



University Hospitals

# 2019

## Community Health Implementation Strategy

UH Geauga Medical Center  
Gauga County





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## Adoption by the Board

University Hospitals adopted the UH Geauga Medical Center Community Health Implementation Strategy on March 20, 2019.

## Community Health Implementation Strategy Availability

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

## Written Comments

Individuals are encouraged to submit written comments, questions or other feedback about the UH Geauga Medical Center Implementation Strategy to [CommunityBenefit@UHhospitals.org](mailto:CommunityBenefit@UHhospitals.org). Please be 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.

## Glossary

### State Assessments and Plans

**SHA (State Health Assessment)**—A health assessment conducted by the state of Ohio to measure the health status of Ohioans. It is conducted every 3 years. The data collected from a SHA informs the state health improvement plan (SHIP).

**SHIP (State Health Improvement Plan)**—An improvement plan conducted by the state of Ohio that contains priorities, strategies, and measurable indicators to address health needs identified in the SHA. The SHIP is conducted every 3 years and serves as a guide for local improvement plans and hospital implementation strategies.

### Hospital Assessments and Strategies

**CHNA (Community Health Needs Assessment)**—A health assessment conducted by hospitals to measure the health status of the population. It is required by Section 501(r) of the Internal Revenue Code and conducted every 3 years. The data collected from a CHNA informs the implementation strategy (IS).

**IS (Implementation Strategy)**—A hospital plan that identifies priorities, strategies, and measurable indicators to address health needs identified in the CHNA. It is required by Section 501(r) of the Internal Revenue Code and conducted every 3 years. IS's are required to align with the SHIP beginning in 2020.

### Local Health Department (LHD) Assessments and Plans

**CHA (Community Health Assessment)**—A collaborative, county-level health assessment conducted by the health department and other community members to measure the health status of the population. It is required by the Public Health Accreditation Board (PHAB) and is conducted every 3 years in Ohio. The data collected from a CHA informs the community health improvement plan (CHIP).

**CHIP (Community Health Improvement Plan)**—A collaborative, county-level improvement plan conducted by the health department and other community members that identifies priorities, strategies, and measurable indicators to address health needs identified in the CHA. It is required by the Public Health Accreditation Board (PHAB) and is conducted every 3 years in Ohio. CHIP's are required to align with the SHIP beginning in 2020.

### Miscellaneous

**Ohio state law (ORC 3701.981)**—A state law that requires all hospitals to collaborate with their local health departments on CHAs and CHIPs.

**PHAB (Public Health Accreditation Board)**—A national body that issues accreditation to health departments based on a set of standards. All health departments in Ohio are mandated to become accredited by 2020.

## Acronyms

### National, State, and Local Organizations

**CDC**—Centers for Disease Control and Prevention

**ODH**—Ohio Department of Health

**HCNO**—Hospital Council of Northwest Ohio

**UH**—University Hospitals

### Miscellaneous

**BRFSS**—Behavioral Risk Surveillance System

**YRBSS**—Youth Risk Behavior Surveillance System

**NSCH**—National Survey of Children's Health



**MAPP**—Mobilizing for Planning and Partnerships

**CHR**—County Health Rankings

## Introduction

In 2018, University Hospitals Geauga Medical Center (the “Hospital”) 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 2018 CHNA served as the foundation for developing an Implementation Strategy (“IS”) to address those needs that, (a) the Hospital determined it is able to meet in whole or in part; (b) is otherwise part of UH’s mission; and (c) is not met (or are not adequately met) by other programs and services in the county. The IS identifies the means through which the Hospital plans to address a number of the needs that are consistent with the Hospital’s charitable mission as part of its community benefit programs. Additionally, the Hospital is addressing some of these needs simply by providing care to all, regardless of ability to pay, every day. The Hospital anticipates that the strategies may change and therefore, a flexible approach is best suited for the development of its response to the 2018 CHNA. For example, certain community health needs may become more pronounced and require changes to the initiatives identified by the Hospital in the IS. More specifically, since this IS was done in conjunction with the existing Geauga County Community Health Improvement Plan, other community organizations will be addressing certain needs.

In addition, the Hospital worked together to align both its CHNA and IS with state plans. Ohio state law (ORC 3701.981) mandates that all hospitals must collaborate with their local health departments on community health assessments (a “CHA”) and community health improvement plans (a “CHIP”). Additionally, local hospitals must align with the Ohio State Health Assessment (a “SHA”) and Ohio State Health Improvement Plan (a “SHIP”); see Appendix A. This requires alignment of the CHNA and IS process timeline, indicators, and strategies. This local alignment must take place by October 2020.

*Note: This symbol  will be used throughout the report when a priority, indicator, or strategy directly aligns with the 2017-2019 SHIP. This symbol , the Geauga County outline, will be used throughout the report when a priority, indicator, or strategy directly aligns with the 2018-2019 CHIP.*

This aligned approach has resulted in less duplication, increased collaboration, and sharing of resources. This report serves as the initial IS to move the Hospital into a more collaborative approach with county partners. As a result of this alignment, the Hospital will be actively participating in the upcoming 2019 Geauga County CHA and CHIP process, which will align partners to be in compliance by 2020.

University Hospitals Health Systems, Inc. (“University Hospitals” or “UH”), contracted with the Hospital Council of Northwest Ohio (“HCNO”) to align the 2019 IS with the existing 2018-2019 Geauga County CHIP and the 2017-2019 SHIP.

HCNO guided the process and reviewed sources of primary data including the 2018 CHNA, 2016 hospital utilization and discharge data, the previous Hospital’s IS, the 2017 evaluation of impact and the 2018-2019 Geauga County CHIP. The goal was to identify strategies to address the priorities identified in the 2018 UH Geauga CHNA, being mindful of any new data or nuances that may have occurred since the 2016 Geauga County CHA was adopted. The following priorities were identified in the 2018 CHNA: mental health and addiction, chronic disease, and maternal and infant health, which mirror the priorities in the Geauga County CHIP.

### Hospital Mission Statement

As a wholly owned subsidiary of University Hospitals, the Hospitals are 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

The community has been defined as Geauga County. About two-fifths (41%) of University Hospitals Geauga Medical Center’s discharges were Geauga County residents. In addition, University Hospital collaborates with multiple stakeholders, most of which provide services at the county-level. For these two reasons, the county was defined as the community.

## 2018 CHNA Observations













### Data Observations


The 2018 UH Geauga Medical Center CHNA is a 165-page report that consists of county-level primary and secondary data for Geauga County. The following data are key findings from the CHNA that support the priorities and strategies found in this IS. The full CHNA report can be found at: <https://www.uhhospitals.org/about-uh/community-benefit/community-health-needs-assessment>

- Six percent (6%) of Geauga County adults were uninsured in 2016.
- In 2016, 9% of Geauga County adults did not have at least one person they thought of as their personal doctor or healthcare provider.
- Three percent (3%) of Geauga County adults considered attempting suicide in 2016.
- According to the Ohio Department of Health (ODH), the suicide death rate for Geauga County was 11.5 per 100,000 population (age-adjusted) from 2012-2017.
- In 2016, 5% of Geauga County adults had used marijuana in the past 6 months, increasing to 13% of those under the age of 30.
- Five percent (5%) of adults had used medication not prescribed for them or they took more than prescribed to feel good or high and/or more active or alert during the past 6 months, increasing to 13% of those under the age of 30.
- From 2012-2017, there were 21.1 unintentional resident drug overdose deaths per 100,000 population (age-adjusted) in Geauga County, according to ODH.
- Nearly two-thirds (64%) of Geauga County adults were either overweight (37%) or obese (27%) by Body Mass Index (BMI) in 2016.
- Four percent (4%) Geauga County adults did not have any servings of fruits and vegetables on the average day in 2016.
- Nearly one in six (16%) adults did not participate in any physical activity in the past week, including 2% who were unable to exercise, in 2016.
- One in ten (10%) Geauga County adults were current smokers in 2016.
- In 2016, 51% of current smokers responded that they had stopped smoking for at least one day in the past year because they were trying to quit smoking.
- In 2016, 3% of adults reported they had angina or coronary heart disease, increasing to 10% of those over the age of 65.
- In 2016, 9% of Geauga County adults had been diagnosed with diabetes, increasing to 25% of those with incomes less than \$25,000.

## 2018 CHNA Adult Trend Summary Table

N/A – Not Available

Adult Variables	Geauga County 2011	Geauga County 2016	Ohio 2016	U.S. 2016
<b>Health Status and Coverage</b>				
Rated health as excellent or very good	67%	63%	51%	52%
Rated general health as fair or poor 	6%	9%	18%	17%
Rated their mental health as not good on four or more days in the previous month	18%	28%	N/A	N/A
Average number of days that physical health was not good in the past month 	N/A	3.8	3.7*	3.8*
Average number of days that mental health was not good in the past month 	N/A	4.8	4.0*	3.8*
Uninsured 	12%	6%	7%	10%
Had at least one person they thought of as their personal doctor or healthcare provider	51%	54%	83%	77%
Visited a doctor for a routine checkup in the past year 	57%	59%	75%	71%
Unable to see doctor due to cost	12%	7%	11%	11%
<b>Diabetes</b>				
Had been diagnosed with diabetes 	6%	9%	11%	11%
<b>Asthma</b>				
Had been diagnosed with asthma 	12%	14%	14%	14%
<b>Arthritis</b>				
Had been diagnosed with arthritis	34%	31%	31%	26%
<b>Cardiovascular Health</b>				
Had angina or coronary heart disease 	N/A	3%	5%	4%
Had a heart attack	2%	4%	5%	4%
Had a stroke	2%	2%	4%	3%
Has been diagnosed with high blood pressure 	30%	27%	34%***	31%***
Has been diagnosed with high blood cholesterol	36%	36%	37%***	36%***
Had blood cholesterol checked within the past five years	N/A	86%	78%***	78%***
<b>Weight Status</b>				
Overweight	38%	37%	35%	35%
Obese 	22%	27%	32%	30%
<b>Alcohol Consumption</b>				
Current drinker (drank alcohol at least once in the past month)	65%	69%	53%	54%
Binge drinker (defined as consuming more than four [women] or five [men] alcoholic beverages on a single occasion in the past 30 days) 	18%	26%	18%	17%
<b>Tobacco Use</b>				
Current smoker (currently smokes some or all days) 	14%	10%	23%	17%
Former smoker (smoked 100 cigarettes in lifetime and now do not smoke)	30%	27%	24%	25%
<b>Drug Use</b>				
Adults who used marijuana in the past six months	5%	5%	N/A	N/A
Adults who misused prescription drugs in the past six months	4%	5%	N/A	N/A

 Indicates alignment with the Ohio State Health Assessment


\* 2015 BRFSS as compiled by 2017 Community Health Rankings

\*\*Ohio and U.S. BRFSS reports women ages 21-65


\*\*\*2015 Ohio and U.S. BRFSS

Adult Variables	Geauga County 2011	Geauga County 2016	Ohio 2016	U.S. 2016
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Preventive Medicine				
Had a pneumonia vaccine in lifetime (age 65 and older)	N/A	81%	75%	73%
Had a flu vaccine in the past year (ages 65 and over)	41%	83%	57%	58%
Had a mammogram in the past two years (age 40 and older)	77%	78%	74%	72%
Had a pap smear in the past three years	N/A	69%	82%**	80%**
Had a PSA test in within the past two years (age 40 and over)	N/A	56%	39%	40%
Had a digital rectal exam within the past year	30%	24%	N/A	N/A
Quality of Life				
Limited in some way because of physical, mental or emotional problem	N/A	28%	21%***	21%***
Mental Health				
Considered attempting suicide in the past year	2%	3%	N/A	N/A
Sexual Behavior				
Had more than one sexual partner in past year	5%	2%	N/A	N/A
Oral Health				
Adults who have visited the dentist in the past year 	68%	79%	68%	66%

N/A – Not Available




 Indicates alignment with the Ohio State Health Assessment


\* 2015 BRFSS as compiled by 2017 Community Health Rankings

\*\*Ohio and U.S. BRFSS reports women ages 21-65

\*\*\*2015 Ohio and U.S. BRFSS

## 2018 CHNA Child Trend Summary Table

Child Comparisons	Geauga County 2011 Ages 0-5	Geauga County 2016 Ages 0-5	Ohio 2016 Ages 0-5	U.S. 2016 Ages 0-5	Geauga County 2011 Ages 6-11	Geauga County 2016 Ages 6-11	Ohio 2016 Ages 6-11	U.S. 2016 Ages 6-11
<b>Health and Functional Status</b>								
Rated health as excellent or very good	96%	96%	94%	93%	96%	96%	91%	89%
Rated health as fair or poor 	4%	4%	N/A	N/A	4%	4%	N/A	N/A
Dental care visit in past year	45%	63%	54%*	59%*	77%	85%	95%	91%
Diagnosed with asthma 	6%	10%	9%	6%	11%	12%	16%	15%
Diagnosed with ADHD/ADD	1%	0%	2%**	3%**	10%	7%	13%	9%
Diagnosed with behavioral or conduct problems	4%	1%	3%**	5%**	4%	2%	13%	11%
Diagnosed with vision problems that cannot be corrected	3%	1%	N/A	1%	2%	3%	N/A	2%
Diagnosed with bone, joint, or muscle problems	2%	3%	N/A	N/A	2%	5%	N/A	N/A
Diagnosed with epilepsy	2%	3%	N/A	1%	1%	2%	N/A	1%
Diagnosed with a head injury	2%	1%	N/A	1%	3%	4%	N/A	2%
Diagnosed with diabetes	1%	1%	N/A	N/A	<1%	1%	N/A	<1%
Diagnosed with depression	1%	1%	N/A	N/A	2%	3%	N/A	2%
Experienced two or more adverse childhood experiences 	N/A	6%	18%	12%	N/A	4%	29%	23%
<b>Health Care Coverage, Access and Utilization</b>								
Had public insurance	8%	17%	28%	37%	8%	5%	33%	38%
Have a personal doctor or nurse	79%	88%	75%	74%	81%	87%	77%	72%
Received all the medical care they needed	88%	95%	N/A	N/A	87%	94%	N/A	N/A
<b>Family Functioning, Neighborhood and Community Characteristics</b>								
Parent reads to child everyday	35%	44%	39%	38%	13%	12%	N/A	N/A
Family eats a meal together every day of the week	38%	43%	51%	53%	15%	33%	43%	45%
Child never attends religious services	27%	28%	N/A	N/A	18%	29%	N/A	N/A

 Indicates alignment with the Ohio State Health Assessment

N/A – Not Available

\*Ages 1-5 years old

\*\*Ages 3-5

\*\*\* The response rate for this question was significantly lower compared to 2011 Assessment. Please use numbers with caution.

Child Comparisons	Geauga County 2011 Ages 0-5	Geauga County 2016 Ages 0-5	Ohio 2016 Ages 0-5	U.S. 2016 Ages 0-5	Geauga County 2011 Ages 6-11	Geauga County 2016 Ages 6-11	Ohio 2016 Ages 6-11	U.S. 2016 Ages 6-11
<b>Early Childhood (0-5 Years Old)</b>								
Never breastfed their child	N/A	17%	30%	21%	N/A	N/A	N/A	N/A
<b>Middle Childhood (6-11 Years Old)</b>								
Parent felt child was usually/always safe at school	N/A	N/A	N/A	N/A	98%	99%	N/A	N/A
Child participated in 1 or more activities	N/A	N/A	N/A	N/A	N/A	51%	82%	76%
<b>Parent Health</b>								
Mother's mental or emotional health is fair/poor	2%	20%***	5%	5%	5%	12%***	9%	6%
Father's mental or emotional health is fair/poor	13%	24%***	5%	3%	2%	14%***	6%	3%

👍 Indicates alignment with the Ohio State Health Assessment



N/A – Not Available

\*Ages 1-5 years old







\*\*Ages 3-5

\*\*\* The response rate for this question was significantly lower compared to 2011 Assessment. Please use numbers with caution.

## Priority Health Needs

*Reminder: This symbol , will be used throughout the report when a priority, indicator, or strategy directly aligns with the 2017-2019 SHIP. This symbol , the Geauga County outline, will be used throughout the report when a priority, indicator, or strategy directly aligns with the 2018-2019 CHIP.*

### Priorities:

1. Mental Health and Addiction  
2. Chronic Disease  
3. Maternal and Infant Health  

### Cross-Cutting Factors:

1. Public health system, prevention and health behaviors  

## Significant Health Needs Not Being Addressed by the Hospital

The Partnership for a Healthy Geauga and key leadership at the Hospital agree that the focus should remain on the priorities identified above. This is based on the magnitude and severity of the conditions and the momentum already underway to address these needs. Although the Hospital is implementing strategies in all three of the 2018 CHNA priority areas, there are some initiatives within the focus areas that will be addressed by other Geauga partners based on their specific expertise, experience or resources. This include: a social marketing campaign promoting the availability of addiction prevention resources in Geauga county; school-based nutrition programming; WIC voucher distribution at farmer's markets and smoke-free worksite/housing advocacy.

## Strategies to Address Health Needs

An ad hoc IS committee was convened in July 2018 to solicit input from key staff at the Hospital, including the Chief Operating Officer, Chief Medical Officer, Chief Nursing Officer, Director of Clinical Services, Director of Operations and Community Outreach Nurse, affiliated community partners, and members of the Geauga County CHA-CHIP planning team. This committee was assembled to identify strategies that the Hospital will execute in view of lessons learned and current opportunities. To do this, the committee reviewed various sources of data including primary data from the 2018 CHNA, hospital utilization and discharge data from 2016, the evaluation of impact, and the previous 2016 IS. The committee agreed to continue the efforts of the previous IS. Therefore, the following strategies, goals and objectives were developed:

## Priority 1: Mental Health and Addiction

Priority #1: Mental Health and Addiction				
Strategy 1: Coordinated Care				
Goal: Decrease drug abuse among adults.				
Objective: By December 31, 2019, admit 10 patients per month to the inpatient medical stabilization program.				
Action Step	Priority Population	Responsible Party/ Collaborator	Timeline	Indicator(s) to measure impact of strategy:
The admission coordinator will continue to screen individuals and refer them to the hospital's inpatient medical stabilization program, or an appropriate outpatient treatment center if they do not qualify for inpatient services.	Adult	Admission Coordinator	December 31, 2019	Reduce unintentional drug overdose deaths: Number of deaths dues to unintentional drug overdoses per 100,000 population (age adjusted) <small>(Source for Data: ODH Public Health Data Warehouse)</small>
<p><b>Type of Strategy:</b></p> <p> <input type="radio"/> Social determinants of health           <input checked="" type="radio"/> Healthcare system and access  <input type="radio"/> Public health system, prevention and health behaviors           <input type="radio"/> Strategy is not specific to the SHIP         </p>				
<p><b>Strategy identified as likely to decrease disparities?</b></p> <p> <input type="radio"/> Yes           <input checked="" type="radio"/> No           <input type="radio"/> Strategy is not specific to the SHIP         </p>				
<p><b>Resources to address strategy:</b></p> <ul style="list-style-type: none"> <li>Hospital-level resources: Program coordinator and admission coordinator</li> <li>Community-level resources: Ravenwood and other mental health services</li> </ul>				

**Priority #1: Mental Health and Addiction** 

**Strategy 2: First responder overdose response training (Naloxone Access)** 

**Goal:** Increase awareness of response strategies to opioid overdoses.

**Objective:** Train 150 first responders on opioid overdose response strategies by January 1, 2020.

Action Step	Priority Population	Responsible Party/ Collaborator	Timeline	Indicator(s) to measure impact of strategy:
<p><b>Year 1:</b> Utilizing SAMHSA's <i>Opioid Overdose Prevention Toolkit: Five Essential Steps for First Responders</i>, or another evidence-based program or toolkit, such as Project DAWN, train first responders (EMS, police and schools) on how to respond to and treat an opioid overdose, such as the use of naloxone.</p> <p>Increase awareness of free naloxone distribution for lay responders.</p>	Adult	TBD	January 1, 2020	<ol style="list-style-type: none"> <li>1. Reduce overdose deaths: Number of overdose-related deaths for EMS/Emergency Room</li> <li>2. Increase naloxone distribution: Number of naloxone doses distributed</li> <li>3. Increase referrals: Number of referrals to treatment</li> </ol> <p><i>(Source for all Data: UH)</i></p>

**Type of Strategy:**

<input type="radio"/> Social determinants of health	<input checked="" type="radio"/> Healthcare system and access
<input type="radio"/> Public health system, prevention and health behaviors	<input type="radio"/> Strategy is not specific to the SHIP


**Strategy identified as likely to decrease disparities?**

Yes       No       Strategy is not specific to the SHIP

**Resources to address strategy:**

- Hospital-level resources: staff, UH pharmacy, Naloxone, curriculum
- Community-level resources: Narcan

## Priority 2: Chronic Disease

Priority #2: Chronic Disease 				
Strategy 1: Wellness Navigator				
Goal: Increase wellness screenings.				
Objective: By December 31, 2019, screen 1,200 patients a year for necessary wellness screenings and services.				
Action Step	Priority Population	Responsible Party/ Collaborator	Timeline	Indicator(s) to measure impact of strategy:
<b>Year 1:</b> The Wellness Navigator will continue to screen inpatients and outpatients, and facilitate scheduling services that are identified (i.e. mammogram, colonoscopy, calcium scoring, etc.)	Adult	Wellness Navigator	December 31, 2019	Increase patient referrals: Percent of inpatients and outpatients referred to another service by a Wellness Navigator. <i>(Source for Data: UH)</i>
<b>Type of Strategy:</b>				
<input type="radio"/> Social determinants of health <input type="radio"/> Healthcare system and access <input type="radio"/> Public health system, prevention and health behaviors <input checked="" type="radio"/> Strategy is not specific to the SHIP				
<b>Strategy identified as likely to decrease disparities?</b>				
<input type="radio"/> Yes <input type="radio"/> No <input checked="" type="radio"/> Strategy is not specific to the SHIP				
<b>Resources to address strategy:</b>				
<ul style="list-style-type: none"> <li>Hospital-level resources: Wellness navigator.</li> <li>Community-level resources: N/A</li> </ul>				

**Priority #2: Chronic Disease**

**Strategy 2: Screening events**

**Goal:** Increase prevention and early detection.

**Objective:** By December 31, 2019, host 175 screening events per year in Geauga County.

Action Step	Priority Population	Responsible Party/ Collaborator	Timeline	Indicator(s) to measure impact of strategy:
<b>Year 1:</b> Community Outreach will provide 175 chronic disease screening events during the year to facilitate early detection and mitigate chronic disease progression.	Adults	Community Outreach	December 31, 2019	1. Reduce coronary heart disease: Percent of adults ever diagnosed with coronary heart disease 2. Reduce diabetes: Percent of adults who have been told by a health professional that they have diabetes  <i>(Sources for all Data: CHNA and BRFSS)</i>

**Type of Strategy:**

Social determinants of health                       Healthcare system and access  
 Public health system, prevention and health behaviors                       Strategy is not specific to the SHIP


**Strategy identified as likely to decrease disparities?**

Yes                       No                       Strategy is not specific to the SHIP

**Resources to address strategy:**

- Hospital-level resources: Community outreach nurses and ancillary staff (lab, radiology, cardiology, SCC staff)
- Community-level resources: N/A



<b>Priority #2: Chronic Disease</b> 				
<b>Strategy 3: Cancer screening events</b>				
<b>Goal:</b> Increase early detection of cancer.				
<b>Objective:</b> By December 31, 2019, host 6 cancer screening events per year in Geauga County.				
Action Step	Priority Population	Responsible Party/ Collaborator	Timeline	Indicator(s) to measure impact of strategy:
<b>Year 1:</b> Community Outreach will provide 6 cancer screening events during the year to facilitate early detection.	Adults	Community Outreach	December 31, 2019	Increase cancer screenings: Number of adults who have been screened for cancer during UH outreach <i>(Source for Data: UH)</i>
<i>Type of Strategy:</i>				
<input type="radio"/> Social determinants of health <input type="radio"/> Healthcare system and access <input type="radio"/> Public health system, prevention and health behaviors <input checked="" type="radio"/> Strategy is not specific to the SHIP				
<i>Strategy identified as likely to decrease disparities?</i>				
<input type="radio"/> Yes <input type="radio"/> No <input checked="" type="radio"/> Strategy is not specific to the SHIP				
<i>Resources to address strategy:</i>				
<ul style="list-style-type: none"> <li>Hospital-level resources: Oncologist and support staff</li> <li>Community-level resources: N/A</li> </ul>				











## Community Collaborators

This IS was commissioned by University Hospitals. The Implementation Planning Team included:

- Adam Beach, University Hospitals
- Danielle Price, University Hospitals
- Diamond Page, University Hospitals
- Dan Ellenberger, University Hospitals
- Christi Gigliotti, Geauga County Health District
- Jason Pirtz, University Hospitals
- Julie Novak, University Hospitals
- Vicki Muir, University Hospitals
- Don DeCarlo, University Hospitals

This IS was facilitated and written by Britney Ward, Director of Community Health Improvement, and Emily Golias, Community Health Improvement Coordinator, of the Hospital Council of Northwest Ohio.

This IS will be implemented in collaboration with other entities including, but not limited to:

- Geauga County Health Department
- Geauga County Mental Health Recovery Services Board
- Geauga YMCA

## Qualifications of Consulting Company

This IS was facilitated and written by Britney Ward, Director of Community Health Improvement, and Emily Golias, Community Health Improvement Coordinator, of the Hospital Council of Northwest Ohio.

The Hospital Council of Northwest Ohio (HCNO) is a 501(c)(3) non-profit regional hospital association founded in 1972 that represents and advocates on behalf of its member hospitals and health systems and provides collaborative opportunities to enhance the health status of the citizens of Northwest Ohio. HCNO is respected as a neutral forum for community health improvement. HCNO has a track record of addressing health issues and health disparities collaboratively throughout northwest Ohio, and the state. Local and regional initiatives include: county-wide health assessments, community health improvement planning, strategic planning, disaster preparedness planning, Northwest Ohio Regional Trauma Registry, Healthcare Heroes Recognition Program and the Northwest Ohio Pathways HUB.

The Community Health Improvement division of HCNO has been conducting community health assessments (CHAs), community health improvement plans (CHIPs), and facilitating outcome focused multi-sectorial collaborations since 1999. HCNO has completed more than 90 CHAs in 44 counties. The model used by HCNO can be replicated in any type of county and therefore has been successful at the local and regional level, as well as for urban, suburban, and rural communities.

The HCNO Community Health Improvement Division has six full time staff members with Master's Degrees in Public Health (MPH), that are dedicated solely to CHAs, CHIPs, and other community health improvement initiatives. HCNO also works regularly with professors at the University of Toledo, along with multiple graduate assistants to form a very experienced and accomplished team. The HCNO team has presented at multiple national, state, and local conferences including the Centers for Disease Control and Prevention's Behavioral Risk Factor Surveillance System (BRFSS) conference, the Association of Community Health Improvement (ACHI) national conference, the Ohio Hospital Association (OHA) state conference, the Ohio Association of Health Commissioners (AOHC), and others.

## Contact

For more information about the Implementation Strategy, please contact:

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## Appendix A

### Ohio State Health Improvement Plan (SHIP)

*Note: This symbol , will be used throughout the report when a priority, indicator, or strategy directly aligns with the 2017-2019 SHIP.*

#### SHIP Overview

The Hospital closely considered the 2017-2019 State Health Improvement Plan (SHIP) when identifying strategies. The SHIP serves as a strategic menu of priorities, objectives, and evidence-based strategies to be implemented by state agencies, local health departments, hospitals and other community partners and sectors beyond health, including education, housing, employers, and regional planning.

The SHIP includes a strategic set of measurable outcomes that the state will monitor on an annual basis. Given that the overall goal of the SHIP is to improve health and wellbeing, the state will track the following health indicators in particular, to measure impact:

- **Self-reported health** status (reduce the percent of Ohio adults who report fair or poor health)
- **Premature death** (reduce the rate of deaths before age 75)

#### SHIP Priorities

In addition to tracking progress on overall health outcomes, the SHIP will focus on three priority topics:

1. **Mental health and addiction** (includes emotional wellbeing, mental illness conditions and substance abuse disorders)
2. **Chronic Disease** (includes conditions such as heart disease, diabetes and asthma, and related clinical risk factors-obesity, hypertension and high cholesterol, as well as behaviors closely associated with these conditions and risk factors- nutrition, physical activity and tobacco use)
3. **Maternal and Infant Health** (includes infant and maternal mortality, birth outcomes and related risk and protective factors impacting preconception, pregnancy and infancy, including family and community contexts)

#### Cross-cutting Factors

The SHIP also takes a comprehensive approach to improving Ohio's greatest health priorities by identifying cross-cutting factors that impact multiple outcomes. Rather than focus only on disease-specific programs, the SHIP highlights powerful underlying drivers of wellbeing, such as student success, housing affordability and tobacco prevention. This approach is built upon the understanding that access to quality health care is necessary, but not sufficient, for good health. The SHIP is designed to prompt state and local stakeholders to implement strategies that address the social determinants of health and health behaviors, as well as approaches that strengthen connections between the clinical healthcare system, public health, community-based organizations and sectors beyond health.

SHIP planners drew upon this framework to ensure that the SHIP includes outcomes and strategies that address the following cross-cutting factors:

- **Health equity:** Attainment of the highest level of health for all people. Achieving health equity requires valuing everyone equally with focused and ongoing societal efforts to address avoidable inequalities, historical and contemporary injustices, and the elimination of health and healthcare disparities.
- **Social determinants of health:** Conditions in the social, economic and physical environments that affect health and quality of life.
- **Public health system, prevention and health behaviors:**
  - The public health system is comprised of government agencies at the federal, state, and local levels, as well as nongovernmental organizations, which are working to promote health and prevent disease and injury within entire communities or population groups.
  - Prevention addresses health problems before they occur, rather than after people have shown signs of disease, injury or disability.
  - Health behaviors are actions that people take to keep themselves healthy (such as eating nutritious food and being physically active) or actions people take that harm their health or the health of others (such as smoking). These behaviors are often influenced by family, community and the broader social, economic and physical environment.
- **Healthcare system and access:** Health care refers to the system that pays for and delivers clinical health care services to meet the needs of patients. Access to health care means having timely use of comprehensive, integrated and appropriate health services to achieve the best health outcomes.

Alignment with the 2017-2019 SHIP

Beginning in 2020, IS’s will be required to select at least 2 priority topics, 1 priority outcome indicator, 1 cross cutting strategy and 1 cross-cutting outcome indicator to align with the SHIP (see Figure 1.1 on the next page). While SHIP-alignment is not a requirement for the 2019 IS, the SHIP was used as a guide in the creation of this document. The following 2019 IS priority topics, priority outcomes, cross cutting factors and cross-cutting outcomes very closely align with the 2017-2019 SHIP priorities:

<b>2019 IS Alignment with the 2017-2019 SHIP</b>			
<b>Priority Topic</b>	<b>Priority Outcome</b>	<b>Cross-Cutting Strategy</b>	<b>Cross-Cutting Outcome</b>
<b>Mental health and addiction</b>	<ul style="list-style-type: none"> <li>• Reduce unintentional drug overdose deaths</li> </ul>	<ul style="list-style-type: none"> <li>• Public health system, prevention and health behaviors</li> </ul>	<ul style="list-style-type: none"> <li>• N/A</li> </ul>
<b>Chronic Disease</b>	<ul style="list-style-type: none"> <li>• Reduce diabetes</li> <li>• Reduce heart disease</li> </ul>		
<b>Maternal and Infant Health</b>	<ul style="list-style-type: none"> <li>• N/A</li> </ul>		

**Figure 1.1. State Health Improvement Plan (SHIP) Overview**

**State health improvement plan (SHIP) overview**

**Overview of guidance for local alignment with the SHIP**

See [ODH guidance for aligning state and local efforts](#) for details

