Implementation Plan for Sinai Hospital's and Grace Medical Center's Prioritized CHNA Needs

2024-2027

The following community-identified needs were selected as **priorities** for improvement by Sinai Hospital of Baltimore and Grace Medical Center for their 2024-2027 Community Health Needs Assessment (CHNA) Implementation Plan. Each of these plans are described in the following pages.

1. **Access to Care**
2. **Mental Health/Substance Use Disorders**
3. **Health Disparities**
4. **Physical Health**
5. **Food Security**

Sinai Hospital and Grace Medical Center will additionally work to address many of the following specific needs identified through their latest Community Health Needs Assessment that informed the above-listed priorities.

Health Problems:

1. *High Blood Pressure*
2. *Diabetes*
3. *Addiction/Substance Use*
4. *Mental Health*
5. *Chronic Pain/Arthritis*

Social Problems:

1. *Gun Violence*
2. *Can't Afford Healthy Foods*
3. *Poor Neighborhood Safety*
4. *Housing Problems/Homelessness*
5. *Limited Knowledge about Healthy Foods*

Access to Care

Prioritized Need: Access to clinical care providers, health screening and education, and health-supporting resources.

Population Definition: Underserved communities in LifeBridge service areas.

Potential Programs and Tools for Improvement:

- Provision of transportation vouchers (e.g., Uber, Lyft) to help individuals access medical appointments and health-supporting social services.
- LifeBridge Mobile Clinic outreach that brings to where people live health screenings and clinical care, health education, and access to health insurance sign-up and social resources.
- Wider access to interpretation and translation services for community members for whom English is not their first language.
- Form and maintain partnerships with community organizations who have regular contact with underserved community members.
- Increase virtual appointments and digital medicine access for Sinai and Grace community members.
- Explore primary care access expansion in the Sinai/Grace area (including developing, strengthening relationships with area FQHCs if necessary).
- Consider expansion of “Open Doors” model of embedding Community Health Workers in select LifeBridge clinics and/or community organizations.
- Research and segment health care access data, including by demographics and neighborhood, in the West Baltimore/Grace service areas.
- Explore provision of specialty services at Grace Medical Center, which may include a strategy for new specialty physician recruitment for the Grace service area.

Metrics to Assess Progress may include:

- **Outcome measure:** Reduction in Emergency Department visits or hospitalizations over time among a defined panel of program participants who have had their access to primary care improved.
- **Outcome measure:** Improvement in clinical outcome measures (e.g., A1c and/or Blood Pressure) over time among a defined panel of program participants who have had their access to primary care improved.
- **Process measure(s):** Measurable increase in primary care access for Sinai/Grace neighborhood residents. E.g., may include through such quantifiable actions as: adding new providers; establishing local—including regular mobile—clinics; increasing virtual appts. and digital care access; expanding hours (evening/weekend); and/or creating/strengthening partnerships with existing FQHCs.
- **Process measure:** Number of Mobile Clinic events and/or number of Mobile Clinic encounters.

- **Process measure:** Number of active community organization partners that provide clinical or social resources for our community members.
- **Process measure:** Number of transportation vouchers provided.
- **Process measure:** Evidence supporting improved access to interpretation and translation services for community members for whom English is not their first language.

Mental Health/Substance Use Disorders

Prioritized Need: Improved access to clinical and social resources to treat behavioral health (mental health and/or substance use disorders) of Sinai Hospital and Grace Medical Center community members.

Population Definition: Sinai Hospital and Grace Medical Center community members with mental health and/or substance use disorders.

Potential Programs and Tools for Improvement:

- Educate providers how to take advantage of services for their patients provided by the Sinai Hospital Addiction and Recovery Program (SHARP) and New Hope Addiction and Recovery Services program.
- Active involvement in the Central Maryland Regional Crisis System (formerly the GBRICS Partnership).
- Train technicians, front desk, registrars, and/or other support staff in the Emergency Department, and Primary Care Practices, as well as Community Health Educators in evidence-based emergency response techniques for people who appear to be in mental health or substance abuse crisis.
- Explore cross-training Emergency Department Peers as Community Health Workers, to include mental health training.
- Explore making training available for frontline staff on trauma-informed care.
- Explore funding and a treatment plan for patients with alcohol use disorder.
- Explore development of an in-house consult physician for psychiatric and substance use disorder issues.

Metrics to Assess Progress may include:

- **Outcome measure:** Reduction in Emergency Department visits and/or hospitalizations over time among a defined panel of program participants.
- **Process measure:** Use of the Central Maryland Regional Crisis System (formerly GBRICS) by area residents.
- **Process measure:** Number of Sinai Hospital and Grace Medical Center providers and staff receiving education in evidence-based emergency response techniques for people who appear to be in mental health or substance abuse crisis.
- **Process measure:** Number of providers referring patients to SHARP and New Hope services.
- **Process measure:** Number of Emergency Department Peer Counselors cross-trained as Community Health Workers.
- **Process measure:** Number of frontline staff trained in trauma-informed care.
- **Process measure:** Steps taken to develop funding and a treatment plan for patients with alcohol use disorder.
- **Process measure:** Steps taken to develop an in-house consult physician for psychiatric and substance use disorder issues.

Health Disparities

Prioritized Need: Sinai Hospital and Grace Medical Center community members face health disparities associated with race, ethnicity, neighborhood of residence, and/or other demographic factors and social determinants of health (SDOH).

Population Definition: Sinai Hospital and Grace Medical Center community member population(s) experiencing health disparities (to be identified).

Potential Programs and Tools for Improvement:

- Examine disparities in hospital quality indicators—including readmissions and potentially avoidable utilization rates—by race, ethnicity, neighborhood of residence, and/or other demographic factors and social determinants of health.
- Expand the use of SDOH assessment to increase identification and interventions on Sinai Hospital and Grace Medical Center patients experiencing social challenges that may affect their health.
- Develop and focus action plans around key areas of disparity we identify.
- Provide training on recognizing and correcting implicit bias to health care providers and staff.

Metrics to Assess Progress may include:

- **Outcome measure:** Reduction in Emergency Department visits and/or hospitalizations over time among a defined panel of program participants.
- **Outcome measure:** Improvement in clinical outcome measures (e.g., A1c and/or Blood Pressure) over time among a defined panel of program participants who have had their access to primary care improved.
- **Process measure:** Number of community education and/or outreach events that target defined population with health disparities.
- **Process measure:** Number of action plans created and implemented to address identified health disparities.

Physical Health

Prioritized Need: Improved access to clinical and social resources to improve health and well-being of Sinai Hospital and Grace Medical Center community members.

Population Definition: Sinai Hospital and Grace Medical Center community members with diabetes, prediabetes, obesity, and/or hypertension.

Potential Programs and Tools for Improvement:

- LifeBridge Mobile Clinic outreach (on-site health screenings, referrals to social, clinical resources)
- Digital Care Center (virtual clinical support)
- Medication Management team (virtual pharmacist support)
- Healthy food partners (home delivery, food pantry access)
- Chronic disease education and management support, e.g.:
    - LifeBridge's Community Health and Wellness team
    - GetWell Loop tool
    - Health-Shared.com platform
- Implementation and use of "closed loop" platform (e.g., *Findhelp*) by LifeBridge care teams to identify and track completion of referrals to social resources
- Implement "StrokeSmart" initiative to better identify and more quickly act on signs that someone may be having a stroke.
- Address gun violence with evidence-based interventions.

Metrics to Assess Progress may include:

- **Process measure:** % of Sinai/Grace diabetes patients (inpatient and/or outpatient) who get their A1c checked at least 3x a year.
- **Outcome measure:** % of Sinai/Grace diabetes patients (inpatient and/or outpatient) who reduce A1c level during year.
- **Process measure:** % of Sinai/Grace diabetes patients (inpatient and/or outpatient) connected to diabetes/health management education and support (including diabetes management education, healthy eating, and/or exercise).
- **Outcome measure:** % of Sinai/Grace diabetes patients (inpatient and/or outpatient) connected to diabetes/health management education and support (including diabetes management education, healthy eating, and/or exercise) and who show reduction in weight and/or A1c level at the end of year.
- **Process measure:** % of Sinai/Grace patients with diabetes or prediabetes and/or who are obese and state they lack access/can't afford healthy food who are enrolled in a healthy food program.
- **Outcome measure:** % of Sinai/Grace patients with diabetes or prediabetes and/or who are obese and state they lack access/can't afford healthy food who are enrolled in a healthy food program and show reduction in:
    a) Weight and/or A1c level

b) ED/hospital visits (compared to themselves or to a non-enrolled control group)

- **Process measure:** % of Sinai/Grace high blood pressure (BP) patients (inpatient and/or outpatient) seen by their Primary Care Provider/Cardiologist at least 1x a year.
- **Outcome measure:** % of a defined panel of Sinai/Grace high BP patients (inpatient and/or outpatient) who reduce BP levels over time.
- **Process measure:** % of Sinai/Grace high BP patients (inpatient and/or outpatient) seen by their Primary Care Provider/Cardiologist at least 1x a year and connected to BP/cardiovascular health education and support (including medication management, healthy eating, and/or exercise).
- **Outcome measure**: % of Sinai/Grace high BP patients (inpatient and/or outpatient) seen by their Primary Care Provider/Cardiologist at least 1x a year and connected to BP/cardiovascular health education and support (including medication management, healthy eating, and/or exercise) who show reduction in:
    a) Weight and/or BP level
    b) ED/hospital visits (compared to themselves or to a non-enrolled control group)
- **Process measure:** Number of gun violence interventions conducted.
- **Outcome measure**: Number of Sinai ED admissions for gunshot wounds.

Food Security

Prioritized Need: Improved access to healthy food for Sinai Hospital and Grace Medical Center community members who lack it.

Population Definition may include:

- Individuals with diabetes or obesity lacking access to healthy food who are referred to LifeBridge's healthy food access program.
- LifeBridge patients who select lack of access to healthy food as a social determinant of health.

Potential Programs and Tools for Improvement:

- Maryland-funded (HSCRC) Diabetes Regional Partnership program (through December 2024).
- LifeBridge partnerships with community-based food partners to improve access to healthy food.
- Employment of a Healthy Food Access Program Coordinator to manage referrals of eligible residents to food partners.
- Educate LifeBridge providers about eligibility criteria for, and availability of, healthy food access services.
- Referrals to healthy food access services by LifeBridge providers, diabetes education and nutrition specialists, and/or Community Health and Wellness teams.

Metrics to Assess Progress may include:

- **Process measure:** Number of people receiving education on diabetes and/or weight management.
- **Process measure:** Number of people gaining access to healthy food (e.g., fruits and vegetables) through one of LifeBridge Health's community-based food partners.
- **Outcome measure:** Number of people with reduced A1c levels after receiving education and healthy food access.
- **Outcome measure:** Number of people with reduced weight levels after receiving education and healthy food access.
- **Satisfaction measure:** Satisfaction survey results for education and healthy food access program participants.