University Hospitals

2026-2028 UNIVERSITY HOSPITALS

# COMMUNITY HEALTH IMPLEMENTATION STRATEGY

Cuyahoga County

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**UH Ahuja Medical Center**
**UH Beachwood Medical Center**
**Beachwood RH, LLC (UH Rehabilitation Hospital)**
**UH Cleveland Medical Center**
**UH Parma Medical Center**
**UH Rainbow Babies & Children's Hospital**
**UH St. John Medical Center**

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## BOARD ADOPTION

University Hospitals adopted the 2026-2028 Community Health Implementation Strategy on March 19, 2026.

It includes the following UH facilities located in Cuyahoga County, collectively referred to in this report as the "Hospitals":

- University Hospitals Ahuja Medical Center
- University Hospitals Beachwood Medical Center
- Beachwood RH, LLC (UH Rehabilitation Hospital)
- University Hospitals Cleveland Medical Center
- The Parma Community General Hospital Association d/b/a University Hospitals Parma Medical Center
- University Hospitals Rainbow Babies & Children's Hospital
- University Hospitals St. John Medical Center

## COMMUNITY HEALTH IMPLEMENTATION STRATEGY AVAILABILITY

The Implementation Strategy can be found on University Hospitals' website at www.UHhospitals.org/CHNA-IS or a hard copy can be mailed upon request at CommunityBenefit@UHhospitals.org.

## WRITTEN COMMENTS

Individuals are encouraged to submit written comments, questions or other feedback about this Implementation Strategy to CommunityBenefit@UHhospitals.org. Please make sure to include the name of the UH facility that you are commenting about and, if possible, a reference to the appropriate section within the Implementation Strategy.

# HOSPITAL MISSION STATEMENT

As wholly owned subsidiaries of University Hospitals, the Hospitals are committed to supporting the UH mission, "To Heal. To Teach. To Discover." by providing a wide range of community benefits including clinical services, community health improvement programs, medical education and research. UH is an integrated delivery system and thus can provide benefits by coordinating within and among various entities.

* Beachwood RH, LLC (UH Rehabilitation Hospital) is a joint venture between University Hospitals and Kindred Healthcare Corporation. Its mission is to promote healing, provide hope, preserve dignity and produce value for each patient, family member, customer and employee they serve.

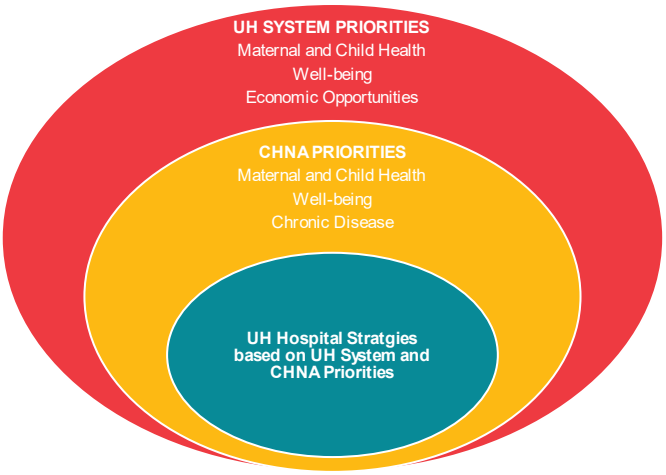
# INTRODUCTION

University Hospitals (UH) presents the 2026–2028 Implementation Strategy (IS) for Cuyahoga County developed in response to the 2025 Community Health Needs Assessment (CHNA) University Hospitals Ahuja Medical Center, University Hospitals Beachwood Medical Center, Beachwood RH, LLC (UH Rehabilitation Hospital), University Hospitals Cleveland Medical Center, The Parma Community General Hospital Association d/b/a University Hospitals Parma Medical Center, University Hospitals Rainbow Babies & Children's Hospital, and University Hospitals St. John Medical Center, (the "Hospitals") conducted a community health needs assessments (a "CHNA") compliant with the requirements of Treas. Reg. §1.501(r) ("Section 501(r)") and Ohio Revised Code ("ORC") 3701.981. The 2025 Cuyahoga County CHNA served as the foundation for developing University Hospital's Implementation Strategy ("IS") to address those needs that, (a) the Hospitals determine they are able to meet in whole or in part; (b) are otherwise part of UH's mission; and (c) are not met (or are not adequately met) by other programs and services in the county. The IS identifies the means through which the Hospitals plan to address a number of the needs that are consistent with UH's charitable mission as part of its community benefit programs. Together the CHNA and IS serve to align hospital resources and activities to address health needs identified in the CHNA.

Likewise, the Hospitals are addressing some of these needs simply by providing care to all, regardless of ability to pay, every day. They anticipate that the strategies may change and therefore, a flexible approach is best suited for the development of its response to the 2025 Cuyahoga County CHNA.

The purpose of this Implementation Strategy is to describe how UH will address the priority health needs identified through the 2025 CHNA. These priorities include Chronic Disease, Maternal and Child Health, and Well-being. To support coordinated planning and alignment with UH strategic priorities, the CHNA findings are organized under UH's Community Health Investment (CHI) Strategy priority areas: Maternal and Child Health, Well-being, and Economic Opportunity as seen in Figure 1.

Figure 1. UH Priorities Alignment




This IS outlines the goals, objectives, and strategies that UH hospitals will implement, both independently and in collaboration with community partners, to address these priority health needs. The strategies were developed through a series of virtual planning workshops involving UH staff.

The strategies outlined in this IS are designed to leverage existing community resources, strengthen cross-sector partnerships, and guide UH's community health improvement efforts from 2026 through 2028.

# ALIGNMENT WITH LOCAL AND STATE STANDARDS

Ohio law requires local health departments (LHDs) and tax-exempt hospitals to submit their Community Health Improvement Plans and Implementation Strategy reports to the Ohio Department of Health (the department). As of January 1, 2020, Ohio law also requires LHDs and tax-exempt hospitals to complete assessments and plans "in alignment on a three-year interval established by the department."

While the Ohio Revised Code does not mandate alignment with specific state-level assessments or plans, the department encourages consistency with the Ohio State Health Assessment (SHA) and the Ohio State Health Improvement Plan (SHIP) to promote coordinated public health priorities across the state. As a result, many communities choose to align their CHNA and Implementation Strategy timelines, indicators, and strategies with those of their local health departments and with broader statewide goals.

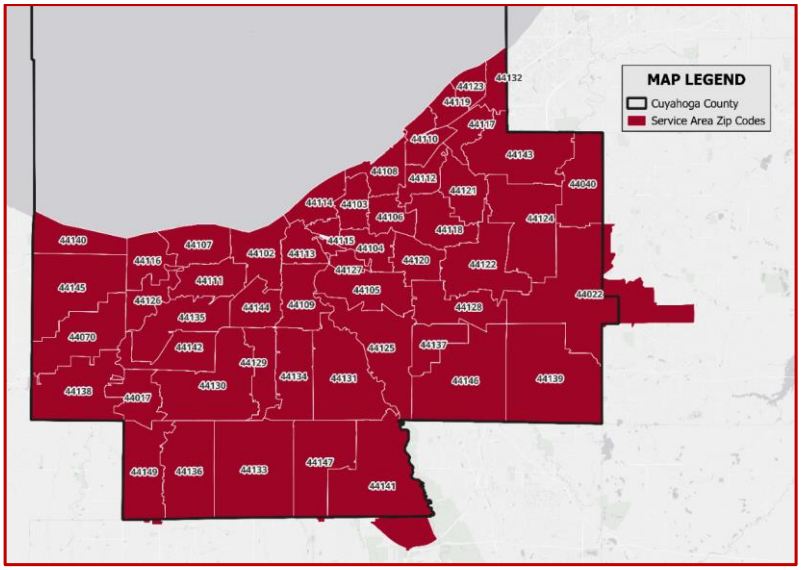
University Hospitals meets these expectations by coordinating its CHNA process with local health departments within its service area and by submitting its CHNAs and Implementation Strategies to the Ohio Department of Health in accordance with state requirements. UH's CHNAs and Implementation Strategies also maintain broad alignment with the priorities and focus areas outlined in the SHA and SHIP, supporting consistency between local needs and statewide health improvement efforts.

Recently, the local health department completed its Community Health Needs Assessment (CHNA) and is now developing its Community Health Improvement Plan (CHIP). UH will review the priorities, strategies, and indicators identified in the local CHIP and, where appropriate, align its Implementation Strategies to support and advance shared community health goals.

# COMMUNITY DEFINITION

The service area for University Hospitals (UH) implementation strategies is in Cuyahoga County, Ohio, outline 51 zip codes, as shown in red on the map in Figure 2. This service area includes an estimated population of 1,228,231 residents, whose health needs and outcomes are the focus of this Implementation Strategy.

Figure 2. UH Service Area




Clearly defining the service area establishes the geographic scope of the IS and supports a coordinated, comprehensive approach to addressing identified community health priorities across Cuyahoga County.

Additional details describing the Cuyahoga County community, including demographics and social and economic determinants of health, can be found in the CHNA report on the UH website at: [uhhospitals.org/CHNA-IS](uhhospitals.org/CHNA-IS).

# 2025 CUYAHOGA COMMUNITY HEALTH NEEDS ASSESSMENT FINDINGS

University Hospitals (UH) conducted its 2025 Community Health Needs Assessment (CHNA) between January and July 2025 to identify and prioritize the most significant health needs in the community. The CHNA was designed to guide planning and inform community health improvement efforts.

The assessment was conducted by Conduent Healthy Communities Institute (HCI) using both primary and secondary data. Secondary data included community health indicators from state and national sources, while primary data were collected through key informant interviews with community stakeholders. All data were analyzed using standardized methods, and findings were organized by health topic. Results from both data sources were combined to identify the community's most significant health needs.

A health need was considered significant if it had a secondary data score of 1.50 or higher or was frequently discussed during key informant interviews. Based on these criteria, ten health needs were identified and advanced for prioritization. On June 5, 2025, Conduent HCI facilitated a virtual data synthesis and prioritization session with 21 participants representing UH hospital systems. During the session, participants reviewed the CHNA findings and scored each health need using an online tool.

Following the prioritization process, the UH CHNA Steering Committee reviewed the results and selected three priority health areas for inclusion in the Implementation Strategy: Chronic Disease, Maternal and Child Health, and Well-being.

**CHNA Priority Area 1: Chronic Disease**

**CHNA Priority Area 2: Maternal and Child Health**

**CHNA Priority Area 3: Well-being**

Although cancer was not identified as a prioritized health need in the overall assessment, it remains a key focus for the Seidman Cancer Center and will continue to be a priority. Cancer care will also be integrated into the focus on the priority population of older adults.

For more information on the CHNA findings and the identification of significant health needs, please refer to the 2025 CHNA report at: uhhospitals.org/CHNA-IS.

# 2026-2028 IMPLEMENTATION STRATEGY OVERVIEW

This section presents the strategies, objectives, and activities that University Hospitals (UH) hospitals intend to deliver, support, or collaborate on to address significant, prioritized community health needs over the next three years. Planned actions are aligned with current community needs as well as UH's mission, vision, and strategic initiatives. The plan may be amended as circumstances change, including shifts in community needs or available resources.

## Implementation Strategy Planning Process

The University Hospitals (UH) Implementation Strategy (IS) planning process began with a Kick-Off on September 16, 2025, and continued through a series of virtual workshops until Feb 2026. Participants included hospital staff with expertise in community needs and services for each priority area.

Conduent Healthy Communities Institute (HCI) facilitated the workshops. During the first virtual session, HCI guided participants in reviewing CHNA findings and identifying:

- Desired changes based on CHNA results to inform goals and community-level indicators
- Potential actions to shape strategies

Following the initial workshop, virtual follow-up sessions were held to refine draft overarching goals, community-level indicators, and implementation plans for each priority area. Collaborative tools, including Google Slides and shared Google documents, supported interactive planning and engagement.

The resulting work plans outline strategies for each hospital focusing on the selected priority areas, including:

1. Broad overarching goals and community-level indicators to track long-term progress
2. Strategies with measurable short-term objectives
3. Specific activities, timelines, and responsible teams or individuals

Work plans will be reviewed and updated to reflect evolving community needs, available resources, and ongoing activities.

The number one priority for UH Community Health Investment for 2026–2029 and beyond is the UH Medicaid Enrollment Optimization Program (MEOP). This focus is driven by anticipated federal changes under the One Big Beautiful Bill Act (HR1), which will significantly tighten Medicaid eligibility requirements for adults in the Medicaid

expansion group (ages 19–64) beginning January 1, 2027. Key provisions include requiring 80 hours per month of work, volunteering, or schooling; more frequent eligibility redeterminations every six months instead of annually; and shortening retroactive eligibility from three months to two months. With more than 774,000 Ohioans currently enrolled in Medicaid expansion, these shifts are expected to increase the risk of coverage loss. While UH is still working through final systemwide MEOP strategies, we expect to adjust and refine approaches to meet these changing conditions. Many of our existing strategies will also be leveraged to educate the community, strengthen connections to coverage, and proactively identify individuals at risk of becoming uninsured or disenrolled through socio-medical touchpoints. This implementation plan includes a Medicaid enrollment strategy that operates at the system level but will be operationalized and supported across our hospitals. (see page X for the MEOP strategy).

Commented [MP1]: Change Strategies to Address health needs to Implementation strategies

# STRATEGIES TO ADDRESS HEALTH NEEDS


**System Wide Initiative**

# MEDICAID ENROLMENT OPTIMIZATION PROGRAM: SYSTEM-WIDE INITIATIVE

University Hospitals is implementing the Medicaid Enrollment Optimization Program (MEOP) as a system-wide initiative to help eligible individuals maintain and attain coverage and to ensure our hospitals and community partners are ready for forthcoming policy changes. While MEOP will touch every part of UH, early operational focus is concentrated at UH locations within Cuyahoga, Lorain, Lake, and Portage counties where high utilization and risk are especially high. Piloting at sites within these communities will allow rapid learning and scaling across the system. As part of this effort, UH will work closely with community-based organizations, government partners, managed care entities, and other health systems to develop shared strategies, aligned workflows, and coordinated communication plans that support consistent messaging and maximize impact across the region.

## Why coverage matters across CHNA priorities

Consistent health insurance coverage is a foundational component supporting all priority areas identified across UH Community Health Needs Assessments. Reliable access to coverage plays a critical role in ensuring that individuals and families can obtain the care and resources they need. Strengthening these connections aligns with UH's Community Health Investment framework particularly the Economic Opportunity priority, as insurance coverage is a critical gateway to financial stability, reduced medical debt, and improved access to preventive and ongoing care.

Medicaid Enrollment Optimization will serve as a shared systemwide goal and will be reflected across implementation plans throughout the UH footprint. This marks the first time a systemwide strategy has been integrated into implementation plan development. While the full program design is still in progress, planning efforts are underway, and updates will be incorporated as the implementation plan evolves.

## What's at stake if people lose Medicaid

Forthcoming federal and state changes—work requirements, shorter redetermination intervals, and other eligibility and cost-sharing shifts could increase churn among expansion adults and other populations. Loss of coverage threatens continuity of care, produces avoidable coverage gaps, and increases the likelihood that patients re-enter the system through higher-acuity, higher-cost settings.

For hospitals, these shifts can lead to rising uncompensated care, operational strain, and worsened outcomes, which in extreme cases could affect the viability of departments or facilities due to unsustainable reimbursement levels. For communities, coverage loss widens inequities and destabilizes families.

## Our approach

MEOP mobilizes cross-functional workstreams—education, communications, operational workflow, government & community outreach, and data—to build a repeatable, scalable model for enrollment and re-enrollment. The program roadmap moves from discovery and solution design to pilot and scale, so that by **January 2027,** UH and partners have a tested workflow embedded in operations across priority hospitals and community settings. This approach reflects the program's OKRs and phased timeline already socialized with stakeholder.

# SYSTEM WIDE INITIATIVE

| UH Community Health Investment (CHI) Priority Area: Economic Opportunities |
|---|
| **CHNA Priority Area: Overarching Strategy** |
| **Hospital: Systemwide Strategy** |
| **Goal:** Improve access to and continuity of Medicaid coverage by optimizing enrolment, re-enrolment, and redetermination workflows across UH and community settings. |
| **Community-Level Indicators to track long-term outcomes:**<br>• Medicaid enrolment and retention rates<br>• Reduction in uninsured ED utilization<br>• Reduction in coverage gaps (churn)<br>• Increased patient awareness of Medicaid requirements |
| **Strategy 1:** Implement a system-wide Medicaid Enrolment Optimization Program that integrates education, workflow standardization, data analytics, and community partnerships. |
| **Objective 1:** By January 2027, deploy a scalable MEOP workflow across priority UH sites and community settings to support eligible individuals in maintaining or attaining Medicaid coverage. |

| Activities | Measures | Year 1 | Year 2 | Year 3 |
|---|---|---|---|---|
| Develop standardized Medicaid education materials and scripts. | Materials developed and deployed | X | | |
| Map and standardize Medicaid enrolment workflows. | Workflow documented and implemented | X | X | |
| Launch MEOP pilot at priority UH hospitals and community sites. | Number of pilot sites | X | X | |
| Train caregivers and community partners. | Number trained | X | X | X |

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| Scale MEOP system wide. | Sites expanded | | X | X |
| Host/participate in community outreach events in priority locations. | Number of events | X | X | X |
| Patients connected to UH or partner organizations for work requirements | Number of patients | | X | X |

University Hospitals
Ahuja Medical Center

**Implementation Strategy**

# UH AHUJA MEDICAL CENTER

| UH Community Health Investment (CHI) Priority Area: Well-being | | | | | |
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| **CHNA Priority Area: Well-being** | | | | | |
| **Hospital: UH Ahuja Medical Center** | | | | | |
| **Goal:** To improve community well-being by increasing access to healthy, affordable food and promoting nutrition education that empowers residents to prepare more home-cooked meals and achieve greater food security. | | | | | |
| **Community-Level Indicators to track long-term outcomes:**<br>• Obesity: Medicare Population<br>• High Blood Pressure Prevalence | | | | | |
| **Strategy 1:** Provide Community-Based Nutrition and Healthy Lifestyle Education. | | | | | |
| **Objective 1:** By December 2028, increase the number of community-based health and nutrition initiatives offered to Cuyahoga County residents by 10%. | | | | | |
| **Measure:** Number of healthy habit initiatives provided per year | | | | | |
| **Activities** | **Measures** | **Collaborators** | **Year 1** | **Year 2** | **Year 3** |
| Conduct at least ten health and wellness presentations per year to educate community members on nutrition, physical activity, and chronic disease prevention. | Total number of health and wellness presentations conducted | Ahuja Outreach Team | X | X | X |
| Organize walking clubs year-round to promote physical activity, social | Total number of walking sessions conducted | Ahuja Outreach Team | X | X | X |

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| connection, and overall well-being. | | | | | |
| Implement a Summer Lunch Program each summer to provide a minimum of 300 nutritious meals to children | Total number of meals served each summer | Ahuja Outreach Team | X | X | X |

| UH Community Health Investment (CHI) Priority Area: Well-being |
|---|
| **CHNA Priority Area: Chronic Disease** |
| **Hospital: UH Ahuja Medical Center** |
| **Goal:** To strengthen community capacity to prevent and manage chronic diseases by promoting identification of risk factors, increasing access to high-quality care, and improving continuity of care through coordinated community and clinical partnerships. |
| **Community-Level Indicators to track long-term outcomes:**<br>• High Blood Pressure Prevalence<br>• Chronic Kidney Disease: Medicare Population<br>• Stroke: Medicare Population<br>• Adults 20+ with Diabetes |
| **Strategy 1:** Enhance Internal Collaboration to Support Community Resources |
| **Objective 1:** By December 2028, increase the number of collaborative internal events that connect University Hospitals' clinical departments with community members in Cuyahoga County by 10%. |
| **Measure: Total** number of internal collaborative events conducted |

| Activities | Process Measures | Collaborators | Year 1 | Year 2 | Year 3 |
|---|---|---|---|---|---|
| Partner with the neuro institute in organizing two events per year to provide stroke-prevention education, brain health resources, and risk-factor screenings at community events. | Total number of events | Ahuja Outreach Team | X | X | X |

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| Partner with HHVI (Harrington Heart and Vascular Institute) to organize two events per year to deliver cardiovascular health education and screening opportunities focused on blood pressure and cholesterol. | Total number of events | Ahuja Outreach Team | X | X | X |
| Partner with the Cutler Center for Men in organizing two events per year to promote men's health awareness and preventive screenings. | Total number of events | Ahuja Outreach Team | X | X | X |
| Partner with the UH Emergency Medical Services Institute (EMSI) in organizing two events per year to provide CPR training and emergency preparedness education. | Total number of events | Ahuja Outreach Team | X | X | X |
| Partner with UH Women's Health in organizing two events per year to promote preventive screenings and wellness education for women. | Total number of events | Ahuja Outreach Team | X | X | X |
| Partner with a Diabetes Educator in organizing one event per year to provide diabetes prevention and | Total number of events | Ahuja Outreach Team | X | X | X |

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| management education to community members. | | | | | |
| **Strategy 2:** Maintain and Expand Community Screening and Education Programs | | | | | |
| **Objective 1:** By December 2028, increase the number of residents screened for chronic disease risk factors in Cuyahoga County by 10%. | | | | | |
| **Measure:** Total number of individuals screened annually | | | | | |
| **Activities** | **Process Measures** | **Collaborators** | **Year 1** | **Year 2** | **Year 3** |
| Conduct two community blood pressure screening events per month throughout the year to identify individuals at risk for hypertension. | Total number of blood pressure screening sessions conducted | Ahuja Outreach Team | X | X | X |
| Conduct ten cholesterol screening events per year to promote heart health awareness. | Total number of cholesterol screening events conducted | Ahuja Outreach Team | X | X | X |
| Conduct ten blood glucose screening events per year to identify individuals at risk for diabetes. | Total number of glucose screenings | Ahuja Outreach Team | X | X | X |
| Conduct five CPR training sessions per year. | Total number of events | Ahuja Outreach Team | X | X | X |

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| Partner with the Cutler Center for Men in organizing one event per year to provide PSA (Prostate Cancer) screenings. | Total number of events | Ahuja Outreach Team | X | X | X |
| Conduct ten health and wellness presentations per year. | Total number of health and wellness presentations conducted | Ahuja Outreach Team | X | X | X |
| Partner with UH Women's Health in organizing one event per year to provide mammogram screenings | Total number of mammogram screening events conducted | Ahuja Outreach Team | X | X | X |
| **Strategy 3: Enhance Collaboration with Community Organizations** | | | | | |
| **Objective 1:** By December 2028, increase the number of collaborative community health events co-hosted with local organizations in Cuyahoga County by 10%. | | | | | |
| **Measure:** Total number of community partnership events conducted | | | | | |
| **Activities** | **Process Measure** | **Collaborators** | **Year 1** | **Year 2** | **Year 3** |
| Partner with local fire departments in organizing four events per year to provide community health and safety education. | Total number of fire department partnership events | Ahuja Outreach Team | X | X | X |

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| Partner with senior and recreation centers in organizing ten events per year | Total number of senior/recreation center events conducted | Ahuja Outreach Team | X | X | X |
| Partner with local schools to organize five events per year. | Total number of school-based events conducted | Ahuja Outreach Team | X | X | X |
| Partner with local police departments in organizing four events per year. | Total number of police department partnership events held. | Ahuja Outreach Team | X | X | X |
| Partner with local churches and faith-based organizations in organizing five events per year. | Total number of church-based health events conducted | Ahuja Outreach Team | X | X | X |

# UH AHUJA MEDICAL CENTER: UH COMMUNITY WELLNESS CENTERS AT BEDFORD & RICHMOND

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| **UH Community Health Investment (CHI) Priority Area: Maternal and Child Health** | | | | | |
| **CHNA Priority Area: Maternal and Child Health** | | | | | |
| **Hospital: UH Community Wellness Center at Bedford & Richmond** | | | | | |
| **Goal:** Improve maternal and child health by increasing access to supportive services, education, and community resources for Cuyahoga County community members. | | | | | |
| **Community-Level Indicators to track long-term outcomes:**<br>• Child Food Insecurity Rate<br>• Infant Mortality Rate<br>• Ever Breastfed a New Infant<br>• Chronic Health Condition(s) During Pregnancy<br>• Postpartum Depression | | | | | |
| **Strategy 1:** Expand Wellness Center programming through partnerships with internal stakeholders and local organizations. | | | | | |
| **Objective 1:** By December 2028, increase the number of programs offered at the UH Wellness Center that target maternal and child health topics. | | | | | |
| **Measure:** Total number of programs | | | | | |
| **Activities** | **Process Measures** | **Collaborators** | **Year 1** | **Year 2** | **Year 3** |
| Partner with local organizations to host programs at UH space. (Bedford) | Number of events | Wellness Center Outreach Team | X | X | X |

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| Create new partnerships with local organizations. | Number of partnerships | Wellness Center Outreach Team | X | X | X |
| Provide physician/health talks. (Bedford) | Number of physicians/health talks | Wellness Center Outreach Team | X | X | X |
| **Strategy 2:** Strengthen support for birthing individuals and families by expanding access to perinatal related services, nutrition education, resources, and lactation support. | | | | | |
| **Objective 1:** By December 2028, increase access to maternal and child health resources to Cuyahoga County community members. | | | | | |
| **Measure:** Number of program offerings | | | | | |
| **Activities** | **Process Measures** | **Collaborators** | **Year 1** | **Year 2** | **Year 3** |
| Conduct cooking demos with students. (Bedford) | Number of cooking demos | Wellness Center Outreach Team | X | X | X |

| UH Community Health Investment (CHI) Priority Area: Well-being |
|---|
| **CHNA Priority Area: Well-being & Chronic Disease** |
| **Hospital: UH Community Wellness Center at Bedford & Richmond** |
| **Goal:** Improve overall community well-being and reduce chronic disease risk by expanding access to healthy lifestyle programming, nutrition supports, and preventive services while fostering education, connection, and navigation that empower Cuyahoga County residents to lead healthier, more active lives. |
| **Community-Level Indicators to track long-term outcomes:**<br>• Self-Reported General Health Assessment: Good or Better<br>• Adults who Frequently Cook Meals at Home<br>• Poor Physical Health: Average Number of Days<br>• Obesity: Medicare Population<br>• High Blood Pressure Prevalence<br>• Age-Adjusted Death Rate due to Kidney Disease<br>• Adults 20+ with Diabetes<br>• Chronic Kidney Disease: Medicare Population |
| **Strategy 1:** Expand Access to Whole-Person Wellness (Fitness, Nutrition, and Well-Being Activities). |
| **Objective 1:** By December 2028, increase participation in fitness, nutrition, and wellness programs by 10%. |
| **Measure:** Percentage change increase in programming |

| Activities | Measures | Collaborators | Year 1 | Year 2 | Year 3 |
|---|---|---|---|---|---|
| Collaborate with new internal (UH service lines) and external stakeholders on programming. | Number of new collaborations | Wellness Center Outreach Team | X | X | X |

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| Provide financial literacy education through offering workshops that are facilitated by financial experts for all ages. | Number of workshops on financial literacy | Wellness Center Outreach Team | X | X | X |
| Provide fitness classes. (Bedford) | Number of fitness classes | Wellness Center Outreach Team | X | X | X |
| Offer programming focused on mental wellness. | Number of programs | Wellness Center Outreach Team | X | X | X |
| Provide nutrition-based programming. | • Number of cooking demos<br>• Number of nutrition education programs | Wellness Center Outreach Team/Sodexo | X | X | X |
| Conduct annual holiday distribution giveaway events. | Number of people served through holiday distribution giveaway events | Wellness Center Outreach Team | X | X | X |
| **Strategy 2:** Strengthen Preventive Health and Chronic Disease Management through Screenings, Education, and Navigation. | | | | | |
| **Objective 1:** By December 2028, increase the number of health screenings among the Cuyahoga County population by 10%. | | | | | |
| **Measure:** Total number of health screenings | | | | | |
| **Activities** | **Measures** | **Collaborators** | **Year 1** | **Year 2** | **Year 3** |
| Provide screenings (biometrics) for early | Number of screenings for | Wellness Center Outreach Team | X | X | X |

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|---|---|---|---|---|---|
| disease detection: hypertension, diabetes, and cholesterol. | early disease detection | | | | |
| SDOH screenings. | Number of SDOH screenings | Wellness Center Outreach Team | X | X | X |
| Deliver evidence-based health education programs on chronic diseases such as heart disease, diabetes, and kidney disease, with an emphasis on prevention, early detection, and effective management. | • Number of programs<br>• Number of participants | Wellness Center Outreach Team | X | X | X |

# UH AHUJA MEDICAL CENTER: UH CUTLER CENTER FOR MEN

| **UH Community Health Investment (CHI) Priority Area: Well-being** | | | | | |
|---|---|---|---|---|---|
| **CHNA Priority Area: Chronic Disease & Well-being** | | | | | |
| **Hospital: UH Cutler Center for Men** | | | | | |
| **Goal:** Improve the overall well-being of men in Cuyahoga County by increasing clinical engagement, preventive health behaviors, and access to care, with a targeted focus on men ages 18–40. | | | | | |
| **Community-Level Indicators to track long-term outcomes:**<br>Prostate Cancer Incidence Rate<br>High Blood Pressure Prevalence<br>Adults 20+ with Diabetes<br>Self-Reported General Health Assessment | | | | | |
| **Strategy 1:** Increase engagement, preventive health behaviors, and clinical activation among adult men—particularly ages 18–40—through targeted outreach, health education, and streamlined linkages to UH primary care. | | | | | |
| **Objective 1:** Strengthen and grow UH Cutler Center for Men membership by sustaining enrollment, engaging new and re-engaged patients, and increasing member participation in annual programming. | | | | | |
| **Measure:** Maintain 30% enrollment growth<br>Maintain 10% of members as net-new UH patients<br>Achieve 2% year-over-year enrollment growth for men aged 18–40<br>Ensure 85% of members are established with a primary care provider (PCP) | | | | | |
| **Activities** | **Measures** | **Collaborators** | **Year 1** | **Year 2** | **Year 3** |
| Launch Annual Member Meeting | Event attendance | UH Cutler Team | X | X | X |

| | | | | | |
|---|---|---|---|---|---|
| Connect members to primary care | PCP establishment | UH Cutler Team | X | X | X |
| Engagement through social media | Follower rate<br>Engagement rate<br>Reach | UH Marketing, UH Cutler Team | X | X | X |
| **Strategy 2:** Strengthen and expand community outreach and partnerships to improve men's health and access to care. | | | | | |
| **Objective 2:** Enhance, sustain, and grow community-based outreach and partnerships to increase health education, preventive screenings, and care navigation for men ages 18–40. | | | | | |
| **Measure:** Increase screenings, referrals, navigation encounters, outreach engagement, partner events, and enrollment conversion. | | | | | |
| **Activities** | **Measures** | **Collaborators** | **Year 1** | **Year 2** | **Year 3** |
| Provide preventive screenings and on-site navigation | Number of screenings completed | UH Cutler Outreach Team | X | X | X |
| Connect participants to JOE Team for ongoing care | Number of participants connected to JOE Team | UH Cutler Outreach Team | X | X | X |
| Host annual Men's Full-Life Fitness Summit | Number of participants<br><br>Number of health screenings<br><br>Number of partnerships<br><br>Number of adult Men ages 18-64 engaged | Cuyahoga County Community College, UH Cutler Outreach Team | X | X | X |

| | | | | | |
|---|---|---|---|---|---|
| Expand reach of Cutler Center events | 10% increase in reach<br><br>2% enrollment conversion | UH Cutler Outreach Team | X | X | X |
| Enhance American Red Cross Partnership | Blood drive participation (+2%) | American Red Cross, UH Cutler Outreach Team | X | X | X |
| Participate in American Cancer Society Ambassador Program | Number of participants | American Cancer Society, UH Cutler Outreach Team | X | X | X |
| Plan PSA event | Number of participants<br><br>Number of screenings | UH Seidman Cancer Center, Gathering Place, Bayer, UH Cutler Outreach Team | X | X | X |
| Colorectal Cancer Outreach | Number of individuals engaged | UH Cutler Outreach Team | X | X | X |

University Hospitals
Beachwood Medical Center

**Implementation Strategy**

# UH BEACHWOOD MEDICAL CENTER

| **UH Community Health Investment (CHI) Priority Area: Well-being** | | | | | |
|---|---|---|---|---|---|
| **CHNA Priority Area: Well-being & Chronic Disease** | | | | | |
| **Hospital: University Hospitals Beachwood Medical Center** | | | | | |
| **Goal:** Increase utilization of preventative health biometric screenings and reduce preventable deaths. | | | | | |
| **Community-Level Indicators to track long-term outcomes:**<br>• High Blood Pressure Prevalence<br>• Adults 20+ with Diabetes | | | | | |
| **Strategy 1:** Provide Education and Screening for Chronic Disease. | | | | | |
| **Objective 1:** By December 31, 2028, increase the number of screenings provided. | | | | | |
| **Measure:** Number of screenings conducted number of referrals provided | | | | | |
| **Activities** | **Measures** | **Collaborators** | **Year 1** | **Year 2** | **Year 3** |
| Provide free biometric screenings (blood pressure, cholesterol, glucose) and referrals at community events. | • Number of screenings<br>• Number of referrals | UH Beachwood Community Outreach Team, Cuyahoga County General Health District | x | x | x |

| UH Community Health Investment (CHI) Priority Area: Well-being | | | | | |
|---|---|---|---|---|---|
| **CHNA Priority Area: Well-being** | | | | | |
| **Hospital: University Hospitals Beachwood Medical Center** | | | | | |
| **Goal:** Optimize wellness through improved nutrition and increased physical activity. | | | | | |
| **Community-Level Indicators to track long-term outcomes:**<br>• Self-Reported General Health Assessment: Good or Better<br>• Adults who Frequently Cook Meals at Home<br>• Poor Physical Health: Average Number of Days<br>• Obesity: Medicare Population<br>• High Blood Pressure Prevalence | | | | | |
| **Strategy 1:** Provide Nutrition and Wellness Education. | | | | | |
| **Objective 1:** By December 31, 2028, increase the number of residents educated about nutrition and exercise by 10%. | | | | | |
| **Measure:** Number of educational opportunities, number of participants | | | | | |
| **Activities** | **Measures** | **Collaborators** | **Year 1** | **Year 2** | **Year 3** |
| Provide nutritional education, including cooking demonstrations. | • Number of educational opportunities<br>• Number of participants | UH Beachwood Community Outreach, Food Pantries | x | x | x |
| Partner with corporations to provide educational grocery store tours. | Numbers of participants in tours | UH Beachwood Community Outreach, Grocery Stores | x | x | x |
| Provide referrals for dietary consultations. | Number of referrals | UH Beachwood Community Outreach | x | x | x |

| | | | | | |
|---|---|---|---|---|---|
| Explore opportunities to provide referrals to UH Community Health Workers. | Number of referrals by year 3 | UH Beachwood Community Outreach, | | | x |
| Host wellness-focused events, including orthopedic education related to exercise. | • Number of events<br>• Number of participants | UH Beachwood Community Outreach, | x | x | x |

University Hospitals
Rehabilitation Hospital

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**Implementation Strategy**

# UH REHABILITATION HOSPITAL

| UH Community Health Investment (CHI) Priority Area: Well-being | | | | | |
|---|---|---|---|---|---|
| **CHNA Priority Area: Chronic Disease** | | | | | |
| **Hospital: UH Rehabilitation Hospital** | | | | | |
| **Goal:** Improve the well-being of adults in Cuyahoga County through disease prevention and management, with a particular focus on individuals affected by stroke. | | | | | |
| **Community-Level Indicators to track long-term outcomes:**<br>Stroke: Medicare Population<br>Age-Adjusted Death Rate due to Cerebrovascular Disease (Stroke)<br>High Blood Pressure Prevalence | | | | | |
| **Strategy 1: Increase access to information related to stroke prevention, management, and support** | | | | | |
| **Objective 1: By December 2028, increase participation in stroke-related education, support, and navigation services among adults.** | | | | | |
| **Measure:** Number of people engaged | | | | | |
| **Activities** | **Measures** | **Collaborators** | **Year 1** | **Year 2** | **Year 3** |
| Stroke Support Groups (stroke survivors and caregivers) | Number of participants<br>Number of events | | X | X | X |

| | | | | | |
|---|---|---|---|---|---|
| Stroke Education Sessions<br><br>Provide education on stroke signs and symptoms, prevention strategies, risk factors (including hypertension), and post-stroke care. | Number of participants<br>Number of events | | X | X | X |
| Annual Stroke Awareness Event<br><br>Host an annual event focused on stroke awareness, prevention, and available community and clinical resources. | Number of participants | | | X | X |
| **Strategy 2: Enhance chronic disease awareness and self-management through targeted events and aligned outreach materials** | | | | | |
| **Objective 1:**<br>**By December 2028, increase chronic disease education, screening, and care connection opportunities for northeast Ohio residents.** | | | | | |
| **Measure: # of people engaged** | | | | | |
| **Activities** | **Measures** | **Collaborators** | **Year 1** | **Year 2** | **Year 3** |
| Community Health Events<br>Participate in community and hospital-based events to provide education on stroke, | Number of encounters<br>Number of events | | X | X | X |

| | | | | | |
|---|---|---|---|---|---|
| high blood pressure, and related chronic conditions. | | | | | |
| Provide Screenings at Events: Blood pressure, grip strength and balance | Number screened<br>Number screened positive | | X | X | X |
| Care Navigation and PCP<br>Connections | Number of referrals | | X | X | X |
| Education Materials Distributed- Share stroke prevention and chronic disease management materials through mailings and event-based outreach. | Number of people reached | | X | X | X |

University Hospitals
Cleveland Medical Center

**Implementation Strategy**

# UH CLEVELAND MEDICAL CENTER:

# UH COMMUNITY WELLNESS CENTER AT GLENVILLE

| **UH Community Health Investment (CHI) Priority Area: Maternal and Child Health** |
|---|
| **CHNA Priority Area: Maternal and Child Health** |
| **Hospital: UH Community Wellness Center at Glenville** |
| **Goal:** Improve maternal and child health by increasing access to supportive services, education, and community resources for Cuyahoga County community members. |
| **Community-Level Indicators to track long-term outcomes:**<br>• Child Food Insecurity Rate<br>• Infant Mortality Rate<br>• Ever Breastfed a New Infant<br>• Chronic Health Condition(s) During Pregnancy<br>• Postpartum Depression |
| **Strategy 1:** Expand Wellness Center programming through partnerships with internal stakeholders and local organizations. |
| **Objective 1:** By December 2028, increase the number of programs offered at the UH Wellness Center that target maternal and child health topics. |
| **Measure:** Total number of programs |

| **Activities** | **Process Measures** | **Collaborators** | **Year 1** | **Year 2** | **Year 3** |
|---|---|---|---|---|---|
| Partner with local organizations to host programs at UH space. | Number of events | Wellness Center Outreach Team | X | X | X |

| | | | | | |
|---|---|---|---|---|---|
| Create new partnerships with local organizations. | Number of partnerships | Wellness Center Outreach Team | X | X | X |
| Provide physician/health talks. | Number of physicians/health talks | Wellness Center Outreach Team | X | X | X |
| **Strategy 2:** Strengthen support for birthing individuals and families by expanding access to perinatal related services, nutrition education, resources, and lactation support. | | | | | |
| **Objective 1:** By December 2028, increase access to maternal and child health resources to Cuyahoga County community members. | | | | | |
| **Measure:** Number of program offerings | | | | | |
| **Activities** | **Process Measures** | **Collaborators** | **Year 1** | **Year 2** | **Year 3** |
| Conduct a community baby shower. | Number of community baby showers | Wellness Center Outreach Team | X | X | X |
| Conduct cooking demos with students. | Number of cooking demos | Wellness Center Outreach Team | X | X | X |
| Lactation education. | Number of education classes about lactation | Wellness Center Outreach Team | X | X | X |

| UH Community Health Investment (CHI) Priority Area: Well-being |
|---|
| **CHNA Priority Area: Well-being & Chronic Disease** |
| **Hospital: UH Community Wellness Center at Glenville** |
| **Goal:** Improve overall community well-being and reduce chronic disease risk by expanding access to healthy lifestyle programming, nutrition supports, and preventive services while fostering education, connection, and navigation that empower Cuyahoga County residents to lead healthier, more active lives. |
| **Community-Level Indicators to track long-term outcomes:**<br>• Self-Reported General Health Assessment: Good or Better<br>• Adults who Frequently Cook Meals at Home<br>• Poor Physical Health: Average Number of Days<br>• Obesity: Medicare Population<br>• High Blood Pressure Prevalence<br>• Age-Adjusted Death Rate due to Kidney Disease<br>• Adults 20+ with Diabetes<br>• Chronic Kidney Disease: Medicare Population |
| **Strategy 1:** Expand Access to Whole-Person Wellness (Fitness, Nutrition, and Well-Being Activities) |
| **Objective 1:** By December 2028, increase participation in fitness, nutrition, and wellness programs by 10%. |
| **Measure:** Percentage change increase in programming |

| Activities | Measures | Collaborators | Year 1 | Year 2 | Year 3 |
|---|---|---|---|---|---|
| Collaborate with new internal (UH service lines) and external stakeholders in programming. | Number of new collaborations | Wellness Center Outreach Team | X | X | X |

| | | | | | |
|---|---|---|---|---|---|
| Provide financial literacy education through offering workshops that are facilitated by financial experts for all ages. | Number of workshops on financial literacy | Wellness Center Outreach Team | X | X | X |
| Provide fitness classes. | Number of fitness classes | Wellness Center Outreach Team | X | X | X |
| Offer programming focused on mental wellness. | Number of programs | Wellness Center Outreach Team | X | X | X |
| Offer Food for Life (FFL) market at Glenville. | Number of FFL appointments attended | Wellness Center Outreach Team/Sodexo | X | X | X |
| Partner with a local food bank to provide access to food. | Number of people served | Wellness Center Outreach Team | X | X | X |
| Provide nutrition-based programming. | • Number of cooking demos<br>• Number of nutrition education programs | Wellness Center Outreach Team/Sodexo | X | X | X |
| Conduct annual holiday distribution giveaway events. | Number of people served through holiday distribution giveaway events | Wellness Center Outreach Team | X | X | X |

| **Strategy 2:** Strengthen Preventive Health and Chronic Disease Management through Screenings, Education, and Navigation. | | | | | |
|---|---|---|---|---|---|
| **Objective 1:** By December 2028, increase the number of health screenings among the Cuyahoga County population by 10%. | | | | | |
| **Measure:** Total number of health screenings | | | | | |
| **Activities** | **Measures** | **Collaborators** | **Year 1** | **Year 2** | **Year 3** |
| SDOH screenings. | Number of SDOH screenings | Wellness Center Outreach Team | X | X | X |
| Deliver evidence-based health education programs on chronic diseases such as heart disease, diabetes, and kidney disease, with an emphasis on prevention, early detection, and effective management. | Number of programs<br>Number of participants | Wellness Center Outreach Team | X | X | X |

# UH CLEVELAND MEDICAL CENTER: HARRINGTON HEART & VASCULAR INSTITUTE

| **UH Community Health Investment (CHI) Priority Area: Well-being** |
|---|
| **CHNA Priority Area: Chronic Disease** |
| **Hospital: UH Cleveland Medical Center (Harrington Heart & Vascular Institute)** |
| **Goal:** Reduce preventable chronic disease and premature mortality while decreasing health disparities through hospital-led prevention, early detection, and effective disease management strategies. |
| **Community-Level Indicators to track long-term outcomes:**<br>• Adults 20+ with Diabetes<br>• Stroke: Medicare Population<br>• Age-Adjusted Death Rate due to Cerebrovascular Disease (Stroke)<br>• High Blood Pressure Prevalence |
| **Strategy 1:** Implement community-based education and health screening initiatives to expand access to preventive services. |
| **Objective 1:** By 2028, increase cardiovascular health engagement among adults in Cuyahoga County, including calcium score screenings, participation from under-resourced populations, and knowledge of heart disease prevention and chronic disease management. |
| **Measure:**<br>• Number or % of eligible adults who complete a calcium score or other cardiovascular risk screening.<br>• Number of participants from under-resourced or priority populations engaged in hospital-led programs. |

| Activities | Process Measures | Collaborators | Year 1 | Year 2 | Year 3 |
|---|---|---|---|---|---|

| | | | | | |
|---|---|---|---|---|---|
| Physician-led health talks and/or screening events. | • Number of health talks<br>• Number of screening events | Community Outreach Team | X | X | X |
| Annually screen 1,000 or more individuals for cardiovascular disease and provide information about their results. | Number of screenings | Community Outreach Team | X | X | X |
| Annually educate 2,000 or more individuals regarding vascular disease, cardiovascular risk factors and lifestyle, medication adherence, CPR, AED and smoking/vaping cessation/education. | Total Number of individuals who attend or participate in hospital-led education sessions | Community Outreach Team | X | X | X |
| **Strategy 2:** Provide community safety training programs in Cuyahoga County to increase knowledge and preparedness for emergencies, including CPR, AED use, and injury prevention. | | | | | |
| **Objective 1:** By December 2028, increase the number of students and community members who are prepared to respond to traumatic injuries and cardiac emergencies through CPR and AED training | | | | | |
| **Measure:** Number of individuals/students trained in CPR and AED use | | | | | |
| **Activities** | **Process Measures** | **Collaborators** | **Year 1** | **Year 2** | **Year 3** |
| Continue to train community members and first responders in various locations throughout the county on CPR and AED as | Total Number of trainings | Community Outreach Team | X | X | X |

| | | | | | |
|---|---|---|---|---|---|
| part of the Cardiac Free Zone initiative. | | | | | |
| Train students in local schools in Cuyahoga County through the “Stop the Bleed” program, with a target of 5,000 trained in CPR/AED/Stop the Bleed. | Total Number of participants | Community Outreach Team | X | X | X |
| Continue to provide youth violence prevention programs and activities. | Total Number of prevention programs and activities | Community Outreach Team | X | X | X |
| Host a survivor’s dinner. | Number of dinners hosted | Community Outreach Team | X | X | X |
| Offer workshops on the dangers of vaping. | Number of workshops conducted | Community Outreach Team | X | X | X |

# UH CLEVELAND MEDICAL CENTER:UH OTIS MOSS JR. HEALTH CENTER

| **UH Community Health Investment (CHI) Priority Area: Well-being** |
|---|
| **CHNA Priority Area: Well-being & Chronic Disease** |
| **Hospital: UH Cleveland Medical Center (UH Otis Moss Jr. Health Center)** |
| **Goal:** Create access to culturally relevant education and support programs that empower individuals to prevent and manage chronic diseases through sustainable lifestyle habits. |
| **Community-Level Indicators to track long-term outcomes:**<br>• Osteoporosis: Medicare Population<br>• Adults 20+ with Diabetes<br>• High Blood Pressure Prevalence<br>• Obesity: Medicare Population<br>• Self-Reported General Health Assessment: Poor or Fair |
| **Strategy 1:** Increase access to healthy food and deliver education and prevention efforts to reduce chronic disease and food insecurity. |
| **Objective 1:** By 2028, increase the number of underserved individuals accessing healthy foods and nutrition education programs by 10%. |
| **Measure:** Number of individuals served through nutrition focused programming and food-based appointments. |

| **Activities** | **Measures** | **Collaborators** | **Year 1** | **Year 2** | **Year 3** |
|---|---|---|---|---|---|
| Food for Life Market. | • Pounds of food distributed<br>• Number of individuals served | Sodexo, Greater Cleveland Foodbank | X | X | X |

| | | | | | |
|---|---|---|---|---|---|
| Nutrition based programming. | • Number of classes<br>• Number of participants | Sodexo Dietitians, Community Chefs, UH Glenville Wellness Center Staff | X | X | X |
| **Strategy 2:** Provide programs that support healthy lifestyle changes and promote understanding of whole-person health. | | | | | |
| **Objective 2:** By 2028, expand community participation in fitness programming and health-related events to support healthier lifestyle. | | | | | |
| **Measure:** Number of individuals served through fitness and whole-health related programming. | | | | | |
| **Activities** | **Measures** | **Collaborators** | **Year 1** | **Year 2** | **Year 3** |
| Fitness Classes. | • Number of classes<br>• Number of participants | UH Otis Moss Health Center Staff, UH Glenville Wellness Center Staff, Local Fitness Instructors | X | X | X |
| Health Provider Talks. | • Number of sessions<br>• Number of participants | UH Clinical Staff, UH Glenville Wellness Center Staff | X | X | X |
| Walking Club with regular BP checks. | Number of participants | UH Glenville Wellness Center Staff | X | X | X |

# UH CLEVELAND MEDICAL CENTER:SEIDMAN CANCER CENTER

| **UH Community Health Investment (CHI) Priority Area: Well-being** |
|---|
| **CHNA Priority Area: Cancer** |
| **Hospital: UH Cleveland Medical Center (Seidman Cancer Center)** |
| **Goal:** Reduce cancer incidence and mortality by improving prevention education, expanding access to primary and diagnostic care, strengthening navigation services, and addressing social determinants of health. |
| **Community-Level Indicators to track long-term outcomes:**<br>• Prostate Cancer Incidence Rate<br>• Age-Adjusted Death Rate due to Prostate Cancer<br>• Breast Cancer Incidence Rate<br>• Age-Adjusted Death Rate due to Breast Cancer |
| **Strategy 1:** Expand community-based outreach to deliver education and screenings. |
| **Objective 1:** By December 2028, increase the number of collaborations and strategic placements in our screenings among under resourced communities. |
| **Measure:** Number of collaborations/events attended |

| **Activities** | **Process Measures** | **Collaborators** | **Year 1** | **Year 2** | **Year 3** |
|---|---|---|---|---|---|
| Conduct health fairs. | Number of health fairs | Seidman Community Outreach Team | X | X | X |
| Conduct health talks. | Number of health talks | Seidman Community Outreach Team | X | X | X |

| | | | | | |
|---|---|---|---|---|---|
| Conduct symposiums. | Number of symposiums | Seidman Community Outreach Team | X | X | X |
| **Strategy 2:** Provide strategic based community mammogram, PSA (Prostate Specific Antigen) and lung screenings and strengthen navigation support for SDoH and follow-up appointments. | | | | | |
| **Objective 1:** By December 2028, increase the number of cancer screenings in the Cuyahoga County community. | | | | | |
| **Measure:** Total number of cancer screenings | | | | | |
| **Activities** | **Process Measures** | **Collaborators** | **Year 1** | **Year 2** | **Year 3** |
| Conduct mammogram screenings. | Number of mammogram screenings | Seidman Community Outreach Team | X | X | X |
| Conduct PSA screenings. | Number of PSA screenings | Seidman Community Outreach Team | X | X | X |
| Conduct lung cancer screenings. | Number of lung cancer screenings | Seidman Community Outreach Team | X | X | X |
| Conduct gynecological screenings (Pap through mobile unit). | Number of gynecological screenings | Seidman Community Outreach Team | X | X | X |
| Conduct skin cancer screenings. | Number of skin cancer screenings | Seidman Community Outreach Team | X | X | X |

| | | | | | |
|---|---|---|---|---|---|
| Conduct colorectal screenings. | Number of colorectal screenings | Seidman Community Outreach Team | X | X | X |

| **Strategy 3:** Strengthen partnerships with community organizations and FQHCs to expand lay navigation and survivorship support for patients. | | | | | |
|---|---|---|---|---|---|
| **Objective 1:** By December 2028, increase the number of oncology navigation opportunities with FQHCs. | | | | | |
| **Measure:** Number of referrals<br>Number of navigations | | | | | |
| **Activities** | **Process Measures** | **Collaborators** | **Year 1** | **Year 2** | **Year 3** |
| Referrals to service lines. | Number of referrals | Seidman Community Outreach Team | X | X | X |
| Screen for SDOH needs. | • Number of patients screened<br>• Number of patients referred | Seidman Community Outreach Team | X | X | X |

University Hospitals
Parma Medical Center

**Implementation Strategy**

# UH PARMA MEDICAL CENTER

| UH Community Health Investment (CHI) Priority Area: Well-being |
|---|
| **CHNA Priority Area: Well-being** |
| **Hospital: UH Parma Medical Center** |
| **Goal:** Strengthen community knowledge and access to essential health and support services to improve community wellbeing. |
| **Community-Level Indicators to track long-term outcomes:**<br>• Obesity: Medicare Population<br>• High Blood Pressure Prevalence<br>• Insufficient Sleep<br>• Self-Reported General Health Assessment: Poor or Fair<br>• Adults who Feel Life is Slipping Out of Control |
| **Strategy 1:** Enhance community support by improving referrals, expanding education, and advancing both new and existing programs. |
| **Objective 1:** By December 2028, increase outreach for wellbeing awareness and access through community-based events/programs. |

| Activities | Process Measures | Collaborators | Year 1 | Year 2 | Year 3 |
|---|---|---|---|---|---|
| Conduct summer lunch program. | Number of participants | Parma Community Outreach Team | X | X | X |
| Meals on Wheels Program. | Number of meals | Parma Community Outreach Team | X | X | X |
| Provide community-based programs to improve | Number of programs | Parma Community Outreach Team | X | X | X |

| | | | | | |
|---|---|---|---|---|---|
| nutritional and healthy lifestyles. | Number of individuals served | | | | |
| **Strategy 2: Strengthen community awareness by developing and collaborating with UH departments on shared educational materials.** | | | | | |
| **Objective 1:** By December 2028, increase the distribution of UH and other resources to Cuyahoga County community members. | | | | | |
| **Activities** | **Process Measures** | **Collaborators** | **Year 1** | **Year 2** | **Year 3** |
| Provide materials at all events to bring awareness of UH programs and other resources in the community. | Number of events | Parma Community Outreach Team | X | X | X |
| Provide handouts at events of financial aid programs/information for those who are uninsured or underinsured. | Number of events | Parma Community Outreach Team | X | X | X |
| Provide educational materials to inpatients with an A1C greater than 5.7 (pre-diabetic) upon discharge. | Number of individuals educated | Parma Community Outreach Team | X | X | X |

| UH Community Health Investment (CHI) Priority Area: Well-being | | | | | |
|---|---|---|---|---|---|
| **CHNA Priority Area: Chronic Disease** | | | | | |
| **Hospital: UH Parma Medical Center** | | | | | |
| **Goal:** To improve the well-being of adults in Cuyahoga County via chronic disease prevention and providing tools for self-management, especially for diabetes & hypertension. | | | | | |
| **Community-Level Indicators to track long-term outcomes:**<br>• Adults 20+ with Diabetes<br>• High Blood Pressure Prevalence<br>• Stroke: Medicare Population<br>• Age-Adjusted Death Rate due to Cerebrovascular Disease (Stroke) | | | | | |
| **Strategy 1:** Increase community outreach events and screening in Cuyahoga County. | | | | | |
| **Objective 1:** By December 2028, increase healthy lifestyle behaviors among Cuyahoga County residents by 10% through screenings, education, and health talks. | | | | | |
| **Activities** | **Process Measures** | **Collaborators** | **Year 1** | **Year 2** | **Year 3** |
| Host and participate in community events offering free screenings and health education to engage and support residents. | Number of screenings and/or participants | Parma Medical Center Community Outreach Team | X | X | X |
| Deliver educational sessions through lifestyle speakers at local community organizations. | Number of participants | Parma Medical Center Community Outreach Team | X | X | X |
| **Strategy 2:** Build new strategic partnerships to expand community reach in Cuyahoga County | | | | | |
| **Objective 1:** By December 2028, establish 6 new strategic partnerships with local community organizations and internal departments. | | | | | |
| **Activities** | **Process Measures** | **Collaborators** | **Year 1** | **Year 2** | **Year 3** |

| | | | | | |
|---|---|---|---|---|---|
| Establish connections with new partners to plan, coordinate, and implement at least 2 events per year that promote community health and education. | Total number of events | Parma Medical Center Community Outreach Team | X | X | X |
| Initiate and coordinate new programs with internal departments to host two events each year that advance organizational and community goals. | • Total number of programs<br>• Total number of events | Parma Medical Center Community Outreach Team | X | X | X |

University Hospitals
Rainbow Babies & Children's

**Implementation Strategy**

# UH RAINBOW BABIES & CHILDREN'S HOSPITAL

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|---|
| **UH Community Health Investment (CHI) Priority Area: Maternal and Child Health** |
| **CHNA Priority Area: Maternal and Child Health** |
| **Hospital: UH Rainbow Babies & Children's Hospital** |
| **Goal:** To improve maternal and child health by expanding access to mental health care, addressing social needs, and strengthening support for pregnant women, parents, and youth through community collaboration. |
| **Community-Level Indicators to track long-term outcomes:**<br>• Child Food Insecurity Rate<br>• Babies with Low Birthweight<br>• Child Mortality Rate: Under 20<br>• Teen Birth Rate: 15-17<br>• Chronic Health Condition(s) During Pregnancy<br>• Postpartum Depression |
| **Strategy 1:** Increasing awareness and navigation of maternal health patients to prenatal and postnatal care. |
| **Objective 1:** By December 2028, increase the show rate of attended prenatal and postnatal visits by 5% of OB/GYN patients. |
| **Measure:** Number of show rates for prenatal and postnatal care |

| Activities | Process Measures | Collaborators | Year 1 | Year 2 | Year 3 |
|---|---|---|---|---|---|
| Navigator in place in Maternal Health. | Hire navigator | Women's Health Leadership Team | X | X | X |

| | | | | | |
|---|---|---|---|---|---|
| Adding to the availability of mental health resources in women's health. | Add slots in the template | Women's Health Leadership Team | X | X | X |
| Potential acquisition of funding to support a Women's Mental Health Care Coordinator. | Funder is identified | Women's Health Leadership Team | X | X | X |
| Improve the process of ensuring PPVs (post–partum visits) are scheduled prior to L&D (labor and delivery) discharge. | Number of postpartum patients with a PPV scheduled prior to L&D discharge. | Women's Health Leadership Team | X | X | X |
| **Strategy 2:** Strengthen community-based care by expanding social needs screening, using closed-loop referral systems to connect families to wraparound services, and integrating evidence-based programs. | | | | | |
| **Objective 1:** By December 2028, enhance family access to comprehensive support services, including social needs resources and early childhood development programs through expanded screening and referral processes. | | | | | |
| **Measure:** Number of individuals served | | | | | |
| **Activities** | **Process Measures** | **Collaborators** | **Year 1** | **Year 2** | **Year 3** |
| PRAF (Pregnancy Risk Assessment Form) screening is in place in MH. | Number of PRAF screenings | Women's Health Leadership Team | X | X | X |

| | | | | | |
|---|---|---|---|---|---|
| Hunger vital sign screening. | Number of hunger vital sign screenings | Women's Health Leadership Team | X | X | X |
| Referrals to the food for life pantry. | Number of referrals | Women's Health Leadership Team/Pediatric Team | X | X | X |
| Emergency food bags distributed. | Number of emergency bags distributed | Women's Health Leadership Team | X | X | X |
| Mental Health Screenings such as SEEK, STEPP. | Number of mental health screenings | Women's Health Leadership Team | X | X | X |
| Rainbow connects social needs screening. | Number of social needs | Women's Health Leadership Team | X | X | X |
| HealthySteps Program (Evidence-based pediatric primary care initiative aimed at improving the health, well-being and school readiness of babies and toddlers. It is available for UH Rainbow families with children ages 0 – 3 years old). | • Number of children served<br>• Eligible children who completed at least one screening<br>• Percentage of children who received | Pediatric Team | X | X | X |

| | | | | | |
|---|---|---|---|---|---|
| | follow-up services | | | | |

| **Strategy 3:** Increase lead screening for pediatric populations - both initial testing and repeat testing go for elevated blood lead levels. | | | | | |
|---|---|---|---|---|---|
| **Objective 1:** By December 2028, increase the number of children screened for lead. | | | | | |
| **Measure:** Total number of screenings (completed) | | | | | |
| **Activities** | **Process Measures** | **Collaborators** | **Year 1** | **Year 2** | **Year 3** |
| Contact families to provide support after a positive lead test. | Number/percentage of families contacted and supported after a positive lead test (≥3.5 µg/dL) | Pediatric Team | X | X | X |
| Provide clear explanations to the families about the next steps and the investigation process. | Number/percentage of families provided with clear explanations of the next steps and the investigation process | Pediatric Team | X | X | X |
| Connect families successfully to resources and services following lead level detection. | Number/percentage of families successfully connected to resources and services following lead-level detection | Pediatric Team | X | X | X |
| Provide case management and follow-up to children with | Number/percentage of children with elevated lead levels receiving case management and follow-up | Pediatric Team | X | X | X |

| | | | | | |
|---|---|---|---|---|---|
| elevated lead levels. | | | | | |


University Hospitals
St. John Medical Center
A CATHOLIC HOSPITAL

# UH ST. JOHN MEDICAL CENTER

| **UH Community Health Investment (CHI) Priority Area: Well-being** |
|---|
| **CHNA Priority Area: Wellbeing** |
| **Hospital: UH St. John Medical Center** |
| **Goal:** Strengthen community knowledge and access to essential health and support services to improve community wellbeing. |
| **Community-Level Indicators to track long-term outcomes:**<br>• Obesity: Medicare Population<br>• High Blood Pressure Prevalence<br>• Insufficient Sleep<br>• Self-Reported General Health Assessment: Poor or Fair<br>• Adults who Feel Life is Slipping Out of Control |
| **Strategy 1:** Enhance community support by improving referrals, expanding education, and advancing both new and existing programs. |
| **Objective 1:** By December 2028, increase outreach for wellbeing awareness and access through community-based events/programs. |

| **Activities** | **Process Measures** | **Collaborators** | **Year 1** | **Year 2** | **Year 3** |
|---|---|---|---|---|---|
| Provide community-based programs to improve nutritional and healthy lifestyles. | Number of programs | St. John's Community Outreach Team | X | X | X |
| Outreach for behavioral health issues and safety through events and education. | Number of outreach events | St. John's community outreach team | X | X | X |

| **Strategy 2: Strengthen community awareness by developing and collaborating with UH departments on shared educational materials.** | | | | | |
|---|---|---|---|---|---|
| **Objective 1:** By December 2028, increase the distribution of UH and other resources to Cuyahoga County community members. | | | | | |
| **Activities** | **Process Measures** | **Collaborators** | **Year 1** | **Year 2** | **Year 3** |
| Provide materials at all events to bring awareness of UH programs and other resources in the community. | Number of materials distributed | St. John's Community Outreach Team | X | X | X |
| Implement get-connected programs in communities. | Number of get-connected programs implemented | St. John's community outreach team | X | X | X |
| Provide handouts at events of financial aid programs/information for those who are uninsured or underinsured. | Number of handouts distributed | St. John's Community Outreach Team | X | X | X |

| UH Community Health Investment (CHI) Priority Area: Well-being | | | | | |
|---|---|---|---|---|---|
| **CHNA Priority Area: Chronic Disease** | | | | | |
| **Hospital: UH St. John Medical Center** | | | | | |
| **Goal:** To improve the well-being of adults in Cuyahoga County via chronic disease prevention and providing tools for self-management, especially for diabetes & hypertension. | | | | | |
| **Community-Level Indicators to track long-term outcomes:**<br>• Adults 20+ with Diabetes<br>• High Blood Pressure Prevalence<br>• Stroke: Medicare Population<br>• Age-Adjusted Death Rate due to Cerebrovascular Disease (Stroke) | | | | | |
| **Strategy 1:** Increase community outreach events and screening in Cuyahoga County. | | | | | |
| **Objective 1:** By December 2028, increase outreach events among Cuyahoga County residents through screenings, education, and health talks by 10%. | | | | | |
| **Activities** | **Process Measures** | **Collaborators** | **Year 1** | **Year 2** | **Year 3** |
| Host and participate in community events offering free screenings and health education to engage and support residents. | Number of participants | St. John Community Outreach Team | X | X | X |
| Deliver educational sessions through lifestyle speakers at local community organizations. | Number of participants for the talks | St. John Community Outreach Team | X | X | X |
| **Strategy 2:** Build new strategic partnerships to expand community reach in Cuyahoga County | | | | | |

| **Objective 1:** By December 2028, establish 10 new strategic partnerships with local community organizations and internal departments. | | | | | |
|---|---|---|---|---|---|
| **Activities** | **Process Measures** | **Collaborators** | **Year 1** | **Year 2** | **Year 3** |
| Establish connections with new partners to plan, coordinate, and implement at least 2 events per year that promote community health and education. | Total number of events | St. John Community Outreach Team | X | X | X |
| Initiate and coordinate new programs with internal departments to host two events each year that advance organizational and community goals. | • Total number of programs<br>• Total number of events | St. John Community Outreach Team | X | X | X |

## SIGNIFICANT HEALTH NEEDS NOT BEING ADDRESSED BY THE HOSPITAL

The hospitals are implementing strategies that address all three 2025 priority areas: chronic disease, maternal and child health, and well-being.

## COMMUNITY COLLABORATORS

UH commissioned this document and is aligning its implementation plan with local public health partners, including the Cleveland Department of Public Health and the Cuyahoga County Board of Health. Once the health departments' improvement plan becomes available, it will be incorporated into UH's Implementation Strategy.

## QUALIFICATION OF CONSULTING COMPANY

University Hospitals commissioned Conduent Healthy Communities Institute (HCI) to support the facilitation and development of the Implementation Strategy for University Hospitals 2026-2028. Conduent collaborates with clients across the nation to drive improved community outcomes by providing expert guidance for assessing community needs, developing strategies, and implementing evaluation and monitoring processes. Consultants for this project included Era Chaudhry, MPH, MBA, Public Health Consultant and Irene Ortiz, Communications BA-Delivery Management Analyst.

To learn more about Conduent HCI, visit conduent.com/community-health.

## CONTACT INFORMATION

For more information about the Implementation Plan, please contact:

Martina Pace, MPA

Director, Community Health Engagement

Government, Community & Health Impact

11100 Euclid Avenue Cleveland, Ohio 44106

Martina.Pace@UHhospitals.org


2026-2028 UNIVERSITY HOSPITALS

# COMMUNITY HEALTH IMPLEMENTATION STRATEGY

Cuyahoga County

University Hospitals