PRIORITIZED NEED #1: Address Mental Health/Substance Use Disorder

GOAL: Provide access to hospital and community resources that provide a positive impact on meeting the substance and mental health needs of community members

ACTION PLAN

STRATEGY 1: Build a path toward a comprehensive continuum of care for mental health needs and substance use disorder by creating programs in various hospital divisions with SBIRT and Bupe induction and through creation of community programming with the Health Insitute and community partners.

BACKGROUND INFORMATION

Saint Agnes faces a growing need to address the escalating Substance using population presenting to the ED with near fatal overdoses. With the epidemic of fentanyl overdose now reaching an all time high in the state and City of Baltimore, there is an urgent need to commit all possible strategies to making a significant impact on increasing substance users' connections to assistance and resources and treatment.

RESOURCES: Saint Agnes Hospital, Saint Agnes Health Institute, and community parnters

	ACTIONS (STRUCTURE) *(Include estimated dates for when actions will be implemented)*	LEAD ORG / STAFF	COLLAB ORG / STAFF	**PROCESS MEASURES – OUTPUTS** (# Products, materials, people reached...)			
				Indicator	Baseline Value / Date	Target Value / Date	Source
1	Provide substance use screening and referral to all patients treated in the Adult Emergency Department	HI/JB	Mosaic	1) %of positive SBIRT screenings in Adult ED 2) %of Overdose Survivors linked to treatment 3) % consented pts who linked to treatment after successful brief intervention.	New FY19	1.)75% / FY 19 2) 10% / FY20 3)40%/FY 21	SBIRT Report/Mosaic
2	Increase access to medication assisted treatment for patients with Opioid Use Disorder in the ED and inpatient setting	JB/DO/PM		1) Increase % of patients prescribed MAT in ED 2) Increase patients prescribed MAT in the inpatient setting.	New FY19	1) 10%/FY20 2) 10%/FY20	SBIRT Report
3	Initiate an OB/GYN targeted substance use disorder continuum of care thru SBIRT Screenings and linkages to treatment.	HI/JB	Mosaic	1) %SBIRT screenings in OB/GYN & L & D 2) % of OB/GYN SBIRT Brief Assessments completed 3) % consented pts who linked to treatment after OB/GYN successful brief intervention to treatment .	New FY19	1) 75 % / FY 19 2) 75%/ FY 19 3) 50%/ FY 19	SBIRT Report/Mosaic
4	Increase mental health visits in the CCC and Health Institute programs.	AM/JB		1) patient encounters for mental health 2)# groups for counseling	1)300 2)New FY19	1) 30%/FY21 2) 4 groups/FY20	eCW report CCC Rehab Services BMS Health Institute
5	Conduct Naloxone trainings on the campus and throughout the community	JB/OF	BCHD	1) Train 250 staff, community members, and providers	New	1) 250 FY/20	Records of Attendence
6	Provide Trauma-Informed-Care trainings for SAH and affiliated staff	HI/JB, OF	Trauma Partners	1) Train 200 staff in basic TIC	New	1) 200 FY/20	Records of Attendence

ANTICIPATED IMPACT – OUTCOMES

SMART OBJECTIVES: *(# objectives; link to anticipated outcomes below)*

I. Increase sustainable SU Treatment 30 days post linkage.

II. Increase sustainable OB/GYN SU Treatment 30 days post linkage

III. Increase naloxone training (>100 pp /year). Develop internal workflows /SOW/access for the identification of Opiod SUD patients andimproved access to naloxone

ACTIONS *(Insert # of above action(s) related to outcomes)*	**SHORT-TERM OUTCOMES** *(Knowledge, attitude, skill...)*				**MEDIUM-TERM OUTCOMES** *(Behavior, decision-making, policy...)*				**LONG-TERM OUTCOMES** *(Health status, socioeconomic conditions...)*			
	Indicator	Baseline Value / Date	Target Value / Date	Source	Indicator	Baseline Value / Date	Target Value / Date	Source	Indicator	Baseline Value / Date	Target Value / Date	Source
1,2,3	% of patients linked to treatment	New/ FY19	50%/FY19	SBIRT Report	% report postive connectivity 30 days post linkage.	New/FY19	10% decrease in ED visits/CY20	HI	Decrease in overdose deaths in Baltimore based on SAH initiatives	761/CY17	10%/FY22	BCHD/MDH
2,5	% of Opioid dependent patients will be discharged with naloxone Rx filled	New/FY19	50%/FY19	Medi-tech Report	% of Opioid dependent patients will be discharged with naloxone Rx filled	New/FY19	75%/FY20	HI	Decrease in overdose deaths in Baltimore based on SAH initiatives	761/CY17	10%/FY22	BCHD/MDH
4					% of patients receiving mental health services remaining connected to care for 7 visits	New/FY19	50%/FY19	e-CW				
6					% of TIC trained staff able to understand and express intentions to apply strengths-based approaches in their direct interaction with traumatized patients	New/FY19	40%/FY20	Training Surveys				

SMART OBJECTIVE	**LOCAL/HEALTHY BALTIMORE 2020**	**STATE/SHIP PLAN**	**NATIONAL/HEALTHY PEOPLE 2020**

(I, II, III...)	*(Identify relevant community objective(s))*	*(Identify relevant community objective(s))*	*(Identify relevant community objective(s))*
1,2,3,5	Close the gap in overdose deaths between Baltimore and the rest of Maryland by 10%	Reduce the rate of drug-induced death rate from 24.1 to 12.6 per 100,000 people by 2020	Increase the proportion of persons who need alcohol and/or illicit drug treatment and also receive specialty treatment for abuse or dependence in the past year.
1,2,4,6			Increase the proportion of primary care facilities that provide mental health treatment onsite or by paid referral
1,2,3,5	By 2020 reduce the number of Drug/alcohol ED visits by 10%	Reduce the rate of drug-induced death rate from 24.1 to 12.6 per 100,000 people by 2020	Reduce the rate of drug-induced death rate from 11.3 per 100,000 people by 2020
6	Develop city-wide trauma initiative that addresses trauma training for city residents, front-line workers, educators and community-based trauma interrupters		

PRIORITIZED NEED #2: Reduce Obesity and the Impact of Chronic Diseases

GOAL: Reduce the prevalence of obesity and chronic disease in the community.

ACTION PLAN

STRATEGY 1: Provide increased outreach, education and medical intervention, on campus and in the community, to patients who are suffering from the physical & mental effects of chronic disease and who are seeking a change in their health status.

BACKGROUND INFORMATION

• *Target population: Patients experiencing health problems due to obesity and chronic disease particularly the vulnerable population with limited access to primary care, care management and education.*

RESOURCES: Saint Agnes Hospital (SAH), Saint Agnes Health Institute, and community partners

	ACTIONS (STRUCTURE) *(Include estimated dates for when actions will be implemented)*	LEAD ORG / STAFF	COLLAB ORG / STAFF	**PROCESS MEASURES – OUTPUTS** (# Products, materials, people reached...)			
				Indicator	Baseline Value / Date	Target Value / Date	Source
1	Bariatric Outreach & Support – Increase attendance to bariatric seminars and referrals to bariatric providers where appropriate. Bariatric Surgery – Facilitate and support healthy BMI reduction 1 yr after bariatric surgery.	SAH		1) # attending seminars 2) # of surgical procedures 3)% w/ 20% decrease in BMI	1) 1,257/FY18 2) 580/FY18 3) 57.4%/FY18	1) 1,270/FY19 2) 590/FY19 3) 60%/FY19	1) SAH Seminar attendance list 2) ACD MBSAQIP database 3) ACD MBSAQIP database
2	Partner with key community entities to utilize the CDC/American Diabetes Association Diabetes Risk Test to promote awareness of Type 2 Diabetes risk factors and refer as appropriate to National Diabetes Prevention Program. National Diabetes Prevention Program –increase attendance, completion and weightloss success in an effort to prevent or limit the effets of diabetes. Identification of additional funding sources to suppport additional resources for participants and program expansion.	HI, Mackenzie	MDH, Community providers	1) Administer CDC/ADA Diabetes Risk Test 2)# attending the program 3) % completing the program 4) % w/5% weight loss in those completing program 5) Fundraise 100k for maintenance and expansion	1) 80/FY18 2) 40/FY18 3) 50%/FY18 4)All cohorts combined averaged 2.81% weight loss/FY18 5) $40k/FY18	1) 80/FY19 2) 40/FY19 3) 60%/FY20 4) All cohorts combined average 5% weight loss/FY19 5) $100K/FY20	SAH Attendance database, SAF
3	Partner with AMG Maternal-Fetal Medicine and Baltimore Medical System for the Diabetes in Pregnancy program to provide nutrition therapy and health education and monitoring of mothers-to-be suffering from gestational diabetes, type 1 or 2 diabetes, obesity or pre-diabetes to increase self management skills and prevent fetal macrosomia and decrease mother and child's lifetime risk of developing type 2 diabetes.	AMG MFM HI Diabetes Education team	BMS Community providers	1) % of patients seen receiving monitoring blood sugar 2) % of newborns LGA (large for gestational age)	1) 76%/FY18 2) 6.4%/FY18	1) 80%/FY19 2) ≤ 6%/FY20	Meditech
4	Develop comprehensive CVD prevention programming in the community. Increase the number of people participting in cardiovascular disease screening and self-management education programming	HI, Mackenzie	SAMG MCVS Churches BCountyHD	1) # of CVD risk assessments completed 2) % referred to CVD or HF Prevention intervention 3) % completing the program	New for FY19	1) 150/FY19 2) 50%/FY19 3) 50%/FY19	Health Institute screeners
5	Development and implemenation of institutional care paths for CHF, COPD, diabetes and ESRD patients	SAH, Kinder Mackenzie	SAMG Richardson Swallow	1) Advanced directive education 2) Palliative Care consultation 3) Reduction of PAU	1) New for FY19 2) New for FY19 3) 4,375/FY18	1)250/FY19 2)100/FY21 3)reduce PAU by 600 cases	1) Health Institute (CCC/COPD/HFC) 2) SAH Clinical Staff 3) HI Clinical Staff

6	Develop a multi-tiered food access program that includes Farmer's Market, Food Rx program and other initiatives.	HI	JB, OF	1) # using farmers mkt 2) #SNAP at Farmers Mkt 3)% of eligible chronic complex who meet medical criteria receive idenitified food intervention	New for FY18	1)200/mo/FY19 2)10% use SNAP /FY19 3) 80% receive food intervention/FY19	Data from sales
7	Continue care redesign program including west baltimore collaborative, CCIP, MDPCP to reduce readmission and total cost of care reducing PAU	WBC		Reduction of readmissions	1) 4375/FY18	Reduction by 250/ FY19	SAH EMR

ANTICIPATED IMPACT – OUTCOMES

SMART OBJECTIVES: *(# objectives; link to anticipated outcomes below)*

I. Increase diabetes education to ensure appropriate glucose monitoring and weight loss which has been shown as evidence based to prevent and/or reduce the health risks of diabetes thus decreasing hospitalization for diabetes by 15% and ED visits for diabetes by 10%.

II. Increase awareness of medical weight loss techniques and bariatric surgery as options to reduce BMI by 20% in one year.

ACTIONS *(Insert # of above action(s) related to outcomes)*	**SHORT-TERM OUTCOMES** *(Knowledge, attitude, skill...)*				**MEDIUM-TERM OUTCOMES** *(Behavior, decision-making, policy...)*				**LONG-TERM OUTCOMES** *(Health status, socioeconomic conditions...)*			
	Indicator	Baseline Value / Date	Target Value / Date	Source	Indicator	Baseline Value / Date	Target Value / Date	Source	Indicator	Baseline Value / Date	Target Value / Date	Source
1	# attending seminars	1,257 /FY18	TBD	SAH Seminar attendance list								
1					# of surgical procedures	580/FY18	590/FY19	ACS MBSAQIP database	% w/20% decrease in BMI	57.4%/FY18	60%/FY19	ACD MBSAQIP database AMG EMR
2	#completing ADA/CDC Risk Test	New for FY19	80/FY19	HI database								
2	# attending the NDPP program	40/FY18	40/FY19	HI Attendance database	% completing the program	50%/FY18	60%/FY19	HI Attendance database	% w/5% weight loss	New for FY19	combined cohorts average 5% weight loss/FY19	HI database
2									Fundraise $100k	$40K/FY18	$100K/FY20	SAF HI
3					% attendees monitoring glucose	76%/FY18	80%/FY19	SAH Program data spreadsheet	% LGA birth weight	6.4%/FY18	≤6%/FY20	Meditech
4	# screened for CVD Risk	New for FY19	150/FY19	HI Screening data base	% referred to Intervention or provider	New for FY19	50%/FY19	HI Screening data base	% completing CVD intervention	New for FY19	50%/FY19	HI Screening data base
5,7	Reduction in Overall PAU	4375 cases FY18	Reduction by 250/FY19	SAH EMR	Reduce PAU #s	4,375/FY18	by 600 cases/FY20					

6					% of chronic complex receiving food intervention who do not re-admit to ED or Inpatient w/in 6 mos. of intervention	New for FY19	10%/FY20	SAH EMR				
5,7					Create post acute network	New for FY19	create 2/FY20	DO				

STRATEGY ALIGNMENT WITH LOCAL, STATE & NATIONAL OBJECTIVES – **PRIORITIZED NEED #2**

SMART OBJECTIVE (I, II, III...)	**LOCAL/HEALTHY BALTIMORE 2020** *(Identify relevant community objective(s))*	**STATE/SHIP PLAN** *(Identify relevant community objective(s))*	**NATIONAL/HEALTHY PEOPLE 2020** *(Identify relevant community objective(s))*
1	By 2020 Decrease obesity by 15%.	By 2020, reduce the proportion of adults who are obese to 36.6%. (BRFSS)	By 2020, reduce the proportion of adults who are obese to 30.5%. (NHANES, CDC/NCHS)
2, 3,7	Decrease the hospitalization rate for diabetes by 15%. Decrease the rate of ED visits for diabetes by 10%.	By 2020, reduce the proportion of adults diagnosed with diabetes to less than 9% (MD State level). (BRFSS)	By 2020, reduce the proportion of persons with diabetes with an A1c value greater than 9% to 16.1%. (NHANES, CDC/NCHS)
4,5	Decrease smoking by %15 by 2020		
4,5	Increase % of adults with high blood pressure on medication by 10%	Reduce ED visits due to Hypertension (per 100K population) to 234 by 2020.	By 2020, increase the proportion of adults who have had their blood pressure measured within the preceding 2 years and can state whether their blood pressure was normal or high to 92.6%. (NHANES, CDC/NCHS)
3, 4, 5, 6	By 2020 reduce cardiovascular disease deaths by 15%	Reduce Age-Adjusted Mortality from Heart Disease (per 100K population) to 166.3 by 2020.	By 2020, increase the proportion of adults who have a specific source of ongoing care to 95%. (NHANES, CDC/NCHS)
4, 5			By 2020, increase the proportion of adult heart attack survivors who are referred to a cardiac rehabilitation program at discharge. (NHANES, CDC/NCHS)
6			By 2020, increase the number of community-based organizations providing population-based primary prevention services in chronic disease programs to 90.8%, a 10% increase. (NHANES, CDC/NCHS)
6,7			By 2020, increase the number of community-based organizations providing population-based primary prevention services in chronic disease programs to 90.8%, a 10% increase. (NHANES, CDC/NCHS)

PRIORITIZED NEED #3: Create Person-Centered Healthy Neighborhoods to Address Social Determinants of Health

GOAL: Collaborate with community agencies to provide better access to health care resources and the social determinants of health for populations that have the greatest needs and least resources.

ACTION PLAN

STRATEGY 1: Collaborate with community agencies to provide access to appropriate health program and access to those social determinants resources that improve health outcomes.

• *Target population: Focus on high need patients (high utilizers) in our service area that lack connection to community programs that would address medical and social determinants of health to improve quality of life, particularly in West Baltimore.*

RESOURCES: **Saint Agnes Hospital (SAH), Saint Agnes Medical Group(SAMG), Baltimore Medical Systems, Inc.(BMS), West Baltimore Collaborative(WBC), Health Care Access Management(HCAM)**

ACTIONS (STRUCTURE) *(Include estimated dates for when actions will be implemented)*		LEAD ORG / STAFF	COLLAB ORG / STAFF	**PROCESS MEASURES – OUTPUTS** (# Products, materials, people reached...)			
				Indicator	Baseline Value / Date	Target Value / Date	Source
1	Initiate Social Determinates of Health Screening at two Primary Care clinics.	HI/JB	AMG Care Mgt Pop Health	%of pts at Pine Hghts screened	New for FY19	80%/FY19	Jen, HI reporting
2	Implement two new community-based health programming or social determinants-related initiatives	HI/OF	Various Partners	# new community-based health programs	New for FY19	2 by FY20	HI reporting
3	Identify a mechanism for a sustainable path for employment opportunities at St. Agnes or at other employers for West Baltimore residents via workforce development programming or partnerships	HI & SAH HR/OF	Goodwill, MOED and various partners	1)Establish path for employment targeted for West Baltimore residents	New for FY 19	1 pathway created/FY20	SAH HR and HI reporting
4	Increase Primary Care & OB Services in West Balt by increasing access for Medicaid primary, specialty care and pediatric visits to Saint Agnes Medical Group.	AMG BMS		1) # total visits 2) # new patients 3) % Medicaid visits	1) 132,110/FY18 2) 16,667/FY18 3) 8.75%/FY18	1)140,000/FY21 2)17,000/FY21 3) 10%/FY21	Data from BMS & SAMG
5	Promote the continued development of Gibbons Commons through exploration of bringing a full-service grocery store and various types of housing stock to the site. Continue to support the development of a full service Y.	SAH	Balt. Develop. Corp/other development partners	1) Initiate one new site study for housing stock and/or grocery store	New for FY19	1) Complete one study FY19	SAH/HI
6	Create a SAH Community Council that will provide advice and counsel to SAH and HI on its initiatives and CHNA and serve as partners on new health and social initiatives.	OF	Various community partners	1) Initiate regular convenings of the Council	New for FY19	7 mtgs /FY19	OF/HI
7	Conduct a Medical Mission at Home event in collaboration with other stakeholders to provide medical and dental care and resource referrals to vulnerable populations within the Baltimore City community.	HI United Way of Central MD/ UMD School of Dentistry	AMG UMD - Schools of Pharmacy & Nursing Notre Dame of MD University - School of	1) # patients receiving medical assessment	New for FY19	500/FY19	HI reporting

ANTICIPATED IMPACT – OUTCOMES

SMART OBJECTIVES: *(# objectives; link to anticipated outcomes below)*

I. By 2020, complete 2,250 SDoH Screenings with successful education and linkage to resources of those patients triggered with positive needs. Linkage is defined as person has made contact and is assisted, as needed, by resource provider.

II. By 2020 decrease hospital usage by high utilizers, including ED, IN and INO services by using care management efforts.

ACTIONS *(Insert # of above action(s) related to*	**SHORT-TERM OUTCOMES** *(Knowledge, attitude, skill...)*				**MEDIUM-TERM OUTCOMES** *(Behavior, decision-making, policy...)*				**LONG-TERM OUTCOMES** *(Health status, socioeconomic conditions...)*			
	Indicator	Baseline Value / Date	Target Value / Date	Source	Indicator	Baseline Value / Date	Target Value / Date	Source	Indicator	Baseline Value / Date	Target Value / Date	Source

1,2,4	% of patients who screen in need who are linked to at least one SoDH resource such that patient has made contact and is assisted, as needed, by resource provider.	New FY19	25%/FY19	CM/ CHW Data					Reduction in PAU	4375/FY18	600/FY20	CRISP
2,3, 6	No. of patients and/or West Baltimore residents who connected to workforce opportunities	New FY19	10/FY19	HI, OF	% of those connected, improve income by at least 10%	New	25%/FY20	HI, OF				
5, 6	Implement SAH Health Ministry mission of improving community health outcomes through direct investment in community initiatives.								Provide free memberships for community members for newly built Y	NewFY19	1000 memberships/ FY22 (or upon completion)	SAH
7	Implement change in practice through lessons learned during the MMaH.				Implement one new practice	New FY19	One new practice implemented/ FY20	SAH/AMG				

STRATEGY ALIGNMENT WITH LOCAL, STATE & NATIONAL OBJECTIVES – **PRIORITIZED NEED #3**			
SMART OBJECTIVE (I, II, III...)	**LOCAL/HEALTHY BALTIMORE 2020** *(Identify relevant community objective(s))*	**STATE/SHIP PLAN** *(Identify relevant community objective(s))*	**NATIONAL/HEALTHY PEOPLE 2020** *evant community objective(s))*
1, 2, 4,6,7	Decrease the percent of adults with unmet mental health care needs by 25%.	Increase the percentage of persons with a Usual Primary Care Provider to 83.9% by 2020.	By 2020, increase the proportion of adults who have a specific source of ongoing care to 95%. (NHANES, CDC/NCHS)
1, 2, 3, 4	Decrease the rate of alcohol and drug-related hospital admissions by 10%.		
1, 3	Decrease rate of ED visits for ambulatory sensitive indicators by 10%.	Decrease uninsured ED visits to 14.7% by 2020.	Increase the proportion of persons who have access to rapidly responding prehospital emergency medical services.
2, 4	Decrease hospitalization rate for ambulatory sensitive indicators by 15%.		
1,3,6	Decrease the food insecurity by 10%.	Increase the percentage of affordable housing to 54.4% of units sold at a median teachers salary by 2020.	Decrease the proportion of households that experience housing cost burden.
3			Reduce the percentage of household food insecurity to 6% by 2020 and in doing so reduce hunger.
5		Increase the percentage of people reporting physical activity within the last 30 days to 50.4% by 2020.	Increase policies for built environment that enhance access to and availability of physical activity opportunities.
3			Decrease the proportion of households living in poverty.