BALTIMORE CITY HEALTH DEPARTMENT

# Local Health Improvement Coalition (LHIC) Meeting

*September 29, 2023*

*Brandon M. Scott*
Mayor, Baltimore City
*Mary Beth Haller, Esq.*
Acting Commissioner of Health, Baltimore City

@Bmore_Healthy
BaltimoreHealth
*health.baltimorecity.gov*

# Meeting Norms

- When you join, please chat-in or say your name.
- State your name before speaking.
- Verbalize messages in chat.
- Speak for yourself only, using "I" statements: "I do not like…" instead of "we do not like…"
- Raise your hand to speak and use your camera when possible.
- Closed Captioning is available through Teams by clicking on More Actions and selecting "Turn on live captions".
- Meeting notes will be sent in "text only" format at the end of each meeting.

***The meeting will be recorded. The recording will be shared after the meeting.***

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# Mission

To protect health, eliminate disparities, and enhance the wellbeing of everyone in our community through education, coordination, advocacy, and direct service delivery.

# Vision

An equitable, just, and well Baltimore where everyone has the opportunity to be healthy and to thrive.

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# Our Values

Data-Driven

Integrity

Innovation

Collaborative

Empowerment

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# LHIC Goals & Purpose

## Local Health Improvement Coalition (LHIC)

1. The coalition's purpose is to identify and address Baltimore City's most **pressing structural health disparities** by bringing together a **multisector group,** with representation from community, health, and government.
2. Requires the **shared leadership** of healthcare, government and community organizations, and community members.
3. The LHIC works to address **Diabetes, Care Coordination, and Social Needs** through a diversity of perspectives, collaboration, and pooling of resources.

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# Agenda

| Topic | Mins |
|---|---|
| Introduction &<br>Welcome from Acting Commissioner Haller | 15 |
| BCHD News and Updates:<br>• CHNA (Dr. Tamara Green)<br>• Medicaid Enrollment (Elise Bowman)<br>• Community Member Update/Recruitment (Stephane Bertrand)<br>• Policy Learning Collaborative (Sadiya Muqueeth) | 20 |
| Updates from Our Priority Areas<br>• Social Determinants of Health (Keyonna Mayo, Dr. Teresa Leslie, and Rashad Staton )<br>• Citywide Care Coordination (Diana Quinn)<br>• Diabetes (Pam Xenakis, Alice Chan, Michelle Peralta) | 40 |
| Community Spotlight: Featuring Dr. Yolanda Ogbolu | 10 |
| Community Announcements | 5 |

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# Welcome- Acting Commissioner Haller

- Community Health Needs Assessment (CHNA)
- Community Health Improvement Plan (CHIP)
- CDC Diabetes Grant
- Thank you to our members!

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# BCHD News and Updates

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# Community Health Needs Assessment

*Dr. Tamara Green*

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# Community Health Needs Assessment

| Date | Activity | Status |
|---|---|---|
| July 28 | CHNA Kick-off | Complete |
| August 25 | Community Survey Open Aug. 25- Nov. 3 | In progress |
| Sept. 5 | Key Information Survey Open Sept. 5- Nov. 3 | In progress |
| Oct. 16 | Focus Groups Oct. 16- 20 | |
| Nov. 17 | Review of CHNA Data | |
| Dec. 15 | Prioritization of Data Findings | |
| Feb. 23 | Draft of CHNA Report | |
| March 2024 | Final CHNA Report Mid-Late March | |

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# Emily McCallum, Ascendient

- Baltimore residents' survey
  - City of Baltimore 2024 Community Health Needs Survey (qualtrics.com)

- Key Leaders' survey
  - Baltimore City 2024 CHNA Key Leader Survey (qualtrics.com)

- Focus group participation

- Questions/Point of contact: emilymccallum@ascendient.com

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# Medicaid Enrollment Changes

*Elise Bowman*

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# Need Help?

**Healthcare Access Maryland**

(410) 500-4710

1 N Charles Street

Baltimore, MD 21201

Or

**Maryland Health Connection**

marylandhealthconnection.gov/


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# Community Member Engagement & Recruitment

*Stephane Bertrand*

*Brandon M. Scott*
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# Community Member Recruitment

## Qualifications & Responsibilities

- $30 stipend for each hour of participation
- 4-10 hours a month
- Representation sought for older adults, youth, PLWD, LGBTQIA+, preferred but not required
- Baltimore City Resident
- Interest in or passion for addressing Diabetes, Social Determinants, or Care Coordination
- Desire and ability to work on diverse groups with long-term goals
- Ability to think about big problems and offer solutions


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For more information, contact Stephane Bertrand, LHIC Coordinator at Stephane.Bertrand2@baltimorecity.gov

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# Community Member Recruitment


1. Representation and Equity
2. Cultural Competency
3. Local Knowledge
4. Community Engagement and Ownership
5. Trust and Credibility
6. Effective Communication
7. Identifying Priorities and Gaps
8. Accountability and Transparency
9. Community Resilience

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# Policy Learning Collaborative (PLC)

*Health Policy Office*

*Brandon M. Scott*
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# Background

- Policy greatly impacts health outcomes of community members
- Communities want to get engaged in policy
- Train and engage community members about health and the policy process
- Policy Learning Collaborative (PLC)

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# Overview of PLC

**What:** Short-series of learning sessions

**Topics:** Health and the policy process

**When:** Spring 2024 - 8 sessions over 2 months

**Where:** TBD (hope to do this in person)

**Who:** participant 15-20 community members

More on recruitment later!

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# Updates from Our Priority Areas

*Workgroup Members*

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# Social Determinants of Health

*Keyonna Mayo, Dr. Teresa Leslie, and Rashad Staton*

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# Social Determinants of Health Workgroup

**Leads**: Dr. Teresa Leslie & Keyonna Mayo

**Active Members**: Many active and dedicated members who have a passion for the work. We are continuing to recruit community members and are soon to include youth members!

# Social Determinants of Health Workgroup

**Our Goal:** Improve health and well being outcomes of City residents by addressing social determinants of health

***Agriculture is multi-sectorial and transdisciplinary!***

***It is important to work outside of silos to get the job done and improve the health and well being of those who need it most.***

**Our Objectives:**

1. Improve food availability, access and utilization by fostering engagement between farmers and communities (allow farmers to take the lead)
2. Increase knowledge of healthy food through community education (tap into the resources already existing in communities)
3. Assist in the growth and development of a sustainable urban agricultural industry in Baltimore City to improve the economic stability of Baltimore City residents (increase autonomy and self-determination)

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# Our Continuing Work

- Applying for funding through USDA/NIH (in collaboration with farmers and community
- Working to align funding with other working groups (diabetes & care coordination
- Paying close attention to 2023 Farm Bill
- Plans to meet with public health policy office
- Integrating youth into workgroup

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# LHIC – SDOH (Intergenerational Collaboration) led by Community Law In Action

**Sept 27, 2023 – Jan 1, 2024**

clia

Youth Voices for Community Change

# LHIC – SDOH (Intergenerational Collaboration) led by Community Law In Action

**Sept 27, 2023 – Jan 1, 2024**

clia
Youth Voices for Community Change

## Phase 1: Youth Engagement and Development Training – "Norm Setting & Affinity Group Training"

(June – August 2023)

- CLIA has facilitated 2 trainings on youth engagement and intergenerational collaborative training for current adult professionals serving on SDOH workgroup.
- In preparation of joining collaborative efforts, CLIA's youth leaders successfully completed Summer Leadership Institute training, developing skillsets on youth leadership development, civic engagement, peer to peer training, etc.

## Phase 2: Implementing an Intergenerational Approach to LHIC-SDOH Workgroup – "Supporting Youth Voice and Agency"

(Sept – January 2024)

- CLIA has identified 3- 5 youth leaders to participate on workgroup as equitable thought partners.
- Workgroup meetings and content discussed will be youth friendly and create space for collective empowerment. Affinity groups and pre planning meetings will take place to ensure continuity and momentum of workgroup's impact and effectiveness.
- Meeting times will be changed to compliment youth availability and not conflict with instructional learning. (Meetings to be held either on PD, Mindfulness Days, and/or Thursdays at 4:30 pm with virtual or in person options). – *ref; Doodle Poll*

## Phase 3: Sustaining Intergenerational Collaborative Partnership

(Oct – February 2024)

- Assessment (Reflection, Data Collecting, and Implementing)
- Pre/Post Surveys (youth/adult/)
- Peer to Peer Interviews (co-led)
- Replicating Framework
- Developing a process model to later fully integrate youth as committee members across the diabetes and care coordination working groups and the general LHIC.

# LHIC - SDOH Intergenerational Collaborative and Workgroup

01

October 20, 2023

November 17, 2023

November 22, 2023

December 22, 2023

January 26, 2024

February 16, 2024

* Thursday 4:30pm (virtual)

02

LHIC -SDOH meeting times will be changed to compliment youth availability and not conflict with instructional learning.

SDOH workgroup will implement an intergenerational collaborative workgroup for 3-4 months.

03

Proper onboarding, preparation, and evaluation will take place as additional youth will begin to participate on other LHIC workgroups.

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Youth Voices for Community Change

# Care Coordination

*Diana Quinn*

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September 29,2023

# Baltimore City LHIC: Social Screenings Update

## Quarterly Meeting

Diana Quinn, Community Health Advisor

Community Health- Clinical Care Transformation

# SDOH Evolution at MedStar Health

**2015**
SDOH 1st identified as CHNA priority

**2016**
NAM-based social needs screening tool developed
Community resources platform (Aunt Bertha) piloted

**2017**
Screening tool and online platform (Aunt Bertha) accessible medstarsupports.com

**2018**
Social needs screening tool added to CHA Power form
CHAs begin social needs screening
SDOH a CHNA priority

**2019**
CMS AHC screening tool pilot
Baltimore Population Health Workforce Collaborative
Oversight committee established

**2020**
Custom domain established: socialneeds.medstar.org
Covid-19 triggered increased need for screening, linkage to resources

**2021**
SDOH a CHNA priority
Cerner integration complete
Social needs tool link added to patient portal
Expansion of screening tool use and findhelp resources within MSH

**2022**
Z code integration into findhelp referral
MSH Coding interest in SDOH/ Z-code documentation
Continued expansion
SDOH regulations announced

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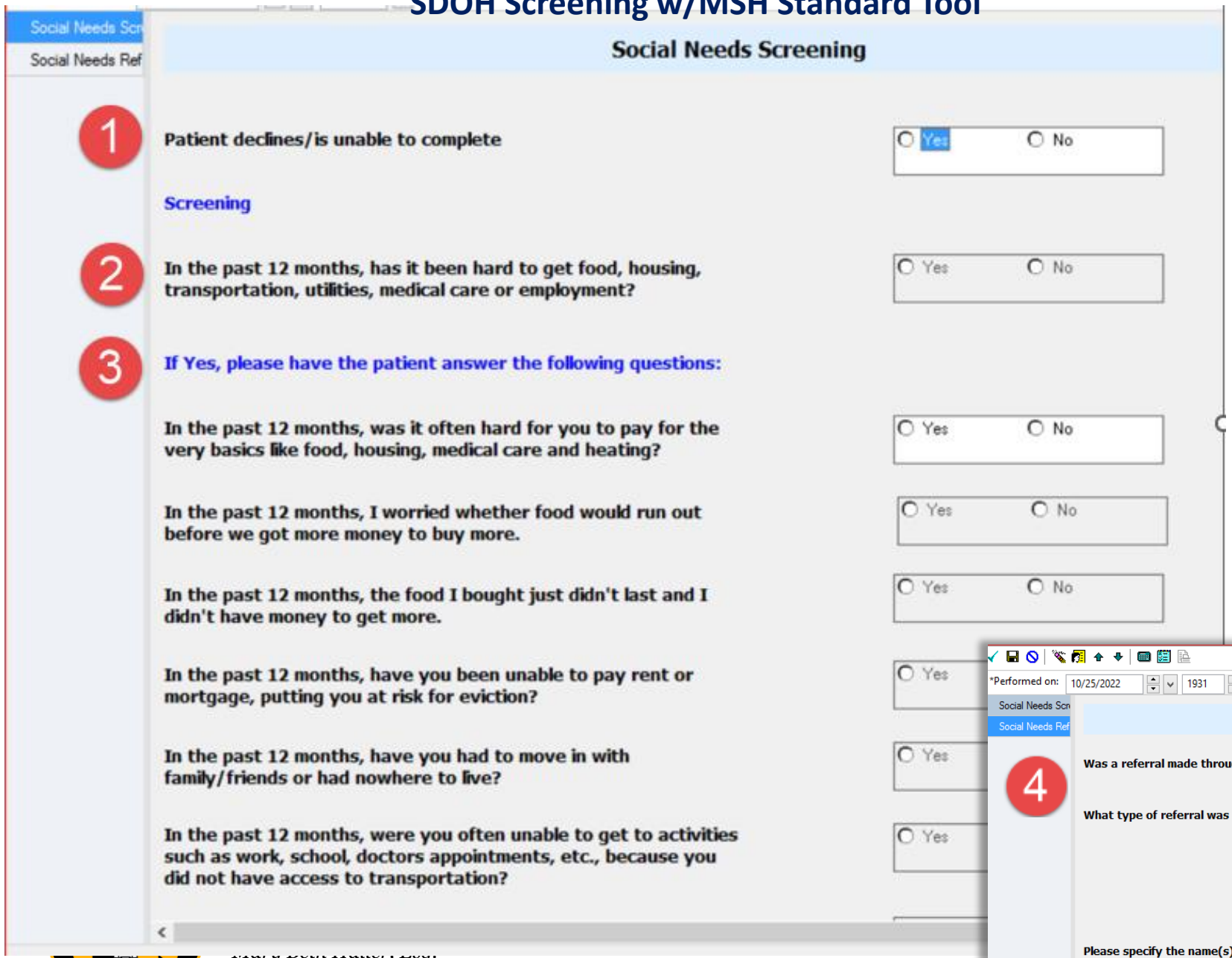
# SDOH Screening w/MSH Standard Tool

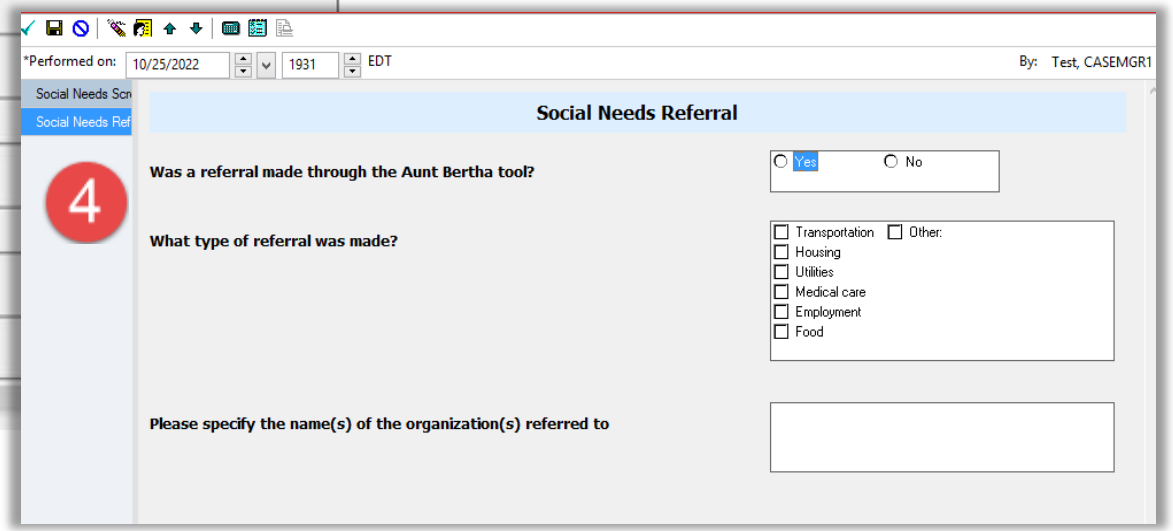



1. Assess if Patient is willing and/or able to complete screen

2. If the answer to the first question is no, the screen is complete

3. If yes, the additional 8 questions populate, each are reviewed/answered to complete the screen

4. Identification of and Linkage to Post-Discharge Needs & Community Services





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# Social Needs Screening Follow Up Recommendations

MedStar Health

## Patient Declines

- Patient declines or is unable to complete screening = **No Further Action**

## No Risk

- **Zero (0)** score = **No Further Action**

## Low Risk

- **Score 1** on SDOH screening = **Independent Navigation**
  - ChatBox text message and/or email with MSH Social Needs Tool link
  - Social Needs flyer with QR Code to MSH Social Needs Tool in discharge packet
  - Embed MSH Social Needs Tool link to all discharge instructions
- Add Telehealth Technology Coordinator for computer literacy assessment. Consider Acute Case Management or Transitional Care Coordinator engagement if computer literacy is low.

## Moderate Risk

- **Score 2 to 3** on SDOH screening = **Secondary Screen** to Assess Independent vs. Supported Navigation
- Entity Defined Response
- Acute Case Management and/or Transitional Care Coordinators encouraged to support discharge planning if needs still active. May consider independent navigation if computer literate.

## High Risk

- **Score ≥ 4** on SDOH screening **OR positive IPS** screen AND Voluntary to Receive Support = **Supported Navigation**
  - Involve Acute Case Management and/or Transitional Care Coordinators for supportive discharge planning
- **Score ≥ 4** on SDOH screening **AND** age ≥ 18 **AND** Discharge Home = **Follow Up Intervention After Discharge**

## Complex Care Needs

- Complex Care Needs identified by ACM/TCN/SW not addressable by Home Health Services (e.g. Substance Abuse) or Patient Ineligible for Home Health (e.g. Uninsured) = **Follow Up Intervention After Discharge**
- Complex Care Needs defined as individuals who are high-utilizers or at risk for high utilization, e.g. low health literacy, uncontrolled chronic conditions.
- Referral to entity peer teams to assist with external referrals and linkages to social services
  - Navigators, Peer Recovery Coaches, CRM Assistants, and Community Health Advocates

# Independent Navigation

- Empower community to locate resources through MedStar Health Social Needs Tool powered by Findhelp
- Computer Literacy assessment available by Telehealth Technology Coordinators at entities
- Provide embedded QR links on discharge instructions and postcard to patients, which directly links them to web-based platform of local social services on the MedStar website and/or MyHealth Patient Portal.
- Utilize chat box/text message features to provide direct links to support service web-base directory on Medstar website.

**SOCIAL NEEDS TOOL**

**The MedStar Health Social Needs Tool is a social services and community resource. The tool provides access for local listings to find programs and assistance for food, shelter, healthcare, work, financial assistance and more.**

**Scan the QR code to take you to the site. You may also access the Social Needs Tool from the myMedStar Patient Portal (https://www.medstarhealth.org/mymedstar-patient-portal).**

**MedStar Health Social Needs Tool.**

May 2023

**S: Situation**

Meeting community needs around social determinants is essential to enhancing patient wellness and delivering quality, patient-centered care. Healthcare teams can better support patients with social challenges by asking about their social history, providing advice and referrals to local support services, facilitating access to these services, and acting as a reliable resource throughout the process.

**B: Background**

In 2021, the MedStar Health Community Health Needs Assessment (CHNA) identified social determinants of health as a priority area for our community.

**A: Assessment**

As a result of the CHNA feedback, MedStar Health now offers a Social Needs Tool, which is an online social services and community resource. The Tool is available in MedConnect under the Social Needs Tool tab on the main menu in a patient's chart. Within the tab is an eight-item screening for adult patients that assesses key social needs, such as housing, food, medical care, transportation, and employment. All members of the patient care team can access the Social Needs Tool and provide referrals to resources in the community.

**R: Recommendation**

Even after discharge, patients and families can access the MedStar Health Social Needs Tool. To begin a search, a zip code for anywhere in the U.S. is entered. This will bring up the total number of resources in that area, which are then broken down by category.

The following options are available for patients and community members to access The MedStar Health Social Needs Tool.

1. Visit https://socialneeds.medstarhealth.org
2. Log in to the myMedStar Patient Portal homepage
3. Scan the QR code on the last page of discharge instructions

The nurse will inform patients and families of the Social Needs Tool. A brief overview of the tool, how to use it, and the options of how to access it should be provided.

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# Supported Navigation with Care Coordination and Referrals

- Acute Case Management and Transitional Care Managers play a vital role
- Identify vulnerable populations before they leave the hospital to facilitate:
  - Supportive discharge planning and access to ongoing care needs, including medications, outpatient appointments, therapies, DME, medical transportation, & healthy nutrition.
- Utilize MedStar Social Needs Tool to support successful discharge planning to social services.
- Referrals for Complex Cases – Community Health Advocates/ Peer Recovery Coaches/Patient Navigators/CRM Assistants
  - ***Eyes & ears of the hospital after discharge, may provide follow up for up to 60 days***
  - Provide telephonic and home visit follow ups for at risk patients in local service area
  - Supports adults going home independently who are high-utilizers, have multiple social needs, low health literacy, and/or uncontrolled chronic conditions
  - Utilizes MedStar Social Needs Tool to refer and link to community social services
  - Assist with application assistance to long term services

# City Care Coordination Opportunities

- Continue CRISP data sharing collaboration and utilize SDOH tab.
- Referrals to HealthCare Access Maryland.
- Referrals to MCO and ACO care managers.
- Referrals to Aging Services at BCHD.
- Referrals to upcoming lifestyle management workshops/programs based by zip code or East-West areas.
- Submit 311 requests to meet community needs.

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# SDoH Screening and Referral Management Workflow


### 1. Screen

Nursing initial admission assessment completed by nursing, acute care management (RN or SW) staff.

Includes interpersonal safety question.

### 2. Refer

Nursing, acute care management staff submit referral for positive screen.

### 3. Receive referral

Nursing, acute care management staff submit referral for positive screen.

### 4. Manage referral

Care Coordination and support care triage by SDOH risk score and discharge plan.

### 5. Close Loop

ACM or Support Teams closes loop to ensure engagement in services.

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# Thank you

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# Diabetes Workgroup

*St Agnes Ascension and Life Bridge Health*

*Baltimore Metropolitan Diabetes Regional Partnership (BMDRP)*

*Michelle Peralta, LHIC Manager*

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# Baltimore City LHIC report out: LifeBridge Health and Ascension St. Agnes RP

September 2023

# Education Services

## Diabetes Prevention Program

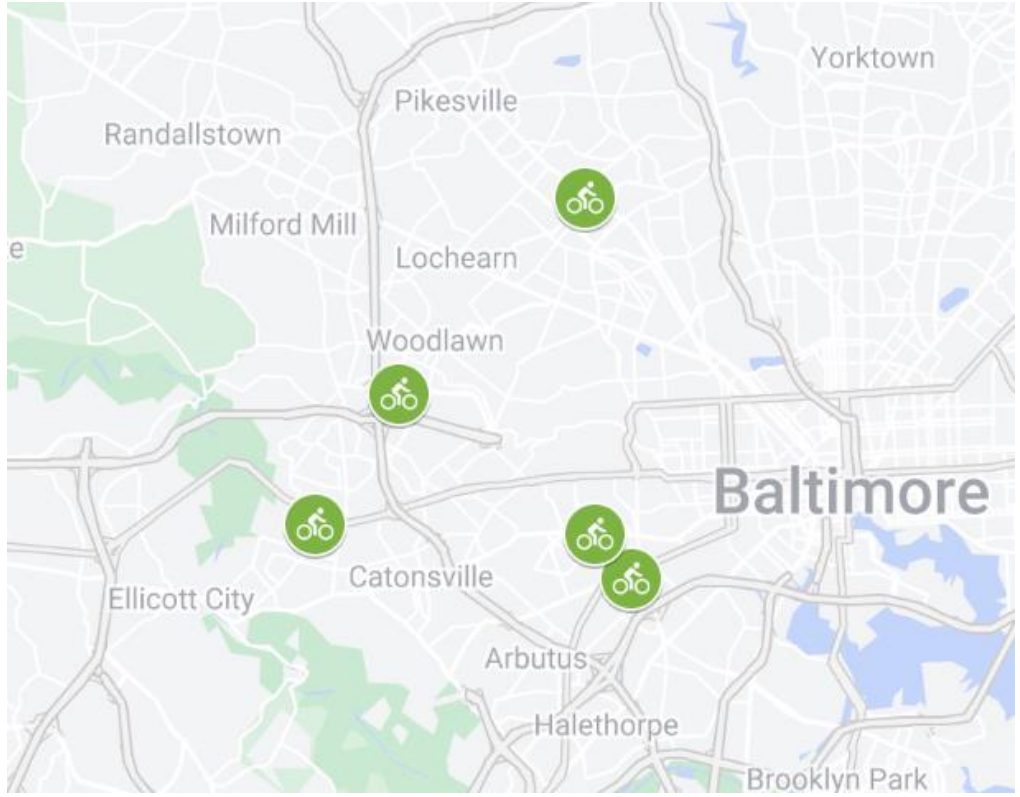
## Diabetes Self Management Training/Support

American Diabetes Association®

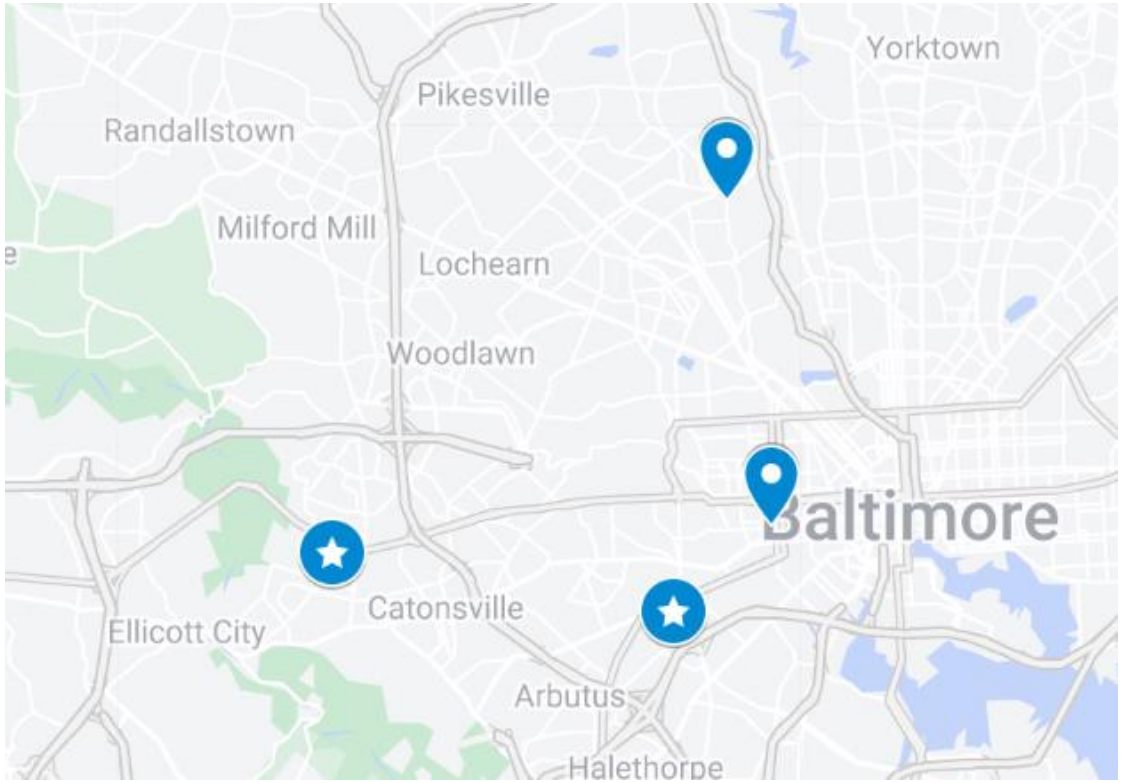
*The American Diabetes Association Recognizes this education service as meeting the National Standards for Diabetes Self-Management Education and Support.

# Locations

DPP




DSMT



# Education Successes

Staffing

- LBH and St Agnes have a total of 8 diabetes educators serving the DSMT population and 5 DPP coaches
- The success of a primary care educator has led to expanded opportunities to expand reach throughout service area.
- Improved process with credentialing RDs in unregulated space.

Retention/Feedback

- DSMT classes at St Agnes has 96% completion rate.
- 100% of participants say report positive changes in Diabetes Distress and Improved confidence in managing their condition.

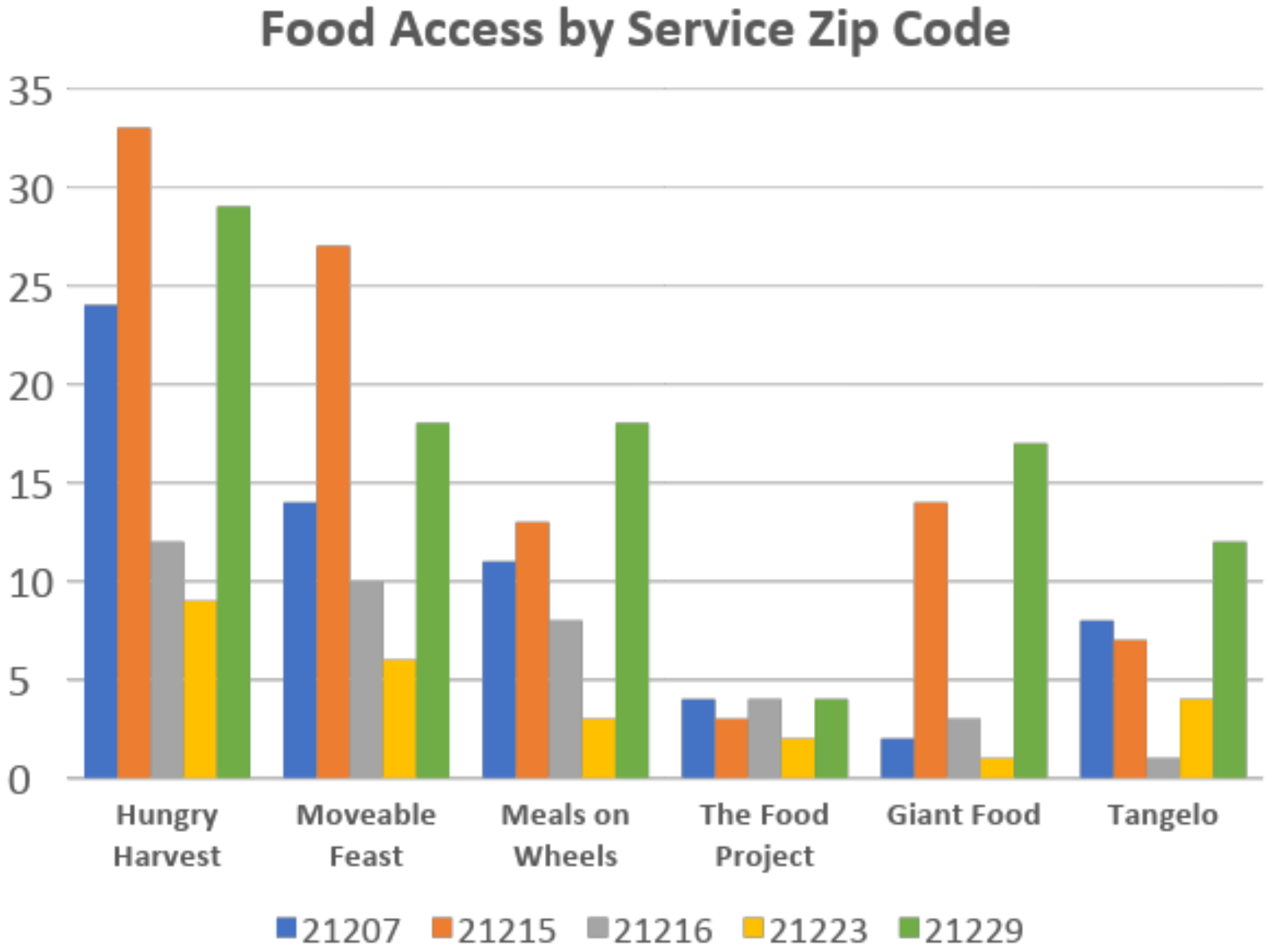
# Food Access

## Every participant in target zip codes has access to 6 months of food support

# Vendor Collaborations

| Food Partner | Service |
|---|---|
| Meals on Wheels | 12 weeks of prepared/packaged foods delivered |
| Hungry Harvest | 12 weeks of a fresh produce box delivered |
| Movable Feast | 12 weeks of packaged meals & 1 bag of fresh produce |
| Food Project | 12 weeks of prepared meals delivered |
| Giant Foods | 20 weeks of $20 dollars allotted for fresh/frozen produce at Giant stores |
| Tangelo | 14 weeks of grocery box deliveries and participant support |
| Virtual Supermarket (BCHD) | Launched June 2023. Establishing VSMs in food insecure neighborhoods in DRP zip codes |

# Food Access Participants



# Food Survey Feedback

**Sample Responses**

"Hungry Harvest & Giant Food's fruit and vegetables were outstanding! LifeBridge afforded me items I would have never tried. It gave me options to make different and healthy foods for me and my family. Enjoyable experience."

"The prepared meals help with controlling my salt intake and with trying new types of food. This helps me see other food options and prepare my meals at home."

# Food Survey Results

Does the food program help with meeting your weight loss goals?

24 responses

# We need your support

PreDM Awareness:
Only 1 in 10 people know they have prediabetes
We are limited to seeing patient who have a verified diagnosis
Help us normalize knowing our glucose status

DSMT:
Diabetes is 1 in 4 Healthcare dollars and cardiovascular disease in a key driver
Care standards recommend DSMT for all people with diabetes (PWD) to REDUCE the LIKELIHOOD of complications. Yes, even people with great HbA1cs ☺
Help us normalize every PWD accessing their education team

Contact us:
Education questions pamela.xenakis@ascension.org
Food Access questions: nikdixon@lifebridgehealth.org

# Baltimore Metropolitan Diabetes Regional Partnership

JOHNS HOPKINS MEDICINE

HEALTHIER 2GETHER

UNIVERSITY OF MARYLAND MEDICAL CENTER

UNIVERSITY of MARYLAND MEDICAL SYSTEM

# Diabetes Prevention Program (DPP) – Patient Story

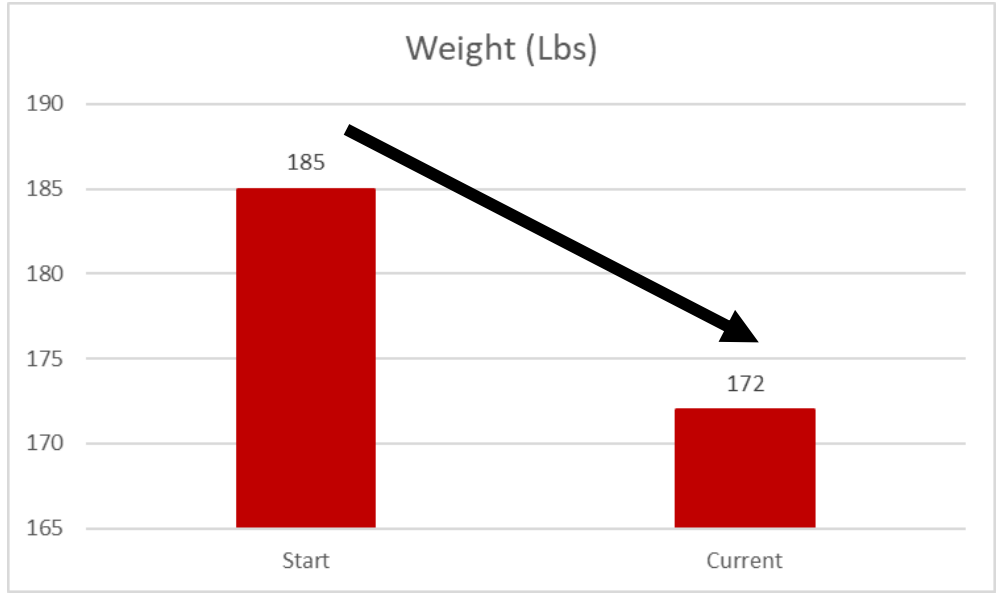
A female patient
Hx: Dairy and tomato allergies

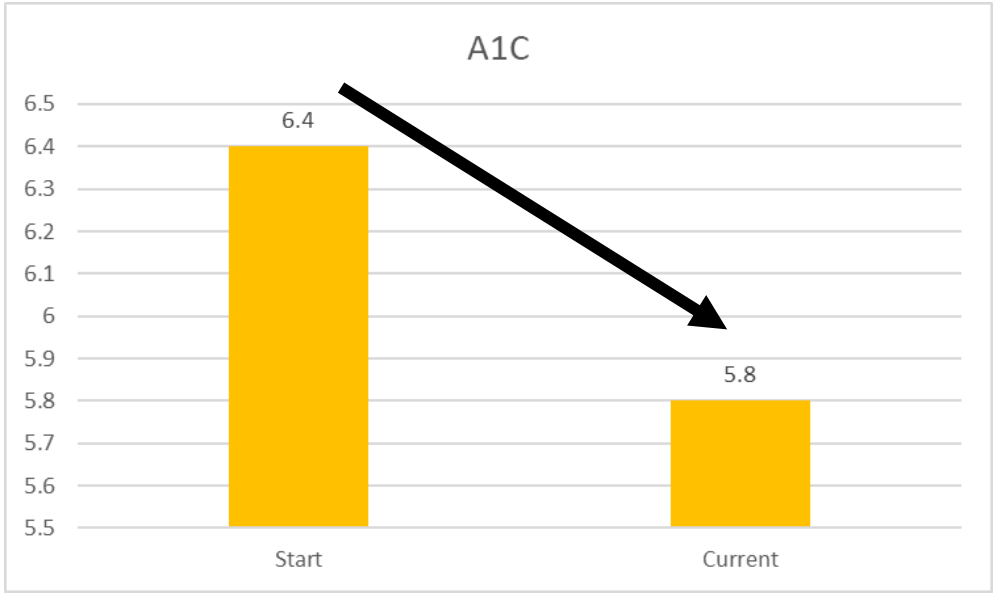
***"I had no idea about what was even wrong with my health until I was encouraged to get tested for my A1C. Once I got back the test results, I knew that I had a problem as I was in the pre-diabetic range."***

***"I was able to see results in a pretty short time frame. I started in February and by the end of May I had reached my target weight!"***

Weight Starting at 185 Lbs
Weight Currently at 172 Lbs
Lost : 13 Lbs
A1c Started at 6.4
Current A1C 5.8

**Increased Activity Minutes Weekly.**



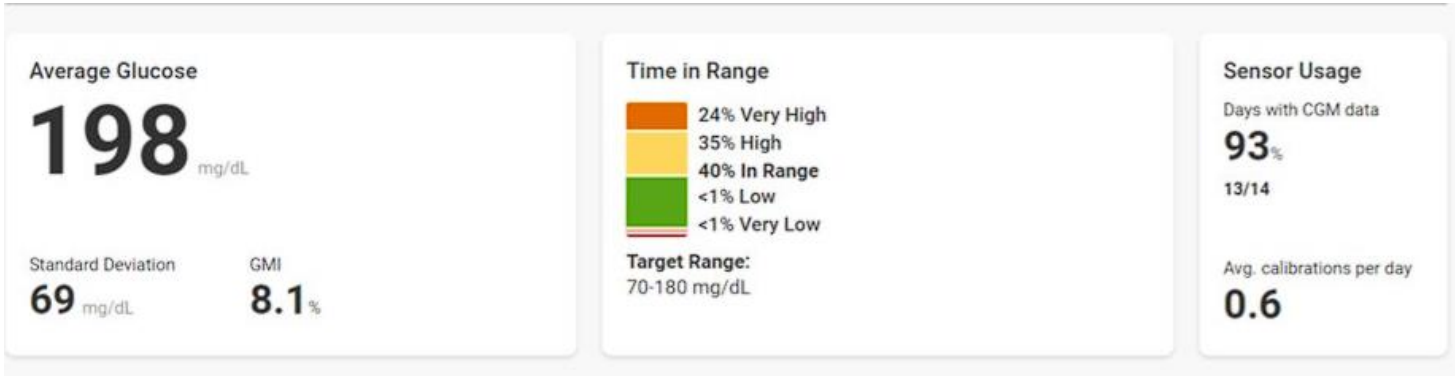



# Diabetes Self-Management Training (DSMT) – Patient Story

Demographics:
- 76-year-old male
- Type 1 diabetes diagnosed in 1999

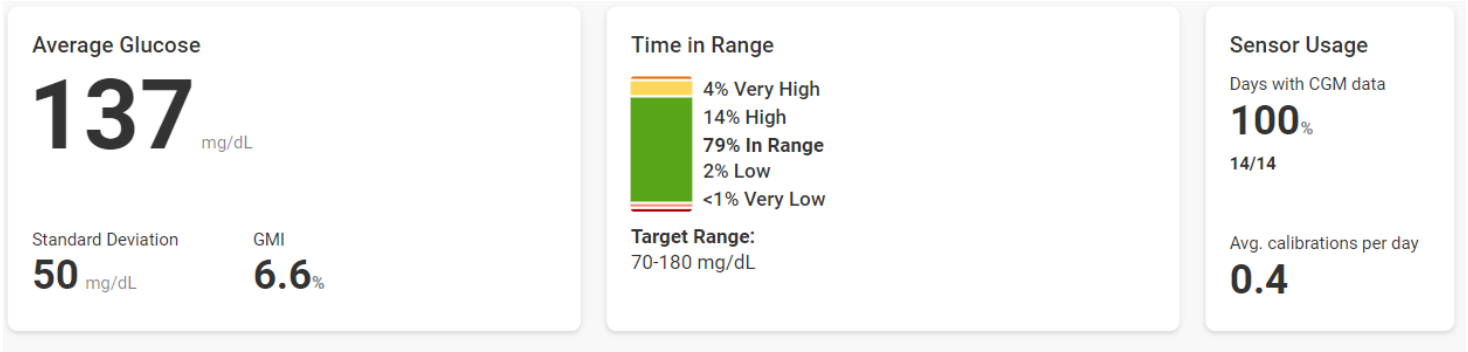
A1c levels before DSMT:
- 2021: 8.8%
- 2022: 8.9%, 9.6%

Therapy
- Multiple daily injections
- Continuous glucose monitor




During 3/23 visit, CDCES identified potential issue regarding insulin absorption. Patient had been using small area for injections for ~20 years.

CDCES recommendations:
1. Begin rotating insulin injection sites
2. Loosen carbohydrate ratios by 1 gram per unit each time postprandial hypoglycemia occurred.




- Data shown is from the **two-week period immediately following DSMT visit #2**
- Average CGM glucose improved by 61 mg/dl.
- Subsequent A1c: 7.2%
- Insulin doses were reduced by 66% due to enhanced insulin absorption

# https://www.healthier2gether.org/





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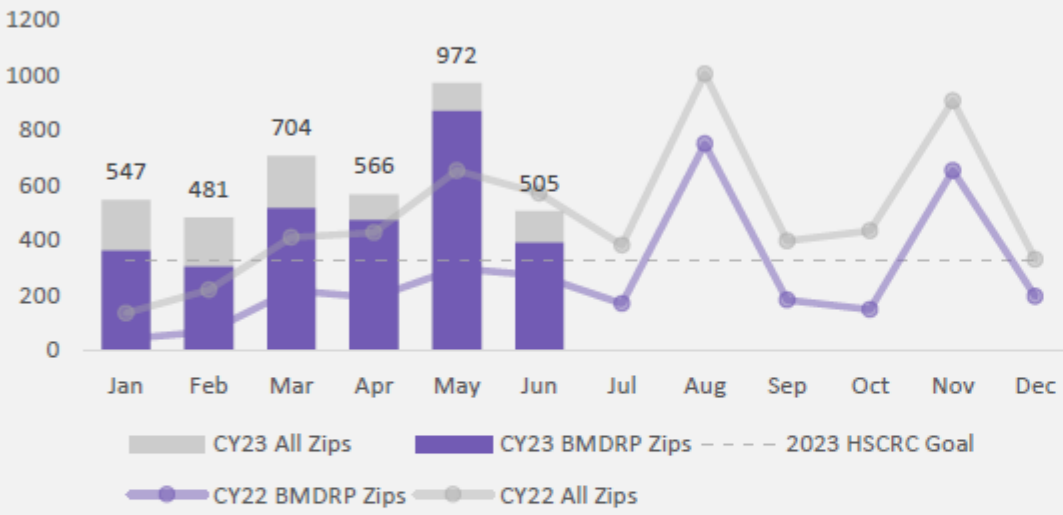
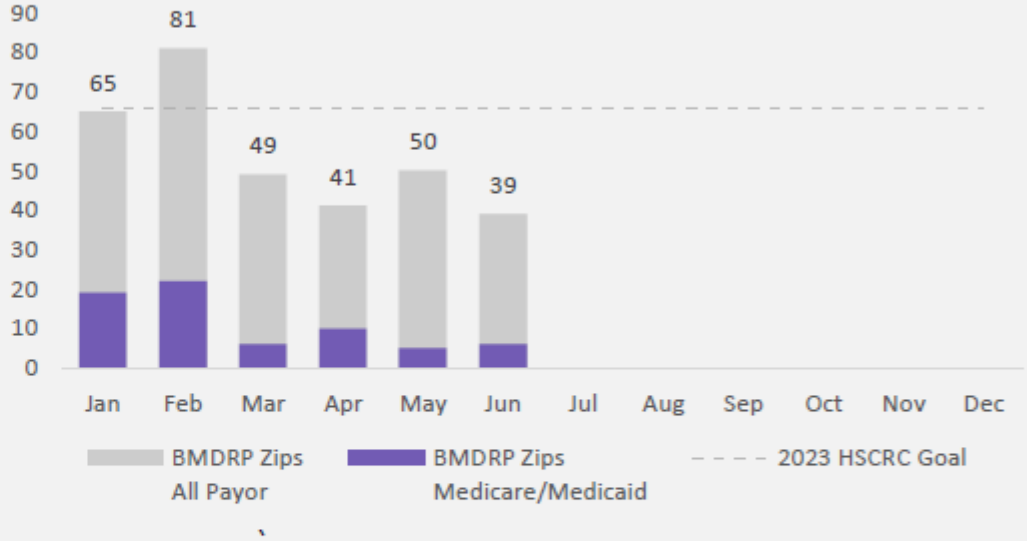
# Diabetes Prevention Program (DPP)

## DPP

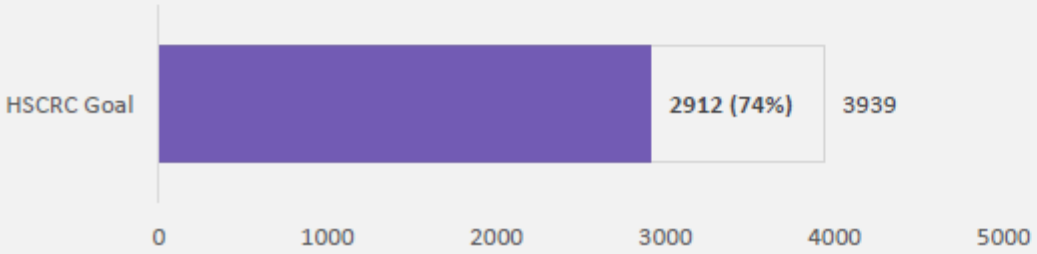
### CY22 - CYTD23 Referrals




### CYTD23 Enrollment




### Progress Towards Referral Goal

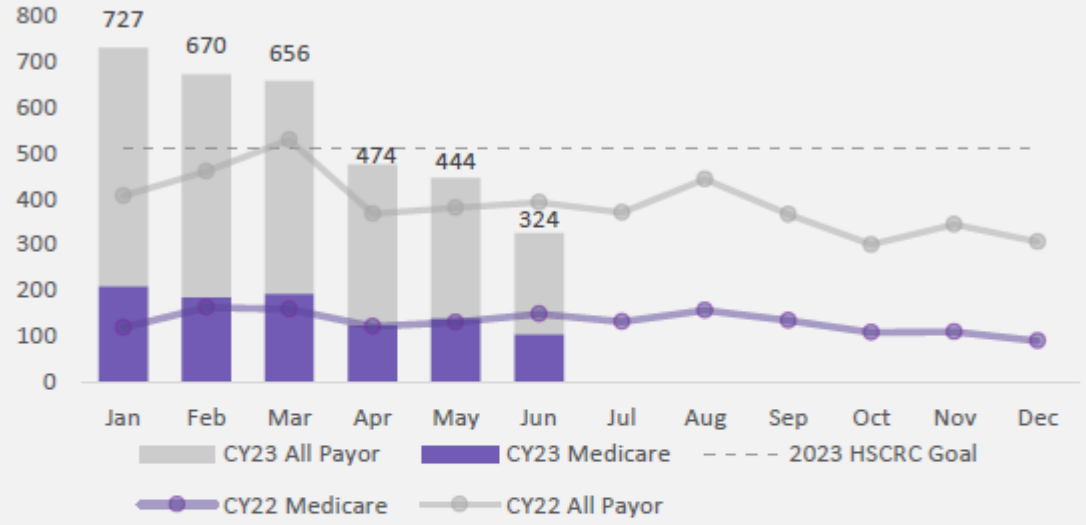



### Progress Towards Enrollment Goal

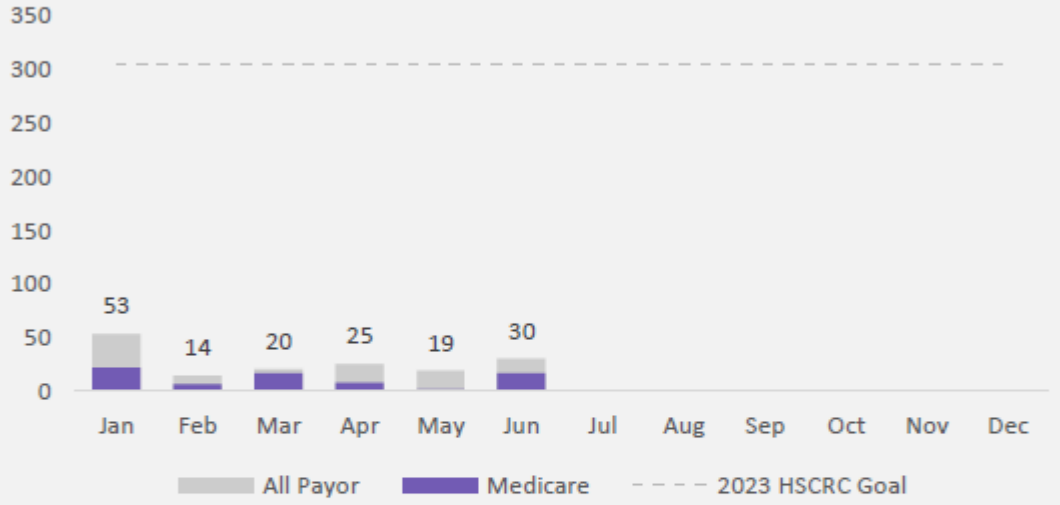
# Diabetes Self Management Training (DSMT)

## DSMT

### CY22 - CYTD23 Initiations




### CYTD23 Retention




### Progress Towards Initiation Goal


### Progress Towards Retention Goal


Helping Marylanders Prevent and Manage Diabetes

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# BCHD Updates

*CDC-RFA-DP-23-0020: A Strategic Approach to Advancing Health Equity for Baltimoreans at Risk for Diabetes*

*Brandon M. Scott*
*Mayor*, Baltimore City
*Mary Beth Haller, Esq.*
Acting Commissioner of Health, Baltimore City

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# Background

- In alignment with our 3 key priorities, BCHD actively pursued funding opportunities to enhance and bolster ongoing LHIC initiatives.
- BCHD was awarded the *CDC-RFA-DP-23-0020: A Strategic Approach to Advancing Health Equity for Baltimoreans at Risk for Diabetes* on June 30, 2023.
- 5-Year Grant for $5MM to address the individual and systems barriers to diabetes prevention and reduction
- Prevent or delay onset of Type 2 Diabetes among adults with prediabetes and improve self-care practices, quality of care, and early detection of complications among people with diabetes.
- Reduce health disparities and achieve health equity for priority populations, or people who face the most systemic barriers to health.

# Year 1 Goals

Increase enrollment and retention of priority populations in the Diabetes Prevention Program (DPP) by improving access, appropriateness, and feasibility of the programs.

**By 6/29/2024, we will:**

- Outreach to 49,000 residents in neighborhoods most likely to be at risk for diabetes
- Refer 4,000 residents to the Diabetes Prevention Programs

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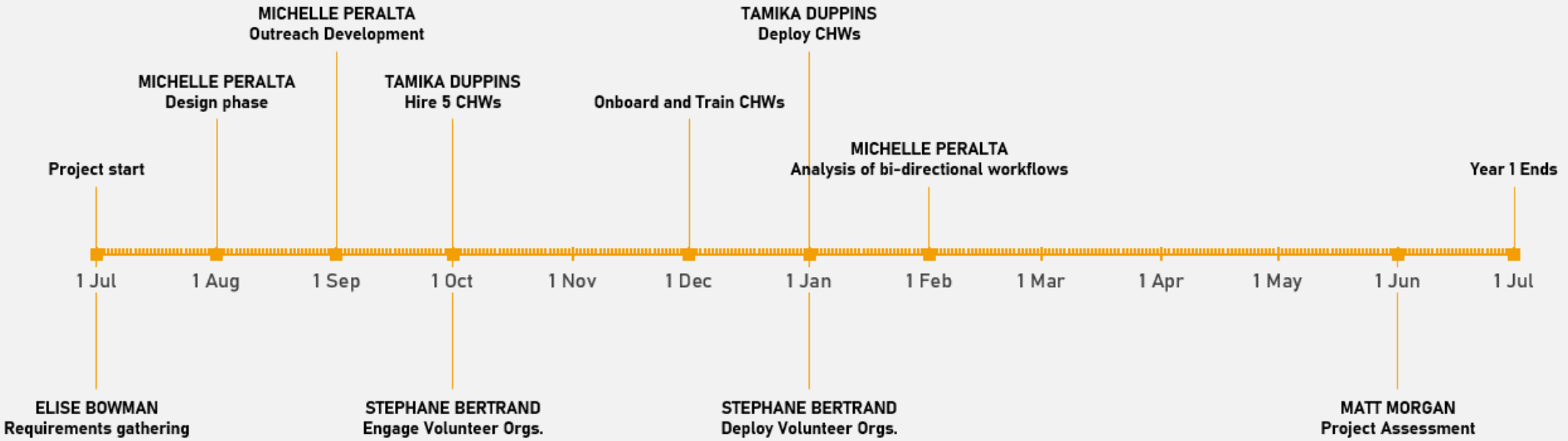
# PROJECT TIMELINE

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## Project Milestones

| DATE | MILESTONE | ASSIGNED TO | COMPLETED |
|---|---|---|---|
| 7/1/2023 | Project start | | ☑ |
| 7/1/2023 | Requirements gathering | ELISE BOWMAN | ☑ |
| 8/1/2023 | Design phase | MICHELLE PERALTA | ☑ |
| 9/1/2023 | Outreach Development | MICHELLE PERALTA | |
| 10/1/2023 | Engage Volunteer Orgs. | STEPHANE BERTRAND | |
| 10/1/2023 | Hire 5 CHWs | TAMIKA DUPPINS | |
| 12/1/2023 | Onboard and Train CHWs | | |
| 1/1/2024 | Deploy CHWs | TAMIKA DUPPINS | |
| 1/1/2024 | Deploy Volunteer Orgs. | STEPHANE BERTRAND | |
| 2/1/2024 | Analysis of bi-directional workflows | MICHELLE PERALTA | |
| 6/1/2024 | Project Assessment | MATT MORGAN | |
| 7/1/2024 | Year 1 Ends | | |

# Design Phase

- ✓ Build a geographic map of Baltimore City highlighting several risk factors for developing type 2 diabetes including obesity rates, income-level, diabetes rates, rate of 'have you been to see primary care in the last year,' and density of African American populations

- ✓ Monthly, convene a multisector group of CHWs, community members, diabetes providers, and community organizations to assess, refine, and continuously improve the quality of our CHW outreach and referral strategy.

- Develop outreach plan

- Develop screening tool

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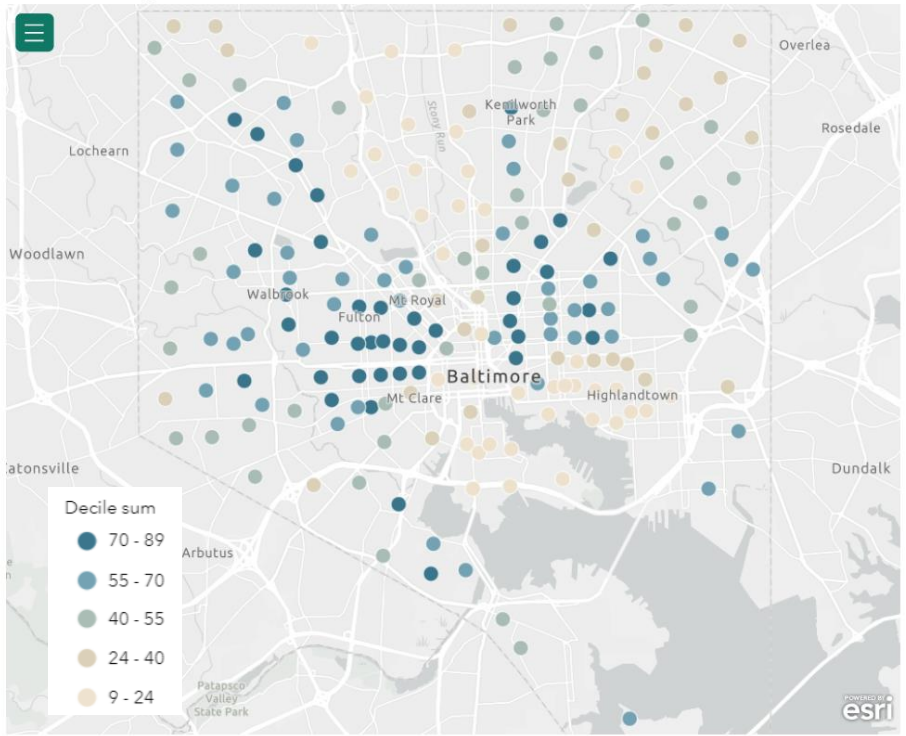
# Mapping and Outreach Strategy

## Overview of Baltimore City Census tracts by Diabetes Risk Score

| CSA | Tract | Decile sum | Diabetes % decile | Diabetes # decile | Residents 18+ (#) |
|---|---|---|---|---|---|
| Oldtown/Middle East | 1002 | 89 | 10 | 10 | 2,253 |
| Cherry Hill | 2502.04 | 88 | 10 | 9 | 2,451 |
| Poppleton/The Terraces/Hollins Market | 1801 | 86 | 10 | 6 | 1,293 |
| Oldtown/Middle East | 2805 | 86 | 10 | 9 | 2,400 |
| Upton/Druid Heights | 1702 | 85 | 10 | 8 | 1,686 |
| Sandtown-Winchester/Harlem Park | 1501 | 84 | 9 | 7 | 1,642 |
| Sandtown-Winchester/Harlem Park | 1502 | 84 | 9 | 9 | 2,114 |
| Sandtown-Winchester/Harlem Park | 1603 | 84 | 10 | 7 | 1,218 |
| Southern Park Heights | 1512 | 83 | 10 | 10 | 2,902 |
| Sandtown-Winchester/Harlem Park | 1602 | 83 | 9 | 6 | 1,571 |
| Sandtown-Winchester/Harlem Park | 1604 | 83 | 10 | 5 | 1,185 |
| Southwest Baltimore | 1901 | 83 | 10 | 7 | 1,467 |
| Southwest Baltimore | 2001 | 83 | 10 | 6 | 1,284 |
| Pimlico/Arlington/Hilltop | 2718.01 | 83 | 10 | 8 | 1,754 |
| Greenmount East | 1001 | 82 | 10 | 6 | 1,425 |
| Greater Rosemont | 1605 | 82 | 9 | 9 | 2,400 |
| Greater Rosemont | 1506 | 81 | 9 | 9 | 2,328 |
| Belair-Edison | 801.02 | 81 | 9 | 5 | 1,349 |
| Clifton-Berea | 805 | 81 | 10 | 5 | 1,168 |
| Southern Park Heights | 1513 | 80 | 9 | 10 | 3,604 |
| Sandtown-Winchester/Harlem Park | 1601 | 80 | 10 | 6 | 1,474 |
| Midway/Coldstream | 908 | 80 | 10 | 8 | 1,823 |

Census tracts by sum of decile rank across 9 diabetes-related factors




Decile sum (max=90) is calculated by adding a tract's decile rank across 9 diabetes-related factors. Seven factors are health-related: % of residents 18 years or older old with 1) diabetes; 2) high blood pressure; 3) obesity; 4) no leisure-time physical activity; 5) less than 7 hours sleep per night; 6) currently smoke; 7) total # with diabetes. Two are demographic factors: 8) % of residents Black/African-American; 9)% of households earning <$25k/year. Data is from CDC Places and 2020 Census results. Analysis by BCHD.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# Year 1 Outreach

## Breakdown of Potential Outreach

| Outreach group, by minimum decile sum | Residents 18+ in group (#) | Census tracts in group (#) |
|---|---|---|
| 80 | 40,791 | 22 |
| 70 | 42,453 | 21 |
| 60 | 66,799 | 31 |
| 50 | 75,002 | 31 |
| 40 | 64,698 | 24 |
| 30 | 68,483 | 25 |
| 20 | 42,300 | 17 |
| 10 | 63,823 | 25 |
| 0 | 6,085 | 3 |

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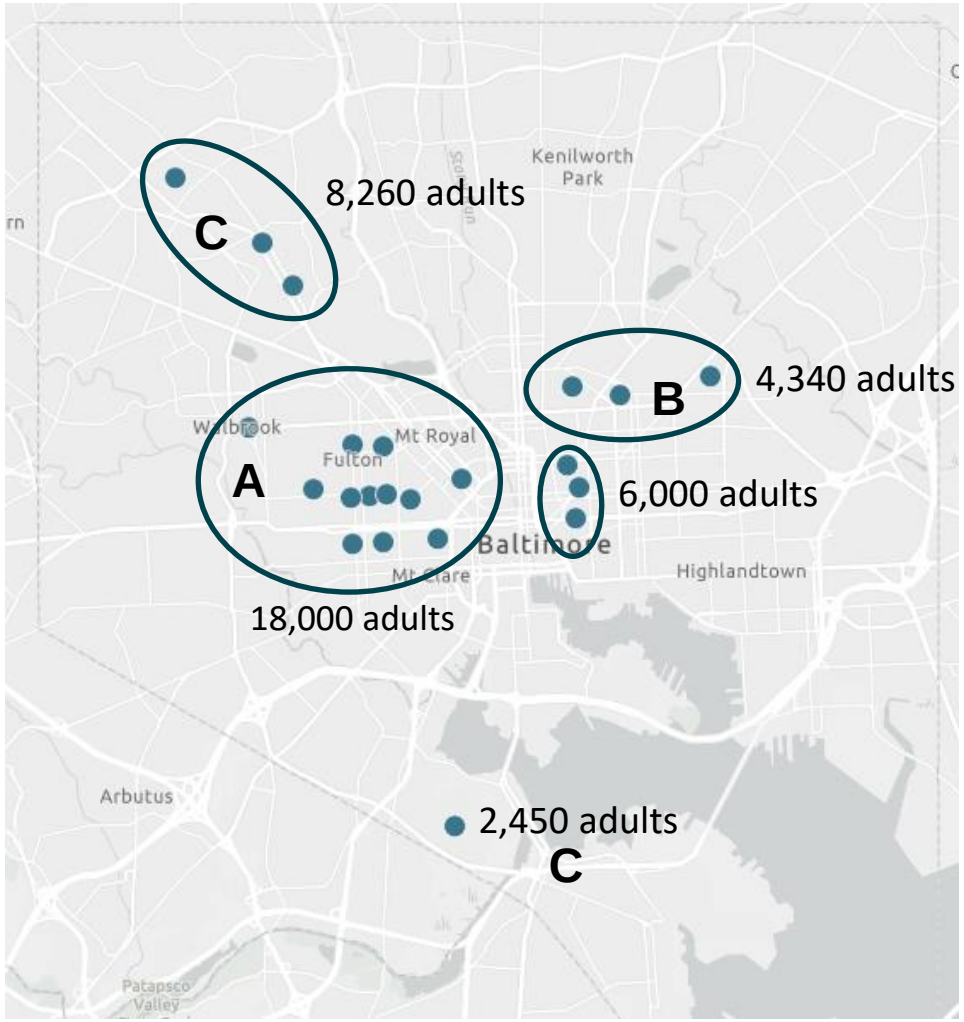
# Potential Outreach Schedule in Year 1

A. 6 months in West Baltimore
B. 3 months in East Baltimore
C. 3 months in Pimlico/Park Heights and Cherry Hill

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# Questions/Feedback

# Community Spotlight

*Dr. Yolanda Ogbolu, PhD, CRNP-Neonatal, FNAP, FAAN*

*Janette North-Kabore, MPH*

*Asunta Johnson, MS*

*Brandon M. Scott*
*Mayor*, Baltimore City
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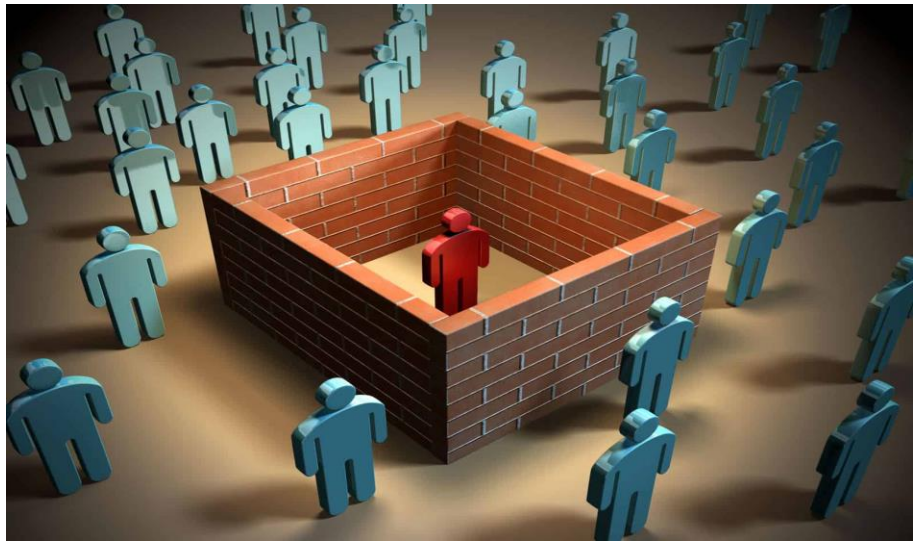
# The West Baltimore RICH Collaborative

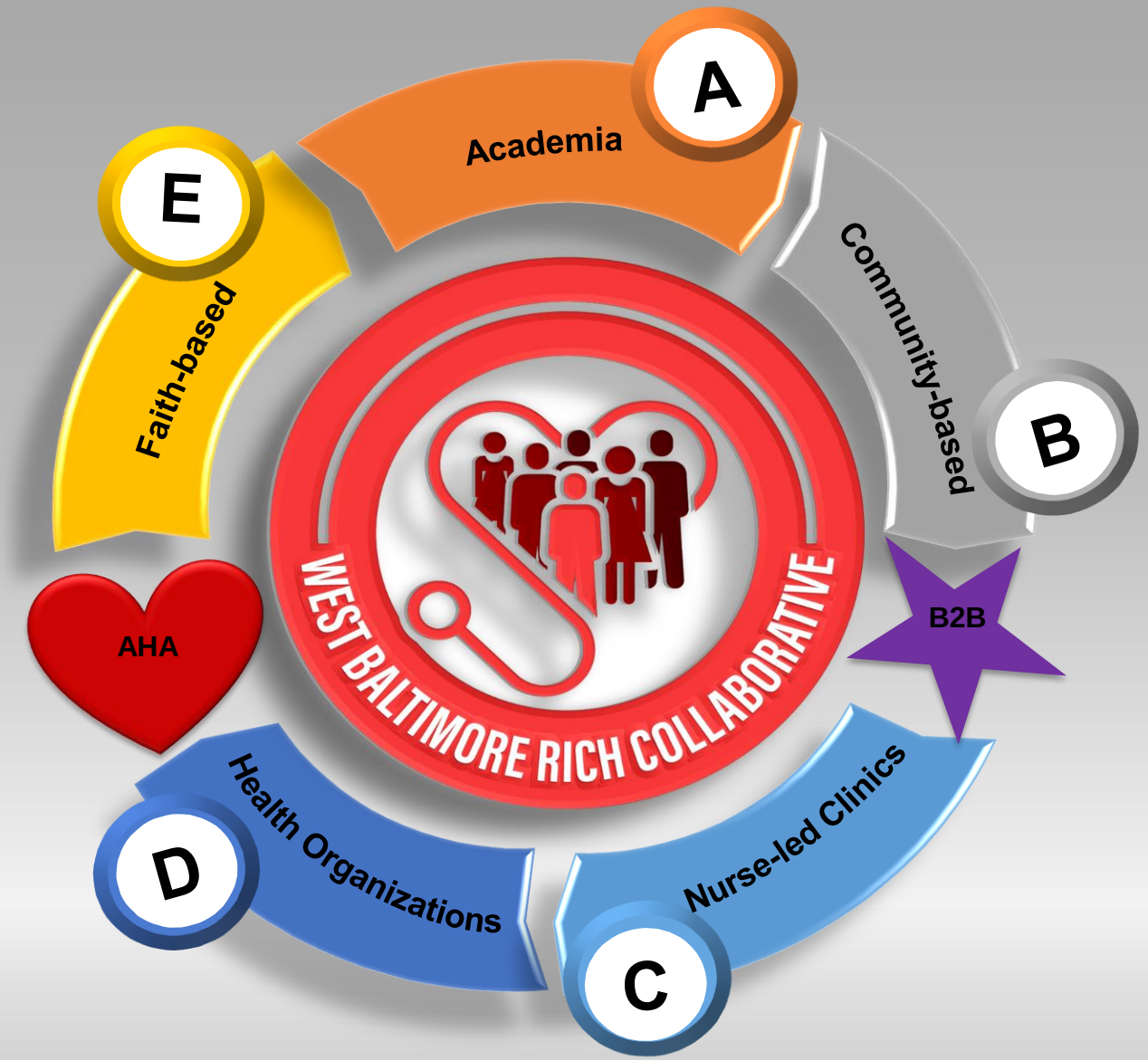
## **R**educing **I**solation and **I**nequities in **C**ardiovascular **H**ealth


Yolanda Ogbolu, PhD, NNP, FNAP, FAAN
Bill and Joanne Conway Dean, Professor
University of Maryland School of Nursing

Janette North-Kabore, MPH
Community Program Director
University of Maryland School of Nursing

Asunta Johnson, MS
Community Program Director
University of Maryland School of Nursing




***Within Baltimore City, aiming to reach 5000 people, with 2000 unduplicated (ongoing relationship with provision of services)**

## A – Academic Institutions (2)

- Lead Institution: University of Maryland Baltimore (SON, SOM, SOP, CEC)
- Coppin State University

## B – Community-based Organizations (CBOs) (6)

- A Better Tomorrow Starts Today
- Druid Heights Community Development Corp.
- Light Health and Wellness
- Lori's Hands
- Roberta's House

## C – Nurse-led Clinics (3)

- UMB Community Engagement Center Health Suite
- Coppin State University Health Suite
- McCullough Home Health Suite

## D – Health Organizations

- University of Maryland Medical Center (Downtown and Midtown)
- Ascension St. Agnes
- Chase Brexton
- Total Healthcare

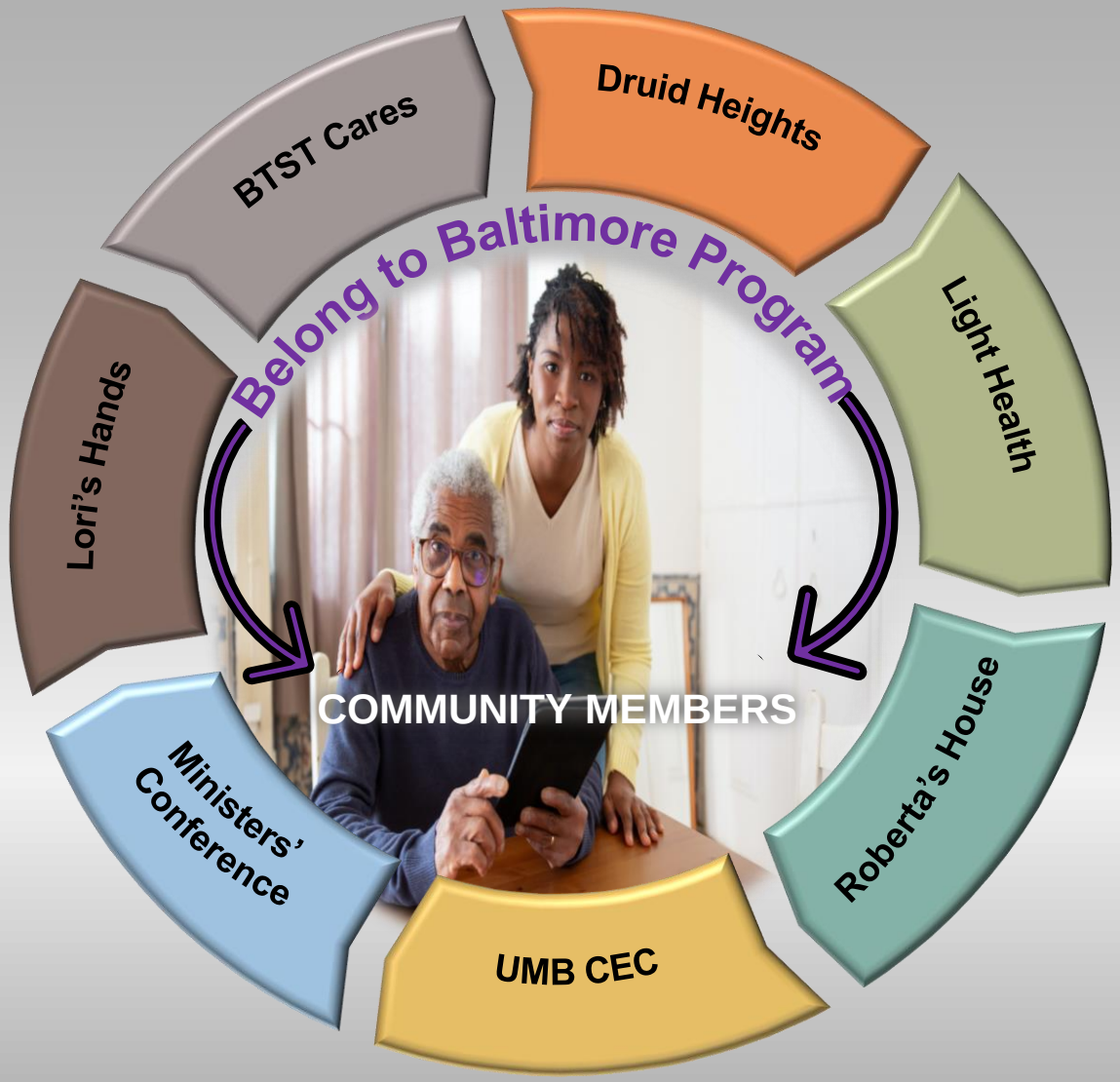
## E – Faith-based Organization

- Ministers' Conference Empowerment Center

## *Additional Organizations

- AHA -American Heart Association
- B2B -Belong to Baltimore

# Community Engagement-Key Partners and Roles




**Continuous community engagement process-prior to and during**

**Steering and governance committees**

**Facilitate community outreach events**

**Trusted community access points for patients and senior facilities**

**Youth advocates and community outreach workers opportunities**

**Facilitate support groups-grief, racial trauma, isolation, dancing and fun and creative events**

**Serve as feedback loops for community engagement process**

# Reducing Isolation and Inequities in Cardiovascular Health [RICH]

Social isolation - Increased attention during the coronavirus pandemic **but not a new challenge.**

- **Research has shown that those who are socially isolated are over 40% more likely to have a cardiovascular event, such as a heart attack or stroke, than those who were integrated and socially connected in society[25].**
- **Poor social relationships were associated with 29% increase in risk for coronary heart disease** and a 32% increased risk of stroke in **middle-aged adults**.
- Addressing social isolation in middle-aged adults (45 or older) residing in marginalized communities in West Baltimore could reduce premature death from hypertension and heart disease and benefit public health and well-being.

## KEY INTERVENTIONS

- Health Equity Learning Collaborative
- SDoH and Social Support
- Mobile Health
- Community Health Workers
- Nurse Led Clinics
- Primary and Secondary Prevention Events

# Project Goals & Metrics

## Cost Savings

| | |
|---|---|
| Reduce | Reduce Health Disparities |
| Improve | Improve Health Outcomes |
| Increase | Increase Access to Primary Care |
| Promote | Promote Primary and Secondary Preventive Services |
| Reduce | Reduce Costs, Admissions and Readmissions |

# Referrals

Nurse-led clinics

Health Organizations


Community events


Mobile health care

## RICH Community Outreach Worker


Enrolls, Identifies SDoH needs, Connects to resources, Provides individual with blood pressure cuff, and Conducts follow-ups

# West Baltimore RICH Community Outreach Worker


BEFORE working with RICH community Outreach Worker

## 1. ENROLLMENT

BEGIN working with RICH Community Outreach Worker

## 2. CONNECTED TO RESOURCES

AFTER working with RICH Community Outreach Worker

## 3. FOLLOW-UP

Images courtesy of www.pexels.com/@alex-green/

# Sustainability

- The **West Baltimore RICH Collaborative** is a network of diverse partners with long-term commitments to West Baltimore
- Integration into **West Baltimore RICH Collaborative** partner sites will be one sustainability lever
- Participating FQHCs will have expanded health care services and/or wrap-around support services including in-home monitoring, telehealth, and mobile health
- CBOs serving West Baltimore residents will be strengthened and have increased capacity.
- Nurse-led clinics will seek opportunities to partner with health care organizations to generate revenue for service delivery

# Current Impact

## Nurse led Clinics

- McCulloh Homes @ City view
- UMB Community Engagement Center
- Coppin State Health Center
- Garwyn Family Medical Center

## Mobile Health

- >275 Home Blood Pressure Cuffs distributed
- Attended 80 health prevention, community events related to high blood pressure management

## SDoH & Social Isolation

- 65% of participants screened, reports having a SDoH challenge
- Over 800 social needs has been identified and is receiveing support

# In their own words...

## Positive Anticipation

- Looking forward to checking in next Wednesday
- Looking forward to RICH Light Health and Wellness
- Looking forward to seeing his outreach worker

## Trust

- Is helpful; [she] trusts her outreach worker

## Appreciation

- He appreciates all that we do
- He is so thankful for RICH and the Community
- Client really appreciates the assistance and follow-up
- Client was in a good mood and was happy to hear

## Gratitude

- I THANK GOD for this program
- I thank the RICH program
- I thank you for continue to help me
- I thank you for your help and assistance

## INTERESTED IN...

- PARTNERING WITH THE WEST BALTIMORE RICH COLLABORATIVE?
- HAVING US PRESENT AT YOUR UPCOMING EVENTS?
- HAVING US HOST WORKSHOPS FOR YOUR GROUP?
- HELPING US TO REDUCE HEALTH INEQUITIES AND SOCIAL ISOLATION?

# Contact Us


Community Program Director

**Janette North-Kabore (443) 706-4448**

jnorth-kabore@umaryland.edu

or

Community Program Director

**Asunta Johnson (443) 706-0647**

asunta.johnson@umaryland.edu

Lead Director

**Dr. Yolanda Ogbolu**

ogbolu@umaryland.edu

# Community Announcements

# Thank you from the BCHD LHIC team

Tamara Green, Chief Medical Officer: Tamara.Green@baltimorecity.gov

Elise Bowman, LHIC Program Director: Elise.Bowman@baltimorecity.gov

Michelle Peralta, LHIC Manager: Michelle.Peralta@baltimorecity.gov

Stephane Bertrand, LHIC Program Coordinator: Stephane.Bertrand2@baltimorecity.gov

Matt Morgan, LHIC Data Manager: Matt.Morgan@baltimorecity.gov

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