

Ascension Saint Agnes Implementation Strategy

Fiscal Years 2022 through 2024

Overview

The Ascension Saint Agnes community health needs assessment (ASA CHNA) process is about improving health—the health of individuals, families, and communities. The CHNA evaluates the health status of the people residing in our surrounding communities to identify the greatest health needs and to determine how ASA can best respond to them. In addition to analyzing public health and hospital utilization data, ASA engaged the public through a structured online survey and a series of focus groups. We presented findings to several groups of external stakeholders to solicit feedback from leaders among the communities we serve. Internal stakeholders representing clinical care, population health, care management, and pastoral care also provided input. ASA continues to collaborate with other Baltimore City Hospitals to establish shared health priorities and collectively address health needs.

Priority Needs to be Addressed

The three community health need priorities to be addressed by ASA for the FY 2022 through FY 2024 cycle are as follows:

- **Address mental health and substance use disorder;**
- **Prevent diabetes and improve health outcomes for individuals with diabetes; and**
- **Build person-centered healthy neighborhoods to address social determinants of health.**

Implementation Strategy

Below is an implementation strategy for each of the three prioritized needs, including the resources, proposed actions, and anticipated outcomes.

Prioritized Need 1: Address mental health and substance use disorder

GOAL: Provide access to hospital and community resources that help meet the mental health and substance use disorder needs of community members.

Action Plan

STRATEGY: Build a path toward a comprehensive continuum of care for mental health needs and substance use disorder by strengthening programs in various hospital divisions with SBIRT and buprenorphine induction. Create and strengthen community programming with the Health Institute and community partners.

BACKGROUND:

- Mental health needs and substance use disorder have been greatly exacerbated by the COVID-19 pandemic. ASA faces a continued need to address mental health and substance use disorder needs of individuals presenting to the ED. Efforts must continue to increase connections to resources and treatment for individuals experiencing substance use disorder.
- Addressing mental health and substance use disorder needs is a shared priority among all Baltimore City hospitals. ASA is participating in the Greater Baltimore Regional Integrated Crisis System (GBRICS) to reduce unnecessary ED use and police interaction for people in behavioral health crisis.

RESOURCES:

- ASA Hospital
- ASA Health Institute
- Community Partners (hospital partners, GBRICS Council, Mosaic, Baltimore City Health Department, Trauma Partners)

ACTIONS:

- Provide SBIRT to ASA patients during inpatient stays, in the ED, and through primary care and OB/GYN practices.
- Increase access to medication assisted treatment for patients with opioid use disorder treated in the ED and inpatient settings.
- Increase mental health visits in the Ascension Medical Group and Health Institute programs.
- Conduct naloxone training on campus and throughout the community.
- Provide trauma-informed care trainings for ASA staff.

ANTICIPATED OUTCOMES:

- Increase by 10% the proportion of patients with opioid dependency who have naloxone prescriptions filled upon discharge.
- Increase to 25% the proportion of patients enrolled with the Ascension Medical Group behavioral health Hope Counseling Program who remain connected to care for three visits.
- ASA staff and the larger community will be better able to meet individuals' mental health and substance use disorder needs.

Prioritized Need 2: Prevent diabetes and improve health outcomes for individuals with diabetes

GOAL: Reduce the burden of diabetes and improve quality of life for individuals who have, or are at risk for, diabetes.

Action Plan

STRATEGY: Provide increased outreach, education, and medical intervention, on campus and in the community, to individuals who face physical and mental effects of diabetes or prediabetes and who seek a change in health status.

BACKGROUND:

- The ASA service area is significantly impacted by diabetes. Communities surrounding ASA have rates of diabetes two times the state average.
- The target population is patients experiencing health problems related to diabetes or prediabetes, with particular emphasis on vulnerable populations who lack access to primary care, care management, and education.
- The State of Maryland has prioritized diabetes prevention and management.

RESOURCES:

- ASA Hospital
- ASA Health Institute
- Saint Agnes Medical Group
- Additional community partners (Maryland Department of Health, Baltimore City Health Department, Associated Catholic Charities of America/My Brother's Keeper, Food Project, Central Baptist Church, Baltimore Medical System, Partnership for a Healthier America, Meals on Wheels of Central Maryland, Moveable Feast, Hungry Harvest, and other partners within the faith-based community)

ACTIONS:

- Expand Food Rx to meet the nutritional needs of more patients with diabetes or prediabetes.
- Expand the ASA Diabetes Prevention Program (DPP).
- Develop an ASA care pathway for diabetes care management.
- Increase care management services for primary care patients with diabetes.
- Continue to offer the Diabetes in Pregnancy program to provide nutrition therapy, health education, and monitoring for pregnant women with or at risk for diabetes.

ANTICIPATED OUTCOMES:

- Reduce diabetes composite PQI¹ by 2.5% by CY 2023 and by 5% by CY 2025, equating to a total reduction of 52 patient admissions.
- Expand Diabetes Self-Management Education (DSME) to provide 2,884 unique individuals at least one DSME visit by year-end CY 2023.
- Expand DPP to enroll 351 unique individuals who have attended at least one session by year-end CY 2023.
- DPP 5% weight loss goal: 316 unique individuals (from cohorts starting CYs 2021 - 2024) by year-end CY 2025.
- Proportion of patients with uncontrolled diabetes, defined as A1C levels greater than 8%: ≤ 22% for all patients, and ≤ 24% for African American patients.
- Among mothers participating in the Diabetes in Pregnancy program, ≤ 9% of newborns born large for gestational age.

Prioritized Need 3: Build person-centered healthy neighborhoods to address social determinants of health.

GOAL: Improve quality of life by improving access to health care resources and resources to address the social determinants of health.

Action Plan

STRATEGY: Collaborate with community agencies to provide access to health programs and resources that address social determinants and improve health outcomes.

BACKGROUND:

- The target population is high-utilizing patients with the greatest need and fewest resources. The focus will be on individuals who lack connection to community programs, particularly in West Baltimore.

RESOURCES:

- ASA Hospital
- ASA Health Institute
- Saint Agnes Medical Group
- Additional community partners (Baltimore Medical Systems, Inc., West Baltimore Collaborative, Health Care Access Maryland)

ACTIONS:

- Establish violence prevention programming for patients suffering from violent injuries.

¹ “Prevention Quality Indicators” or “PQIs” are nationally recognized measures that examine hospital utilization to help assess access to health care in the community. PQI 93 is a composite measure that includes admissions for diabetes with short-term complications, diabetes with long-term complications, uncontrolled diabetes without complications, and diabetes with lower-extremity amputation.

- Provide health services in the community to help meet local neighborhood needs.
- Grow the volunteer chaperoned ride program to reduce transportation barriers to accessing healthcare.
- Expand access to technology infrastructure for individuals to access telehealth.
- Identify a partner to provide affordable housing on ASA-owned property.
- Connect patients to community resources that address social determinants of health.

ANTICIPATED OUTCOMES:

- Among individuals receiving annual wellness visits, 80% will be screened for social determinant of health needs.
- Implement core elements of violence prevention programming by the end of FY 2022, providing initial intervention to 100 patients.
- For patients served by the chaperoned ride program, decrease the missed or canceled appointment rate by 35% compared to the period prior to chaperoned ride participation.
- Support the post-acute and social determinant needs among ASA patients by applying to operate a Program of All-Inclusive Care for the Elderly (PACE) site and expanding care management services.
- By the end of FY 2022, expand health services provided in the community.
- Decrease the Prevention Quality Indicator Rate to the Statewide rate.

Needs Addressed through Referral Relationships

The ASA CHNA identified some needs not specifically addressed above. These include the following:

- Economic opportunity;
- Affordable housing and safe neighborhoods; and
- Affordable health care.

ASA focused its three prioritized needs on areas that fall within the core competency of the hospital and health system. ASA will rely on referral relationships with other organizations that have the core competencies to address areas such as housing and economic opportunity. For example, the ASA Implementation Strategy includes identifying a partner to provide affordable housing on ASA-owned property.

ASA's existing initiatives to screen for social determinants of health and refer individuals to available community resources will continue to address the above areas. As described in the outcomes for Prioritized Need 3, ASA will continue to screen patients for social determinant of health needs and refer them to available community services.

Many of ASA's prior initiatives have focused on overweight/obesity, heart disease, and blood pressure. ASA is reorienting its focus to diabetes to be consistent with State of Maryland health priorities. However, within our diabetes initiatives we will still address these other chronic health conditions.