

Implementation Plans for Sinai Hospital Prioritized Needs 2021-2024

The following Identified Needs were selected as **Priorities** for Sinai Hospital of Baltimore and will be included in the 2021 – 2024 Implementation Plan:

1. Chronic Heart Disease
2. Mental Health, Depression, and Substance Use Disorder
3. Community Health and Wellness Education
4. Diabetes
5. Housing
6. Food Insecurity
7. Community Safety
8. Health Disparities

Specific implementation plans for each of these areas are described in the following pages.

In addition, Sinai Hospital will also work to address the following needs identified by the community:

- Workforce Development
- Transportation
- Improved Access to Care and Health Insurance
- Community Engagement and Coordination of Services

CHRONIC HEART DISEASE - IMPLEMENTATION PLAN

July 2021

Aims and Drivers Diagram

Improvement Drivers	Tactics	Metrics to Assess Progress
<p>Provider adherence to latest cardiac disease management guidelines.</p>	<ul style="list-style-type: none"> • CIN Heart Failure Pathway implementation (e.g., consistent use of HF order set in hospital). • Cardiologists update LBH primary and specialty care providers on best practice management for Ischemic Heart Disease, Heart Failure (i.e., via series of CME webinars). • Define, measure, and improve use of Guideline-Directed Medical Therapy for pts with Ischemic Heart Disease, Heart Failure. • Define expectations, criteria, and process to assess for and refer eligible patients to Palliative/Supportive Care. • Implement comprehensive training (clinical, medication reconciliation, use of SDOH tools, etc.) at various intervals to keep all care providers up to date on optimal approaches for care of this population. • Develop reporting to track progress on performance measures. 	<ul style="list-style-type: none"> - Usage of HF order set. - Cardiologist-led webinars for Primary Care Providers completed; number of participants. - % patients on ACE/ARB, Beta Blocker, Statin - # of palliative/ supportive care consultations.
<p>Reliable transition planning and communication at discharge.</p>	<ul style="list-style-type: none"> • Follow-up appt with PCP set, prior to hospital discharge, for within 7 days post-discharge. • Med Rec completed, Rx filled prior to discharge. Med Rec includes assessment of meds patient already has at home. • Communicate discharge summary with primary care provider within 2 days of discharge. • Follow-up call to patient within 2 days of discharge (preferably by RN). 	<ul style="list-style-type: none"> - % of follow-up phone calls to patients completed within 2 days of discharge. - % of discharges with clinic visits within 7 days. - Number of medication issues identified post-discharge. - Track and document standard categories of social issues identified, i.e., financial, health literacy/ numeracy issues.
<p>Regular access to primary care and cardiologists.</p>	<ul style="list-style-type: none"> • Utilize mobile clinics and/or community partnerships to improve health care access for cardiovascular patients in communities. • Outreach to established patients who haven't been seen in primary care in last year. • Monitor/improve screening for heart disease in primary care. • Explore expansion of home/remote monitoring (e.g., BP cuff, scales) • Regularly screen to identify and address depression. • Increase annual visits with cardiac specialists. 	<ul style="list-style-type: none"> - % of Ischemic Heart Disease, Heart Failure pts with 1+ primary care/ cardiologist visits per year. - % of CVD, HF pts screened for depression and action taken if depressed.
<p>Identify, address social barriers to better health management.</p>	<ul style="list-style-type: none"> • Regularly screen this population to identify Social Determinants of Health (SDOH). • Refer patients with social needs to support programs. 	<p>% of SDOH pts with completed referrals to social support programs.</p>

CHRONIC HEART DISEASE - IMPLEMENTATION PLAN

July 2021

Improvement Drivers	Tactics	Metrics to Assess Progress
	<ul style="list-style-type: none"> • Assess for, then create and implement strategies for patient health literacy/numeracy issues. • Caretaker – Ask patient if they have someone who helps them manage; invite that person to encounters. • Review and teach clinicians/community health workers best practices on how to conduct SDOH assessments and enhance patient self-reporting. 	<p>- Create strategies to target/track specific patients for more individualized/focused support.</p>
<p>Community/ Patient education and engagement on prevention and self-management.</p>	<ul style="list-style-type: none"> • Regular educational calls, webinars, screenings for community members, focused on high-risk populations. • Create and distribute comprehensive Heart Failure patient self-management guide. • Utilize mobile clinics and/or community partnerships to improve health care access for cardiovascular patients in communities. • Identify/establish healthy, affordable recipe resources, including recipes that are culturally relevant. • Identify/establish grocery store partnerships on nutrition, medication support. • Support physical activity resources and opportunities for this population (e.g., walking groups, 'Fitness Fridays,' LBH Health and Fitness). 	<p># of PCP pts, caretakers referred to education sessions. # of pts, caretakers participating in education programs. # of pts with improved meds adherence, diet or exercise habits, reduced tobacco usage.</p>
<p>Partner with American Heart Association.</p>	<ul style="list-style-type: none"> • Work with American Heart Assn. to identify and implement relevant AHA resources/tools to support this population. 	<p>- AHA programs/ tools implemented.</p>

MENTAL HEALTH AND SUBSTANCE USE DISORDER – IMPLEMENTATION PLAN

July 2021

Aims and Drivers Diagram

Improvement Drivers	Tactics	Metrics to Assess Progress
Develop crisis response alternatives to ED for Mental Health/SUD.	<ul style="list-style-type: none"> • GBRICS Program (including a centralized call center) 	- GBRICS call volumes and related data.
Access to Medically Assisted Treatment (MAT) for SUD	<ul style="list-style-type: none"> • Sinai Hospital Addiction Recovery Program (SHARP) 	- # of individuals treated in SHARP program
Peers counsel patients into SUD treatment	<ul style="list-style-type: none"> • SBIRT Program with Peer Counselors based in Emergency Departments 	- # of SBIRT/OSOP referrals - # of SBIRT/OSOP Referrals kept.
Screen/refer patients with substance abuse disorder	<ul style="list-style-type: none"> • Implement universal screening questionnaire in Cerner for outpatient practices. 	- # of LBH internal referrals received from PCPs.
Screen/refer patients with depression/anxiety	<ul style="list-style-type: none"> • Implement universal screening questionnaire in Cerner for outpatient practices. 	- # of LBH internal referrals received from PCPs.
Expand availability/access to non-crisis behavioral health services: e.g., walk-in, virtual behavioral health services, resources	<ul style="list-style-type: none"> • Reassess need for more community-based clinics in Sinai service area. • Explore embedding behavioral health at Sinai Community Care. • Explore use of Mosaic Community Services to improve rapid accessibility to mental health services. • Explore Telehealth/TelePsych as a mode of improving access. 	- Readmission data - ED visit data Market analysis
Improve access, reduce barriers to residential, long-term care	<ul style="list-style-type: none"> • Explore local area/Pimlico real estate purchase to support residential, long-term care for Sinai community residents. 	-# of Sinai patients using residential, long-term care
Stigma reduction campaign	<ul style="list-style-type: none"> • Explore stigma reduction campaign opportunities with City government. 	

COMMUNITY HEALTH & EDUCATION – IMPLEMENTATION PLAN

July 2021

Aims and Drivers Diagram

Improvement Drivers	Tactics	Metrics to Assess Progress
Education on prevention of chronic disease	<ul style="list-style-type: none"> • Develop and implement educational initiatives in communities about preventing chronic disease (e.g., preparation of healthy foods, transportation to supporting resources/activities). • Explore referral ‘bonus’ for referring family and friends to education programs. 	<ul style="list-style-type: none"> -# of patients participating in programs - # of patients demonstrating decreased risk factors and/or hospital utilization based on pre and post measurements
Targeted education/support on diabetes management	<ul style="list-style-type: none"> • Implement Diabetes Regional Partnership grant (with St. Agnes): zips 21229, 21223, 21216, 21215, 21207. <ul style="list-style-type: none"> - Improve healthy behaviors through education and support with focus on pre-diabetes • Create and distribute comprehensive Diabetes and Heart Failure patient self-management guides. • Implement regular educational calls, webinars, screenings for community members focusing on high-risk populations. • Explore/implement use of Mobile Clinic to assist with education in community. 	<ul style="list-style-type: none"> -# of pts participating in education programs. - # of pts with improved medication adherence, diet or exercise habits, reduced tobacco usage.
Reliable transition planning and communication at discharge	<ul style="list-style-type: none"> • Med Rec completed, Rx filled prior to discharge. Med Rec includes assessment of meds patient already has at home. Ensure patient/family member understands medication regimen (e.g., use “teach back”) • Provide needed education, resources/equipment prior to discharge (e.g., testing strips). • Follow-up call to patient within 2 days of discharge (preferably by RN). Provide education to support self-management. • Communicate discharge summary with primary care provider within 2 days of discharge. • Explore implementation of a Community Pastoral Outreach process for spiritual needs of hospitalized patients and to reach individuals who have been discharged. 	<ul style="list-style-type: none"> - Number of medication issues identified post-discharge. - Track and document categories of social issues identified that can impact health.
Target disease processes with specific disease management education	<ul style="list-style-type: none"> • Education offerings that focus on living in a community of limited resources and managing disease • Education offerings that focus on resources that are available both during crisis and when patient may just need something small • Explore marketing and public relations initiatives to educate/benefit community members 	<ul style="list-style-type: none"> -Decrease in ED visits -Increase in the use of other resources (e.g., 24 hr nurse line)

DIABETES – IMPLEMENTATION PLAN

July 2021

Aims and Drivers Diagram

Improvement Drivers	Tactics	Metrics to Assess Progress
<p>Provider adherence to latest diabetes disease management guidelines.</p>	<ul style="list-style-type: none"> • CIN Diabetes Pathway implementation (e.g., update and implement inpatient Diabetes order set) • Endocrinologists update LBH primary and specialty care providers on best practice management for Diabetes (i.e., via series of CME webinars). • Monitor and improve guideline-directed medical therapy for pts with Diabetes. • Assess for and refer eligible patients to Palliative/Supportive Care. • Develop reporting to track progress on performance measures. 	<ul style="list-style-type: none"> - Consistent use of Diabetes order set - Webinars completed, number of participants - # of palliative/ supportive care consultations
<p>Reliable transition planning and communication at discharge.</p>	<ul style="list-style-type: none"> • Follow-up appt with PCP set, prior to hospital discharge, for within 7 days post-discharge. • Med Rec completed, Rx filled prior to discharge. Med Rec includes assessment of meds patient already has at home. • Communicate discharge summary with primary care provider within 2 days of discharge. • Follow-up call to patient within 2 days of discharge (preferably by RN). 	<ul style="list-style-type: none"> - % of follow-up phone calls completed within 2 days of discharge. - % of discharges with clinic visits in 7 days. - # of meds issues identified post-discharge. - Track and document standard categories of social issues identified that can impact health outcomes, i.e., financial, health literacy/ numeracy issues.
<p>Improve healthy food availability in priority areas</p>	<ul style="list-style-type: none"> • Implement Diabetes Regional Partnership grant (with St. Agnes): zips 21229, 21223, 21216, 21215, 21207. <ul style="list-style-type: none"> - Improve education around diabetes prevention/management and access to healthy food 	
<p>Improve access to care. Regular primary care visits; endocrinologist visits when needed.</p>	<ul style="list-style-type: none"> • Primary Care reaches out to patients with Diabetes and A1c\geq7 for regular testing (3x a year). • Outreach to established patients who haven't been seen in primary care in last year. • Monitor/improve screening for pre-diabetes in primary care. • Utilize mobile clinics and/or community partnerships to improve health care access for diabetes patients in communities. • Regularly screen for and address depression. • Refer to Endocrinologist pts with Type 1 diabetes or poorly controlled Type 2 diabetes. 	<ul style="list-style-type: none"> - % of pts with new primary care access. - % of diabetic pts w/ A1c test 3x annually. - % of Diabetic pts screened for depression and action taken if depressed.

DIABETES – IMPLEMENTATION PLAN

July 2021

Improvement Drivers	Tactics	Metrics to Assess Progress
<p>Identify, address social barriers to better health management.</p>	<ul style="list-style-type: none"> • Regularly screen this population to identify Social Determinants of Health (SDOH). • Refer patients with social needs to support programs. • Assess for, then create and implement strategies for patient health literacy/numeracy issues. • Review and teach clinicians/community health workers best practices on how to conduct SDOH assessments and enhance patient self-reporting. 	<p>- % of SDOH pts with completed referrals to social support programs.</p> <p>- Create strategies to target/track specific patients for more individualized/focused support.</p>
<p>Community/Patient education and engagement focused on prevention and mgmt.</p>	<ul style="list-style-type: none"> • Regular educational calls, webinars, screenings for community members focused on high-risk populations. • Create and distribute comprehensive Diabetes patient self-management guide. • Implement Diabetes Regional Partnership grant (with St. Agnes): zips 21229, 21223, 21216, 21215, 21207. <ul style="list-style-type: none"> - Improve healthy behaviors with focus on pre-diabetes • Utilize mobile clinics and/or community partnerships to improve health care access for diabetic patients in communities. • Identify/establish healthy, affordable recipe resources, including recipes that are culturally relevant. • Identify/establish grocery store partnerships on nutrition, medication support. • Support physical activity resources and opportunities for this population (e.g., walking groups, 'Fitness Fridays,' LBH Health and Fitness). 	<p>- Pts participating in education programs.</p> <p>- Pts with improved medication adherence, diet or exercise habits, reduced tobacco usage.</p>
<p>Partner with American Diabetes Association.</p>	<ul style="list-style-type: none"> • Work with ADA to identify and implement relevant ADA resources/tools for this population. 	<p>- ADA programs/ tools implemented.</p>

HOUSING INSECURITY – IMPLEMENTATION PLAN

July 2021

Aims and Drivers Diagram

Improvement Drivers	Programs/Tactics	Metrics to Assess Progress
Create health care resources/access where people live (meet individuals where they are)	<ul style="list-style-type: none"> • Explore partnerships with large residences to provide periodic health education programs. • Possible pilot: “Integrated Complex Care at Home (ICCH)” for seniors in affordable housing. Potential CHRC grant opportunity (Aug/Sep 2021). Collaboration with National Well Home Network, Enterprise Community Development. • Live Near Your Work program 	-# of educational program participants. -CRISP Pre/Post report assessing hospital utilization before and after program enrollment. -# of LifeBridge employees participating in Live Near Your Work program.
Improve living conditions to reduce injuries and chronic disease exacerbations (e.g., grab bars, air conditioners, address mold, lead paint, radon)	<ul style="list-style-type: none"> • Housing Upgrades to Benefit Seniors (HUBS) program. 	-Sinai/Levindale patients accepted into HUBS program.
Reduce homelessness	<ul style="list-style-type: none"> • Baltimore City and 10-hospital partnership to provide housing for homeless residents. 	-# of Sinai/Levindale patients benefiting from program.
Identify/help address social determinant of health barriers that may impact housing security.	<ul style="list-style-type: none"> • Identify housing and/or social issues that threaten housing security at hospital or primary care visit. • Address housing and/or social issues that threaten housing security at hospital or primary care visit. • Referrals to community housing support partners. • Keep active directory of housing counseling services. 	-# of Sinai/Levindale patients with identified social issues that may impact housing security. -# of Sinai/Levindale patients referred to services that support housing security.
Address loneliness and isolation	<ul style="list-style-type: none"> • Partner with or create neighborhood-based programs, clubs, walks that can bring residents together to reduce isolation. 	
Help enhance quality of neighborhoods (green space, crime reduction, walkability)	<ul style="list-style-type: none"> • Explore connecting Cylburn and Pimlico (e.g., development of a shared-use biking path) • Explore programs to “green” Lanier and Cylburn areas • Explore implementation of a Pimlico safe walkability/ wayfinding project 	
Temporary respite – safe place	<ul style="list-style-type: none"> • Explore creation/use of housing resources for a health recovery support program 	

FOOD INSECURITY – IMPLEMENTATION PLAN

July 2021

Aims and Drivers Diagram

Improvement Drivers	Tactics	Metrics to Assess Progress
<p>Healthy Food Availability (quality, quantity, variety, price, location)</p>	<ul style="list-style-type: none"> • Partner with community organizations working to enhance healthy food availability and/or delivery. • Explore partnership with community organizations working to establish/expand urban vegetable gardens. • Explore creation of farmers market on or near Sinai/Levindale facilities. • Diabetes Regional Partnership grant (with St. Agnes): zips 21229, 21223, 21216, 21215, 21207 to improve access to healthy food for residents at risk for diabetes. 	<ul style="list-style-type: none"> - # of individuals served through programs. - Sales at farmers’ market. - Community testimony.
<p>Access (transportation, income, social support, time, priorities)</p>	<ul style="list-style-type: none"> • Explore Hungry Harvest program implementation (farmers market; tailored food delivery (e.g., diabetic friendly)) • Explore ongoing area Food Waste Reduction initiatives for potential to redirect/repurpose food. • Explore implementation of Healthy Food as Medicine programs (e.g., providers can provide vouchers for vegetables). • Explore opportunities with Maryland Food Bank on access points and delivery. • Explore partnerships with schools on access to and distribution of healthy food. • Explore partnerships with schools to provide teaching on nutrition for health. 	<ul style="list-style-type: none"> - # of individuals served through programs. - # of new initiatives launched. - Community testimony.
<p>Utilization (food literacy, cooking ability, cooking facilities, time)</p>	<ul style="list-style-type: none"> • Diabetes Regional Partnership Program – Food Project – meal preparation classes planned. Identify/create/adapt healthy recipe book. Consider food preferences, especially re: cultural needs (e.g., Passover). • Identify and refer patients to cooking demonstrations for healthy/affordable/culturally relevant meals. • Explore collaboration with American Heart Association, American Diabetes Association to improve access to healthy meal options. • Explore opportunities through 4H Extension offices – curriculum geared around healthy meal preparation in city. 	<ul style="list-style-type: none"> - # of individuals served through programs. - # of cooking demonstrations held. - Community testimony
<p>Stability (Availability and Access at all times)</p>	<ul style="list-style-type: none"> • Explore sustainability of farmers markets at or near Sinai/Levindale. • Identify/develop and make accessible to LifeBridge care managers and social workers a list of active food pantries in area and their schedules. • Explore funding to provide food vouchers to community residents at Sinai/Levindale (e.g., to get meals at facility’s cafeteria, etc.) 	<ul style="list-style-type: none"> - # of multi-year food access initiatives launched/underway.

COMMUNITY SAFETY – IMPLEMENTATION PLAN

July 2021

Aims and Drivers Diagram

Improvement Drivers	Tactics	Metrics to Assess Progress
<p>Improve economic opportunity for youth and adults (e.g., job opportunity, job placement)</p>	<ul style="list-style-type: none"> • Work with community elementary/middle schools to assist with training in workforce expectations and career skills. • Support local training programs to develop Community Health Workers. • LBH Talent Acquisition works to hire candidates from community organizations that provide job training. • Partner with “Turnaround Tuesday” community organization • Clean and Green Initiative (training, mentorship) - partner with Park Heights Renaissance Foundation. 	<ul style="list-style-type: none"> - # of completed trainings/ initiatives at community elementary/middle schools. - # of students participating in training. - Funding/resources expended to support CHW training. -# of individuals hired by LBH through community organizations that provide job training.
<p>Address mental health, stress, depression/anxiety</p>	<ul style="list-style-type: none"> • Connect referred community residents to case managers and victim advocates • Incorporate trauma training into mental health treatment • Partnership with the National Alliance on Mental Illness (NAMI) to focus on support for adults in our community 	<ul style="list-style-type: none"> -% improvements in Hope & Resiliency scores
<p>Build a strong social network; support a robust socio-cultural environment to counter community trauma and promote healing and connection</p>	<ul style="list-style-type: none"> • Promote community violence prevention education & awareness • Implement youth mentoring programs. • Build/Foster neighborhood support groups. 	<ul style="list-style-type: none"> -# of people trained/benefiting from prevention/awareness programs. -# of neighborhood support groups created/supported.
<p>Address Adverse Childhood (abuse, neglect, household dysfunction) & Adverse Community Experiences (witness to violence, poverty, foster care)</p>	<ul style="list-style-type: none"> • Screening in practices, ED, and various points of entry • Improve internal LBH education & awareness 	<ul style="list-style-type: none"> -% improvements in Hope & Resiliency scores
<p>Provide a coordinated system of response and care to suspected abuse, intrapersonal violence, and trauma</p>	<ul style="list-style-type: none"> • Operate accredited advocacy centers in coordination with partners in law enforcement, social services, prosecution 	<ul style="list-style-type: none"> Satisfaction survey results of partner agencies
<p>Improve Safety</p>	<ul style="list-style-type: none"> • Track number of people supported through Safe Streets Program. • Track number of individuals benefiting from work of Kuji Center. 	<ul style="list-style-type: none"> -# of individuals served by/benefiting from Safe Streets and Kuji programs.

HEALTH DISPARITIES REDUCTION – IMPLEMENTATION PLAN

July 2021

Goal: Reduce disparities, especially for communities of color in targeted areas compared to white population at baseline. In addition, reduce disparities for non-English speaking populations and LGBTQ communities.

Aims and Drivers Diagram

Improvement Drivers	Tactics	Metrics to Assess Progress
Build trust in health care services by linking to existing community relationships	<ul style="list-style-type: none"> • Work with Faith-Based Organizations in prioritized communities to better provide community residents with education, information about maintaining health. • Work with Barbershops/Salons in prioritized communities to better provide community residents with education, information about maintaining health and accessing care resources. 	<ul style="list-style-type: none"> - # of pts participating in education programs, screenings. - # of new pts referred to LBH providers.
Reduce implicit bias in provision of health care services	<ul style="list-style-type: none"> • Explore implementation of training for health care providers on what implicit bias is and how to recognize and address it. 	<ul style="list-style-type: none"> - # of health care workers trained
Bring health care access closer to where people are	<ul style="list-style-type: none"> • Deploy Mobile Clinic to communities of opportunity. • Work with Barbershops/Salons in prioritized communities to increase access/referrals to health care services. • Explore expansion of behavioral health care access in community. • Explore partnerships with school-based health centers (e.g., on topics such as healthy behaviors, telehealth, obesity, depression). 	<ul style="list-style-type: none"> - COVID vaccination uptake among communities of color. - # of pts referred to LBH providers.
Expand non-traditional access to primary health care	<ul style="list-style-type: none"> • Use Mobile Clinic to reach underserved neighborhoods. • Explore options to expand telehealth access in communities. • Explore implementation of a 24-hour nurse line. 	<ul style="list-style-type: none"> - # of telehealth visits in priority communities. - # of calls to 24-hour nurse line.
Improve patients' skills to manage their chronic conditions	<ul style="list-style-type: none"> • Implement regular educational calls, webinars, community screenings to support better patient understanding and self-management of their chronic conditions. • Update and distribute comprehensive chronic condition patient self-management guides (e.g., diabetes, heart failure). 	<ul style="list-style-type: none"> - # of ED visits of pts with diabetes, chronic heart disease. - Change in # of primary care visits among priority populations. - # of participants in educational events, screenings.
Identify and address Health Literacy, Numeracy, Cultural, Language differences	<ul style="list-style-type: none"> • Implement screening for patient health literacy/numeracy across the care continuum. • Develop recommendations for care team on ways to assist patients with low health literacy/numeracy. • Create/update patient education materials, instructions that take into account potential health literacy and numeracy barriers. 	<ul style="list-style-type: none"> -# of patients screened for health literacy/numeracy. -Sharing of health literacy/numeracy status among health care team (e.g., in electronic medical record)

HEALTH DISPARITIES REDUCTION – IMPLEMENTATION PLAN

July 2021

Goal: Reduce disparities, especially for communities of color in targeted areas compared to white population at baseline. In addition, reduce disparities for non-English speaking populations and LGBTQ communities.

Improvement Drivers	Tactics	Metrics to Assess Progress
Reduce Food Insecurity, Expand access to healthier food	<ul style="list-style-type: none">• Diabetes Regional Partnership grant (with St. Agnes): zips 21229, 21223, 21216, 21215, 21207.<ul style="list-style-type: none">○ Improve access to healthier food and knowledge about diabetes prevention and management• Partner with local organizations, businesses, and/or government to explore improvements to community access to healthy, affordable food choices.• Advocate policy changes with City, State governments.	<ul style="list-style-type: none">- # of healthy food initiatives/ access points established in priority communities.- # of community members served by new food initiatives.