MedStar Health

Improving the health of the communities we serve in Baltimore.

The impact of philanthropic partnerships on the H.E.A.R. Institute, Collaborative Care Program, and Food Rx Program at MedStar Good Samaritan Hospital

Commitment to the communities we serve

At MedStar Health, we recognize that a person's health is interwoven with the health of their community. Various life factors, or social determinants of health, including physical, social, and economic challenges—such as access to housing, transportation, and employment—all play a major role in how healthy a person can be. In a city frequently faced with negative health outcomes, food insecurity, and a lack of socioeconomic mobility, our teams work to improve health equity by supporting those demonstrating the greatest need in Baltimore City.

With generous support from philanthropic partners, our experts at the Health Economics and Aging Research (H.E.A.R.) Institute at MedStar Health supported the design and implementation of our new evidenced-based programs, the Collaborative Care Program and the Food Rx program, to address these critical health and social challenges for our communities. Together, these programs evaluate best practices with data-driven solutions to improve health and reduce cost for our patients.

Statistics about the people for whom we care

- **133,000+** residents live below the poverty line
- **50%** of residents live in deep poverty
- **22.6%** of residents are food insecure
- **Three out of four** older adults are managing two or more chronic conditions
- The number of older adults living with multiple chronic conditions is projected to **quadruple** by 2030

"Collectively, the H.E.A.R. Institute, Collaborative Care Program, and Food Rx program have developed a team of people whose mission is to care for and about patients. They have identified the most important barriers that prevent patients from getting good health care. Through research we are refining new care models and programs. We are focused on improving access to the highest quality of care while reducing cost, and philanthropic partners are helping us accomplish our mission."

Dana Frank, MD, FACP
Chairman of Medicine
MedStar Good Samaritan Hospital
MedStar Union Memorial Hospital

The Health Economics and Aging Research (H.E.A.R.) Institute at MedStar Health

The focus of the H.E.A.R. Institute extends beyond today's best practices in health care; our teams identify and deploy research discoveries across a variety of care settings, reaching a large number of diverse patients. The goal is to understand how innovations in care delivery can be most effectively and rapidly disseminated to improve health outcomes. An expert team of economists, data scientists, and clinicians work together to improve care for Baltimore residents while working to steward the financial resources of patients and reduce the total cost of care.

Through the H.E.A.R. Institute, teams have designed and implemented two evidence-based clinical programs that reduce the total cost of care for patients and improve access and coordination of essential health and social services for patients in Baltimore City. The **Collaborative Care Program** and **Food Rx** program were born out of research efforts started at the H.E.A.R. Institute.

As these programs evolve, patient outcomes are continuously evaluated to inform program refinements and serve as rationale for future expansion efforts. Metrics include patient satisfaction scores, reductions in acute care utilization, and the cost of care for patients and their families, as well as for the health system. Additional evaluation will include the impact of programs on patient outcomes, such as confidence in managing chronic conditions, experience of care, and quality of life.

Addressing patients' complex health concerns: the Collaborative Care Program

Part of the Good Health Center at MedStar Good Samaritan Hospital, the Collaborative Care Program offers an integrated model of specialty and behavioral health care that focuses on social determinants of health and behavioral change. The comprehensive chronic disease management program was designed to provide innovative patient and family-centered care to those living with multiple complex chronic conditions and has been providing essential health services to the patients who need it most.

The Collaborative Care Program, through philanthropic and community partnerships, supports many people in the community who suffer from chronic diseases by offering a single location that provides comprehensive, coordinated care and centralized services. Rather than requiring patients to make multiple follow-up care appointments, the clinical team goes to the patient and family, providing continuity of care from the hospital to the community. These patients have frequent hospital admissions and emergency department visits due to multiple social barriers to healthcare, including limited income, lack of transportation, and an inability to access healthy foods. This multidisciplinary approach helps target each of these needs and addresses these barriers.

Patient snapshot

- **181** patients were served from March through December 2021
- **77%** are Black patients
- **57%** are over 60 years of age

"This program places the patients and their families at the center of care to ensure they get the comprehensive services they need from a multidisciplinary team with extensive experience managing complex conditions. What differentiates this program is that it fully integrates the clinical and social aspects of medicine to create a truly collaborative chronic disease management plan."

Malek Cheikh, MD
Medical Director, Good Health Center
MedStar Good Samaritan Hospital

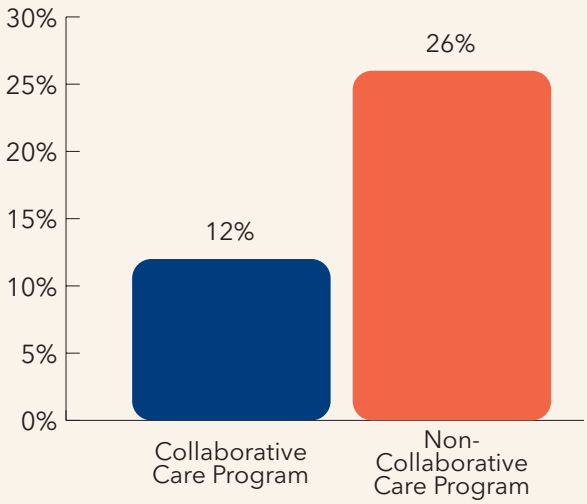
This comprehensive model addresses a wide variety of needs, both medical and social, culminating in management plans that are as unique as each patient that is served. In collaboration with the H.E.A.R. Institute, the aim is to improve outcomes, eliminate barriers to health care, and lower costs for patients by reducing hospital readmissions for their chronic conditions. As of March 2022, 124 patients have been connected to key resources, such as diabetes and medication management education, Maryland Transit Authority Mobility services, and clinical referrals.

"I have cared for patients both in and out of the hospital for over 40 years. This is the first time I have had the chance to work with such a coordinated care team that includes, dietary, social work, community health, physician assistants, and nurse practitioners. I see the impact that my colleagues in the Collaborative Care Program have on a patient's well-being both in the present and in the future. These resources allow us to overcome so many barriers that previously prevented improving the health of our patients."

Herbert Friedman, MD, MBA, FCCP, FACP
Associate Medical Director
Collaborative Care Program
MedStar Good Samaritan Hospital

Readmission rates

Among patients who received care in the Collaborative Care Program after a recent hospitalization, only 12% returned to the hospital within 30 days. Among similar high-risk patients who did not receive care in collaborative care, 26% returned to the hospital. **Collaborative care patients had 46% fewer readmissions than non-collaborative care patients.**



Uncontrolled diabetes successfully addressed

Our program cared for an 84-year-old man with uncontrolled diabetes and frequent congestive heart failure exacerbations. He had general mistrust of the healthcare system and did not take his medications regularly. When he started with our program, he had significantly lower extremity edema, shortness of breath, and hyperglycemia. We saw him once a week and arranged his pill box each visit, and with the simple intervention of frequent weekly visits and taking medications regularly, we saw an improvement in his overall symptoms. With our support, he was no longer at risk of being hospitalized from uncontrolled diabetes.

Malnourishment and transportation issues resolved

A 68-year-old male patient had difficulty accessing food and transportation. He was malnourished at the time of his initial consultation because he was unable to prepare foods at home, especially meals that were beneficial for his diagnosis. Our team set him up with Meals on Wheels of Central Maryland™ to receive prepared meals delivered to his home that only required minimal reheating. He was also enrolled in Maryland Transit Authority mobility and Call-A-Ride (taxi access) services, and we assisted him in scheduling transportation so that he could attend upcoming appointments.

Addressing issues of food insecurity and chronic disease: the Food Rx program

With the generous support of our philanthropic partners, the team launched a first-of-its-kind program in the region. This new Food Rx program is designed for adult patients with Type 2 Diabetes, heart failure, and food insecurity. Patients receive ongoing one-on-one care, education, consultations by a community health advocate and dietitian, and customized, healthy food options at no cost. Based out of the new Collaborative Care Program site, Food Rx offers food storage and safe pickup and delivery options—ultimately removing transportation barriers and increasing access to health care and food.

"Many chronic conditions, such as diabetes, can be better managed by following a specific diet. Unfortunately, a lot of patients with these conditions have limited budgets and cannot afford the fresh and nutrient-rich foods they need. Through this initiative, we are able to 'prescribe' and supply them with the type of meals that will help keep their disease under control."

Lucas Carlson, MD, MPH
Regional Medical Director, Care Transformation
MedStar Health

The Food Rx program provides integrative solutions to addressing chronic disease and disease management, resulting in positive clinical outcomes, increased food access, and decreased medical expenses. Guided by a culture mindset that recognizes larger systemic barriers to health equity, the program connects patients to holistic community resources and supplemental educational opportunities. These opportunities are provided through MedStar Health and a robust network of community and corporate partners, including The Y of Central Maryland, Hungry Harvest, Maryland Food Bank, Sodexo®, and the American Heart Association®.

The Food Rx program provides patients and their families with medically tailored meals in addition to healthy one-on-one nutrition coaching and cooking education programs. Each week, patients receive food to prepare two healthy meals a day for five days, and in total, each patient receives over 20 hours of diet education. Program success is measured by changes in clinical outcomes and health-related quality of life indicators. Program impact is measured by the number of patients served and improvement in health-related measures, such as decreases in weight and blood glucose levels.

From July 2021 to January 2022, **a total of 120 visits were made to the Food Rx program, and 3,428 meals were provided to these patients and families.**

MedStar Health's partnership with the Maryland Food Bank provided **6,635 lbs of nonperishable food,** and through a partnership with Sodexo®, **598 lbs of frozen food** has been provided.

A partnership with the American Heart Association® has resulted in **registering patients for weekly virtual cooking classes,** and the Y in Central Maryland has been providing **reduced cost memberships and access to fitness classes.**

Hyperglycemia managed through Food Rx program

A 50-year-old male patient came to us after several hospitalizations for hyperglycemia and a recent toe amputation. He was enrolled in our Food Rx program and started receiving diabetes diet education along with food for 10 healthy meals per week. His A1c was 10.5% in August 2021, and by November 2021, it came down to 7.7%. He now packs his lunch for work rather than eating fast food, and he was able to reduce his amount of daily insulin needed.

Gratitude matters.

We are grateful for the generous philanthropic partners whose support has fueled the development of these impactful initiatives to help provide better care for the community. This important work does not stop with what has already been achieved. Medical professionals and patients understand that these programs must continue to advance and grow to meet community health needs. Philanthropic investments remain critical to fulfilling this mission, providing for opportunities to continue advancing these innovative programs forward while also defining a new future for impacting the healthcare needs of the community.

We invite you to explore how you can play a role in partnering to impact and advance patient care through these exciting initiatives. To learn more, please contact Kristi Rasmussen, CFRE, vice president for philanthropy at MedStar Good Samaritan Hospital and MedStar Union Memorial Hospital, at **443-444-4256** or **kristi.rasmussen@medstar.net.**

MedStar Good Samaritan Hospital
Office of Philanthropy
5601 Loch Raven Blvd.
Baltimore, MD 21239

MedStarHealth.org/Philanthropy

It's how we treat people.

MedStar Health