Implementation Plan for Levindale Hospital's Prioritized CHNA Needs

2024-2027

The following community-identified needs were selected as **priorities** for improvement by Levindale Hospital for their 2024-2027 Community Health Needs Assessment (CHNA) Implementation Plan for community residents 65 years and older. Each of these plans are described in the following pages.

1. **Physical Health: Stroke Identification and Prevention**
2. **Mental Health: Improved Access to Levindale's Outpatient Services**
3. **Health Disparities and Quality of Care**

Levindale 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. *Chronic Pain/Arthritis*
4. *Addiction/Substance Abuse*
5. *Cancer*

Social Problems:

1. *Limited Knowledge About Healthy Foods*
2. *Gun Violence*
3. *Affordability of Healthy Food*
4. *Social Isolation*
5. *Poor Neighborhood Safety*

Physical Health: Stroke Identification and Prevention

Prioritized Need: Improved capabilities among Levindale Hospital staff and community members to be able to identify strokes and help prevent or minimize negative outcomes.

Population Definition: Levindale Hospital community members.

Potential Programs and Tools for Improvement:

- Baltimore City's "StrokeSmart" initiative.
- Collaboration with LifeBridge Health's Stroke Coordinator.
- Distribute education and resource materials in the community on how to recognize people who may be experiencing a stroke and on what actions to take to prevent or minimize negative consequences.
- Education for LifeBridge Health's Community Health Educators on how to recognize people who may be experiencing a stroke and on what actions to take to prevent or minimize negative outcomes.

Metrics to Assess Progress may include:

- **Process measure:** Number of meetings/training events held to train Levindale and LifeBridge Health providers and staff to recognize signs and symptoms of a stroke and how to respond.
- **Process measure:** Number of Levindale and LifeBridge Health providers and staff trained to recognize and act on signs and symptoms of a stroke.
- **Process measure:** Number of StrokeSmart magnets and/or other stroke educational material distributed to health care providers, staff, and the Levindale community.
- **Outcome measure:** Number of people who are identified early with signs and symptoms of a stroke and who are referred to emergency medical care.

Mental Health: Improved Access to Levindale's Outpatient Services

Prioritized Need: Improved access to clinical and social resources to address mental health issues of Levindale Hospital community members.

Population Definition: Levindale Hospital community members with mental health issues.

Potential Programs and Tools for Improvement:

- Educate LifeBridge providers about the variety of Levindale's Outpatient Mental Health services offered and how their patients can take advantage of them.
- Train LifeBridge Community Health Educators in Levindale's Outpatient Mental Health service offerings and how to refer community members to it.
- Active involvement in the Central Maryland Regional Crisis System (formerly the GBRICS Partnership).

Metrics to Assess Progress may include:

- **Process measure:** Number of LifeBridge providers referring patients to Levindale's Outpatient Mental Health services offerings.
- **Process measure:** Number of LifeBridge Community Health Educators trained in Levindale's Outpatient Mental Health Service offerings and how to refer community members to it.
- **Process measure:** Use of the Central Maryland Regional Crisis System (formerly GBRICS) by area residents.
- **Outcome measure:** Reduction in Emergency Department visits and/or hospitalizations over time among a defined panel of patients referred to Levindale's Outpatient Mental Health service offerings.

Health Disparities and Quality of Care

Prioritized Need: LifeBridge community members experience health disparities associated with race, ethnicity, neighborhood of residence, and/or other demographic factors and social determinants of health (SDOH).

Population Definition: Levindale Hospital community members experiencing health disparities (to be identified).

Potential Programs and Tools for Improvement:

- Examine disparities in hospital quality indicators—including readmissions and potentially avoidable utilization rates—by race, ethnicity, neighborhood of residence, and/or other demographic factors and social determinants of health.
- Expand the use of SDOH assessment to identify and intervene on Levindale Hospital patients experiencing social challenges that may affect their health.
- Develop and focus action plans around key areas of disparity we identify.
- Provide training on recognizing and correcting implicit bias to health care providers and staff.

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.
- **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 health care or health-associated supports improved.
- **Process measure:** Number of community education and/or outreach events that target the defined population with health disparities.
- **Process measure:** Number of action plans created and implemented to address identified health disparities.