

Grace Medical Center CHNA Implementation Plan

Health

Prioritized Need - Behavioral Health/Substance Abuse/Opioids	
Goal – Reduce fatalities among residents of West Baltimore who accidentally overdose.	
Actions:	<ol style="list-style-type: none"> 1. Provide Overdose Prevention Education and Training to 100% of all patients enrolled in Grace Medical Center operated OTP's. 2. Provide naloxone kits to enrollees within two business days after completing an overdose prevention training document.
Anticipated Impact:	Prevention of overdose fatalities among enrollees in OTP programs as well as the southwest Baltimore community in general.
Metrics Used to determine Progress:	<u># Naloxone Kits distributed</u> <u>#Total Enrollment in all OTP's.</u>
Resources (Staff and/or Budget):	Existing OTP staff to provide overdose prevention education and training to all OTP enrollees. Naloxone kits procured with grant funds
Leader(s):	Tara Buchanan, RN Heather Young, FNP

Prioritized Need – Behavioral Health/Substance Abuse/Opioids	
Goal – Improve the health status of residents of southwest Baltimore by increasing the number of SBIRT Interventions and Overdose Survivor's Outreach Program (OSOP) referrals by 10% over FY 19 totals for individuals who screen positive during their ED visits.	
Actions:	<ol style="list-style-type: none"> 1. Provide SBIRT Interventions and OSOP referrals in the Emergency Department and on the Observation unit at Grace Medical Center for individuals with a positive SBIRT screening. 2. Conduct follow-up telephone surveys to validate treatment referrals
Anticipated Impact:	Reduce ED visits for individuals diagnosed with identified Substance Use Disorders. Increase the number of Individuals who accept referrals to Substance Abuse Treatment.
Metrics Used to determine Progress:	<u># SBIRT/ OSOP referrals who kept referral appointments</u> <u># SBIRT/ OSOP referrals</u>
Resources (Staff and/or Budget):	Existing SBIRT Peer Recovery staff/ budget

Leader:	Dr. Nicole Wagner
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Health

Prioritized Need – Access to Care Providers (Primary, Pediatric, Specialty)	
Goals: 1) Improve and expand access to Primary Care, Preventive Services, and Specialty Care 2) Improve the health of the community by increasing the number of people connected to a primary care medical home and increasing annual primary care visits	
Actions:	<ol style="list-style-type: none"> 1. Increase capacity of services by reconstructing a new area to house Primary Care, and expanded Specialty Services including Ophthalmology, OB/GYN, and Pediatrics 2. Establish a Pediatric Clinic within our current Family Practice and protocols for referral 3. Establish OB/GYN Clinic 4. Establish Eye Clinic 5. Develop communications to the community in which we increase awareness of services and how to access 6. Ongoing referral coordination provided by Referral Coordinator in collaboration with Providers, and ED/Observation and Ambulatory Care Management teams. 7. Provide patient outreach by use of patient portal, letters, or phone calls to patients not seen in the practice within six months to schedule appointments 8. Referrals made from Community Programs and activities which identify patients without a medical home and/or patients at risk for chronic conditions 9. Conduct focused events (men’s health, and women’s health) and refer community members for utilization of services as needed 10. Community awareness and education provided to promote the importance of establishing a medical home, receiving preventive screenings and routine well visits 11. Transitions of Care activities from both ED/Observation Care - Transitions team and Ambulatory Care Management team to connect patients with Primary Care and Specialty Services to include appointment assistance, referrals, care coordination, and follow up with patients 12. Continue to assist patients with obtaining medical insurance via onsite vendor. Care Management teams identify and refer patients without insurance to the onsite vendor for assistance.
Anticipated Impact:	Overall improved access to Primary Care, Preventive Services, and Specialty Care.

Metrics Used to determine Progress:	<ol style="list-style-type: none"> 1. Increased Primary Care and Specialty Care volumes 2. Decreased inappropriate ED utilization 3. Improved preventive screening rates i.e. CRC, Breast Cancer 4. % of patients with post discharge appointment within 7 days 5. Number of people referred to care from Community Programs
Resources (Staff and/or Budget):	<ol style="list-style-type: none"> 1. Ambulatory Department 2. CHW Department 3. Care Management Team
Leader:	Dr. Sheikh and Michelle Berkley-Brown

Health

Prioritized Need – Chronic Conditions	
<p>Goal – Improve the health status of southwest Baltimore residents by engaging the community in screenings and educational events that promote healthier lifestyles and better self-management of health and chronic conditions</p> <p>Goal – Improve management of Chronic Conditions by early identification of patients at risk, provision of care, and management of those with chronic conditions</p>	
Actions:	<ol style="list-style-type: none"> 1. Health Education programs, Community Screenings, and Chronic Disease Management programs will be conducted in the community, independent senior buildings, and faith-based organizations to promote healthier lifestyle and self-management of chronic illness. These programs include: Healthy Living Series, Chronic Disease Self-Management Program, Freedom from Smoking, Health and Housing Program, and Faith Community Partnership 2. Provision of blood pressure devices and education for patients to monitor blood pressure at home and communicate readings with provider. 3. Diabetic education provided by DM educator to diabetic patients in both ambulatory and observation care setting. 4. Provide educational programs to youth in public schools about proper nutrition, diet and exercise and the interplay with health and wellness. 5. Care Transitions team completes high risk assessment on all admissions to ED and Observation level of care; and team ensures a primary care appointment is obtained prior to discharge. This effort includes connecting to Community Care Management 6. Enrollment into Community Care Management programs for specific disease state education and management

	<ol style="list-style-type: none"> 7. Care Transitions team will complete home visits to high risk community members with chronic conditions to ensure medication reconciliation, medication compliance, and follow up appointment compliance. 8. Care Transitions will assist with nutritional support through Meals on Wheels
Anticipated Impact:	Decreased morbidity and mortality from chronic conditions such as Diabetes, HTN, heart disease, and COPD.
Metrics Used to determine Progress:	<ol style="list-style-type: none"> 1. Decreased readmission rate. 2. Decreased primary care no show rates. 3. Increased number of patients connected to primary care. 4. Decreased inappropriate ED utilization 5. Increased number of people reached through health fairs, educational workshops and events
Resources (Staff and/or Budget):	<ol style="list-style-type: none"> 1. Community Health & Wellness team 2. Care Transitions Team 3. Ambulatory Care Management team 4. Ambulatory Providers
Leader:	Karen Jarrell, Michelle Berkley-Brown, and Rhonda Williams

Social and Environmental

Prioritized Need – Community Engagement [and Development]	
Goal - To address key health and socio-economic challenges in West Baltimore through community-based initiatives.	
Actions:	<ul style="list-style-type: none"> • In partnership with Population Health and Baltimore Child Abuse Center (BCAC); offer two health education-based workshops and/or events each year to the West Baltimore community. • Build partnerships with two workforce development organizations and conduct two outreach events per year to connect area residents to employment opportunities. • Test two new non-technological strategies to reduce information gaps and improve communication to both community members and medical personnel on hospital services, programs, and initiatives as well as community-based resources. • Promote quality, healthy food access in West Baltimore through an initiative, e.g. food education, food market or organizational partnership. • Expand LifeBridge Health <i>Live Near Your Work</i> program in the West Baltimore service area.
Anticipated Impact:	<ul style="list-style-type: none"> • Increase access to health education, child abuse prevention, violence prevention, and other outreach opportunities to West Baltimore residents.

	<ul style="list-style-type: none"> • Increase opportunities for skills training, workforce development and employment for West Baltimore residents. • Decrease communication barriers while increasing access to health resources within the community. • Enhance community and hospital stability, through neighborhood revitalization efforts. • Expand access to healthy food options and resources to west Baltimore residents
Metrics Used to determine Progress:	<p>Reach:</p> <ul style="list-style-type: none"> • # of people attending events • # of classes/workshops/events offered • # of communication strategies initiated • # of partnerships initiated <p>Outcomes:</p> <ul style="list-style-type: none"> • # of people completing post event surveys • % of participants completing classes/workshops • # of communication strategies implemented • # of partnerships cultivated and maintained
Resources (Staff and/or Budget):	<ul style="list-style-type: none"> • Dedicated HSCRC/Community Benefit funding • Foundation Board Members • Additional Partnerships as Needed
Leader:	Sommer/Merritt

Social and Environmental

Prioritized Need – Crime and Trauma	
Goal - To address existing trauma and to prevent future trauma caused by violence within the west Baltimore community (zip codes 21223, 21217, 21216 – in descending order)	
Actions:	<ol style="list-style-type: none"> 1. Provide Violence Intervention & Prevention Awareness training for all GMC staff on all forms of violence & abuse 2. Assess need for onsite violence responders & community violence interrupters (i.e. establish a Safe Streets site) to ensure that patients who have been victims of gun violence, stabbings, domestic violence, elder abuse, and other forms of violence have the support needed while at Grace Medical and within the community 3. Provide Case Management, including individualized needs assessments, tailored case planning, and community-based client advocacy, for survivors of violence related trauma 4. Provide trauma-responsive mental health services for survivors of violence related trauma 5. Provide school-based violence prevention services, including academic enrichment opportunities, life skills training, and

	student support groups through an evidence-based violence prevention curriculum	
Anticipated Impact:	<ol style="list-style-type: none"> 1. 100% of staff trained in violence-related risk and protective factors and other challenging dynamics within 12 months 2. Increase safety planning and continuity of community care with survivors of violence by 50% within 12 months 3. Increase school attendance rates for program participants by 40% within 24 months 4. Decrease arrests of program participants by 30% within 24 months 5. Decrease CPS referrals of program participants by 30% within 24 months 6. Increase community resource connections of program participants by 80% within 12 months 7. Increase access to mental health services for survivors of violence by 25% within 18 months 	
Metrics Used to determine Progress:	<ol style="list-style-type: none"> 1. Number of staff trained in Violence Intervention and Prevention dynamics compared to total number of staff 2. Number of patients connected to hospital and community-based violence response compared to number of patients presenting with violence-related injuries 3. Client-reported school attendance rates; verified by school records 4. Client-reported arrests; verified by arrest records 5. Client-reported CPS referrals; verified by CPS records 6. Client-reported community resource connections made 7. Number of mental health clients compared to need assessed within community 	
Resources (Staff and/or Budget):	Manager of Case Management Team (35%)	
	School-based Coordinator (100%)	
	Case Manager (100%)	
	Hospital-based Violence Responder (100%)	
	Trauma Therapist (100%)	
	Fringe (22%)	
	Total Cost	\$ 295,240
Leader:	Adam Rosenberg	

Access

Prioritized Need – Transportation	
Goal – Provide transportation to community residents for clinic appointments and dialysis treatments	
Actions:	<ol style="list-style-type: none">1) Further develop request system for rides to Primary Care and Specialty Care clinic appointments2) Continue to provide transportation to dialysis patients to facilitate treatments3) Assess fleet needs to accommodate additional riders who need transportation to physician appointments or outpatient dialysis4) Assess community needs for transportation of family members to visit loved ones at Sinai, Northwest and Levindale hospitals.
Anticipated Impact:	Improved access by community for medical services at Grace Medical Center; Increased availability for hemodialysis services to the community; increased efficiency and effective use of Grace clinics
Metrics Used to determine Progress:	Patient ride volumes and reduced missed appointments
Resources (Staff and/or Budget):	4 drivers, 3 fourteen passenger buses
Leader:	Stephen Winstead/John Knapp