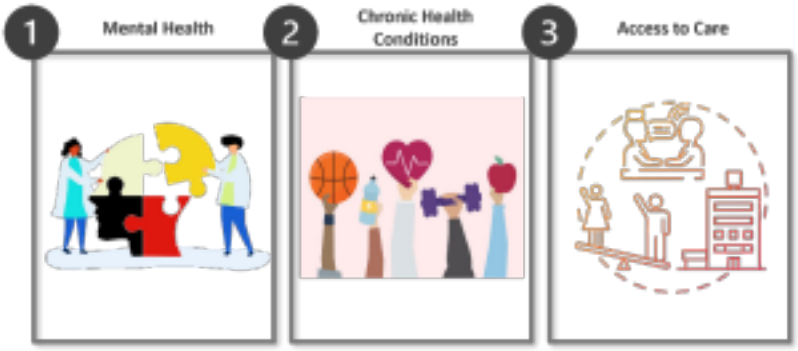
# Ascension Saint Agnes Implementation Strategy

# Fiscal Years 2025-2027

## Introduction

Ascension St. Agnes Hospital (ASA) participated in a collaborative Community Health Needs Assessment (CHNA) for Baltimore City in Fiscal Year 2024. Representatives from ASA, Baltimore City Health Department, and the eight other City hospitals worked together as the CHNA Collaborative to guide the development of the report. The Collaborative also engaged the services of Ascendient Healthcare Advisors to assist with gathering and analyzing data and assembling the final report.

The CHNA Collaborative, including ASA, met to review CHNA findings and seek recommendations to prioritize the identified needs. Following review of secondary and primary (survey and focus group) data, the participants were asked to identify the highest priority needs based on the size and scope, severity, the ability for the hospital or health department to make an impact, associated health disparities, and importance to the community.




## Demographic Highlights

The ASA service area is predominantly located in Baltimore City and includes small portions of Baltimore and Howard counties as well. In total, the hospital service area includes nearly half a million residents.

When compared to Baltimore City as a whole, the ASA service area has slightly higher proportions of residents who are Black or African American, white and Asian. It also has slightly higher proportions of individuals ages 18 and under, and over the age of 65.

## Implementation Strategy

Based on the work and collaboration with community and the CHNA Collaborative, the three community health need priorities to be addressed by ASA for the FY2025 through FY 2027 cycle are as follows:

- Mental Health
- Chronic Health Conditions
- Access to Care(incorporating a focus on social determinants of health).

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

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

## Action Plan

**Strategy:**

Continue to build a path toward a comprehensive continuum of care for mental health needs by strengthening programs in various hospital divisions. Create and strengthen community programming with the Health Institute and community partners.

**Background:**

Secondary data collected through the CHNA process identified mental health as an area of particular concern for residents of Baltimore City. In 2021, 20.7% of Baltimore City residents self-reported that a health professional has told them that they have a depressive disorder, higher than both the state of Maryland (16.6%) and the US (20.5%). Multiple mental health indicators in Baltimore City were higher than the state and national averages, with 16% of the population experiencing frequent mental distress (compared to 13% for state and 14% for national, respectively), and residents reporting an average of 5.4 poor mental health days per month (4.1 for state and 4.4 for national, respectively).

Key leaders surveyed during the CHNA process identified mental health as the top health issue impacting residents of Baltimore City. Among 33 key leaders from various organizations who responded to the survey, 66.7% identified mental health and suicide as a top community health need in Baltimore City. Multiple community resources to address behavioral and mental health were identified in this survey as being both helpful to address these concerns and insufficient to meet existing levels of community need. Key leaders described a need for more comprehensive resources or easier access to existing resources.

**Resources**
ASA Hospital
ASA Health Institute (Population Health Department)
Community Partners

**Actions**

- Screen community members receiving resources and/or medical care from the ASA Mobile Clinic for depression, anxiety and social isolation.
- ASA staff and the larger community will be better able to meet individuals' mental health and co-occurring substance use disorder needs, through naloxone training.

**Anticipated Outcomes**

- Screen 80% of community members at the ASA Mobile Clinic for depression, anxiety and social isolation.
- Connect 30% of community members screening positive for depression, anxiety and social isolation with appropriate mental health service providers.
- Provide 20% of inpatients with an opioid disorder with naloxone upon discharge.
- 20% of patients counseled by Peer Recovery Coaches on the Mobile Unit received naloxone.

## Prioritized Need 2: Improve health outcomes for individuals with chronic health conditions

## Action Plan

**Strategy:** Provide increased outreach, education, and medical intervention, on campus and in the community, to individuals who face chronic health conditions.

**Background:**
Community members who responded to the survey identified several chronic conditions among the top community health needs in Baltimore City

When compared to the state overall, Baltimore City had measurably worse rates of hospitalization for Alzheimer's disease or other dementias, as well as higher rates of mortality due to stroke, heart disease and cancer. Most notably, the rate of sudden unexpected infant deaths in Baltimore City was more than 1.5 times higher than the rate in the state overall.

Baltimore City also underperformed relative to the state in a number of health behaviors that have an impact on physical health. Baltimore City residents had higher rates of physical inactivity and smoking –both of which have been shown to increase the risk of various chronic health conditions. Food insecurity was also a concern for Baltimore City residents, which is notable due to the impact diet has on overall physical health.

Among respondents to the key leader survey, approximately 24% identified diabetes and 15% identified heart disease, stroke or hypertension among the five most pressing health needs in Baltimore City.

**Resources:**

- ASA Hospital
- ASA Health Institute
- Saint Agnes Medical Group
- Saint Agnes Hospital Foundation
- Additional community partners (Maryland Department of Health, Baltimore City Health Department, Food Project, Baltimore Medical System, Meals on Wheels of Central Maryland, Moveable Feast, Hungry Harvest, home health provider partners, and other community partners)

**Actions:**

- Continue to provide diabetes management programming to reduce impact on participants' health outcomes.
- Increase primary care services delivered from the ASA Mobile Clinic.

- Provide supportive home health care and food supports to patients upon hospital discharge to prevent hospital readmission through Care in the Gap program.

**Anticipated Outcomes:**
- Expand Diabetes Self-Management Education (DSME) and reach 1400 visits by participants.
- Expand the number of sites served by the ASA Mobile Clinic by 50%.
- Provide enhanced care coordination to 100 patients post discharge through Care-in-the Gap.

## Prioritized Need 3: Access to Care

## Action Plan

**Strategy:**
Improve access to care for all community members so they are able to get high quality, affordable healthcare to achieve the best possible health outcomes.

**Background:**
The ability to access healthcare is not evenly distributed across groups in the population. Groups who may have trouble accessing care include the chronically ill and disabled (particularly those with mental health or substance use disorders), low-income or homeless individuals and individuals with limited English proficiency (LEP).

Over half (51.5%) of respondents to the key leader survey ranked access to care among the highest priority health needs in Baltimore City, while 21.2% identified the need for primary and preventive healthcare as a top concern. Key leaders identified various SDoH needs among the top health needs of the community. Housing and homelessness was ranked as the second highest community health need, selected by 63.6% of respondents. Food security (60.6%) and gun violence prevention (54.5%) were also highlighted as top health needs by key leaders, highlighting a growing understanding of the impact these factors have on individual and community health. Transportation was another category of focus for Baltimore City, due to the impact it has on patients' ability to access medical care

**Resources:**
- ASA Hospital
- ASA Health Institute
- Saint Agnes Medical Group
- Additional community partners (Baltimore Medical Systems, Inc., Health Care Access Maryland, Action in Maturity and other partners)

**Actions:**
- Provide chaperone supported rides for older adults and adults with disabilities to and from ASA medical appointments.
- Provide primary care services for uninsured community members at the ASA Mobile Clinic.
- Connect patients with substance use disorder to appropriate treatment services.

**Anticipated Outcomes:**
- Provide 400 visits for primary care services at the ASA Mobile Clinic.
- Provide 800 chaperoned rides to and from medical appointments for older adults and adults with disabilities.
- Connect 100 patients with substance use disorder to treatment services.