters presentations • Free screenings • Healthy cooking demonstrations • Family Health and Safety Day activities
Cancer is the leading cause of death in Geauga, Lake and Ashtabula counties	• UH Seidman Cancer Center monthly screenings and presentations • Family Health and Safety Day activities • Women's Expo • Smokeless classes • Free screenings
Habitual behaviors play a role in all counties (obesity and smoking)	• Healthy cooking demonstrations • Smokeless classes • Health Matters presentations • Free screenings • Family Health and Safety Day • Teddy Bear clinics • DARE • Weight Management and bariatric seminars
Increase in depression rates from 13.2% to 15.6% in all counties; 32.9% self-described mental health as "not good" for at least one day in the past 30 days	• Family Health and Safety Day • Health Matters presentations • Medical stabilization service • Behavioral Health Unit – 18 bed unit
A large Amish community in Geauga County is uninsured and paid for care out-of-pocket	• Amish nurse navigator • Medical home visits • Amish Family Health and Safety Day • Safety Days auction • Health clinics – screenings and education • Monthly screenings and education

Additional observations from the 2015 CHNA:

- The population of the Hospital's PSA and SSA has remained stable; in the first five years of the decade it saw only a 0.3% decrease in overall population size. However, the population 65 years of age and older increased by 1.8 percentage points from 2010 to 2013.
- Ashtabula County had a higher poverty rate than the national and state averages in 2013.
- A large uninsured Amish population resides in Geauga County.
- The Hospital's PSA and SSA show that the basic demographic composition of all three counties remained essentially unchanged from 2010 to 2014.
- Across the PSA and SSA, about 16.8% of discharges were found to be ambulatory care sensitive or potentially preventable if patients were accessing primary care resources at optimal rates.

PRIORITY HEALTH NEEDS

In order to devote significant resources to improving identified health needs, UH Geauga Medical Center will be focusing its efforts on a few select health issues identified in the 2015 CHNA:

1. The Hospital will expand its services related to Substance Abuse and Mental Health. These two health needs were chosen after much review for three reasons. First, each includes subsets of other identified needs. Substance abuse impacts aspects of unemployment, cancer, heart disease, asthma and respiratory disease. Mental illness can play a role in aging, unemployment, poverty and access to care. Second, according to the Ohio agency on Mental Health and Addiction Services both mental illness and substance abuse are on the rise in our communities. These health needs are and will continue to challenge the members of our communities in growing numbers. Third, UH Geauga Medical Center already provides robust programming and services in the areas of cancer, obesity, heart disease, digestive health and provider access. We believe renewed focus on mental illness and substance abuse can have the largest impact on the communities we serve at this time.

2. It is well known that lack of access to primary care and/or specialty care is strongly related to unnecessary disease progression. Therefore, improved access to primary and specialty care is among the top priorities for this 2016 – 2018 plan.

3. Finally, those with chronic disease conditions benefit from early detection and ongoing patient education in order to improve self-management. In particular, diabetes, which impacts about 10% of the adult population, is twice as common in the UH Geauga Medical Center's adult inpatient population; that is, diabetes is strongly associated with conditions which require hospitalization. An aggressive community program that identifies diabetics (and others with chronic diseases) and links them to health care and other supportive services will have an impact on a large proportion of Geauga County's residents as well as positively impact the hospitalization rates of those with chronic diseases.

Health Disparities	Plan to Address
Aging Population	No
Unemployment	No
Poverty	No

Access Barriers	Plan to Address
Access to Primary Care Providers	Yes
Access to Dental Care	No
Access to Specialty Care	Yes
Access to providers that accept Medicare	No
Cost of care	No
Access to transportation	No

Chronic Disease Conditions	Plan to Address
Cancer	Yes
Heart Disease	Yes
Diabetes	Yes
Alzheimer's	Yes
Asthma (Older Adult and Children)	Yes
Mental Illness (Adult and Children)	Yes
Respiratory Disease	Yes
Digestive Disease	Yes

Lifestyle Barriers	Plan to Address
Obesity	No
Drug abuse	Yes
Alcohol abuse	Yes
Smoking	Yes

IMPLEMENTATION STRATEGY TO ADDRESS SIGNIFICANT HEALTH NEEDS

Lifestyle Barriers: Substance Abuse and Mental Health Illness

Goals:

- With the addition of 2 Behavioral Health Unit beds, the number of patients seeking treatment for mental health issues will increase to 800 patients per year by 2018.
- With the addition of a psychiatrist to UH, we will see an increase of 200 patients that can receive care locally.
- We will see an increased use of the medical stabilization program to such a degree that 360 patients may be able to receive care locally.

Actions:

- Add necessary service capacity for a growing need of substance abuse and mental health treatment
- Recruit one (1) new psychiatrist to provide increased consultation within the hospital
- Expand education//awareness in the community about services using Pandora, print and radio ads for medical stabilization
- Provide psychiatric consultation to community nursing facilities to assist in coordinating the health care needs of our older population
- Provide Smokeless training to employees, thus allowing smoking cessation classes to be held for the community
- Encourage the use of OARRS to all ED Physicians

Anticipated Impact:

- Community members will gain knowledge on substance abuse and mental health illnesses and steps that one can take in treatment
- Individuals will be educated on local services available
- More nursing home patients will receive psychiatric care coordination and consultation when needed
- By using OARRS, high-risk patients for substance abuse will be identified and educated on the medical stabilization program.

Access Barriers:

Goals:

- Increase the number of appointments that the concierge services schedules by 15%.
- Mobile Integrated Health will provide support to patients after discharge in meeting their follow-up appointment in 75% of the patients seen.

Actions:

- Expand education/awareness in the community about:
  - UH Hospital Assistance program
  - Insurance Assistance Line
  - Concierge services for scheduling appointments
  - Zocdoc scheduling
  - Hospital services
- Attend community events in underserved areas to deliver education/awareness communication

Anticipated impact:

- Community members will gain knowledge on programs that one can take to obtain financial support on health care services
- Community members will gain knowledge on the different avenues to schedule appointments with a health care provider, both primary and specialty providers

Chronic Disease Conditions (Diabetes):

Goals:

- Decrease the number of hospitalizations with chronic disease conditions by 5% by having patients referred to the Mobile Integrated Health program.
- Decrease the number of ED visits of patients with chronic disease conditions by 5% by having the patients referred to the Mobile Integrated Health program.
- Decrease the number of patients that are readmitted within 30 days by 5%.

Actions:

- Expand education/awareness on disease conditions (diabetes specifically) in the community by hosting monthly Health Matters seminars and quarterly regional events.
- Expand screenings for disease prevention and maintenance in the community by hosting free health clinics, including underserved areas.

- Host Family Health and Safety Day with multiple free screenings, tables of our multiple service lines with education on services.
- Include HbA1c in basic screenings in addition to a blood sugar.
- Visit patients at-risk for readmission, provide education on diagnosis and treatment plan. Provide support to not only the patient but the caregiver/family member. Assist with engaging the patient in his/her own health and wellness.

Anticipated Impact:

- Community members will participate in screenings to receive information on disease prevention or maintenance.
- Community members will gain knowledge on disease prevention and management.
- Community members will have access to discuss health questions with health care providers.

Commitment of programs and resources:

- UH Geauga Medical Center is committed to provide the financial support needed to recruit, hire and retain one psychiatrist.
- UH Geauga Medical Center is committed to provide the training for the Smokeless program.
- UH Geauga Medical Center is committed to provide the space and equipment needed to increase access to care by two rooms in its Behavioral Health Unit.
- UH Geauga Medical Center is committed to providing the financial and coordinated support of the monthly and quarterly Health Matters events.
- UH Geauga Medical Center is committed to hosting events both at the hospital and in the community to provide education/screenings/awareness to community members.
- UH Geauga Medical Center is committed to providing the coordination and financial support to improve community members' awareness of local services.

Priority Community Health Issues Identified in 2015 CHNA	Reason Issue is Not Being Addressed in 2016 – 2018 Implementation Plan
HEALTH DISPARITIES	
Poverty Unemployment	The hospital does not address these systemic population economic issues. However, the lack of access to needed care based on financial need has been and will continue to be addressed through numerous Hospital programs (Financial Assistance Service, Free Screening, etc.).
Aging Population	A majority of inpatients of the Hospital are those over age 65. Therefore, the Hospital will adjust capacity to serve a growing elderly population as it continues to manifest in the market area.
ACCESS BARRIERS	
Access to Dental Care	While dentists are included in community-based programs (e.g., health fairs) sponsored by the Hospital, increased access to dental care is not within the Hospital's area of focus.
Access to providers that accept Medicare	This issue is being addressed at the state level.
Access to transportation	The Hospital will maintain its collaborative relationship with Geauga Transit (the public transportation system), but is not working toward improving transportation for community members.
Cost of care	While decreasing the cost of care is not being addressed in this plan, the Hospital provides financial assistance to patients with a financial need.
LIFESTYLE BARRIERS	
Obesity	The increasing levels of obesity, while not addressed in this Plan directly, are addressed through the efforts pointed at diabetes detection and patient education.

DESCRIBE WHY HOSPITAL IS NOT ADDRESSING A SIGNIFICANT HEALTH NEED

No hospital facility can address all of the health needs present in its community to the fullest. The Hospital is committed to adhering to its Mission and remaining financially healthy so that it can continue to enhance its clinical, teaching and research activities and to provide a wide range of community benefits. The 2016 – 2018 Strategy leverages the Hospital's strengths and expertise yet utilizes existing community resources to address several community health needs. It is with that collaboration that needs can be met.

Actions outlined above are not the only things the Hospital will do to meet community health needs. The Hospital will continue to provide many free health fairs in the community, in addition to hosting free seminars and presentations for all to attend. The Hospital will continue to host the highly attended Family Health and Safety Day on hospital grounds, which gathers local community organizations in one location to provide assistance, guidance and answers to questions on a variety of topics, some of which include government assistance, county resources, diet and exercise conditions, unemployment resources, dental providers and resources for seniors.

IMPLEMENTATION STRATEGY COLLABORATORS

- UH Case Medical Center
- UH Ahuja Medical Center
- UH Bedford Medical Center, a campus of UH Regional Hospitals
- UH Conneaut Medical Center
- UH Elyria Medical Center
- UH Geneva Medical Center
- UH Parma Medical Center
- UH Portage Medical Center
- UH Rainbow Babies & Children's Hospital
- UH Richmond Medical Center, a campus of UH Regional Hospitals
- UH St. John Medical Center
- UH Samaritan Medical Center
- Southwest General Health Center, an affiliate of University Hospital
- County board of mental health and recovery
- Ohio Department of Mental Health
- Local long-term care facilities
- Geauga County Health Improvement Plan committee
- The Center for Health Affairs
- Geauga County Department on Aging
- Lake County General Health District
- Geauga County Sherriff Department
- NAMI
- Ravenwood Mental Health
- United Way 2-1-1
- Diabetes Partnerships of Cleveland
- Alzheimer's Association
- Arthritis Foundation
- Catholic Charities
- Geauga County Library
- Valley Zumba
- TOPS (Taking Pounds Off Sensibly)
- Middlefield Care Center
- Life 4 Diabetes
- Geauga Growth Partnerships
- Geauga County Part Districts

Among the nation's leading academic medical centers, University Hospitals Case Medical Center is the primary affiliate of Case Western Reserve University School of Medicine, a nationally recognized leader in medical research and education.

2016 IMPLEMENTATION PLAN




This Implementation Plan was approved by the University Hospitals Board of Directors on March 15, 2016

University Hospitals
St. John Medical Center
A CATHOLIC HOSPITAL

INTRODUCTION

University Hospitals St. John Medical Center conducted a community health needs assessment (CHNA) of the geographic areas served by UH St. John Medical Center pursuant to the requirements of Section 501(r) of the Internal Revenue Code.[1] The CHNA findings were published on UH St. John Medical Center's website in December of 2015 (the "2015 CHNA"). This CHNA was adopted by the UH Board of Directors on December 2, 2015.

This CHNA was conducted in response to federal government regulation.[2] The 2015 UH St. John Medical Center CHNA served as the foundation for developing an implementation strategy to address those needs that (a) the Hospital determines it is able to meet in whole or in part; (b) are otherwise part of its mission; and (c) are not met (or are not adequately met) by other programs and services in the Hospital's service area. This implementation strategy ("Strategy"), also required by Section 501(r), documents the Hospital's efforts to address the community health needs identified in the 2015 CHNA.

The Implementation Strategy identifies the means through which UH St. John Medical Center plans to address the identified needs that are consistent with UH St. John Medical Center's charitable mission during 2016 through 2018 as part of its community benefit programs. Beyond these programs, UH St. John Medical Center addresses some of these needs regardless of individuals' ability to pay, every day.

UH St. John Medical Center anticipates the strategies may change and therefore, a flexible approach is well suited for the development of its response to the 2015 CHNA. For example, certain community needs may become more pronounced and require changes to the initiatives identified by UH St. John Medical Center in the 2015 Implementation Strategy. During 2016 through 2018, other community organizations may address certain needs or new opportunities for collaboration on the identified strategies may present themselves. These opportunities may indicate that UH St. John Medical Center should refocus its implementation plan or move on to alternative community health needs that have been identified. In addition, changes to IRS final regulations may also compel changes to the 2015 Implementation Strategy.

OVERVIEW OF THE IMPLEMENTATION STRATEGY

The Strategy includes the following information:

1. UH St. John Medical Center Mission Statement
2. Communities served by UH St. John Medical Center
3. Identified priority community health needs
4. Implementation Strategies: 2016 through 2018
5. Needs beyond the hospital's Mission or service programs
6. Community collaborations

UH ST. JOHN MEDICAL CENTER MISSION STATEMENT

UH St. John Medical Center is a community health care resource committed to excellence. Our Mission is rooted in a deep reverence and respect for human life and the dignity of each person. Our service is characterized by a spirit of love, truth, justice and stewardship. We strive to always provide care which is compassionate and professional, continuing the healing ministry of Jesus in our community. To Heal. To Teach. To Discover.

COMMUNITY SERVED BY UH ST. JOHN MEDICAL CENTER

The community served by UH St. John Medical Center is defined based on the geographic origins of UH St. John Medical Center's inpatients. UH St. John Medical Center's service area includes parts of Lorain County, Ohio, and Cuyahoga County, Ohio. In terms of population, UH St. John Medical Center's service areas cover 78.9% of the population in Lorain County and 17.3% of the population in Cuyahoga County. Eight of the ZIP codes comprise UH St. John Medical Center's Primary Service Area (PSA) and nine of the ZIP codes comprise the Secondary Service Area (SSA).

[1] *The Patient Protection and Affordable Care Act (Pub. L. 111-148) added section 501(r) to the Internal Revenue Code, which imposes new requirements on nonprofit hospitals in order to qualify for an exemption under Section 501(c) (3), and adding new reporting requirements for such hospitals under Section 6033(b) of the Internal Revenue Code*

[2] *UH St John Medical Center followed the 2013 Proposed Regulations, published by the Treasury Department and IRS on April 5, 2013, in the Federal Register (REG-106499-12, 2013-21 I.R.B. 1111, [78 FR 20523]), in accordance with Notice 2014-2 that confirms that hospital organizations can rely on proposed regulations under section 501(r) of the Internal Revenue Code issued on June 26, 2012, and April 5, 2013, pending the publication of final regulations or other applicable guidance. The final rule entitled "Additional Requirements for Charitable Hospitals; Community Health Needs Assessments for Charitable Hospitals"; Requirement of a Section 4959 Excise Tax Return and Time for Filing the Return, was published by the IRS on December 31, 2014, and requires compliance after December 29, 2015.*

FIGURE 1: UH ST. JOHN MEDICAL CENTER MARKET AREAS

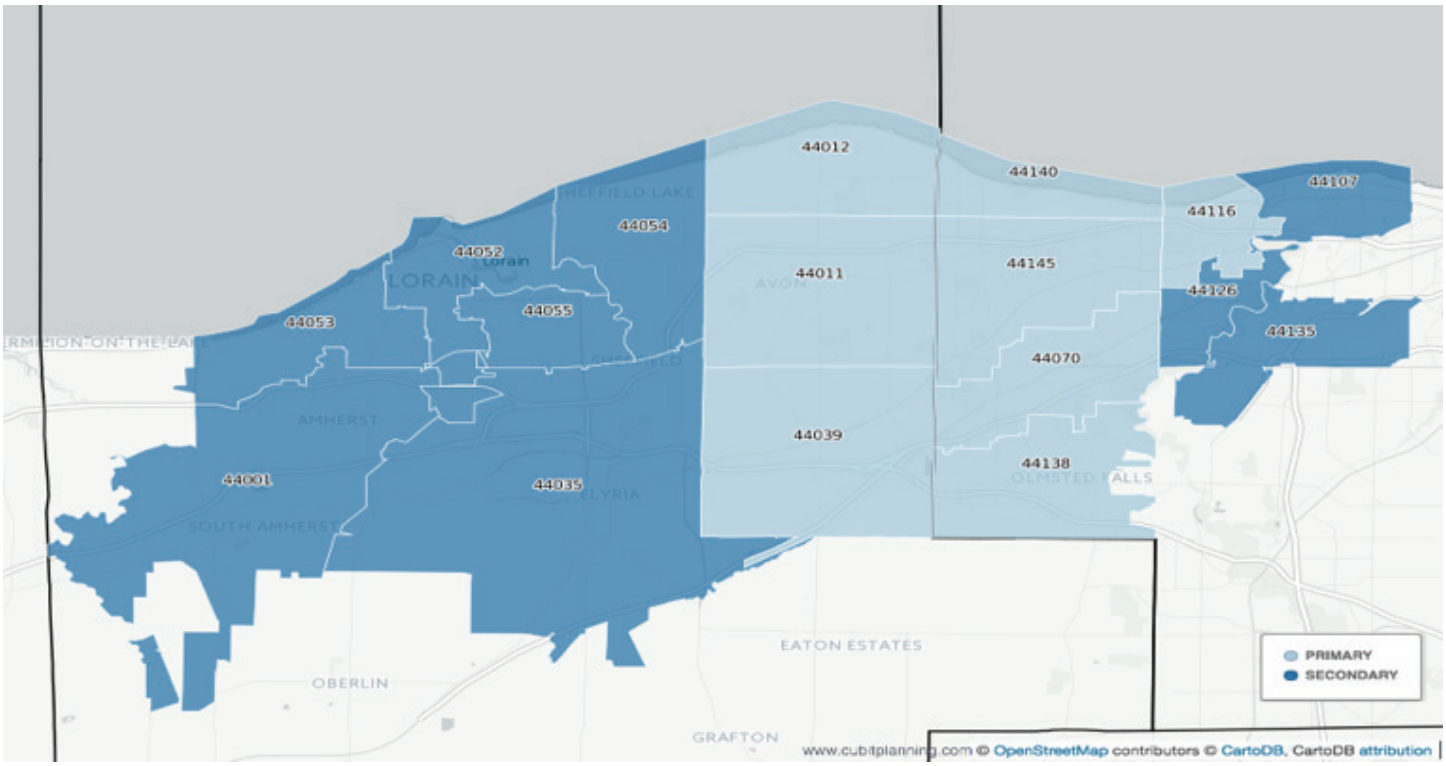


FIGURE 1 (ABOVE) DEPICTS THE HOSPITAL'S PSA AND SSA.

UH ST. JOHN MEDICAL CENTER BY THE NUMBERS

- Seventeen (17) ZIP codes in 2 counties: Cuyahoga and Lorain
- Total population in 2013: 438,520
  - Primary Service Area (PSA): 197,361
  - Secondary Service Area (SSA): 241,159
- 66.2% of discharges in 2013 were in UH St. John Medical Center's PSA
- 19.5% of discharges in 2013 were in UH St. John Medical Center's SSA
- 14.3% of discharges in 2013 were from other service areas
- In 2013, the percentage of discharges without an Ambulatory Care Sensitive (ACS) primary diagnoses was 78.8%. The percent of discharges without ACS secondary diagnoses was 17.6%. ACS diagnoses are believed to be preventable admissions with appropriate preventive and outpatient care.
  - ACS diagnoses were more common among Medicare patients, especially CHF, COPD, and bacterial pneumonia
  - The ACS diagnosis of cellulitis was most common among Medicaid, commercial insurance and self-pay patients; Cellulitis is often associated with intravenous recreational drug use
- Population changes between 2010 and 2013
  - Lorain County's population increased from 301,478 to 303,006 (+0.5%)
  - Cuyahoga County's population decreased from 1,278,172 to 1,269,839 (-1.3%)
  - Both Lorain County and Cuyahoga County experienced a decrease in average income of 4.7%
  - Percentage of people in Lorain County under the poverty line has increased from 14.1% to 15.0% (+0.9%)
  - Percentage of people in Cuyahoga County under the poverty line has increased from 17.3% to 18.7% (+1.4%)
- The largest percentage of people in both counties living under the poverty line are families with female headed household with related children under the age of 5 years
- Little change in racial demographics in either Lorain or Cuyahoga Counties
- Unemployment in Lorain County is the 16th highest in Ohio (6% in 2015); unemployment in Cuyahoga County is 30th highest in Ohio (5.5% in 2015)

PRIORITY HEALTH NEEDS

Below we list all of the community health issues identified in the Hospital's 2015 CHNA. Two of those issues are addressed in this Plan. However, the Hospital also has programs to help address each of the issues not described in this Plan; those are shared in Section 5.

Identified Needs	Plan to Address
Diabetes management and education	Yes
Obesity – adults and children	No
Behavioral health	No
Drug use (Opiates)	Yes
Concern for the uninsured and underinsured	No
Cost of prescription drugs	No
Lack of transportation	No
Print resources of community services for those without access to use the computer	No

IMPLEMENTATION STRATEGIES: 2016 – 2018

UH St. John Medical Center, through its Mission has a strong tradition of meeting community health needs through the provision of ongoing community benefit programs and services. UH St. John Medical Center will continue this commitment through the strategic initiatives set forth here that focus primarily on the gaps/needs identified in the 2015 Community Health Needs Assessment (CHNA).

UH St. John Medical Center has provided community benefit programs for many years and will continue to provide these programs. Not all such programs provided by UH St. John Medical Center that benefit the health of patients in UH St. John Medical Center's Primary Service Area and Secondary Service Area are discussed in the Strategy. The programs described in this Implementation Strategy highlight new initiatives that have been adopted to meet needs identified in the 2015 Community Health Needs Assessment.

2016 – 2018 CHNA Implementation Strategy Health Issue Planning Profile	
University Hospitals St. John Medical Center	
CHNA Health Issue	Type 2 Diabetes

Description of health issue:

Diabetes is one of the nation's leading causes of death and disability. Research shows that type 2 diabetes and much of the illness and premature death caused by diabetes can be prevented or delayed.

While only 1.7% of inpatients for UH St. John Medical Center in 2013 had a primary diagnosis of diabetes, almost one-third (30.1%) of inpatients had a secondary diagnosis of diabetes. Since fewer (9.3%) of the adult population have diabetes, the inpatient population having an incidence of diabetes three times the incidence in the general population suggests that uncontrolled diabetes is strongly associated with, and probably a cause of, a significant proportion of adult hospitalizations.

Goal: Reduce diabetes related hospital re-admissions by 10% in 2016 through 2018.

Objective: Promote a multidisciplinary community plan to improve and enhance diabetes self-management skills; provide programs to individuals with diabetes on self-management education, screenings, activities, and support.

2016 – 2018 CHNA Implementation Strategy Health Issue Planning Profile	
University Hospitals St. John Medical Center	
CHNA Health Issue	Type 2 Diabetes

Strategies: (By Objective)

1. Provide community education of diabetes and diabetes self-management skills.

   UH St. John Medical Center supports existing free programs designed to promote the importance of diabetes education and assist people with diabetes in obtaining the knowledge, skills, and abilities required for effective, sustained self-management of their condition. A Community Health Resource Guide of programs will be provided to program participants, connecting them with available community resources. The resource guide will be provided at hospital discharge, community events, physician's offices, senior centers, local newspapers, hospital website, through the Cleveland Food Bank food distribution (a focus of under-utilizers of health care services), among others. Community biometric screening, health consultation, and disease specific educational literature, are provided by UH St. John Medical Center community nurses, along with diabetes health talks and discussions which are provided by physicians and UH St. John Medical Center health care professionals.

   Diabetes self-management education is the provision of supportive interventions, including education and skills training. The Diabetes Education Group, recognized by the American Diabetes Association as a best-practice, is a four class series administered by UH St. John Medical Center staff. Participants have historically been referred through a physician. In 2016 UH St. John Medical Center will, in addition, identify diabetic patients in our primary market area who have shown high hospitalization rates (more than 3 hospitalizations within the past year). Many of these patients are un/under insured and financially challenged, often a barrier to diabetes education and appropriate preventive care. These patients will be targeted for class participation and/or alternative ways to improve their diabetes management. Our goal is to reduce the average re-hospitalization days per year.

2. Promote improvements in behavioral lifestyle choices which contribute to the development of pre-diabetes and diabetes including diet, healthy weight and exercise, as well as cooking and grocery shopping skills.

   At community events and programs, we will assist with goal setting to help people better manage diabetes which builds patients' confidence in their abilities to perform self-management skills and to increase self-efficacy. We will provide opportunities for patients to practice skills, and provide information at teachable moments whenever possible. UH St. John Medical Center supports many structured programs which allow individuals to practice and improve patient outcomes such as:

   - A walking and Wellness Challenge. Participants are screened before they walk for six weeks, then again after, and are able to recognize successful improvements. Last Challenge involving 65 participants saw an increase in exercise and a collective weight loss of 130 lbs., a significant decrease in blood glucose levels, cholesterol levels, waist circumference, BMI and blood pressure.
   - We will promote the Mall Walker Program which provides the opportunity to exercise without weather restrictions.
   - Opportunities to partner with local exercise facilities for participants will be explored.

3. We will collaborate with area hospitals, community organizations and health care professionals to provide quality education to individuals and families, so that by the end of 2016, we will align joint resources to expand the population of those who use community education programs, and especially entice those who under-utilize the free educational programs and events, which also offer resources, assistance and referral.

2016 – 2018 CHNA Implementation Strategy Health Issue Planning Profile	
University Hospitals St. John Medical Center	
CHNA Health Issue	Type 2 Diabetes

Anticipated Outcomes and Evaluation:

1. The aim of education and screening is for individuals with diabetes to improve their knowledge base, skills and confidence, enabling them to increase control of their own diabetes, and integrate effective self-management into their daily routines. Structured, measurable education and programs will have a positive effect on health outcomes and can significantly improve quality of life.

   During community events, at-risk individuals will be identified by abnormal biometric screenings (A1C, blood glucose, cholesterol and lipids). They will be given an explanation of screening results, educational information on lifestyle choices, referred to UH St. John Medical Center weight programs and educational programs and events, and referred for physician follow-up.

2. Community interventions and programs aimed at promoting improvement of behavioral lifestyle choices will see more participation each year until 2018. The numbers of individuals who live well with diabetes and effectively manage their disease to prevent or delay complications and improve quality of life will show a significant increase.

3. To promote a collaborative approach where individuals with diabetes, members of the health care team, and community organizations will work together to establish goals, create an action plan for self-management behavior change, and evaluate outcomes.

   Evaluation: Impact of the above efforts will be measured via 1) the incidence of diabetes diagnoses among residents in the market areas; 2) hospitalization and re-admission rates for diabetics within the Hospital's market area.

2016 – 2018 CHNA Implementation Strategy Health Issue Planning Profile	
University Hospitals St. John Medical Center	
CHNA Health Issue	Opiate Abuse

Description of health issue:

Heroin and opiate abuse is an epidemic in Cuyahoga County and surrounding counties. It affects people of all ages, races and backgrounds. The rapid and alarming increase in drug overdose deaths has created a public health crisis in our community.

Goal: To increase awareness/understanding on heroin and opiate abuse in our community and among our staff.

Objectives: Hospitalization provides an opportunity to identify drug abusers and potentially intervene and link abusers with treatment options. The objective of this Strategy is to not only respond to the medical needs of those who are treated in the emergency room or as inpatients but also to link those patients with treatment options. In addition, prescription procedures in the emergency room will be optimized to limit the unnecessary prescribing of narcotics.

Strategies: (By Objective)

Create an Opiate Abuse Advisory Committee within the organization. This group will be responsible for planning events, arranging education, and working with patients in the hospital. It will be a multidisciplinary group and include a member of the Cuyahoga County Health Department Opiate Task Force, Community Outreach, ED staff, Pharmacy, Social Work, ICU and various other departments.

1. Establish a protocol for overdose patients and addicted patients where members of the intervention team (social worker/RN) round on these patients, and offer support, drug abuse treatment options, and other various social service referrals. Develop and maintain a database of patients seen and outcomes, using year 2016 as the baseline since this is a new initiative. Develop an updated resource guide of treatment facilities placed online, and in units.

2. Encourage physicians and other prescribers to register and use OARRS system by providing education on the importance of OARRS system. Determine the number of Emergency Room physicians that are currently using OARRS system before prescribing narcotics to patients and use that number as a baseline. Develop a tracking system that will monitor the use of OAARS system by Emergency Room physicians. Encourage and educate Emergency Room physicians to use OARRS system before prescribing narcotics to patients, with the goal to be 90% participation by all Emergency Room physicians over the three-year time period. Develop easy access to OARRS system throughout hospital on devices and have eligible support staff readily trained and able to assist in obtaining reports for physicians.

3. Financially support two physicians, residents, medical students or pharmacists to attend conferences on controlled substance prescribing or addiction; these physicians/residents will then be expected to educate staff on topics they have learned.

4. Partner with the Cuyahoga County Opiate Task Force, support and sponsor their community events, this will include maintaining membership on the Opiate Task Force, attending events, and financially supporting their events. Hold/Sponsor events that may include education, drug take back days, naloxone kit distribution, community speakers to speak on topics of addiction, stigma, pain management, and other relevant topics that will increase awareness on the heroin/opiate abuse epidemic for staff and community members of UH St. John Medical Center primary service area.

2016 – 2018 CHNA Implementation Strategy Health Issue Planning Profile	
University Hospitals St. John Medical Center	
CHNA Health Issue	Opiate Abuse

Anticipated Outcomes and Evaluation:

1. Increase the number of hospital Emergency Dept. and admitted patients who are counseled on and/or enter into treatment programs. Develop a database and use 2016 as a baseline. Over a three-year period, the goal is for 100% of overdose/addicted patients to be seen by the intervention team and offered treatment options.
2. Measurable improvement in physicians using OARRS system and education on addiction. Create a database using 2016 as a baseline and goal for 90% Emergency Room physicians using OARRS report before prescribing narcotic medication over three-year time period.
3. Maintain membership and sponsor Opiate Task Force events.
4. Provide education and use measurable evaluation tools (pre- and post-tests) for effectiveness.

IDENTIFIED NEEDS/GAPS NOT BEING ADDRESSED BY UH ST. JOHN MEDICAL CENTER IMPLEMENTATION PLAN

The 2015 CHNA identified 8 unmet community health needs. UH St. John Medical Center selected two of them to focus on in this Implementation Plan. However, the Hospital has and will continue to sustain several efforts which do address each of those community health needs in some way. Below we outline the reason an identified health issue was not included in the current Plan along with key efforts the Hospital will continue.

1. Obesity is a growing problem in both the adult population and among children and is often related to poor health. Although UH St. John Medical Center is not able to address this directly, it will be part of the education program for diabetics. Obesity is strongly liked with diabetes – so any program which aims to decreases diabetes includes, by definition, efforts to limit overweight in the population.

2. Behavioral health services. There continues to be a shortage of available inpatient and outpatient behavioral health services in UH St. John Medical Center's primary and secondary service areas. UH St. John Medical Center does not have a Behavioral Health Department, so there are neither the resources nor expertise available within the UH St. John Medical Center community. Through Community Outreach, UH St. John Medical Center offers education talks on behavioral health topics and support groups for individuals living with various behavioral health challenges.

3. Concern for the uninsured and underinsured. A social worker is available for both inpatient and outpatient referrals to assist patients in navigating the health care system. The social worker helps complete Medicaid applications, enroll patients in the Insurance Exchange Programs and Medicare, and access free clinics.

4. Cost of prescription drugs. A social worker is also available for inpatient and outpatient referrals to help patients access medications through pharmaceutical companies, a prescription voucher program, discount cards and pharmaceutical samples.

5. Transportation for the elderly population, as well as others who rely on public transit, remains a challenge. It is particularly problematic in Lorain County. This is a need that is beyond UH St. John Medical Center's mission and service programs and requires the attention and funds of local, regional, and state governmental services. When possible, UH St. John Medical Center will continue to advocate for better public transportation. Community Outreach works closely with senior centers and senior living communities and will continue to partner with them to ensure service coordination, which often includes addressing transportation issues.

6. Print resources of community services for those without access to use the computer. As part of this Plan UH St. John Medical Center will provide print materials to support its programs on diabetes and opiate abuse. Other community members provide print materials to address other community health needs and the Hospital will continue to provide medical information to support the creation of those materials.

Many of the implementation strategies adopted in the 2012 CHNA Implementation Plan have been very successful and will be continued and in some cases expanded. They are geared toward solving health, education or economic issues for small but vulnerable portions of the community. These include:

- Continue the Deaf Access Program. The Deaf Access program provides consultation/guidance to medical center managers and staff as it relates to patients who are deaf or hard of hearing. The program coordinator provides quality patient access (deaf patients) including assistance at patient/family meetings with patients physicians and other caregivers; assists with development of policies and procedures related to deaf patients; and participates in community events such as wellness fairs, health screenings, and health education.

- Continue Women's Health and Wellness Service Line. All About You is a free women's health membership program that provides health and wellness education, support and encouragement. Membership includes an e-newsletter featuring health information, recipes, exercise tips and more; invitations to special events that focus on women's health and wellness; notification of women's health screenings, education programs, and support groups; and patient navigator to provide support with healthcare access.

- Expand the shadowing program for high school/college students interested in the medical professions. A shortage of health care professionals, especially those in allied health, nursing, primary care and urban medicine is expected. Additional demand is expected as population health/prevention programs grow.
- Continue to participate in the St. Martin de Porres work/study program. St. Martin de Porres is a member of the Cristorey network of schools established for students in communities of modest economic means. St. Martin de Porres offers students college preparatory education along with a corporate work/study program. The work/study program offers the students workplace learning that is an integral part of the student's development as a scholar, as a professional, and as a person. UH St. John Medical Center has been a corporate partner, mentoring four or five students during the academic year.

COMMUNITY COLLABORATIONS

- Center for Health Affairs
- Cuyahoga County Opiate Task Force
- Catholic Charities' Matt Talbot for Women
- American Diabetes Association
- Lions Club
- Westlake Recreation Center
- Cuyahoga County Opiate Task Force
- City of Westlake Community Services
- City of Westlake Police Department
- City of Westlake EMS
- Project DAWN
- UH Case Medical Center
- West Shore Enforcement Bureau
- Ohio Pharmacy Board
- Various school systems, drug treatment providers and prevention specialists.

2016 IMPLEMENTATION PLAN




This Implementation Plan was approved by the University Hospitals Board of Directors on March 15, 2016

University Hospitals
Elyria Medical Center

INTRODUCTION

In 2015, University Hospitals Elyria Medical Center conducted a community health needs assessment (CHNA) of the geographic areas served by the hospital pursuant to the requirements of Section 501(r) of the Internal Revenue Code.[1] The assessment was approved by the University Hospitals Board of Directors on September 24, 2015.

This CHNA was conducted in response to federal government regulation. The 2015 UH Elyria Medical Center CHNA served as the foundation for developing an implementation strategy to address those needs that (a) the Hospital determines it is able to meet in whole or in part; (b) are otherwise part of its mission; and (c) are not met (or are not adequately met) by other programs and services in the Hospital's service area.

This implementation strategy ("Strategy"), also required by Section 501(r), documents the Hospital's efforts to address the community health needs identified in the 2015 CHNA and is consistent with the Hospital's charitable mission for the 2016 through 2018 time frame as part of its community benefit programs. Beyond these programs, the Hospital is addressing some of these needs simply by providing care to all, regardless of their ability to pay, every day.

UH Elyria Medical Center anticipates the strategies may change and therefore, a flexible approach is best suited for the development of its response to the 2015 CHNA. Other community organizations may address certain needs or new opportunities for collaboration may be identified, all of which may lead to modification to the hospital's implementation plan. In addition, changes to IRS final regulations may also require changes to this Implementation Strategy.

OVERVIEW OF THE IMPLEMENTATION STRATEGY

The Strategy includes the following information:

1. UH Elyria Medical Center Mission Statement
2. Communities served by UH Elyria Medical Center
3. Observations from the 2015 CHNA
4. Identified priority community health needs
5. Implementation Strategies: 2016 – 2018
6. Needs beyond the hospitals' programs
7. Community collaborations

UH ELYRIA MEDICAL CENTER MISSION STATEMENT

To Heal. To Teach. To Discover.

COMMUNITY SERVED BY UH ELYRIA MEDICAL CENTER

UH Elyria Medical Center is located in the city of Elyria in Lorain County, Ohio. Lorain County amasses a land area of nearly 493 square miles, with approximately 612 persons per square mile. Lorain County is considered a rural, rustbelt community comprising cities, villages and townships. While some cities, such as Avon, Avon Lake and North Ridgeville, are experiencing bustling growth, others such as Elyria and Lorain have seen businesses close in the past several years, resulting in job loss and people leaving the county.

As illustrated in this graphic, UH Elyria Medical Center's market area in Lorain and Erie counties includes 15 municipalities (four in its Primary market area and 11 in its secondary market area).

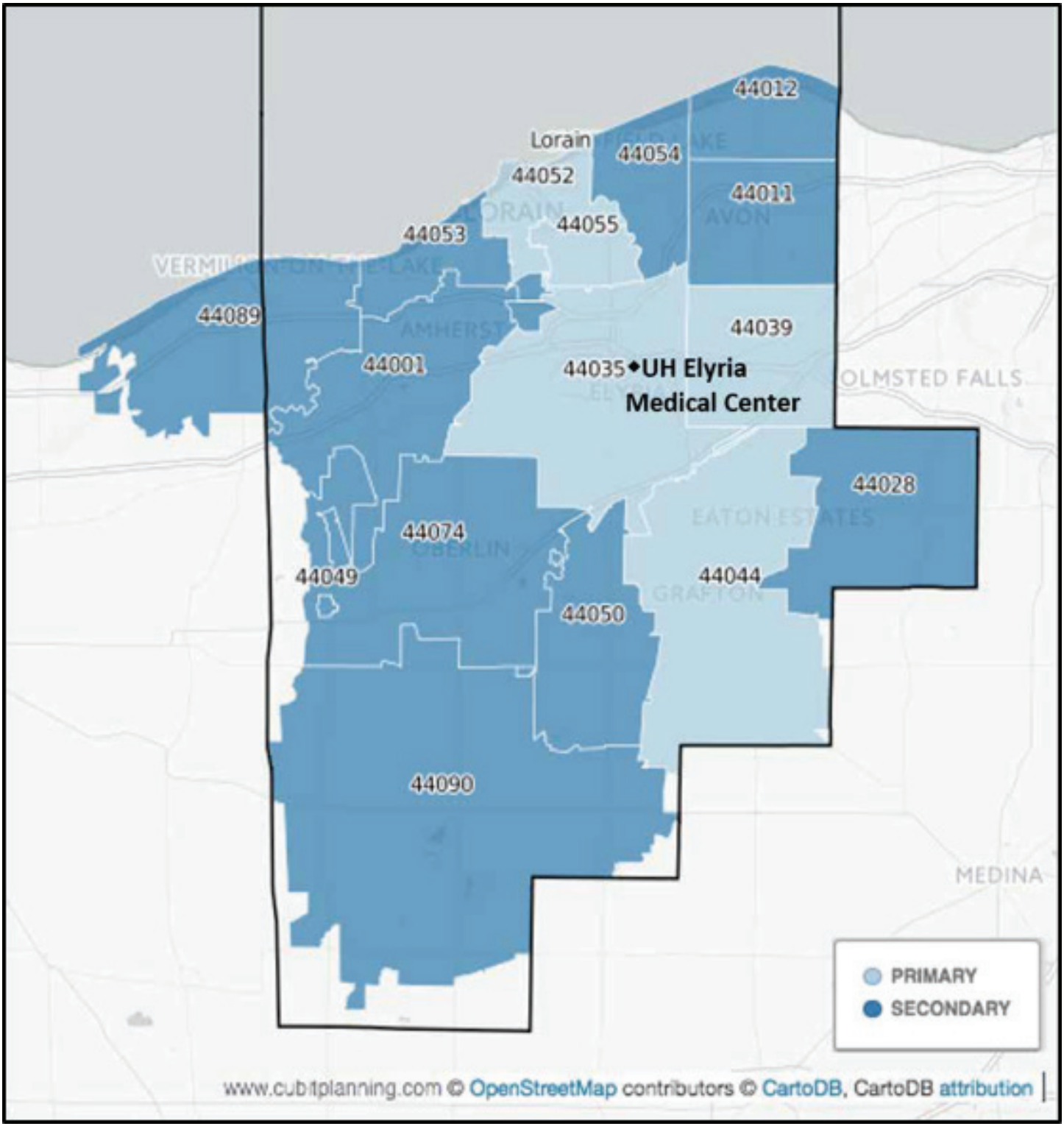
In 2013, 94.9% of UH Elyria Medical Center's discharges were in either its primary (71.5%) or secondary (23.3%) market areas. In 2013, just under half (45.2%) of the population in UH Elyria Medical Center's market area lived in its primary market area. Most of the remaining 52% lived in its secondary market area. Although the city of Elyria contains just 17.8% of Lorain County's population, Elyria residents accounted for 48.5% of UH Elyria Medical Center's discharges in 2013.

In 2013, 85.2% of UH Elyria Medical Center's emergency room visits came from its primary market area (cities of Elyria, North Ridgeville, Lorain or Grafton) and just under half (45.2%) of the county's population lived in these cities. Likewise, 65.7% of the emergency room visits came from Elyria residents even though the city contains just 17.8% of the county's population.

[1] *The Patient Protection and Affordable Care Act (Pub. L. 111-148) added section 501(r) to the Internal Revenue Code, which imposes new requirements on nonprofit hospitals in order to qualify for an exemption under Section 501(c) (3), and adding new reporting requirements for such hospitals under Section 6033(b) of the Internal Revenue Code.*

UH Elyria Medical Center followed the 2013 Proposed Regulations, published by the Treasury Department and IRS on April 5, 2013, in the Federal Register (REG-106499-12, 2013-21 I.R.B. 1111, [78 FR 20523]), in accordance with Notice 2014-2 that confirms that hospital organizations can rely on proposed regulations under section 501(r) of the Internal Revenue Code issued on June 26, 2012, and April 5, 2013, pending the publication of final regulations or other applicable guidance. The final rule entitled "Additional Requirements for Charitable Hospitals; Community Health Needs Assessments for Charitable Hospitals"; Requirement of a Section 4959 Excise Tax Return and Time for Filing the Return, was published by the IRS on December 31, 2014, and requires compliance after December 29, 2015.

FIGURE 1 DEPICTS THE HOSPITAL'S PSA AND SSA.



UH ELYRIA MEDICAL CENTER COMMUNITY BY THE NUMBERS

- 4 Primary Service Area municipalities (all in Lorain County): Elyria, North Ridgeville, Lorain, Grafton
- 11 Secondary Service Area municipalities (all in Lorain County): Amherst, Avon, Avon Lake, Columbia Station, Kipton, Lagrange, Lorain, Sheffield Lake, Oberlin, Vermilion, Wellington
- Service Area Population, 2013: 251,070
- 71.5% of inpatient discharges originate from the Primary Service Area
- 54.2% of community discharges were for patients with Medicare
- 15% of community discharges were for patients with Medicaid
- 23.2% of households with incomes <$25,000
- 88.7% of population is White; 10.3% is Black
- Hispanic/Latino population grew from 8% in 2010 to 8.6% in 2013
- There exists a wide range of health status and access challenges across the community

OBSERVATIONS FROM THE 2015 CHNA

UH Elyria Medical Center's service area extends into 15 municipalities within Lorain County. Key findings from analyses of that population are as follows:

- Poverty and unemployment in the area create barriers to access (to health services, healthy food and other necessities) and thus contribute to poor health.
- The number of households in Lorain County increased by 0.8% from 2010 to 2013. However, the average income has decreased in Lorain County by 4.7% from 2010 to 2013. As the Lorain County population ages, its proportion of households with Social Security and retirement income increases, but the mean retirement income decreased by 3.7% during that same time period.
- The proportion of Lorain County residents with related children living below the poverty line increased 2.9% from 2010 to 2013. Fewer had commercial health insurance and more had government-provided coverage.
- The unemployment rate in Lorain County is the 24th highest in Ohio and was 6.4% in March of 2015.
- In 2013, 21.6% of patient discharges were Ambulatory Care Sensitive (ACS) discharges of residents within the primary and secondary market areas combined. Those in the primary market area were more likely (by 5 percentage points) to have an ACS condition. This may signal lower availability or access to primary care within the primary market area. The most common conditions were Chronic Obstructive Pulmonary Disease, Congestive Heart Failure, Bacterial Pneumonia, Cellulitis, Kidney/ Urinary Infections, Diabetes and Asthma.

The priority health needs identified in the 2015 CHNA align with the priority health needs identified by Elyria Medical Center prior to joining University Hospitals Health System, Inc. in 2014. Given the short period of time between these assessments, there have not been many significant improvements in overall community health. The problems identified in the CHNA report have deep roots (many based on social and economic conditions) that do not change quickly over time.

These needs were also prioritized to align with UH Elyria Medical Center's participation in the Lorain County Community Health Improvement Plan ("CHIP"), which prioritizes health issues in Lorain County based on a comprehensive needs assessment conducted by the Lorain County General Health District and addresses measurable outcomes for health improvement in the county. UH Elyria Medical Center has collaborated with the Elyria City Health District, Lorain County General Health District, Lorain County Health & Dentistry (the county's Federally Qualified Health Center), Lorain County Metro Parks, Mercy Regional Medical Center & Mercy Allen Hospital, The Alcohol and Drug Addiction Services Board of Lorain County, and the Lorain County Board of Mental Health on this comprehensive CHIP for Lorain County. As a participant in the Lorain County CHIP, UH Elyria Medical Center is working to address these county health needs: improving access to care; expanding coordinated education and prevention services; improving weight and obesity; reducing alcohol, tobacco and drug abuse among adults and children; and improving mental health of adults and children.

In 2015, UH Elyria Medical Center did solicit input from public health and community leaders through a combination of surveys and in-person interviews. Top health issues identified included obesity, diabetes, heart disease, mental health and substance abuse. Access issues, like the lack of bilingual providers or those accepting Medicaid, were also identified. The most significant barrier to access cited by a majority of respondents was lack of transportation.

PRIORITY COMMUNITY HEALTH NEEDS

Identified Needs	Plan to Address
Weight Status	Yes
Access to Care (Transportation, specifically, not addressed)	Yes
Preventive Health	Yes
Leading Causes of Death	Yes
Maternal & Child Health, including teen births	Yes
Mental Health	Yes
Alcohol, Tobacco and Other Drug Use among Adults and Youth	No
Outpatient Mental Health	No

IMPLEMENTATION STRATEGIES: 2016 – 2018

UH Elyria Medical Center, through its Mission, has a strong tradition of meeting community health needs through its provision of ongoing community benefit programs and services. UH Elyria Medical Center will continue this commitment through the strategic initiatives set forth here that focus primarily on the gaps/needs identified in the 2015 Community Health Needs Assessment (CHNA).

UH Elyria Medical Center has provided community benefit programs for many years and will continue to provide such programs. Not all such programs provided by UH Elyria Medical Center that benefit the health of patients in the hospital's Primary Service Area and Secondary Service Area are discussed in the Strategy. The programs described in this implementation strategy emphasize the new initiatives that have been adopted to meet the needs identified in the 2015 Community Health Needs Assessment.

2016 – 2018 CHNA Implementation Strategy Health Issue Planning Profile	
University Hospitals Elyria Medical Center	
CHNA Health Issue:	Weight Status

Description of the health issue:

Obesity is a major factor in the development of most chronic diseases such as diabetes, heart disease and cancer. Data published by the CDC in 2015 shows a 29.4% rate of obesity among adults in Lorain County, slightly below the national rate of 30.4% and improved since 2011 (32%).

Goal:

To provide weight management programs to adults and children in the community to lower the overall rate of obesity.

Objective:

Reduce the rate of obesity among adults in Lorain County to 28% by 2018

Strategies and Anticipated Outcomes:

1. **Enlighten Program:** Enroll eight participants in 2016
   - A year-long program – a six-month weight reduction program combined with a six-month weight maintenance program. Educational services and weekly seminars directed by RNs, a registered dietitian, a degreed exercise physiologist and certified personal trainers as well as NP assessment.
2. **Extreme Loser:** Enroll 50 participants in 2016
   - A 12-week session, groups of six people with two personal trainers. Teams work out two times a week and educational information will include nutrition by a registered dietitian.
3. **Healthy Kids (New):** Enrolled 30 in 2015 and the goal for 2016 is 90 children.
   - Pediatric weight management program that teaches families how to make healthy lifestyle choices. This is a 12-week program including kids and families who meet once a week. Evaluations by an endocrinologist, dietitian, behavioral specialist and exercise physiologist.
4. **Avon/Avon Lake Wellness Challenge:** Enroll 250 participants in 2016
   - A community challenge between Avon and Avon Lake where one community competes against another in a program rewarding participants for health, wellness and fitness activities. Assessment will include waist circumference, weight and BP.

Evaluated Outcomes: Program completion rate; average of weight loss per participant; average improvement in health indicators (cholesterol levels, triglycerides, blood sugar, etc.); proportion of participants who see measureable improvement.

Collaboration and Partnership: UH Rainbow Babies & Children's Hospital; Cities of Avon and Avon Lake, Ohio

2016 – 2018 CHNA Implementation Strategy Health Issue Planning Profile	
University Hospitals Elyria Medical Center	
CHNA Health Issue:	Access to Care

Description of the health issue:

Lack of access to care can result when the number or type of providers is inadequate or when barriers exist, such as lack of transportation, underinsurance or lack of insurance, trouble navigating the health care system, or language/cultural barriers.

Goal:

Improve network of primary care physicians and reduce access-to-care barriers.

Objective:

Increase the availability of primary care services (e.g., physicians, nurse practitioners)

Strategies and Anticipated Outcomes (by Objective):

1. **Primary care physician recruitment:** Continue to add adult and pediatric PCPs to existing offices and develop new locations like UH North Ridgeville Health Center; collaborate with other providers (e.g., Lorain County Health and Dentistry) to ensure primary care is available in other communities.
2. **Patient Navigators (New):** For ER patients without an identified PCP, provide information and arrange follow-up appointments with UH physicians.
3. **Expand needed medical services (New):** Develop UH North Ridgeville Health Center to offer primary care, emergency/urgent care, specialty care, diagnostic services.
4. **Establish the Hospital as an access point to other UH Services:** UH Case Medical Center's quaternary care services and other UH specialty services near our community, such as UH Westlake Health Center; expand use of Gates Specialty Suite and other Gates Building offices for UH specialty services.

Evaluated Outcomes: Proportion of nonemergent patients who seek care at the Emergency Department; number of Emergency Department patients who presented with a nonemergent issue who are connected with a primary care provider.

Collaboration and Partnership: UH St. John Medical Center; Lorain County Health and Dentistry; University Hospitals Institutes

2016 – 2018 CHNA Implementation Strategy Health Issue Planning Profile	
University Hospitals Elyria Medical Center	
CHNA Health Issue:	Preventive Health

Description of the health issue:

Preventive Health refers to measures, such as education and health screenings, taken to prevent the onset of disease or the development of complications once a disease is present. The community desires more preventive health opportunities.

Goal:

To increase the number of successful preventive health programs in the community.

Objective:

Measure the number of successful programs offered to the community in 2016

Strategies and Anticipated Outcomes (by Objective):

1. **Health Matters (NEW):** Goal of 10 participants at monthly program and 200 at quarterly event
   - A systemwide UH program offering 12 monthly educational presentations and four quarterly multidisciplinary special event programs (e.g. Cardiac, Men's and Women's Health) annually. UH Elyria Medical Center hosts the monthly events in Gates Auditorium.
2. **Strong Women, Healthy Hearts (New):** Program starts April 2016. Enroll 25 participants.
   - Designed for women 40 and over – a 12-week program offering education, exercise, diet and nutrition. Goal is to reduce the risk of heart disease in women.
3. **Age Well Be Well (New):** Enroll 250 members in 2016
   - Club for seniors offering health and wellness education, monthly activities, walking club, newsletter, magazine and special events.
4. **Lorain County Diabetes Prevention Program (New):** Start two UH-sponsored DPP classes in 2016
   - 12-month program developed by YMCA and certified by the Centers for Disease Control and Prevention. At-risk patients identified by primary care physicians and at informational sessions. Initially 16 weekly one-hour educational sessions followed by monthly meetings. Goal is to prevent or delay onset of diabetes in at-risk individuals by losing 7% of body weight and maintaining a minimum of 150 minutes activity per week.
5. **North Ridgeville Heart and Sole:** Remain community partner
   - Community collaborative with the goal of increasing awareness and access to physical activity and nutrition resources to reduce metabolic syndrome (obesity, heart disease, and diabetes).
6. **Smoking Cessation:**
   - Participating in Lorain County CHIP tobacco subcommittee; pulmonary lung function screening to promote smoking cessation; researching the feasibility of UH Elyria Medical Center Wellness staff becoming certified smoking cessation instructors. Start regular smoking cessation classes in 2016.

Evaluated Outcomes: Physical risk factors for disease states (overweight, hypertension, blood sugar, high cholesterol, etc.) should all be reduced if programs are impactful. Ultimately incidences and death rates from these diseases should decline.

Collaboration and Partnership: UH Center for Lifelong Health, Lorain County General Health District, YMCA of Greater Cleveland, City of North Ridgeville

2016 – 2018 CHNA Implementation Strategy Health Issue Planning Profile	
University Hospitals Elyria Medical Center	
CHNA Health Issue:	Leading Causes of Death
Description of the health issue: Cancer, Heart Disease, Stroke, and Diabetes are among the leading causes of death in Lorain County in 2015.	
Goal: Provide targeted programming to reduce the death rate for these leading diseases	
Objective: Lower death rate for Cancer, Heart Disease, Stroke, and Diabetes in 2016 – 2018.	

2016 – 2018 CHNA Implementation Strategy Health Issue Planning Profile	
University Hospitals Elyria Medical Center	
CHNA Health Issue:	Leading Causes of Death

Strategies and Anticipated Outcomes (by Objective):

Diabetes Education Initiative: Increase in referral base in 2016

- Increase identification and education of diabetic hospitalized patients through automated EMR notifications to the diabetes education program.
- Diabetes educator moved to hospital from offsite office in 2015. Now more readily available to provide inpatient education and can collaborate with physicians and staff.

Cancer

- Commission on Cancer Accreditation (community-based program). Maintain accreditation.
- Hampson Mole Breast Health Suite (New)
- Dedicated breast surgeon (New)
- Two UH thoracic surgeons (New)

Heart Disease

- Dedicated cardiac surgeon (New)
- Recruitment of third electrophysiologist (New)
- Recruitment of vascular surgeon in 2016
- EMS Lucas Devices (New): Funding one device for each community under UH Elyria Medical Center EMS medical control.

The LUCAS™ Chest Compression System is a tool that standardizes chest compressions in accordance with the latest scientific guidelines. It provides the same quality for all patients over time, independent of transport conditions, rescuer fatigue, or variability in the experience level of the caregiver. By doing this, it frees up rescuers to focus on other life-saving tasks and creates new rescue opportunities.

Stroke

- Primary Stroke Center: Joint Commission Certification 2015; Integrated with UH Case Medical Center and UH Neurological Institute. Goal is to treat 24 stroke patients with thrombolytics in 2016.

Evaluated Outcomes: Death rates.

Collaboration and Partnership: American College of Surgeons Commission on Cancer; Hampson Family Foundation; UH Elyria Medical Center Foundation; UH Harrington Heart & Vascular Institute; North Ohio Heart; The Joint Commission; UH EMS Institute; Lorain County EMS Association.

2016 – 2018 CHNA Implementation Strategy Health Issue Planning Profile	
University Hospitals Elyria Medical Center	
CHNA Health Issue:	Maternal & Child Health, including teen births

Description of the health issue:

High rates of infant mortality indicate broader issues pertaining to access to care and maternal and child health. Rates in Lorain County remain higher than national rates, and rates for African-Americans are significantly higher than those for Caucasians.

Goal:

Provide targeted programming to improve maternal and child health and reduce infant mortality.

Objective:

Reduce infant mortality rate to 5.0 per 1000 live births by 2019 (Lorain County CHIP Goal)

Strategies and Anticipated Outcomes:

Infant mortality and teen births

- Breastfeeding Education and Support Group – In collaboration with Elyria City Health District and Lorain County Health and Dentistry (LCHD), UH Elyria Medical Center Lactation consultants will offer education sessions in Elyria, Lorain and Oberlin at LCHD clinics to target underserved, minority women. A UH Elyria Medical Center nutritionist will also provide six classes in the program.
- Baby-friendly designation (New)
- Congenital Heart Disease screening done on all newborns
- Education to every parent on the Safe to Sleep campaign
- University Hospitals Obstetrics Network – Implementation of Standard Procedures in 2016

Access to Maternal and Child Health Services

- Addition of two obstetricians and one pediatrician to Gates Office Building on hospital campus (New)
- Natural Beginnings – Natural childbirth option

Evaluated Outcomes: Premature birth rates; infant mortality rates.

Collaboration and Partnership: UH Rainbow Babies & Children's Hospital; Lorain County General Health District; UH Physician Services; Elyria City Health District; Lorain County Health and Dentistry

2016 – 2018 CHNA Implementation Strategy Health Issue Planning Profile	
University Hospitals Elyria Medical Center	
CHNA Health Issue:	Mental Health

Description of the health issue:

Mental Health is an integral part of overall health. Surveys of community residents and leaders indicate ongoing concerns about access to mental health services. In addition, there is concern about a growing problem with drug addiction, resulting in increasing numbers of drug overdose deaths from opiates, especially heroin.

Goal:

Provide high quality hospital-based mental health services, including addiction services for hospitalized patients.

Objective:

Measure volume of inpatient services provided. Reduce the number of drug overdose deaths in Lorain County.

Strategies and Anticipated Outcomes:

Inpatient Behavioral Health Unit:

- Increased patient volume due to integration with UH mental health network
- Explore further capacity expansion

Drug Addiction

- Addiction consultants for hospitalized patients
- Project DAWN: Participant in county-wide planning meetings
- Narcan Rescue Kits: Continue to supply first responders (police and fire)
- Prescription drop boxes: located at local Sheriff's Department and Police Stations

Evaluated Outcomes: Overdose patients in Emergency Room; overdose deaths; waiting list length for addiction treatment services; proportion of psychiatric patients who present in the Emergency Department who are admitted into UH Elyria Medical Center as opposed to transported to a different facility.

Collaboration and Partnership: Lorain County Project DAWN; GMA Consultants; UH Case Medical Center Department of Psychiatry

IDENTIFIED NEEDS NOT BEING ADDRESSED BY UH ELYRIA MEDICAL CENTER IMPLEMENTATION PLAN

1. Access To Care: Transportation

Transportation for those who rely on public transit remains a challenge in Lorain County. This is a need that is beyond UH Elyria Medical Center's mission and service programs and requires the attention and funds of local, regional, and state governmental services. When possible, UH Elyria Medical Center will continue to advocate for better public transportation.

2. Mental Health Services: Outpatient

There are private psychiatrists and psychologists in the community as well as outpatient mental health service providers funded by the Lorain County Board of Mental Health, such as the Nord Center, and behavioral health services provided by Lorain County Health and Dentistry, the county's Federally Qualified Health Center. UH Elyria Medical Center does not offer outpatient mental health services.

3. Alcohol, Tobacco and Other Drug Use among Adults and Youth

This issue is being directly addressed by the ADAS (Alcohol, Drug Abuse Services Board for Lorain County); however, UH Elyria Medical Center is a leader in the Opiate Task Force and is a co-provider of Narcan to first responders throughout the County.

COMMUNITY COLLABORATIONS

- American College of Surgeons Commission on Cancer
- Cities of Avon and Avon Lake, Ohio
- City of North Ridgeville
- Elyria City Health District
- GMA Consultants
- Hampson Family Foundation
- The Joint Commission
- Lorain County Health and Dentistry
- Lorain County General Health District
- Lorain County EMS Association
- Lorain County Project DAWN
- North Ohio Heart
- UH Rainbow Babies & Children's Hospital
- UH St. John Medical Center
- University Hospitals Institutes
- UH Center for Lifelong Health
- UH Elyria Medical Center Foundation
- UH Case Medical Center Department of Psychiatry
- UH Harrington Heart & Vascular Institute
- UH EMS Institute
- UH Physician Services
- YMCA of Greater Cleveland

Among the nation's leading academic medical centers, University Hospitals Case Medical Center is the primary affiliate of Case Western Reserve University School of Medicine, a nationally recognized leader in medical research and education.

2016 IMPLEMENTATION PLAN




This Implementation Plan was approved by the University Hospitals Board of Directors on March 15, 2016

University Hospitals
Parma Medical Center

INTRODUCTION

University Hospitals Parma Medical Center ("Hospital") conducted a community health needs assessment ("CHNA") of the geographic areas served by the Hospital pursuant to the requirements of Section 501(r) of the Internal Revenue Code ("Section 501(r)"). The CHNA findings were published on the Hospital's website in December 2015. This CHNA was adopted by the UH Board of Directors on September 24, 2015.[1]

This is the second UH Parma Medical Center CHNA in response to the federal government regulation.[2] The 2015 UH Parma Medical Center CHNA served as the foundation for developing an implementation strategy to address those needs that (a) the Hospital determines it is able to meet in whole or in part; (b) are otherwise part of its mission; and (c) are not met (or are not adequately met) by other programs and services in the Hospital's service area. This implementation strategy ("Strategy"), also required by Section 501(r), documents the Hospital's efforts to address the community health needs identified in the 2015 CHNA.

The Strategy identifies the means through which the Hospital plans to address a number of the needs that are consistent with the Hospital's charitable mission from 2016 through 2018 as part of its community benefit programs. Beyond these programs, the Hospital is addressing some of these needs simply by providing care to all, regardless of their ability to pay, every day.

The Hospital anticipates the strategies may change and therefore, a flexible approach is best suited for the development of its response to the 2015 CHNA. For example, certain community health needs may become more pronounced and require changes to the initiatives identified by the Hospital in the Strategy.

During 2016 through 2018, other community organizations may address certain needs, indicating that the Hospital's strategies should be refocused on alternative community health needs or assume a different focus on the needs identified in the 2015 CHNA. In addition, changes may be warranted by the publication of final regulations.

OVERVIEW OF THE STRATEGY

The Strategy includes the following information:

1. Hospital Mission Statement
2. Community Served by the Hospital
3. Observations from the 2015 CHNA
4. Priority Health Needs
5. Implementation Strategies: 2016 Through 2018
6. Needs the Hospital Will Not Address
7. Implementation Strategy Development Collaborators

HOSPITAL MISSION STATEMENT

As a wholly owned subsidiary of University Hospitals Health System, Inc. ("University Hospitals" or "UH"), the Hospital is committed to supporting the UH mission, "To Heal. To Teach. To Discover." (the "Mission"), by providing a wide range of community benefits including clinical services, medical education and research. UH is an integrated delivery system and thus can provide benefits by coordinating within and among its various entities ("UH System").

[1] *The Patient Protection and Affordable Care Act (Pub. L. 111-148) added section 501(r) to the Internal Revenue Code, which imposes new requirements on nonprofit hospitals in order to qualify for an exemption under Section 501(c)(3), and adding new reporting requirements for such hospitals under Section 6033(b) of the Internal Revenue Code.*

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COMMUNITY SERVED BY THE HOSPITAL

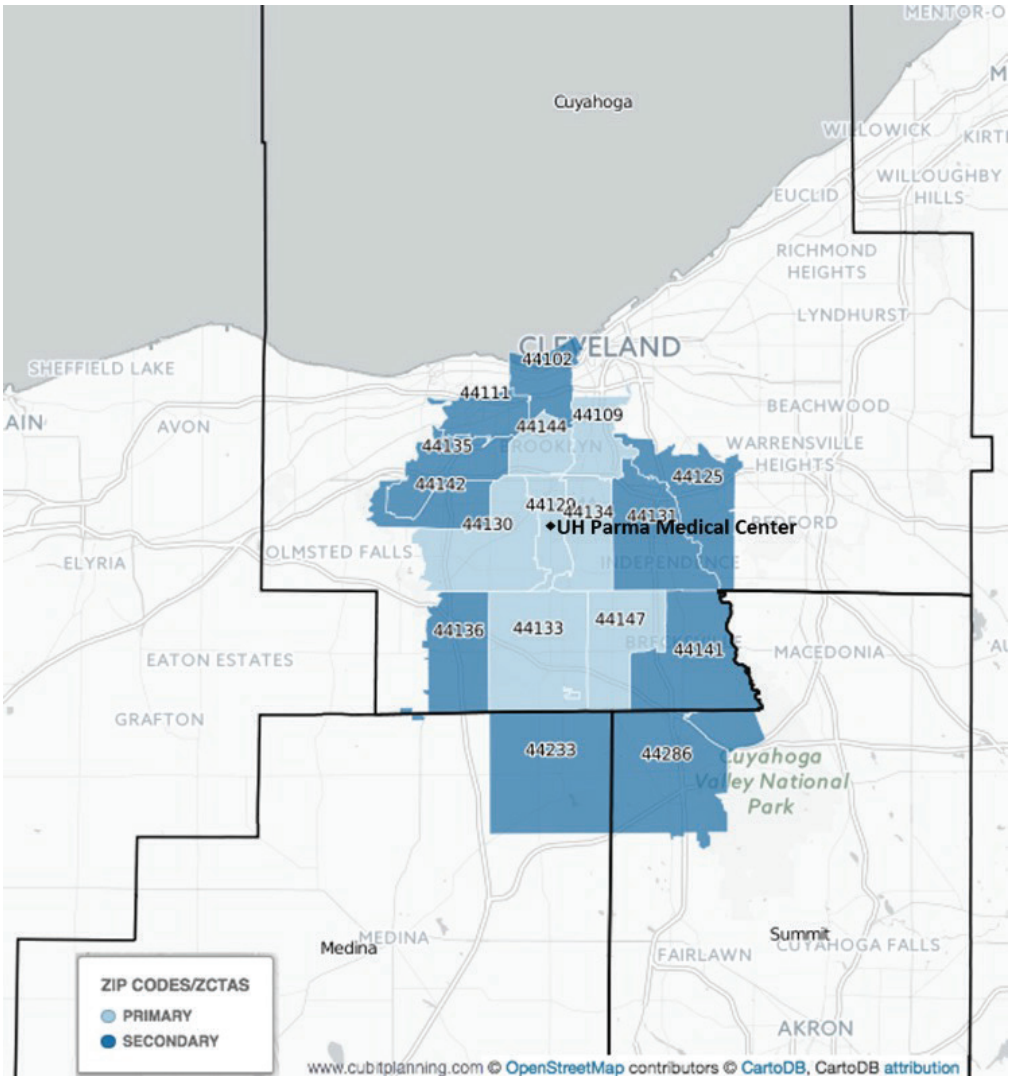
Definition of Market Area (Communities Served by the Hospital)

UH Parma Medical Center is located in Parma, Ohio, Cleveland's most populous suburb. It was founded as Parma Community General Hospital in 1961 by the cities of Parma, Parma Heights, Brooklyn, Brooklyn Heights, Seven Hills and North Royalton. The Hospital became part of the University Hospitals Health System in January 2014. UH Parma Medical Center's market area includes 17 municipalities (seven in its primary market area and 10 in its secondary market area), shown in Figure 1: UH Parma Medical Center Market Areas. All of UH Parma Medical Center's primary market area is contained within Cuyahoga County. A small portion of its secondary market is in Summit and Medina counties.

In 2013, 75.4% of UH Parma Medical Center's discharges were residents of its primary market area; 14.8% were residents of its secondary market area. Of the seven ZIP code areas which comprise UH Parma Medical Center's primary market area, Parma Heights/Middleburg Heights has the largest population (10.9% of the hospital's total market area). However, the ZIP code with the largest number of discharges from UH Parma Medical Center was Parma (2,377 discharges, or 19.5%), which comprises 8.2% of UH Parma Medical Center's market area population.

Figure 1 (below) depicts the Hospital's PSA and SSA.

FIGURE 1: UH PARMA MEDICAL CENTER MARKET AREAS



OBSERVATIONS FROM 2015 CHNA

Poor health status results if a complex interaction of challenging social, economic, environmental and behavioral factors combined with a lack of access to care are present. Addressing these "root" causes is an important way to improve a community's quality of life and to reduce mortality and morbidity. After careful analysis of both qualitative and quantitative data, UH Parma Medical Center identified four categories of health needs that impact the community served by the hospital.

The 2015 UH Parma Medical Center's Community Health Needs Assessment deepened our understanding of the current health needs of our community:

- While the basic demography of the community which UH Parma Medical Center serves has not changed significantly during the past few years, the economic conditions of the community residents, as a whole, have weakened:
  - There were more households receiving cash public assistance income in 2013 compared to 2010 in Cuyahoga County (an increase of 0.6%). The size of cash public assistance decreased by 6.9% in those three years. Likewise, the proportion of households receiving Food Stamp/SNAP benefits increased by 3.8% in Cuyahoga County from 2010 to 2013.
  - The proportion of Cuyahoga County households living below the poverty line increased by 1.3% (from 13.1% to 14.4%) from 2010 to 2013. Almost 1 in 4 Cuyahoga County households with children under age 18 lived below the poverty line in 2013 (23.9%), an increase of 2.7%.
- Examination of UH Parma Medical Center's 2013 inpatient discharges shows that just over 1 in 4 (25.8%) discharged patients were admitted with a primary diagnosis that is considered Ambulatory Care Sensitive ("ACS"). These are cases that are presumed to be avoidable if patients receive high-quality primary care. ACS cases were more common among older adults.
- Also, examination of the secondary diagnoses of inpatients in 2013 highlight the very strong association between lifestyle options and hospitalizations. Diabetes, which is strongly associated with being overweight and obesity, was a secondary diagnosis for 32.3% of adult inpatients (although only present in about 1 in 10 of the adult population). 5% of inpatients had a primary diagnosis of Chronic Obstructive Pulmonary Disease ("COPD"), and almost 20% had a secondary diagnosis of COPD (strongly associated with tobacco use). Almost 1 in 5 (18%) had a secondary diagnosis of esophageal disease (highly associated with obesity and/or tobacco use). Also, 14.5% had a secondary diagnosis of nondependent drug abuse.

Primary care, which focuses on increasing health care access and patient compliance among those with chronic diseases, will decrease the amount of hospitalizations among these patients.

To that end, UH Parma Medical Center is establishing a new Primary Care Institute and a Residency Clinic and as such has framed CHNA priorities around issues related to health care access. Captured within that framework are the recognized health needs listed under:

1. Health Disparities
2. Access to Care
3. Chronic Disease Conditions
4. Lifestyle Factors

These include (not listed in a specific order):

A. Health Disparities

- Aging Population
- High Poverty Rates
- High Rates of Unemployment
- Infant Mortality

B. Chronic Disease Conditions

- Heart Disease
- Cancer
- Alzheimer's (cognitive impairment)
- Diabetes
- Respiratory Diseases
- Mental Illness

C. Lifestyle Barriers

- Obesity
- Tobacco/Drug/Alcohol Abuse
- Chronic Stress

D. Access Barriers

- Lack of Insurance
- Cost of Care
- Transportation Barriers
- Food Deserts
- Access to Primary Care
- Access to Bilingual Providers
- Access to Mental Health Care

Additionally, significant portions of the community served by UH Parma Medical Center are seniors. The health needs associated with an aging population have become increasingly important considerations.

PRIORITY HEALTH NEEDS

Health Disparities	Plan to Address
Aging Population	Yes
High Poverty Rates	No
High Rates of Unemployment	No
Infant Mortality	No

Chronic Disease Conditions	Plan to Address
Heart Disease	Yes
Cancer	Yes
Alzheimer's	Yes
Diabetes	Yes
Respiratory Diseases	Yes
Mental Illness	Yes

Lifestyle Barriers	Plan to Address
Obesity	Yes
Tobacco/Drug/Alcohol Abuse	No
Chronic Stress	No

Access to Care	Plan to Address
Lack of Insurance	Yes
Costs of Care	Yes
Transportation Barriers	Yes
Food Deserts	Yes
Access to Primary Care	Yes
Access to Bilingual Providers	Yes
Access to Mental Health Care	Yes

IMPLEMENTATION STRATEGIES: 2016 THROUGH 2018

The Hospital, through its mission, has a strong tradition of meeting community health needs through its provision of ongoing community benefit programs and services. The hospital will continue this commitment through the strategic initiatives set forth below that focus on significant health needs identified in the 2015 CHNA. The Hospital has provided community benefit programs for many years and will continue to provide such programs. Not all programs provided by the Hospital are discussed in the Strategy. For each significant health need that the hospital plans to address, the Strategy describes:

- Actions the Hospital intends to take, including programs and resources it plans to commit;
- Anticipated impact of these actions and a plan to evaluate such impact; and
- Any planned collaboration between the Hospital and other organizations.

A. Strategic Initiative – Health Disparities

1. **Aging Population:** Within UH Parma Medical Center's primary and secondary markets, the pattern of ACS (ambulatory care sensitive) discharges suggests there may be a lack of primary care that is more severe for Medicare and Medicaid patients. Establishing a new Primary Care Institute and a Residency Clinic will provide access to primary care physicians to meet the needs of the growing aging population in this area.

   Goal: Ensure access to primary care that keeps up with the growing size of the senior population in the Hospital's market areas.

   Objective: Increase the market area's capacity to provide primary care to senior citizens through its new Primary Care Institute and Residency Clinic.

   Evaluation: Number of ACS cases of those aged 65 and older admitted to the Hospital will decrease by 2018.

B. Strategic Initiative – Chronic Disease Conditions

(Heart Disease, Cancer, Alzheimer's disease, Diabetes, Respiratory Diseases, Mental Illness)

1. The Hospital will continue to offer classes at the Health Education Center to community members at low cost. Classes change twice per year and consist of exercise, healthy eating options, and lifestyle programs. Adults and the elderly are target audiences. Health screenings will continue to be offered at the Health Education Center to community members and are free of charge or reduced cost. Blood pressure, bone density, and cholesterol screenings are performed monthly. Residents within the hospital's primary and secondary market receive direct mail twice per year informing them of these programs. Attendance tracking is performed by ZIP code.

2. Partner with the YMCA of Greater Cleveland to offer the YMCA Diabetes Prevention Program that helps adults at high risk of developing type 2 diabetes reduce their risk for developing this disease by taking steps that will improve their overall health and well-being. Classes will be offered at the UH Parma Medical Center Health Education Center. The YMCA's Diabetes Prevention Program uses a Centers for Disease Control-approved curriculum and is part of the Centers for Disease Control led National Diabetes Prevention Program. The YMCA's Diabetes Prevention Program is available to ALL individuals who qualify, regardless of their insurance status. Education to primary care physicians and case managers of this program will be held to target those individuals at risk for diabetes. Patients will be measured throughout the program with BMI and glucose screenings.

   Goal: Reduced chronic disease incidences in the Hospital's market area population.

   Objective: Increased awareness of chronic disease causes and implications and improved health literacy among current chronic disease patients to improve patient disease self-management.

   Evaluation: Reduced chronic disease incidence levels in market area population; reduced hospital readmission rates among chronic disease patients.

C. Strategic Initiative – Lifestyle Factors

1. **Obesity**

   a. Continue the free Healthy Kids program in partnership with UH Rainbow Babies & Children's Hospital to address diet- and exercise-related health conditions.

   b. Partner with the North Royalton YMCA to offer members of the community an obesity weight loss program targeting individuals with high obesity markers. Patients will be monitored throughout the program with BMI, blood pressure and glucose screenings.

   Goal: Reduced obesity incidences in the Hospital's market area population.

   Objective: Increased awareness of chronic disease causes and implications and improved health literacy among current chronic disease patients to improve patient disease self-management.

   Evaluation: Reduced chronic disease incidence levels (especially diabetes) in market areas population; reduced hospital admission rates of diabetic patients.

D. Strategic Initiative – Access to Care

1. **Improve Access to Primary Care:** Provide access to affordable health care through the UH Parma Medical Center Residency Clinic, open 5 days per week offering both Family Medicine and Internal Medicine resident care along with their respective preceptors. The clinic has 12 residents. Anticipated 2,400 patient visits under the care of Family Medicine residents and 2,000 patient visits under the care of Internal Medicine residents in one year. The residency clinic will have a part-time behavioral specialist on staff to assist with the management of mental and behavioral health services. This need addresses those whose only source of care is through free clinics.

2. **Lack of Insurance:** Provide access to health care services through the UH Hospital Financial Assistance Program.

3. **Transportation Barriers:** Reduce transportation barriers through the use of Hospital van that transports patients from their homes to the Hospital for treatment services. The van operates five days a week and serves residents in Broadview Heights, Brooklyn, Brooklyn Heights, Brook Park, Independence, Middleburg Heights, Parma, Parma Heights, Seven Hills and parts of Cleveland. This service is for patients who cannot drive and/or do not have transportation available and is free of charge. This service is used by elderly residents and chronically ill residents. Van usage will be tracked by number of residents utilizing the van by ZIP code.

4. **Cost of Care:** Continue providing in-kind services including space and medical services to the Parma Health Ministry, a free clinic that delivers health services to residents of Parma, Parma Heights, North Royalton, Brooklyn, Brooklyn Heights and Seven Hills. Health care services are provided at no cost for the uninsured or those who are below the federal poverty level.

Goal: Reduce lack of access to primary care.

Objective: Remove barriers to primary care (financial, transportation).

Evaluation: Reduced number of ACS cases admitted to UH Parma Medical Center by 2018.

5. **Food Deserts:** The Hospital hosts a farmers' market from July through September of each year. The market consists of local farmers selling fresh fruit and vegetables and is open to the public. Coordinating with local senior centers, vans bring the seniors to the market. Participation is tracked by ZIP code from the senior centers.

6. **Access to Bilingual Providers:** The Hospital plans to upgrade video interpreting services by providing hospital iPads for all of the units, which will allow immediate access to an interpreter. Usage of this service will be tracked.

7. **Access to Mental Health Care:** The Hospital will continue its Behavioral Center for Older Adults, an inpatient program that delivers comprehensive mental health assessments, individual and group therapy, medication management, and patient and family education to people 55 years of age and older who are experiencing serious emotional and/or mental health difficulties. In 2015, there were 370 admissions to the Behavioral Center. Patients are referred through the emergency department, medical floors, primary care physicians, and nursing homes in the area. It is anticipated that these numbers will continue to increase in 2016 – 2018.

Overall Anticipated Impact and Plan to Evaluate

The Hospital anticipates that the above program initiatives will contribute to improved access to preventive, primary and hospital care, especially for low-income and at-risk populations. The Hospital will monitor progress and program performance annually, including the numbers of people reached, served by, or participating in programs, and select satisfaction indicators where available. The UH Parma Medical Center Community Implementation Planning Committee will meet periodically to review progress and any changes in the strategies. When the Hospital conducts its next CHNA, it plans to seek community input and to review updated data and literature regarding the impacts associated with the specified activities.

OTHER NEEDS NOT ADDRESSED BY THE HOSPITAL

No hospital facility can address all of the health needs present in its community to the fullest. The Hospital is committed to adhering to its Mission and remaining financially healthy so that it can continue to enhance its clinical, teaching and research activities and to provide a wide range of community benefits. The Strategy does not address the following community health needs identified in the 2015 CHNA:

HIGH POVERTY RATES AND HIGH RATES OF UNEMPLOYMENT, INFANT MORTALITY, CHRONIC STRESS, TOBACCO/DRUG AND SUBSTANCE ABUSE

These community priorities are important and are being addressed by other organizations in the community. The Hospital continues to be one of the largest employers in its community. This strategy utilizes community resources to meet several community health needs addressed. It is with collaboration that needs can be met. The Hospital will continue to provide many free health fairs in the community, in addition to hosting free seminars and presentations for all to attend. The Hospital will partner with the City of Parma in its highly attended Family Health and Safety Day, which gathers local resource facilities in one location to provide assistance, guidance and answers to questions on a variety of topics, including county resources, diet and exercise, and resources for seniors. Due to limited resources and the need to allocate significant resources to the items outlined in the Implementation Strategy, the hospital will not address the stated needs directly.

Identified Needs	Reason Issue Not Directly Addressed in Current Plan
High Poverty Rates High Rates of Unemployment	Economic conditions within the market areas of the Hospital are outside its locus of control. However, as aforementioned, the Hospital does address the cost of care as a barrier to access of care and addresses it through several programs (e.g., the Parma Health Ministry, Section D.4, above).
Infant Mortality	This community health issue is being addressed by First Year Cleveland, a public-private initiative among local governments and hospitals, including University Hospital Systems. This comprehensive multi-year initiative, beginning in 2016, will harness the needed resources to reduce the higher-than-average infant mortality rates in Cuyahoga County.
Tobacco/Drug/Alcohol Abuse	While the Hospital has not adopted this community health need as a priority in its 2016 – 2018 Plan, it does provide treatment services to the community. The UH Connor Integrative Health Network offers classes to the public at the Health Education Center at UH Parma Medical Center. For these programs there is an aggressive outreach (semi-annual direct mailing of class schedules) to all households in the market area. In addition, primary care physicians are also kept updated on the class schedule and routinely refer patients to classes.
Chronic Stress	This condition is also addressed through community-based classes at the Health Education Center, described above. Classes include stress management, mindfulness, yoga as well as acupuncture sessions.

PLANNED COLLABORATIONS WITH OTHER ORGANIZATIONS

The Hospital plans to collaborate with the following organizations. This is only a partial list of all current and potential collaborators:

- Parma Health Ministry
- Cities and agencies where health screenings are conducted
- Parma City School District
- North Royalton City School District
- Brecksville-Broadview Heights School District
- Parma Area Family Collaborative
- North Royalton YMCA
- Partnership for a Healthy North Royalton
- Independence Schools Advisory Council
- Senior Centers within PSA and SSA
- CBS Connects (through Parma City School District)
- Alzheimer's Association
- The Arthritis Foundation
- The Carolyn F. Farrell Foundation
- UH Rainbow Babies & Children's Hospital
- YMCA of Greater Cleveland

Adoption of University Hospitals Parma Medical Center 2016 – 2018 Implementation Strategy

The University Hospitals Health System Board adopted the Community Health Needs Implementation Strategy on March 15, 2016.

UH Parma Medical Center is a successful, not-for-profit, community hospital in Cuyahoga County. Founded in 1961, the Hospital now has 332 beds with a medical staff of over 500 physicians in more than 30 specialties and a comprehensive campus of services. It became part of the University Hospitals health system in January 2014.

2016 IMPLEMENTATION PLAN




This Implementation Plan was approved by the University Hospitals Board of Directors on March 15, 2016

University Hospitals
Richmond Medical Center
A Campus of UH Regional Hospitals

INTRODUCTION

UH Richmond Medical Center offers myriad programs and activities to address the surrounding community health needs. These range from health education and health screenings to EMS training programs and a senior emergency department. UH Richmond Medical Center continually strives to meet the health needs of its community.

In 2015, University Hospitals Richmond Medical Center (the "Hospital") conducted a community health needs assessment (a "CHNA") that was adopted by the UH Board of Directors on September 24, 2015.[1] CHNAs seek to identify priority health states and access issues for particular areas and populations.

This is the second UH Richmond Medical Center CHNA in response to federal government regulation. The 2015 UH Richmond Medical Center CHNA served as the foundation for developing an implementation strategy to address those needs that (a) the Hospital determines it is able to meet in whole or in part; (b) are otherwise part of its mission; and (c) are not met (or are not adequately met) by other programs and services in the Hospital's service area.

This implementation strategy ("Strategy"), also required by Section 501(r), documents the Hospital's efforts to address the community health needs identified in the 2015 CHNA and is consistent with the Hospital's charitable mission for the 2016 through 2018 time frame as part of its community benefit programs. Beyond these programs, the Hospital is addressing some of these needs simply by providing care to all, regardless of their ability to pay, every day.

The Hospital anticipates the strategies may change and therefore, a flexible approach is best suited for the development of its response to the 2015 CHNA. For example, certain community health needs may become more pronounced and require changes to the initiatives identified by the Hospital in the Strategy. During 2016 through 2018, other community organizations may address certain needs, indicating that the Hospital's strategies should be refocused on alternative community health needs or assume a different focus on the needs identified in the 2015 CHNA.

In order to devote significant resources to improving identified health needs, UH Richmond Medical Center will focus on expanding services related to chronic conditions including 1) heart disease, 2) respiratory disease and 3) diabetes. These three health needs, combined with an aging population, were chosen due to their higher-than-average prevalence in our patient population. Also, the diagnoses often overlap with one being primary and the other secondary. Obesity, substance abuse (smoking in particular) and advancing age are often coincident with these diseases and therefore will be addressed in parallel in the Strategy. We believe that expanded education, screenings and awareness of these three disease states will have the largest impact on the communities we serve at this time.

OVERVIEW OF THE STRATEGY

The Strategy includes the following information:

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3. Observations from the CHNA
4. Priority Community Health Needs
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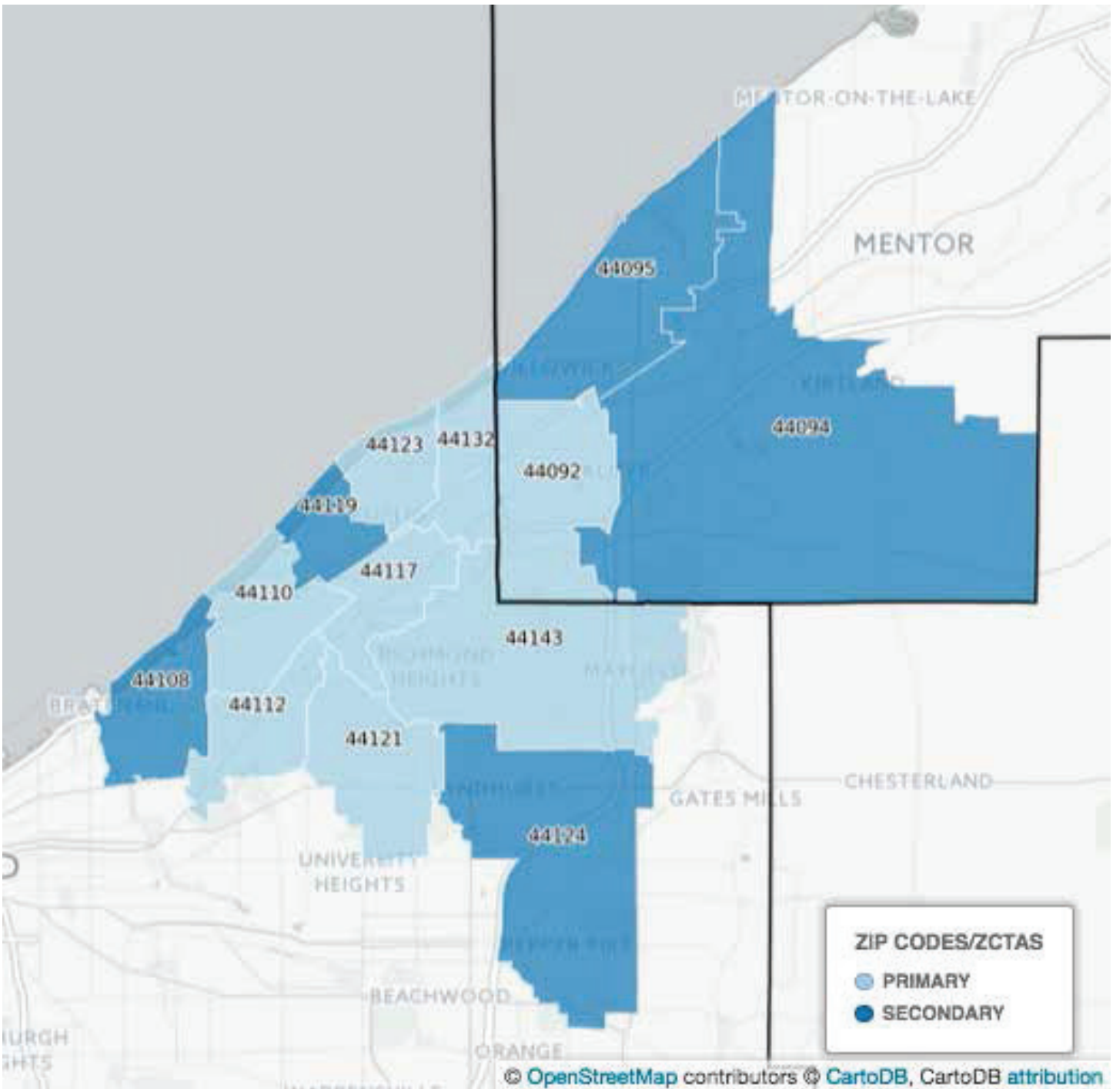
COMMUNITY SERVED BY THE HOSPITAL

The communities served by the Hospital are defined based on the geographic origins of the Hospital's inpatients. The Primary Service Area (PSA) is the geographic area from which the majority of the Hospital 's patients originate . The Secondary Service Area (SSA) is where an additional population of the Hospital's inpatients reside. The PSA is comprised of eight ZIP codes in Cuyahoga and Lake counties in Ohio. The SSA is comprised of five ZIP codes, also in Cuyahoga and Lake counties. In 2013, the PSA and SSA were home to approximately 304,409 persons. In 2013, more than 81% of the Hospital's inpatients lived in the specified ZIP codes.

FIGURE 1 DEPICTS THE HOSPITAL'S PSA AND SSA.



OBSERVATIONS FROM 2015 CHNA (2010 – 2013 DATA)

Key points from CHNA	Relate to the Implementation Strategy
19.1% of adult patients discharged in 2013 had a primary diagnosis of coronary heart disease. More than half (54%) had a secondary diagnosis of coronary heart disease. Cuyahoga County had a higher-than-average death rate for coronary heart disease compared to peer counties nationally.	Heart Health Day, Health Matters presentations, free screenings, healthy cooking demonstrations, Age Well Be Well activities, screenings and health fairs
15.5% of adult patients discharged in 2013 had a secondary diagnosis of lung disease which is often tied to smoking and lifestyle choices.	Health Matters presentations, Age Well Be Well activities, screenings and health fairs
2.2% of discharged patients had a primary diagnosis of diabetes and 14.7% had a secondary diagnosis of diabetes.	One-on-one nutrition counseling and diabetes education classes, annual Diabetes Health Fair to include A1C screening
20% of those hospitalized at UH Richmond Medical Center in 2013 were obese or morbidly obese, which is often a component of chronic disease.	Often linked to diabetes, heart disease and respiratory disease, obesity will be addressed through the strategies listed above
26.5% of discharged patients had a primary or secondary diagnosis of hypertension.	Heart Disease strategies to address this health condition
79.5% of adults in UH Richmond Medical Center's market area reported having a primary care provider. However, 27.6% reported that their financial situation could prevent them from seeking care due to cost of co-pays and high deductibles.	Increased awareness of financial counseling services available, free screenings and education to increase awareness and teach lifestyle modifications to help manage disease, opportunities to meet one-on-one with local physician specialists

Additional observations from the 2015 CHNA:

- 27.7% of discharges were Ambulatory Care Sensitive with two primary diagnoses: congestive heart failure (6.3%) and COPD (6.3%). Secondary diagnoses for ACS cases were also congestive heart failure (18.9%) and COPD (7.9%).
- Cuyahoga and Lake counties, like their neighboring counties, are growing older, on average. In 2013, the proportion of senior citizens increased by 0.4 percentage points in Cuyahoga County and 1.2 percentage points in Lake County. Given that the use of health care increases substantially with age, especially after age 65, the aging of the population will have significant impact on the demand for health care in regions where the proportion of older citizens is increasing.
- Cuyahoga County is majority White, but the percentage of the population that is White decreased by 1% from 2010 to 2013. Black is the dominant minority race in Cuyahoga County (29.7% of the total population). Lake County is also majority White, but saw an increase (+0.6%) in Black or African-American residents from 2010 to 2013.
- The average (median) income decreased by 4.6% in Cuyahoga County and 5.3% in Lake County from 2010 to 2013.
- Of all UH Richmond Medical Center's discharges in 2013, 67.3% were Medicare patients and 12.2% were Medicaid patients.

PRIORITY HEALTH NEEDS

Poor health status can result if a complex interaction of challenging social, economic, environmental and behavioral factors, combined with a lack of access to care, is present. Addressing the more common "root" causes of poor community health can serve to improve a community's quality of life and to reduce mortality and morbidity. The table below lists the community health needs identified through the 2015 UH Richmond Medical Center's CHNA as priorities. Those needs that the Hospital plans to help address during 2016 through 2018 are noted.

Priority Community Health Issues Identified in 2015 CHNA	Plan to Address in 2016 – 2018 Implementation Plan
Health Disparities	
Poverty	No
Unemployment	No
Aging Population	No
Infant Mortality	No
Chronic Disease Conditions	
Heart Disease	Yes
Alzheimer's	No
Respiratory Diseases	Yes
Cancer	No
Diabetes	Yes
Mental Illness	No
Lifestyle Barriers	
Substance Abuse (Tobacco/Drug/Alcohol)	No
Obesity	No
Access Barriers	
Cost of Care	No
Lack of Primary Care Providers	No
Transportation	No

IMPLEMENTATION STRATEGIES TO ADDRESS HEART DISEASE, RESPIRATORY DISEASE AND DIABETES

Objectives of All Programs:

All parts of the Strategy have the overarching objective of improving outreach and care to an aging population – a group that is susceptible to chronic disease due to lack of education, lack of access and financial considerations. The Strategy is also intended to:

- Encourage compliance by making expert care available close to home.
- Encourage compliance by increasing awareness of financial counseling services to make care affordable for those with financial limitations.
- Establish tracking mechanisms and metric goals for those individuals in the community who participate in our various programs.
- Monitor ongoing progress of programming and implementation strategy.

Anticipated Impact:

- Community members will gain knowledge and a better understanding of the chronic condition.
- Individuals will be educated on local services.
- Education regarding lifestyle modifications may prevent or reduce the incidence of these diseases.
- Detection of disease in participants that may not have been identified without the screening programs.
- Hospitalization and re-admission rates will decrease because of better chronic disease outpatient and self-management.

Heart Disease

Congestive heart failure is known to be a frequent cause of hospitalizations with hypertension, obesity and smoking as risk factors; therefore, preventing cardiovascular disease by improving cardiovascular disease self-management among patients in the market area is our goal. We will identify best-in-class patient communication programs and ensure implementation of them in all primary care and cardiovascular UH-affiliated physician practices within the Hospital's primary market area. Through our hospital inpatient records we will track hospitalization rates (and other key measures, like length of stay and readmission rates) of patients with a primary diagnosis of heart disease.

Board-certified cardiologists will provide oversight and analysis of diagnostic non-invasive and invasive testing.

Goal: Reduce hospitalization rates of adults with heart disease by 20% by 2018 utilizing local expertise to provide comprehensive cardiac care including the diagnosis and treatment of hypertension, coronary artery disease, arrhythmias and heart failure.

Actions:

- Education through monthly educational seminars (Health Matters).
- Host and/or participate in regular health fairs with a focus on heart health.
- Expand screening programs including coronary artery disease risk assessments.
- Increase community awareness of services available and local physician specialists.
- Aggressive recruitment of Age Well Be Well members to provide increased access to education, community resources and peer support.
- Increase education on 2-1-1 and its services.
- Annual Family Health and Safety Day to offer comprehensive screenings related to heart health.
- Participation in system Heart Day events and screenings.

Respiratory Diseases

Pneumonia and COPD are known to be frequent causes of hospitalizations; therefore improving respiratory disease self-management among patients in the market area is our goal. We will identify best-in-class patient communication programs and ensure implementation of them in all primary care and pulmonology UH-affiliated physician practices within the Hospital's primary market area. Through our hospital inpatient records we will track hospitalization rates (and other key measures, like length of stay and readmission rates) of patients with a primary diagnosis of respiratory disease.

Goal: Reduce hospitalization rates of adults with respiratory diseases by 20% by 2018.

Actions:

- Education through monthly educational seminars (Health Matters).
- Host annual respiratory wellness event in November (National COPD Month) with spirometry screenings and physician specialist presentations.
- Increase community awareness of services available and local physician specialists.
- Aggressive recruitment of Age Well Be Well members to provide increased access to education, community resources and peer support.
- Increase education on 2-1-1 and its services.
- Annual Family Health and Safety Day to offer comprehensive screenings related to respiratory health.

Diabetes

Uncontrolled diabetes is known to be a frequent cause of hospitalizations; therefore improving diabetes self-management among the large population of diabetics in the market area is our goal. We will identify best-in-class patient communication programs and ensure implementation of them in all primary care and endocrinology UH-affiliated physician practices within the Hospital's primary market area. In August 2016, we will launch a hospital outpatient diabetes program, through which we will track behavioral and metabolic outcomes including Ha1c results, fasting glucose results and pre- and post-test scores on diabetic education measurement tools.

Goal: Reduce Ha1C scores among program participants by 1 to 3% and fasting glucose by an average of 25 points. Patients will also set personal goals and self-report on their progress. For those who choose physical activity as a goal, our expectation will be that they meet that goal 75% of the time.

Actions:

- Education through monthly educational seminars (Health Matters).
- Access to education classes specific to diabetes; one-on-one support and counseling; and access to dietitians, pharmacists and physician specialists.
- Host an annual diabetes health fair with A1C glucose testing.
- Engage endocrinologist Stephen Burgun, MD, to support our efforts with educational presentations and health fair participation.
- Outpatient nutrition counseling (beginning March 2016) and healthy cooking demonstrations will be offered to control glucose and combat obesity, which is a major contributing factor to diabetes.
- Annual Family Health and Safety Day to offer comprehensive screenings related to diabetes.
- Monthly Diabetes Support Groups offered by Age Well Be Well Club will continue and efforts will be made to grow participation.

Commitment of programs and resources:

- UH Richmond Medical Center is committed to provide the financial support needed to recruit, hire and retain physician specialists in these fields
- UH Richmond Medical Center will continue to collaborate with Euclid, Brush and Richmond Heights schools to promote safety, drug and alcohol awareness and obesity prevention in school-age children

WHY HOSPITAL IS NOT ADDRESSING A SIGNIFICANT HEALTH NEED

No hospital facility can address all of the health needs present in its community to the fullest. The Hospital is committed to adhering to its Mission and remaining financially healthy so that it can continue to enhance its clinical, teaching and research activities and to provide a wide range of community benefits. The Strategy utilizes community resources to meet several community health needs.

Below we outline those priority community health issues identified in the 2015 UH Richmond Medical Center CHNA that this Strategy will not address specifically in 2016 – 2018 along with the reasons for not doing so.

Priority Community Health Issues Identified in 2015 CHNA	Reason Health Issue Is Not Being Addressed in Plan
Health Disparities	
Poverty	The Hospital is very cognizant of the relationship between economic status and poor health. It is not in a position, however, to directly impact the long-term economic status of the residents of its market area.
Unemployment	
Aging Population	A focus on older residents within the Hospital's market area is inherent in this plan.
Infant Mortality	This issue is being addressed through a collaborate effort among the City of Cleveland, Cuyahoga County and area hospitals, including the University Hospitals system as of January, 2016.
Chronic Disease Conditions	
Alzheimer's	These issues are being left to institutions with a larger focus on those health issues.
Cancer	
Mental Illness	
Lifestyle Barriers	
Substance Abuse (Tobacco/Drug/Alcohol)	This issue is being left to institutions with a larger focus on those health issues.
Obesity	The Hospital is cognizant of obesity being coincident with chronic disease, especially diabetes. Weight management will be part of the Strategies used to combat diabetes.
Access Barriers	
Cost of Care	While decreasing the cost of care is not being addressed in this plan, the Hospital has numerous ongoing programs to provide financial assistance to patients with a financial need.
Lack of Primary Care Providers	The lack of primary care providers is a statewide problem currently being addressed at the state level.
Transportation	This issue is not within the Hospital's locus of control.

IMPLEMENTATION STRATEGY COLLABORATORS

- UH Case Medical Center
- UH Ahuja Medical Center
- UH Avon Rehabilitation Hospital
- UH Bedford Medical Center, a campus of UH Regional Hospitals
- UH Conneaut Medical Center
- UH Elyria Medical Center
- UH Geauga Medical Center
- UH Geneva Medical Center
- UH Parma Medical Center
- UH Portage Medical Center
- UH Rainbow Babies & Children's Hospital
- UH Rehabilitation Hospital (Beachwood)
- UH St. John Medical Center
- UH Samaritan Medical Center
- Southwest General Health Center, a joint-venture of University Hospital
- Center for Lifelong Health and UH Institutes (UH Harrington Heart & Vascular Institute, UH Primary Care Institute, UH Digestive Health Institute, UH Neurological Institute)
- UH Bedford Medical Center Senior Network members (an independent network of facilities that support seniors in Cuyahoga and Lake counties)
- Local and civic leaders in the community (for example, collaboration with EMS to provide improved Emergency Response services to seniors in the community)
- Cuyahoga County Board of Health
- Lake County Council on Aging
- City of Euclid, Euclid City Schools and Euclid Recreation Center

Among the nation's leading academic medical centers, University Hospitals Case Medical Center is the primary affiliate of Case Western Reserve University School of Medicine, a nationally recognized leader in medical research and education.

2016 IMPLEMENTATION PLAN




This Implementation Plan was approved by the University Hospitals Board of Directors on March 15, 2016

University Hospitals
Bedford Medical Center
A Campus of UH Regional Hospitals

INTRODUCTION

UH Bedford Medical Center offers myriad programs and activities to address the surrounding community health needs. These range from health education and health screenings to EMS training programs and a senior emergency department. UH Bedford Medical Center continually strives to meet the health needs of its community.

In 2015, University Hospitals Bedford Medical Center (the "Hospital") conducted a community health needs assessment (a "CHNA") that was adopted by the UH Board of Directors on September 24, 2015.[1] CHNAs seek to identify priority health states and access issues for particular areas and populations.

This is the second UH Bedford Medical Center CHNA in response to the federal government regulation. The 2015 UH Bedford Medical Center CHNA served as the foundation for developing an implementation strategy to address those needs that (a) the Hospital determines it is able to meet in whole or in part; (b) are otherwise part of its mission; and (c) are not met (or are not adequately met) by other programs and services in the Hospital's service area.

This implementation strategy ("Strategy"), also required by Section 501(r), documents the Hospital's efforts to address the community health needs identified in the 2015 CHNA and is consistent with the Hospital's charitable mission for the 2016 through 2018 timeframe as part of its community benefit programs. Beyond these programs, the Hospital is addressing some of these needs simply by providing care to all, regardless of their ability to pay, every day.

The Hospital anticipates the strategies may change and therefore, a flexible approach is best suited for the development of its response to the 2015 CHNA. For example, certain community health needs may become more pronounced and require changes to the initiatives identified by the Hospital in the Strategy. During 2016 through 2018, other community organizations may address certain needs, indicating that the Hospital's strategies should be refocused on alternative community health needs or assume a different focus on the needs identified in the 2015 CHNA.

In order to devote significant resources to improving identified health needs, UH Bedford Medical Center will focus on expanding services related to chronic conditions including 1) heart disease, 2) respiratory disease, and 3) diabetes. These three health needs, combined with an aging population, were chosen due to their higher-than-average prevalence in our patient population. Also, the diagnoses often overlap with one being primary and the other secondary. Obesity, substance abuse (smoking in particular) and advancing age are often coincident with these diseases and therefore will be addressed in parallel in the Strategy. We believe that expanded education, screenings and awareness of these three disease states will have the largest impact on the communities we serve at this time.

OVERVIEW OF THE STRATEGY

The Strategy includes the following information:

1. Hospital Mission Statement
2. Community Served by the Hospital
3. Observations from the CHNA
4. Priority Community Health Needs
5. Implementation Strategies: 2016 through 2018
6. Needs the Hospital Will Not Addresss
7. Implementation Strategy Development Collaborators

HOSPITAL MISSION STATEMENT

As a wholly owned subsidiary of University Hospitals Health System, Inc. (University Hospitals or UH), the Hospital is committed to supporting the UH mission, "To Heal. To Teach. To Discover." (the "Mission"), by providing a wide range of community benefits including clinical services, medical education and research. UH is an integrated delivery system and thus can provide benefits by coordinating within and among its various entities.

COMMUNITIES SERVED BY THE HOSPITAL

The communities served by the Hospital are defined based on the geographic origins of the Hospital's inpatients. The Primary Service Area (PSA) is the geographic area from which the majority of the Hospital's patients originate . The Secondary Service Area (SSA) is where an additional population of the Hospital's inpatients reside. The PSA is comprised of three ZIP codes in Cuyahoga and Summit counties in Ohio. The SSA is comprised of five ZIP codes, also in Cuyahoga and Summit counties. In 2013, the PSA and SSA were home to approximately 187,023 persons. In 2013, more than 82% of the Hospital's inpatients lived in the specified ZIP codes.

[1] *The Patient Protection and Affordable Care Act (Pub. L. 111-148) added section 501(r) to the Internal Revenue Code, which imposes new requirements on nonprofit hospitals in order to qualify for an exemption under Section 501(c)(3), and adding new reporting requirements for such hospitals under Section 6033(b) of the Internal Revenue Code.*

UH Bedford Medical Center followed the 2013 Proposed Regulations, published by the Treasury Department and RIS on April 5, 2013, in the Federal Register (REG-106499-12, 2013-21 I.R.B. 1111, [78 FR 20523]), in accordance with Notice 2014-2 that confirms that hospital organizations can rely on proposed regulations under section 501(r) of the Internal Revenue Code issued on June 26, 2012, and April 5, 2013, pending the publication of final regulations or other applicable guidance. The final rule entitled "Additional Requirements for Charitable Hospitals; Community Health Needs Assessments for Charitable Hospitals"; Requirement of a Section 4959 Excise Tax Return and Time for Filing the Return, was published by the IRS on December 31, 2014, and requires compliance after December 29, 2015.

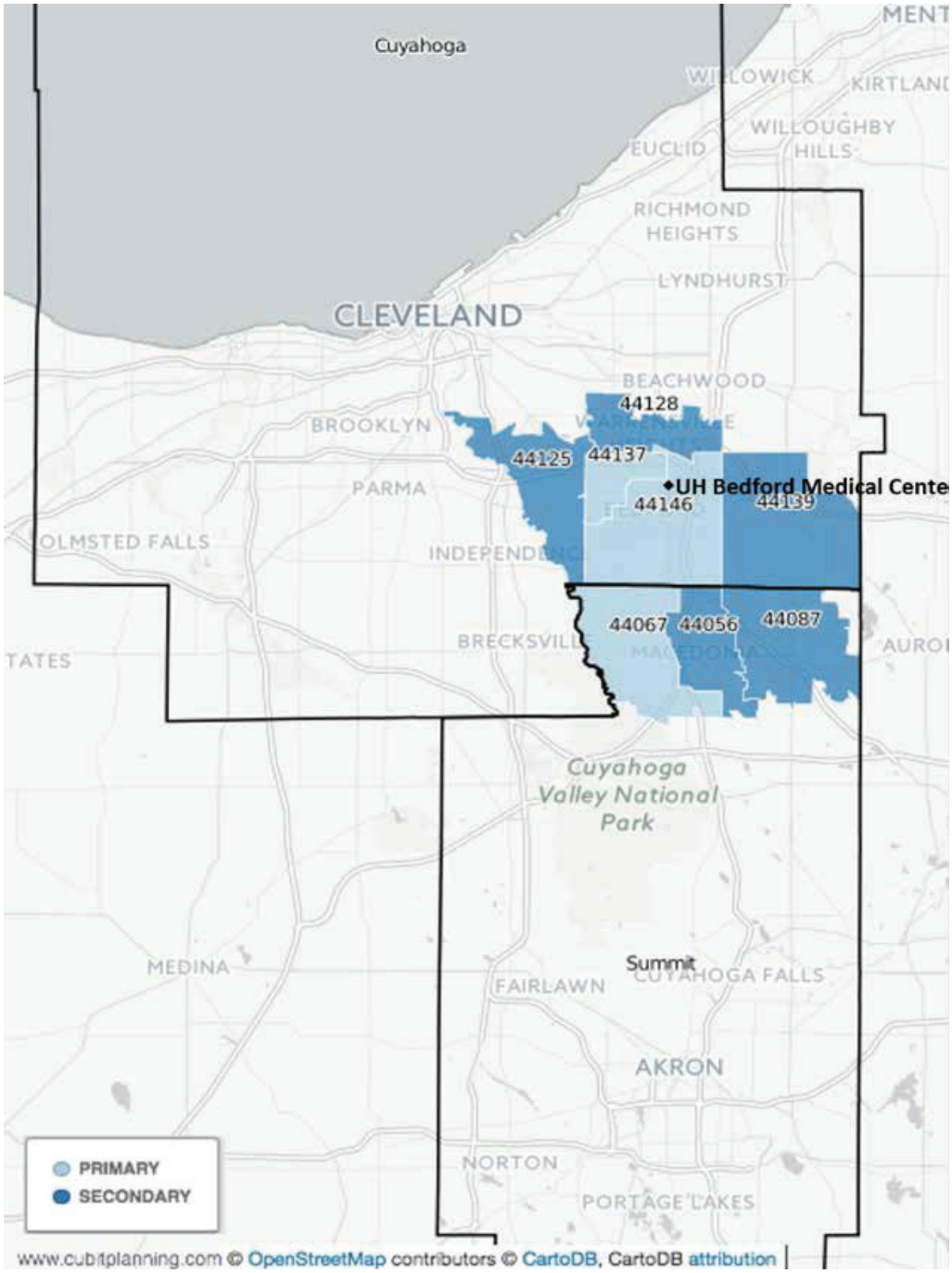


FIGURE 1 (ABOVE) DEPICTS THE HOSPITAL'S PSA AND SSA.

OBSERVATIONS FROM 2015 CHNA (2010 – 2013 DATA)

Key points from CHNA	Relate to the Implementation Strategy
20% of adult patients discharged in 2013 had a primary diagnosis of coronary heart disease.	Heart Health Day, Health Matters presentations, free screenings, healthy cooking demonstrations, Age Well Be Well activities, screenings and health fairs.
18% of adult patients discharged in 2013 had a secondary diagnosis of lung disease, which is often tied to smoking and lifestyle choices.	Health Matters presentations, free screenings including spirometry, annual Respiratory Wellness event, Age Well Be Well activities, screenings and health fairs.
The diabetes mortality rate in Cuyahoga County is higher than average when compared to peer counties. We can estimate that approximately 9% of the general adult population within the market is diabetic; one-third (34%) of adult inpatients in 2013 were diabetic (which is closely associated with being overweight and obesity).	Expansion of accredited Diabetes Center, one-on-one nutrition counseling and diabetes education classes, annual Diabetes Health Fair to include A1C screening.
20% of those hospitalized at UH Bedford Medical Center in 2013 were obese or morbidly obese, which is often a component of chronic disease.	Often linked to diabetes, heart disease and respiratory disease, obesity will be addressed through the strategies listed above.
48.4% of discharged patients had a primary or secondary diagnosis of hypertension.	Heart Disease strategies to address this health condition.
87.7% of adults in UH Bedford Medical Center's market area reported having a primary care provider. However, 39.4% reported that their financial situation could prevent them from seeking care due to cost of copays and high deductibles.	Increased awareness of financial counseling services available, free screenings and education to increase awareness and teach lifestyle modifications to help manage disease, opportunities to meet one-on-one with local physician specialists.

Additional observations from the 2015 CHNA:

- 33.9% of discharges were Ambulatory Care Sensitive with three primary diagnoses: congestive heart failure (6.9%), bacterial pneumonia (6.5%) and COPD (5.7%).
- Cuyahoga and Summit counties, like their neighboring counties, are growing older, on average. In 2013, the proportion of senior citizens increased by 0.4 percentage points in Cuyahoga County and 0.9 percentage points in Summit County. Given that the use of health care increases substantially with age, especially after age 65, the aging of the population will have significant impact on the demand for health care in regions where the proportion of older citizens is increasing.
- Cuyahoga County is majority White, but the percentage of the population that is White decreased by 1% from 2010 to 2013. Black is the dominant minority race in Cuyahoga County (29.7% of the total population). Summit County is also majority White, but that majority percentage decreased by 0.8% from 2010 to 2013.
- The average (median) income decreased by 4.6% in Cuyahoga County and 2% in Summit County from 2010 to 2013.
- Of all UH Bedford Medical Center's discharges in 2013, 73% were Medicare patients and 9% were Medicaid patients.

PRIORITY HEALTH NEEDS

Poor health status can result if a complex interaction of challenging social, economic, environmental and behavioral factors, combined with a lack of access to care, is present. Addressing the more common "root" causes of poor community health can serve to improve a community's quality of life and to reduce mortality and morbidity. The table below lists the community health needs identified through the 2015 UH Bedford Medical Center's CHNA as priorities. Those needs that the Hospital plans to help address during 2016 through 2018 are noted.

PRIORITY COMMUNITY HEALTH ISSUES IDENTIFIED IN 2015 CHNA	PLAN TO ADDRESS IN 2016 – 2018 IMPLEMENTATION PLAN
Health Disparities	
Poverty	No
Unemployment	No
Aging Population	No
Infant Mortality	No
Chronic Disease Conditions	
Heart Disease	Yes
Alzheimer's	No
Respiratory Diseases	Yes
Cancer	No
Diabetes	Yes
Mental Illness	No
Lifestyle Barriers	
Substance Abuse (Tobacco/Drug/Alcohol)	No
Obesity	No
Access Barriers	
Cost of Care	No
Lack of Primary Care Providers	No
Transportation	No

IMPLEMENTATION STRATEGIES TO ADDRESS HEART DISEASE, RESPIRATORY DISEASE AND DIABETES

Objectives of All Programs:

All parts of the Strategy have the overarching objective of improving outreach and care to an aging population – a group that is susceptible to chronic disease due to lack of education, lack of access and financial considerations. The Strategy is also intended to:

- Encourage compliance by making expert care available close to home.
- Encourage compliance by increasing awareness of financial counseling services to make care affordable for those with financial limitations.
- Establish tracking mechanisms and metric goals for those individuals in the community who participate in our various programs.
- Monitor ongoing progress of programming and implementation strategy.

Anticipated Impact:

- Community members will gain knowledge and a better understanding of the chronic condition.
- Individuals will be educated on local services.
- Education regarding lifestyle modifications may prevent or reduce the incidence of these diseases.
- Detection of disease in participants that may not have been identified without the screening programs.
- Hospitalization and re-admission rates will decrease because of better chronic disease outpatient and self-management.

Heart Disease

Congestive heart failure is known to be a frequent cause of hospitalizations with hypertension, obesity and smoking as risk factors; therefore, preventing cardiovascular disease by improving cardiovascular disease self-management among patients in the market area is our goal. We will identify best-in-class patient communication programs and ensure implementation of them in all primary care and cardiovascular UH-affiliated physician practices within the Hospital's primary market area. Through our hospital inpatient records we will track hospitalization rates (and other key measures, like length of stay and readmission rates) of patients with a primary diagnosis of heart disease.

Board-certified cardiologists will provide oversight and analysis of diagnostic non-invasive and invasive testing.

Goal: Reduce hospitalization rates of adults with heart disease by 20% by 2018 utilizing local expertise to provide comprehensive cardiac care including the diagnosis and treatment of hypertension, coronary artery disease, arrhythmias and heart failure.

Actions:

- Education through monthly educational seminars (Health Matters).
- Host and/or participate in regular health fairs with a focus on heart health.
- Expand screening programs including coronary artery disease risk assessments.
- Increase community awareness of services available and local physician specialists.
- Aggressive recruitment of Age Well Be Well members to provide increased access to education, community resources and peer support.
- Increase education on 2-1-1 and its services.
- Annual Age Well Be Well Health Fair to offer comprehensive screenings related to heart health.
- Participation in system Heart Day events and screenings.

Respiratory Diseases

Pneumonia and COPD are known to be frequent causes of hospitalizations; therefore improving respiratory disease self-management among patients in the market area is our goal. We will identify best-in-class patient communication programs and ensure implementation of them in all primary care and pulmonology UH-affiliated physician practices within the Hospital's primary market area. Through our hospital inpatient records we will track hospitalization rates (and other key measures, like length of stay and readmission rates) of patients with a primary diagnosis of respiratory disease.

Goal: Reduce hospitalization rates of adults with respiratory diseases by 20% by 2018.

Actions:

- Education through monthly educational seminars (Health Matters).
- Host annual respiratory wellness event in November (National COPD Month) with spirometry screenings and physician specialist presentations.
- Increase community awareness of services available and local physician specialists.
- Aggressive recruitment of Age Well Be Well members to provide increased access to education, community resources and peer support.
- Increase education on 2-1-1 and its services.
- Annual Age Well Be Well Health Fair to offer comprehensive screenings related to respiratory health including spirometry and pulse oximetry.

Diabetes

Uncontrolled diabetes is known to be a frequent cause of hospitalizations; therefore improving diabetes self-management among the large population of diabetics in the market area is our goal. We will identify best-in-class patient communication programs and ensure implementation of them in all primary care and endocrinology UH-affiliated physician practices within the Hospital's primary market area. Through our hospital outpatient diabetes program, we will track behavioral and metabolic outcomes including Ha1c results, fasting glucose results and pre- and post-test scores on diabetic education measurement tools.

Goal: Reduce Ha1C scores among program participants by 1 – 3% and fasting glucose by an average of 25 points. By reaching these goals and achieving participant satisfaction scores of over 95%, the program will maintain accreditation by the American Diabetes Association. Patients will also set personal goals and self-report on their progress. For those who choose physical activity as a goal, our expectation will be that they meet that goal 75% of the time (in 2015, that goal was met 77.6% of the time).

Actions:

- Education through monthly educational seminars (Health Matters).
- Continue to promote the accredited Diabetes Center which offers blood sugar monitoring and annual screenings; access to education classes specific to diabetes; one-on-one support and counseling; and access to dietitians, pharmacists and physician specialists.
- Host an annual diabetes health fair with A1C glucose testing.
- Engage an endocrinologist to support our efforts with educational presentations and health fair participation.
- Nutrition counseling and healthy cooking demonstrations will be offered to control glucose and combat obesity, which is a major contributing factor to diabetes.
- Annual Age Well Be Well Health Fair to offer comprehensive screenings related to diabetes.
- Monthly Diabetes Support Groups offered by Age Well Be Well Club will continue and efforts will be made to grow participation.

Commitment of programs and resources:

- UH Bedford Medical Center is committed to provide the financial support needed to recruit, hire and retain physician specialists in these fields.
- UH Bedford Medical Center will hire a geriatrician to support the needs of an aging population
- Transition Clinic to be established whereby patients requiring follow-up after discharge will be scheduled with the geriatrician within 7 days if an appointment with a PCP cannot be made. Post-discharge care is vital to disease management and relapse prevention.

WHY HOSPITAL IS NOT ADDRESSING A SIGNIFICANT HEALTH NEED

No hospital facility can address to the fullest all of the health needs present in its community. The Hospital is committed to adhering to its Mission and remaining financially healthy so that it can continue to enhance its clinical, teaching and research activities and to provide a wide range of community benefits. The Strategy utilizes community resources to meet several community health needs.

Below we outline those priority community health issues identified in the 2015 UH Bedford Medical Center CHNA that this Strategy will not address specifically in 2016 – 2018 along with the reasons for not doing so.

PRIORITY COMMUNITY HEALTH ISSUES IDENTIFIED IN 2015 CHNA	REASON HEALTH ISSUE IS NOT BEING ADDRESSED IN PLAN
Health Disparities	
• Poverty	The Hospital is very cognizant of the relationship between economic status and poor health. It is not in a position, however, to directly impact the long-term economic status of the residents of its market area.
• Unemployment	
• Aging Population	A focus on older residents within the Hospital's market area is inherent in this plan.
• Infant Mortality	This issue is being addressed through a collaborate effort among the City of Cleveland, Cuyahoga County and area hospitals, including the University Hospitals system as of January 2016.
Chronic Disease Conditions	
• Alzheimer's	These issues are being left to institutions with a larger focus on those health issues.
• Cancer	
• Mental Illness	
Lifestyle Barriers	
• Substance Abuse (Tobacco/Drug/Alcohol)	This issue is being left to institutions with a larger focus on those health issues.
• Obesity	The Hospital is cognizant of obesity being coincident with chronic disease, especially diabetes. Weight management will be part of the Strategies used to combat diabetes.
Access Barriers	
• Cost of Care	While decreasing the cost of care is not being addressed in this plan, the Hospital has numerous ongoing programs to provide financial assistance to patients with a financial need.
• Lack of Primary Care Providers	The lack of primary care providers is a statewide problem currently being addressed at the state level.
• Transportation	This issue is not within the Hospital's locus of control.

IMPLEMENTATION STRATEGY COLLABORATORS

In developing this implementation strategy, the Hospital collaborated with the following hospitals owned and/or operated by University Hospitals:

- UH Case Medical Center
- UH Ahuja Medical Center
- UH Avon Rehabilitation Hospital
- UH Conneaut Medical Center
- UH Elyria Medical Center
- UH Geauga Medical Center
- UH Geneva Medical Center
- UH Parma Medical Center
- UH Portage Medical Center
- UH Rainbow Babies & Children's Hospital
- UH Rehabilitation Hospital (Beachwood)
- UH Richmond Medical Center, a campus of UH Regional Hospitals
- UH St. John Medical Center, a Catholic hospital
- UH Samaritan Medical Center
- Southwest General Health Center, a joint-venture of University Hospital

Among the nation's leading academic medical centers, University Hospitals Case Medical Center is the primary affiliate of Case Western Reserve University School of Medicine, a nationally recognized leader in medical research and education.

2016 IMPLEMENTATION PLAN




This Implementation Plan was approved by the University Hospitals Board of Directors on March 15, 2016

University Hospitals
Conneaut Medical Center

INTRODUCTION

University Hospitals Conneaut Medical Center (the "Hospital") conducted a community health needs assessment (a "CHNA") of the geographic areas served by the Hospital pursuant to the requirements of Section 501(r) of the Internal Revenue Code ("Section 501 (r)"). The CHNA findings were published on the Hospital's website in December 2015 (the "2015 CHNA"). This CHNA was adopted by the UH Board of Directors on September 24, 2015.[1]

This is the second UH Conneaut Medical Center CHNA in response to federal government regulation.[2] The 2015 UH Conneaut Medical Center CHNA served as the foundation for developing an implementation strategy to address those needs that (a) the Hospital determines it is able to meet in whole or in part; (b) are otherwise part of its mission; and (c) are not met (or are not adequately met) by other programs and services in the Hospital's service area. This implementation strategy ("Strategy"), also required by Section 501(r), documents the Hospital's efforts to address the community health needs identified in 2015 CHNA.

The Strategy identifies the means through which the Hospital plans to address a number of the needs that are consistent with the Hospital's charitable mission during 2016 through 2018 as part of its community benefit programs. The team closely considered the Ashtabula County Community Health Improvement Plan (CHIP) when selecting these priorities. The Hospital is managing programs designed as a result of that plan. The Ashtabula County CHIP focuses on three community health needs:

1. Mental Health and Suicide Prevention
2. Obesity Prevention
3. Chronic Disease Prevention (Diabetes, Heart Disease, Cancer)

CHIP initiatives will serve as part of the foundation of implementation strategies designed by the Hospital in response to this CHNA. While the Hospital is aware of multiple activities and action plans on CHIP, we will address only ones the Hospital is responsible for. We would like to note the Hospital has employees who are activity involved and/or are co-chairs for both Chronic Disease Prevention, Mental Health and Suicide and Obesity Prevention sub-committees. Prioritizing community health needs in this way will allow for greater collaboration between the Hospital, the health department, and the variety of partners involved in CHIP initiatives, and will leverage existing investments for greater community impact. Beyond these programs, the Hospital is addressing some of these needs simply by providing care to all, regardless of their ability to pay, every day.

The Hospital anticipates the strategies may change and therefore, a flexible approach is best suited for the development of its response to the 2015 CHNA. For example, certain community health needs may become more pronounced and require changes to initiatives identified in the Hospital strategy. During 2016 through 2018, other community organizations may address certain needs, indicating that the Hospital's strategies should be refocused on alternative community health needs or assume a different focus on the needs identified in the 2015 CHNA. In addition, changes may be warranted by the publication of final regulations.

[1] *The Patient Protection and Affordable Care Act (Pub. L. 111-148) added section 501(r) to the Internal Revenue Code, which imposes new requirements on nonprofit hospitals in order to qualify for an exemption under Section 501(c)(3), and adding new reporting requirements for such hospitals under Section 6033(b) of the Internal Revenue Code.*

[2] *UH Conneaut Medical Center followed the 2013 Proposed Regulations, published by the Treasury Department and IRS on April 5, 2013, in the Federal Register (REG-106499-12, 2013-21 I.R.B. 1111, [78 FR 20523]), in accordance with Notice 2014-2 that confirms that hospital organizations can rely on proposed regulations under section 501(r) of the Internal Revenue Code issued on June 26, 2012, and April 5, 2013, pending the publication of final regulations or other applicable guidance. The final rule entitled "Additional Requirements for Charitable Hospitals; Community Health Needs Assessments for Charitable Hospitals"; Requirement of a Section 4959 Excise Tax Return and Time for Filing the Return, was published by the IRS on December 31, 2014, and requires compliance after December 29, 2015.*

HOSPITAL MISSION STATEMENT

As a wholly owned subsidiary of University Hospitals Health Systems, Inc. ("University Hospitals" or "UH"), the Hospital is committed to supporting the UH mission, "To Heal. To Teach. To Discover." (the "Mission"), by providing a wide range of community benefits including clinical services, medical education and research. UH is an integrated delivery system and thus can provide benefits by coordinating within and among various entities ("UH System").

COMMUNITY SERVED BY THE HOSPITAL

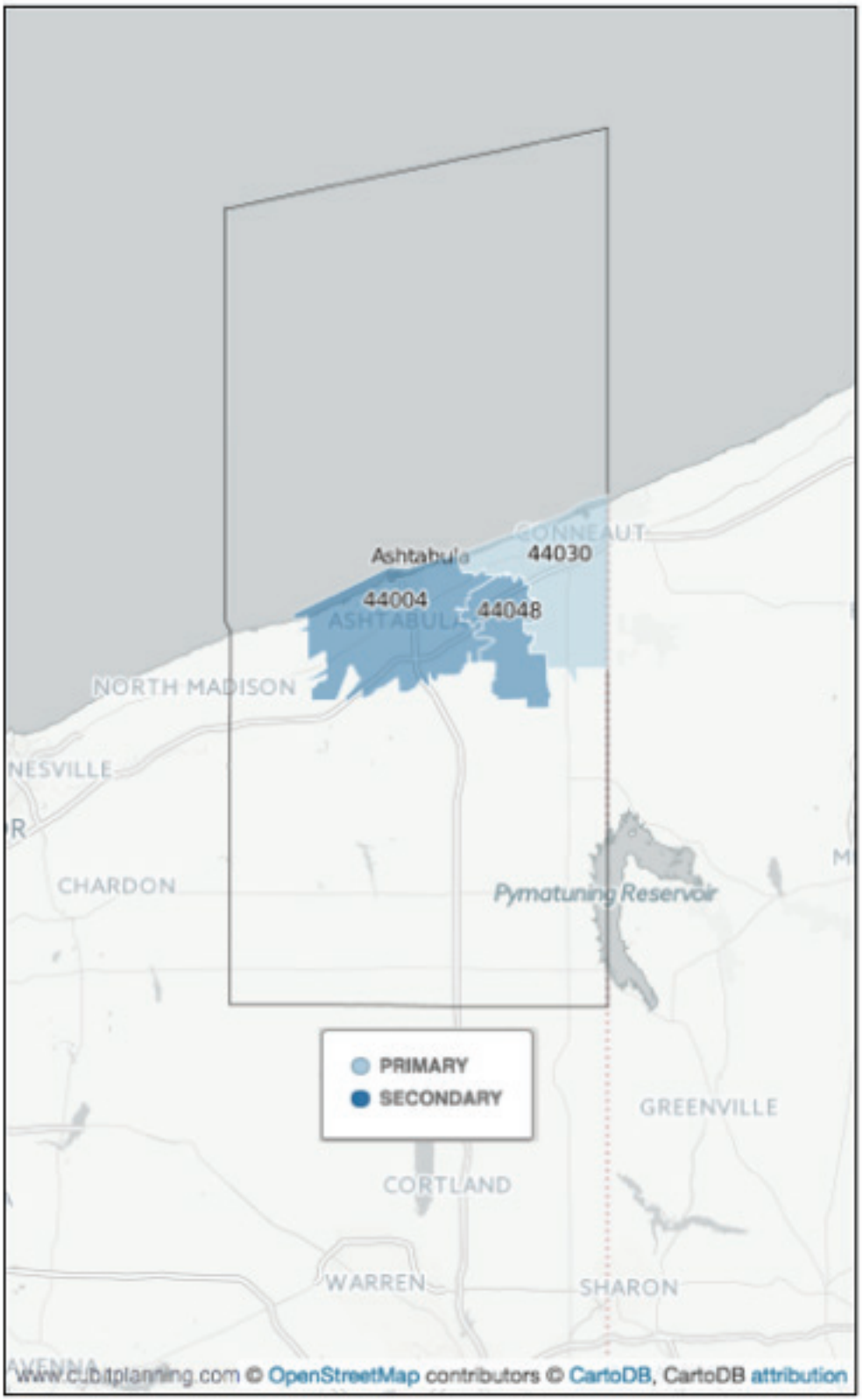
UH Conneaut Medical Center's market area includes three municipalities (one in its primary market area and two in its secondary market area). In 2013, UH Conneaut Medical Center had 415 discharged patients. Of those, 356 were in the medical center's primary or secondary market (83.6%).

In 2013, 62.9% of UH Conneaut Medical Center's discharges were residents of its primary market area; 20.7% were residents of its secondary market area.

Of the three municipalities which make up UH Conneaut Medical Center's market area, Ashtabula has the largest population. Ashtabula comprises 62.8% of the total population of the Hospital's market area. However, proportionately fewer (16.4%) of UH Conneaut Medical Center's discharges in 2013 were Ashtabula residents. Instead, the municipality with the highest proportion of UH Conneaut Medical Center's discharges in 2013 was Conneaut, a relatively small municipality of 16,875 residents.

UH Conneaut Medical Center's three municipalities that comprise its market areas are all in northern Ashtabula County, Ohio.

FIGURE 1: UH CONNEAUT MEDICAL CENTER MARKET AREAS



OBSERVATIONS FROM 2015 CHNA

- Poverty and unemployment in the primary market area and secondary market area create barriers to access (to health services, healthy food and other necessities) and thus contribute to poor health.
- The number of households in Ashtabula County increased by 1.2% from 2010 to 2013. However, the average (median) income has decreased in Ashtabula County by 12.1% from 2010 to 2013. As the Ashtabula County population aged, its proportion of households with Social Security and retirement income increased by 2.7% from 2010 to 2013, necessitating the need for more services for the senior population.
- The proportion of Ashtabula County households living below the poverty line increased from 2010 to 2013. One in four residents of Ashtabula County lived under the poverty line in 2013 (19.7%, an increase from 15.9% in 2010).
- The unemployment rate in Ashtabula County is the 28th highest in Ohio and was 5.6% in April of 2015.
- 27.7% of discharges were 'ambulatory care sensitive discharges' (ACS) of residents within the primary and secondary market areas combined. Ambulatory care sensitive (ACS) conditions are conditions for which "good outpatient care can potentially prevent the need for hospitalization or for which early intervention can prevent complications or more severe disease," according to the Agency for Healthcare Research and Quality. This may signal lower availability or access to primary care within the primary market area. The most common primary ACS diagnoses for the Hospital's discharged patients in 2013 were bacterial pneumonia, congestive heart failure, chronic obstructive pulmonary disease (COPD) and diabetes.
- There is strong support within an analysis of all 2013 inpatients for UH Conneaut Medical Center for community initiatives to reduce obesity and associated chronic diseases (diabetes, cancer, heart disease). It is well-established that type 1 and 2 diabetes are strongly associated with obesity in teens and adults and also that diabetes makes patients at higher risk for heart disease and vascular disease (stroke). Four in ten hospitalized adults at UH Conneaut Medical Center in 2013 had a secondary diagnosis of diabetes.
- Likewise, we also see support for a focus on mental health issues inside the Hospital's inpatient data. Mental health issues were identified as a secondary diagnosis in 21.7% of adult inpatients for UH Conneaut in 2013.

PRIORITY HEALTH NEEDS

Poor health status can result if a complex interaction of challenging social, economic, environmental and behavioral factors, combined with a lack of access to care, is present. Addressing the more common "root" causes of poor community health can serve to improve a community's quality of life and to reduce mortality and morbidity.

After careful analysis of both qualitative and quantitative data, the Hospital identified four categories of priority health needs that impact the community served by the Hospital. Listed below in no specific order:

Health Disparities	Plan to Address
High Unemployment Rates	No
Aging Population	Yes
Chronic Stress	Yes
Infant/Maternal Care High Rates of Infant Mortality Teen Births	No

Access Barriers	Plan to Address
Poor Access to Primary Care	Yes
Poor Access to Dentistry	No
High Cost of Care	Yes
Transportation	Yes
Food Deserts	Yes
Lack of Insurance Coverage	Yes

Chronic Disease Conditions	Plan to Address
Cancer	Yes
Heart Disease	Yes
Diabetes	Yes
Mental Illness	Yes

Lifestyle Barriers	Plan to Address
Obesity	Yes
Violence	Yes
Drug/Substance Abuse	Yes
Smoking	Yes

ADDRESSING A SIGNIFICANT HEALTH NEED

Working in alignment with community agencies in Ashtabula County, below are the action plans, time frame and community resources that the Hospital will engage in to ensure measurable results of the CHNA priorities identified.

CHRONIC DISEASE PREVENTION

PRIORITY: Chronic Disease			
GOAL: To limit the burden and decrease the prevalence of chronic disease in Ashtabula County			
OBJECTIVES:			Source
By 2018, decrease the percentage of adults diagnosed with diabetes from **10%** in 2012 to **8.9%** in 2018.			Health Needs Assessment
By 2018, decrease the heart disease death rate from **367.50/100,000** in 2012 to **330.75/100,000** in 2018.			Ashtabula County Vital Statistics
By 2018, decrease the percentage of adults who identify as a current smoker from **29.5%** in 2012 to **26.5%** in 2018.			Network of Care
ACTION PLAN			
Improvement Strategy	Time Frame	Resources	Responsible Party
Annually update the Intervention and Prevention of Ongoing Disease Resource Guide on available programs and resources in Ashtabula County. Resource guide is located on Ashtabula County Health Dept. website and hard copies are distributed throughout Ashtabula County in various health care settings and community agencies	Annually (Dec. of each year)	Donations from Sub-committee agencies	University Hospitals Conneaut and Geneva medical centers Community Outreach Nursing Team
Annually provide at least one county wide symposium on a chronic disease topic to increase awareness and understanding of disease process and prevention	Annually	Donations from Sub-committee agencies & community partners	Ashtabula County Health Needs Assessment Sub-committee Community Outreach Nursing Team

PRIORITY: Chronic Disease			
ACTION PLAN			
Improvement Strategy	Time Frame	Resources	Responsible Party
Diabetes education programs – targeting both prediabetic and diabetic patients. Goal is to: • Empower persons to effectively manage their prediabetes/diabetes by utilizing skills to enable them to lead healthy, active lives. Focus on SMART Goals, healthy eating, self-monitoring, medication knowledge, physical activity, coping, sick day planning, acute and chronic long term complications • To increase understanding of disease management for existing prediabetics and/or diabetics To increase awareness of the tie between diabetes, obesity and heart disease	Ongoing	Physician referrals, Dietitian referrals, Marketing materials, Case manager referrals, Hospital to Home EMMI education	University Hospitals Community Outreach Nursing Team
Support hospitals, health care organizations, and health departments in offering smoking prevention and cessation programs to the public	Ongoing	Grants and donations	University Hospitals – monthly SMOKELESS Program Ashtabula County Medical Center County Health Dept. – Baby & Me program
Monthly provide Health Matters topic on chronic disease and cancers for the general public	Monthly	University Hospitals	Business Development Manager & UH Physicians
Monthly BP, Glucose, Cholesterol Screenings for general public	Monthly	University Hospitals	Community Outreach Nursing Team
Monthly Senior Forums – Ashtabula and Eastern Lake County	Monthly	University Hospitals	Community Outreach Nursing & Physician Team
Quarterly Health Expos – HHVI, Women's Expo, Family Health and Safety Day, Lifelong Health Event	Quarterly	University Hospitals	Community Outreach Nursing & Physician Team

PRIORITY: Chronic Disease			
ACTION PLAN			
Improvement Strategy	Time Frame	Resources	Responsible Party
Monthly provide free mammogram clinic for uninsured women ages 40 – 64 by financially screening using HCAP/UH financial aid form	Monthly	University Hospitals	University Hospitals Community Outreach Team
Quarterly breast health education to community in various settings	Quarterly	University Hospitals	
Annual Walk for the Cure to celebrate survivors of breast cancer and to bring awareness of the importance of breast health	Annually	Walk for the Cure Community Committee	
Hospital-to-Home Program: A collaborative program designed to help patients transition back to home after a hospital admission. The goal is to provide the patient with one-on-one disease-specific education and tools to help manage condition or illness at home, improving health outcomes, i.e., earlier recognition of exacerbation of disease, decrease re-admission	Ongoing	UH Conneaut Medical Center UH Physician Interdisciplinary Team (IDT)	Inpatient Case Management Team Community Outreach Nursing Team Community Outreach Nursing Team

MENTAL HEALTH AND SUICIDE

GOAL: To promote optimal mental health and prevent suicide			
OBJECTIVE:			Source
By 2018, decrease the suicide death rate from **14.78/100,000** in 2012 to **13.3 /100,000** in 2018.			Ashtabula County Vital Statistics
ACTION PLAN			
Improvement Strategy	Time Frame	Resources	Responsible Party
Implement research-informed communication efforts to prevent suicide by changing knowledge, attitudes and behaviors in the general public including students, young adults, health care workers, older adult populations. To reduce the stigma of suicide and allowing the populations to speak openly regarding suicide	Ongoing	LOSS Team Physician Ashtabula County Suicide Prevention Coalition Local Media	Ashtabula County Mental Health and Recovery Services Board University Hospitals
Sustain a system/protocol to better track the changing knowledge, attitudes and behaviors in the County. (Ashtabula County Medical Health Board surveys students quarterly, along with the Coroner reports that are reviewed to track numbers)	Ongoing	Ashtabula County Coroner's Office Ash. County Suicide Prevention Coalition	Ashtabula County Mental Health and Recovery Services Board University Hospitals
Provide gatekeeper trainings to the teens, veterans, older adults, clergy and teachers in the community; bringing awareness of signs and symptoms of suicidal thoughts and where to report, i.e., Suicide Hotline, ACMHB, 9-1-1	Ongoing	Ashtabula County Suicide Prevention Coalition	Ashtabula County Mental Health and Recovery Services Board University Hospitals
Use social media campaigns to increase awareness of the signs and dangers of depression for all age groups	Ongoing	Help Hotline Text Crisis Line MHRS Board Website Twitter Facebook	Ashtabula County Mental Health and Recovery Services Board
Implement Life Skills Training in all Ashtabula County school districts to reduce youth suicide attempts	Ongoing	Botvin Lifeskills Ashtabula County Prevention Coalition	Ashtabula County Mental Health and Recovery Services Board University Hospitals

OBESITY PREVENTION

PRIORITY: Childhood Obesity			
GOAL: To increase the percentage of children in Ashtabula County who maintain a healthy weight as recommended by the American Academy of Pediatrics			
OBJECTIVES:			Source
By 2018, decrease the percentage of Ashtabula County third graders considered obese according to BMI measurements based on sex and age from **36.3%** in 2009 – 2010 to **34%** in 2018.			ODH Report on BMI in Ohio's 3rd Graders 2004 – 2010
By 2018, decrease the percentage of Ashtabula County Head Start Preschoolers aged 2 – 4 years considered obese from **14%** in 2014 – 2015 to **12%** in 2018.			Ashtabula County Head Start Enrollment Data
ACTION PLAN			
Improvement Strategy	Time Frame	Resources	Responsible Party
Obtain baseline BMI data of 3rd graders in Ashtabula County	2018	Survey instrument	Schools Local Health Dept. University Hospitals
Collaborate with community agencies and organizations to provide nutritional programing in targeted schools and preschools based on grant criteria parameters	2018	MyPlate Let's Move 5-4-3-2-1-0 Rethink Your Drink	Schools Local Health Dept. University Hospitals

SIGNIFICANT HEALTH NEED NOT BEING ADDRESSED

Health Disparities	Reason Why Not Addressing
High Unemployment Rates	Growth Partnership for Ashtabula County 2016 Dashboard forming a Strategic Action Committee for Entrepreneurial Business Growth
Infant/Maternal Care High Rates of Infant Mortality Teen Births	UH Conneaut Medical Center does not have an OB Unit

Access Barriers	Reason Why Not Addressing
Poor Access to Dentistry	Ashtabula County Health Department has collaborated with UH Ronald McDonald Dental Van to provide dental services

IMPLEMENTATION STRATEGY COLLABORATORS

The Strategy will be implemented in collaboration with other entities including, but not limited to:

- Ashtabula County Department of Job and Family Services
- Ashtabula County Children's Services
- Ashtabula County Health Department
- Ashtabula County Head Start
- Ashtabula County Mental Health Recovery Services Board
- Ashtabula County Prevention Coalition
- Ashtabula Senior Center
- Ashtabula Senior Protection and Advocacy Network
- Ashtabula YMCA
- Buckeye Local Schools
- Conneaut Area City Schools
- Conneaut Human Resources Center
- Country Neighbor
- Geneva Area City Schools
- Grand Valley Local Schools
- Jefferson Area Local Schools
- Madison Senior Center
- Madison YMCA
- Pymatuning Valley Schools

2016 IMPLEMENTATION PLAN

This Implementation Plan was approved by the University Hospitals Board of Directors on March 15, 2016

University Hospitals
Geneva Medical Center

INTRODUCTION

University Hospitals Geneva Medical Center (the "Hospital") conducted a community health needs assessment (a "CHNA") of the geographic areas served by the Hospital pursuant to the requirements of Section 501(r) of the Internal Revenue Code ("Section 501(r)"). The CHNA findings were published on the Hospital's website in December 2015 (the "2015 CHNA"). This CHNA was adopted by the UH Board of Directors on September 24, 2015.[1]

This is the second UH Geneva Medical Center CHNA in response to the federal government regulation.[2] The 2015 UH Geneva Medical Center CHNA served as the foundation for developing an implementation strategy to address those needs that (a) the Hospital determines it is able to meet in whole or in part; (b) are otherwise part of its mission; and (c) are not met (or are not adequately met) by other programs and services in the Hospital's service area. This implementation strategy ("Strategy"), also required by Section 501(r), documents the Hospital's efforts to address the community health needs identified in 2015 CHNA.

The Strategy identifies the means through which the Hospital plans to address a number of the needs that are consistent with the Hospital's charitable mission during 2016 through 2018 as part of its community benefit programs. The team closely considered the Ashtabula County Community Health Improvement Plan (CHIP) when selecting these priorities. The Hospital is managing programs designed as a result of that plan. The Ashtabula County CHIP focuses on three community health needs:

1. Mental Health and Suicide Prevention
2. Obesity Prevention
3. Chronic Disease Prevention (Diabetes, Heart Disease, Cancer)

CHIP initiatives will serve as part of the foundation of implementation strategies designed by the Hospital in response to this CHNA. While the Hospital is aware of multiple activities and action plans on CHIP, we will address only ones the Hospital is responsible for. We would like to note the Hospital has employees who are actively involved in and co-chairs of the Chronic Disease Prevention, Mental Health and Suicide, and Obesity Prevention subcommittees. Prioritizing community health needs in this way will allow for greater collaboration between the Hospital, the health department, and the variety of partners involved in CHIP initiatives, and will leverage existing investments for greater community impact. Beyond these programs, the Hospital is addressing some of these needs simply by providing care to all, regardless of their ability to pay, every day.

The Hospital anticipates the strategies may change and therefore, a flexible approach is best suited for the development of its response to the 2015 CHNA. For example, certain community health needs may become more pronounced and require changes to initiatives identified in the Hospital strategy. During 2016 through 2018, other community organizations may address certain needs, indicating that the Hospital's strategies should be refocused on alternative community health needs or assume a different focus on the needs identified in the 2015 CHNA. In addition, changes may be warranted by the publication of final regulations.

HOSPITAL MISSION STATEMENT

As a wholly owned subsidiary of University Hospitals Health Systems, Inc. ("University Hospitals" or "UH"), the Hospital is committed to supporting the UH mission, "To Heal. To Teach. To Discover." (the "Mission"), by providing a wide range of community benefits including clinical services, medical education and research. UH is an integrated delivery system and thus can provide benefits by coordinating within and among various entities ("UH System").

[1] *The Patient Protection and Affordable Care Act (Pub. L. 111-148) added section 501(r) to the Internal Revenue Code, which imposes new requirements on nonprofit hospitals in order to qualify for an exemption under Section 501(c)(3), and adding new reporting requirements for such hospitals under Section 6033(b) of the Internal Revenue Code.*

[2] *UH Geneva Medical Center followed the 2013 Proposed Regulations, published by the Treasury Department and IRS on April 5, 2013, in the Federal Register (REG-106499-12, 2013-21 I.R.B. 1111, [78 FR 20523]), in accordance with Notice 2014-2 that confirms that hospital organizations can rely on proposed regulations under section 501(r) of the Internal Revenue Code issued on June 26, 2012, and April 5, 2013, pending the publication of final regulations or other applicable guidance. The final rule entitled "Additional Requirements for Charitable Hospitals; Community Health Needs Assessments for Charitable Hospitals"; Requirement of a Section 4959 Excise Tax Return and Time for Filing the Return, was published by the IRS on December 31, 2014, and requires compliance after December 29, 2015.*

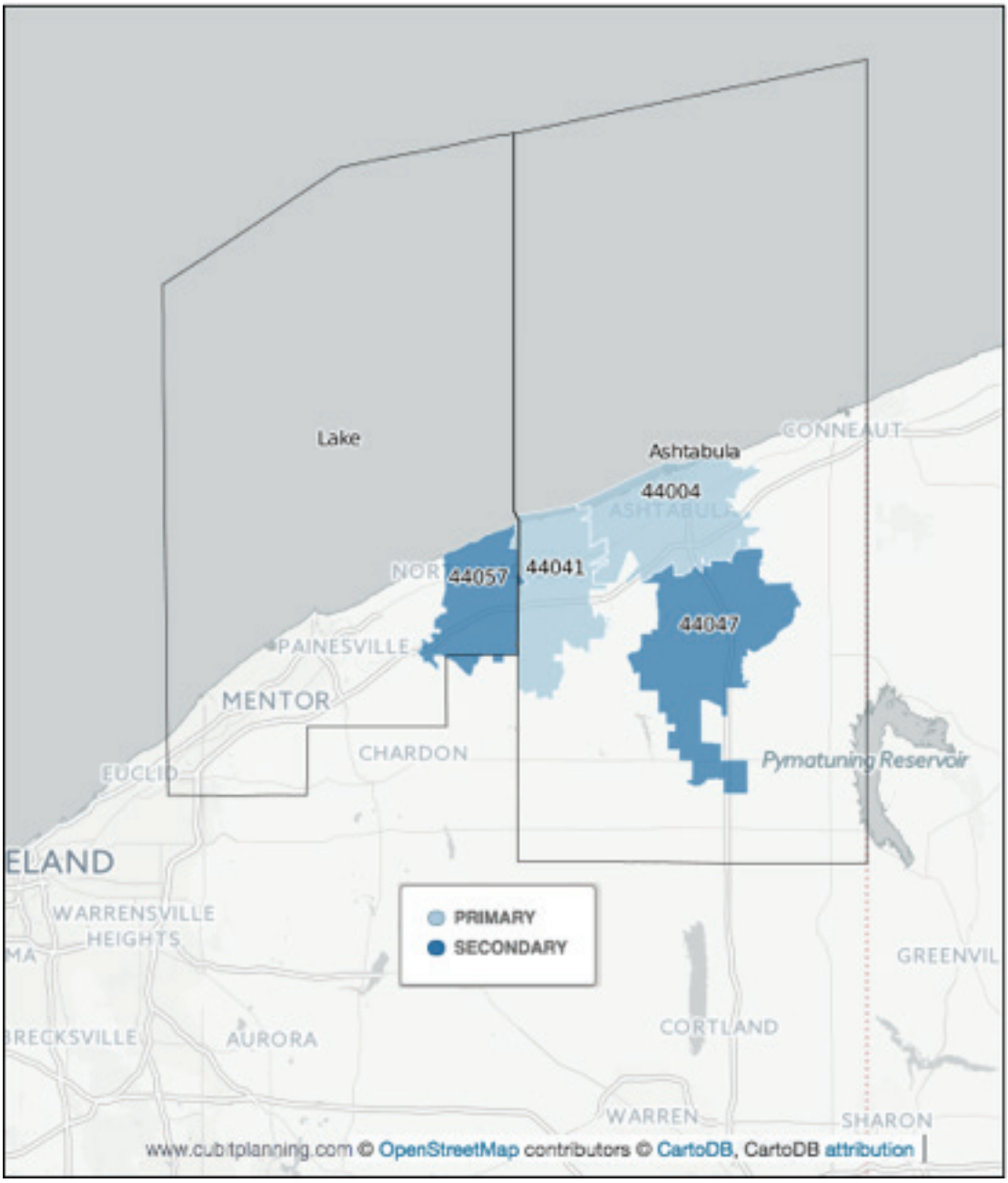
COMMUNITY SERVED BY THE HOSPITAL

The community served by the Hospital includes four municipalities (two in its primary market area and two in its secondary market area). In 2013, the Hospital had 1,022 discharged patients. Of those, 627 were in the Hospital's primary market (61.4%) and 203 were in the Hospital's secondary market (19.9%).

Of the four municipalities that make up the Hospital's market area, Ashtabula has the largest population, comprising 43.2% of the total population of the market area, but only 17.2% of the Hospital's patient population. The municipality with the highest proportion of the Hospital's discharges in 2013 was Geneva (44.1%), a relatively small municipality of 14,766 residents.

Three of the municipalities that comprise the Hospital's market area are in northern Ashtabula County, Ohio. The fourth municipality is in in northeastern Lake County.

FIGURE 1 DEPICTS THE HOSPITAL'S PSA AND SSA.



OBSERVATIONS FROM 2015 CHNA

- Poverty and unemployment in the Primary Service Area ("PSA") and Secondary Service Area ("SSA") create barriers to access (to health services, healthy food and other necessities) and thus contribute to poor health.
- The number of households in Ashtabula County increased by 1.2% from 2010 to 2013. However, the average (median) income has decreased in Ashtabula County by 12.1% from 2010 to 2013. As the Ashtabula County population aged, its proportion of households with Social Security and retirement income increased by 2.7% from 2010 to 2013, necessitating the need for more services for the senior population.
- The proportion of Ashtabula County households living below the poverty line increased from 2010 to 2013. One in four residents of Ashtabula County lived under the poverty line in 2013 (19.7%, an increase from 15.9% in 2010).
- The unemployment rate in Ashtabula County is the 28th highest in Ohio and was 5.6% in April of 2015.
- Across the PSA and SSA, 48.3% of discharges were Ambulatory Care Sensitive ("ACS") discharges of residents within the primary and secondary market areas combined. This may signal lower availability or access to primary care. This is an increase in the proportion of ACS cases identified in the Hospital's 2012 Community Health Needs Assessment, which reported the proportion of 2010 ACS cases as 36.6%. The most common primary ACS diagnoses for the Hospital's discharged patients in 2013 were bacterial pneumonia, congestive heart failure, chronic pulmonary obstructive disease (COPD), cellulitis, kidney/urinary infections, gastroenteritis, and diabetes.
- There is strong support within an analysis of all 2013 inpatients for UH Geneva Medical Center for community initiatives to reduce obesity and associated chronic diseases (diabetes, cancer, heart disease). It is well established that type 1 and 2 diabetes are strongly associated with obesity in teens and adults and also that diabetes makes patients at higher risk for heart disease and vascular disease (stroke). Four-in-ten hospitalized adults at UH Geneva Medical Center in 2013 had a secondary diagnosis of diabetes.
- Likewise, we also see support for a focus on mental health issues inside the Hospital's inpatient data. Mental health issues were identified as a secondary diagnosis in 21.7% of adult inpatients for UH Geneva Medical Center in 2013.

PRIORITY HEALTH NEEDS

Poor health status can result if a complex interaction of challenging social, economic, environmental and behavioral factors, combined with a lack of access to care, is present. Addressing the more common "root" causes of poor community health can serve to improve a community's quality of life and to reduce mortality and morbidity.

After careful analysis of both qualitative and quantitative data, the Hospital identified four categories of priority health needs that impact the community served by the hospital. Listed below in no specific order:

Health Disparities	Plan to Address
High Unemployment Rates	No
Aging Population	No
Chronic Stress	No
Infant/Maternal Care High Rates of Infant Mortality Teen Births	No

Access Barriers	Plan to Address
Poor Access to Primary Care	No
Poor Access to Dentistry	No
High Cost of Care	No
Transportation	No
Food Deserts	No
Lack of Insurance Coverage	No

Chronic Disease Conditions	Plan to Address
Cancer	Yes
Heart Disease	Yes
Diabetes	Yes
Mental Illness	Yes

Lifestyle Barriers	Plan to Address
Obesity	Yes
Violence	No
Drug/Substance Abuse	No
Smoking	No

ADDRESSING A SIGNIFICANT HEALTH NEED

Working in alignment with community agencies in Ashtabula County, below are the action plans, timeframe, and community resources that the Hospital will engage in to ensure measurable results of the CHNA priorities identified.

CHRONIC DISEASE PREVENTION

PRIORITY: Chronic Disease			
GOAL: To limit the burden and decrease the prevalence of chronic disease in hospital's market areas.			
OBJECTIVES:			Source
By 2018, decrease the percentage of adults diagnosed with diabetes from **10%** in 2012 to **8.9%** in 2018.			Health Needs Assessment
By 2018, decrease the heart disease death rate from **367.50/100,000** in 2012 to **330.75/100,000** in 2018.			Ashtabula County Vital Statistics
By 2018, decrease the percentage of adults who identify as a current smoker from **29.5%** in 2012 to **26.5%** in 2018.			Network of Care
ACTION PLAN			
Improvement Strategy	Time Frame	Resources	Responsible Party
Annually update the Intervention and Prevention of Ongoing Disease Resource Guide on available programs and resources in Ashtabula County. Resource guide is located on Ashtabula County Health Dept. website and hard copies are distributed throughout Ashtabula County in various health care settings and community agencies	Annually (Dec. of each year)	Donations from Subcommittee agencies	University Hospitals Conneaut and Geneva medical centers
Annually provide at least one county-wide symposium on a chronic disease topic to increase awareness and understanding of disease process and prevention	Annually	Donations from Subcommittee agencies & community partners	Ashtabula County Health Needs Assessment Subcommittee Community Outreach Nursing Team

PRIORITY: Chronic Disease			
ACTION PLAN			
Improvement Strategy	Time Frame	Resources	Responsible Party
Diabetes education programs – targeting both pre-diabetic and diabetic patients. Goal is to: • Empower persons to effectively manage their pre-diabetes/diabetes by utilizing skills to enable them to lead healthy active lives. Focus on SMART Goals, healthy eating, self-monitoring, medication knowledge, physical activity, coping, sick day planning, acute and chronic long term complications • To increase understanding of disease management for existing pre-diabetics and/or diabetics • To increase awareness of the tie between diabetes, obesity and heart disease	Ongoing	Physician referrals, Dietician referrals, Marketing materials, Case manager referrals, Hospital to Home EMMI education	University Hospitals Community Outreach Nursing Team
Support hospitals, health care organizations, and health departments in offering smoking prevention and cessation programs to the public	Ongoing	Grants and donations	University Hospitals – monthly SMOKELESS Program Ashtabula County Medical Center County Health Dept. – Baby & Me program
Monthly provide Health Matters topic on chronic disease and cancers for the general public	Monthly	University Hospitals	Business Development Manager & UH Physicians
Monthly BP, Glucose, Cholesterol Screenings for the general public	Monthly	University Hospitals	Community Outreach Nursing Team
Monthly Senior Forums – Ashtabula and Eastern Lake County	Monthly	University Hospitals	Community Outreach Nursing & Physician Team
Quarterly Health Expos – UH Harrington Heart & Vascular Institute, Women's Expo, Family Health and Safety Day, Lifelong Health Event	Quarterly	University Hospitals	Community Outreach Nursing & Physician Team

PRIORITY: Chronic Disease			
ACTION PLAN			
Improvement Strategy	Time Frame	Resources	Responsible Party
Monthly provide free mammogram clinic for uninsured women ages 40-64 by financially screening using HCAP/UH financial aid form	Monthly	University Hospitals	University Hospitals Community Outreach Team
Quarterly breast health education to community in various settings	Quarterly	University Hospitals	
Annual Walk for the Cure to celebrate survivors of breast cancer and to bring awareness of the importance of breast health	Annually	Walk for the Cure Community Committee	
Hospital-to-Home Program: A collaborative program designed to help patients transition back to home after a hospital admission. The goal is to provide the patient with one-on-one disease-specific education and tools to help manage condition or illness at home, improving health outcomes, i.e., earlier recognition of exacerbation of disease, decrease re-admission.	Ongoing	UH Geneva Medical Center UH Physician Interdisciplinary Team (IDT)	Inpatient Case Management Team Community Outreach Nursing Team Community Outreach Nursing Team

MENTAL HEALTH AND SUICIDE

GOAL: To promote optimal mental health and prevent suicide			
OBJECTIVE:			Source
By 2018, decrease the suicide death rate from **14.78/100,000** in 2012 to **13.3/100,000** in 2018.			Ashtabula County Vital Statistics
ACTION PLAN			
Improvement Strategy	Time Frame	Resources	Responsible Party
Implement research-informed communication efforts to prevent suicide by changing knowledge, attitudes, and behaviors in the general public including students, young adults, health care workers, older adult populations. To reduce the stigma of suicide and allow the populations to speak openly regarding suicide	Ongoing	LOSS Team Physician Ashtabula County Suicide Prevention Coalition Local Media	Ashtabula County Mental Health and Recovery Services Board University Hospitals
Sustain a system/protocol to better track the changing knowledge, attitudes, and behaviors in the County. (Ashtabula County Medical Health Board surveys students quarterly, along with the Coroner reports that are reviewed to track numbers)	Ongoing	Ashtabula County Coroner's Office Ashtabula County Suicide Prevention Coalition	Ashtabula County Mental Health and Recovery Services Board University Hospitals
Provide gatekeeper trainings to the Teens, Veterans, Older Adults, Clergy and Teachers in the community; bring awareness of signs and symptoms of suicidal thoughts and where to report, i.e., Suicide Hotline, ACMHB, 9-1-1.	Ongoing	Ashtabula County Suicide Prevention Coalition	Ashtabula County Mental Health and Recovery Services Board University Hospitals
Use social media campaigns to increase awareness of the signs and dangers of depression for all age groups	Ongoing	Help Hotline Text Crisis Line MHRS Board Website Twitter Facebook	Ashtabula County Mental Health and Recovery Services Board
Implement Life Skills Training in all Ashtabula County school districts to reduce youth suicide attempts	Ongoing	Botvin Lifeskills Ashtabula County Prevention Coalition	Ashtabula County Mental Health and Recovery Services Board University Hospitals

OBESITY PREVENTION

PRIORITY: Childhood Obesity			
GOAL: To increase the percentage of children in Ashtabula County who maintain a healthy weight as recommended by the American Academy of Pediatrics			
OBJECTIVES:			Source
By 2018, decrease the percentage of Ashtabula County third graders considered obese according to BMI measurements based on sex and age from **36.3%** in 2009 – 2010 to **34%** in 2018.			ODH Report on BMI in Ohio's 3rd Graders 2004 – 2010
By 2018, decrease the percentage of Ashtabula County Head Start Preschoolers aged 2 – 4 years considered obese from **14%** in 2014 – 2015 to **12%** in 2018.			Ashtabula County Head Start Enrollment Data
ACTION PLAN			
Improvement Strategy	Time Frame	Resources	Responsible Party
Obtain baseline BMI data of 3rd graders in Ashtabula County	2018	Survey instrument	Schools Local Health Dept. University Hospitals
Collaborate with community agencies and organizations to provide nutritional programing in targeted schools and pre-schools based on grant criteria parameters	2018	MyPlate Let's Move 5-4-3-2-1-0 Rethink Your Drink	Schools Local Health Dept. University Hospitals

SIGNIFICANT HEALTH NEED NOT BEING ADDRESSED

Health Disparities	Reason Why Not Addressing
High Unemployment Rates	Growth Partnership for Ashtabula County 2016 Dashboard forming a Strategic Action Committee for Entrepreneurial Business Growth
Aging population Chronic stress	The hospital's existing health care services address these ongoing health needs.
Infant/Maternal Care High Rates of Infant Mortality Teen Births	UH Geneva Medical Center does not have an OB Unit

Access Barriers	Reason Why Not Addressing
Poor Access to Dentistry	Ashtabula County Health Department has collaborated with UH Ronald McDonald Dental Van to provide dental services
Poor Access to Primary Care High Cost of Care Transportation Food Deserts Lack of insurance coverage	These issues are economic issues facing Ashtabula County as a whole; UH Geneva Medical Center is not in a position to significantly impact these problems at this time.

Lifestyle Barriers	Reason Why Not Addressing
Violence Drug/Substance Abuse Smoking	These issues are highly related to economics and social determinants of health. UH Geneva Medical Center addresses these issues via treatment of associated injuries or disease states.

IMPLEMENTATION STRATEGY COLLABORATORS

The Strategy will be implemented in collaboration with other entities including, but not limited to:

- Ashtabula County Department of Job and Family Services
- Ashtabula County Children's Services
- Ashtabula County Health Department
- Ashtabula County Head Start
- Ashtabula County Mental Health Recovery Services Board
- Ashtabula County Prevention Coalition
- Ashtabula Senior Center
- Ashtabula Senior Protection and Advocacy Network
- Ashtabula YMCA
- Buckeye Local Schools
- Conneaut Area City Schools
- Conneaut Human Resources Center
- Country Neighbor
- Geneva Area City Schools
- Grand Valley Local Schools
- Jefferson Area Local Schools
- Madison Senior Center
- Madison YMCA
- Pymatuning Valley Schools

2016 IMPLEMENTATION PLAN




This Implementation Plan was approved by the University Hospitals Board of Directors on March 15, 2016

University Hospitals
Rehabilitation Hospital

A Joint Venture with Kindred Healthcare

INTRODUCTION

This is the first UH Rehabilitation Hospital community health needs assessment (CHNA) in response to Federal government regulation.[1] It was adopted by the UH Board of Directors on September 24, 2015. The 2015 UH Rehabilitation Hospital CHNA will serve as a foundation for developing an implementation strategy to address those needs (a) the hospital determines it is able to meet in whole or in part; (b) are otherwise part of its mission; and (c) are not met (or are not adequately met) by other programs and services in the hospital's service area.

UH Rehabilitation Hospital is located in the Chagrin Highlands area in the city of Beachwood in Cuyahoga County, Ohio. UH Rehabilitation Hospital's market areas lie within five counties in Northeast Ohio. These include 27 municipalities (nine in its primary market area, 13 in its secondary market area, and five in its tertiary market area) and includes Geauga, Lake, Cuyahoga, Summit and Portage counties.

University Hospitals Rehabilitation Hospital (the "Hospital") conducted a community health needs assessment (a "CHNA") in 2015 of the geographic areas served by the Hospital. The strategies herein identify the means through which the Hospital plans to address a number of the needs that are consistent with the Hospital's charitable mission during 2016 through 2018 as part of its community benefit programs. Beyond the programs discussed in the Strategy, the Hospital is addressing a number of these needs simply by providing care to all, regardless of their ability to pay, every day.

The Hospital anticipates the strategies may change and therefore, a flexible approach is best suited for the development of its response to the 2015 CHNA. For example, certain community health needs may become more pronounced and require changes to the initiatives identified by the Hospital in the Strategy.

UH Rehabilitation Hospital will be focusing on expanding community outreach services related to **diabetes** and **cardiovascular disease**. These health needs were chosen due to their higher than average prevalence in our patient population and their strong association with high hospitalization rates and the need for patient education, disease management and compliance. We believe expanded education, screenings and awareness of these diseases will have the greatest impact on the communities we now serve.

OVERVIEW OF THE STRATEGY

The Strategy includes the following information:

1. Hospital Mission Statement
2. Community Served by the Hospital
3. Observations for the CHNA
4. Priority Community Health Needs
5. Implementation Strategies: 2016 through 2018
6. Implementation Strategy Development Collaborators
7. Needs the Hospital Will Not Address

HOSPITAL MISSION STATEMENT

UH Rehabilitation Hospital is a joint venture between University Hospitals and Kindred Healthcare Corporation and as such the Hospital is committed to supporting the UH mission, "To Heal. To Teach. To Discover." (The "Mission"), by providing a wide range of community benefits including clinical services, medical education and research. UH is an integrated delivery system and thus can provide benefits by coordinating within and among its various entities ("UH System").

COMMUNITIES SERVED BY THE HOSPITAL

The communities served by the Hospital are defined based on the geographic origins of the Hospital's inpatients. The Primary Service Area (PSA) is the geographic area from which the majority of the Hospital's patients originate. The Secondary Service Area (SSA) is where an additional population of the Hospital's inpatients reside. The PSA is comprised of three ZIP codes in Cuyahoga and Summit counties in Ohio. The SSA is comprised of five ZIP codes, also in Cuyahoga and Summit counties. In 2013, the PSA and SSA were home to approximately 187,023 persons. In 2013, more than 82% of the Hospital's inpatients lived in the specified ZIP codes.

[1] *The Patient Protection and Affordable Care Act (Pub. L. 111-148) added section 501(r) to the Internal Revenue Code, which imposes new requirements on nonprofit hospitals in order to qualify for an exemption under Section 501(c)(3), and adding new reporting requirements for such hospitals under Section 6033(b) of the Internal Revenue Code.*

UH Rehabilitation Hospital followed the 2013 Proposed Regulations, published by the Treasury Department and IRS on April 5, 2013, in the Federal Register (REG-106499-12, 2013-21 I.R.B. 1111, [78 FR 20523]), in accordance with Notice 2014-2 that confirms that hospital organizations can rely on proposed regulations under section 501(r) of the Internal Revenue Code issued on June 26, 2012, and April 5, 2013, pending the publication of final regulations or other applicable guidance. The final rule entitled "Additional Requirements for Charitable Hospitals; Community Health Needs Assessments for Charitable Hospitals"; Requirement of a Section 4959 Excise Tax Return and Time for Filing the Return, was published by the IRS on December 31, 2014, and requires compliance after December 29, 2015.

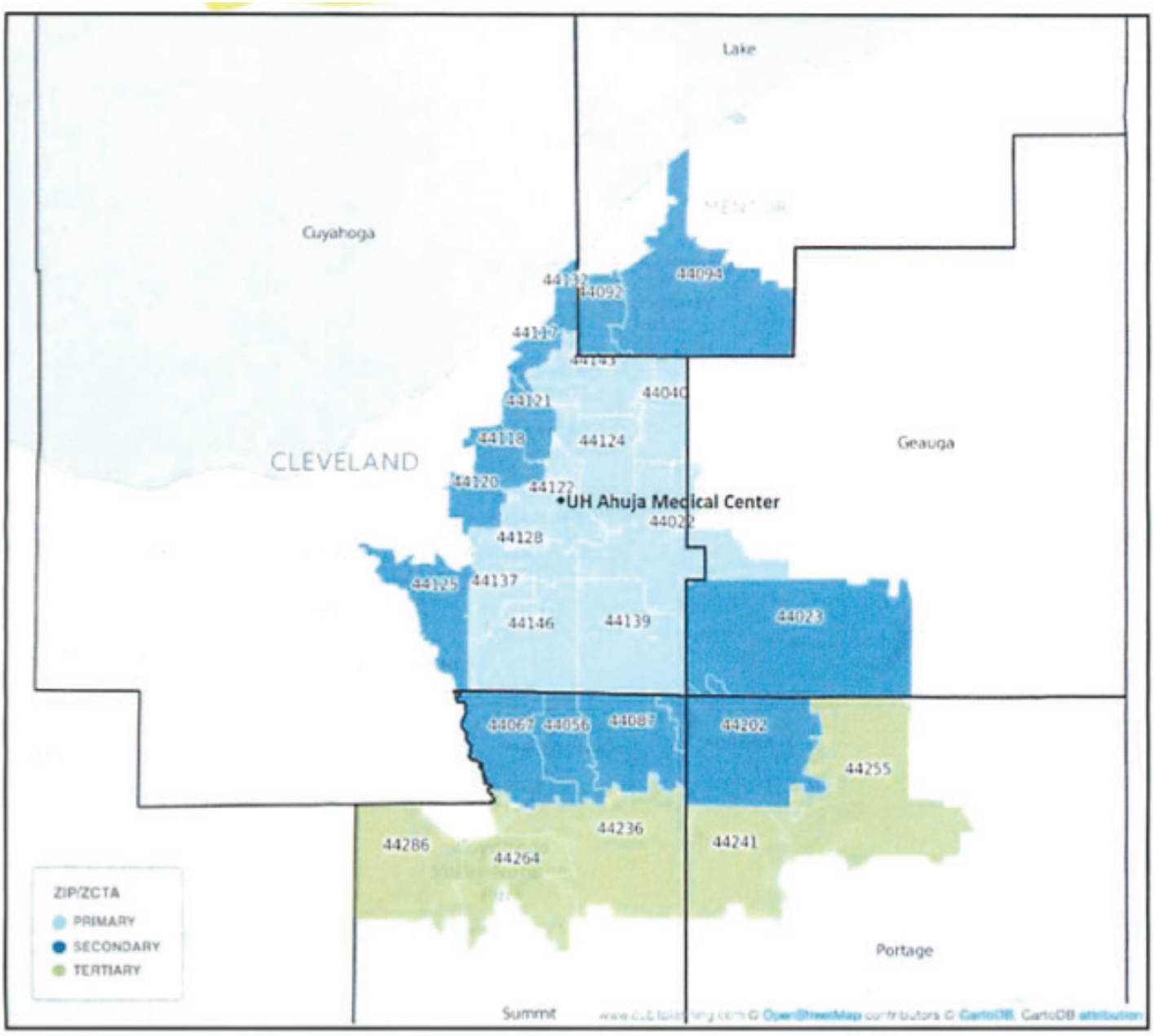


Figure 1 (above) depicts the Hospital's PSA and SSA.

OBSERVATIONS FROM 2015 CHNA (2010 – 2013 DATA)

Key points from CHNA	UH Rehabilitation Hospital Programs in Partnership with UH Ahuja Medical Center Related to the Implementation Strategy
5.7% of adult patients discharged in 2013 had a primary diagnosis of congestive heart failure.	Heart Health Day, Beachwood High School Medical Academy, New Leaf Program; Warrensville Middle School, "Medical Big Tent," Health Matters presentations; quarterly and monthly, healthy cooking demonstrations, Age Well Be Well senior initiatives, Building Life-Saving Communities; Mayors' initiative, screenings and health fairs
32.1% of adult patients discharged in 2013 had a secondary diagnosis of congestive heart failure, which was far more common among older (age 40+) discharges.	Heart Health Day, Beachwood High School Medical Academy, New Leaf Program; Warrensville Middle School, Health Matters presentations; quarterly and monthly, healthy cooking demonstrations, Age Well Be Well senior initiatives, Building Life-Saving Communities; Mayors' initiative, screenings and health fairs
52% of discharged patients had a secondary diagnosis of hypertension.	Heart Disease strategies to address this health condition through the strategies listed above.
29.8% of discharged patients were diabetic. The diabetes mortality rate in Cuyahoga County is higher than average when compared to peer counties.	Expansion of accredited Diabetes Center "Medical Big Tent," one-on-one nutrition counseling and diabetes education classes, annual Diabetes Health Fair to include A1C screening
26.4% of those hospitalized at UH Rehabilitation Hospital in 2013 were obese or morbidly obese which is often a component of chronic disease.	Often linked to diabetes, heart disease and respiratory disease, obesity will be addressed through the strategies listed above.
	Smoothies for Seniors program will be a partnership with Ohio Dept. of Aging. To enhance overall health, provide access to Primary Care physicians that will order/instruct on diet and lifestyle changes.

Additional observations from the 2015 CHNA:

- In 2013, 22.7% of discharges were Ambulatory Care Sensitive ("ACS") cases with three primary diagnoses: congestive heart failure (5.7%), bacterial pneumonia (4.8%) and chronic obstructive pulmonary disease (2.2%). ACS cases are those that are presumed to be avoidable if patients receive high-quality primary care. A high proportion of ACS cases in a community signal a shortage of adequate primary care providers.
- Cuyahoga and Summit counties, like their neighboring counties, are growing older, on average. In 2013, the proportion of senior citizens increased by 0.4 percentage points in Cuyahoga County and 0.9 percentage points in Summit County. Given that the use of health care increases substantially with age, especially after age 65, the aging of the population will have significant impact on the demand for health care in regions where the proportion of older citizens is increasing.
- UH Rehabilitation Hospital's market area is becoming more racially diverse. Cuyahoga County is majority White, but the percentage of the population that is White decreased by 1% from 2010 to 2013. Black is the dominant minority race in Cuyahoga County (29.7% of the total population). Summit County is also majority White, but that majority percentage decreased by 0.8% from 2010 to 2013.
- Poverty levels in the Hospital's market area are increasing. The average (median) income decreased by 4.6% in Cuyahoga County and 2% in Summit County from 2010 to 2013.
- Of all discharges in 2013, 73% were Medicare patients and 9% were Medicaid patients.

PRIORITY HEALTH NEEDS IDENTIFIED IN CHNA

Health Disparities: Aging Population, Unemployment, Poverty

Access Barriers: Cost of Care, Lack of Primary Care Providers, Access to Transportation

Lifestyle Barriers: Obesity, Substance abuse (drug/alcohol/tobacco), Violence

Chronic Disease Conditions: Heart Disease, Respiratory Diseases, Diabetes, Alzheimer's, Cancer and Mental illness

Poor health status can result if a complex interaction of challenging social, economic, environmental and behavioral factors, combined with a lack of access to care, is present. Addressing the more common "root" causes of poor community health can serve to improve a community's quality of life and to reduce mortality and morbidity. This team decided to select two chronic disease conditions as the hospital's primary priorities for this CHNA implementation plan of 2016 – 2018.

1. Diabetes
2. Cardiovascular disease

The following table describes the community health needs identified through the 2015 CHNA as priorities. Those needs that the Hospital plans to proactively address during 2016 through 2018 and it will conduct these implementation plans in this document jointly with UH Ahuja Medical Center. However, the UH Rehabilitation Hospital in collaboration with UH Ahuja Medical Center will continue to offer several programs, either alone or in collaboration with others, which address numerous community health needs. Those are also briefly described below.

Identified Needs	Plan To Address
HEALTH DISPARITIES	
Aging Population	No
High Rate of Poverty	No
High Rate of Unemployment	No
Infant Mortality/Premature Births	No
ACCESS BARRIERS	
High Cost of Care	No
Access to Primary Care Providers	No
LIFESTYLE BARRIERS	
Obesity	No
Substance Abuse (tobacco, drugs, alcohol)	No
Violence	No
CHRONIC DISEASE CONDITIONS	
Cardiovascular Disease	Yes
Respiratory Diseases	No
Diabetes	Yes
Kidney Disease	No
Alzheimer's	No
Gonorrhea	No
Mental Health	No
– Older Adult Depression	No
– Mental Illness	No

IMPLEMENTATION STRATEGIES: 2016 THROUGH 2018.

To address the following significant health needs: Heart Disease and Diabetes

The Hospital, through its Mission, has a strong tradition of meeting community health needs through its provision of ongoing community benefit programs and services. The Hospital will continue this commitment through the strategic initiatives set forth below that focus primarily on high-priority health needs.

Goals & Objectives

UH Rehabilitation Hospital's efforts on two priority health issues will have the following overall long-term goals:

- Increased community member knowledge and understanding of these chronic conditions
- Increased awareness levels of local services available to help them avoid or treat these conditions
- Increased detection of disease in participants that may not have been identified without the screening programs
- Reduced readmission and mortality due to chronic disease

Likewise, all of the programs aimed at the two priority health issues will share the following objectives:

- All plans have the overarching goal of serving a disease-specific population – a group that is susceptible to chronic disease due to lack of health education, lack of access to care and financial considerations
- Encourage compliance by making expert care available close to home
- Encourage compliance by increasing awareness of available medical and community resources and financial counseling services, to make care affordable for those with financial limitations
- Develop relationships with community physicians, the UH Primary Care Institute physicians, extended care facilities, community and faith-based nonprofit organizations and public health departments to extend care management, community outreach and health education services into the community
- Establish tracking mechanisms and metric goals for those individuals in the community who participate in our various programs to ensure programs are helping us reach our goals
- Monitor ongoing progress of all programming and implementation strategies

UH Rehabilitation Hospital will partner with UH Ahuja Medical Center in their launch of the "Medical Big Tent" (Figure 2 below) in 2016 to serve chronic disease populations. UH Rehabilitation Hospital will provide funding and staff support to this UH Ahuja Medical Center program. The Tent will address two primary chronic diseases stated in our CHNA 2015: Cardiovascular and Diabetes diseases. Under the Tent will offer all the community, social, disease-specific, medical and self-help resources a patient or member of this population will need to enhance their knowledge on how to best manage their chronic disease. A full-day event will offer a comprehensive evaluation of their disease and resource needs. They will work with the clinicians to create an individualized Care plan to manage their disease.

The overall goal of the Medical Big Tent is to eliminate fragmentation of service delivery that can interfere with the development of and compliance with a comprehensive plan to manage the disease.

FIGURE 2: "MEDICAL BIG TENT" MODEL FOR COORDINATED CHRONIC CARE

EDUCATION & SELF CARE	OUTREACH & NETWORKING	MEDICAL CARE	SUPPORT
SUPPORT GROUPS & ASSOCIATIONS	PRIMARY CARE PROVIDERS	PRIMARY CARE	DISEASE SPECIFIC ORGANIZATIONS
PRIMARY CARE PROVIDERS	EMERGENCY ROOMS	SPECIALIST REFERRALS	HOME CARE
HOSPITALS	HEALTH CLINICS/CENTERS	MEDICAL HOME	SENIOR CENTERS
CARE MANAGEMENT	COMMUNITY GROUPS	COMMUNITY BENEFIT	INSURANCE RESOURCES
			COUNTY/CITY PROGRAMS

Cardiovascular Disease

Actions:

- Education through monthly educational seminars (Health Matters).
- Host and/or participate in regular health fairs with a focus on heart health.
- Expand screening programs including Coronary Artery Disease risk assessments.
- Increase community awareness of services available and local physician specialists.
- Increase education on CPR/AED to community, employers and high school seniors (3,000 individuals trained in 2015).
- Annual Family Health & Safety Day to offer comprehensive screenings related to heart health.
- Participation in system annual Heart Day events.
- Creating a "Medical Big Tent."

Evaluated Outcomes:

- Decreased hospitalization rates and length-of-stay for hospitalizations of those with cardiovascular disease (as measured by inpatient data).
- Proportion of discharged patients with a referral to a specialist.
- Steadily increasing participation rates for community members in outreach programs, especially by those who are at risk (lower socioeconomic status, previously hospitalized patients, those with the high priority chronic diseases).

Diabetes

Actions:

- Education through monthly educational seminars (Health Matters).
- Continue to promote the accredited Diabetes Center, which offers blood sugar monitoring and annual screenings; access to education classes specific to diabetes; one-on-one support and counseling; and access to dietitians, pharmacists and physician specialists.
- Host an annual "Medical Big Tent," with A1C glucose testing, physician presentations, nutrition counseling and community resource specialist to combat diabetes.
- Annual Family Health & Safety Day to offer comprehensive screenings related to diabetes.

Evaluated Outcomes:

- Decreased hospitalization rates and length-of-stay for hospitalizations of those with diabetes (as measured by inpatient data). This would be achieved through improved compliance and disease self-management of diabetic patients (which are numerous – approximately 10% of the adult population has diabetes).
- Proportion of discharged patients with a referral to a specialist.
- Steadily increasing participation rates for community members in outreach programs, especially by those who are at risk (lower socioeconomic status, previously hospitalized patients, those with the high priority chronic diseases).

Commitment of programs and resources:

- UH Rehabilitation Hospital is committed to providing the financial support and staff needed to partner with UH Ahuja Medical Center in executing this strategy.
  - "Medical Big Tent" to be established. Post-discharge care is vital to disease management.
  - Education and support groups will be formed to provide ongoing education and support in an effort to enhance overall health and decrease unnecessary hospital readmissions.
  - Improve access to care: Provide access to health care services for those who cannot afford care through the UH Hospital Financial Assistance Program.

Who will UH Rehabilitation Hospital collaborate with to ensure success:

- UH Institutes
- UH Center for Lifelong Health (Age Well Be Well members is an independent network of facilities that support seniors in UH Rehabilitation Hospital's primary and secondary markets)
- Local and civic leaders in the community
- EMS Institute and Providers
- Cuyahoga County Board of Health
- American Diabetes Association
- American Heart Association
- American Cancer Society
- American Red Cross
- Ohio Department of Aging

WHY HOSPITAL IS NOT ADDRESSING A SIGNIFICANT HEALTH NEED

No hospital facility can address all of the health needs present in its community to the fullest. The Hospital is committed to adhering to its Mission and remaining financially healthy so that it can continue to enhance its clinical, teaching and research activities and to provide a wide range of community benefits. The Strategy utilizes community resources to meet several community health needs address. It is with that collaboration that needs can be met.

Identified Needs	Reason Issue is Not Being Addressed
HEALTH DISPARITIES	
Aging Population	No, due to the presence and effort of other facilities and organizations that address this need
High Rate of Poverty	No, due to lack of expertise and the presence and effort of other organizations who focus on this need
High Rate of Unemployment	No, due lack of expertise and the presence and effort of others who focus on this need
Infant Mortality/Premature Births	No, due to lack of expertise
ACCESS BARRIERS	
High Cost of Care	No, due to presence and effort of others who address this need; however the hospital provides a financial assistance policy to provide free or reduced cost care to those who qualify and are unable to pay their bills
Access to Primary Care Providers	No, due to the presence and effort of others who address this need
LIFESTYLE BARRIERS	
Obesity	No, due to presence and effort of others who address this need
Substance Abuse (tobacco, drugs, alcohol)	No, due to lack of expertise

Violence	No, due to lack of expertise
Health Disparities	**Will The Health Need be Addressed?**
CHRONIC DISEASE CONDITIONS	
Cardiovascular Disease	Yes, as outlined above
Respiratory Diseases	No, due to lack of expertise
Diabetes	Yes, as outlined above
Kidney Disease	No, due to lack of expertise
Alzheimer's	No, due to lack of expertise
Gonorrhea	No, due to lack of expertise
Mental Health	No, due to lack of expertise
– Older Adult Depression	No, due to lack of expertise
– Mental Illness	No, due to lack of expertise

IMPLEMENTATION STRATEGY COLLABORATORS

- UH Ahuja Medical Center
- Ohio Department on Aging
- Cuyahoga County Department of Job and Family Services
- Cuyahoga County Board of Health
- Bellefaire JC
- Warrensville Heights YMCA
- American Diabetes Association
- Diabetes Partnership of Cleveland
- American Heart Association
- Cuyahoga County Health Care Council/Joint Advisory Committee
- Health Improvement partnership – Cuyahoga Universal Health Care Action Network
- Local Municipalities in the primary service area
- Local schools, libraries and community centers in the primary service area