Community Health Needs Assessment Report & Implementation Strategy

June 30, 2013

Northwest Hospital
A member of LifeBridge Health, Inc.
Baltimore, Maryland
# Table of Contents

I. Executive Summary........................................................................3

II. Introduction.....................................................................................4
   A. Overview of Northwest Hospital ............................................4
   B. Northwest Hospital Demographics ........................................4
   C. The Community We Serve ......................................................5
   D. Community and Public Health Data .......................................6
   E. Local Community Health Resources ......................................9

III. Process/Methods...........................................................................10

IV. Findings.........................................................................................15

V. Implementation Strategy.................................................................25
   A. Prioritized Community Health Need .......................................25
   B. Other Top Community Health Needs .....................................26
   C. Existing Resources and Partners ..........................................29
   D. Adoption of Implementation Strategy ....................................32
   E. Motion to Approve Northwest’s
      Community Health Improvement Project ..........................33

VI. Appendix A
   Community Health Needs Assessment Survey ..........................34
I. Executive Summary

Northwest Hospital ("Northwest") conducted its first federally required Community Health Needs Assessment (CHNA) in fiscal year 2013 (July 1, 2012 – June 30, 2013). Involvement of residents, stakeholders, and community partners was an essential component of the CHNA process.

Northwest’s CHNA complies with the new Internal Revenue Service (IRS) mandate requiring all not-for-profit 501(c) (3) hospitals to conduct a CHNA and implement a community health improvement project once every three years.

The process used to identify health needs of Northwest’s community included analyzing primary and secondary health data at both the hospital and community level, and involving public health experts, community members and key community groups in further identification of priority concerns and needs. The CHNA team collected and analyzed 339 surveys from individuals living in Northwest’s primary service area zip codes and held a community feedback session attended by community residents and stakeholders.

The CHNA team evaluated results from surveys, one community feedback session and public health experts’ recommendations to prioritize Northwest’s top community health needs. An assessment of hospital resources, expertise and capacity led to a decision to focus the resulting community health improvement project on the ‘Heart Disease Cluster’ (including heart disease, diabetes and stroke).

Throughout the assessment process, the hospital worked to align its priorities with local, state, and national health improvement initiatives including the Baltimore County Health Improvement Plan, Maryland State Health Improvement Plan (SHIP), and Healthy People 2020.

On April 22, 2013 and May 23, 2013 respectively, the Boards of Northwest Hospital and Lifebridge Health, Inc., Northwest’s parent organization, approved Northwest’s plan for a community health improvement project focused on the heart disease cluster.
II. Introduction

Northwest Hospital ("Northwest") completed its formal community health needs assessment (CHNA) as required and defined by the Patient Protection and Affordable Care Act and Section 501(r)(3) of the Internal Revenue Code during fiscal year (FY13).

A. Overview of Northwest Hospital

Northwest is an acute care, 268-bed community hospital located in Randallstown, Maryland. The hospital was originally established in 1962 as the Liberty Court Rehabilitation Center. A year later, the Center changed its name to the Baltimore County General Hospital, and in 1993, changed to the Northwest Hospital Center. In 1998, Northwest merged with Sinai Hospital, a neighboring hospital serving northwest Baltimore, to form the LifeBridge Health system. Today, Northwest Hospital maintains its mission to improve the well-being of the community by nurturing relationships between the hospital, medical staff, and patients, while providing the highest quality of care in a patient-centered environment. Northwest delivers a broad array of inpatient, emergency, and outpatient services to residents from throughout the northeast corridor of the state, including Baltimore County, southern and eastern Carroll County, Baltimore City, and northern Howard County. Northwest is a private, nonprofit 501(c)(3) organization and an entity under the LifeBridge Health system umbrella.

As a community focused hospital center, Northwest’s services respond to a broad continuum of health care needs and serve patients either directly, through joint programs with other providers and health related agencies, or as an advocate for alternate sources of care. The hospital’s Community Health Education Department educates the community via health fairs, lectures and group discussions, and special topic classes for the community on a variety of health topics. Health education programs, such as diabetes self-management, smoking cessation, caregiver education, cardiovascular health, and prostate cancer screenings, are offered to the public free-of-charge. Northwest operates 14 Centers of Excellence including the Sandra and Malcolm Berman Brain & Spine Institute, The Herman & Walter Samuelson Breast Care Center, and The Krieger Eye Institute. In 2010, Northwest received the Silver Plus Award from the American Heart Association and the Primary Stroke Designation from the American Stroke Association. In 2011, the hospital’s Subacute Unit was named a US News and World Report Best Nursing Home.

B. Northwest Hospital Demographics

Of the 110,226 patients treated at Northwest in FY 2012, 13,665 (12.4%) were treated as Acute Care Inpatients, 45,495 (41.3%) had outpatient or same day surgery procedures, and 51,066 (46.3%) were treated in the Emergency Department.

a) Race and Ethnicity

Approximately 65% of all patients in FY 2012 were Black/African American and 31.0% were White. Smaller percentages of patients identified as ‘Other’ (1.4%), Hispanic (1.2%), Asian (0.9%), American Indian (0.4%) and Multiracial (0.2%).
Data reveal some variation in race/ethnicity by the area in which patients received care (e.g. inpatient, outpatient and emergency). Sixty percent (60.0%) of patients treated in inpatient settings were Black/African American followed by White patients at 36.7%. Patients receiving outpatient services were 54.9% Black/African American and 41.3% White. Finally, the Emergency Room treated nearly four times as many Black/African American patients (75.0%) as White patients (20.4%).

b) **Age**

The age categories representing the highest percentage of both inpatient and outpatient encounters (excluding ED visits) are ‘41-65 years old’ and ‘above 65 years old.’ Patients aged 41 and above account for a total of 86.5% of inpatient encounters and 90.0% of outpatient encounters. In the inpatient setting, there are slightly more individuals aged 66 and above (47.5%) compared to those aged 41-65 years old (39.0%) while the outpatient setting sees nearly identical percentages of patients in these categories, 45.3% and 44.3% respectively.

The age breakdown of patients treated in the Emergency Department (ED) differs from the age breakdown of those treated in inpatient and outpatient settings. The top age category in the ED is 19-40 years old (40.9%), followed by 41-65 years old (30.8%), 0-18 years old (16.8%) and above 65 years old (11.5%).

c) **Gender**

In all hospital settings in FY 2012, females made up a higher percentage of patients (61.6%) compared to males (38.3%). The setting with the highest percentage of females was outpatient at 65.1%. The setting with the highest percentage of males was inpatient at 41.2% followed closely by the ED at 40.6% male.

C. The Community We Serve

Northwest Hospital is located in the Randallstown (zip code 21133) community of Baltimore County, serving both its immediate neighbors and others from throughout the Baltimore County region. The community served by Northwest Hospital can be defined by its (a) Primary Service Area (PSA) and (b) Community Benefit Service Area (CBSA), the area targeted for community health improvement.

a) The **Primary Service Area (PSA)** is comprised of zip codes from which the top 60% of patient discharges originate. Listed in order from largest to smallest number of discharges for fiscal year 2012, Northwest’s PSA includes the following zip codes: 21133 (Randallstown), 21208 (Pikesville), 21207 (Gwynn Oak), 21244 (Windsor Mill), and 21117 (Owings Mills).

b) The **Community Benefit Service Area (CBSA)** is comprised of zip codes, or geographic areas, targeted for Community Benefit programming due to the area’s

---

1 Health Services Cost Review Commission (HSCRC), 2012.
demonstration of need. Due to the proximity of zip codes 21133, 21244, and 21207 to Northwest, and the high volume of residents from these zip codes in need of community benefit services, 21133, 21244 and the county portion of 21207 make up the hospital’s ‘community benefit service area’ (CBSA). For the purposes of conducting a CHNA and implementing a resulting community health improvement project, this area will also be defined as the community served by Northwest Hospital. The chart below displays basic demographics for Northwest's community.

<table>
<thead>
<tr>
<th>CBSA Zip Codes</th>
<th>21133</th>
<th>21244</th>
<th>21207</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Population in CBSA</td>
<td>111,281</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sex:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male:</td>
<td>51,315</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Female:</td>
<td>59,966</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Age:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>0-14:</td>
<td>22,959</td>
<td>20.6%</td>
<td></td>
</tr>
<tr>
<td>15-17:</td>
<td>5,166</td>
<td>4.6%</td>
<td></td>
</tr>
<tr>
<td>18-24:</td>
<td>10,127</td>
<td>9.1%</td>
<td></td>
</tr>
<tr>
<td>25-34:</td>
<td>16,209</td>
<td>14.6%</td>
<td></td>
</tr>
<tr>
<td>35-54:</td>
<td>31,732</td>
<td>28.5%</td>
<td></td>
</tr>
<tr>
<td>55-64:</td>
<td>12,718</td>
<td>11.4%</td>
<td></td>
</tr>
<tr>
<td>65+:</td>
<td>12,370</td>
<td>11.1%</td>
<td></td>
</tr>
<tr>
<td>Race/Ethnicity:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>White non-Hispanic:</td>
<td>11,308</td>
<td>10.2%</td>
<td></td>
</tr>
<tr>
<td>Black non-Hispanic:</td>
<td>89,348</td>
<td>80.3%</td>
<td></td>
</tr>
<tr>
<td>Hispanic:</td>
<td>4,465</td>
<td>4.0%</td>
<td></td>
</tr>
<tr>
<td>Asian and Pacific Islander non-Hispanic:</td>
<td>3,385</td>
<td>3.0%</td>
<td></td>
</tr>
<tr>
<td>All others:</td>
<td>2,775</td>
<td>2.5%</td>
<td></td>
</tr>
<tr>
<td>Household Income:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>&lt; $15,000</td>
<td>4,229</td>
<td>9.9%</td>
<td></td>
</tr>
<tr>
<td>$15,000-25,000</td>
<td>3,598</td>
<td>8.4%</td>
<td></td>
</tr>
<tr>
<td>$25,000-50,000</td>
<td>12,178</td>
<td>28.4%</td>
<td></td>
</tr>
<tr>
<td>$50,000-75,000</td>
<td>9,641</td>
<td>22.5%</td>
<td></td>
</tr>
<tr>
<td>$75,000-100,000</td>
<td>6,376</td>
<td>14.9%</td>
<td></td>
</tr>
<tr>
<td>&gt; $100,000</td>
<td>6,911</td>
<td>16.1%</td>
<td></td>
</tr>
<tr>
<td>Educational Level (Individuals 25+)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Less than High School:</td>
<td>2,677</td>
<td>3.7%</td>
<td></td>
</tr>
<tr>
<td>Some High School:</td>
<td>5,921</td>
<td>8.1%</td>
<td></td>
</tr>
<tr>
<td>High School Degree:</td>
<td>21,058</td>
<td>28.8%</td>
<td></td>
</tr>
<tr>
<td>Some College/Assoc. Degree:</td>
<td>23,846</td>
<td>32.7%</td>
<td></td>
</tr>
<tr>
<td>Bachelor’s Degree or Greater:</td>
<td>19,527</td>
<td>26.7%</td>
<td></td>
</tr>
</tbody>
</table>

D. Community and Public Health Data

The chart below displays social, economic and environmental characteristics that have an impact on the health of residents in Northwest’s community. In addition, the chart includes life expectancy and mortality data by race/ethnicity.

---

3 21207 spans city/county lines. Northwest primarily serves the county-portion of the zip code.
<table>
<thead>
<tr>
<th>Community Benefit Service Area (CBSA): Zip Code</th>
<th>21133</th>
<th>21207</th>
<th>21244</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Socioeconomic</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Average Household Income&lt;sup&gt;2&lt;/sup&gt;</td>
<td>$72,655</td>
<td>$52,106</td>
<td>$63,722</td>
</tr>
<tr>
<td>Percentage of households with incomes below the federal poverty guidelines&lt;sup&gt;4&lt;/sup&gt;</td>
<td>5.1%</td>
<td>8%</td>
<td>6.5%</td>
</tr>
<tr>
<td>Percentage of civilian, non-institutionalized 18-64 yr olds with any type of health insurance&lt;sup&gt;5&lt;/sup&gt;</td>
<td></td>
<td></td>
<td>Baltimore County: 87.8%; (12.2% uninsured)</td>
</tr>
<tr>
<td>Average Number of all Medicaid Eligible Persons by Month&lt;sup&gt;6&lt;/sup&gt;</td>
<td></td>
<td></td>
<td>Baltimore County: 134,926 Medicaid Eligible Persons Per Month (Avg)</td>
</tr>
<tr>
<td>Ratio of population to primary care physicians&lt;sup&gt;7&lt;/sup&gt;</td>
<td></td>
<td></td>
<td>Baltimore County: One primary care physician to every 672 residents (672:1 ratio)</td>
</tr>
<tr>
<td>Percentage of Medicaid recipients (excluding active duty service members and incarcerated persons)&lt;sup&gt;5&lt;/sup&gt;</td>
<td></td>
<td></td>
<td>Baltimore County: 24.5%</td>
</tr>
<tr>
<td><strong>Education</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Percentage of Students who graduate 4 years after entering 9&lt;sup&gt;th&lt;/sup&gt; grade&lt;sup&gt;1&lt;/sup&gt;</td>
<td></td>
<td></td>
<td>Baltimore County: 80.0%</td>
</tr>
<tr>
<td>Highest Educational Attainment (Adults 25 or older)&lt;sup&gt;7&lt;/sup&gt;</td>
<td>35.3% Bachelors Degree or Greater</td>
<td>20.8% Bachelors Degree or Greater</td>
<td>27.5% Bachelors Degree or Greater</td>
</tr>
<tr>
<td><strong>Housing</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Median Home Value&lt;sup&gt;4&lt;/sup&gt;</td>
<td></td>
<td></td>
<td>Baltimore County: $273,600; Randallstown CDP: $271,400</td>
</tr>
<tr>
<td>Percent of owner-occupied housing units&lt;sup&gt;4&lt;/sup&gt;</td>
<td></td>
<td></td>
<td>Baltimore County: 66.0%; Randallstown CDP: 73.2%</td>
</tr>
<tr>
<td><strong>Access to Healthy Food</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Percentage of restaurants that are fast food establishments&lt;sup&gt;7&lt;/sup&gt;</td>
<td></td>
<td></td>
<td>Baltimore County: 64%</td>
</tr>
<tr>
<td>Percentage of census tracts with food deserts&lt;sup&gt;8&lt;/sup&gt;</td>
<td></td>
<td></td>
<td>Baltimore County: 4.9%</td>
</tr>
<tr>
<td><strong>Transportation</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Percent commuting on public transit&lt;sup&gt;7&lt;/sup&gt;</td>
<td></td>
<td></td>
<td>Baltimore County: 4.3%; Randallstown CDP: 9.2%</td>
</tr>
<tr>
<td>Mean travel time to work (minutes)&lt;sup&gt;4&lt;/sup&gt;</td>
<td></td>
<td></td>
<td>Baltimore County: 28.2 minutes; Randallstown CDP: 33.2 minutes</td>
</tr>
<tr>
<td><strong>Built and Social Environment</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rate of recreational facilities per 100,000 population&lt;sup&gt;1&lt;/sup&gt;</td>
<td></td>
<td></td>
<td>Baltimore County: 15.1 facilities per 100,000 population</td>
</tr>
<tr>
<td>Percent of children that live in household headed by single parent&lt;sup&gt;7&lt;/sup&gt;</td>
<td></td>
<td></td>
<td>Baltimore County: 35%</td>
</tr>
<tr>
<td><strong>Life Expectancy and Mortality</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Life Expectancy&lt;sup&gt;1&lt;/sup&gt;</td>
<td></td>
<td></td>
<td>Baltimore County: 77.8 years</td>
</tr>
</tbody>
</table>

<sup>4</sup> U.S. Census, 2011.
<sup>6</sup> Maryland Medicaid eHealth Statistics, Department of Health and Mental Hygiene (DHMH), 2012.
<sup>7</sup> DHMH, County Health Rankings, 2012.
<sup>8</sup> U.S. Department of Agriculture (USDA), 2000.
Age-Adjusted Death Rate per 100,000 risk population: Baltimore County: 795 per 100,000 risk population

Years of potential life lost before age 75 per 100,000 population (age-adjusted premature death): Baltimore County: 7,365 per 100,000 population

DISEASE-SPECIFIC MORTALITY RATE BY RACE/ETHNICITY

**Age-Adjusted Death Rate due to Diabetes by Race/Ethnicity**

<table>
<thead>
<tr>
<th>Race/Ethnicity</th>
<th>Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Black</td>
<td>34.4</td>
</tr>
<tr>
<td>White</td>
<td>18.8</td>
</tr>
<tr>
<td>Overall</td>
<td>18.1</td>
</tr>
</tbody>
</table>

**Baltimore County**

**Age-Adjusted Death Rate due to Coronary Heart Disease by Race/Ethnicity**

<table>
<thead>
<tr>
<th>Race/Ethnicity</th>
<th>Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Asian/Pacific Islander</td>
<td>71.1</td>
</tr>
<tr>
<td>Black</td>
<td>229.0</td>
</tr>
<tr>
<td>Hispanic</td>
<td>189.3</td>
</tr>
<tr>
<td>White</td>
<td>192.5</td>
</tr>
<tr>
<td>Overall</td>
<td>192.5</td>
</tr>
</tbody>
</table>

**Baltimore County**

---

9 Maryland Family Health Administration, 2009.
10 Healthy Communities Institute, 2012.
E. Local Community Health Resources

The following health care resources are available to eligible residents living in or around Northwest’s CBSA.

**Chase Brexton Health Services (Randallstown Office)**
3510 Brenbrook Drive, Randallstown, MD 21233

Chase Brexton Health Services, Inc. is the closest Federally Qualified Health Center (FQHC) to Northwest Hospital. The primary purpose of FQHCs is to expand access to primary health care for uninsured and underserved populations, who experience financial, geographic, or cultural barriers to care and who live in or near medically underserved areas and areas that are federally designated as having a health professional shortage (HPSAs). FQHCs accept Medicaid and Medicare patients as well as uninsured individuals.

**Mission of Mercy, Health Van**
Reisterstown Stop, Two Tuesdays a month

Mission of Mercy is an independent nonprofit 501 (c)(3), nonsectarian community-based organization that utilizes active and retired licensed medical professionals to provide free medical and dental services and prescription medications to the uninsured working poor, homeless and economically disadvantaged people via a mobile medical clinic.
III. Process/Methods

The process used to identify health needs of Northwest’s community included analyzing primary and secondary data at both hospital and community levels, and involving public health experts, community members and key community groups in further identification of priority concerns and needs. Throughout the assessment process, the hospital worked to align its priorities with local, state, and national health improvement initiatives: Baltimore County Health Improvement Plan, the local action plan developed by the Baltimore County Health Department to implement the state of Maryland’s health improvement plan, the Maryland State Health Improvement Plan (SHIP), and Healthy People 2020.

The steps taken to complete the CHNA and plan for a resulting community health improvement project included the following:

A. Exploration of Public Health Data Collection Mechanisms

In order to respond to IRS guidelines requiring non-profit hospitals to complete a CHNA, Northwest partnered with fellow LifeBridge Health facilities, Sinai and Levindale Hospitals, the Maryland Hospital Association (MHA), Baltimore City and County Health Departments, and other area hospital systems to explore mechanisms/methods for performing required CHNAs. Methods considered included the use of data software platforms, hiring an external consultant to conduct the assessment, or having hospital staff members conduct a community health needs assessment. LifeBridge Health, Inc. decided to explore the Healthy Communities Institute (HCI) product, a web-based platform offering over 130 community health indicators from reputable data sources such as U.S. Census and American Community Survey to support the CHNA.

Early in the exploration, Northwest held discussions with the Baltimore County Health Department and another hospital system on the joint purchase of a shared product. These discussions did not ultimately lead to such partnership, but LifeBridge Health, Inc. contracted with the Healthy Communities Institute (HCI) to purchase a web-based software product to support Northwest’s CHNA. Data provided by HCI is updated in real-time as soon as sources such as the American Community Survey of the U.S. Census release new reports. In addition to presenting public health data values, measurement periods, and sources, the HCI software has a built-in progress tracker that helps users identify how the location of interest (i.e. Baltimore County) compares to other county-level, state-level and national-level data. Other product features include promising practices searchable by health topic or keyword, health disparities data and a report center enabling users to create and send customized data reports.

In order to supplement the public health data obtained from the HCI product and to complete the CHNA, LifeBridge Health, Inc. staff, comprising the CHNA Team, engaged with local public health partners and community residents to gather input from persons representing broad community interest.
B. Engagement with Public Health Partners and Community Human Services Partners

LifeBridge Health, Inc., a regional Maryland health system with hospitals located in both Baltimore City and Baltimore County, initiated early talks with both Baltimore City and Baltimore County Health Departments around local health improvement plans to support the Maryland State Health Improvement Plan (SHIP). Because Northwest serves patients in Baltimore County as well as Baltimore City, partnerships developed with both health departments were important for assessment completion as well as the planning and implementation of community health improvement projects.

In support of Northwest’s growing partnership with the Baltimore County Health Department and the Baltimore City Health Department, representatives from each were invited to present their local health improvement plans to LifeBridge Health, Inc.’s Community Mission Committee (CMC), a LifeBridge board committee that guides and monitors community benefit programming. Baltimore County Health Department’s Deputy Director, Ms. Della Leister, presented the Baltimore County Health Improvement Plan and Ms. Sarah Morris-Comptom, Director of Policy and Planning, presented the Baltimore City Health Department’s health improvement initiative, Healthy Baltimore 2015. Due to location of hospitals, Sinai Hospital representatives take primary responsibility for partnership with the Baltimore City Health Department, and a Northwest representative participates as a member of the Baltimore County Health Improvement Coalition. The CHNA team further strengthened Northwest’s partnership with Baltimore County by meeting with Baltimore County Health Department representatives in early 2013 to share community feedback and explore opportunities to partner on the development of a community health improvement project in response to Northwest’s CHNA results.

Another participant in Northwest’s CHNA process was the Northwest Hospital Health Policy Advisory Board (NWHPAB), a group of hospital and community stakeholders whose group purpose is to engage community leaders around important health issues. This group provided key guidance in the development of a process for conducting the CHNA. For example, the group provided an early recommendation to use written and electronic surveys to reach community members. To supplement the data received from surveys, the CHNA team decided to also hold a community feedback session at the Randallstown Community Center, a location recommended by a NWHPAB member. Overall, the NWHPAB’s contribution to the assessment process included spreading the word about the assessment through both oral and written methods, distributing and collecting community surveys within personal and professional networks, at community meetings and events, offering recommendations for the planning of community forums, distributing community forum flyers and attending key community events in support of the assessment.

Northwest also used its routine practice of collaborating with community and human service partners in order to enhance community involvement and input during the CHNA process. Partners who provided support for the CHNA include: Tony Baysmore, Special Assistant to Baltimore County Executive Kevin Kamenetz, the
Randallstown Community Center, the local chapter of Delta Sigma Theta sorority, as well as local area churches, faith-based institutions, schools and recreation-based programs. In addition, a new partnership emerged following Northwest’s first community feedback session in November 2012. In attendance was an active member of the Liberty Road Community Council (LRCC) who invited members of the CHNA team to attend a LRCC Board Meeting to present and receive feedback about community health needs and strategies for improving community health.

Assistance from partners described above included spreading the word about the assessment, distributing and collecting community surveys, providing space and allocating meeting time for gathering community input on health needs, and offering consistent support for other tasks as needed. In addition, partners contributed their own feedback about community health needs. Another key role of community partners will be participation in project-planning as we determine specific components of the community-wide community health improvement project and the role that each community partner will play in its implementation.

In addition to seeking input and assistance from external partners, Northwest identified clinical and community needs based on feedback from individual hospital departments. Such clinical input was derived from the treatment of patients and interactions with both patients and family members. This practice continues and offers additional clinical input regarding identification and prioritization of health needs.

C. Data Collection: Surveys and In-person Feedback

In order to gather community input on health needs, the CHNA team, consisting of members of LifeBridge Health’s Community Health Education Department, located at Northwest, and Sinai Hospital’s M. Peter Moser Community Initiatives Department, decided to use a two-pronged approach yielding both written survey and in-person feedback session data.

a) Surveys: Paper and Electronic Surveys

With approval from the source, Tanner Health System (Carrollton, Georgia), the CHNA team adapted an existing community health needs assessment survey created by Tanner during their 2011-2012 Community Health Needs Assessment process. The survey (Appendix A) had a total of 19 questions, including 18 forced-choice questions and one final question asking for additional comments about health needs in the community. The first section of the survey asked questions about health concerns, barriers to seeking or receiving quality health care, community needs, and health information sources. The second section asked eight demographic questions including gender, age, race, ethnicity, highest level of education, etc in order to capture a snapshot of the survey respondents. The survey was available in paper and electronically via Survey Monkey, an online survey tool. The majority of respondents filled out a paper survey. An identical survey was used for Northwest and LifeBridge Health’s other hospitals, Sinai and Levindale. Therefore, the available response for ‘zip code of residence’ on the survey included primary service area (PSA) zip codes for all hospitals.
The CHNA team distributed paper surveys at community events, meetings and fairs, as well as in waiting rooms, lobbies and communal spaces in or around various community sites in Northwest's community. Sites included libraries, fitness centers, community centers, restaurants, pharmacies, schools, churches, etc. The team also relied upon partners to spread awareness about the survey as well as to hand out surveys for completion. All completed surveys were returned to the CHNA team.

Over 300 surveys were collected for the Northwest community. Due to the relatively close proximity of LifeBridge Health’s three hospitals and the fact that the hospitals share certain primary service area zip codes, a second level of decision-making beyond looking at ‘zip code of residence’ was required to categorize survey responses as ‘Northwest’ or ‘Sinai and Levindale’. Sinai and Levindale were combined because they are geographically located on a joint campus in Baltimore City. The respondent’s answer to the question ‘When seeking care, which [acute care] hospital would you visit first?’ became the tiebreaker for categorizing responses from individuals living in a service area zip code shared by Northwest and Sinai/Levindale.

b) In-Person Feedback: Community Feedback Sessions

The CHNA team worked with local partners to hold a face-to-face community feedback session in Randallstown, MD, the community in which Northwest is located. The session was open to the general public including residents and representatives from local community-based organizations, churches, schools, etc. Community members and stakeholders learned about the feedback sessions through a variety of mechanisms including paper flyer distribution, e-mail notices, event postings on community calendars and social media sites, announcements at community meetings and gatherings, and through word of mouth.

Northwest’s community feedback session was held on November 14, 2012 from 6:00 – 7:30pm in the multi-purpose room of the Randallstown Community Center at 3505 Resource Drive, Baltimore, MD 21133. The feedback session lasted approximately one and 1/2 hours. During the session, participants were asked the same set of questions included in the community health needs assessment survey but were able to give in-depth narrative responses instead of the forced choice answers required by the survey.

In order to prioritize community health needs, the CHNA team facilitated a multi-voting exercise with feedback session participants. Each participant used three Post-It® notes to represent three votes for the health need(s) that they perceived to be greatest in their community. Participants were instructed to vote by placing the Post-It® notes onto flip charts posted around the meeting room. Each flip chart represented a different health concern. Topics were selected based on preliminary survey results of the top five (5) community health concerns identified by survey respondents.
Survey respondents selected the following most concerning health conditions, each of which was eligible for selection during the multi-voting exercise:

1. Diabetes
2. Heart Disease
3. Cancer
4. Drug/Alcohol Abuse
5. HIV/AIDS

Community feedback session participants were asked to place their three votes in any distribution, weighting any health condition with more than one vote, if they wished; they could also submit write-in votes for health concerns not posted.

Following a period of data analysis, the CHNA team returned in early 2013 to the original community feedback session site to present data results and request community input on how to prioritize and address identified needs. Participants offered ideas for resources, partners and community health improvement project strategies related to the top three community health needs: Cancer, Heart Disease, and Diabetes.

In addition to returning to the community feedback session site, the team presented CHNA results and solicited feedback at additional meetings. Meetings included:

- Community Mission Committee of the LifeBridge Health Board
- Liberty Road Community Council
- Northwest Hospital Health Policy Advisory Board
IV. Findings

The following section is a compilation of responses from all CHNA participants including those who completed the paper or online community health needs assessment survey and those who attended the community feedback session. These results, combined with secondary data from the Healthy Communities Institute (HCI) data sources and information about community health needs from our partners and stakeholders, will help to inform future community benefit programming and a Community Health Improvement Project (CHIP) that will be initiated in response to this needs assessment process.

A. Survey Demographics

A total of 339 individuals completed a community health needs assessment survey on paper or online. The zip code represented by the largest number of respondents (37%) is 21133, the hospital's zip code, followed by 21207 (17%), 21117 (16%), 21244 (15%) and 21208 (13%). This distribution is representative of the top 5 zip codes of Northwest's FY 2012 discharges.

Approximately 69% of respondents were female and 29% were male. The majority of respondents (88%) were Black or African American and non-Hispanic (96%). These results can be compared to the demographic breakdown of Northwest’s primary service area, which is 55% female and 85% Black, Non-Hispanic.

The age breakdown of survey respondents (n = 339) was:

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>No Answer</td>
<td>1</td>
</tr>
<tr>
<td>75 or older</td>
<td>10</td>
</tr>
<tr>
<td>65-74</td>
<td>59</td>
</tr>
<tr>
<td>55-64</td>
<td>84</td>
</tr>
<tr>
<td>45-54</td>
<td>70</td>
</tr>
<tr>
<td>35-44</td>
<td>65</td>
</tr>
<tr>
<td>25-34</td>
<td>31</td>
</tr>
<tr>
<td>18-24</td>
<td>9</td>
</tr>
<tr>
<td>Under 18</td>
<td>10</td>
</tr>
</tbody>
</table>

It is important to note that the make-up of community residents responding to the survey is not representative of the whole community due to convenience sampling and not random sampling.
B. Survey Results

**Top Cause of Death**
Of the 295 respondents who answered the question “What do you think is the health cause that most people in your community die from?” with only one top cause of death, as instructed, 35% answered ‘Heart Disease’ followed by Cancer (27%), Diabetes (13%) and Violence (9%).

The chart below shows leading causes of death for Baltimore County compared to the survey respondents’ perception of the top five causes of death in their community.

![Graph showing the comparison between Baltimore County leading causes of death and the survey respondents' perception.]

<table>
<thead>
<tr>
<th>Leading Causes of Death</th>
<th>Community Survey Feedback</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Diseases of the Heart</td>
<td>Heart Disease 33%</td>
</tr>
<tr>
<td>2 Malignant Neoplasms (i.e. Cancer)</td>
<td>Cancer 24%</td>
</tr>
<tr>
<td>3 Cerebrovascular Disease (i.e. Stroke)</td>
<td>Diabetes 17%</td>
</tr>
<tr>
<td>4 Chronic Lower Respiratory Disease</td>
<td>Violence 12%</td>
</tr>
<tr>
<td>5 Accidents</td>
<td>Stroke &amp; HIV/AIDS (Tie) 5%</td>
</tr>
</tbody>
</table>

% of ‘cause of death’ over total responses

---

**Top Health Concern**
In addition to identifying the ‘top cause of death,’ we asked respondents to select their ‘biggest health concern’ from a provided list. Of the 322 respondents who answered the question *“What do you think is the biggest health concern in your community?”* with only one *top* health concern, as instructed, 28% chose Diabetes followed by Cancer (22%), Heart Disease (17%), Drug/Alcohol Abuse (7%), HIV/AIDS (5%) and Violence (5%).

![Top Health Concern Graph](image)

**Additional Survey Results**
The survey also included questions related to the respondents’ perceptions about barriers to seeking medical treatment and other factors that impact the quality of care community members receive or their own health literacy and ability to access and use existing health care resources.

*What do you think is the main reason why people in your community may not seek medical treatment?*
1. Fear 29%
2. Lack of Insurance 28%
3. Unable to Pay 19%

*In your opinion, which factor most affects the quality of the health care you or people in your community receive?*
1. Economic Reasons 57%
2. ‘Do Not Know’ 17%
3. Age 9%
What health screenings or education/information services are needed in your community?\(^{12}\)

Top 10:
Needed Health Screenings/Education (n = 330)
2027 Total Responses

<table>
<thead>
<tr>
<th>Service</th>
<th>Responses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blood pressure</td>
<td>239</td>
</tr>
<tr>
<td>Diabetes</td>
<td>223</td>
</tr>
<tr>
<td>Heart disease &amp; stroke</td>
<td>204</td>
</tr>
<tr>
<td>Cancer</td>
<td>195</td>
</tr>
<tr>
<td>Cholesterol</td>
<td>181</td>
</tr>
<tr>
<td>Mental Health</td>
<td>149</td>
</tr>
<tr>
<td>Nutrition</td>
<td>145</td>
</tr>
<tr>
<td>Dental Health</td>
<td>139</td>
</tr>
<tr>
<td>HIV/STD</td>
<td>137</td>
</tr>
<tr>
<td>Physical activity</td>
<td>134</td>
</tr>
</tbody>
</table>

What does your community need in order to improve the health of your family, friends and neighbors?\(^{13}\)

Top 10: Community Health Improvement Ideas (n = 330)
896 Total Responses

<table>
<thead>
<tr>
<th>Improvement Idea</th>
<th>Responses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Job opportunities</td>
<td>149</td>
</tr>
<tr>
<td>Healthier food choices</td>
<td>122</td>
</tr>
<tr>
<td>Wellness services</td>
<td>104</td>
</tr>
<tr>
<td>Quality education</td>
<td>100</td>
</tr>
<tr>
<td>After-school programs</td>
<td>84</td>
</tr>
<tr>
<td>Affordable housing</td>
<td>83</td>
</tr>
<tr>
<td>Recreation facilities</td>
<td>60</td>
</tr>
<tr>
<td>Mental health services</td>
<td>48</td>
</tr>
<tr>
<td>Safe places to walk/play</td>
<td>48</td>
</tr>
<tr>
<td>Substance abuse services</td>
<td>38</td>
</tr>
</tbody>
</table>

\(^{12}\) Respondents were instructed to ‘Check all that apply’.

\(^{13}\) Respondents were instructed to ‘Check the TOP 3 Needs’.
3. Community Feedback Results

Qualitative results represent responses provided at one in-person community feedback session, as well as comments written on the community health needs assessment survey.

On November 14, 2012, the CHNA team held a community feedback session at the Randallstown Community Center located less than one mile from Northwest Hospital. The meeting took place on a weekday evening. A total of 18 attendees participated in the feedback session.

The CHNA team organized the community feedback session by dividing responsibilities into three roles—facilitator, recorder and note-taker. Each attendee was asked to sign in upon entry and complete an anonymous registration form. Registration forms asked for age, sex, zip code, race, ethnicity, highest level of education and insurance status. Such data was obtained for all participants at both meetings.

Of the 18 feedback session participants, 14 were female and 4 were male. Sixty-seven percent (67%) of participants were aged 55 or older and the majority (67%) of participants lived in zip code 21233. Seventy-two percent (72%) identified as Black of African American. The highest level of education of participants ranged from ‘some college’ to ‘doctorate level’, and 67% reported ‘some college’ or ‘college graduate’.

The results of the community feedback session were compiled from hand-written notes taken by the recorder and note-taker throughout the session. While the recorder interacted directly with the facilitator and participants while writing participant responses on a large flip chart, the note-taker took more detailed notes on a laptop computer. Following each feedback session, the recorder and note-taker met to compare notes. A brief qualitative analysis of the results was conducted by the facilitator of the feedback sessions. Themes derived from analysis are listed below.

Community Feedback Session Themes

Guided by questions extracted from the CHNA survey, community residents in attendance offered insight into community health needs and challenges. While participants suggested diseases and health conditions (e.g. obesity, heart disease, cancer, diabetes, Alzheimer’s, drug addiction, etc.) when answering questions related to top cause of death and greatest health concern, detailed discussions arose related to the following themes related to health, as well as the social and environmental conditions that impact health.

- **Access**
  Many participants discussed access concerns including lack of insurance, affordability of health care and health care coverage, and the availability of 24-hour or walk-in health care facilities.
- **Education (Health-related)**
  Respondents cited a need for education about common health conditions (e.g. diabetes, high blood pressure) and practical tips and tools for preventing and treating such conditions. They suggested the use of health fairs, community forums and seminars at local organizations or faith-based centers as a means for getting important health-related education out to the community. They specifically identified the need for ‘experts’ to provide education and practical tools for disease conditions such as diabetes, stroke, etc.

- **Access to Healthy Foods**
  The lack of available healthy foods rose as a significant concern. Respondents felt that community members, specifically those who have existing health conditions such as hypertension, diabetes, etc., need more opportunities for healthy eating. The participants stated that the Liberty Road corridor in Randallstown is full of fast food options but absent of restaurants offering healthier options such as salads, fresh fruit, lean meats, etc. Related to the lack of healthy food options is the health concern, as voiced by the residents, of obesity.

- **Social and Psychological Concerns**
  Participants readily provided psycho-social reasons for poor health and mortality in the community. Their concerns included youth drug use and abuse of prescription drugs by all age groups, teenage pregnancy, and isolation/loneliness in the elderly population.

- **Chronic Disease**
  Participants consistently cited cancer, heart disease, diabetes, high blood pressure and stroke as health concerns and reasons why people in their community die. One participant explained that he did not realize the prevalence of diabetes in the community until he volunteered to sell baked goods at a community yard sale and encountered many neighbors who could not eat brownies due to their diabetes. Another remarked that ‘cancer is everywhere’ and that no one knows where it comes from.

- **Emergent Themes**
  Emergent themes, or new learning from the qualitative analysis, included concerns related to the environment. Multiple residents spoke about the spread of West Nile Virus in areas near streams and waterways where mosquitoes gather. They requested more notification from Baltimore County agencies about the threat and health risks, as well as notification before spraying for mosquitoes. A related concern arose about deer ticks and the spread of Lyme disease. A representative from the Baltimore
County Executive’s Office was present at the meeting and offered to follow-up with residents about these specific environmental concerns.

The residents also discussed the health consequences of an increasingly aging population. They voiced concerns about seniors aging alone in their homes and needing assistance related to navigating and using health care and health insurance systems, and prescribed medication information and instructions. Some residents noted that isolation and Alzheimer’s disease are causes of death for seniors in the community.

When discussing top causes of death in the community, multiple residents spoke about traffic concerns and vehicular accidents especially on the nearby busy and perceived dangerous Liberty Road.

In addition to seeking information from participants about community health concerns, the facilitator also asked for information about barriers to seeking and receiving medical care, methods used to receive health information, and ideas for health improvement.

**Medical Care: Seeking Care and Information**

Respondents use a variety of sources for medical care and medical information. They visit hospitals, urgent care centers, medical specialists’ offices and the Emergency Department when they (or their family members) are ill. One respondent said that the place they go to receive care depends on the type and severity of the condition. The same individual said she searches for doctors who are rated highest on ‘best-of’ lists such as *Baltimore Magazine*’s Best Doctors issue or doctors who are recommended by friends and family. Another respondent said that health insurance status impacts where you go for care and that those with insurance can typically see a specialist for specific conditions faster than those who are without insurance.

When seeking health information, respondents ask their primary care doctor, church group, family, friends and neighbors; they attend health fairs and screenings; and they reference media sources (e.g. television programming, magazines, newspapers, Internet pages related to health, health version of consumer reports). Participants also stated that they like to receive medical information through the mail from hospitals or their insurance company.

Reasons cited for not seeking medical care included lack of information/understanding, fear (i.e. fear of unknown, fear of hospital/doctors, etc.), denial and inability to pay. One respondent stated “I believe if people had finances to go to the hospital, they would go regularly. Because they don’t have the finances, some people deal with the old remedies instead to deal with pain, sickness, etc.” Another respondent
stated that individuals without insurance may not seek care due to fear that they will be treated differently than those with insurance.

Practical barriers for seeking care included lack of transportation, affordability of insurance/co-pays, and inability to navigate the medical system. For elderly people, living alone at home can exacerbate barriers to receiving good medical care according to participants. For example, loneliness may reduce the likelihood that an elderly person will seek care or will understand when and how to seek care.

➢ Health Improvement

Participants provided suggestions for improving community health. They voiced a need and request for education through in-person methods and through literature or media sources. They asked for help from health experts who could attend health fairs, organize webinars, etc. to discuss certain diseases and conditions, risk factors, prevention strategies, etc. They specifically asked for education related to nutrition.

A few individuals shared their own experience developing educational events and expressed disappointment over the turnout of such events. This led to the suggestion to work together to improve the way events are promoted in the community. For example, respondents suggested promoting events using ‘2012 technology’ such as Facebook, Twitter, etc. to reach residents. They also suggested building partnerships with local schools to spread the word to parents and youth about health-related events and to use school space to hold events. Although the participants said the Randallstown Community Center is a good space for holding events, some said the space lacks parking capacity and break-out rooms for large events such as health fairs.

Many participants asked for help learning about nutrition and increasing access to healthy foods in the community. They spoke of a local community farmers’ market that is poorly advertised and held during the middle of the day when most individuals are working.

Another cited a need to educate the community about personal health records and how the new health care reform law will change the way our personal health information is tracked and stored. In addition, another resident said that residents need help organizing their own medical information at home.
D. Community Feedback Session, Multi-Voting Results

In addition to recording participants’ answers to questions about community health and needs, the facilitators asked participants to prioritize community health needs by use of the multi-voting method described previously. The results are pictured below.

<table>
<thead>
<tr>
<th>Top Health Concerns based on Community Prioritization</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Cancer</td>
</tr>
<tr>
<td>2. Heart Disease</td>
</tr>
<tr>
<td>3. Diabetes</td>
</tr>
</tbody>
</table>

Write In ‘Health Concerns’:
- Obesity
- Violence
- Traffic accidents
- Alzheimer’s
- Denial
- Dementia
E. Baltimore County Health Department Health Improvement Coalition Priorities

In addition to the community feedback session organized by Northwest and its community partners, a Northwest representative attended meetings of the Baltimore County Health Improvement Coalition, a group developed to implement the Maryland State Health Improvement Plan (SHIP) in Baltimore County.

The coalition meets quarterly to address the following top priorities:

1. Low/Very Low Birth Weight Babies
2. Childhood Obesity
3. Youth Tobacco Use

The major activities of the coalition during Year 1 of its existence included data analysis, community data assessment and web site development. One strategy implemented to reduce the proportion of young children and adolescents who are obese was achieved by purchasing of exercise mats for the three schools with the top % of children who are obese and the hiring of a nutrition consultant and data analyst.
V. Implementation Strategy

The CHNA team evaluated results from surveys, one community input session and public health experts’ recommendations to arrive at the top community health needs indicated by those sources. Additionally, the CHNA team made an assessment of hospital resources, expertise and capacity to arrive at a decision to focus Northwest’s Community Health Improvement Project (CHIP) on the ‘HEART DISEASE CLUSTER’ (including heart disease, diabetes and stroke).

A. Prioritized Community Health Need: Heart Disease Cluster

Survey respondents perceived heart disease as the leading cause of death and diabetes as the top health concern in their community. The community feedback session participants prioritized cancer as their community’s top health need followed closely by heart disease and diabetes. Due to the fact residents continually cited heart disease and diabetes as both deadly and concerning, and health improvement efforts to address one have a great impact on addressing the others, the CHNA team decided to develop a health improvement project to address and prevent the cluster of heart disease related conditions including diabetes, high blood pressure, stroke, obesity, etc.

According to the American Diabetes Association, two out of three individuals with diabetes die from heart disease or stroke\(^\text{14}\); therefore, the prevention and treatment of diabetes is a step towards reducing the incidence and mortality of cardiovascular disease and stroke. Community residents and stakeholders also highlighted a priority for addressing the lack of healthy foods in the Randallstown community. Reducing risk factors for cardiovascular disease such as poor diet, limited physical activity, etc. are important components of any cardiovascular health improvement plan and will be included in Northwest’s CHIP.

The chart below details justification for selecting heart disease as the focus for Northwest’s CHIP, described in section D. Adoption of Implementation Strategy.

<table>
<thead>
<tr>
<th>Heart Disease Cluster</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Public Health Evidence</strong></td>
</tr>
<tr>
<td>Heart Disease or ‘diseases of the heart’ is the leading cause of death in Baltimore County for all races.(^\text{15}). Stroke and Diabetes, conditions that will also be addressed by the CHIP, are 3(^\text{rd}) and 7(^\text{th}) leading causes of death in Baltimore County respectively.</td>
</tr>
<tr>
<td><strong>CHNA Survey and Input Session Feedback</strong></td>
</tr>
<tr>
<td>35% of survey respondents (n = 295) selected ‘heart disease’ as the top health cause that most people in their community die from. Heart disease was also the third greatest health concern following diabetes and cancer.</td>
</tr>
</tbody>
</table>

\(^\text{14}\) American Diabetes Association, 2013

In community feedback sessions, participants consistently cited heart disease and diabetes as significant health concerns. Health improvement ideas offered by participants frequently addressed risk factors for heart disease such as lack of access to healthy foods and educational events related to nutrition.

### Evidence of Health Disparities

In Baltimore County, there is a racial disparity for:

1. Age-adjusted heart disease mortality rates\(^1^6\)
   - 237 per 100,000 population for Black residents
   - 193 per 100,000 population for White residents

2. Unadjusted diabetes ED visit rates\(^1^0\)
   - 746 visits per 100,000 population for Black residents
   - 263 visits per 100,000 population for White residents

### Existing Hospital Resources and Strengths

The LifeBridge Health Community Health Education Department (CHE), which is housed at Northwest Hospital, has provided successful wellness, health promotion and disease prevention programming in the community for over 30 years. Community Health Education provides comprehensive health education lectures, behavior change programs, individualized coaching and counseling, prevention screenings and risk assessments. Its most successful screening program began as a Women’s Heart Screening program over ten years ago.

### Alignment with local, state and national health improvement goals

The Baltimore County Department of Health identified ‘childhood obesity’ and tobacco use, both significant contributors to cardiovascular disease, as two of three priority health areas for health improvement. Strategies to reduce the prevalence of childhood obesity include promotion of physical activity and healthy eating for youth, and strategies to reduce tobacco use include preventing initiation of tobacco use, promoting quitting and eliminating exposure to second hand smoke.

Baltimore County’s rate of heart disease deaths per 100,000 population is 195.4\(^1^7\) compared to the Maryland SHIP 2014 Target of 173 and Healthy People 2020 Target of 153 per 100,000 population.\(^1^0\)

### B. Other Top Community Health Needs Not Selected for Intervention

Northwest recognizes that not all identified community health needs can be addressed and that difficult choices must be made to properly allocate limited resources to the areas of greatest need. Fortunately, the results of the CHNA reveal that services offered by Northwest as well as its parent organization, LifeBridge Health, Inc., are already well aligned with the following prioritized community health needs that were not selected as the focus of the CHIP.

---


a) Cancer
Cancer is the second leading cause of death in Baltimore County and a significant health concern in the Randallstown community surrounding Northwest Hospital according to survey respondents and feedback session participants. Just over a quarter of all survey respondents (n = 295) selected ‘cancer’ as the top health cause that most people in their community die from. In community feedback sessions, participants cited cancer as both a top cause of death and top health concern. In particular, breast cancer was cited as a type of cancer for which screenings and education was needed.

The LifeBridge Health Alvin & Lois Lapidus Cancer Institute offers advanced specialized care in all areas of cancer diagnosis and treatment. Cancer treatment centers and programs address the following conditions: breast, gynecologic, hematologic, lung/thoracic, gastroenterologic and urologic cancers, as well as bone, soft tissue and endocrine tumors. In addition to diagnosis and treatment, the Institute provides supportive services and personal development and enrichment opportunities for patients undergoing cancer treatment. Integrated therapies designed to relieve anxiety and promote socialization include stress reduction techniques for patients and families, art workshops, writing workshops, and music and beading therapy classes. Programs such as the American Cancer Society’s Look and Feel Better Program, which provides makeup demonstrations, skin care therapies and special products, are also available to patients.

The Freedom to Screen program at Northwest Hospital provides community outreach, breast cancer education, screenings and exams, mammograms, and follow-up diagnostic procedures for lower-income, uninsured and under-insured women in Baltimore County and City. The goal of the program is to provide women with the resources they need to increase breast cancer awareness and prevention. Additional assistance is offered to women who need help with patient navigation services. Patient navigators help women who have received a breast cancer diagnosis deal with their medical fears and develop a road to recovery.

b) HIV/AIDS
Survey respondents and community feedback session participants ranked HIV/AIDS as the fifth greatest health concern and fifth top cause of death in their communities. Northwest’s sister hospital, Sinai, the Baltimore County Health Department and Chase Brexton provide important resources and services to residents living in Northwest’s service area who are impacted by HIV.

Sinai’s HIV Support Services aim to address the social and economic barriers that impair the health and well-being of individuals and families affected by HIV who live in Baltimore City and Baltimore County. Services are provided by Clinical Social Workers and Community Health Workers who use interventions that enhance access to care and facilitate integration of medical and psychosocial services. The overall goal is to improve HIV-positive persons’ health by enhancing
access to and utilization of care, and enhancing emotional and social well-being through psychosocial support and counseling.

Although Sinai is equipped to offer case management services to Baltimore County residents, the Baltimore County Health Department’s own case management service is an additional resource. Their client-centered services link clients with medically appropriate health care and support services and provide supportive services to ensure that the clients’ assessed needs are met and that clients remain in care.

Chase Brexton, a federally qualified health center located in Randallstown, MD, also supports uninsured and under-insured residents of Northwest’s service area who are impacted by HIV/AIDS. They provide HIV/AIDS medical care services including physical exams, diagnostic tests, intensive educational and adherence support for HIV medications and ongoing follow-up visits. Services of Chase Brexton’s case management and outreach program include assessments, care planning, referrals, client advocacy, education, supportive counseling, etc.

c) Drug/Alcohol Abuse
Drug/Alcohol Abuse arose as the fourth top health concern according to survey results. Although Northwest does not directly address this health need, its sister hospital Sinai offers outpatient substance abuse treatment services to uninsured and under-insured individuals who are opioid-dependent and living in Baltimore City through the Sinai Hospital Addictions Recovery Program (SHARP). SHARP uses a comprehensive model of treatment that combines methadone maintenance with comprehensive treatment services. Services include: individual, group and family counseling; substance abuse education for patients and families; primary medical care (assessment and referral) for uninsured patients until connected with a provider; fully integrated dual diagnosis services for patients with co-existing psychiatric disorders; on-site testing and counseling for HIV and sexually transmitted diseases; and linkages with adjunctive services as needed.

For residents of Baltimore County in need of drug/alcohol abuse treatment services, Northwest defers to its partners at the Baltimore County Health Department who provide treatment services for adult and youth substance abusers and their families, as well as prevention services, most of which target Baltimore County youth.

d) Infant Mortality
Although results of the survey and community feedback session did not reveal significant concern of participating residents for infant mortality, the Baltimore County Health Department identified the reduction of infant mortality as one of the top priorities to be addressed by its Local Health Improvement Coalition. Due to the fact that Northwest does not offer obstetric services or pediatric care, the reduction of infant mortality is a health priority better suited for its sister hospital, Sinai Hospital.
C. Existing Resources & Partners to Support Implementation Strategy

Northwest’s implementation of a heart disease-focused community health improvement project will require substantial support and involvement from hospital-based and community partners.

1. Hospital-based Resources and Partners:
   The following hospital resources and partners will join the CHNA team in implementing a CHIP to address heart disease in the community surrounding Northwest.

   a. Community Health Education at LifeBridge Health
      For over 30 years, the Community Health Education (CHE) Department at LifeBridge Health has played an important role in improving the health of communities in Baltimore County and City through education and prevention services. When Northwest and Sinai merged to form LifeBridge Health in 1998, Northwest’s approach to providing community benefit services centered on community health education while Sinai, located in a neighborhood of extreme poverty, focused on providing direct services to people living in poverty. As a result of different approaches to community benefit programming, CHE’s physical home remains at Northwest and the M. Peter Moser Community Initiatives Program, which provides direct services to individuals impacted by both medical conditions and the social determinants of health (e.g. poverty, poor housing, lack of insurance, etc.), is housed at Sinai Hospital.

      The CHE department provides comprehensive health education lectures, behavior change programs, individualized coaching and counseling, prevention screenings and risk assessments. The comprehensiveness of CHE programs, the high quality education that is provided, and the collaborative nature of the health education team place CHE as a leader in the area of health promotion and disease prevention programming; as well as in the areas of wellness, disease management, and health coaching.

      The Department’s Heart Health and Lifestyle Screening program, an expansion of the former Women’s Heart Program, incorporates hospital specialty services for in-depth follow-up including a Cardiologist who will survey the laboratory results of those demonstrating risk, and LifeBridge Health and Fitness for lifestyle change.

   b. The Diabetes and Nutrition Center at Northwest Hospital
      The Diabetes & Nutrition Center at Northwest Hospital is recognized by the American Diabetes Association as meeting the National Standards for Diabetes Self Management Education. The center not only serves patients with diabetes but also those with other medical conditions that can be improved through nutritional counseling, diet and lifestyle changes. Through one-on-one evaluation and group classes, patients receive the
tools they need to better manage their medical condition and feel healthier. Services include diabetes management (i.e. customizable plans to manage food intake, physical activity and glucose levels), medical nutrition therapy and diabetes education.

2. Community-based Resources and Partners:
The following public health and community-based organizations will collaborate with Northwest Hospital to address identified the identified heart disease cluster as the focus of a joint community health improvement effort.

a. Baltimore County Health Department
The Baltimore County Health Department’s Local Health Improvement Coalition is working to achieve the Maryland State Health Improvement Plan (SHIP) in Baltimore County. The coalition’s priority area of childhood obesity and tobacco use reduction is relevant to Northwest’s focus on improving heart health for its patient and community members. In addition, discussions around adding a fourth priority area to address chronic disease occurred in early 2013. A member of the CHNA team has been selected as a member of the Coalition and will continue to build partnerships to implement Northwest’s CHIP.

Examples of available services related to heart health include:

- **Healthscope** — The program offers education presentations and screenings at senior centers on topics including chronic disease self-management nutrition education.
- **Take Charge of Your Health: Living Well** — The program is offered free of charge by the Baltimore County Department of Aging (BCDA) to provide chronic disease self-management workshops for people 18 years and older with chronic conditions, chronic pain or diabetes.

b. Chase Brexton
Chase Brexton is the closest federally qualified health center (FQHC) to Northwest Hospital. As a FQHC, Chase Brexton provides medical services to the uninsured and underinsured. Participants of the CHIP who have primary care needs may be referred to Chase Brexton to obtain a medical home. In addition, the facility may be a useful place for identifying at-risk community members who could benefit from services to address poor cardiac health.

c. Liberty Road Family Resource Center
The Liberty Road Family Resource Center is conveniently located within the same lot as the Randallstown Community Center and provides area residents with information and resources related to their health and well-being. Individuals seeking services at Liberty Road may be recruited for the CHIP project.
d. Local Sororities
Local sororities, including Delta Sigma Theta, Baltimore County Alumni Chapter, will continue to provide community engagement support as the CHIP project begins. Their contribution may include participant recruitment and identifying physical space for health screenings and educational events.

e. Office of Community Outreach, Baltimore County Executive Office
The newly created Office of Community Outreach is staffed by special assistants assigned to specific areas of Baltimore County. Mr. Tony Baysmore is the special assistant assigned to areas around Northwest. He has been involved with the CHNA process through assistance with and attendance at the community feedback session, and will continue to collaborate with the CHNA team to secure space for CHIP events and programs and recruit participants.

f. Baltimore County Department of Recreation and Parks
In order to provide CHIP participants with opportunities for safe physical activity, the CHIP team will partner with the Department of Recreation and Parks and its local volunteer council, the Liberty Road Recreation and Parks Council, to compile a resource listing of activities and programs related to increasing physical activity for all ages as well as opportunities to increase access to healthy foods.

g. Randallstown Community Center
The 58,000 square foot center is the largest community center in Baltimore County and provides community residents with free access to a multi-purpose gymnasium that holds three basketball courts, two volleyball courts and a four-lane indoor track. Other features of the center include a 300 seat performance hall with a stage and theater lighting, a tech center/computer room and activity room. In addition, next door to the facility is a 25-meter, six lane indoor pool managed by the YMCA of Central Maryland. The Community Center is an ideal location for holding health screening and educational events and an important resource for CHIP participants who need a safe and supportive environment for physical activity.

h. Baltimore County Public Schools
Collaboration with Baltimore County Public Schools will connect health improvement efforts with the community’s youth population and lead to family engagement around increasing physical activity, understanding cardiac risk factors and improving overall heart health. At the suggestion of community feedback session participants, the CHNA team will explore the possibility of holding screening events at local school facilities.

i. American Heart Association (AHA)
The Community Health Education Department has an existing partnership with the AHA and will refer to them for resources and programmatic guidance.
D. Adoption of Implementation Strategy

In order to address the identified health needs of the heart disease cluster, the CHNA team will implement the Cardiovascular Screening and Health Improvement Project.

The **Cardiovascular Screening and Health Improvement Project** will expand the services of the Community Health Education Department’s Heart Health & Lifestyle Screening Program and offer health and lifestyle screenings and risk assessments in the community to identify at-risk patients/residents. Community residents who are uninsured/underinsured will be targeted for assessment and enrollment. Those assessed as at-risk who enroll in the project will receive follow-up services in order to improve their cardiac health and link them with resources related to disease management, healthy eating and physical activity. Each program participant will receive follow-up services for six months to one year depending on their individualized service plan. Specific follow-up activities will include:

- health education on topics related to heart health, nutrition, diabetes, etc.
- individualized counseling
- routine follow-up (e.g. phone calls and/or home visits)
- disease management
- healthy eating and lifestyle counseling
- routine evaluations for outcomes-based measurements (e.g. metabolic blood profile, cholesterol, glucose, blood pressure, body composition, etc.)

Partnerships with the Baltimore County Health Department and community-based organizations focusing on health improvement (described above in **Section C**) will be essential in implementation and evaluation of the project.
E. Motion to Approve Northwest’s Community Health Improvement Project (CHIP)

The following motion to implement the community health improvement project described above was approved by the Community Mission Committee, a committee of the LifeBridge Board, on March 7, 2013, and by the Northwest Hospital and LifeBridge Health Boards on April 22, 2013 and May 23, 2013 respectively. Proof of presentation and approval of Northwest’s CHIP are documented in Board Meeting Minutes.

**Approved Motion:**
As a result of the Community Health Needs Assessment (CHNA) performed, Northwest Hospital will implement a community health improvement project (CHIP) that will address identified priority health needs. This project will specifically address prevention and treatment of the heart disease cluster to include heart disease, diabetes and stroke.
# Appendix A: Community Health Needs Assessment Survey

**LIFEBRIDGE HEALTH**  
2012 COMMUNITY HEALTH NEEDS ASSESSMENT SURVEY

LifeBridge Health (including Sinai, Northwest, and Levindale) is conducting a Community Health Needs Assessment. As a resident of our area, your thoughts about the community’s health needs are very important to us. Your participation in this survey will help us to identify the greatest health needs and develop goals to meet them.

1. What do YOU think is the health cause that most people die from in your community? (Check only one)
   - Asthma/lung disease
   - HIV/AIDS
   - Cancer
   - Stroke
   - Diabetes
   - Substance abuse
   - Heart disease
   - Suicide
   - Other (please specify)
   - Violence

2. What do YOU think is the biggest health concern in your community? (Check only one)
   - Asthma/lung disease
   - HIV/AIDS
   - Cancer
   - Infant mortality
   - Dental health
   - Mental health
   - Diabetes
   - Stroke
   - Drug/alcohol abuse
   - Tobacco use
   - Heart disease
   - Violence
   - Other (please specify)

3. What do YOU think is the main reason why people in your community may not seek medical treatment? (Check only one)
   - Cultural/religious beliefs
   - Fear (not ready to face health problem)
   - No appointment available/too long
   - Other (please specify)
   - No transportation
   - Unable to pay
   - Lack of insurance
   - Do not understand the medical need
   - Not enough doctors
   - None/No barriers

4. In your opinion, which factor most affects the quality of the health care you or people in your community receive? (Check only one)
   - Ability to read/write
   - Age
   - Economic (low income, no insurance, etc.)
   - Other (please specify)
   - Gender
   - Language barrier
   - Race/ethnicity
   - I don’t know

5. What health screenings or education/information services are needed in your community? (Check all that apply)
   - Blood pressure
   - Mental health
   - Cancer
   - Nutrition
   - Cholesterol
   - Physical activity
   - Dental health
   - Prenatal care
   - Diabetes
   - Vaccinations
   - Eating disorders
   - Immunizations
   - Heart disease and stroke
   - I don’t know
   - HIV/sexually transmitted diseases
   - Other (please specify)

6. What does your community need in order to improve the health of your family, friends, and neighbors? (Check the TOP 3 needs)
   - Affordable housing
   - Recreation facilities
   - After-school programs
   - Safe places to walk/play
   - Healthier food choices
   - Job opportunities
   - Substance abuse services
   - Literacy programs
   - Mental health services
   - Transportation
   - Quality education for children and adults
   - Wellness services
   - I don’t know
   - Other (please describe)

7. In your opinion, what do you think people in your community cannot afford to buy? (Check all that apply)
   - Clothing
   - Medicine
   - Food
   - Transportation
   - Health insurance
   - Utilities (fuel, electricity, etc.)
   - Home/shelter
   - Other (please specify)
   - I don’t know

8. Where do you and your family get most of your health information? (Check all that apply)
   - Family or friends
   - Television/radio
   - Doctor/health professional
   - Library
   - Magazines/newspaper
   - Church
   - Health department
   - Hospital
   - Health fairs
   - I don’t know
   - Other (please specify)
9. If you or someone in your family were ill and required medical care, where would you go? (Check only one)
   - Would not seek care
   - Doctor’s office
   - Emergency department
   - Clinic
   - Health department
   - I don’t know
   - Walk-in/urgent care center
   - Other (please specify) ________________

10. When seeking care, which hospital would you visit first? (Check only one)
    - Sinai Hospital
    - Northwest Hospital
    - Other hospital (please specify) ________________

The following questions will not be used to identify you in any way. Answers you provide will help us to characterize the groups of people filling out this survey.

11. I am:
    - Male
    - Female

12. My age is:
    - Under 18
    - 18-24
    - 25-34
    - 35-44
    - 45-54
    - 55-64
    - 65-74
    - 75 or older

13. My zip code is:
    - 21117
    - 21133
    - 21136
    - 21207
    - 21208
    - 21209
    - 21215
    - 21216
    - 21217
    - 21244
    - Other (Zip Code: ________________)

14. Were you born in the United States?  
    - Yes
    - No

*If No, where were you born? ________________

15. Are you Hispanic or Latino?
    - Yes
    - No

16. What is your race? (Choose one or more)
    - American Indian or Alaska Native
    - Native Hawaiian or Other Pacific Islander
    - Asian
    - Black or African American
    - White

17. What is your highest level of education?
    - Some high school
    - High school graduate
    - Doctorate
    - Technical school
    - Some college
    - Other (please specify)
    - College graduate

18. Do you currently have health insurance?
    - Yes
    - Other (please specify)
    - Not now
    - No, but I did before

19. We appreciate any additional comments you have about health needs in your community. Please describe in the space below:
    ___________________________________________________________________
    ___________________________________________________________________
    ___________________________________________________________________
    ___________________________________________________________________
    ___________________________________________________________________
    ___________________________________________________________________
    ___________________________________________________________________

THANK YOU FOR YOUR INPUT!
PLEASE RETURN to the box provided or to the person who provided the survey

If you have questions about this survey, please contact:
Danielle Marks
Program Coordinator, Health Equity Initiative
LifeBridge Health
(410) 601-0572 or dmarks@lifebridgehealth.org