IMPLEMENTATION PLAN – PRIORITY AREAS

Priority Area #1 – Health Disparities

Overarching Goal: Reduce barriers related to accessing care by increasing resources, targeting racial and geographic disparities by focusing on social determinants of health. (Address root causes of other priority areas)

Focus Area #1 – Address social determinants of health (SDOH), with a focus on food insecurity.

Actions	Responsible Parties/ Partners	Timeline	Metrics for Success	Status
Expand social determinants of health resources • Integrate Aunt Bertha community referrals with GBMC's electronic health record	Adam Conway D'Ambra Anderson EPIC Team Marketing	3-year CHNA Cycle	• Creation of GBMC community site • Integration of Aunt Bertha into EHR • Number of organizations for referral • Number of referrals closed • Number of Care Team members trained on referral system	Initial program plan has been drafted and key roles have been identified
Partner with food service providers (e.g. Moveable Feast, BMore Community Food) to address food insecurity for high risk patients and communities.	Rhandi Morgan D'Ambra Anderson Diane Sancilio	3-year CHNA Cycle	• Number of patients referred • Number of meals delivered • Pounds of food provided to communities • Pre-/post- utilization changes • Change in a1C, BMI, and blood pressure • Client satisfaction survey • Health outcomes tool (in process of being implemented by Moveable Feast) • Medical nutrition survey	MOU with Moveable Feast complete. Piloting phase 2 of the program for diabetic patients at practices with highest rates of food insecurity, Elder Medical Care, and Complex Care.
Partner with organizations that improve the quality of life of Baltimore County/	Karen Thompkins	3-year CHNA Cycle	MVLS Housing Stabilization/Aging in Place Initiative	MVLS MOU executed December 2021.

City residents through initiatives that address the social determinants of health. • Maryland Volunteer Lawyers Services (MVLS) MOU			• Number of residents reached via door knocking • Number of community events • Number of participants in community events • Resources distributed • Number of residents participating in city/state homeowner assistance and repair programs	
Expand SDOH screenings throughout the GBMC system (e.g. pediatric practices)	GBMC Practice Managers (e.g. Harold Kuwazi) and EPIC Team (Jessica Swank)	3-year CHNA Cycle	• Patients receiving screening • Number of connections to resources • Adolescent obesity • Tobacco screening	Workflows and screenings are in place for primary care practices.
Identify opportunities to partner with the Baltimore County CHNA Collaborative to address health disparities.	Adam Conway, Baltimore County CHNA health system leads	3-year CHNA Cycle	Identify at least 1 health system for partnership and resource sharing.	

Focus Area #2 – Expand access to care for underserved and low-income populations for Baltimore County and surrounding areas.

Actions	**Responsible Parties/ Partners**	**Timeline**	**Metrics for Success**	**Status**
Conduct meetings of providers in the Baltimore County CHNA Collaborative to discuss barriers to care and initiatives and resources reaching underserved populations.	Adam Conway CHNA health system leads	3-year CHNA Cycle	• Number of meetings held • Number of new partnerships to address barriers identified	CHNA health system leads have been identified.

Expand reach of GBMC's Helping Up Mission practice and Stadium Place	Ericka Easley	3-year CHNA Cycle	• Number of new patients per month • Ratio of HUM residents to community patients • Increase services for Stadium Place patients served for EOL and Serious Illness by 10%	Epic report has been built for monitoring HUM resident patients.
Provide free community health screening events to residents in underserved areas.	Dr. Collins Ericka Easley D'Ambra Anderson	3-year CHNA Cycle	• Number of patients served • Number of patients connected to medical services • Participants in community events • Number of resources shared	Piloting hearing and vision screenings at HUM practice.

Priority Area #2 – Behavioral Health (Mental Health and Substance Use Disorder)

Overarching Goal: Increase access to behavioral health resources in the community by removing barriers and supporting regional initiatives.

Focus Area #1 – Expand access to mental health services (and reduce barriers) for patients experiencing routine and crisis mental health needs.

Actions	Responsible Parties/ Partners	Timeline	Measures/Outcomes	Status
Support Greater Baltimore Regional Integrated Crisis System (GBRICS) Implementation • Educate GBMC system on GBRICS objectives and program components • Provide status reports on key deliverables • Conduct community-wide educational campaign	Karen Thompkins D'Ambra Anderson Dr. Robin Motter-Mast	CHNA 3-Year Cycle	• # of committees joined • Marketing outreach metrics • Status reports to GBMC leadership	Currently member of the Community Engagement Committee and attending GBRICS Council.

Expand opportunities for integrated behavioral health care • Conduct test pilots to identify strategies to improve access to mental health services (2 Medicaid pilots, Jarrettsville specialty practice)	Rachel Smolowitz	CHNA 3-year Cycle	• Patients/practices served by CoCM program • Change in PHQ-9 and GAD-7 scores (are they getting better) • Number of patients enrolled in pilot program • Summary of lessons learned	Priority Partners (in development) has approved CoCM pilot for select practices.
Advocate for expansion of CoCM services and coverage in Maryland.	Rachel Smolowitz Adam Conway Tommy Glenn	CHNA 3-year Cycle	• Number of meetings with stakeholders • Number of payers covering CoCM codes. • Number of CoCM providers in MD	Met with advocates for Medicaid coverage
Train Care Coordinators on how to deliver CoCM to expand access and reduce stigma (those with Bachelor's degrees are able to provide collaborative care).	Rhandi Morgan Rachel Smolowitz	CHNA 3-year Cycle	• Number of staff trained	
Identify opportunities to partner with the Baltimore County CHNA Collaborative to increase access to behavioral and mental health services.	Adam Conway Karen Thompkins	CHNA 3-Year Cycle	• Identify at least 1 health system for partnership and resource sharing. • # of partnership meetings or initiatives completed	

Focus Area #2 – Promote early detection of substance use disorder and reduce overdoses due to opioids and other drugs

Actions	**Responsible Parties/ Partners**	**Timeline**	**Measures/Outcomes**	**Status**
Develop or enhance prescription drug monitoring programs (PDMP) throughout the GBMC system.	Dr. Joseph Fuscaldo	CHNA 3-Year Cycle	• Reduce the amount of Rx drugs prescribed (7-day max e-prescribe vs. 30-day) • PDMP policies and practices created or updated • # of providers or educational sessions held on PDMP policies/practices	
Create education and communication campaign for Prescription Drug Takeback Day to facilitate safe disposal of drugs and educate the community on signs and resources for medication abuse.	Karen Thompkins Kimberly Davenport	CHNA 3-Year Cycle	• # of community members reached • # of medications safely disposed • # planning meetings	GBMC convening Baltimore County partners to plan for April 2022 Drug Takeback
Improve and expand SBIRT within GBMC system and county-wide • Reassess SBIRT workflows and reeducate staff across care continuum. • Expand SBIRT referral to treatment options by partnering with the Baltimore County CHNA Collaborative.	Dr. Karin Mirkin Mosaic Rachel Smolowitz Karen Thompkins	CHNA 3-Year Cycle	• # of positive screens • # of brief interventions • # of referrals to treatment • # of referral partners	Reassessment and re-education has occurred by Mosaic

Priority Area #3 – Physical Health

Overarching Goal: Create an environment that expands access to healthier resources to reduce heart disease, obesity, and diabetes risk factors.

Focus Area #1 – Develop health engineering strategies that guide patients, staff, and community members to make healthier choices.

Actions	Responsible Parties/ Partners	Timeline	Measures/Outcomes	Status
Provide patients, staff, and community members with more access to healthy foods. • Partner with organizations (Hungry Harvest, BMore Community Food, Moveable Feast) that provide healthy and affordable foods. • Sponsor events that create opportunities to distribute healthy foods.	Karen Thompkins D'Ambra Anderson Diane Sancilio	CHNA 3-Year Cycle	• Number/pounds of produce items distributed • Number of customers • Customer satisfaction surveys	Successful pilot in fall 2020with Hungry Harvest. Expand beyond GBMC's campus to primary care practices. BMore Community Food and Moveable Feast are being tracked under health disparities implementation.
Improve the built environment at GBMC (and surrounding communities) to promote physical activity and social interaction. • Create signage to identify safe walking routes, trails, and distance. • Create a regional map (GBMC, Towson University, St. Joseph, Sheppard Pratt) to identify walking routes and trails • Promote and educate opportunities for physical activity	Grounds Managers of GBMC, Towson University, St. Joseph, and Sheppard Pratt Director of Community Partnerships Marketing Departments of GBMC, Towson, St. Joseph, Sheppard Pratt	CHNA 3-Year Cycle	• Regional map of walking routes and trails. • Marketing analytics • Number of events held on campuses to promote physical activity • Number of individuals using routes/trails • Community surveys	GBMC campus has safe sidewalks, but no signage for mileage, encouragement of physical activity on campus, etc. Preliminary meetings with adjacent organizations were held to confirm their interest in a joint effort to improve the built environment in the Towson community.

utilizing various marketing strategies.				
Expand healthy vending machines on GBMC campus to reach more patients, staff, and physicians.	Adam Conway D'Ambra Anderson	CHNA 3-Year Cycle	• # of vending machines • # of healthy items added	Health vending machine has been implemented, but not across campus.
Identify opportunities to partner with the Baltimore County CHNA Collaborative to address physical health.	Adam Conway, Baltimore County CHNA health system leads	CHNA 3-Year Cycle	• Identify at least 1 health system for partnership and resource sharing.	

Focus Area #2 – Provide patients and community members with tools to prevent and manage diabetes, heart disease, and obesity risk factors.

Actions	**Responsible Parties/ Partners**	**Timeline**	**Measures/Outcomes**	**Status**
Develop program to address patients at high risk for obesity, diabetes, and heart disease. • Implementation of the Community Health Resources Commission (CHRC) Pathways to Health Equity Grant in Baltimore City • Conduct community wide initiative for early detection of diabetes with deployment of diabetes risk test. • Provide access to the online CDC Pre-Diabetes Risk Assessment	Karen Thompkins Erlene Washington Marketing	CHNA 3-Year Cycle	• Number of patients enrolled in program • Changes in a1C, blood pressure, and BMI. • Completed risk assessments	GBMC has been awarded CHRC grant in February 2022.