MedStar Health

Knowledge and Compassion
Focused on You

FY18 Community Health Needs Assessment
MHH Implementation Strategies

February 5, 2018

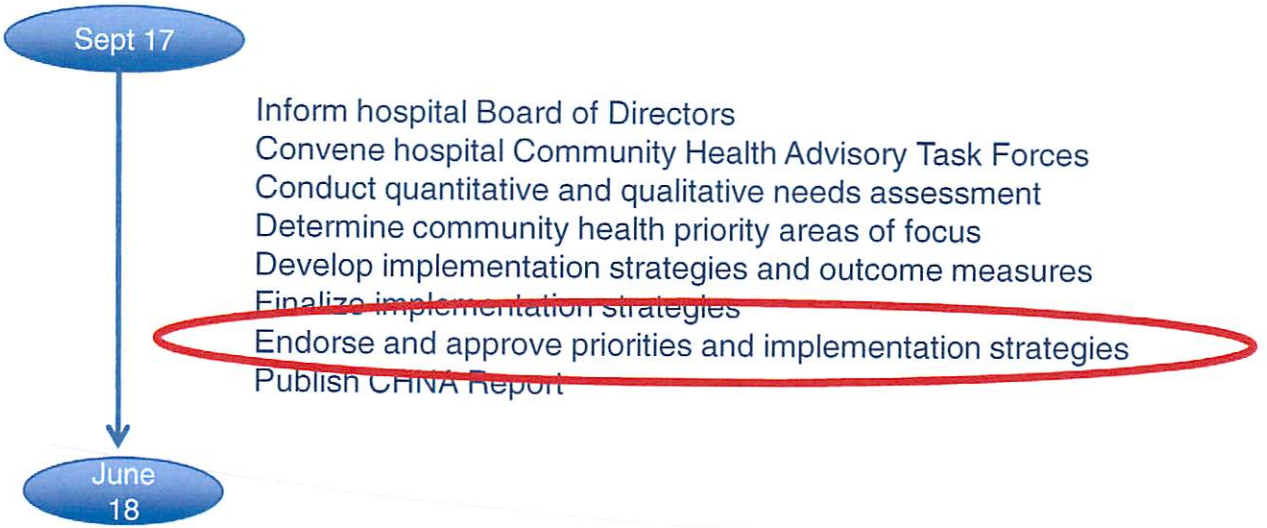
Agenda

Time	Topic
2:30 – 2:40	**Welcome and Introductions**
2:40 – 3:45	**Recap: Overview of CHNA** o Progress to date **Prioritization – A Regional View** **Implementation Strategy Review** o Regional o Hospital-Based **Other areas in development**
3:30 – 4:00	**Next Steps** o Make appropriate revisions o MHH Board Approval – March 1st o Published Report – June 2018 **Meetings moving forward**

CHNA Recap: Purpose of CHNA

- Conducted once every three years as part of the Affordable Care Act

- All MedStar Health hospitals participate; identifies and develops strategies to prioritize needs across FY 2019-2021



CHNA: Data Sources, Collection Tools & Analysis

- Secondary public health data
- Hospital ED re-admissions and charity care data ≥2
- CHNA surveys (N= 251)
- Community input sessions
  - Content Domains:
    - ✓ Access to Care/Services
    - ✓ Health & Wellness
    - ✓ Social Determinants of Health

Focus 21225

Health & Wellness

- Behavioral Health (drug/alcohol addiction; mental health conditions)
- Chronic Disease Prevention & Management (diabetes, heart disease, obesity, cancer)

Access to Care/Services

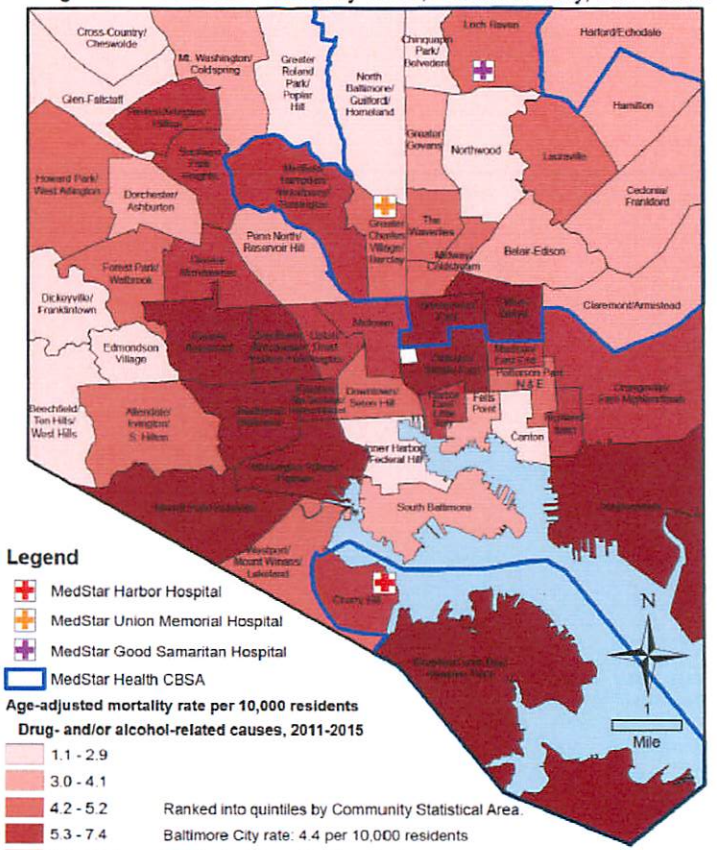
- Mental health and substance use services
- Transportation to/from health services

Andrea

SDOH

- Housing; Healthy Food Access

MedStar Health Community Benefit Service Area (CBSA)
Drug-/Alcohol-Related Mortality Rate, Baltimore City, 2011-2015



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BALTIMORE CITY HEALTH DEPARTMENT

Baltimore City - Priorities and Roles				
	Topic	MGSH	MHH	MUMH
Health & Wellness	Behavioral Health •Alcohol/drug Addiction •Mental Health Conditions	L	L	L
	Chronic Disease Prevention and Management	L	L	L
	Medication Adherence			
	Dental Care			
Access to Care	Substance Abuse Services	L	L	L
	Mental Health Services	L	L	L
	Transportation		P	
	Availability/Access • Insurance • Providers •Wait times			
Social Determinants	Housing	S	S	S
	Jobs	P		P
	Neighborhood Violence	S		S
	Food Access		S	

L = Leader
P = Partner
S= Supporter

MedStar Harbor Hospital

FY19-21 PRIORITY 1: BEHAVIORAL HEALTH SERVICES

Screening, Brief Intervention, and Referral to Treatment (SBIRT) Basics

Component	Goal
Screening	• Quickly assess all ED patients' severity of substance use w/ validated tool as part of initial patient ED intake process • Identify appropriate level of intervention Peer recovery coaches
Brief Intervention	• Peer Coaches provide real-time feedback • Increase insight and awareness regarding substance use and motivation to change • Negotiate and set goals
Referral to Treatment	• For those identified as needing more extensive care • Peer Coaches provide linkage to behavioral health provider for further assessment, diagnosis, and intake at proper level of care

52,000 ER visits/yr.

Implementation Strategy (FY19-21)

CBSA: 21225

Focus Area: Health & Wellness *Behavioral Health*
GOAL STATEMENT: To identify people with at-risk and dependent substance and/or alcohol use behaviors, and to provide a brief early intervention services to those who screen positively for risky drug and alcohol use
PROGRAMS AND SERVICES: Screening, Brief Intervention, and Referral to Treatment (SBIRT) Program and Peer Recovery Coaches
KEY PARTNERS: Substance Abuse and Mental Health Services Administration (SAMSHA); Behavioral Health departments; Mosaic Group; Primary Care Providers; ED providers
PROGRAM-SPECIFIC ANNUAL TARGETS: 75% of eligible patients complete SBIRT screenings annually 60% of patients with positive scores receive a Brief Intervention annually 15% of patients who receive Brief Intervention are referred to treatment annually 60% of MHH patients referred are linked to treatment annually

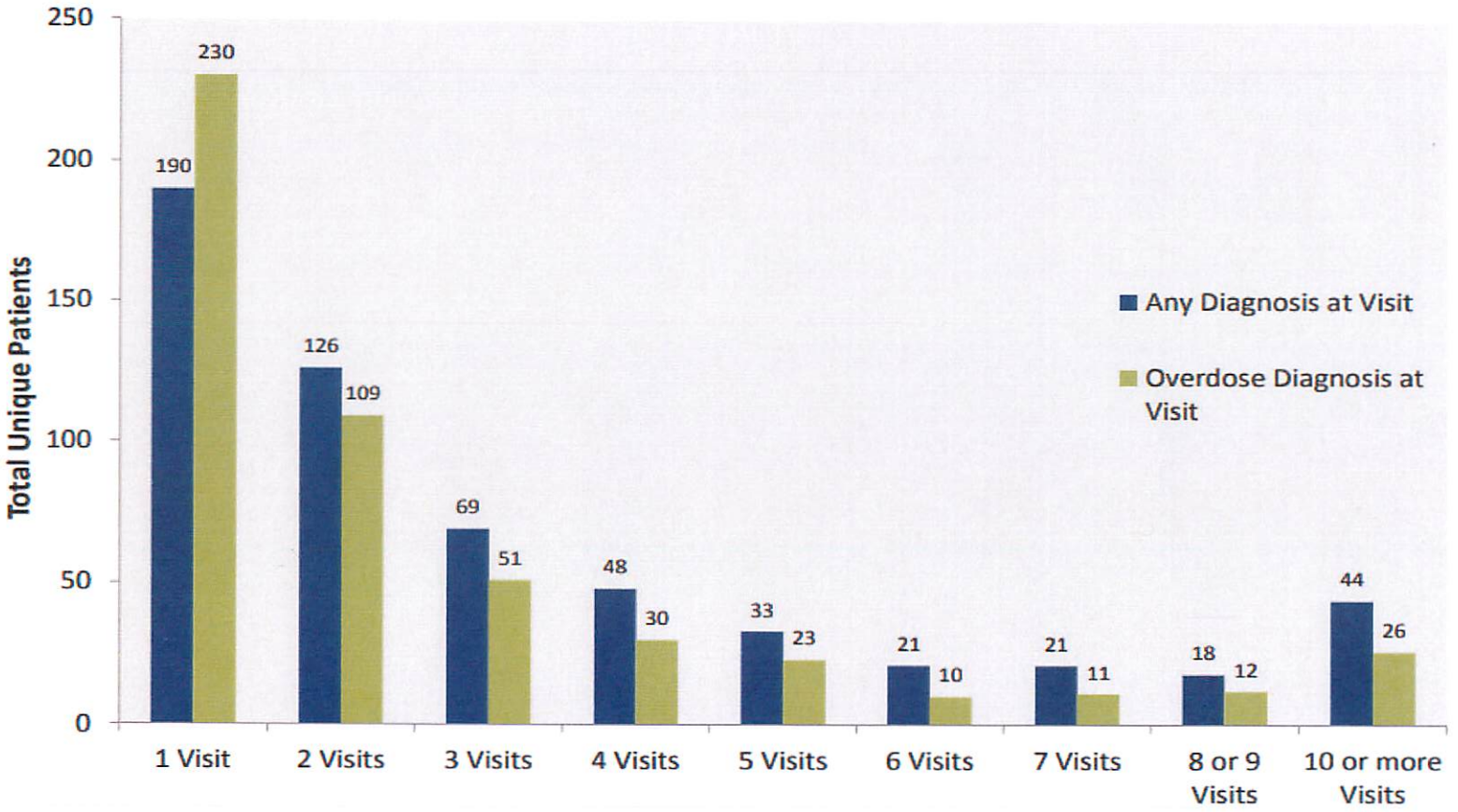
FY17 – Baltimore Region:

68,381 unique patients screened

7,998 patients screened positive for Brief Intervention

Nearly 1100 referrals to services

Figure 2: Maryland: Total Hospitalizations/ED Visits Occurring within 1 Year Prior to Overdose Death, By Number of Visits*



OSOP
In person will start
@ HH in March, 2018

Implementation Strategy (FY19-21)

CBSA: 21225

Focus Area: Health and Wellness

Behavioral Health – Opioid/Addiction Management

GOAL STATEMENT:

Naloxone Training: To empower community members and stakeholders to save lives in response to an opioid overdose.

Opioid Survivor Outreach Program: To identify people with at-risk and dependent substance abuse behaviors and provide community navigation and support services.

PROGRAMS AND SERVICES:

Offer Naloxone training to community

Development and implementation of Opioid Survivor Outreach Program to provide support and resources to opioid survivors that visit hospital-based emergency departments

KEY PARTNERS: Baltimore City Health Department (naloxone training); Mosaic; ED Providers and Clinical Leadership; Existing Community Partners; **SEEKING NEW PARTNERS!**

PROGRAM-SPECIFIC ANNUAL TARGETS:

Conduct at least 2 naloxone training sessions annually
Enroll at least 50 participants in naloxone training annually
60% of MGSH patients eligible for OSOP outreach engaged annually
20% of MGSH patients referred are linked to treatment annually

PROGRAM-SPECIFIC METRICS:

# of naloxone administration trainings offered at the hospital or community partner locations annually
# of community members trained to administer naloxone annually
# of referrals to treatment annually
# of suspected overdoses annually
# of referrals to OSOP Community Recovery coaches annually
# of patients successfully contacted by OSOP recovery coach annually
# of OSOP patient referred to treatment monthly
# of OSOP patients linked to recovery support groups annually
# of naloxone kits provided to OSOP patients annually
# of naloxone prescriptions provided to OSOP patients annually
# of known OSOP deaths annually

OSOP – Metrics and Targets

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# of known OSOP deaths annually

CHA - Community Health Advocate
PRC - Peer Recovery Coach

Implementation Strategy (FY19-21)

CBSA: 21225

Focus Area: Social Determinants of Health *Improving Job Opportunities*
GOAL STATEMENT: To hire individuals from underserved communities as CHAs and PRCs to contribute to MSH's population health management efforts in the Baltimore region through the Baltimore Population Health Workforce Collaborative (BPHWC)
PROGRAMS AND SERVICES: Baltimore Population Health Workforce Collaborative (BPHWC) "Jobs" Program
KEY PARTNERS: Baltimore Alliance for Careers in HealthCare (BACH); Case Management, Behavioral Health departments; BUILD; Turnaround Tuesday; Other participating health systems.
PROGRAM-SPECIFIC ANNUAL TARGETS: Hire and train 9 CHA and PRC associates by 2019

NAMI partnership HH a hub for NAMI

Implementation Strategy (FY19-21)

CBSA: 21225

Focus Area: Health and Wellness *Behavioral Health – Mental Health Support Services*
GOAL STATEMENT: To provide educational programs to ensure individuals and families experiencing or impacted by mental illness get the support and information needed
PROGRAMS AND SERVICES: Offer a series of three educational programs/events: o National Alliance on Mental Illness Basics Class – geared to parents and family caregivers of children and adolescents who have been diagnosed with a mental health condition o Peer to Peer Class – peer recovery education course open to anyone experiencing a mental health challenge o Mental Health Forum (hosted annually)
KEY PARTNERS: National Alliance on Mental Illness
PROGRAM-SPECIFIC ANNUAL TARGETS: Conduct at least 2 Mental Illness Basics Classes annually Enroll at least 40 people into Mental Illness Basics Classes annually Conduct at least 2 Peer to Peer Classes annually Enroll at least 40 people into Peer to Peer Classes annually Conduct NAMI Baltimore Mental Health Forum annually Achieve 60% completion rate for each of the classes/sessions offered annually

out patient program

Implementation Strategy (FY19-21)

CBSA: 21225

Focus Area: Access to Care/Services *Access to Mental Health Services*
GOAL STATEMENT: To increase access to mental health services as part of the primary care model
PROGRAMS AND SERVICES: Mental Health Services in Primary Care
KEY PARTNERS: Primary Care – Internal Medicine Departments; Community-based addiction and mental health services organizations
PROGRAM-SPECIFIC ANNUAL TARGETS: 80% of people with positive mental health screening referred or linked to services annually
PROGRAM-SPECIFIC METRICS: Number of people who receive mental health treatment services in program primary care setting annually Number of people screened for selected mental health conditions (substance use, depression and anxiety) annually Number of people with positive mental health screening annually Number of people who screen positively for mental health conditions that are referred or linked to services annually ED Readmission and PAU rates of people with positive mental health screening that were referred or linked to services

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Document needs - esp unmet needs

MedStar Harbor Hospital

FY19-21 PRIORITY 2: CHRONIC DISEASE MANAGEMENT

Implementation Strategy (FY19-21)

CBSA: 21225

Focus Area: Health and Wellness *Chronic Disease Prevention and Management*
GOAL STATEMENT: To deliver evidence-based, outcome-focused chronic disease management and prevention programs and services in or targeting individuals living in MHH community benefit service area.
PROGRAMS AND SERVICES: Living Well Chronic Disease Self Management
KEY PARTNERS: Baltimore City Department of Health and Human Services; Baltimore City Department of Aging; Maryland Department of Aging; MAC, Inc.; Brooklyn Park Library; Cherry Hill Senior Manor; Family Health Centers of Baltimore; **SEEKING NEW PARTNERS!**
PROGRAM-SPECIFIC ANNUAL TARGETS: Conduct at least 4 Living Well 7-week sessions annually Enroll at least 80 participants across the 4 Living Well sessions annually Achieve a 60% completion rate for each of the 4 Living Well sessions annually

Tucan key leaders

Mar. Brooklyn Park Library

Implementation Strategy (FY19-21)

CBSA: 21225

Focus Area: Health and Wellness *Chronic Disease Prevention and Management*
GOAL STATEMENT: To prevent the onset of type 2 diabetes through a 12 month lifestyle change program
PROGRAMS AND SERVICES: Diabetes Prevention Program
KEY PARTNERS: CDC, Baltimore City Department of Health and Human Services; Maryland Department of Health; MedStar Family Choice; Brooklyn Park Library; Cherry Hill Senior Manor; Family Health Centers of Baltimore; **SEEKING NEW PARTNERS!**
PROGRAM-SPECIFIC ANNUAL TARGETS: Conduct at least 2 Diabetes Prevention Programs annually Enroll at least 30 participants across the 2 DPP programs annually Achieve a 60% completion rate for each of the 2 DPP programs annually Achieve an average weight loss of at least 5% across all participants over the 12 month intervention period 70% of completers achieve a minimum of 150 minutes of physical activity per week

Healthy eating training

Community food liaison

Meet weekly 1 hr/wk for 12 wks Feb. in Cherry Hill Senior Center Manor

Implementation Strategy (FY19-21)

CBSA: 21225

Focus Area: Health and Wellness *Chronic Disease Prevention and Management*
GOAL STATEMENT: To increase awareness and the intention to quit among smokers.
PROGRAMS AND SERVICES: Smoking Cessation Program
KEY PARTNERS: MedStar Cancer Network, American Cancer Society, Baltimore City Health Department,
PROGRAM-SPECIFIC ANNUAL TARGETS: Conduct at least 2 Smoking Cessation programs annually Enroll at least 40 participants annually Achieve a 75% completion rate for each of the 2 Smoking Cessation Programs annually

Implementation Strategy (FY19-21)

CBSA: 21225

Focus Area: Health and Wellness *Chronic Disease Prevention and Management - Breast, Cervical and Colon Screening Programs*
GOAL STATEMENT: To detect breast, cervical and colon cancer through screening for those that may not be able to afford the screening services on their own
PROGRAMS AND SERVICES: Breast and Cervical Cancer Screening: eligible participants include, ages 40 and older, Baltimore City/County residents, uninsured or underinsured, and living on limited income Colon Cancer Screening: eligible participants include, Baltimore City or Anne Arundel County residents, ages 50 and older, uninsured or underinsured, living on limited income
KEY PARTNERS: Baltimore City Health Department; Baltimore City Breast and Cervical Cancer Screening Program; MedStar Health Cancer Network; MUMH
PROGRAM-SPECIFIC ANNUAL TARGETS: Conduct at least 750 breast and cervical cancer screenings annually Conduct at least 275 colon cancer screenings annually 100% of participants who are diagnosed with cancer referred and provided treatment annually

both hospitals

MedStar Harbor Hospital

FY19-21 PRIORITY 3: SOCIAL DETERMINANTS OF HEALTH – HOUSING, TRANSPORTATION, JOBS, AND FOOD ACCESS

A Simple Search for Social Services

Aunt BERTHA

1.

Enter Location

Zip: 78704 Search → Programs.

Aunt Bertha has indexed the country's government and charitable health and human services programs.

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Health Care Access Now

Implementation Strategy (FY19-21)

CBSA: 21225

Focus Area: Access to Care/Services *Linkage to Resources and Services*
GOAL STATEMENT: To improve appropriate healthcare utilization practices and health outcomes of high need, high risk patients by identifying social unmet needs and linkage to community social needs resources at point of care.
PROGRAMS AND SERVICES: Social Needs Screen and Aunt Bertha Resource Platform
KEY PARTNERS: Aunt Bertha, Inc.; Primary Care; ED; Case Management and Post-Discharge Planning Teams, Community-based social services organizations
PROGRAM-SPECIFIC ANNUAL TARGETS: Use of uniform social needs screener in MHH care delivery sites and as part of the Living Well Program Active use of Aunt Bertha tool at a minimum of one site at MHH At sites using Aunt Bertha, at least 75% patients screened for social needs annually 80% of people with positive social needs screening referred or linked to services annually

Implementation Strategy (FY19-21)

CBSA: 21225

Focus Area: Access to Care/Services *Transportation*
GOAL STATEMENT: To remove the barrier of transportation to medical/health services and programs among individuals who identify transportation as a social need.
PROGRAMS AND SERVICES: UBER Program
KEY PARTNERS: UBER, Inc.; Mi2
PROGRAM-SPECIFIC ANNUAL TARGETS: MHH to support at least 125 rides to/from medical/health services and community health programs annually

Implementation Strategy (FY19-21)

CBSA: 21225

Focus Area: Social Determinants of Health *Improving Job Opportunities*
GOAL STATEMENT: To prepare local underserved students for healthcare-related collegiate studies and careers through an established pipeline internship program.
PROGRAMS AND SERVICES: To deliver internship programs to underserved high school students
KEY PARTNERS: Vivien T. Thomas Medical Arts Academy; Start on Success – Humanim; Baltimore Youth Works
PROGRAM-SPECIFIC ANNUAL TARGETS: MHH to accept and place at least 10 underserved, racial/ethnic minority interns at MHH annually (at least 3 students will be accepted and placed at MHH from the Rx for Success Program annually) Provide information and resources related to open positions within MHH to 100% of eligible seniors interns annually

Partner/Collaboration Area (FY19-21)

CBSA: 21225

Partner/Collaboration Area: Social Determinants of Health

Food Access and Insecurity

EVIDENCE OF NEED for Topic:

24% of CHNA respondents identified access to affordable, health food as a community need. Food access was prioritized by the MHH CHNA Task Force as the second highest community need among all resources and services.

STRATEGY:

Seek Opportunities and Funding Sources: Apply and participate in applicable grants through Baltimore City – Baltimarket; actively seek out other opportunities to address food insecurity in MHH CBSA

Partnership: United Way, MedStar Harbor Hospital / Morrison's Food Service, and American Heart Association
Due to the limited number of grocery stores in the South Baltimore region, corner stores are often the best access for fresh produce. However, if purchased at all, fresh produce is purchased at Sam's Club or other supermarket locations. To reduce to cost to both the corner store and consumer, as well as provide fresh produce access to the community, MHH/Morrison's Food Service will purchase produce at whole-sale price and provide crates of fresh produce to corner stores. American Heart Association has a curriculum developed to train MHH Community Health Advocates to provide both nutritional education and cooking demonstrations to the community on-site at corner stores.

INTERNAL LEADS:

Morrison's Food Service
MHH Dietitians
MHH Community Health

EXTERNAL PARTNERS:

United Way of Central Maryland
American Heart Association
Baltimore City – Baltimarket
Cherry Hill Town Center – Community Action Partnership
Baltimore South Gateway Partnership

Heart Assoc - Community education

Supporter/Participation Area (FY19-21)

CBSA: 21225

Supporter/Participation Area: Social Determinants of Health *Housing*
EVIDENCE OF NEED for Topic: 29% of CHNA respondents identified housing/homelessness as an important social/environmental problem affecting the health of the community and 38% of CHNA respondents noted that access to affordable housing is needed in the community.
EXPLANATION: MHH does not have the expertise to have a leadership role in these areas; therefore, MHH will support external leadership in these areas.
LEAD ORGANIZATIONS: Public Housing Associations in South Baltimore Healthcare for the Homeless Habitat for Humanity / Baltimore South Gateway Partnership Greater Bay Alliance Baltimore City governmental agencies

Other Opportunities in Development

- Urban Health Internal Medicine Residency Track
- "Ask a Doc" – development of community outreach strategy
- Baltimore City Accountable Healthcare Communities
  - ✓ National Pilot Project with CMS
- Baltimore City Health Department High Utilizer Task Force
- Funding Underway: Mobile Transportation Unit
- Engaging Church Congregations
  - ✓ Cherry Hill Ministerial Alliance
- American Hospital Association: Equity Now
  - ✓ Healthcare Equality Index – LBGT Access to Care

By the numbers…improving health status in Baltimore City

450
Trained to
administer naloxone

120
Quit Smoking

240
residents trained in Living Well
With Chronic Disease

Up to 15,000
Patients screened and linked
To SOD services

68,000+
SBIRIT Screenings

132
Interns and Jobs for
Community members

120
Prevented Type 2 Diabetes
Through DP Program

360 +
Support Group
Attendees

375
Uber rides to accessing
services

500+
Free cancer
screenings

3,840 lbs
Produce to
Corner stores

15+
New Partners

1,000 +
CHW
Patient Interactions

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Next Steps- CHNA Endorsements and Approval

Review and Approval - MedStar Harbor Hospital
- March 1, 2018
- Published June 2018

Continued engagement with MHH Task Force
- Meeting Cadence - TBD