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
Integrate Aunt Bertha community referrals with GBMC's electronic health record to expand social determinants of health resources.	Director of Community Partnerships Rhandi Morgan D'Ambra Anderson 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 Moveable Feast to address food insecurity for high risk patients.	Rhandi Morgan D'Ambra Anderson	3-year CHNA Cycle	• Number of patients referred • Number of meals delivered • Pre-/post- utilization changes • Change in a1C, BMI, and blood pressure	MOU with Moveable Feast complete. Piloting phase 2 of the 0program for diabetic patients at practices with highest rates of food insecurity, Elder Medical Care, and Complex Care.
Expand SDOH screenings to pediatric practices	Harold Kuwazi Jessica Swank	3-year CHNA Cycle	• Patients receiving screening • Number of connections to resources • Adolescent obesity • Tobacco screening	Workflows and screenings are already in place for primary care practices.

Integrate health disparities plan with the CHNA Collaborative.	Adam Conway 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 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, new partnership with Baltimore County provides Local Health Improvement Coalition forum.
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	Piloting hearing and vision screenings at HUM practice.
Identify referral partners that provide support for patients and community members seeking employment.	Dir of Community Partnerships	3-year CHNA Cycle	• Number of patients referred • Number of partners identified • Number of successful job fillings	Screening for financial insecurity to help identify patients in need.

Other Focus Areas Considerations:

- **Engage Diversity and Inclusion team to address job opportunities disparity; organization to support job opportunities.**
- **Community Health Worker (CHW) engagement – Complex Care, primary care.**

- **Partner with the Collaborative to provide mobile health services to underserved areas.**
- **Conduct focus groups/surveys with patients to determine ongoing barriers to healthcare access.**
- **Incorporate Dementia and Congestive Heart Failure (CHF)**
- **Children in poverty trending in the wrong direction.**
    - **Community groups geared toward children in poverty**
    - **Mobile pediatric unit**
    - **Reduced price for lunch**
    - **Food insecurity**

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 for patients experiencing routine and crisis mental health needs.

Actions	Responsible Parties/ Partners	Timeline	Measures/Outcomes	Status
Expand behavioral health resources to Medicaid and specialty practice patients.	Adam Conway Rachel Smolowitz	CHNA 3-year Cycle	• Patients/practices served by CoCM program • Change in PHQ-9 and GAD-7 scores • Patients served by SP Access Center • Number of patients enrolled in pilot program	Amerigroup has approved CoCM pilot for select practices. Hiring new staff in fall to address expanded need.
Advocate for expansion of CoCM coverage in Maryland.	Rachel Smolowitz Adam Conway	CHNA 3-year Cycle	• Number of meetings with stakeholders • Number of payers covering CoCM codes.	Meeting with Medicaid providers, serving as behavioral health convener for Baltimore County.

Train Care Coordinators on how to deliver CoCM to expand access and reduce stigma.	Rhandi Morgan IP team Rachel Smolowitz	CHNA 3-year Cycle	• Number of staff trained	
Serve as behavioral health convener/ access to care subject matter expert for Baltimore County Health Department (BCHD).	Adam Conway Leana Hoover	CHNA 3-year Cycle	• # of meetings attended • # of meeting participants	GBMC met with BCHD for introductory meeting.
Integrate behavioral health plan with the CHNA Collaborative.	Adam Conway	CHNA 3-Year Cycle	Identify at least 1 health system for partnership and resource sharing.	

Focus Area #2 – Promote early detection of substance use disorder and reduce barriers for accessing treatment services.

Actions	**Responsible Parties/ Partners**	**Timeline**	**Measures/Outcomes**	**Status**
E-prescribe for opioids and follow-up efforts on better practices. Educate prescribers Overdose Prevention	Primary Care JoAnn Ioannou	CHNA 3-Year Cycle	• # of patients receiving opioids • # of 7-day max e-prescribe vs. 30-day • Increase prescriber education by 20% • Rates of SUDs in the patient population or in the community • Rates of hospitalization for SUD or overdose • Rates of substance misuse-related emergency department visits	
Create education and communication campaign for Prescription Drug Takeback Day to facilitate safe disposal of drugs and	Marketing	CHNA 3-Year Cycle	• # of community members reached	

educate the community on signs and resources for medication abuse.			• # of medications safely disposed	
Reassess SBIRT workflows and reeducate staff across care continuum.	Dr. Karin Mirkin Mosaic	CHNA 3-Year Cycle	• # of positive screens • # of brief interventions • # of referrals to treatment	
Participate in Greater Baltimore Regional Integrated Crisis System (GBRICS) committees.	D'Ambra Anderson Dr. Robin Motter-Mast	CHNA 3-Year Cycle	• # of committees joined	Currently participating in Community Engagement and GBRICS Council. Opportunities to participate in policy and other workgroups
Support GBRICS implementation through staff and physician educational campaign of partnership objectives, program components, and key deliverables.	Marketing ED leaders Dr. Motter-Mast	CHNA 3-Year Cycle	• # of staff and physicians reached • # of messages sent • # of meetings attended	
Support GBRICS implementation through distribution of community educational campaign of partnership objectives, program components, and key deliverables, driven by GBRICS staff.	Marketing Director of Community Partnerships D'Ambra Anderson	CHNA 3-Year Cycle	• # of community members and partners reached • # of messages sent • # of meetings attended	
Expand SBIRT referral to treatment options by partnering with the Collaborative.	Director of Community Partnerships	CHNA 3-year Cycle	• # of referral partners • # of referrals	

Other Focus Area Considerations:

- **Substance use resource expansion (prior SP personnel embedded) (high rate of overdose deaths)**
- **COVID recovery – address additional mental health needs**
    - **Expand mindfulness webinars/resources to larger community**

- **Access Center/ CoCM expansion - Medicaid advocacy, specialty**
- **SAFE Program Integration**
- **Community outreach and education within our PCMH. Make people aware of services that are available. It's under advertised and Marketing would welcome the opportunity to lift it up**

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 access to healthy foods through partnership with Hungry Harvest. Hungry Harvest market expansion.	Director of Community Partnerships Ericka Easley D'Ambra Anderson	CHNA 3-Year Cycle	• Number of produce items sold • Number of customers • Customer satisfaction surveys	Successful pilot in fall 2020. Preliminary conversations with Hungry Harvest have occurred. Discussion of expanding beyond GBMC's campus to Padonia Road parking lot. Also considering HUM market.
Improve the built environment at GBMC by adding signage for safe walking routes, mileage and education on physical activity.	Grounds Managers	CHNA 3-Year Cycle	• Community surveys	GBMC campus has safe sidewalks, but no signage for mileage, encouragement of physical activity on campus, etc.
Expand healthy vending machines on campus to reach more patients, staff, and physicians.		CHNA 3-Year Cycle	• # of vending machines • # of healthy items added	Health vending machine has been implemented, but not across campus.
Integrate physical health plan with the CHNA Collaborative.	Adam Conway	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
Create remote patient monitoring program for overweight patients and those at high risk for diabetes and heart disease patients.	Epic Dr. Small Rhandi Morgan	CHNA 3-Year Cycle	• Number of patient-entered flow sheets • Number of RPM devices deployed • Changes in a1C, blood pressure, and BMI.	Pilot program is in process for blood pressure. Workflows have been developed for devices and patient-entered flowsheets
Provide support and education for self-blood pressure monitoring through education events and advocacy with payers to reimburse for blood pressure machines.	Dr. Sarah Whiteford Marketing	CHNA 3-Year Cycle	• Number of patients reached • Number of blood pressure machines provided	Some payers are now covering BP machines as DME. Partnership established with American Heart Association to support educational initiatives.
Conduct community wide initiative for early detection of diabetes with deployment of diabetes risk test.	Marketing Geckle	CHNA 3-Year Cycle	• Patients reached • Patients referred to services	ADA has a prevent type 2 assessment.
Expand use of Epic Care Companion app to reach patients with hypertension, diabetes, heart disease, and obesity.	Epic Dr. Small Deb Jones-Shook Dr. Minn	CHNA 3-year Cycle	• Patients engaged in program • Number of messages sent • Improvement in diabetes, hypertension, and obesity • Patient ratings of self-management	
Partner with Geckle Diabetes Center and CHNA Collaborative to refer patients to	Geckle CHNA health system leads	CHNA 3-Year Cycle	• Patients referred to program	Relationships established with St. Joes for referral to CDC-recognized program.

Diabetes Prevention Programs across the county.			• Patients who complete the program	

Other Focus Area Considerations:

- **DPP expansion to other CHNA partners like St. Joes.**
- **Dr. Ferentz obesity management initiative**
- **GBMC walking/running groups**
- **Giant and Towson University grocery shopping project for older adults**
- **Alternatives for Bariatric surgery for patients who don't qualify**
- **GBMC Fit and Healthy Program expansion to diabetics?**