



Lankenau Medical Center

Main Line Health

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Community Health Needs Assessment: *Community Health Needs Priorities and Implementation Plan*

May 2013

Overview and Background : Lankenau Medical Center

Located 20 minutes from downtown Philadelphia, Lankenau Medical Center (LMC) includes a 331-bed acute care teaching hospital offering a wide variety of diagnostic and treatment options, the latest medical technology and access to cutting-edge research through the Lankenau Institute for Medical Research. It is especially known for its nationally-acclaimed cardiovascular services, a state-of-the-art Cancer Center, a Level III Neonatal Intensive Care Unit and Kidney Transplant program. LMC has been recognized for its outstanding care by a variety of independent organizations, including US News & World Report, HealthGrades® and Truven Health Analytics.

LMC's commitment to teaching and research complements its clinical programs. LMC's Walter and Leonore Annenberg Conference Center for Medical Education opened in 2004 and serves as an educational hub for health care professionals in the region. In addition, the faculty of the Lankenau Institute for Medical Research conducts research and post-graduate training with the goal of improving the diagnosis and treatment of conditions such as cancer, diabetes and heart disease.

In 1985, Lankenau became a member of Main Line Health, a not-for-profit, integrated health care system that includes four acute care hospitals (Lankenau, Bryn Mawr, Paoli and Riddle), a physical rehabilitation hospital (BMRH), outpatient centers, home care services, physician practices, and the Lankenau Institute for Medical Research. In 1996, Main Line Health joined with Thomas Jefferson University Hospital to become founding members of the regional Jefferson Health System in metropolitan Philadelphia. Our mission is to provide a comprehensive range of accessible health services that meet community needs and improve the quality of life in the communities we serve. Our service area extends from West Philadelphia through the suburbs of Delaware, Montgomery and Chester counties.



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Overview and Background: Lankenau Medical Center

A transformation of LMC is underway with the construction of a new Patient Pavilion – a 260,000+ square-foot, state-of-the-art facility -- that will advance LMC's position as a leader in heart and vascular care. The Patient Pavilion is expected to be complete in June 2013.

Furthermore, LMC has embarked on a multi-year initiative designed to address the growing needs of our diverse community of patients. LMC serves both vulnerable populations and patients with very high socioeconomic status. This is represented by Robert Wood Johnson Foundation's "County Health Rankings & Roadmaps" website, where Philadelphia County is ranked 67th, the least healthiest county in Pennsylvania and Montgomery County is ranked as the sixth healthiest county. These rankings reflect the overall health of the population served by Lankenau Medical Center.

The LMC implementation plan, addressing our community health need priorities, was developed to address the complex needs of our community and it specifically targets efforts to communities that are disproportionately burdened by disease. With this as an area of focus, many of our interventions will focus on patients served by Lankenau's Clinical Care Center, which cares for uninsured and underinsured patients with complex health and psychosocial needs.



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Overview and Background: Focus on Lankenau Clinical Care Center

Lankenau's vision is to transform the way care is delivered in our Clinical Care Center, and thereby reinvigorate primary care as a driver to improve our community's health. For over 50 years, the Lankenau Clinical Care Center (LCCC) has provided primary and specialty outpatient care to uninsured and underinsured individuals in our primary service area. Most patients seen at LCCC reside in West Philadelphia, a disadvantaged community where 28% of the population is uninsured. The median income for West Philadelphia is \$29,107 and 25.8% of adults have a college degree.

LCCC is undergoing a transformation to the more comprehensive and strategic Patient-Centered Medical Home model, which has demonstrated that it can provide the structure for delivering higher quality and more cost-effective care, especially for patients suffering from multiple medical problems.

According to Public Health Management Corporation's Community Health Database, 26.9% of adults residing in the Clinic's service area (19131, 19139, and 19151) report a fair/poor health status. The major morbidities of our patients include: diabetes, hypertension, obesity, tobacco and coronary disease.

In addition to complex health challenges such as multiple chronic diseases, our patients also face psychosocial issues, including insufficient food or inadequate housing, further compromising health. Over half of adults in the Clinic's service area report difficulty making housing payments and nearly a quarter have reduced the size of their meal due to cost. Among the uninsured, 32% report that cost is a major barrier to health care. Adults age 40-59 report that transportation is another barrier.



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Priority: Address cultural barriers to care and other specific needs for LMC orthodox Jewish patients and their families*

Supporting Information:

- The Jewish population consists of 21.8 % of our patient population in the suburban core as compared with 4.9% in SEPA.
- Specialized services are needed for Jewish population to seek care in an environment that supports their faith.

Goal 1: Increase access and remove barriers for the orthodox Jewish population to obtain care at LMC*

Action Items:

- Hospital committee comprised of LMC representatives, community members and local Rabbi will identify needs and work towards implementation.

Goal 2: LMC will focus on prevention of diseases that are significant to the Jewish community in our service area, such as breast cancer, through increased screening and genetic testing

Action Items:

- Collaborate with Jewish Community Center of Philadelphia on delivering health and wellness lecture series and screening opportunities to over 200 of their members.
- Collaborate with local community-based organizations, synagogues, schools and housing complexes to deliver screening and health education.
- Provide free health education and prevention to children through local Jewish educational centers and schools.

* Amended November 4, 2015 by specifying barriers and needs for the orthodox Jewish population.



Priority : Improve understanding, prevention, and treatment of cardiovascular disease for our community

Supporting Information:

- Percentage of adults reporting a diagnosis of hypertension in Urban West is higher than in SEPA for both young adults age (18-64 at 34.9% vs. 25.5%) and older adults (74.4% vs. 58.9%).
- Adults in both the Urban West (42%) and Urban NW (36%) are substantially above the SEPA percentage for high blood pressure. Residents in the Urban NW were also least likely to have their blood pressure checked.
- The data indicates that there is a gap in knowledge and awareness between cardiovascular disease and the risk factors associated with this disease for the Urban West community. An opportunity exists for increased education as well as more access to screening.

Goal 1: Focus on prevention: Increase access to screening of cardiovascular disease, with special emphasis on communities that have an increase burden of disease

Action Items:

- Develop 15 (five per year) additional community-based partners (i.e. YMCA, faith-based organizations, schools) to enhance outreach efforts.
- Explore the development of a SHAPE (Society for Heart Attack Prevention and Eradication) Certified Center of Excellence Program.
- Provide cardiovascular screening and educational seminars to current and new community-based partners.
- Provide 200 free monthly blood pressure screening through our Wellness Wednesday Series at local Whole Foods.



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Priority: Improve understanding, prevention, and treatment of cardiovascular disease for our community (continued)

Goal 2: Enhance outpatient, inpatient and community education

Action Items:

- Promote and increase use of a web-based stroke and cardiovascular risk assessment tool that can be used in the inpatient, outpatient and community setting. Each web-based tool will prompt the user to connect with their Primary Care Physician (PCP) for more information or link them to a new PCP, if they currently do not have one
- Conduct 60 cardiovascular specific health education “Pop-Up Classes” for LCCC patients, with the goal of reaching over 800 patients annually.
- Conduct community-based outreach, in partnership with community-based organizations, to provide cardiovascular education to community members.
- Implement and refine Electronic Medical Record (EMR) based alerts for all readmitted congestive heart failure (CHF) patients. Alerts prompt outreach and follow-up education by nurses.
- In year two, develop process, plan and evaluate effectiveness of launch of similar EMR-based alert and follow up for patients readmitted for core measures (i. e. acute myocardial infarction (AMI), pneumonia, and CHF).
- To meet outreach requirements for re-certification as a Certified Chest Pain Center with the Society of Cardiovascular Patient Care.
- Develop a plan for coordination of care between inpatient setting and Lankenau Clinical Care Center’s outpatient setting through the Patient Centered Medical Home model.
- Provide and distribute printed materials and/or CDs/DVDs/videos on early heart attack care (EHAC) and signs and symptoms of acute coronary syndrome (ACS).



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Priority: Improve understanding, prevention, and treatment of cardiovascular disease for our community (continued)

Goal 2: Enhance outpatient, inpatient, and community education

Action Items:

- Provide free heart health and cardiovascular education to 3,000 elementary students yearly.
- Increase participation and outreach for “Heart Care 101” education to patients and their families of patients dealing with cardiovascular disease.
- Increase outreach and participation for free continuing education for Emergency Medical Service (EMS) personnel on chest pain, ACS and stroke. Increase participation from 80 to 96 participants, a 20% increase (with focused outreach to Philadelphia Fire Rescue).
- Offer education to local Emergency Medical Dispatch Services (EMDS) on EHAC and signs and symptoms of ACS.
- Provide free first responder education to over 125 first responders in Lower Merion Township. In year two and three, increase participation by 20% and include employees of Lower Merion Township.
- Conduct 20 community-based events specifically on early heart attack care with the goal of having individuals understand the early warning signs and symptoms of a heart attack and when and how to seek medical care.
- Explore developing a comprehensive set of heart-health materials and education programs for the public and EMS.
- Continue partnership with American Heart Association’s Mission Life Line, with the goal of providing community-based education about heart disease.
- Increase outreach and health education to patients and families in the Emergency Department.



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Priority: Improve understanding, prevention, and treatment of cardiovascular disease for our community (continued)

Goal 3: Reduce smoking and increase quit attempts for inpatient and outpatient

Action Items:

- Provide smoking cessation and counseling in primary care and LCCC's OB Clinic prenatal patients.
- Provide free smoking cessation programs and access to smoking counseling to all patients within Lankenau Clinical Care Center's Patient Centered Medical Home Teams. Will conduct targeted outreach to moderate and high risk patients.
- Provide free smoking cessation, through individual counseling for over 600 inpatient session a year with the aim to increase by 5% annually.
- Provide free smoking prevention programming to 1,000 children yearly through Health Education Center.
- Continue to provide free six-week smoking cessation counseling to Lankenau employees.
- Sustain status as a "Smoke Free" Campus.



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Priority: Improve understanding, prevention, and treatment of cardiovascular disease for our community (continued)

Goal 4: Focus on Management of Cardiovascular Disease in LCCC's Patient Centered Medical Home

Action Items:

- Use evidence-based guidelines and EMR reports to track gaps in care for all LCCC patients diagnosed with cardiovascular disease.
- Conduct outreach to patients and families for health education, health maintenance and follow-up.
- Stratify patients based on risk and review patient progress and outcomes during LCCC Multidisciplinary Medical Home team.
- Develop and solidify community-based partnership to support patients non-medical needs to improve cardiovascular health.

Goal 5: Support and Encourage employees to participate in Wellness Program on risk factors for cardiovascular disease

Action Items:

- 200 Lankenau employees participate in yearly employee physical fitness competition with an aim to increase participation 10% annually.
- Conduct over 250 free cholesterol, blood pressure and stroke screenings for employees during yearly employee health fair.
- Provide free monthly blood pressure screening open to employees and the public at Lankenau Medical Center.
- Provide free smoking cessation classes throughout the year for all employees
- Maintain mandatory computer-based education class for all Lankenau employees on heart health and the signs and symptoms of a heart attack.

Priority: Improve screening, prevention and treatment of lung disease in Lawrence Park (LP)service area

Supporting Information:

- High incidence of lung cancer in the Suburban LP area and Suburban Core area.
- Average age of mortality for pneumonia for Suburban LP is younger than SEPA.

Goal 1: Enhance continuity of care for pulmonary patients in the Lawrence Park Community

Action Items:

- Provide education through relevant brochures surrounding the importance of screenings and check-ups.
- Offer additional screenings (i.e. Angioscreen and Blood Pressure) to capture patients who seek additional relevant health needs.
- Explore feasibility of outpatient screenings and follow-up care for patients with a variety of lung diseases and respiratory complaints.

Goal 2: Reduce smoking and increase quit attempts for those who live in the surrounding LP community

Action Items:

- Introduce Smoking Cessation Counseling at LP.
- Provide free lecture series from pulmonary physicians and sleep medicine team at LP surrounding lung health management.



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Priority: Improve Breast Cancer Prevention with special emphasis on Urban West Community

Supporting Information:

- Breast Cancer Screenings: In Urban West, the incidence rate for breast cancer is below SEPA, while the mortality rate is higher than SEPA. This indicates an opportunity to increase screening, particularly among younger women (50-59) when it can have greater benefit.
 - This finding was confirmed in a study conducted by LMC, “Breast Screening: A Health Disparities Study.”
 - The study found that compliance to mammography screenings was lower than the national average in both the private practice and LCCC. LCCC had a significantly lower compliance rate than the private practice.

Goal 1: Increase breast cancer screening with targeted outreach to patients age 50-59

Action Items:

- Implement and market state and Lankenau Foundation Healthy Women Program to provide free mammograms to women without insurance.
- Conduct prevention outreach to all women seen in LCCC who are in need of a mammogram.
- Streamline internal processes to increase the number of same-day mammogram and PCP office visit.

Goal 2: Provide education and awareness seminars to 1500 women (500 women per year)

Action Items:

- Partner with community-based organizations to conduct outreach and link women to screenings. Community-based partners include: Jewish Community Center of Philadelphia, Whole Foods, Christ Lutheran Church, St. Mathews Church, Pinn Memorial Church and the Junior League.



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Priority: Improve Colon Cancer Prevention with special emphasis on Urban West Community

Supporting Information:

- Colon Cancer Screening: Urban West and Urban NW areas have the highest percentage of adults who have never received a colonoscopy or sigmoidoscopy. Of the 30+ percent of adults who were never screened, the majority are ages 50-59. This indicates an opportunity to increase and improve access to screening in these areas.
- This finding was supported by research conducted by Lankenau Medical Center, “Colon Cancer Screening: A Health Disparities Study.”
 - Compliance increased with age. The age group 50-59 are most likely to have the greatest benefit from early intervention but were found to be least likely to comply. Major disparities in compliance were found in respect to patients’ employment and insurance status. Uninsured and underinsured patients were much less compliant than those with insurance.

Goal 1: Increase colon cancer screening with special emphasis on patients 50-59 years old

Action Items:

- Explore how to provide community-based referrals for patients dealing with employment needs, a significant barrier to obtaining screening or our patient population.
- Develop programming and community-based partnerships to increase screening for underinsured or uninsured patients.
- Improve education on the value, importance, risks and benefits of colon cancer screening.
- Explore joint outreach/screening events with Colon Cancer Alliance, a national organization dedicated to the awareness and prevention of colon cancer.
- Work with Gastroenterology physicians to raise awareness for genetic testing available to support patients at higher risk for colon cancer.

Goal 2: Continue to track disparities research outcomes

Priority: Address prevention, education, and treatment of adult and childhood obesity and diabetes

Supporting Information:

- Diabetes is higher for both younger and older adults in the Urban West service area as compared to SEPA. Almost one in three adults over 65 have diabetes in Urban West.
- Urban West has the highest number of adults that are obese across all of our service areas for both 18-64 and 65+(over 30%). There are also significant barriers to exercise for our parts of our service population.
 - Urban West has the highest number of adults that do not exercise at all (approx. 20%). In addition, the data shows that Urban West has the lowest percent of their population having five or more servings of fruits and vegetables at day. Obesity is a major risk factor for developing diabetes.

Goal 1: Provide outpatient care management for high-risk diabetic patients

Action Items:

- LCCC will be conducting an intervention for intensive care management for diabetics (focusing on medication management, patient education, and psychosocial support, monthly dietician, group education classes, physical activity).
- Provide free “pop-up” classes on nutrition and physical activity for 300 Lankenau Clinical Care patients in an outpatient setting.

Goal 2: Explore the development of Weight Management Program at LMC



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Priority : Address prevention, education, and treatment of adult and childhood obesity and diabetes (continued)

Goal 3: Develop Community-Based partnership that increases access to physical activity, access to healthy food, and nutrition education for our patient population for prevention and treatment of obesity and diabetes

Action Items:

- Provide free Health Education Series reaching over 80 high-risk and vulnerable participants a year that focus on physical activity and healthy eating. Deliver series to local community-based organizations and faith-based organizations.
- Provide free nutrition education, (i.e. food labeling education), at local Whole Foods Markets to the community, with the goal of reaching 300 individuals.
- Provide individual case management and social work support for vulnerable populations to increase food access (i.e. SNAP benefits, access to local food pantries, meal delivery).
- Explore opportunities to develop a stronger partnership with Philabundance to support food access for our community.
- Partner with local YMCAs to link vulnerable patients with low-cost access for physical activity.
- Increase utilization of diabetic education and management for LCCC patients.
- Conduct two yearly Lankenau-based food drives to support local food pantries.
- Continue to build upon our work with Just 4 You, a MLH senior executive committee, that works to identify healthy and fresh food offerings across our campus to support access to healthy food options for patients, visitors and employees.



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Priority: Address prevention, education, and treatment of adult and childhood obesity and diabetes (continued)

Goal 4: Create and provide targeted, grade-specific education to over 5,000 children yearly on the importance of healthy eating and physical activity

Action Items:

- Build upon current program with the development of a web-based health education component to link HEC-based classes to parents and enhance healthy living/wellness conversations at home. Will link with MLH Well Ahead web-based content.
- Work to continue to evaluate and refine curriculum for HEC classes.

Goal 5: Engage over 50 high school seniors in becoming community health workers and provide community-based education to underserved areas via the ER Academy

Goal 6: Create a Community Garden, Walking Trails, and Farmers Market at LMC that is utilized by patients, staff; and community to enhance access to affordable fresh foods, knowledge and awareness of healthy eating and increased physical activity

Action Items:

- Develop a program to integrate the community garden and farmers market into LCCC Patient Centered Medical Home.
- Explore the creation of healthy eating demonstration classes for Lankenau patients.
- Develop a program to integrate the community garden and farmers market into health education of over 10,000 children reached by Lankenau Health Education Center.
- Explore the development of a Lankenau Wellness Council to support Lankenau employees in making healthy choices and improve overall health.

Priority: Improve Quality of Life and Increase Education, Awareness and Access to Senior Services

Supporting Information:

- Older adults are the fastest increasing age segment in the LMC CHNA sub-areas with the first “Baby Boomers” (adults born between 1946 and 1964) having turned 65 in 2011. The percentage of persons age 65+ is 18.1% in the LMC Suburban Core area, higher than in SEPA at 13.5%.
- There is a higher percentage of the population over the age 65 that is diagnosed with high blood pressure and high cholesterol, and about one in three older adults are coping with a chronic condition across all LMC sub areas.
- Healthy People 2020 reports that each year, about one-third of men and women age 65 and older experience a fall, and 20% to 30% of them suffer a moderate to severe injury, such as a hip fracture or head injury. These injuries can make it more difficult for older adults to live independently, and injuries increase older adults' risk of premature death.



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Priority: Improve Quality of Life and Increase Education, Awareness and Access to Senior Services

Goal 1: Explore the development of a falls reduction program in conjunction with other MLH hospitals

Action Items:

- Explore the development of and participation in MLH falls reduction program.
- Develop and implement an evidence-based fall prevention education program – **Matter of Balance®**. The **Matter of Balance®** program emphasizes practical strategies to reduce fear of falling and increase activity levels. The program was designed to benefit community-dwelling older adults who are concerned about falls, sustained falls in the past, restrict activities because of concerns about falling, are interested in improving flexibility, balance and strength and are age 60 or older, ambulatory and able to problem solve.
- Host three community lectures annually on fall preventions

Goal 2: Continue the efforts of the MLH Transitions in Care teams to identify and decrease readmissions and risk to patients after hospital discharge

Action Items:

- Continue to participate in the Our Patients in Common (OPIC) initiative, a MLH program collaborating with numerous organizations (churches, senior centers, home health and government agencies, nursing homes, housing, education, etc.) to work to improve transitions in care, reduce hospitalizations and coordinate care among clients.



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Priority: Improve Quality of Life and Increase Education, Awareness and Access to Senior Services (continued)

Goal 3: Explore the feasibility of developing a geriatric assessment program in conjunction with other MLH hospitals

Action Items:

- Explore the feasibility of developing a Geriatric program staffed by geriatricians, social work and nurse practitioners to provide evaluative services, prepare care plans and connect seniors to medical and community resources.



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Priority: Improve Quality of Life and Increase Education, Awareness and Access to Senior Services

Goal 4: Address the needs of our patients' caregivers as they take the lead in the care of their loved ones

Action Items:

- LCCC will create a database of senior care services that are available in our community for our underserved and vulnerable populations.
- Explore the development of caregiver programs on campus geared toward the sandwich generation and focused on activities of daily living, medication management and emotional support.
- Introduction of a monthly Alzheimer's Support Group for caregivers.
- Provide education to caregivers about the advanced directive process and encourage them to discuss planning for decision making with parents and significant others.



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Priority: Cultural/Diversity

Supporting Information

Cultural awareness and competence improves the quality of care and health outcomes. Being culturally competent and understanding the varying health needs of diverse populations is important to eliminate disparities of care and to remove any cultural barriers for accessing care.

There may be pockets of diverse population in the LMC community. Although there is limited information on these sub-populations, they may contain persons with varying health needs that may need to be addressed.

Goal 1: Participate in the Main Line Health System-wide Diversity and Inclusion Initiative that is comprised of numerous high level committees and Diversity and Cultural Competence work groups.

Action Items:

- Active participation on MLH “Disparities in Care Work Group” to assess current and projected state of care across MLH related to diverse patient base (racial, cultural, age, gender, sexual preference).
- Active participation on MLH “Community Work Group” to convey the findings and recommendations of the community health needs assessment, better understand the health needs of pockets of diverse populations and ensure that care and education is aligned with the health needs of the community.
- Participate in Lankenau Diversity and Inclusion Workgroup that focuses on creating patient and employee focused initiatives to support diversity and inclusion across the campus

Goal 2: Implement goals and action items for priority “Improve access and care to the Jewish Community.”

Goal 3: Implement goals and action items embedded in all priorities that the needs of the underserved are met.



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Community priorities not being addressed in this plan

The following health needs are important to the community. However, they will not be addressed with specific implementation plans since these needs are already being addressed throughout the LMC and MLH System communities or action items have been developed under the heading of another priority (i.e. “uninsured” being addressed within the health need priorities of obesity, cardiovascular disease, cancer).

Behavioral Health

As noted, there are some data gaps to thoroughly understand the specific behavioral health issues in the community. Regardless, MLH has several uniquely designated behavioral health centers, each specializing in a level of care and treatment. For families and individuals coping with issues like psychiatric disorders, addictions or other problems which affect one's sense of well-being and participation in life, the Main Line Health Behavioral Health network provides numerous services for the LMC and MLH community. Additionally, LMC provides services and referrals through the LCCC, which serves patients residing in the Urban West area where the highest rates of stress are reported.



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Community priorities not being addressed in this plan

Uninsured

As noted, most patients seen at the LCCC reside in the Urban West area, a disadvantaged community where 28% of the population is uninsured. This population also reports higher rates of fair or poor health. Embedded in the implementation plans for the selected priorities of obesity, cardiovascular disease, lung disease and cancer, are specific action items addressing the uninsured residing in the Urban West and other LMC areas. These action items are specific for persons that utilize the LCCC and for uninsured persons that may not be accessing health services due to financial and other barriers. Some of these action items include eliminating disparities of care, free health screenings and health education at local community organizations/events for the underserved and uninsured to make healthy choices, identify risk factors and seek treatment when needed in the most appropriate care setting.

Additionally, LMC participates in the “Healthy Women Program” to provide free mammograms and provide financial counselors to address insurance needs and/or charity care.

Prescriptions

Filling prescriptions is not an area that LMC can address directly. However, LMC works closely with the Deavers Fund which provides free or low cost prescriptions to persons in need.



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Appendix

Community Partners

OPIC: Our Patients in Common (OPIC) is a group of community/hospital/long-term care facilities. This collaborative was developed and launched by LMC's Community Health Center in 2008. OPIC is a collaboration of over 35 organizations (churches, senior centers, home health and government agencies, nursing homes, housing, education, ambulance transport, assisted living, subsidized housing) and individuals (physicians, elder lawyers, case managers, MLH employees) that work to improve transitions in care, reduce hospitalizations and coordinate care among clients. OPIC meets several times each year.

Government

- Philadelphia Corporation for Aging
- Philadelphia Housing Authority
- Qual Med
- Lower Merion School District
- Lower Merion Township
- Narberth Township

Social Service Agencies

- Surrey Services
- Eldernet
- Jewish Family and Children's Service



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Community Partners

Education

- Widener University
- West Chester University
- Villanova University
- St. Joseph's University
- Overbrook High School
- Lincoln High School
- Martin Luther King High School
- Senkow Elementary
- Highland Park Elementary
- Penn Wynne Elementary
- West Philadelphia Achievement Charter
- Robert Morris School
- Media Elementary
- Overbrook Educational Center
- John Barry School
- Holy Child Academy
- Wallingford Elementary
- Torah Academy

Community Organizations

- Kaiserman Jewish Community Center of Philadelphia
- YMCA Main Line
- YMCA West Philadelphia
- LIFT
- Junior League of Philadelphia
- Food Trust
- Whole Foods-Wynnewood

Ambulance-Transport

- Transcare

Subsidized Housing

- Ardmore House
- Trinity House

Churches

- Christ Lutheran Church
- Overbrook Presbyterian
- Bryn Mawr Presbyterian Church
- Good Samaritan Church
- St. Matthews's AME
- Pinn Memorial Church



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Community-Based Resource Referrals for Lankenau Clinical Care Center Service Area

The Robert Wood Johnson Foundation's Commission to Build a Healthier America called upon "health care providers, particularly those whose patients have lower incomes or live in disadvantaged communities, [to] help connect patients with community services and resources." Preventative referrals to key resources – affordable housing, child care, employment, GED classes, job training – enable families to increase their income and education, two critical determinants of better long-term health.

To support our health care providers in addressing the psychosocial needs of our patients within LCCC, we have developed an electronic database of community-based resources. Our providers are able to make community-based referrals to local organizations that address the needs of our patients. We have an electronic compendium of over 70 community-based resources in the following areas:

- Childcare
- Employment/Job Training
- Adult Education
- Food Access and Commodities
- Housing and Utilities
- Summer Camps
- Resources for Seniors
- Resources for Youth
- After-school programs
- Dental Care
- Smoking Cessation
- Weight Management
- Low-cost or free exercise programs
- Support groups—abuse, substance abuse
- Money /Financial Management
- Intimate Partner Violence
- Family Support
- Breastfeeding



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