Implementation Plan for Northwest Hospital's Prioritized CHNA Needs
2024-2027

The following community-identified needs were selected as **priorities** for improvement by Northwest Hospital for their 2024-2027 Community Health Needs Assessment (CHNA) Implementation Plan. Each of these plans are described in the following pages.

1. **Physical Health**
2. **Mental Health, Substance Use Disorders**
3. **Access to Care**
4. **Quality of Care**
5. **Food Security**

Northwest Hospital will additionally work to address many of the following specific needs identified through their latest Community Health Needs Assessment that informed the above-listed priorities.

Health Problems:

1. *High Blood Pressure*
2. *Diabetes*
3. *Overweight/Obesity*
4. *Behavioral Health*
5. *Cancer*

Social Problems:

1. *Safety/Violence*
2. *Access to Insurance*
3. *Housing Problems/Homelessness*
4. *Availability/Access to Doctor's Office*
5. *Limited Access to Healthy Foods*

Physical Health

Prioritized Need: Improved access to clinical and social resources to improve health and well-being of Northwest Hospital community members.

Population Definition: Northwest Hospital community members with diabetes, prediabetes, obesity, and/or hypertension.

Potential Programs and Tools for Improvement:

- LifeBridge Mobile Clinic outreach (on-site health screenings, referrals to social, clinical resources)
- Digital Care Center (virtual clinical support)
- Medication Management team (virtual pharmacist support)
- Healthy food partners (home delivery, food pantry access)
- Chronic disease education and management support, e.g.:
    - LifeBridge's Community Health and Wellness team
    - GetWell Loop tool
    - Health-Shared.com platform
- Implementation and use of "closed loop" platform (e.g., *Findhelp*) by LifeBridge care teams to identify and track completion of referrals to social resources
- Implement "StrokeSmart" initiative to more quickly act on signs that someone may be having a stroke.
- Address interpersonal violence with evidence-based interventions.

Metrics to Assess Progress may include:

- **Process measure:** % of Northwest diabetes patients (inpatient and/or outpatient) who get their A1c checked at least 3x a year.
- **Outcome measure:** % of Northwest diabetes patients (inpatient and/or outpatient) who reduce A1c level during year.
- **Process measure:** % of Northwest diabetes patients (inpatient and/or outpatient) connected to diabetes/health management education and support (including diabetes management education, healthy eating, and/or exercise).
- **Outcome measure:** % of Northwest diabetes patients (inpatient and/or outpatient) connected to diabetes/health management education and support (including diabetes management education, healthy eating, and/or exercise) and who show reduction in weight and/or A1c level at the end of year.
- **Process measure:** % of Northwest patients with diabetes or prediabetes and/or are obese and state they lack access/can't afford healthy food who are enrolled in a healthy food program.
- **Outcome measure:** % of Northwest patients with diabetes or prediabetes and/or who are obese and state they lack access/can't afford healthy food who are enrolled in a healthy food program and show reduction in:
    a) Weight and/or A1c level
    b) ED/hospital visits (compared to themselves or to a non-enrolled control group)

- **Process measure:** % of Northwest high blood pressure (BP) patients (inpatient and/or outpatient) seen by their Primary Care Provider/Cardiologist at least 1x a year.
- **Outcome measure:** % of a defined panel of Northwest high BP patients (inpatient and/or outpatient) who reduce BP levels over time.
- **Process measure:** % of Northwest high BP patients (inpatient and/or outpatient) seen by their Primary Care Provider/Cardiologist at least 1x a year and connected to BP/cardiovascular health education and support (including medication management, healthy eating, and/or exercise).
- **Outcome measure**: % of Northwest high BP patients (inpatient and/or outpatient) seen by their Primary Care Provider/Cardiologist at least 1x a year and connected to BP/cardiovascular health education and support (including medication management, healthy eating, and/or exercise) who show reduction in:
  - a) Weight and/or BP level
  - b) ED/hospital visits (compared to themselves or to a non-enrolled control group)
- **Outcome measure**: Number of interpersonal violence cases addressed.

Mental Health/Substance Use Disorder

Prioritized Need: Improved access to clinical and social resources to treat behavioral health (mental health and/or substance use disorder) of Northwest Hospital community members.

Population Definition: Northwest Hospital community members with mental health issues and/or substance use disorders.

Potential Programs and Tools for Improvement:

- Active involvement in the Central Maryland Regional Crisis System (formerly the GBRICS Partnership).
- Train technicians, front desk, registrars, and/or other support staff in the Emergency Department, and Primary Care Practices, as well as Community Health Educators in evidence-based emergency response techniques for people who appear to be in mental health or substance abuse crisis.
- Explore cross-training Emergency Department Peers as Community Health Workers, to include mental health training.
- Explore making training available for frontline staff on trauma-informed care.
- Explore funding and a treatment plan for patients with alcohol use disorder.
- Explore development of an in-house consult physician for psychiatric and substance abuse issues.

Metrics to Assess Progress may include:

- **Outcome measure:** Reduction in Emergency Department visits and/or hospitalizations over time among a defined panel of program participants.
- **Process measure:** Use of the Central Maryland Regional Crisis System (formerly GBRICS) by area residents.
- **Process measure:** Number of Northwest Hospital staff receiving education in evidence-based emergency response techniques for people who appear to be in mental health or substance abuse crisis.
- **Process measure:** Number of Emergency Department Peer Counselors cross-trained as Community Health Workers.
- **Process measure:** Number of frontline staff trained in trauma-informed care.
- **Process measure:** Steps taken to develop funding and a treatment plan for patients with alcohol use disorder.
- **Process measure:** Steps taken to develop an in-house consult physician for psychiatric and substance abuse issues.

Access to Care

Prioritized Need: Access to clinical care providers, health screening and education, and health-supporting resources.

Population Definition: Underserved communities in Northwest Hospital service areas.

Potential Programs and Tools for Improvement:

- Provision of transportation vouchers (e.g., Uber, Lyft) to help individuals access medical appointments and health-supporting social services.
- LifeBridge Mobile Clinic outreach that brings to where people live health screenings and clinical care, health education, and access to health insurance sign-up and social resources.
- Wider access to interpretation and translation services for community members for whom English is not their first language.
- Form and maintain partnerships with community organizations who have regular contact with underserved community members.
- Increase virtual appointments and digital medicine access for Northwest community members.
- Explore primary care access expansion in the Northwest area (including developing, strengthening relationships with area FQHCs if necessary).
- Research and segment health care access data, including by demographics and neighborhood, in the Northwest Hospital service area.

Metrics to Assess Progress may include:

- **Outcome measure:** Reduction in Emergency Department visits or hospitalizations over time among a defined panel of program participants who have had their access to primary care improved.
- **Outcome measure:** Improvement in clinical outcome measures (e.g., A1c and/or Blood Pressure) over time among a defined panel of program participants who have had their access to primary care improved.
- **Process measure(s):** Measurable increase in primary care access for Northwest neighborhood residents. E.g., may include through such quantifiable actions as: adding new providers; establishing local—including regular mobile—clinics; increasing virtual appts. and digital care access; expanding hours (evening/weekend); and/or creating/strengthening partnerships with existing FQHCs.
- **Process measure:** Number of Mobile Clinic events and/or number of Mobile Clinic encounters.
- **Process measure:** Number of active community organization partners that provide clinical or social resources for our community members.
- **Process measure:** Number of transportation vouchers provided.
- **Process measure:** Evidence supporting improved access to interpretation and translation services for community members for whom English is not their first language.

Quality of Care

Prioritized Need: Improve perception of discrimination/stigma based on patient's race/ethnicity or medical diagnosis and/or concerns about long wait times for appointments or waiting to be seen in various care settings like the ED or the waiting room at a doctor's office.

Population Definition: Northwest Hospital patients.

Potential Programs and Tools for Improvement:

- Sensitivity, diversity, and/or cultural competency training for providers/staff.
- Efforts to improve long wait times and/or perception of long wait times in the Northwest ED and doctors' offices.
- Efforts to improve long wait times for appointments with providers at Northwest Hospital.

Metrics to Assess Progress may include:

- **Outcome measure:** Improved HCAHPS scores related to patients' perception of how they are treated at Northwest Hospital.
- **Outcome measure:** Improved CG-CAHPS scores related to patients' perception of how they are treated at Northwest Hospital outpatient offices.
- **Outcome measure:** Improved CG-CAHPS scores related to patients' perception of wait time at Northwest Hospital outpatient offices.

Food Security

Prioritized Need: Improved access to healthy food for Northwest Hospital community members who lack it.

Population Definition may include:

- Northwest Hospital community members with diabetes and/or obesity lacking access to healthy food who are referred to LifeBridge's healthy food access program.
- Northwest Hospital patients who select lack of access to healthy food as a social determinant of health.

Potential Programs and Tools for Improvement:

- Maryland-funded (HSCRC) Diabetes Regional Partnership (through December 2024).
- LifeBridge partnerships with community-based food partners to improve access to healthy food.
- Employment of a Healthy Food Access Program Coordinator to manage referrals of eligible residents to food partners.
- Educate Northwest Hospital providers about eligibility criteria for, and availability of, healthy food access services.
- Referrals to healthy food access services by Northwest Hospital providers, diabetes education and nutrition specialists, and/or Community Health and Wellness teams.
- Explore creation and management of a Northwest Hospital food pantry.

Metrics to Assess Progress may include:

- **Process measure:** Number of people receiving education on diabetes and/or weight management.
- **Process measure:** Number of people gaining access to healthy food (e.g., fruits and vegetables) through one of LifeBridge Health's community-based food partners.
- **Process measure:** Number of Northwest Hospital patients receiving food from a Northwest Hospital food pantry.
- **Outcome measure:** Number of people with reduced A1c levels after receiving education and healthy food access.
- **Outcome measure:** Number of people with reduced weight levels after receiving education and healthy food access.
- **Satisfaction measure:** Satisfaction survey results for education and healthy food access program participants.