UNIVERSITY of MARYLAND
REHABILITATION &
ORTHOPAEDIC INSTITUTE

Hospital Implementation Strategy | 2024

This is the hospital specific implementation strategy for the University of Maryland Rehabilitation & Orthopaedic Institute (UMROI) and addresses the community health needs identified through a collaborative community health needs assessment (CHNA) process conducted with local and regional partners. This document outlines plans for UMROI to support specific community benefit efforts as part of a larger community-wide and system plan.

OUR COMMUNITY AND KEY PARTNERS

University of Maryland Rehabilitation & Orthopaedic Institute Community

The University of Maryland Rehabilitation & Orthopedic Institute (UM Rehab and Ortho) is Maryland's largest and most comprehensive rehabilitation and orthopedic specialty hospital and has been serving Maryland for more than 120 years. The highly specialized staff provides an interdisciplinary continuum of care, with four distinct rehabilitative specialty units including Stroke, Brian Injury, Spinal Cord Injury/Multi-Trauma, and Comprehensive Medical Rehabilitation in a restorative environment. The University of Maryland Rehabilitation & Orthopedic Institute is a leader in the research and treatment of musculoskeletal disease, joint replacement, and sports injuries.

The University of Maryland Rehabilitation & Orthopedic Institute is licensed for 140 beds. In FY2024, UM Rehab provided care for 1,893 inpatient admissions, 3,497 outpatient surgical cases, 40,960 outpatient visits and 5,768 dental visits.

Community Health Needs Assessment

Process and Product

The University of Maryland Rehabilitation & Orthopaedic Institute community health needs assessment (CHNA) was conducted in partnership with several local health organizations came together as the CHNA Collaborative to help develop this CHNA, including:

- Ascension St. Agnes Hospital
- Baltimore City Health Department
- Johns Hopkins Health System
- Lifebridge Health
- Medstar Health
- Mercy Medical Center
- Mt. Washington Pediatric Hospital
- University of Maryland Medical Center

This written report describes:

- The community served
- Community demographics
- Existing health resources in the community available to respond to needs
- How data was collected in the assessment process
- The priority health needs of the community
- Health needs and issues of uninsured, low-income, and minority groups
- The process for identifying and prioritizing community needs and services to meet the needs
- The process for consulting with persons representing the community's interests

Sharing Results

Detailed findings for our assessment are posted on the UMROI website *https://www.umms.org/rehab/*. The CHNA was presented to the UMROI on August 14, 2024 for discussion and approval.

PRIORITY HEALTH NEEDS & HOW THEY WERE ESTABLISHED

Prioritization Process

Process & Criteria

Since a large number of individual data measures were collected and analyzed to develop these 20 focus areas, it was not reasonable to make each of them a priority. The CHNA Collaborative considered which focus areas had data measures of high need or worsening performance, priorities from the primary data, and how possible it is for health departments or hospitals to impact the given need to help determine which health needs should be prioritized. Once the primary and secondary data had been grouped into the focus areas detailed in Appendix 3, the CHNA Collaborative used a polling software to evaluate and prioritize the city's health needs while considering the following factors:

- Size and scope of the health need;
- Severity and intensity of the health need;
- Whether possible interventions would be possible and effective;
- Health disparities associated with the need; and
- Importance the community places on addressing the need

The final priority need areas were not ranked in any particular order of importance, and each will be addressed by the Collaborative. The following three focus areas (mental health, chronic health conditions and access to care) were identified as the City of Baltimore's top priority health needs to be addressed over the next three years,

Identified Priorities

The following priority health issues are the final community-wide priorities that were selected through the process described above:

- Priority 1 – Mental Health

During the CHNA process, some community health data was broken down by age, gender, race and ethnicity, in order to further determine specific need in populations. When reviewing responses identifying the top 5 community health needs, white respondents were more likely to rank mental health as a top concern (45%) when compared to Black (38%) or Hispanic (39%) respondents. Female respondents also ranked mental health higher than male respondents (40% vs. 36%). When breaking down the responses by age group, younger respondents ranked mental health higher than their older counterparts, with those between the ages of 30-39 ranking mental health the highest (53%).

Initial responses related to individual mental health concerns were largely positive, with nearly half of respondents (42.2%) reporting that they had not experienced any poor mental health days the prior 30-day period. Conversely, just under half of respondents reported that they had experienced between 1 and 10 poor mental health days in the previous month (44%), and an additional 14% reported having poor mental health on 11 or more days in the previous month. While the majority of Baltimore City residents reported fewer poor mental health days than the state average (4.1 days per month), a significant proportion of residents (14%) spent more than one-third of the month experiencing mental health concerns.

- Priority 2 – Chronic Health Conditions

Chronic health conditions are illnesses that affect a person for one year or longer, and may require ongoing medical care or limit one's ability to live their daily life. As society has changed and people live longer, chronic health conditions have become more common than communicable diseases like typhoid and cholera. According to the WHO, chronic diseases are influenced by a combination of genetic, environmental, psychological, or behavioral factors.

- Priority 3 – Access to Care

Access to care means patients are able to get high quality, affordable healthcare in a timely fashion to achieve the best possible health outcomes. It includes several components, including health coverage (i.e. insurance), a physical location where care is provided, the ability to receive timely care when needed, and enough providers in the workforce. The CHNA Collaborative identified access to care as a high priority need for residents of Baltimore City.

From a national perspective, according to Healthy People 2030, approximately one in ten people in the U.S. do not have health insurance, which means they are less likely to have a primary care provider or to be able to afford the services or medications they need.24 Access challenges are a concern even for those who do have health insurance.25

Throughout the primary and secondary data findings below, various SDoH emerged as areas of priority need for Baltimore City. Specifically, based on these findings, key concerns include dynamics related to food insecurity, violence and neighborhood safety, affordable housing, and transportation. City health leaders will continue to evaluate their potential to play a role in impacting these domains in the years to come.

How This Implementation Strategy Was Developed

Engagement in a Community-Wide Plan

As a next step following the development of a community health needs assessment (CHNA), which includes prioritization of health needs, UMROI collaborated with local public health experts and other key community stakeholders to develop a written description of the activities that hospital facilities, public health agencies, and other local organizations plan to undertake collectively to address specific health needs in our community. This collaborative action planning process will result in the development of a community health improvement plan (CHIP) for each county in our defined community, which include

IMPLEMENTATION STRATEGY DETAILS

Priority Health Issue #1: *Mental Health*

Desired Community Result

1) Our transitional care coordinator (TCC) program provides consultation post discharge to provide resource assist for:
    a. Follow up medical appointments.
    b. Financial assistance
    c. Transportation
    d. Home Health services
    e. Substance Abuse Disorder Treatment
2) Success is noted by low hospital readmission rate. Support services are important to assist patients and families post discharge in multiple areas of need.

Description of Community Need

1) Patients post stroke, brain injury, spinal cord injury, traumatic injuries, organ transplants and amputation often require assistance to gain access to medical appointments and various support services post discharge.

Partner Agencies and Roles

The TCC team partners with various entities that provide resources to patients. These include, but are not limited to transportation services, various PCP offices, financial assistance services, food resourcing, home health agencies and entities providing needed equipment.

Related Hospital Strategies

FY2024 Priority Area 1 Transitional Care Coordinator Services
Population Level Data:
We monitor the readmission rate to acute care hospitals within 30 days of discharge.
Collaborative Efforts:

Our teams, including but not limited to nursing, medical, therapy, and case management, make referrals to our transitional care team when a patient is identified as high risk for readmission secondary to complexity of their diagnosis, limited family support and/or working caregivers.	
Implementation Strategy	
Member Organization Strategy	**Evaluation**
Strategy 1 Provide transitional navigation Services	***How much did we do?*** *# of patients navigated to successful graduation,* ***How well did we do it?*** *# of navigated patients who graduated/all navigation referrals Additionally: # of graduated navigated patients/ all patients enrolled.* ***Is anyone better off?*** *Readmission rate for navigated patients.*

Our strategy is to provide transitional navigation services to any patient referred who is accepting of the service. Last year, 95% of our patients were enrolled in transitional care services although only 77% completed the episode. Our goal in FY25 is to increase the number of patients successfully completing the program to serve additional patient needs and prevent additional readmissions.

Priority Health Issue #2: Chronic Conditions: Diabetes

Desired Community Result

3) Reduce the hospital disparity in out-of-range A1C between non-Hispanic White patients to non-Hispanic Black patients 6 months post discharge from inpatient rehabilitation services.

Description of Community Need

- Some patients (especially those uninsured, undocumented, and unhoused) are admitted without primary care providers. In addition, some patients may have difficulty finding transportation to their PCP's secondary to changes in their physical status post discharge from UMROI.
- Some patients may not have had access to diabetes education services prior to admission, they may also have a limited awareness of their A1C. Complicating these factors, many patients at UMROI may have altered cognitive and physical status post-stroke and have new or changed diabetes education needs.
- SDOH screening results indicate that our patients indicate the biggest need for transportation resources, followed by food resourcing. Transportation is challenging post-stroke to access MD, pharmacy, and health food sources secondary to a change in physical status (i.e., wheelchair bound). In addition, healthy food is difficult to find in some food deserts and there is sometimes a cultural perception difference in what foods are healthy.

Partner Agencies and Roles

This effort partners with Hungry Harvest to provide 1 health food share either from our onsite market or delivered to their home post discharge.

Related Hospital Strategies

FY2024 Priority Area 1 Diabetes Disparity	
Population Level Data: We monitor A1C at admission to the CVA unit and again 6 months post discharge (through EPIC and CRISP records). **Collaborative Efforts:** Collaboration begins on our inpatient stroke unit where the patients are identified, seen by a diabetes educator, and selected for a food donation if their A1C is >9% at admission and they are discharging to home. Our transitional navigation team also may navigate on patients deemed complex to provide follow up and assist to ensure proper Primary Care Provider/endocrine visits after discharge as well as transportation and any financial need resources.	
Implementation Strategy	
Member Organization Strategy	**Evaluation**
Strategy 1 ***Transportation Assist:*** *Provide early applications for transportation services & transportation assistance fund, to patients with Stroke and Diabetes to ensure attendance at a first primary care provider visit within 30 days of hospital discharge.*	***How much did we do?*** *# patients missing PCP visit secondary to lack of transport.* ***How well did we do it?*** *# patients requiring funding to access cab services for first PCP visit/ total admissions/total number of home discharges* ***How well did we do it?*** *# of patients missing PCP visits secondary to transport/total discharges* ***Is anyone better off:*** *# of patients discharged to home, with stroke and A1C>9%, that had a lower A1C 6 months post discharge/ # of patients with A1C > 9 at admission and discharged to home*
Strategy 2 ***Food Resourcing:*** *Increase food resourcing with community resource finder and through Hungry Harvest shares at discharge. Hungry Harvest holds a low-cost, fresh produce market, every Thursday afternoon. We give a free bag of fresh produce to patients discharging on Thursdays and Fridays to jump start their healthy eating upon arriving home or send a box of fresh produce to their home if discharging on other days (new Nov 2024)*	***How much did we do?*** *# of food donations provided to patient with stroke, accepting donations./total stroke admissions* ***How well did we do it? #*** *Food donations given to pts with stroke who are discharged home/ of total stroke unit admissions (not all having a diabetes diagnosis.)* ***Is anyone better off?*** *#of patients discharged to home, with stroke and A1C>9%, that had a lower A1C 6 months post discharge/ # of patients with A1C > 9 at admission and discharged to home*

Strategy 3 *Diabetes Educator Access:* *Provide access to a diabetes educator during the inpatient hospital stay.*	***How much did we do?*** *# diabetes educator visits hospital wide and # of visits on stroke unit;* ***How well did we do it?*** ***#*** *of patients with diabetes educator visit/total hospital admissions; # of patients on stroke unit with diabetes educator consult/total stroke unit admissions.* **Is anyone better off?** *#of patients discharged to home, with stroke and A1C>9%, that had a lower A1C 6 months post discharge/ # of patients with A1C > 9 at admission and discharged to home*
Strategy 4 *Transitional Navigation Services:* *Patients are offered navigation services to assist with timely primary care medical visits as well as transportation and financial assistance resourcing. Navigators often help with pharmacy connections to successfully obtain needed diabetes medications and testing tools for patients once home.*	**How much did we do?** ***#*** *patients navigated and "graduated" from the program* **How well did we do it?** ***#*** *of all patient admissions completed the navigation program./# of patients referred to navigation.* **Is anyone better off?** *#of patients discharged to home, with stroke and A1C>9%, that had a lower A1C 6 months post discharge/ # of patients with A1C > 9 at admission and discharged to home.*

- UMROI selected two primary strategies to impact A1C disparity in our patients; transportation and food resourcing, using the Specificity, Leverage, Value, and Reach (SLVR) criteria – i.e., the two strategies with the greatest *specificity* (clear who, what, when, where how), *leverage* (power to turn the curve), *value* (consistent with community values), and *reach* (feasibility and affordability). In addition, the hospital continues to make diabetes education available to our patients to address the health need of more controlled, less out of range, diabetes statuses for our patients. We anticipate that as we continue to emphasize early PCP visits with viable transportation support and healthy food resourcing, that we will see a continued drop in A1C in patients 6 months post discharge. Our goal in the next fiscal year is to build on last year's success and to use navigation and follow up outpatient therapy visits to encourage continued patient follow up with their physicians and reduce those patients lost to follow up. We are engaged in system wide Results-Based Accountability quarterly monitoring of this effort.

Figure 3

Priority Health Issue #3: *Access to Care*

Description of Community Need

Dental services are provided for special needs adults and children who may not receive care otherwise. Many dentists in the community are not comfortable performing dental services to disabled patients.

Desired Community Result

Increase the number of dental treatments available to special needs population. Also, increase awareness of proper brushing, flossing, home care, and proper diet of patients that had comprehensive treatment under general anesthesia

FY2025 Priority Area #3 Access to Care	
Collaborative Efforts: UMROI will collaborate with the University of Maryland Dental School in providing these services.	
Implementation Strategy Update	
Member Organization Strategy	**Evaluation/Note**
Strategy 1: Provide dental care and treatment for special needs adults and children within Maryland: UM Rehab & Ortho Dental Clinic	***Reach:*** *# of patients served (Adults & Children)* ***Outcomes:*** *% of patients receiving preventive dental care.* *% of high caries risk patients that had treatment under general anesthesia that return for 3 month recall over a one year period that will have no new lesions.*

NEXT STEPS

As part of the community health improvement process, UMROI will continue to work with community partners in the development, implementation, and monitoring of our collaborative community health improvement plan (CHIP) that includes some of the hospital strategies outlined in this document. The next community health needs assessment (CHNA) will be conducted in FY 2027. As a note, this implementation is dynamic in nature and reflective of the communities that we serve and partners that we work with. Strategies may change in scope or fluctuate accordingly based on the aforementioned.

APPROVAL

This report was prepared for the November 25, 2024 UMROI Governing Board meeting, and is approved as signed below by the Board Chairperson and Hospital President.

Davis Sherman, Board Chairman

11/25/2024

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Date

Julie Nemens Chief Administrative Officer

11/25/2024

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Date