UNIVERSITY of MARYLAND MEDICAL CENTER

# COMMUNITY HEALTH NEEDS ASSESSMENT

## IMPLEMENTATION PLAN

FY2022-FY2024

APPROVED BY THE COMMUNITY ENGAGEMENT COMMITTEE, BOARD OF DIRECTORS • JUNE 7, 2021

## IV. Selecting Priorities

Analysis of all quantitative and qualitative data described in the above section identified these top five areas of need within Baltimore City. These top priorities represent the intersection of documented unmet community health needs and the organization's key strengths and mission. These priorities were identified by the Community Health and Engagement Team and validated with the health experts from the UMB Campus Panel:

**Adult Health Priorities**

1. Substance Use Disorder
2. Mental Health
3. Chronic Disease Management (CVD, Diabetes, HIV)

**Social Determinants of Health Priorities**

1. Employment and Career Opportunities
2. Neighborhood Safety and Violence Prevention
3. Affordable Housing and /Homelessnes

In addition to identifying adult health needs and priorities, UMMC identify the unmet needs for the children within our community benefits service area. These priorities were also identified by the UMMC Community Health and Engagement Team and the Experts from the UM Children's Hospital:

**Children Health Priorities**

1. Mental Health (ACEs)
2. Obesity/Nutrition
3. Asthma
4. Maternal and Child Health

## V. Documenting and Communicating Results

The UMMC 2022–2024 Community Health Needs Assessment process fully embraced community listening, involvement and collaboration with a broad group of community leaders, the academic community, the general public, and health experts. This report will be posted on the UMMC website under the Community Health and Engagement webpage at https://www.umms.org/ummc/community-health.

Highlights of this report will also be documented in the Community Benefits Annual Report for FY2021. Reports and data will also be shared with our community partners and community leaders as we work together to make a positive difference in our community by empowering and building healthy communities.

# VI. Planning for Action and Monitoring Progress

## A) PRIORITIES AND IMPLEMENTATION PLANNING

UMMC has aligned its identified community health priorities with the National and State Health Priorities. The following matrix shows the alignment of the identified priorities with each of the National and State priorities. UMMC will also track the progress with long-term outcome objectives measured through the National Prevention Strategy Priority Areas. Short-term programmatic objectives, including reach and outcome measures will be measured annually by UMMC for each priority area through the related programming. Adjustments will be made to annual plans as other issues emerge or through our annual program evaluation.

In addition to the identified strategic priorities from the CHNA, UMMC employs the following prioritization framework to address an urgent or emergent need in the community, (i.e., disaster response or infectious disease issue). The CHNA prioritized needs for the Sustained and Strategic Response Categories and the Rapid and Urgent Response Categories' needs will be determined on an as-needed basis.

UMMC will provide leadership and support in partnership with the communities we serve at a variety of response levels. Rapid and Urgent response levels will receive priority over sustained and strategic initiatives as warranted.

- **Rapid Response** - Emergency response to local, national, and international disasters, i.e., civil unrest and weather disasters (earthquake, blizzard, and terrorist attack)
- **Urgent Response** - Urgent response to episodic community needs, i.e., COVID-19 and Flu response
- **Sustained Response** - Ongoing response to long-term community needs, i.e., obesity, tobacco prevention education, health screenings, and workforce development
- **Strategic Response** - Long-term strategic leadership at legislative and corporate levels to leverage relationships to promote health-related policy or reform and build key networks

Future Community Health Needs Assessments will be conducted every three years and strategic priorities will be re-evaluated then. Programmatic evaluations will occur annually, and adjustments to programs will be as needed. All community benefits reporting will occur annually to meet state and federal reporting requirements.

## B) UNMET COMMUNITY NEEDS

Several additional topic areas were identified by the Community Health and Engagement Team during the CHNA process including: Cancer, Homelessness and Transportation. While the UMMC will focus the majority of its efforts on the identified strategic priorities, we will review the complete set of needs identified in the CHNA for future collaboration and work. These areas, while still important to the health of the community, will be met through either existing clinical services and through collaboration with other health care organizations as needed. The unmet needs not addressed by this CHNA will also continue to be addressed by key Baltimore City governmental agencies and existing community-based organizations.

The UMMC identified core priorities target the intersection of the identified community needs and the organization's key strengths and mission. The following table summarizes the programs either currently in use or to be developed to address the identified health priorities.

## VII. Implementation Plans FY2022-2024

**UMMC Strategic Programs FY2022–2024**

| SHCRC Strategic Integrated Health Improvement Domain Goals | National Prevention Strategy: Priority Areas | UMMC Priorities | UMMC Strategic Community Programs |
|---|---|---|---|
| Maternal/Child Health | Reproductive and Sexual Health | Maternal and Child Health<br>Asthma<br>Obesity/Nutrition | B'More Health Babies<br>Breathmobile<br>Kids to Farmer's Market,<br>Safe Kids (Helmets, Fire Safety, Car Seats) |
| Opioid Use Disorder | Mental and Emotional Well-Being<br>Injury and Violence Free Living<br>Preventing Drug Abuse and Excessive Alcohol Use<br>Tobacco Free Living | Mental Health<br>Trauma/Violence Prevention<br>Substance Use Disorder | Mental Health Conference, MH Screenings, MHFA<br>Violence Prevention Program, Bridge Program, PHAT, My Future, My Career<br>Drug Facts campaign, Provider education on prescribing practices, SBIRT, Naloxone, TND |
| Chronic Conditions: Coordinated Care<br>Diabetes | Healthy Eating | Cardiovascular Disease<br>Obesity<br>Diabetes<br>COVID-19 Vaccine | Farmer's Market, Maryland Healthy Men Program, Mobile Market, BMI screenings, BP Screenings, DPP Program, A1C screenings, Nutrition education, Living Well workshops (HTN, Chronic Disease, Diabetes, and HIV) |
| | Active Living | Employment/ Career Advancement | UM Career Academy Project Search, BACH Fellows, Youthworks, NAHSE, Healthcare Career Alliance, Urban Alliance |

## FY2022-FY2024 Community Health Improvement Implementation Plan – Mental Health

**PRIORITY AREA: Mental Health – FY2022-FY2024**

Objectives Supporting SIHIS and The National Prevention Strategy:

1. Reduce the suicide rate and reduce the emergency department visits related to mental health (Healthy People 2030: "for intentional self-harm injuries")
2. Increase the proportion of persons with co-occurring substance use disorders and mental health disorders who receive treatment for both disorders
3. Increase the proportion of adults with serious mental illness (SMI) who receive treatment

| Annual Objective | Strategy | Target Population | Actions Description |
|---|---|---|---|
| Reduce the suicide rate<br><br>Reduce the ED visit rate r/t mental health<br><br>Increase awareness in the community of mental health<br><br>Increase the number of individuals referred to appropriate mental health resources | Provide education and information and training to primary and specialty UMMC clinics about Trauma-informed care<br><br>Integrating Trauma Informed Principals to Target Clinics within UMMC/S<br><br>Educating community members on how to access the Mental Health System for resources and care. (SAMHSA Grant for funding if possible)<br><br>Collaborating with City Police and Greater Baltimore Region Integrated Crisis System to create policies and better practices around trauma informed responses | Health care providers and staff<br><br>West Baltimore Community<br><br>West Baltimore Community | Using SAMHSAs principles and guidance for trauma-informed approaches, provide training to clinics and provide implementation consultation as needed<br><br>Provide education and information about mental health with information on resources<br><br>Provide free mental health screenings using the PHQ2 (then PHQ9 if +) tool in the community. Provide education and information about mental health with information on resources. |

## FY2022-2024 Community Health Improvement Implementation Plan – Substance Abuse

**PRIORITY AREA: Substance Abuse**

Objectives Supporting SIHIS and The National Prevention Strategy:

1. Increase the proportion of persons who need alcohol and/or illicit drug treatment who received specialty treatment for a substance use problem in the past year
2. Reduce the proportion of persons with alcohol use disorder in the past year

| Annual Objective | Strategy | Target Population | Actions Description |
|---|---|---|---|
| Reduce the Drug-induced death rate<br><br>Increase early intervention, treatment, and management of substance use disorders | Provide education and information to community members on identifying substance abuse issues in the community<br><br>Provide education to licensed providers on scope of opioid crisis and appropriate prescribing practices<br><br>Provide education to school aged students about drug use and healthier coping mechanisms | Faith Leaders, Health Ministry Leaders, Community members in West Baltimore, Partner Schools, Parent groups<br><br>Licensed, prescribing health care providers<br><br>High school students (14-19 yrs.) | Develop and utilize Drug Facts campaign to educate and inform West Baltimore City residents about identification of substance abuse behavior and community resources<br><br>Provide free provider education on scope of opioid crisis and relevant prescribing practices utilizing Centers for Disease Control and/or American Hospital Association best practices standards<br><br>Work with commercial insurers to reduce Co-pay for Narcan<br><br>Link SBIRT program to increase referrals<br><br>Provide an evidence-based, interactive classroom-style, substance use prevention program that focuses on three factors that predict tobacco, alcohol, and other drug use, violence-related behaviors, and other problem behaviors among youth (14-19 yrs.) |

**FY2022-2024 Community Health Improvement Implementation Plan - Maternal and Child Health**

**PRIORITY AREA: Maternal and Child Health**

Objectives Supporting SIHIS and The National Prevention Strategy:

1. Reduce the percentage of births that are low birth weight (LBW)
2. Increase the proportion of pregnant women starting prenatal care in the 1st trimester
3. Ease the transition for families and babies to coordinated pediatric care and increase referrals to the BITP for all newborns with NAS
4. Improve outcomes for pregnancies with substance abuse complications
5. Reduce the child motor vehicle crash related deaths buy increasing Baltimore City family access to affordable car seats

| Annual Objective | Strategy | Target Population | Actions Description |
|---|---|---|---|
| Increase the number of families that participate in the Safe Kids low cost program to put more children in appropriate and safe car seats | Increase awareness and participation in program through partnerships with and referrals from Midtown Peds, WIC, Healthy Start, Head Start, and BCHD programs | Baltimore City families with infants and children through 8 yrs. of age | Safe Kids Baltimore strives to reduce unintentional MVC injuries and deaths through monthly car seat check-up events (pre-COVID), education, and providing the availability of low cost ($40) car seats to families in need |
| Increase parent knowledge and awareness of fire safety, pedestrian safety, child passenger safety and safe sleep for infants, and wheel/helmet safety | Provide prevention education and information on the before mentioned unintentional childhood injury areas via Safe Kids Baltimore programs and events | Parents and children in Baltimore City | Safe Kids Baltimore strives to reduce unintentional childhood injuries and deaths in Baltimore City through free education and training on fire safety, pedestrian safety, child passenger safety, safe infant sleep, and wheel/bike safety |
| Increase the proportion of pregnant women starting prenatal care in the 1st trimester<br><br>Increase the proportion and ease the transition for families and babies to coordinated pediatric care | Liaison for continuity of OB and Pediatric care for families and newborn babies<br><br>Ensure each new mom is set up with a Pediatrician consult<br><br>Moms-in-Training to after the child is born with incentives to attend pediatric appointments and having classes for parents on important pediatric topics, i.e., development, newborn care, feeding, immunizations, handling sick children | Women in West Baltimore Communities delivering at UMMC | Partner with Maryland-Moms-in-Training to engage community and offer free resources and education on breastfeeding |

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|---|---|---|---|
| Improve outcomes for pregnancies with substance abuse complications | Address substance abuse during and after pregnancy | Women in West Baltimore Communities | Partner with UMMC in their various outreach efforts to provide free education and resources around substance abuse during pregnancy<br><br>Conduct feasibility analysis of providing a follow-up program for infants experiencing NAS and their mothers. If feasible, implement program and distribute program information to community partners. |
| Reduce the percentage of births that are low birth weight (LBW) | Enroll pregnant women in the B'More Healthy Babies Program | Women in West Baltimore Communities | Continue support of the B'More Healthy Babies Initiatives |

**FY2022-2024 Community Health Improvement Implementation Plan – Chronic Disease Prevention**

**PRIORITY AREA: Chronic Disease – Cardiovascular Disease/Obesity**

Objectives Supporting SIHIS and The National Prevention Strategy:

1. Reduce household food insecurity and in doing so reduce hunger
2. Reduce the proportion of adolescents (ages 12-19) with obesity
3. Age adjusted mortality rate from heart disease
4. Reduce emergency department visit rate due to hypertension
5. Increase the proportion of adults age 19 years or older who get recommended vaccines
6. Increase the proportion of people with vaccine records in an information system

| Annual Objective | Strategy | Target Population | Actions Description |
|---|---|---|---|
| Increase the proportion of adults who are at a healthy weight<br><br>Reduce the proportion of youth who are obese<br><br>Reduce emergency department visit rate due to hypertension | Provide education and information on the importance of heart healthy lifestyle through engaging, evidence-based programs: Know Your Numbers, Hypertension Screening and Outreach Program, Living Well with Hypertension, Living Well with Chronic Disease, Maryland Healthy Men, BP Hubs | Adults and youth in Priority Targeted zip codes | Engage targeted communities on healthy lifestyles through the sponsorship or provision of:<br>- Community-wide education<br>- Store Tours<br>- Cooking Classes/Demos/ Tastings<br>- Community Screenings and Referrals (Blood pressure, BMI/Weights, and Cholesterol)<br>- Exercise Demonstrations<br><br>Provide Living Well with Hypertension class monthly to community members |

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| | | | Provide *Living Well w/ Chronic Disease* workshop twice/annually<br><br>Develop resource guide (pdf) to be used on website and for community events<br><br>Provide info on healthy weight resources at every major outreach event:<br>- Fall Back to Good Health<br>- B'More Healthy Expo<br>- Lexington Market Monthly Health Fair<br>- Mobile Market<br><br>Deploy Blood Pressure Hubs in the community in barber/ beauty shops and churches<br><br>Continue the Maryland Healthy Men hypertension program with 50 men/yr |
| Increase the variety of fruits and vegetables to the diets of the population aged 2 yrs. and older<br><br>Increase healthy food access | Through engaging, evidence-based programs:<br><br>1) Improve access to variety of fruits and vegetables: Farmer's Market, UMMC Mobile Market<br><br>2) Promote awareness of healthy ways to prepare fruits and vegetables: Kids to Farmer's Market, Fruits and Vegetables Prescription Program (pilot), Mobile Market, New Food insecurity initiatives (TBD)<br><br>COVID-19 Food distribution | Adults and children | Sponsor UMMC Farmer's Market:<br>- Maintain WIC and SNAP voucher acceptance by vendors<br>- Pilot prescription program promoting consumption of fruits and vegetables purchased at Farmer's Market<br>- Explore additional Farmer's market and food access options for West Baltimore<br>- Provide educational opportunity for local school children to attend Farmer's Market as a field trip<br>- Provide support for local legislation supporting healthy food options and access to fresh fruits and vegetables<br><br>Mobile Market:<br>- Provide access to healthy produce in West Baltimore food deserts by using Mobile Van and Hungry Harvest in West Baltimore sites weekly<br>- Provide educational materials to encourage use and purchasing of fresh produce<br><br>COVID -19 Food Distribution:<br>- Provide meals to family in need by emergency response |

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| Provide expanded COVID-19 immunization access for the pubic in recognized community locations as a key strategy to reduce COVID-19 related illnesses, hospitalizations, and deaths through the reduction of transmission of COVID-19<br><br>Decrease vaccination disparity among minority populations by providing access in West Baltimore neighborhoods, by partnering with trusted community organizations<br><br>Create equitable access for COVID-19 immunization in underserved locations throughout West Baltimore and for identified target populations | Provide COVID-19 vaccine, education, and information to reduce COVID-19 related illnesses, hospitalizations, and deaths through the reduction of transmission of COVID-19 in vulnerable populations across Baltimore City.<br><br>UMMC Mobile Vaccine Equity Clinic | Seniors, Adults and age appropriate children | Vaccine Clinic:<br>- Create a simplified registration process for seniors and individuals with limited access/knowledge to internet access<br>- Provide accessible vaccine clinics in high-populated neighborhoods. |

## FY2022-2024 Community Health Improvement Implementation Plan – HIV/HCV Prevention

**PRIORITY AREA: Chronic Disease – HIV/HCV Prevention**

Objectives Supporting SIHIS and The National Prevention Strategy:

1. Reduce the incidence of HIV infection

Goals of the National HIV and AIDS Strategy (NHAS) and National Viral Hepatitis Strategic Plan:

1. Reduce new HIV/HCV infections. HP2030: 3,835 persons
2. Increase access to care and improving health outcomes for people living with HIV and HCV
3. Reducing HIV-related health disparities
4. Achieve a coordinated response to the HIV epidemic

| Annual Objective | Strategy | Target Population | Actions Description |
|---|---|---|---|
| To reduce new HIV infections by increasing awareness of individuals' HIV status and their risk factors | Provision of free, POC rapid HIV testing at community sites<br><br>Coordination between UMMC and UMB (JACQUES Initiative) to conduct community outreach activities in collaboration with IHV and the UMB Office of Community Engagement to provide HIV and complementary services in areas within the university's strategic area, particularly within Southwest Partnership | High-risk individuals as defined by CDC, particularly African-American, LGBTQ-identified youth living in Baltimore, sex-workers, women, Latinx, and IV drug users | Offer free HIV/ HCV education and screenings at various community sites, programs and events, including use of the UMMC Community Health Mobile Van within various West Baltimore targeted zip codes<br><br>Provide pre and post HIV-test counseling-education, including information and referral to PrEP |
| Increasing access to care | Linkage to Care for newly identified HIV-positive and PPOOC individuals | High-risk individuals as defined by CDC, particularly African-American, LGBTQ-identified youth living in Baltimore, sex-workers, women, Latinx, and IV drug users | Provide coordination of all aspects of linkage to care (e.g. assessment, identification of barriers and strengths, insurance, and medical provider) to ensure that HIV-positive clients encountered in the community have immediate access to care, particularly through C2C (Connect to Care) at THRIVE Clinic |

HTTPS://WWW.CDC.GOV/HIV/PDF/DHAP/CDC-HIV-DHAP-EXTERNAL-STRATEGIC-PLAN.PDF

## FY2022-2024 Community Health Improvement Implementation Plan – Diabetes Prevention

**PRIORITY AREA: Diabetes**

Objectives Supporting SIHIS and The National Prevention Strategy:

1. Increase the proportion of adults who are at a healthy weight
2. Reduce diabetes-related emergency department visits
3. Reduce household food insecurity and in doing so reduce hunger
4. Increase the proportion of persons with diagnosed diabetes who ever receive formal diabetes education

| Annual Objective | Strategy | Target Population | Actions Description |
|---|---|---|---|
| Increase diabetes awareness and healthy lifestyles to prevent and manage diabetes | Engage the church in a variety of year around activities to improve health of church members living with diabetes and their families | Adults and youth in six church communities within the targeted zip code | Offer six educational workshops, then a support group 1x/month for 9 months following the workshop series<br><br>Each workshop is 1-1.5 hours<br><br>Content areas: Diabetes Basics, Fitness, healthy eating, Heart health, Diabetes prevention for children |
| Increase the proportion of adults who are at a healthy weight<br><br>Provide three cohorts of DPP/annually | CDC Diabetes Prevention Program (DPP) | Adults in Priority Targeted zip codes | Offer the CDC National Diabetes Prevention Program: for people at risk with diabetes<br><br>16-week program and a monthly post core follow-up |
| Increase the variety of fruits and vegetables to the diets of the population aged 2 yrs. and older<br><br>Increase healthy food access | Improve access to variety of fruits and vegetables<br><br>Promote awareness of healthy ways to prepare fruits and vegetables | Adults and children | BDS Healthy Aging Networks<br><br>Monthly series on *Fruits and Veggies Matters* with basket of produce. Cooking demo.<br><br>The goal of this series is to increase intake of produce of the participants<br><br>Each seminar will identify fruit and vegetables of the season and feature a recipe will be provided. The participants will be challenged to try a new fruit and or vegetable and create a new recipe. |
| Decrease food insecurity in the diabetes population served at UMCDE | Therapeutic Food Pantry Access | Positive screening for food insecurity while living with diabetes | Providers and MAs will screen for food insecurity at office visit<br><br>If positive for food insecurity, CHW will provide a bag of food<br><br>The patient will be contacted monthly for a bag of groceries |

## FY2022-2024 Community Health Improvement Implementation Plan – Violence Prevention

**PRIORITY AREA: Violence Prevention**

Objectives Supporting SIHIS and The National Prevention Strategy:

1. Reduce the domestic violence rate
2. Reduce homicides
3. Reduce firearm-related deaths
4. Maintain the low rate of recidivism for VIP participants due to violent injury. (VIP FY17 Performance = < 1.3% ➢ 2021 Target: < 1%)

| Annual Objective | Strategy | Target Population | Actions Description |
|---|---|---|---|
| Reduce the rate of recidivism due to violent injury and domestic violence | Deliver service and intervention via evidence-based, hospital-integrated programs:<br><br>Violence Intervention Program and Bridge Program | Patients admitted to UM Shock Trauma Center due to violence > 15 yrs. Participants include victims of assault, intimate partner violence, gunshot wounds, and domestic violence related incidents. | **VIP** provides intense, post-discharge, trauma-informed case management services to improve health outcomes, increase pro-social and protective supports, and decrease risk for recidivism for violent injury<br><br>- Violence Prevention Specialists enroll patients of violent injury at the bedside in STC and in the EDs<br><br>- Community Trauma Responder provides support and resources to secondary victims and communities exposed to trauma and violence<br><br>- Participants are individual therapy and peer support<br><br>- Participants receive services to help with employment, housing, mental health, substance abuse, physical health, and interpersonal skills<br><br>Bridge Program provides crisis intervention, safety stabilization, and targeted case management to help participants achieve goals of independence, safety, and self-sufficiency<br><br>- Advocates offer 24/7 response to anyone on campus affected by IPV |

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| | | | - Interventions include safety planning, ongoing therapy, and case management<br><br>- Participants benefit from Court accompaniment and legal advocacy<br><br>- Participants receive services to help with employment, housing, mental health, substance abuse, safety planning, and interpersonal skills |
| Promote primary prevention activities for risky behaviors, unhealthy relationships, and the effects of trauma in youth and youth-serving populations | Deliver workshops, presentations, lectures, guest speaking, and group facilitation to youth and youth-impacting audiences impacted by risky behavior, violence, and trauma | Youth and youth-serving individuals on campus and in the adjacent communities | Curriculum: Youth Injury and Violence Prevention |
| Identify underlying causes of violence and effective interventions | Publish peer-reviewed research focused on violence prevention and intervention | Violence prevention, public health, and research community | Facilitate the operations of the Violence Intervention Research Group on campus, and support efforts to move research endeavors and projects forward |

MARYLAND STATE HEALTH IMPROVEMENT PROCESS WEBSITE: HTTP://SHIP.MD.NETWORKOFCARE.ORG/PH/SHIP-DETAIL.ASPX?ID=MD_SHIP12

CALCULATED FROM 342 DEATHS IN 2017 (1F)

HTTPS://WWW.HEALTHYPEOPLE.GOV/2020/DATA/MAP/4768?YEAR=2015

**FY2022-2024 Community Health Improvement Implementation Plan – Local Hiring/Career Advancement**

**PRIORITY AREA: Local Hiring/Career Advancement**

Objectives Supporting SIHIS and The National Prevention Strategy:

1. Lay the foundation for a healthier and more vibrant community, expanding economic opportunity for residents experiencing the greatest barriers to employment
2. Prepare West Baltimore residents for high-demand jobs through training and skills development, and then provide specific entry points for those candidates
3. Connect hires, and other frontline workers, to clear pathways for career advancement within UMMC
4. Improve employee retention and job performance of entry-level workers

| Annual Objective | Strategy | Target Population | Actions Description |
|---|---|---|---|
| Career Advancement | UMMC managers and supervisors have indicated the need for training for incumbent employees who may be new to the workforce or recently re-entered society<br><br>Microsoft Training is technology-focused skills enhancement to train employees and community members in Word, Excel, PowerPoint, Outlook and internet research to equip them with the computer skills required in today's workplace. Training will take place as part of the Southwest Partnership grant obtained in September 2020 and continue as an Academy initiative.<br><br>As we engage with the community to improve community health and wellbeing, our goal is to help build an inclusive and sustainable West Baltimore. UMMC partners with community-based workforce organizations to | The goal is to retain employees (incumbent workers) hired (1st year) through UMMC community partners<br><br>West Baltimore residents hired through our Workforce Training Partnership Programs<br><br>Residents with the most significant barriers to employment including underserved community members, financially fragile community members, returning citizens, recipients of government assistance | Rising Star and Career Coaching focuses on enhancing entry-level employee engagement, improving job readiness skills, reducing turnover, and increasing productivity through training, mentoring, and coaching. New hires and incumbents are coached in career pathways, professionalism, employer expectations, and overall competencies. Employees are referred from their manager or HR Business Partner and will be case managed by Career Academy staff.<br><br>Pathways to Success encompasses a comprehensive review of basic adult education (GED) and college prep (ACCUPLACER) classes. The goal is to prepare individuals for the workplace and higher education by removing promotional barriers. Employees who are hired through a community partner will be evaluated and referred to appropriate classes by the Career Academy staff. |

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|---|---|---|---|
| | provide youth and adults with programs that lead to employment and career advancement. Workforce goals are to build a pipeline of qualified health care workers by leveraging strategic partnerships, removing barriers, and providing advancement opportunities through talent acquisition, career advancement, workforce development, and resource provision. | | |
| Talent Acquisition | UMMC partners with over 30 community organizations that provide various resources to assist West Baltimore residents in obtaining employment. UMMC Human Resources and the Workforce Development offices conduct resource events, informational sessions, speed interviews, and feedback to community partners from referrals made to the hospital. The goal is to hire 250 West Baltimore employees through community partners.<br><br>Satellite Center support will be provided for community partners to enhance workforce development in established centers within the eight target zip codes. Those centers include the UMMC Midtown Campus Outpatient Center (scheduled to open in 2021), the UMB Community Engagement Center and McCulloh Homes (expected to open in 2021). | - Unemployed and underemployed West Baltimore Community Members<br><br>- Returning Citizens and Ex-Offenders<br><br>- Displaced and dislocated adults and career-switchers<br><br>- Baltimore City Public High School Students/Partnership High School Students<br><br>- Opportunity Youth from targeted zip codes<br><br>- Local College and University students<br><br>- Parents from Partnership Schools<br><br>- UMMC employees seeking career advancement and upskilling opportunities | Knowledge Empowers Youth Success (K.E.Y.S.) CNA to BSN with partner high schools<br><br>Edmondson Westside H.S. and Vivien T. Thomas Medical Arts Academy, students will participate in a bridge program to foster the recruitment and development of CNA students who are pursuing careers in Nursing. The Academy will work with the identified schools to recruit UMMC employees, upskill incumbent workers and expose employees to career growth opportunities in Nursing.<br><br>Careers in Healthcare Pathways Training (Multi-Skilled Medical Tech, PCT, Pharm Tech, Surgical Tech, Medical Assistant) will increase the number of new hires pipelined from workforce training partners who receive credential/skilled training by enrolling 50 community members in a career in health care occupational skills training. The Career Academy will partner with schools and organizations that offer the specified occupational skills. |

**FY2022-2024 Community Health Improvement Implementation Plan – Pediatrics Mental Health**

**PRIORITY AREA: Pediatrics Mental Health**

Objectives Supporting SIHIS and The National Prevention Strategy:

1. Increase the proportion of children with mental health problems who receive treatment
2. Increase the number of children who receive preventative mental health care in schools

| Annual Objective | Strategy | Target Population | Actions Description |
|---|---|---|---|
| Increase the proportion of children with mental health problems who receive treatment<br><br>Increase the number of children receiving preventative mental health care in schools<br><br>Increase awareness in the community of mental health | Provide education and information to community members on identifying mental health problems<br><br>Increase funding to school mental health programs in partner schools and Family Connections Program<br><br>Provide education and to community members | West Baltimore Youth<br><br>West Baltimore | Trauma Informed-Care/ Specific Interventions. Utilizing evidence-based programs to address specific needs identified in partner schools in West Baltimore and UMMC pediatric psychiatry clinics; Family Connections Program.<br><br>Co-sponsor Mental Health Conference annually for the community at large |
| Partner with Baltimore City Hospitals on one mental health initiative annually | Partner with the Baltimore City Trauma Informed Care Task Force | Baltimore City | Partner with the City of Baltimore Trauma Informed Care Task Force and implement recommended strategies |

**FY2022-2024 Community Health Improvement Implementation Plan – Pediatrics Asthma**

**PRIORITY AREA: Pediatrics Asthma**

Objectives Supporting SIHIS and The National Prevention Strategy:

1. Reduce emergency department visits for children over 5 years of age with asthma

| Annual Objective | Strategy | Target Population | Actions Description |
|---|---|---|---|
| Pediatrics Asthma Needs Assessment and Community Engagement | Surveys, Zoom and in person individual and focus group meetings | Asthma Caregiver/ Providers/ Community/Leaders | Obtain feedback regarding current asthma services and identify unmet needs |
| Reduce Asthma Hospitalizations and ED visits | UMCH Pediatric Asthma Program Team Clinical Component | Patients seen in the PED and hospital for asthma<br><br>BCPS children with asthma (targeted zip codes) | Identify children in need of services through Asthma RN, review of daily Epic reports, BCHD-CAP referrals, BCPS asthma screening tool and PCP/ Community/Self-referrals<br><br>Asthma RN triages patients for inpatient consults and/or outpatient specialty care through Pulm/Allergy/Breath-mobile in person and/or Telemed service |
| Increase Asthma Awareness and Education | UMCH Pediatric Asthma Program Team Educational Component | Children with asthma and caregivers, PCPs, trainees, BCPS school personnel and general public | Provide asthma education at appointments, "Back to school" nights and health fairs. Develop on line educational resources.<br><br>Provide didactic lectures in person and by webinars<br><br>Certified Asthma Educator (CAE) certification of team |
| Coordination with other UMMC Community Programs to provide resources to address factors impacting asthma control:<br><br>- Adherence<br><br>- Environmental Exposures<br><br>- Obesity<br><br>- Psychosocial factors<br><br>- ACEs | Asthma Program RN and Social Worker<br><br>BCHD-CAP program<br><br>UMMC Community Program | Children and their families in need of additional Support/ Resources | Asthma Program Team Members identify need* for additional services and notify Asthma RN and/or Social Worker for assistance and referrals if indicated<br><br>Asthma RN makes reminder Calls/Texts to PTs for appointments and sets up medication reminder system ("Asthma Storylines" app)<br><br>*Includes screening surveys at appts for maternal depression and ACEs |

## FY2022-2024 Community Health Improvement Implementation Plan – Pediatrics Obesity

**PRIORITY AREA: Pediatrics Obesity**

Objectives Supporting SIHIS and The National Prevention Strategy:

1. Reduce the proportion of children and adolescents with obesity
2. Reduce the consumption of calories from added sugars by persons aged 2 yrs. and over
3. Eliminate very low food security among children

| Annual Objective | Strategy | Target Population | Actions Description |
|---|---|---|---|
| Eliminate very low food security among children | Provide Food Pantry option to Patients and Community at Midtown, General Pediatrics Practice | Children and families in Baltimore City<br><br>Children with BMI over the 95th percentile for their age | Through outreach, provide the community with resources directing them to wellness visits to see a pediatrician and upon their first visit, they will be offered a voucher to the pantry<br><br>Expand these services to include the Mobile Market, which could offer fresh fruits and veggie options. Days they park at Midtown we could offer free community pediatric obesity screenings.<br><br>Strengthen partnership with existing community outreach initiatives and efforts directed at addressing food insecurities |
| Reduce the proportion of children and adolescents with obesity<br><br>Reduce the consumption of calories from added sugars by persons aged 2 yrs. and over | Provide Free Dietician and Social Work Support to increase resources in supporting a holistic approach to obesity and eliminate barriers to access | Children and families in Baltimore City<br><br>Children with BMI over the 95th percentile for their age | Through outreach, provide community with meet and greets, Q&A, free screenings and direct them to visits to see a pediatrician and coordinated visit with a dietician and social worker to support their clinical outcomes<br><br>Offer larger complement of services through stronger partnerships with the community, such as UMCDE by having a bridge with social work and dietician services |


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