Caring Bravely for Our Communities

LifeBridge Health's Community Initiatives to Build a Healthier Population

October, 2024

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Overview

1. Introduction and Community Overview
2. Unique Community Collaborations and Partnerships
3. Breadth and Depth
4. Specific Initiatives:
    a. Center for Hope
    b. Addressing Diabetes (DMHE, Education & Healthy Food Access)
    c. Access Carroll
    d. Care Happens Here Mobile Unit
    e. Community Pastoral Outreach
    f. Addressing Racial Inequities in Infant and Maternal Mortality
    g. Advancing Health Equity for Patients with Limited English Proficiency

Introduction to LifeBridge Health

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- 5 Hospitals
- 7 Nursing Homes
- Senior Living
- 825 Employed Providers
- 2,392 Credentialed Providers
- 13,689 Employees
- 32 Urgent Care Sites
- 137 Locations

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Purpose

Caring for our Communities Together

Mission

To improve the health of the individuals and communities we serve through compassionate, high-quality care.

Vision

To be a nationally recognized, independent health system consistently providing outstanding quality, service, affordability and outcomes.

Senior Leadership Team

Neil Meltzer
Chief Executive Officer

David Krajewski
Executive Vice President and Chief Financial Officer, LifeBridge Health President, LifeBridge Health Partners

Leslie Simmons
Executive Vice President and Chief Operating Officer, LifeBridge Health

Sharon Hendricks
Chief Administrative Officer, Levindale

Craig Carmichael
President, Northwest Hospital
Senior Vice President, LifeBridge Health

Garrett Hoover
President, Carroll Hospital
Senior Vice President, LifeBridge Health

Matthew Poffenroth, MD
Senior Vice President, Chief Physician Executive

Amy Shlossman
President, Sinai Hospital and Grace Medical Center
Senior Vice President, LifeBridge Health

Senior Leadership Team, cont'd

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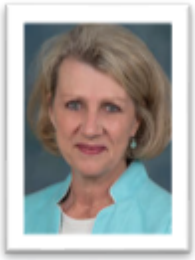
James Roberge
Senior Vice President,
Campus Services

Tressa Springmann
Senior Vice President,
Chief Information and Digital Officer

Jason Weiner
Senior Vice President
and General Counsel

Lisa Whaley
Senior Vice President
and Chief Human Resources Officer,
LifeBridge Health

Joseph Koons
Senior Vice President
and Chief Revenue Officer



Julie Cox
Vice President,
Chief Development Officer

Brian Deffaa
Vice President,
Chief Marketing Officer

LifeBridge Health: Providing a Full Continuum of Care

ACUTE CARE

- The Herman & Walter Samuelson Children's Hospital at Sinai — A LifeBridge Health Center
- Carroll Hospital — A LifeBridge Health Center
- Grace Medical Center — A LifeBridge Health Center
- Levindale — A LifeBridge Health Center
- Northwest Hospital — A LifeBridge Health Center
- Sinai Hospital — A LifeBridge Health Center

POST-ACUTE CARE

- Atlee Hill Skilled Nursing & Rehabilitation Center — A LifeBridge Health Partner
- FutureCare — A LifeBridge Health Partner
- avila home care — A LifeBridge Health Partner
- HomeCare Maryland — A LifeBridge Health Partner
- Baker Rehab Group — A LifeBridge Health Partner
- Levindale — A LifeBridge Health Center
- BridgingLife — Compassionate care for life's transitions
- PAPP — Post-Acute Physician Partners
- Springwell Senior Living Community — a LifeBridge Health Partner

AMBULATORY SERVICES

- Grace Medical Center — A LifeBridge Health Center
- Carroll Occupational Health — Affiliated with Carroll Hospital Center
- The SurgiCenter of Baltimore — A LifeBridge Health Partner
- LifeBridge Health — The Krieger Eye Institute
- LifeBridge Health & Fitness
- Davita Carroll County Dialysis
- LifeBridge Health — Medical Group
- Nation's — Home Medical Equipment; Infusion at Home
- Ellicott City Ambulatory Surgery Center
- LifeBridge Health — Outpatient Pharmacies at Sinai Hospital and Northwest Hospital
- RadNet — (Advanced Radiology)
- HelloBrave by LifeBridge Health
- LifeBridge Health — Physical Therapy in collaboration with NovaCare Rehabilitation

URGENT CARE & TRANSPORTATION

- ExpressCare Urgent Care Centers — A LifeBridge Health Partner
- Children's Urgent Care Pediatric Specialists
- Pulse Medical Transportation

INSURANCE

- Alterwood Advantage — A LifeBridge Health Partner
- KeyCare Advantage

PUBLIC HEALTH & COMMUNITY SERVICE

- A LifeBridge Health Group Center for Hope
- West Baltimore Renaissance Foundation
- Living Well @ the J
- VSP — A LifeBridge Health Partner
- The Family Tree — A LifeBridge Health Group | Raising families up.
- #StrongerHearts — LifeBridge Health | American Heart Association. Life is Why

Programs

Centers of Excellence Developmental Highlights

Cardiovascular Institute

- TAVR and WATCHMAN™ devices deployed for non-invasive structural heart disease operations; PFO and ASD closures also provided
- Established a CTS clinic in Frederick, expanding market reach.
- Dr. Henry Sun named head of Cardiovascular Institute
- Developed Sports Cardiology program
- Dr. Paul Gurbel recently pubished 500th paper

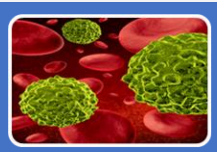
Rubin Institute for Advanced Orthopedics

- Expansion of the Sports Medicine institute to be the exclusive provider of medical services for Loyola University.
- Started ACGME-accredited Orthopedic Surgery Residency Program.
- ICLL added an ultra-low-dose radiation imaging system which allows full-body 3D images using 1/10th the radiation.

Berman Brain & Spine Institute

- LBH is first health system on east coast to fully implement RAPID Software for strokes
- Sinai certified as thrombectomy-capable stroke center – 1st hospital in MD, 16th in USA
- Established Neuroscience Residency for Advance Practice Providers
- Hired a Neurohospitalist
- Sinai certified as a Level 4 Comprehensive Epilepsy Center

Lapidus Cancer Institute



- Introduced Oncology Nurse Navigation Program
- Implemented a Nurse Triage Program
- Offering systemwide Genetic Counseling and Nutrition telehealth appointments at all Oncology programs.
- Implemented Team-Based Care Delivery Model
- Opened "no sleepless nights" community breast center at Pomona Square

Women's Health

- Launched Ob/Gyn ambulatory services at Grace Medical Center and Maternal Fetal Medicine site in Westminster.
- Implemented Laborist Model to improve patient safety
- Introduced Neonatal Couplet Care Suites at Carroll – only 2nd hospital in nation to do so

Pediatrics

- Launched opening of new NICU/Newborn Care Center.
- Expanded EEG services to include 24-hr in home pt monitoring studies.
- Increased market awareness of pediatric services.
- New Pediatrics Service Line established

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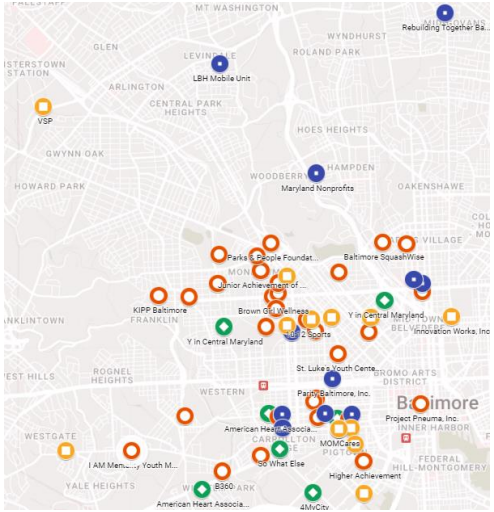
Community Health and Outreach – A History

LifeBridge Health and Grace Medical Center Advancing Health & Community Services in West Baltimore

Initiatives to Date

- Opened a new Emergency department
- Opened new clinic spaces and added several specialties, including physical therapy and dialysis
- Successfully converted to Cerner EMR
- Ongoing conversion of former factory to community center, including space for other community non-profits

Map of WBRF Grant Recipients



Grace Emergency Department

West Baltimore Renaissance Foundation

- Following capital investment, transaction will result in an estimated $27 million of savings annually, to be returned to the community as investment in addressing social determinants, including: job training, population health activities, mentoring, food insecurities
- To date the foundation has deployed $12.3 Million in grant awards in job training programs, community capital investments (ABC Park), population health and food programs

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Brief Community Overview

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LifeBridge Health *Aims* in Our Community

Implement a cohesive, integrated strategy to improve the health status and well-being of our communities.

- **Improve access to health care** where and when needed.
- **Identify and respond to needs of special populations**, such as those facing health inequities and/or at risk of avoidable hospitalization.
- Identify and **address underlying drivers of poor health** (e.g., limited access to healthy food, primary care, social services).

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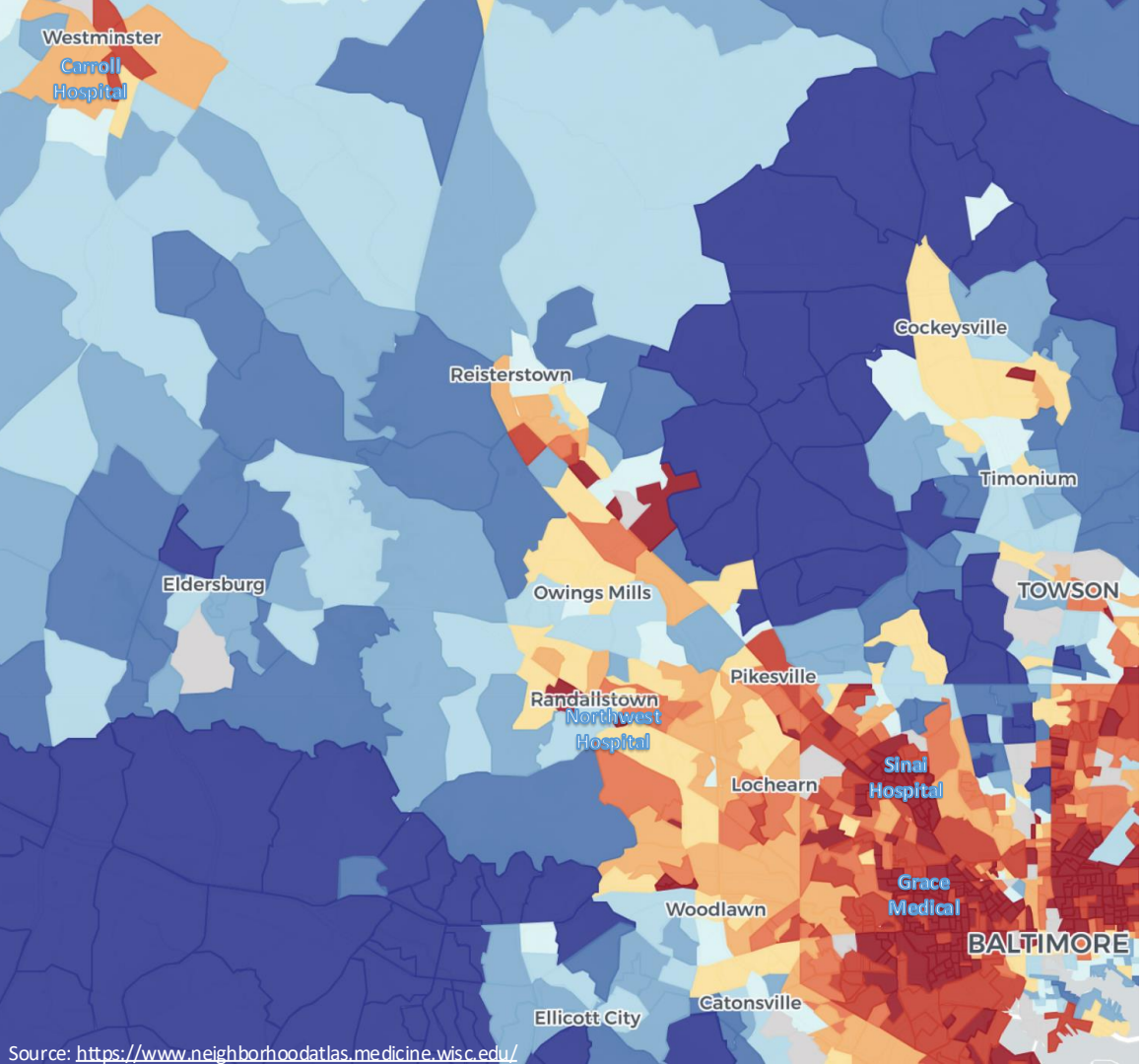
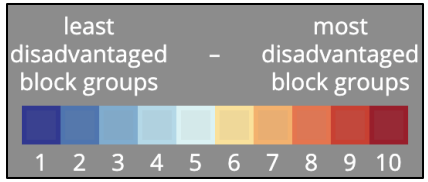


Source: https://www.neighborhoodatlas.medicine.wisc.edu/

LifeBridge Service Area

Mapping Area Deprivation



Kind et al (2014): Risk of readmission if you live in a disadvantaged neighborhood is similar to having emphysema, and worse than having diabetes.

Location-Specific Characteristics:

Baltimore City (Sinai, Levindale, Grace):

- Food Insecurity Rate: 18%
  (vs Maryland's 11%)

Baltimore County (Northwest Hospital):

- Adults with Kidney Disease: 3.5%
  (vs US's 3.2%)

Carroll County (Carroll Hospital):

- High Blood Pressure Prevalence: 34.7%.
  (vs Health People 2020 target of 26.9%)

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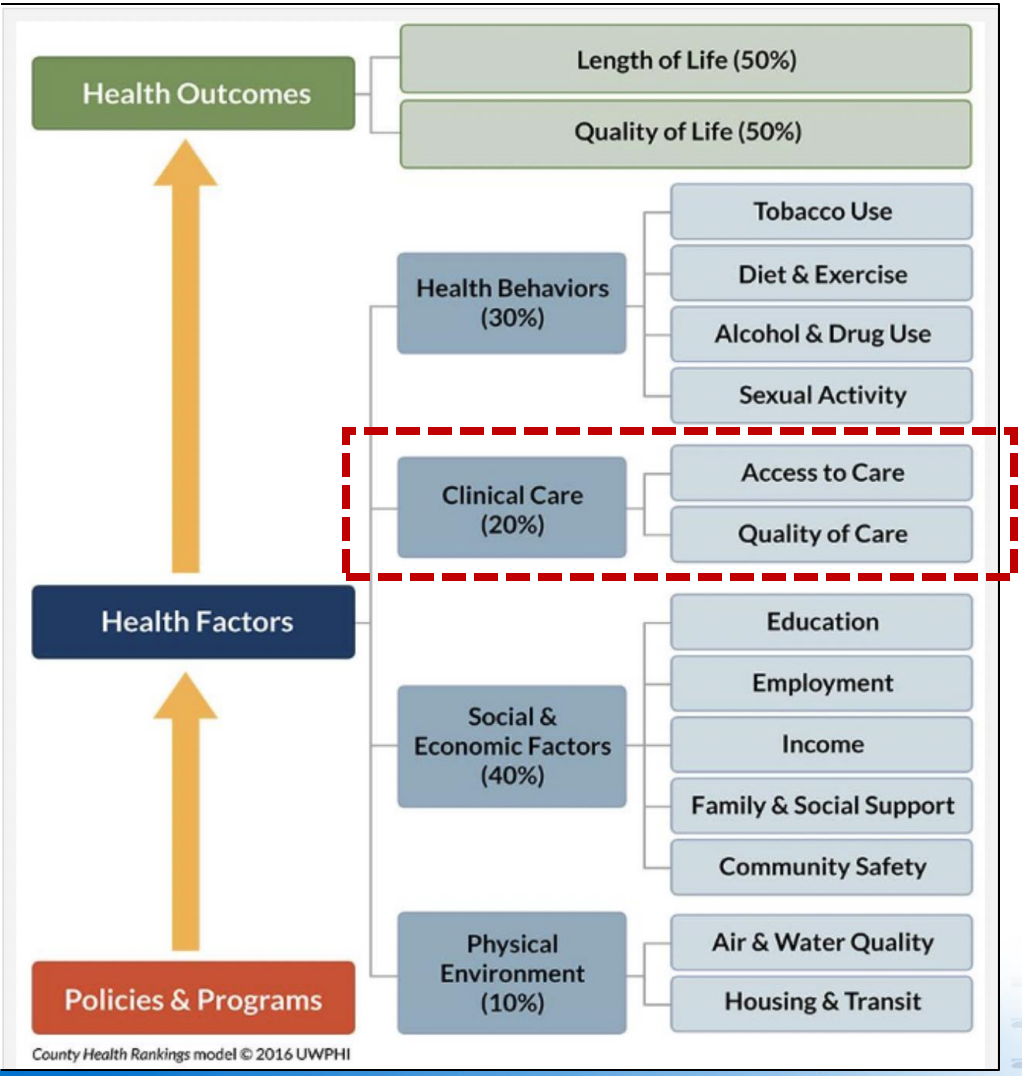

What Impacts Health?

*~80% of health outcomes are **not** shaped by clinical care.*

Why Addressing Social Determinants of Health (SDOH) Is Important

- **SDOH** such as poverty, unequal access to health care, lack of education, stigma, and racism are underlying, contributing factors of health inequities.
- ***Health equity*** means no systematic disparities in health between social groups that have different levels of underlying social advantages or disadvantages.
- **Addressing SDOH** is a primary approach to achieving health equity. *source: WHO

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LBH's Community Health & Social Concerns

Top Priorities from 2024 Community Health Needs Assessment (CHNA)*

Health Concerns:

1. High Blood Pressure, Heart Disease
2. Diabetes/Obesity
3. Addiction/Substance Use
4. Mental Health
5. Chronic Pain/Arthritis
6. Cancer

Health-Related Social Concerns:

1. Gun Violence/Neighborhood Safety
2. Healthy Foods: Can't Afford/Limited Knowledge about
3. Housing Problems/Homelessness
4. Access to Insurance
5. Access to Doctor's Office

*Based on 900-1,200 CHNA survey respondents in each hospital's service area.

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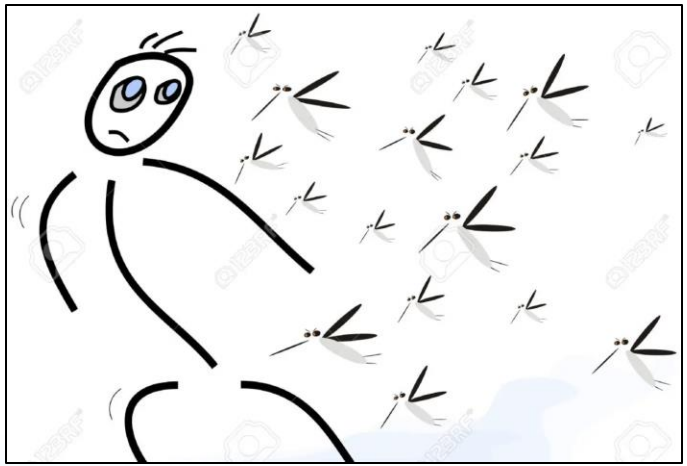
A More Effective Approach

"We can keep swatting mosquitoes or we can drain the swamp."



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Unique Community Collaborations and Partnerships

We have MANY community programs across LifeBridge. We share here a few unique initiatives

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Serving an Underserved Community
Grace Medical Center

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Grace History & Overview

- Grace Medical Center was brought into the LifeBridge Health family in 2019
- The name was chosen with input from team members and the community
- Grace Medical Center continues what Bon Secours started by focusing on social determinants of health and providing healthcare for all regardless of ability to pay
- With the people of West Baltimore in mind, LifeBridge Health committed $85 million in upgrades and renovations to the 100-year old facility
- The first phase of renovations have been completed, primarily on the inside.

Care Offered at Grace Medical Center

- **Primary Care**
- **Pediatric Care**
- **Specialty Care**
  - OB/GYN
  - Orthopedics
  - Cardiology
  - Podiatry
  - Ophthalmology
  - Medication Management
  - Nutrition Services
  - Nephrology
  - Gastroenterology
- **Substance Use Disorder Services & Transitional Housing***
- **Outpatient Mental Health Services***
- **Community Based Mental Health Services***

- **Emergency Medicine**
- **Renal Dialysis***
- **Walgreens Pharmacy**
- **Supporting Services**
  - Transportation
  - Care coordination
  - Patient Education and Advocacy
  - 3D Mammography
  - CT Scan
  - Xray
  - EKG and Stress Test
  - Pulmonary Function Testing
  - Laboratory
  - Outpatient Physical Therapy

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1st Phase of Construction Completed

- Brand new ED with 27 private treatment rooms, a psychiatric pod, observation unit, and a CT scanner to provide clinicians the technology to effectively assess, diagnose, and treat.
- We renovated the outpatient clinic space to provide primary care, multispecialty practices, a lab, and 3D mammography in one location
- We updated the outpatient dialysis unit with 41 new dialysis stations
- Renovated a temporary outpatient behavior health program space for continued services

Final Phase of Construction

- **Transforming a section of the former Bon Secours inpatient facility into a new outpatient behavioral health space**
- **Renovated space will also include rooms for meditation, lactation, community health and wellness, and violence response teams**
- **We are seeking community input to help plan for the green space**
- **To be completed February 2025**

Addressing SDOH in an Underserved Community

West Baltimore Renaissance Foundation (WBRF) & Grace Medical Center

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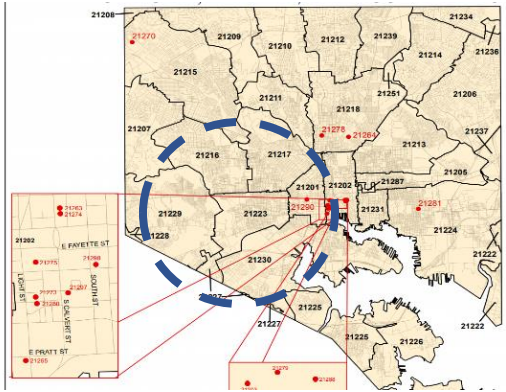
MISSION

To empower West Baltimore residents and communities through strategic investments that expand services, amenities, and opportunities that lead to a lasting impact on health and quality of life.



Key Strategies

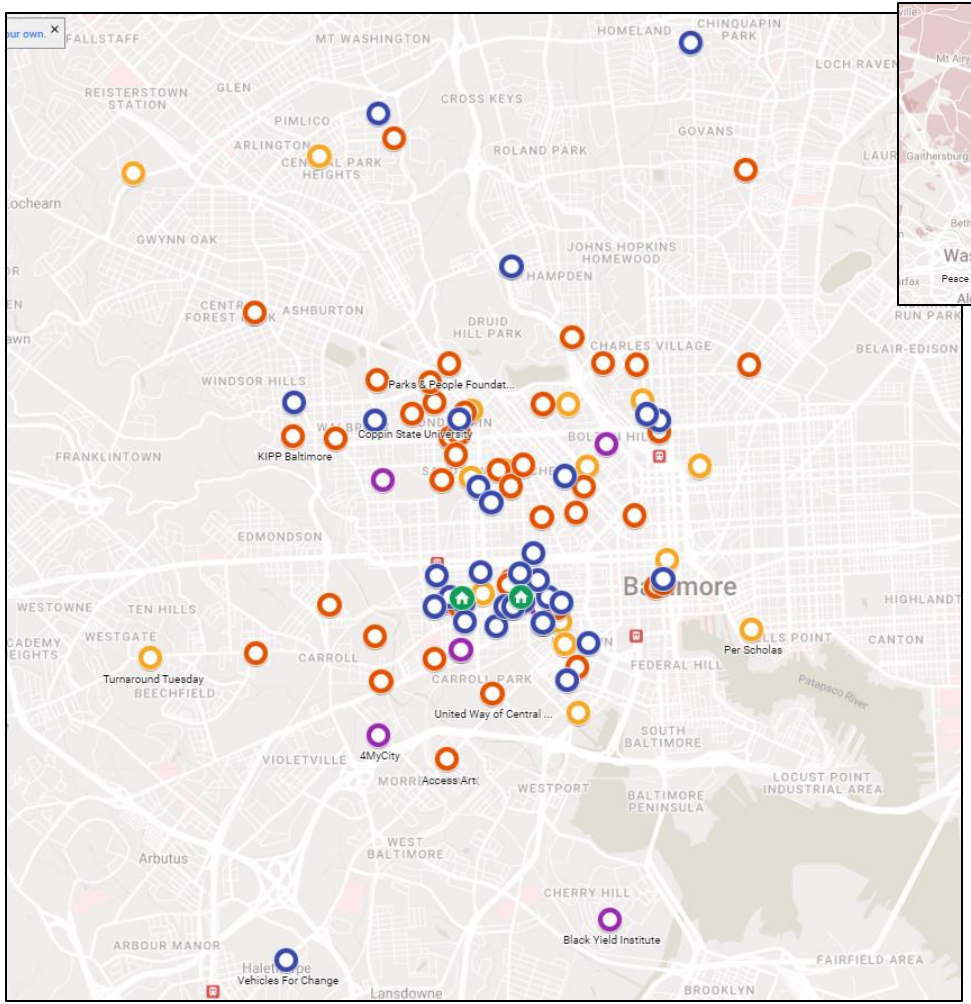
1) Grant Funding for West Baltimore
   a. Small Neighborhood Grants
   b. Program Related Grants
2) Creation/Operation of the Factory

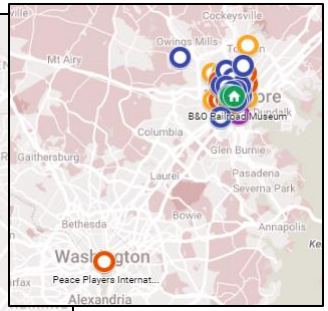
Portfolio Areas

1) Workforce Development
2) Food Access
3) Youth Mentoring
4) Population Health

Values

- Intentionally address racial socio-economic or health disparities.
- Expand and advance technology access for West Baltimore residents.
- Build on existing work and /or create lasting improvements for residents and communities.





WBRF Grantees

- Population Health
- Workforce Development
- Youth Mentoring
- Food Access

Grants Made to Date: 223

Food Access: 14.5
Workforce Development 41
Population Health: 46
Mentoring: 79.5
Small Neighborhood Grants: 38
Factory Programming: 4

Grants for:

Start-Up Org: 20
Program Expansion: 20
West Balt Based/Partnership: 193
Faith-Based Link: 33
BIPOC Led: Over 60%

$18.4 MILLION
Invested to support West Baltimore programs and services

107 ORGANIZATIONS
serving West Baltimore accessing resources to bolster programming and expand operations

1.6 MILLION MEALS
including 2.7 million pounds of produce

9,090 YOUTH
participated in mentoring programming

796 JOB PLACEMENTS
for youth and adults

9,852 RESIDENTS
benefitted from housing, financial education, health, mental health, and other services

138 ORGANIZATIONS
receiving technical assistance and capacity building supports

Let's Thrive

BioTechnical Institute of MD

Clergy United for the Transformation of Sandtown (CUTS)

B&O Restore Baltimore

WEST BALTIMORE
RENAISSANCE FOUNDATION

The Factory: A West Baltimore Opportunity Center

SW View
(From N. Calhoun & W. Baltimore)

SE View
(From W. Baltimore Street)

The Factory Tenants

- Tenants (Letter of Intent/Grant):
  - Baltimore's Promise (youth/philanthropy)
  - Innovation Works (social enterprises and businesses)
  - *Project JumpStart (construction training) – Phase 3*
  - *Franklin Square Safe Streets (violence response)- Phase 3*
  - *So What Else (kitchen / youth mentoring) - Phase 4*

- LifeBridge Health Suite
  - VSP (Healthcare workforce)
  - Center for Hope (Violence / Trauma / Mental Health)
  - WBRF

- Space Users
  - NAMI (Mental Health) – Part time
  - LifeBridge Health (Health Programming) – Part time
  - TBD – Digital / IT training
  - Intent to engage other resource providers

Breadth and Depth of Community Work

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Breadth and Depth of Initiatives (1)

- **Chronic Condition Prevention & Management: 30+ community-based programs** to help prevent and manage Diabetes, Heart Disease, Cancer, Addiction.
- **Bringing Care and Resources Into the Community: 12+ community-based programs** that reach people through mobile health clinics, partnerships with community organizations and health systems, senior housing resident support, HIV+ support, community health screening events and community health workers.
- **Violence Prevention Programs: 6+ community-based programs:** A multi-faceted, partnership-based approach to violence prevention through Hospital Violence Response Team, Neighborhood Violence Intervention, Violence Prevention Membership, Community Case Management, Elder Abuse Prevention, Community Education.

Breadth and Depth of Initiatives (2)

Initiatives Improving Health Equity:

- **Maternal and Child Health:** Improving the health of mothers and children throughout our health system.
- **Housing Initiatives:** includes partnerships with Baltimore City Supportive Housing, Housing Upgrades to Benefit Seniors (HUBS), and Live Near Where You Work.
- **Food Insecurity Reduction:** Community partnerships and hospital-run programs, including, home delivery of fruits and vegetables, virtual healthy cooking classes and holiday food basket delivery.
- **Workforce Development:** Programs include Vocational Services Program (VSP), Youth Summer Employment Program, Kujichangulia Program, LifeBridge Talent Acquisition Program and Middle School Health Sciences Program.
- **Transportation Assistance:** Addresses this common barrier to attending medical appointments through our Ambulatory Care Management department and provision of Uber and Lyft transportation vouchers.

Addressing HRSN & and Disparities in the Exposure of Children in inner City Baltimore to Violence

Center for Hope & Sinai Hospital

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Center for Hope: Overview

Video overview of the Center for Hope

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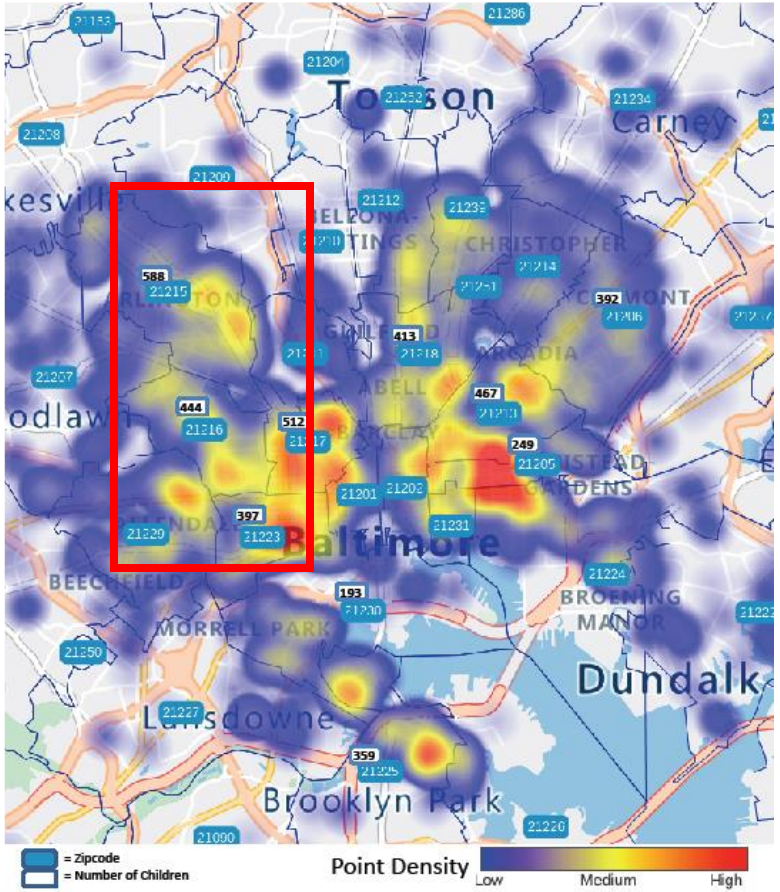
Responding To Community Need

Heat Map:

A 10-year analysis demonstrated that more children who had reported child abuse lived in LifeBridge Health's Baltimore City service areas than any other part of city.

Health-Related Social Concerns from CHNA:

1. **Gun Violence & Neighborhood Safety**
2. Healthy Foods: Can't Afford/Limited Knowledge
3. Housing Problems/Homelessness
4. Access to Insurance
5. Access to Doctor's Office



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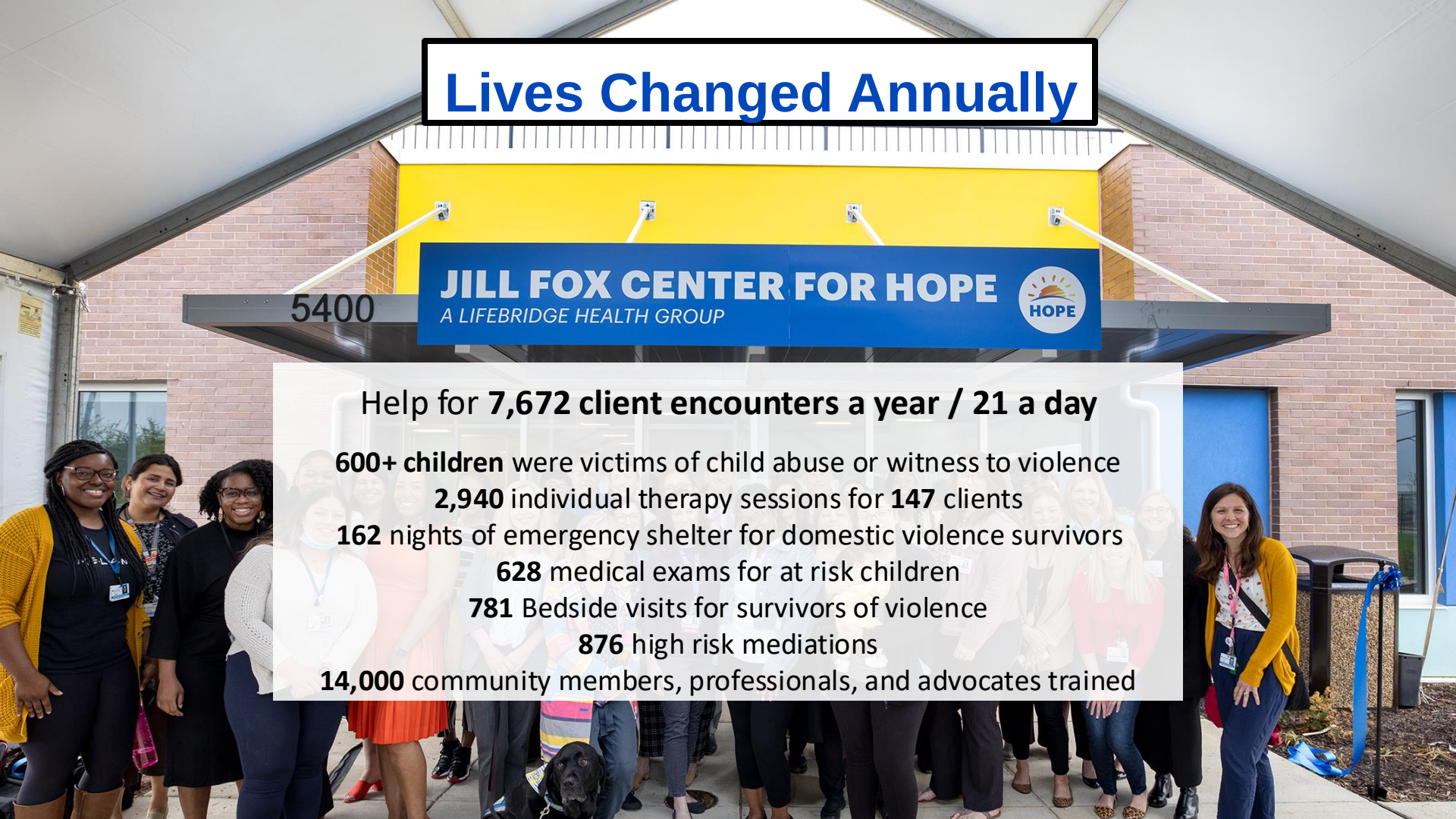
Lives Changed Annually



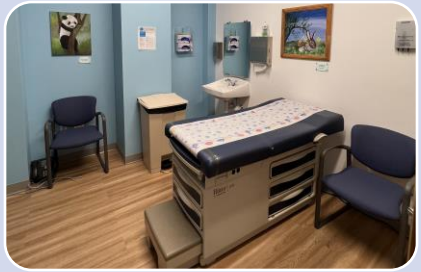
Help for **7,672 client encounters a year / 21 a day**

600+ children were victims of child abuse or witness to violence
2,940 individual therapy sessions for **147** clients
162 nights of emergency shelter for domestic violence survivors
628 medical exams for at risk children
781 Bedside visits for survivors of violence
876 high risk mediations
14,000 community members, professionals, and advocates trained

Key Initiatives

Crisis Intervention 24/7

- Child Advocacy
- Anti-Trafficking & Exploitation
- Domestic Violence
- Elder Abuse



Help Hurt People

- Medical Exams
- Therapy
- Group Support
- Youth Exposed to Homicide
- Resiliency

Prevent **Gun Deaths**

- Safe Streets Interruption
- Bedside Hospital Response
- Digital Violence Interruption
- Provider Resources
- Community Conversations
- Policy Advocacy

Build **Better** Responses

- Mandated Reporter Resources
- Forensic Skills Development
- Statewide Medical Leadership
- Executive Presence Institute

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Effective Partnerships

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Impact: Providing Child Advocacy

"I just want to thank everyone for your kindness and support and for fighting this case for my daughters, bringing them justice. May God Bless each and everyone one of you"
– Caregiver feedback

- Interviewed 556 children
- Interviewed 48 adult survivors
- Conducted 628 medical exams
- Helped 210 victims of exploitation
- 147 clients get trauma therapy
- 95% feel safer
- 90% said "Therapy at CFH was helpful for me"
- 95% report feeling more self-sufficient

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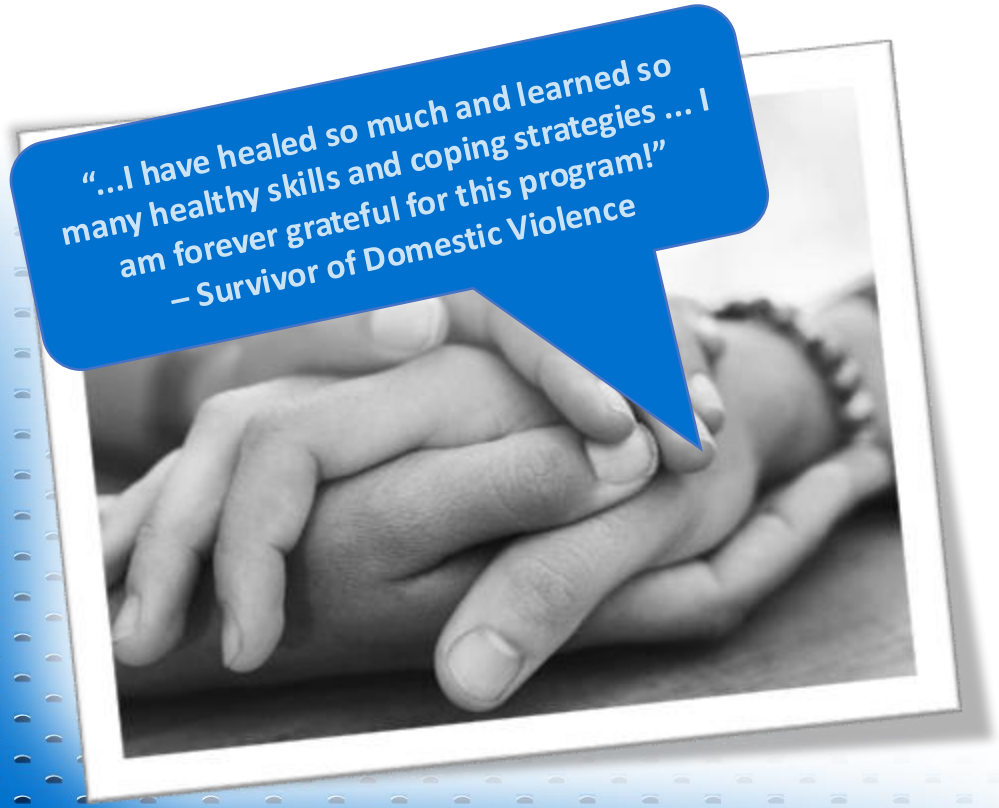
Impact: Responding to Domestic Violence



- 2,329 clients ● 1,381 new referrals
- 162 nights of shelter care
- 1,323 sessions of therapy
- 1,073 legal services provided
- 89% feel safer
- 78% feel more self-sufficient
- 79% understood their rights

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Community Violence Interruption
Safe Streets & Hospital Response

"What I found most helpful about the services I received is how they went above and beyond to get me and my family back to feeling safe and happy again."
– Survivor of Community Violence

"Keep up the great work with the site and community working together we can be a model across the city of how this partnership can work"- Community Member

- Conducted **876** mediations
- Hosted **154** community outreach events
- Engaged **18,710** community members
- Hospital Response teams assisted **753** clients & **1,839** consults
- **100**% feel safer thanks to Safe Streets
- **92**% stated they were more self-sufficient
- **87**% were more informed of available services
- **6 total homicides, 4 sites had no homicides for over 365 days**
- **42%** reduction in GSW admission since 2020

Web Link WMAR 09062024

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Diabetes Medical Home Extender (DMHE) Program

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Diabetes Medical Home Extender Program

Program: Provides comprehensive care coordination for patients with chronically unmanaged diabetes and helps resolve psychosocial barriers and prevent use of the ED for primary care. Ensures patients have appropriate medications, transportation, and home support services.

Location: Sinai and Northwest Hospital service areas.

FY24 Outcomes:

2,239 patient encounters

54 patients enrolled

- **65%** of patients served saw a reduction in A1C levels
- **36%** reduction in costs for ER visits for patients 6 months after program completion
- **89%** of scheduled medical appointments were attended
- **100%** of 185 medical & social barriers were addressed

The DMHE Team at a Baltimore Health Fair.

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Diabetes Medical Home Extender Program

- The DMHE program:
  - **Removes barriers** high-risk diabetes patients face accessing primary and specialty care providers
  - **Provides disease-specific education**
  - **Completes referrals** to supportive resources in the community
- The program **serves residents of 10 Baltimore zip codes** in the Sinai and Northwest Hospital service areas. It is staffed by a nurse and community health workers (one of whom is a certified diabetes educator)

Baltimore City Mayor Brandon Scott showing support for the DMHE Program.

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Diabetes Medical Home Extender Program

Services provided by the DMHE team include:

- Education on managing diabetes
- Management of coexisting comorbidities
- Finds medical providers (PCPs, specialists) and coordinates appointments
- Accompanies patients to doctor's office (if needed), providing confidence
- Helps reconcile and organize patients' medications
- Coaches on problem solving and goal setting
- Helps patients access critical resources: health insurance/Medicare, Diabetes Resource Center, Mobility, SSA/SSI, Social Services, supportive resources for seniors and those with disabilities
- Helps patients address long-term social and economic barriers to health

Diabetes Medical Home Extender Program

Awards & Recognition for DMHE Team Members

- ***Sinai's "Caught in the Act of Caring" Award for Loretta.***
  - Discovered that a client with memory problems likes to sketch/paint.
    - To help her remember doctor's appointments, the team member encouraged her client to sketch a picture of the doctor. They hung his picture on her wall and write her appointments next to her sketch. She now remembers her doctor's appointments.
    - To help this client remember to take her medication, Loretta encouraged the client to sketch/paint the sun and hang in on her wall. Now, when she wakes up/when the sun comes up, she is reminded to take her medication. Since then, the client has consistently taken her medication.
- ***LifeBridge's "Champion of the Month" for Justice, Equity, Diversity and Inclusion: Community Health Worker Dowan.***
  - JEDI Champions are LifeBridge Health team members who go above and beyond to represent the values of justice, equity, diversity and inclusion.

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Diabetes Education & Healthy Food Access

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Diabetes Education & Healthy Food Access

1. **Regional Partnership grant** from Maryland's HSCRC. Program provides diabetes prevention/management education and access to free, healthy food for participants who complete at least one class. Collaboration with nearby St. Agnes Hospital and community food partners.
2. **Targets 4 of LBH Community Health Improvement priorities**:
   - Diabetes
   - Food Security/Access to Healthy Food
   - Health Inequity
   - Community Health & Education
3. **Diabetes education provided virtually or in-person,** then 8 months of **access to fresh fruits/vegetables, medically tailored meals** (via home delivery or grocery store credits) to adults with diabetes who can't afford/lack access to healthy food.
4. **950+ community members** served to date.

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Diabetes Education & Healthy Food Access

How the Program Works

1. **Community & Internal Promotion: 1) "Lunch and Learn" sessions** with Hospital clinical departments to inform LBH clinicians, staff. **2) Medical Group Newsletters announcements** provide awareness and referral instructions to community providers. **3) Community Health & Wellness teams** distribute program flyers during community screenings/events.
2. **Review Eligibility:** Patients and community members are referred to the **Healthy Food Coordinator**, who explains eligibility criteria, which include: diabetes diagnosis; willingness to participate in education; no/limited access to healthy food.
3. **Refer to Diabetes Education: Healthy Food Coordinator** directs eligible community member to a Diabetes Educator at one of our 4 LifeBridge Diabetes Resource Centers. After completion of first diabetes class (virtually or in person), participant can enroll in Healthy Food Access component.
4. **Food Program Enrollment:** The **Healthy Food Coordinator** contacts program participants who complete education and helps patient select a Food Partner. Coordinator then sends referral to the Food Partner through CRISP (Maryland's secure Health Information Exchange). Food Partner then alerts the Coordinator of food delivery start date.

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Diabetes Education & Healthy Food Access

Community Food Partners

***Home-Delivered Food** (3 months):*

- **Hungry Harvest:** Fresh fruit and vegetables delivery, bi-weekly.
- **Moveable Feast:** Prepares, delivers medically tailored meals.
- **The Food Project:** Prepares, delivers medically tailored meals.
- **Meals on Wheels:** Prepares, delivers medically tailored meals.

***Follow-Up Food Access** (5 months):*

- **Giant Food:** Monthly $80 benefit for free, in-store access to fresh/frozen fruits and vegetables, diary, eggs and chicken.
- **Tangelo:** Bi-weekly delivery of fruit, vegetables, grains.

**Prepared meals are low in sodium and use fruits/vegetables appropriate for a diabetic diet.*

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Outcomes: Survey of 85 program participants

(Sep. 22 – Oct. 7, 2024)

Since beginning the program, would you say you eat more, the same, or fewer fruits and vegetables than you did before?

More Details Insights

More	55
About the same	24
Fewer	5
Other	3

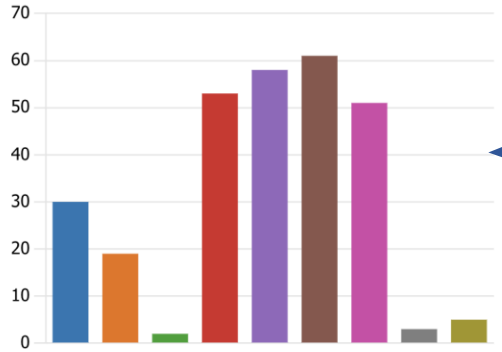
Healthy Food Consumption:

65% reported eating more fruits and vegetables than before.

Have you made any of the following behavior changes since you received diabetes management education? (choose all that apply)

More Details

Regularly test my blood sugar (...	30
Now use a Continuous Glucose ...	19
Stopped smoking	2
Increased exercise/physical activ...	53
Reduced sugary drinks in my diet	58
Reduced highly processed/fast f...	61
Lost weight	51
Not applicable	3
Other	5



Top Behavior Changes:

- Reduced highly processed/fast food in diet
- Reduced sugary drinks
- Increased exercise
- Lost weight
- Regularly test blood sugar
- Regularly use CGM

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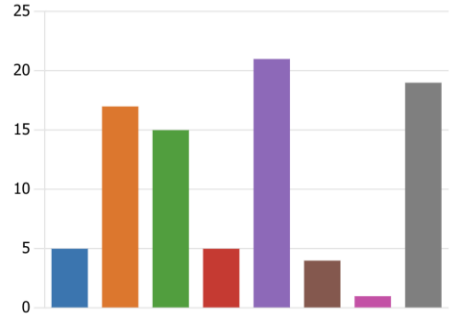
Outcomes: Survey of 85 program participants

(Sep. 22 – Oct. 7, 2024)

Has your blood sugar (A1c) level changed since you joined the Healthy Food Access program?

More Details

Dropped by 0.5%	5
Dropped by 1%	17
Dropped by 2%	15
Dropped by 3%	5
Dropped by 4% or more	21
No	4
Increased	1
I don't know	19



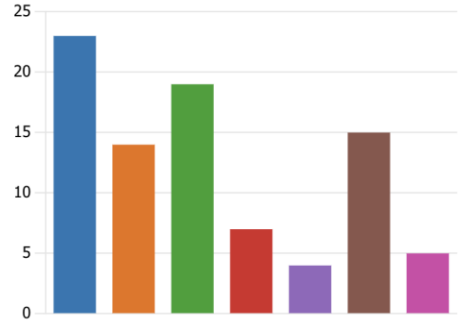
Blood Sugar Levels:

- **88%** reported ***1+% A1c reduction***
  - **62%** saw **2%+ A1c reduction**
  - **32%** saw **4%+ A1c reduction**

What changes in your weight have you noticed since you joined the Healthy Food Access program?

More Details

Lost 2-5 pounds	23
Lost 6-10 pounds	14
Lost 11-20 pounds	19
Lost 21-30 pounds	7
Lost 31 or more pounds	4
No change or gained weight	15
Other	5



Weight Loss:

- **82%** reported losing **2+ pounds**
  - **37%** lost **11+ pounds**

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What Our Recipients Said…

What parts of this program helped you the most?

- Receiving fresh fruits and vegetables has really helped. If I eat my vegetables first, I eat less carbohydrates. The more fruits I eat the less sweets I eat.
- Learning from others and the knowledge of the facilitator.
- Program helped me to understand the diabetes process better.
- I'm more mindful of portion control and best and worst time of the day to eat.
- Having the fresh fruits and vegetables helped as opposed to eating canned which is unhealthy. I have also lowered my blood pressure, so it helped in more ways than one.
- The delivery of healthy foods to my home since I never learned to drive and do not live close to grocery stores. Being able to speak to a Dietitian.
- Not worrying about the cost for food vs whether to use money for meds.
- I stopped being depressed.

Access Carroll

An Integrated, Person-Centered, Health Home

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Who We Are

- Private, nonprofit – 501(c)(3)
- Private and Public Health Partnership
- Integrated medical, dental, and behavioral health care
- Community-based
- No Wrong Door Policy
- Hybrid Staffing - Volunteer driven
- Located in heart of Carroll County
- Addressing local health access needs
- 19 Years Old (opened doors in January 2005)

LIFEBRIDGE HEALTH
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Mission

To champion health and provide quality, integrated health care services for low-income residents of Carroll County, Maryland.

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Vision

We believe every individual should have access to health care that is coordinated, comprehensive, culturally sensitive, community based, accountable and high quality.

We also believe all individuals should have the right to health information, the opportunity to participate in their plan of care and the right to accept responsibility for their own care to the extent to which they are able.

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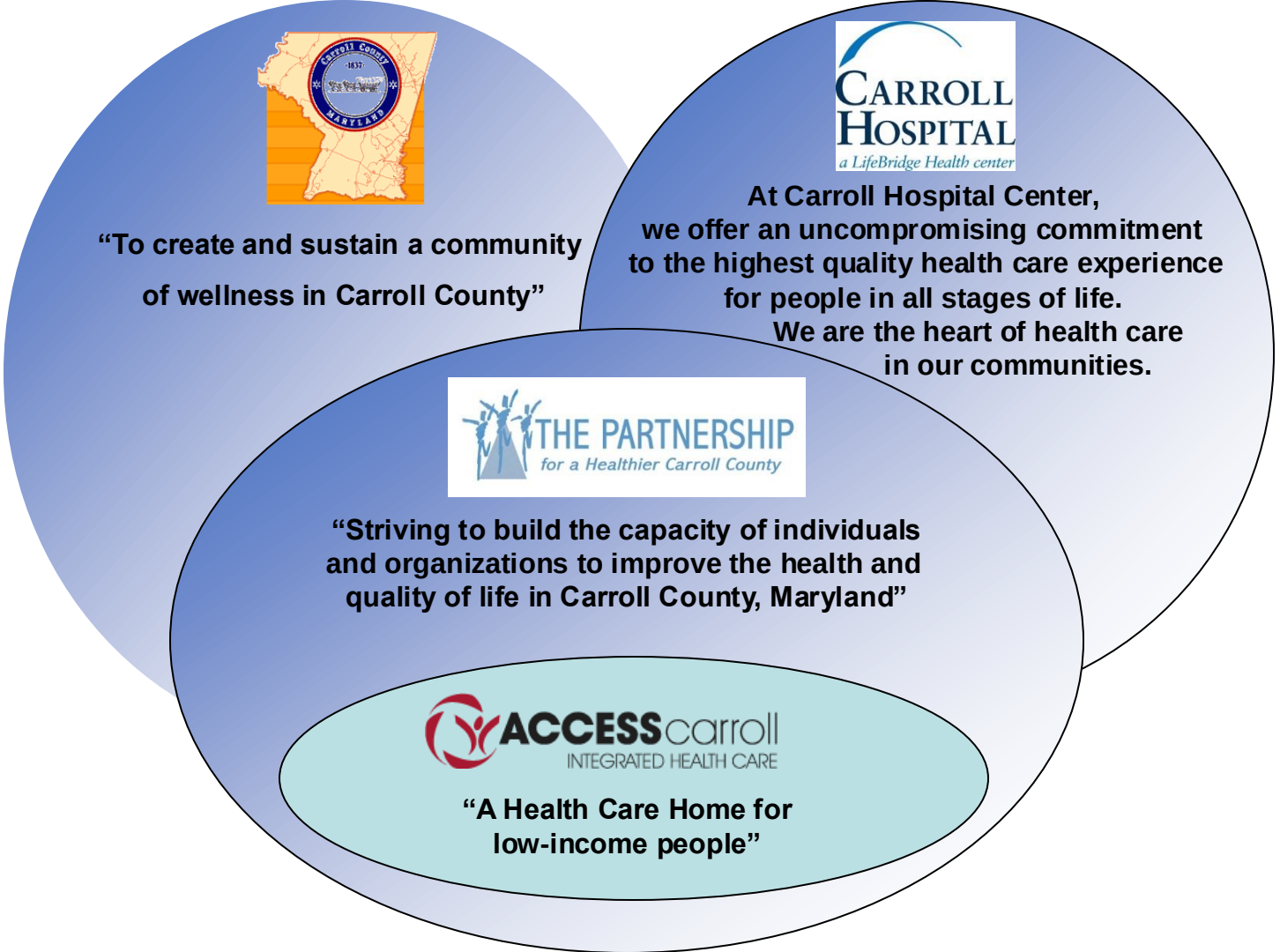
"To create and sustain a community of wellness in Carroll County"
CARROLL HOSPITAL
a LifeBridge Health center
At Carroll Hospital Center, we offer an uncompromising commitment to the highest quality health care experience for people in all stages of life. We are the heart of health care in our communities.
THE PARTNERSHIP
for a Healthier Carroll County
"Striving to build the capacity of individuals and organizations to improve the health and quality of life in Carroll County, Maryland"
ACCESS carroll
INTEGRATED HEALTH CARE
"A Health Care Home for low-income people"

Governance

- VOLUNTEER BOARD
- 12 Board Members representing community
- Strategic Partners – Ex-Officio Seats
  - Carroll Hospital Center
  - Carroll County Health Department
  - Partnership for a Healthier Carroll County
- Business Community
- Medical Community
- Legal & Judiciary
- Schools

Integrated Services

- Primary Health Care – Acute and Chronic
- Behavioral Health Assessment and Treatment
- Withdrawal Management – Detoxification
- Medication Assisted Treatment – Vivitrol and Suboxone
- Overdose Response Education - Naloxone
- Family Dental Care
- Medication Assistance – Medical Supplies
- Laboratory Testing
- Radiology Services
- Referrals to Specialists
- Medical Case Management – Care Navigation
- Peer Assisted Support
- Public Assistance Application Support
- Patient Education
- Community Resource Information
- Health Insurance Exchange and Medicaid Enrollment

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Hybrid Staffing

Hybrid Staff Team, 2023-24

- Paid Employees (32)
- In-Kind - Health Department (1) and Hospital (3)
- Health Department assigned (1)
- Volunteers (121) – 3,846 Hours
- Students (90) 5,087 Hours
- Residents Oral Surgery (14) 146 Hours

Special Populations & Health Equity

In FY2024, we served:

- Homeless - 699 individuals (2,165 medical/BH encounters)
- Veterans – 61 individuals (423 medical/BH encounters)
- CC Detention Center – 77 individuals (2,346 BH encounters)
- Hispanic/Latino – 1,734 individuals (28% patients)

FY2024 Special Services:

- Showers – 277 documented
- Translation and Interpretation Services
- Clean Clothing and Shoes
- Food/Meals
- Housing and Shelter Services
- Transportation to special appointments

Hispanic Ethnicity

- Cultural and Linguistic Appropriate Services (CLAS) Committee and Community Events
- 28% of Patients are Spanish Speaking (FY2024)
- 7 Full Time Staff Speak Spanish throughout the office
- New Initiative in FY24 = Full Time Certified Spanish-Interpreter and Translator for Integrated Health Services
- Partner with Carroll County Government Citizens Services, Health Department, Carroll Hospital, Private Providers, Food Services, Shelter System


WELCOME
WELCOME TO ACCESS CARROLL
ACCESS
United Way
ACCESS Carroll
INTEGRATED HEALTH CARE


WELCOME


HER LUNGS
Ritter

FY24 Operational Highlights

FY2024	MEDICAL	BEHAVIORAL	DENTAL	TOTAL
Visits/Encounters	6,319	5,208	3,710	15,237
New Patients	349	106	472	927
Individual Patients Served	6,150	977	3,255	10,382
Detox/MAT Induction	87			87
Substance Use MAT Mgt	1,146			1,146
Substance Use Assessments		269		269
Case Management Svcs				11,117
Hospital Referrals				383
Peer Recovery Individuals Served		1,341		2,218

* Most medical encounters are level 4 with complex chronic disease issues

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Care Coordination

- Nurse Navigation and Peer Recovery Support
- Specialty Care – coordinated referral process
- High-End Diagnostics
- SSI/SSDI Applications
- Public Assistance Applications
- Case Management
- Direct ED Referrals
- SOAR
- ED Diversion
- Criminal Justice Diversion
- Social Determinants of Health
- Average 110 monthly open cases

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Genoa Pharmacy

- July 2021 – new partnership with Genoa pharmacy
- Licensed pharmacy onsite at Access Carroll
- Accepts all insurances
- Specializes in Medicaid and Medicare
- Medication Case Management
- Medication Education
- Individualized pill packaging
- Free delivery in Westminster
- Open Monday through Friday
- 8:30 AM to 5:00 PM

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LabCorp

- LabCorp Partnership – Licensed Laboratory
- Official LabCorp collection site at Access Carroll
- Monday through Friday 8:30 AM to 5:00 PM

*Access Carroll also collects specimens and processes through **Carroll Hospital** lab for uninsured patients.*

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Funding

- Public Insurances Accepted
  - Accept Maryland Medicaid for all services
  - Accept Medicare for all services
  - Some Private Insurances, including CareFirst
  - Sliding Fee Scale Available for all services
- Grants – public and private
- Donations
  - Individuals (including patients)
  - Organizations
  - Businesses
  - Faith Community
- In-Kind Donations of staff and supplies

WE DEPEND ON COMMUNITY SUPPORT!

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Contact Information

- Main Patient Line: 410-871-1478
- Fax: 410-871-3219
- Email: info@accesscarroll.org
- Web: www.accesscarroll.org
- Facebook & Twitter: Access Carroll

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Care Happens Here Mobile Unit

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LifeBridge Health Mobile Unit Outreach

Bringing Adult and Pediatric Health Services to Baltimore Neighborhoods

Overview of the LifeBridge Mobile Unit

Brief video about LifeBridge Mobile Unit

Alternate link to video

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LBH Mobile Unit Outreach: Overview & History

AIM: **Improve access to health resources in underserved communities**

- **Adult Mobile Services**
  - **Mobile Unit partners with community organizations** to reach and improve the health of residents. LifeBridge brings its Mobile Unit to West Baltimore:
    - Churches, synagogues, faith-based organizations
    - Barber shops and salons
    - Senior centers and buildings
    - Libraries and community centers
  - **Prior to COVID-19 vaccine development,** Mobile Unit staged multiple screening events in West Baltimore neighborhoods.
  - **Post-COVID-19 vaccine development,** Mobile Unit used to deliver thousands of vaccines to community residents.
- **Pediatric Wellness Mobile Services**
  - **School-based immunizations**
  - **Wellness screenings and referrals**

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Mobile Unit – FY24

"Care Happens Here"

- **Serving West Baltimore residents in Grace and Sinai neighborhoods**
- **Mobile Unit outreach at churches, schools & senior buildings**
  - **Health screenings and outreach** *(e.g., **351 screenings** at Clergy United for the Transformation of Sandtown-CUTS)*
  - **198 vaccinations at schools** *(partnership with Baltimore City Schools)*
  - **381 vaccinations for homebound residents** *(partnership with Baltimore City Health Dept.)*
- **66 referrals from churches to Grace for Primary Care**

Community Pastoral Outreach

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Community Pastoral Outreach

History

- Faith and Health Connection
- Population & Community Health
- Community Health and Wellness

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Faith and Health Connection

Faith and Health Connection

- The relationship between faith and health encompasses various aspects of an individual's life
- Spiritual Health serves as a foundation for good Physical Health
- Stress, Faith, Health are all connected
- People who attend worship services regularly tend to have more close friendships, which can in turn lead to better health outcomes
- Faith, spirituality, and a sense of purpose all have a beneficial effect on one's emotional, physical, and mental health
- Faith gives people a sense of meaning and purpose in life, which is linked to better health

Population & Community Health

- LifeBridge aims to improve our communities' health, understanding that **80% of health outcomes are not a result of clinical care**. In fact, the majority of health determinants include *individual behaviors, social and economic factors, access to care, and the physical environmental*.
- **Our three-pronged approach** to improving the health of our communities includes: **1) outreaching into communities around our hospitals; 2) providing the right care at the right time; 3) promoting preventive care and chronic disease management**.
- **Providing education about the social determinants of health was paramount to cultivating relationships** and supporting better health and wellness in our neighborhoods.

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Community Health & Wellness

Community Health and Wellness teams provide essential links between community members and health care services, social support services, and others in the community

3,566 religious organizations and congregations in the greater Baltimore Metro area

More than 75% of requests for community-based services came from faith-based organizations

Expanded staff to include a **Community Pastoral Outreach Coordinator**.

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Community Pastoral Outreach: Initiatives

- **Relaunch: A Live Webinar Discussion on Best Practices to Re-open Churches Well** - The United Baptist Missionary Convention & Auxiliaries of the State of Maryland

- **RE: Health:** The Open Church of Maryland

- **BRIDGES Project:** Manna Bible Baptist Church

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Community Pastoral Outreach: Initiatives

- **RE: Health** - The Open Church of Maryland

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Community Pastoral Outreach: Results

Fiscal Year 2024:

- ***Sinai/Grace:*** **4,485** community members served
- ***Northwest Hospital:*** **1,117** community members served
- **338 events** held *at* faith-based locations serving their surrounding community members as well as congregations
  - screenings
  - risk assessments
  - education on disease prevention & chronic disease management

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Addressing Inequities in Maternal & Infant Mortality

Sinai Hospital

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Addressing maternal health disparities

- Identified significant racial disparities in maternal and infant mortality
- Strategies
  - Prenatal health journey mapping (LBH and Get Well)
  - Navigation tools to identify local and national support
  - Get Well maternal Health Program
  - Actively enrolling mothers in the program

Maternal Health Equity Program:
Overall Performance Summary

Kickoff Date: 10/18/22

Go-Live Date: 1/30/23

Data Updated: 9/9/24

2,483
Total Patients Enrolled in MHE Program
Aug: 2,418

1,914
Postnatal Patients Enrolled in MHE Program
Aug: 1,839

643
Prenatal Patients Enrolled in MHE Program from Sinai Community Care
Aug: 642

654
Prenatal Patients Enrolled in MHE Program from OB Associates
July: 648

74.3%
Overall Engagement Rate

68.8%
Engagement Rate Post-Delivery

74.9%
Engagement Rate Pre-Delivery

46.2%
Survey Completion Rate*

429
Patients Received Baby Live Advice Info via Text
Aug: 414

362
Patients Received One or More SDOH Resource(s)
Aug: 343

866
Patients Received One or More Birth Prep Resource(s)
Aug: 835

64
Patients Received Family Tree Resource
Aug: 61

50%
Prenatal Symptom Checking Loop Activation Rate

160
Prenatal Symptom Checking Loop Alerts Triggered
Aug: 154

25%
Postnatal Symptom Checking Loop Activation Rate

32
Postnatal Symptom Checking Loop Alerts Triggered
Aug: 30

*Completion of one or more linked surveys

Maternal Health Equity Program:

Medicaid & Self-Pay Performance Summary

Kickoff Date: 10/18/22

Go-Live Date: 1/30/23

Data Updated: 9/9/24

146
Total Patients Enrolled in MHE Program
Aug: 146

105
Postnatal Patients Enrolled in MHE Program
July: 102

95
Prenatal Patients Enrolled in MHE Program from Sinai Community Care
Aug: 92

12
Prenatal Patients Enrolled in MHE Program from OB Associates
Aug: 17

67.4%
Overall Engagement Rate

74.3%
Engagement Rate Post-Delivery

56.3%
Engagement Rate Pre-Delivery

39.9%
Survey Completion Rate*

17
Patients Received Baby Live Advice Info via Text
Aug: 17

30
Patients Received One or More SDOH Resource(s)
Aug: 28

43
Patients Received One or More Birth Prep Resource(s)
Aug: 43

3
Patients Received Family Tree Resource
Aug: 3

* Completion of one or more linked surveys

Impact of Maternal Health Program for moms with Medicaid, Self-pay, or MA/Healthchoice/MCO

Sinai Hospital
a LifeBridge Health center

The following outcomes showed **improvement** over historical values with statistical significance for patients with Medicaid insurance or self-pay who delivered at Sinai Hospital between Feb 1, 2023 - Feb 29, 2024

Rate of Admittance to NICU

Rate of Admittance to NICU (14% vs 18%, p<0.05)***

Rate of Preterm Delivery

Rate of Preterm Delivery <37 weeks gestation (12% vs 17%, p=0.05)*

Baby Length of Stay

Baby LOS (3.9 days vs 6.6 days, p<0.001)**

*Preterm Delivery Rate was compared between LBH historical (N=908) and GW MHP (N=504) patients by Chi Square test, p-value=0.05. **Baby Length of Stay (LOS) was compared between LBH historical (N=977) and GW MHP (N=506) patients by Two Sample t-Test, p<0.0001. ***Rate of Admittance to NICU was compared between LBH historical (N=977) and GW MHP (N=506) patients by Two Sample t-Test, p<0.05.

Addressing Inequities for Patients with Limited English Proficiency

Sinai Hospital

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Pilot Program on Pediatrics Unit

- Pilot started in May 2024
  - Patient Identification
  - Delivery of blue phone to patient room
  - Patient education
  - Use of certified interpreter services by provider
  - Documentation of use of certified interpreter services
  - Monthly chart audit to assess documentation
- Monthly audit and presentation to staff
  - 2022-2023
    - 7% of patients preferred a language other than English
    - 80% documentation of interpreter services at least once
      - **Goal to increase daily documentation through program interventions outlined above.**
  - March to May 2024
    - 63% discharge documentation in preferred language
  - August - September2024
    - 42% documentation of interpreter services on discharge day
    - 80% documentation of interpreter services throughout hospitalization on day shift
  - October
    - 54% documentation of interpreter services on discharge day
    - 62% documentation of interpreter services throughout hospitalization on day shift

This is just a snapshot of some of the ways in which we support the health and well-being of our communities.

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THANK YOU
to our team members and partners.
THANK YOU
to our patients and community for the privilege of serving you.

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