



**Main Line Health<sup>®</sup>**

Well ahead.<sup>®</sup>

**Bryn Mawr Hospital  
Lankenau Medical Center  
Paoli Hospital  
Riddle Hospital**

# **2016 Community Health Needs Assessment for the MLH Acute Hospitals: *Community Health Needs Priorities and Implementation Plan***

Adopted: June 2, 2016  
MLH Board of Governors

# Overview and Background: The Main Line Health (MLH) Acute Hospitals (Bryn Mawr Hospital, Lankenau Medical Center, Paoli Hospital and Riddle Hospital)

## About Bryn Mawr Hospital (BMH)

Bryn Mawr Hospital, a member of Main Line Health, is a 319-bed, not-for-profit acute-care teaching hospital dedicated to helping the community stay well ahead on the path to life-long health. Among many regional and national awards and recognitions, Bryn Mawr Hospital has been named to *U.S. News & World Report's* "Best Hospital" rankings and has earned Magnet® designation, the highest distinction for excellence in nursing care. The National Institutes of Health Commission on Cancer has also accredited Bryn Mawr Hospital's Cancer Center, and the Comprehensive Breast Center has been accredited by The Joint Commission and the National Accreditation Program for Breast Centers. Bryn Mawr Hospital's Bariatric Program has been accredited by the American Society for Metabolic and Bariatric Surgery.

The Hospital offers a full range of services, including cancer care, orthopaedic care, cardiovascular care, behavioral health, maternity care, bariatric surgery, neurovascular care and a Level III Neonatal Intensive Care Unit, all aided by a dedicated team of health care professionals and innovative technologies, such as the Intuitive Surgical System's DaVinci Robot and Navio Robotic Arm Orthopedic System. Through Bryn Mawr Hospital's collaboration with the Jefferson Hospital for Neuroscience, the university-affiliated Neurovascular Center offers rapid access to advanced diagnostics and treatment options for stroke care. Bryn Mawr Hospital has also collaborated with Nemours/Alfred I. duPont Hospital for Children to include round-the-clock pediatric care for the pediatric inpatient unit and in the pediatric emergency department with additional board-certified, fellowship-trained pediatric emergency medicine physicians. For more information about Bryn Mawr Hospital, visit [mainlinehealth.org/brynmawr](http://mainlinehealth.org/brynmawr).

### **About Lankenau Medical Center (LMC)**

Lankenau Medical Center, a member of Main Line Health, is recognized as a national leader in advancing new options to diagnose and treat illness, protect against disease and save lives. Located on a 93-acre campus just outside of Philadelphia, Lankenau Medical Center is a 389-bed, not-for-profit teaching hospital that includes one of the nation's leading cardiovascular centers; the Lankenau Institute for Medical Research, one of the few freestanding hospital-associated research centers in the nation; and the Annenberg Conference Center for Medical Education, that trains over 100 new physicians each year through nationally ranked residency and fellowship programs. Lankenau has received both regional and national recognition for its excellence in providing state-of-the-art, quality care from U.S News and World Report, The Joint Commission and Truven Health Analytics, among others. Lankenau has also earned the highest distinction for excellence in nursing care, the American Nurses Credentialing Center Magnet® designation. For more information about Lankenau Medical Center, visit [mainlinehealth.org/lankenau](https://mainlinehealth.org/lankenau).

### **About Paoli Hospital (PH)**

Paoli Hospital, a member of Main Line Health, is a 231-bed, not-for-profit acute care hospital and Regional Trauma Center with outpatient facilities in Exton and Collegetown. Among their many regional and national recognitions for their advanced care and state-of-the-art treatment options, Paoli has been named to the *U.S. News & World Report's* "Best Hospital" rankings and has also earned Magnet® designation, the highest distinction for excellence in nursing care, from the American Nurses Credentialing Center. For more information about Paoli Hospital, visit [mainlinehealth.org/paoli](https://mainlinehealth.org/paoli).

## About Riddle Hospital (RH)

Riddle Hospital, a member of Main Line Health, is a not-for-profit, acute-care hospital with 204 inpatient beds and 23 Transitional Care Center beds. Riddle has been nationally recognized by The Joint Commission, *US News & World Report*, the Society of Cardiovascular Patient Care and other health care rating organizations for its high quality patient care. Riddle offers a full range of services including maternity, orthopaedic care and cardiovascular care—aided by a dedicated team of health care professionals and advanced technology. Riddle’s recently expanded and enhanced Emergency Department serves the growing needs of the Delaware County community and beyond. Health Center 4, a LEED Certified Gold building, houses the Rothman Institute, the Wound Healing and Hyperbaric Center, a variety of outpatient programs and a state of the art surgical center. The Hospital has also achieved Magnet® designation, the nation’s highest distinction for excellence in nursing care, from the American Nurses Credentialing Center. For more information about Riddle Hospital, visit [mainlinehealth.org/riddle](https://mainlinehealth.org/riddle).

Priority Topics Identified by the MLH Acute Hospitals CHNA: (All priorities are of equal weight.)

Priority Topic	Community Stakeholder Interest	Worse than Benchmark* or a Trend	Healthy People 2020	National Prevention Strategy	CMS Equity Plan	Sub-Pop with Special Needs
Healthy Weight (Diabetes)	✓	✓	✓	✓		
Metabolic Syndrome	✓	✓	✓			
Heart Health (Stroke)	✓	✓	✓			
Cancer	✓	✓	✓			
Smoking and Tobacco Use	✓	✓	✓	✓		
Behavioral Health (Mental Health and Substance Abuse)	✓	✓	✓	✓		
Injury Prevention	✓	✓	✓	✓		
Dental Health	✓	✓	✓			
Seniors	✓		✓		✓	✓
Pre-natal Care / Low Birth Weight Infants		✓	✓			✓
Culture / Diversity / Disparities of Care	✓			✓	✓	

A community need was determined to be a priority if it met the following criteria: 1) addressed at least two of the following -- a) met a community stakeholder interest, b) involved a benchmark / trend needing improvement, c) is listed as a community health benchmark, or d) addresses the needs of an at risk population; 2) was in the scope of services / purview of one or more of the MLH acute hospitals; and 3) was not currently being addressed by a MLH partner.

\* Benchmark sources include Healthy People 2020 and Southeastern PA geography data from PHMC Community Health Database

Page Index for each MLH Acute Care Hospital’s “Action Plan initiatives” that address the Priority Community Health Needs:

Health Need Priority	Bryn Mawr Hospital (BMH)	Lankenau Medical Center (LMC)	Paoli Hospital (PH)	Riddle Hospital (RH)
Healthy Weight (Diabetes)	9, 10, 12,13,14,15	9, 10, 11, 12,13,14,15	9, 10, 12,13,15	9, 10, 12,13,15
Metabolic Syndrome	System (19)	System (19)	System (19)	System (19)
Heart Health (Stroke)	22, 23, 25, 26	22, 23, 25, 26	22, 23, 25, 26	22, 23, 25, 26
Cancer	29, 30, 31, 32, 33, 34	29, 30, 31, 32, 33, 34	29, 30, 31, 32, 33	29, 30, 31, 32, 33
Smoking & Tobacco Use	37	37	37	37
Behavioral Health (Mental Health and Substance Abuse)	40, 41, 44, 45, 46	40, 41, 43, 44, 45, 46	41, 44, 45, 46	41, 44, 45
Injury Prevention	51, 52, 54	51, 52, 53, 54, 55	51, 52, 54, 55	51, 52
Dental Health	System (58)	58, System (58)	System (58)	System (58)
Seniors	61, 62, 63, 64	63, 64	63, 64, 65	63, 64
Pre-natal Care / Low Birth Weight Infants	--	69	--	--
Culture / Diversity / Disparities of Care	72	72, 74, 75	72, 74	72

The Action Plan initiatives for the four MLH acute hospitals are color coded throughout the document as follows: (BMH, LMC, PH, RH); MLH System and MLH Community Partners are identified as such: (MLH Partner - ).

**PRIORITY COMMUNITY NEED TOPIC**  
**HEALTHY WEIGHT**  
**(Diabetes)**

**PRIORITY STATEMENT: To improve the percentage of healthy weight individuals and to prevent persons at risk from becoming overweight or obese and thus at risk of associated systemic diseases.**

**Supporting Information / Background:**

- Maintaining a healthy weight is about a lifestyle that includes healthy eating, regular physical activity, and balancing the number of calories you consume with the number of calories your body uses. Staying in control of your weight contributes to good health now and as you age. (CDC: Healthy Weight, 2016)
- Regular exercise can lower the risk of heart disease, stroke, metabolic syndrome, type 2 diabetes, certain cancers, reduce depression, and prevention of falls among seniors. (CDC: Healthy Weight, 2016)
- A healthy lifestyle involves many choices. Among them, choosing a balanced diet or healthy eating plan based on the *Dietary Guidelines for Americans 2010*. (CDC: Division of Nutrition, Physical Activity and Obesity, 2016)
- Diabetes can cause serious health complications including heart disease, stroke, blindness, kidney failure, and lower-extremity amputations. (CDC, Diabetes, March 2016)
- Ten percent (10%) of adults 18+ and eighteen percent (18%) of seniors (60+) have been diagnosed with diabetes in the CHNA Suburban sub-area. Fifteen percent (15%) of adults 18+ and thirty-one percent (31%) of seniors (60+) have been diagnosed with diabetes in the West Philadelphia sub-area. (PHMC, Community Health Database, 2015)
- A person with prediabetes has a blood sugar level higher than normal, but not high enough for a diagnosis of diabetes. Without lifestyle changes to improve their health, 15% to 30% of people with prediabetes will develop type 2 diabetes within five years. (CDC, Diabetes, March 2016)
- MLH System is committed to serving healthy foods / beverages in hospital cafes and vending machines across the System. LMC participates in the PDPH Good Food, Healthy Hospital initiative.



## Goal 1: Increase awareness of prediabetes and its associated clinical risks to decrease the prevalence of type 2 diabetes in the community.

### Action Plan:

- Develop an educational DVD and other materials for area primary care physicians and their patients by June 2018. (MLH System Diabetes Management program)  
Resources: Staff time and budgeted funds  
Sponsor: System Director – Diabetes Management Program; Community Health Services Manager / Director
- Conduct six "lunch and learns" / lectures annually in the community regarding the clinical significance of prediabetes, healthy eating and nutrition by each hospital. (BMH, LMC, PH, RH) (MLH System Diabetes Management program)  
Resources: Staff time  
Sponsor: Community Health Services Manager / Director
- Provide diabetes educational materials and screenings at community health fairs. (BMH = 4, LMC = 5, PH = 3, RH = 4) (MLH System Diabetes Management program)  
Resources: Staff time and printed materials  
Sponsor: System Director – Diabetes Management Program; Community Services Manager / Director
- Develop and initiate a system-wide prediabetes campaign by January 2017. (MLH System Diabetes Management program)  
Resources: Staff time and budgeted funds  
Sponsor: System Director – Diabetes Management Program; Community Health Services Manager / Director

- Explore collaboration and develop program actions with the YMCA's CMS sponsored lifestyle pilot program or other programs by September 2016. (BMH, LMC, PH, RH) (LMC)

**Resources:** Staff time and budgeted funds

**Sponsor:** System Director – Diabetes Management Program; Community Health Services Manager / Director; Hospital Marketing Managers

**Goal 2: Increase awareness and engagement of adults in the most vulnerable populations served by the Lankenau Medical Center to (a) decrease the prevalence of prediabetes and type 2 diabetes and (b) increase the percentage of adults and children in the population who have a healthy weight.**

*Action Plan:*

- Embedded health educators in Lankenau Medical Associates (LMA) and Lankenau Obstetrics Gynecology Care Center (LOGCC) will provide 50 programs per year in LMA and 25 programs per year in LOGCC. (LMC)

**Resources:** Staff time

**Sponsor:** Associate Director - LMC

- Health Educators will conduct 24 “pop-up cooking demonstrations” in LMA and LOGCC per year. (Cooking demonstrations will incorporate the Delema G. Deaver Wellness Garden organic produce into the demonstration classes. Patients participating in the cooking demonstration classes will receive recipes and organic produce for the recipe.) (LMC)

**Resources:** Staff time and Wellness Garden resources

**Sponsor:** Associate Director - LMC

- The Medical Student Advocate Program and Nursing Student Advocate Program will address the needs of our vulnerable populations in LMA and LOGCC and aim to identify and address approximately 150 food related resource needs (i.e. SNAP benefits, transportation to farmers market, nutrition education) per year. (LMC)

**Resources:** Staff time

**Sponsor:** Associate Director - LMC

- Expand partnership with the Food Trust by developing programming in local Healthy Corner Store to provide health screenings (BMI and blood pressure), health education on modifiable risk factors, and linking participants to primary care. Philly Food Bucks are vouchers that can be redeemed at over 30 Food Trust operated farmers markets for fresh and affordable fruits and vegetables. (LMC)
  - Continue Philly Food Bucks Program aiming to provide approximately 150 patients in Lankenau Medical Associates (LMA) with Philly Food Bucks. The LMA will link nutrition counseling to all patients receiving Philly Food Bucks.
  - Aim to conduct 12 monthly programs per year throughout the Implementation Plan cycle.
  - Explore adding additional Healthy Corner Store locations in FY17.
  - Aim to conduct 150 screenings a year in the Healthy Corner Store program beginning in FY17.
  - Expand community farmers market outreach and health education. Conduct 10 programs a year at local farmers markets providing health education and screenings.

**Resources:** Staff time

**Sponsor:** Associate Director – LMC

### **Goal 3: Increase awareness of the health benefits of physical activity to increase the percentage of adults and children who exercise at least 3 times a week.**

#### *Action Plan:*

- Partner with YMCA, ACAC, Community Resource and Educational Center at Haverford Reserve, schools, trails, etc. to host events / educational programs focusing on fitness and health. (BMH = 6, LMC = 6, PH = 6, RH = 3)

**Resources:** Staff time

**Sponsor:** Community Health Services Manager / Director

- Provide yearly sponsorship to the “Healthy Kids Running Series” to introduce young children to exercise. (BMH, LMC, PH, RH) (Partner with Nemours Foundation)

**Resources:** Budgeted funds

**Sponsor:** Community Health Services Manager / Director; Hospital Marketing Manager

- Continue partnership with local trail organizations (“Rails to Trails”) to conduct rail-based programs each year. (LMC = 3, PH = 3) (Community partner – Rails to Trails)

**Resources:** Staff time and physician speakers

**Sponsor:** Community Health Services Manager / Director

**Goal 4: Increase awareness of the importance of healthy eating across the lifespan as recommended by the American Dietetic Association to increase the percentage of healthy weight children and adults in the CHNA communities.**

*Action Plan:*

- Provide corporate, over-55 communities, and community lectures on healthy eating and nutrition. (BMH = 6, LMC = 12, PH = 6, RH = 3)  
**Resources:** Staff time  
**Sponsor:** Community Health Services Manager / Director
- Update the MLH Obesity Resource Guide and distribute to physicians, employees and community partners so latest information is available to providers and patients by September 2016. (MLH System CHNA Healthy Weight leaders)  
**Resources:** Staff time and budgeted funds  
**Sponsor:** MLH Obesity Committee Chair
- Develop a listing of weight management programs for distribution to area physicians by September 2016. (MLH System Diabetes Management program)  
**Resources:** Staff time and budgeted funds  
**Sponsor:** System Director - Diabetes Management Program; Community Health Services Coordinator - Dieticians
- Partner with area public and private schools to provide education on healthy eating and nutrition for children and their parents. (BMH = 4, PH = 6, RH = 2)  
**Resources:** Staff time  
**Sponsor:** Community Health Services Manager / Director; System Community Services - Nutrition Coordinator

- Lankenau Health Education Center will provide 100 sessions each year on healthy eating and nutrition for area public and private school children. (LMC)  
**Resources:** Staff time  
**Sponsor:** Chief Academic Officer – MLH; Associate Director – LMC
- Participate on local school districts' Health Advisory Councils (Wellness Councils) throughout the Implementation Plan cycle. (BMH, LMC)  
**Resources:** Staff time  
**Sponsor:** Community Health Services Director
- Create a comprehensive program incorporating the Delema G. Deaver Wellness Garden and the Lankenau walking trail for patients, families, and visitors by June 2017. (LMC)  
**Resources:** Staff time  
**Sponsor:** Associate Director, LMC
- Develop partnerships with schools and local community based organizations to utilize the garden and walking trail for prevention strategies by June 2018. (LMC) (Community partner – local non-profits)  
**Resources:** Staff time  
**Sponsor:** Associate Director, LMC

## **Goal 5: Promote healthy eating and weight management options for residents of the CHNA communities.**

### *Action Plan:*

- Increase staff to allow access to disease-specific and general nutrition counseling with MLH dietitians to serve additional community members by January 2017. (BMH, LMC, PH, RH) (MLH System Diabetes program)

**Resources:** Increased budgeted funds to support addition Diabetes Management staff

**Sponsor:** System Manager – Diabetes Management Program; Campus VP Leadership

- Expand the “New Direction” weight management program from one campus to a system-wide program by December 2018. (MLH System Diabetes Management program)

**Resources:** Increased budgeted funds

**Sponsor:** Hospital VP Leadership

## **Goal 6: MLH System will attempt to engage its 12,000 employees (the majority whom live in the CHNA area) to live healthy, active lifestyles.**

- The MLH System will expand the “Take Charge of Your Weight” program to each hospital campus twice per year starting in FY17 and continuing throughout the Implementation Plan cycle. (BMH, LMC, PH, RH) (MLH partner – Human Resources)

**Resources:** Staff Time

**Sponsor:** Manager - Health & Productivity (HR)

**PRIORITY COMMUNITY NEED TOPIC**  
**METABOLIC SYNDROME RISKS**



**PRIORITY STATEMENT:** To develop a comprehensive MLH System and CHNA community approach to deal with major community health needs improvements for obesity, diabetes, heart health and stroke thereby improving the overall health status of the community.

**Supporting Information / Background:**

- Metabolic syndrome is the name for a group of risk factors that raises your risk for heart disease and other health problems, such as diabetes and stroke.
- The term "metabolic" refers to the biochemical processes involved in the body's normal functioning. Risk factors are traits, conditions, or habits that increase your chance of developing a disease.
- The five conditions described below are metabolic risk factors. You can have any one of these risk factors by itself, but they tend to occur together. You must have at least three metabolic risk factors to be diagnosed with metabolic syndrome.
  1. A large waistline. This also is called abdominal obesity or "having an apple shape." Excess fat in the stomach area is a greater risk factor for heart disease than excess fat in other parts of the body, such as on the hips.
  2. A high triglyceride level (or you're on medicine to treat high triglycerides). Triglycerides are a type of fat found in the blood.
  3. A low HDL cholesterol level (or you're on medicine to treat low HDL cholesterol). HDL sometimes is called "good" cholesterol. This is because it helps remove cholesterol from your arteries. A low HDL cholesterol level raises your risk for heart disease.

**Supporting Information / Background (Continued):**

4. High blood pressure (or you're on medicine to treat high blood pressure). Blood pressure is the force of blood pushing against the walls of your arteries as your heart pumps blood. If this pressure rises and stays high over time, it can damage your heart and lead to plaque buildup.
  5. High fasting blood sugar (or you're on medicine to treat high blood sugar). Mildly high blood sugar may be an early sign of diabetes.
- The risk for heart disease, diabetes, and stroke increases with the number of metabolic risk factors present for an individual. The risk of having metabolic syndrome is closely linked to overweight and obesity and a lack of physical activity. (National Heart, Lung and Blood Institute, NIH, 2016)

**Goal 1: Develop a MLH System-wide approach to positively impact the CHNA communities with improved public health statistics for healthy weight, diabetes, heart health and stroke.**

*Action Plan:*

- Prepare a white paper on options for developing a MLH System-wide approach for a coordinated “Metabolic Syndrome” strategy to benefit the public health of the CHNA communities. Distribute the plan for discussion at senior levels of the MLH System and the medical staff. (In conjunction with MLH System)

**Resources:** Executive staff time and professional writer to prepare document

**Sponsor:** Senior Vice President, CMO

**PRIORITY COMMUNITY NEED TOPIC**  
**HEART HEALTH**  
**(Stroke)**

**PRIORITY STATEMENT:** To increase awareness for improved heart health and for the prevention of stroke, along with making sure adequate resources exist in the area with the intent to improve health outcomes in the CHNA communities.

**Supporting Information / Background:**

- High blood pressure, high LDL cholesterol, and smoking are key heart disease risk factors for heart disease. Several other medical conditions and lifestyle choices can also put people at a higher risk for heart disease, including diabetes, overweight and obesity, poor diet, physical inactivity, and excessive alcohol use. (CDC: Division for Heart Disease and Stroke Prevention, 2016)
- Over 23% of adults\* (18+) in the MLH Suburban sub-area and over 35% in both NW Philadelphia (36%) and West Philadelphia (39%) have at some point been diagnosed with high blood pressure.
- Heart disease is the leading cause of death for African American and white women in the United States. Despite increases in awareness over the past decade, only 54% of women recognize that heart disease is their number 1 killer. (CDC: Division for Heart Disease and Stroke Prevention, 2016)
- Some medical conditions including high blood pressure, high cholesterol, heart disease, diabetes, overweight or obesity, and previous stroke or transient ischemic attack (TIA) can also raise your stroke risk. Some stroke risk factors, like heredity, age, gender, and ethnicity can't be controlled. (CDC: Division for Heart Disease and Stroke Prevention, 2016)

\* Age adjusted.

**Goal 1: Increase awareness through education and screenings on the importance of heart health with the intent of improved health for residents of the CHNA community.**

*Action Plan:*

- Conduct screenings (any combination of blood pressure, cholesterol, glucose and stroke) each year throughout the CHNA community. (BMH = 140 screens, LMC = 400 screens, PH = 10, RH = 60)  
**Resources:** Community Services staff and funds budgeted for cholesterol screenings  
**Sponsor:** Community Health Services Manager / Director
- Provide cardiac seminars at corporations and in community settings each year. (BMH = 2, LMC = 4, PH = 4, RH = 2)  
**Resources:** Staff time  
**Sponsor:** Community Health Services Manager / Director
- Provide stroke education sessions in middle and high schools each year. (BMH = 1, LMC = 48, PH = 3)  
**Resources:** Staff time  
**Sponsor:** Community Health Services Manager / Director
- Provide heart health lectures / information tables at senior centers and / or “Senior Supper” per year. (BMH = 3, LMC = 6, PH = 3, RH = 3)  
**Resources:** Staff time  
**Sponsor:** Community Health Services Manager / Director

- Provide heart health information education emphasizing low sodium and low saturated fats options through displays at public health fairs. (BMH = 3, LMC = 4, PH = 6, RH = 3)  
**Resources:** Staff time  
**Sponsor:** Community Health Services Manager / Director
- Provide patients with written details of their community health screening findings and encourage them to link with their PCP when in need of follow-up care. (BMH, LMC, PH, RH)  
**Resources:** Staff time  
**Sponsor:** Community Health Services Manager / Director
- Promote awareness of cardiovascular risks and prevention to the CHNA community on the Lankenau Heart Institute (LHI) website. (MLH partner – Lankenau Heart Institute)  
**Resources:** Staff time; Website manager; Budgeted marketing dollars  
**Sponsor:** System Marketing Manager – Cardiovascular Services and Women’s Health

**Goal 2: To maintain a MLH focus on women’s heart health with the intent to decrease the impact of heart disease.**

*Action Plan:*

- Conduct community based programming, outreach, and educational events focusing on women 35-65 years old. Aim to conduct two programs a year reaching 150-200 women per event. (MLH partner – Women’s Heart Health Initiative)  
**Resources:** Staff time; Budgeted program resources  
**Sponsor:** Program Director for Women’s Heart Health Initiative and LHI physician leaders

- Continue the partnership with the American Heart Association to address issues related to increased cardiovascular mortality in pregnant and postpartum women (provider and patient education) throughout this Implementation Plan cycle. (MLH partner – Women’s Heart Health Initiative)  
**Resources:** Staff time; project resources  
**Sponsor:** Program Director for Women’s Heart Health Initiative and LHI physician leaders
- Explore the development of a MLH System Women's Heart Health Resource Center at LMC for providing education and learning resources on heart health for women by June 2018. (MLH partner – Women’s Heart Health Initiative)  
**Resources:** Staff time; budgeted resources along with foundation / donor funding  
**Sponsor:** Program Director for Women’s Heart Health Initiative and LHI Physician Leaders
- Explore the development of programming that utilizes former patients as volunteers to serve as ambassadors to the community for education, awareness, and prevention by June 2018. (MLH partner – Women’s Heart Health Initiative)  
**Resources:** Staff and volunteer time  
**Sponsor:** Program Director for Women’s Heart Health Initiative and LHI physician leaders

**Goal 3: Continue to provide education to first responders with programming specific to heart health to improve pre-hospital care in the community.**

*Action Plan:*

- Provide at least one education program for over 50 first responders during each year of the Implementation Plan cycle. (MLH partner – EMS Operations)  
**Resources:** Staff and volunteers’ time  
**Sponsor:** System Director – EMS Operations



**Goal 4: MLH System will collaborate with external organizations to promote cardiovascular health.***Action Plan:*

- Maintain participation in the American Heart Association activities: (BMH, LMC, PH, RH) (In conjunction with MLH System)
  - Heart Walk
  - Go Red for Women
  - Women's Heart Initiative

**Resources:** Staff time

**Sponsor:** Marketing Manager, Cardiovascular & Women's Health Services

- Participate in:
  - Heart Awareness month in February (BMH, LMC, PH, RH) (In conjunction with MLH System)
  - Stroke Awareness month in May (BMH, LMC, PH, RH) (In conjunction with MLH System)

**Resources:** Staff time

**Sponsor:** Marketing Manager, Cardiovascular & Women's Health Services; Marketing Manager - Stroke

- Advocate for access to cardiac rehab services all cardiac patients through the work of Bryn Mawr Hospital Cardiac Rehabilitation Manager with the American Association of Cardiovascular and Pulmonary Rehabilitation (AACVPR). (MLH acute hospitals)

**Resources:** Staff time

**Sponsor:** BMH Manager, Cardiovascular Rehabilitation

**Goal 5: MLH will maintain stroke care resources at the acute hospitals with the intent to provide quality stroke care in the local community with the intent that this care will reduce disabilities and stroke mortality.**

*Action Plan:*

- Maintain the MLH acute hospitals as Joint Commission certified stroke centers. (BMH, LMC, PH & RH)  
**Resources:** Staff time and training; Budgeted resources  
**Sponsor:** Campus Quality Directors
- Continue to provide a neuro-interventional program for the immediate treatment of stroke patients to reduce disability and mortality from strokes in the MLH acute hospitals suburban CHNA area. (BMH)  
**Resources:** Budgeted resources  
**Sponsor:** Vice President - Administration

**PRIORITY COMMUNITY NEED TOPIC**  
**CANCER**

**PRIORITY STATEMENT: To focus on improving awareness and access by reducing barriers to cancer services, reduce disparities in care, and enhance health outcomes in the CHNA communities.**

**Supporting Information / Background:**

- All cancers is the leading cause of death in the MLH acute hospitals CHNA area. (Pennsylvania Department of Health, 2009-2012\*) (Note: Heart disease is the single leading cause in the CHNA area.)
- The mortality rate (171.4 per 100,000) for all cancers in the total CHNA area exceed the Healthy People 2020 goal (161.4 per 100,000). (Healthy People 2020) Only the BMH and Paoli Hospital CHNA sub-areas do not exceed the HP2020 goal.
- The MLH acute hospitals CHNA area (and all the hospital sub-areas) exceed the Healthy People 2020 mortality goal for female breast cancer and female genital cancer. (Pennsylvania Department of Health, 2009-2012\*)
- The lung cancer mortality rate for the MLH hospitals CHNA area is slightly below the Healthy People 2020 goal (45.0 per 100,000 vs. 45.5 per 100,000) (Pennsylvania Department of Health, 2009-2012\*)
- The colon / rectum / anus cancer incidence rate exceeds to Healthy People 2020 goal. (Pennsylvania Department of Health, 2009-2012\*)
- The female breast cancer incidence rate\* exceeds the rate for SEPA in all CHNA sub-areas except NW Philadelphia. (PHMC, Community Health Database, 2015)
- Prostate cancer is the third and fourth leading cause of death\* in West Philadelphia and NW Philadelphia, compared to being the sixth leading cause in the suburban CHNA sub-area. It is also higher in the Lawrence Park sub-area. These sub-areas have higher percentages of black males who have a higher incidence of prostate cancer. (PHMC, Community Health Database, 2015)

\*Mortality and incidence rates were calculated by the Public Health Management Corporation (PHMC).

**Goal 1: To raise awareness of cancer in the CHNA community and by providing screenings, have the intent to discover early stage cancers and increase cancer survival rates.**

*Action Plan:*

- Participate in corporate and community health fairs focusing on cancer awareness each year. (BMH = 4, LMC = 4, PH = 4, RH = 4)  
**Resources:** Staff time and presentation materials  
**Sponsor:** Community Health Services Manager / Director
- Conduct prostate cancer awareness presentations / events at various events each year. (BMH = 3, LMC = 3, PH = 3, RH = 1)  
**Resources:** Staff time and presentation materials  
**Sponsor:** Community Health Services Manager / Director, MLH Campus Cancer Center Director
- Conduct colon cancer awareness presentations / events to various CHNA area audiences each year. (BMH = 3, LMC = 2, PH = 3, RH = 1)  
**Resources:** Staff time and presentation materials  
**Sponsor:** Community Health Services Manager / Director, Campus Cancer Center Director
- Conduct breast health awareness presentations / events to various CHNA area audiences each year. (BMH = 4, LMC = 4, PH = 3, RH = 1)  
**Resources:** Staff time and presentation materials  
**Sponsor:** Community Health Services Manager / Director, Campus Cancer Center Director

- Conduct skin cancer screenings in the community each year (BMH = 2, LMC = 1, PH = 4, RH = 4)  
**Resources:** Staff time and presentation materials  
**Sponsor:** Community Health Services Manager / Director
- Host “Lung Cancer Screening” awareness events at YMCAs and other community locations each year of the Implementation Plan cycle (with focus on West Philadelphia, Northwest Philadelphia and Lawrence Park CHNA sub-areas). (BMH = 1, LMC = 1, PH = 1, RH = 1) (MLH Partner – MLH Cancer Program)  
**Resources:** Staff time and presentation materials  
**Sponsor:** Community Health Services Manager / Director, MLH Lung Screening Navigators,
- Sponsor population health / cancer awareness tent at two “Relay for Life” events per year. (PH)  
**Resources:** Staff time and presentation materials  
**Sponsor:** Community Health Services Manager / Director
- Distribute “Colon Screening Menus” to area physicians offices that highlights the less invasive, less intensive prep needed for colon screenings starting in FY17. (MLH Partner – MLH Cancer Program)  
**Resources:** Staff time and presentation materials  
**Sponsor:** System Director – Cancer Services

- Maintain participation in the following events each year of the Implementation Plan cycle: (BMH, LMC, PH, RH) (In conjunction with MLH System)
  - American Cancer Society “Bike-A-Thon”
  - American Lung Association “Free to Breathe Walk”

**Resources:** Staff time and budgeted funds

**Sponsor:** Campus Cancer Center Director; Campus Marketing Manager; System event chairs

**Goal 2: To reduce barriers for those in need of cancer screenings and services and work to eliminate disparities of care in vulnerable populations in the CHNA area.**

*Action Plan:*

- By June 2017, upload information on MLH website and produce a hard copy booklet with a list of financial resources and charity care available to cancer patients in need. (MLH Partner – MLH Cancer Program)

**Resources:** Staff time, web content staff and budgeted cost for booklet

**Sponsor:** MLH Cancer Navigators

Review and update the web content and hard copy versions of the list of financial resources and charity care available to cancer patients in need in each remaining CHNA Implementation Plan year. (MLH Partner – MLH Cancer Program)

**Resources:** Staff time, Web content staff, Budgeted cost for booklet

**Sponsor:** MLH Cancer Navigators

- Annually host a Linda Creed and/or Susan B. Komen free mammography screenings for up to 30 women in need in the CHNA area per hospital. (PH, RH)  
**Resources:** Staff time and diagnostic imaging resources  
**Sponsor:** Community Health Services Manager
- In partnership with the Access Matters “Healthy Women” program, provide breast and cervical cancer screening to 55 uninsured and underinsured women per year of the Implementation Plan cycle and connect them with Healthy Women services. (LMC)  
**Resources:** Staff time and budgeted diagnostic services costs  
**Sponsor:** Community Health Services Director
- Starting in FY17 and annually thereafter during this CHNA Implementation Plan cycle, review the roles, responsibilities, and focus of the MLH navigation process to identify / update barriers to care and to discuss resources that can be utilized to address barriers. (MLH Partner – MLH Cancer Program)  
**Resources:** Staff Time  
**Sponsor:** System Director – Cancer Services

**Goal 3: To support cancer patients / survivors and their families with necessary emotional and information needs to assist them in their care path.**

*Action Plan:*

- Present at least one cancer survivorship presentation on each campus for patients and families to address concerns and challenges after cancer treatment as well as underscore surveillance guidelines each year during the Implementation Plan cycle. (BMH, LMC, PH, RH) (MLH Partner – MLH Cancer Program)  
**Resources:** Staff Time  
**Sponsor:** Campus Cancer Center Director



- Continue to host a prostate support group each year during this Implementation Plan cycle. (BMH, PH, RH)  
**Resources:** Staff time  
**Sponsor:** MLH Campus Cancer Center Director
- Continue to host a breast cancer support group each year throughout this Implementation Plan cycle. (BMH, LMC, PH, RH)  
**Resources:** Staff time  
**Sponsor:** Campus Cancer Center Director
- Create a system-wide lung cancer support group by June 2017. (MLH Partner – MLH Cancer Program)  
**Resources:** Staff time  
**Sponsor:** System Director – Cancer Services
- Continue to host the oral cancer support group each year throughout this Implementation Plan cycle. (BMH)  
**Resources:** Staff time  
**Sponsor:** Campus Cancer Center Director
- Continue to partner with “Unite for Her” (a support program providing complementary amenities for breast cancer patients) each year throughout this Implementation Plan cycle. (Community partner – “Unite for Her”)  
**Resources:** Staff time  
**Sponsor:** System Director – Cancer Services

- Continue to provide a bra fitting clinic for women in need in partnership with “Yellow Daffodils” each year throughout this Implementation Plan cycle. (BMH, LMC) (Community partner – Yellow Daffodils)

**Resources:** Staff time and partner resources

**Sponsor:** Campus Cancer Center Director

**PRIORITY COMMUNITY NEED TOPIC**  
**SMOKING AND TOBACCO USE**

**PRIORITY STATEMENT: To reduce the percentage of adults and adolescents who smoke or use tobacco products and to heighten awareness of the dangers of second-hand smoke.**

**Supporting Information / Background:**

- Cigarette smoking is the leading cause of preventable disease and death in the United States. (CDC: Smoking & Tobacco Use, 2016)
- The percentage\* of adults (18+) who smoke cigarettes in the CHNA equals (BMH sub-area) or exceeds (all other CHNA sub-areas) the Healthy People 2020 goal of 12%. The highest percentage of adults who smoke is in the West Philadelphia sub-area (27%). (PHMC, Community Health Database, 2015)

\* Age adjusted percentage.

**Goal 1: Provide smoking cessation programs to reduce tobacco use and education sessions to adults and adolescents to warn of the health risks associated with smoking and smokeless products.**

*Action Plan:*

- Continue offering on-going community tobacco cessation programs across the MLH System hospitals. (BMH = 6, LMC = 4, PH = 2, RH = 6)  
**Resources:** Staff time  
**Sponsor:** Community Health Services Health Program Specialist (Tobacco)
- Provide ongoing inpatient tobacco counseling at the acute MLH hospitals. (BMH, LMC, PH, RH)  
**Resources:** Staff time  
**Sponsor:** Community Health Services Health Program Specialist (Tobacco)
- Provide tobacco education awareness in area middle and high schools, colleges, and the community during this Implementation Plan cycle. (BMH, LMC, PH, RH)  
**Resources:** Staff time  
**Sponsor:** Community Health Services Manager / Director
- Maintain the MLH hospital campuses as tobacco and smoke free. This includes the inpatient psychiatric facilities at BMH. (BMH, LMC, PH, RH)  
**Resources:** Staff time  
**Sponsor:** Hospitals' President
- Participate in the Chester County, Delaware County and Montgomery County Tobacco - Free Coalitions' meetings. (BMH, LMC, PH, RH)  
**Resources:** Staff time  
**Sponsor:** Community Health Services Manager / Director; Community Health Prevention Specialist

**PRIORITY COMMUNITY NEED TOPIC**  
**BEHAVIORAL HEALTH – MENTAL HEALTH AND**  
**SUBSTANCE ABUSE**

**PRIORITY STATEMENT: To improve the availability and access to behavioral health resources to those in need in the CHNA communities, while improving outcomes and quality of care.**

**Supporting Information / Background:**

- Behavioral Health (substance abuse and mental health) was unanimously identified as a priority health need in the MLH acute hospitals CHNA area from available data and by all sectors of the community.
- There are insufficient behavioral health resources in the MLH CHNA communities.

**Goal 1: Continue community outreach and education for persons in need of care with the intent of reducing the percentage of persons in the community not receiving treatment.**

*Action Plan:*

- Continue Lankenau Health Education Center programming with a focus on drug education and prevention related to substance abuse. Provide 10 programs per year with this focus. (LMC)  
**Resources:** Education center support and staff time  
**Sponsor:** Chief Academic Officer - MLH
- Continue to provide space for on-site Alcoholics Anonymous meetings during this Implementation Plan cycle. (BMH, LMC)  
**Resources:** Staff time and space allocation  
**Sponsor:** Community Health Services Director
- Continue the partnership with the National Alliance of Mental Illness by hosting “Family to Family” courses and monthly support meetings for survivors during this Implementation Plan cycle. (BMH, LMC)  
**Resources:** Staff time and space allocation  
**Sponsor:** Community Health Services Director
- Continue to provide weekly sessions of the “Family Education Program” (which focuses on substance abuse) at Mirmont during this Implementation Plan cycle. (System partner – Mirmont)  
**Resources:** Mirmont clinical staff  
**Sponsor:** Clinical Director - Mirmont



- Continue to host monthly “Survivors of Suicide” meetings during this Implementation Plan cycle. (BMH, LMC, RH)  
**Resources:** Staff time and space allocation  
**Sponsor:** Community Health Services Manager / Director
- Continue to offer “Bereavement and Grief” support groups during this Implementation Plan cycle. (PH, RH)  
**Resources:** Staff time and space allocation  
**Sponsor:** Community Health Services Manager
- The MLH Behavior Health Education and Training Committee will initiate an education program, to identify behavioral health patients and available resources, that will be offered to MLH staff twice a year during this Implementation Plan cycle. (BMH, LMC, PH, RH) (System partner – MLH Behavioral Health)  
**Resources:** Staff time  
**Sponsor:** Main Line Health Behavioral Health Leadership

**Goal 2: Expand population-based community health services to improve the care and treatment of persons in need with the intent of reducing the percentage of persons in the community not receiving treatment.**

*Action Plan:*

- By June 2018, increase outpatient mental health services (for adolescents and seniors) offered at MLH behavioral health sites in Broomall and Exton in order to serve those in the community who need behavioral health treatment. (System partner – MLH Behavioral Health)  
**Resources:** Additional budgeted staffing  
**Sponsor:** Main Line Health Behavioral Health Leadership
- Add one geropsychiatric IOP (Intensive Outpatient) service at the MLH behavioral health outpatient sites in Broomall and Exton by June 2019. (System partner – MLH Behavioral Health) (System partner – Senior Services)  
**Resources:** Additional budgeted staffing  
**Sponsor:** Main Line Health Behavioral Health Leadership; System Director – Senior Services
- Add one adolescent IOP (Intensive Outpatient) service at the MLH behavioral health outpatient sites in Broomall and Exton by June 2019. (System partner – MLH Behavioral Health)  
**Resources:** Additional budgeted staffing  
**Sponsor:** Main Line Health Behavioral Health Leadership

**Goal 3: Increase mental health services to individuals from the community who use LMC patient care clinics (LMA and LOGCC) by embedding mental health clinicians in these practices.**

*Action Plan:*

- Explore a partnership with Philadelphia College of Osteopathic Medicine's Clinical Psychology Program to develop additional mental health resources for underserved patient populations of LMA and LOGCC by June 2018. (LMC)

**Resources:** Staff time and PCOM staff resources

**Sponsor:** Chief Academic – MLH, Associate Administrator – LMC

If feasible, this program will be replicated and sustained through the remaining year(s) of the Implementation Plan cycle. (LMC)

**Resources:** Staff time and PCOM staff resources

**Sponsor:** Chief Academic – MLH, Associate Administrator - LMC

- Explore opportunities to train staff in LMA, LOGCC, Community Health Services in “Mental Health First Aid”. (LMC)

**Resources:** Staff time and PCOM staff resources

**Sponsor:** Chief Academic – MLH, Associate Administrator - LMC

If feasible, conduct one on-site Lankenau based training session per year during this Implementation Plan cycle. (LMC)

**Resources:** Staff time and PCOM staff resources

**Sponsor:** Chief Academic – MLH, Associate Administrator - LMC

**Goal 4: Increase availability of substance use disorders treatment, screening and information for those in the community in need of behavioral health services with the intent of reducing the percentage of persons in the community not receiving treatment.**

*Action Plan:*

- Bi-annually, MLH Behavioral Health Services physician liaisons will visit MLH primary care physician offices to educate physicians and office staff and make available materials to their patients on availability of MLH behavioral services and resources in the CHNA area. (System partner – MLH Behavioral Health)  
**Resources:** Staff time and printed materials  
**Sponsor:** Main Line Health Behavioral Health Leadership
- Implement a substance abuse disorder screening program by clinical staff in MLH acute hospitals (including emergency departments) to help link patients to behavioral health treatment services in the community by June 2019. (BMH, LMC, PH, RH) (System partner – MLH Behavioral Health)  
**Resources:** Staff time  
**Sponsor:** Main Line Health Behavioral Health Leadership
- Increase patient services over previous FY for outpatient medication assisted treatment (MAT) and existing services at behavior health sites in Broomall and Exton by January 2017 with the intent to increase access to behavioral health treatment available to those in need in the MLH CHNA community. (System partner – MLH Behavioral Health)  
**Resources:** Staff time  
**Sponsor:** President - Mirmont and Main Line Health Behavioral Health Leadership

- Implement Narcan education program at Mirmont Treatment Center for families affected by substance abuse in the MLH CHNA area by June 2019. (System partner – Mirmont)

**Resources:** Mirmont clinical staff

**Sponsor:** Clinical Director - Mirmont

**Goal 5: Improve access to care for those who need behavioral health services in the MLH CHNA area with the intent of reducing the percentage of persons in the community not receiving treatment.**

*Action Plan:*

- Increase psychiatric coverage (over FY16 FTEs) including consultation and liaison at MLH hospitals by June 2017. (BMH, LMC, PH) (System partner – MLH Behavioral Health)

**Resources:** Additional budgeted staff

**Sponsor:** Main Line Health Behavioral Health Leadership

- Increase psychiatric coverage with telepsychiatry and outpatient substance abuse and mental health services by an additional 80 hours per week at MLH behavioral health sites in Broomall and Exton by December 2017. (System partner – MLH Behavioral Health)

**Resources:** Additional budgeted staff

**Sponsor:** Main Line Health Behavioral Health Leadership

- Expand physician FTE coverage to increase number of patients receiving neuromodulation services including re-implementation of TMS for those in the CHNA area who require such treatments by December 2017. (BMH) (System partner – MLH Behavioral Health)

**Resources:** Budgeted staff time and space allocation

**Sponsor:** Main Line Health Behavioral Health Leadership

**Goal 6: Support efforts to prevent suicides in MLH CHNA communities.***Action Plan:*

- Explore and develop MLH Suicide Prevention Initiative for MLHS clinical environment by identifying, developing and integrating comprehensive behavioral health resources to assure continuity for individuals at risk for suicide by December 2018. (BMH, LMC, PH, RH) (System partner – Mirmont) (System partner – MLH Behavioral Health/Quality/Risk Management)

**Resources:** Staff time

**Sponsor:** Director of Acute Care - Behavioral Health

- MLH will continue to support the Suicide Prevention Task Forces in Chester County, Montgomery County, and Delaware County by way of 1) meeting attendance by physician liaison staff, and 2) financial support in order to increase education and prevention efforts in the MLH CHNA area. (System partner – MLH Behavioral Health)

**Resources:** Staff time and budgeted funds

**Sponsor:** Main Line Health Behavioral Health Leadership

**Goal 7: To determine the need for mental health services for patients, family members and the community.***Action Plan:*

- Develop a mental health screening strategy for the MLH System by June 2018. (System partner – MLH Behavioral Health Services)

**Resources:** Staff time

**Sponsor:** Main Line Health Behavioral Health Leadership

- Explore opportunities to place mental health screening kiosks in key MLH System locations by June 2018. (LMC) (System partner – MLH Behavioral Health)

**Resources:** Staff time and budgeted costs for kiosks

**Sponsor:** Main Line Health Behavioral Health Leadership; Associate Administrator - LMC

**PRIORITY COMMUNITY NEED TOPIC**  
**INJURY PREVENTION**



## **PRIORITY STATEMENT: To reduce the number of accidental and violence injuries (including falls and trauma related injuries) resulting in disability or death occurring in the CHNA area.**

### **Supporting Information / Background:**

- Motor vehicle crashes are the leading cause of death for U.S. teens. Six teens ages 16 to 19 die every day from motor vehicle injuries. Per mile driven, teen drivers ages 16 to 19 are nearly three times more likely than drivers aged 20 and older to be in a fatal crash. (CDC, Injury Prevention and Control: Motor Vehicle Safety, March 2016)
- In 2012, there were almost 36 million licensed drivers ages 65 and older in the United States. Driving helps older adults stay mobile and independent, but the risk of being injured or killed in a motor vehicle crash increases as you age. Per mile traveled, fatal crash rates increase noticeably starting at ages 70–74 and are highest among drivers age 85 and older. This is largely due to increased susceptibility to injury and medical complications among older drivers rather than an increased tendency to get into crashes. (CDC, Injury Prevention and Control: Motor Vehicle Safety, March 2016)
- Falls are the leading cause of traumatic brain injury (TBI), accounting for 40% of all TBIs in the United States that resulted in an ED visit, hospitalization, or death. Falls disproportionately affect the youngest and oldest age groups. Motor vehicle crashes were the leading cause of hospitalizations for adolescents and persons ages 15-44 years. Assaults account for 10% of all TBIs. (CDC, Injury Prevention and Control: Traumatic Brain Injury and Concussion, March 2016)
- Twenty-two percent (22%) of seniors (60+) in the suburban CHNA sub-area experienced a fall in the past year and 24% in the West Philadelphia CHNA sub-area. (PHMC, Community Health Database, 2015)

- For seniors (65+) in the United States, one out of five falls causes a serious injury such as broken bones or a head injury. Each year, 2.5 million older people are treated in emergency departments for fall injuries. Over 700,000 patients a year are hospitalized because of a fall injury, most often because of a head injury or hip fracture. More than 95% of hip fractures are caused by falling. (CDC, Home and Recreational Safety, March 2016)

**Goal 1: To educate high school students on the risks of impaired / distracted driving with the potential for reducing accident injuries and fatalities.**

*Action Plan:*

- MLH acute hospitals will continue to seek grant support from corporations and foundations to conduct “mock crashes” each year. “Mock crashes”, held in conjunction with the BMRH Smart Cruisin® program, provide area high school students with a realistic scenario of the possible outcome of impaired / distracted driving. The programs are offered throughout the year. (BMH = 1, LMC = 1, PH =4, RH = 3) (System partner – BMRH) (Community partner – State Farm Insurance) (Community partner – Participating school administrators)

**Resources:** Hospital staff time; Foundation / corporate grants; Public and private school administrators

**Sponsor:** Community Health Services Manager / Director; BMRH Community Service Manager

**Goal 2: Promote safe driving for seniors with the intent to reduce accidental injuries and mortality.**

*Action Plan:*

- Continue to promote and accommodate the AARP “Smart Driver” course for adults 50+ each year during this Implementation Plan cycle. (LMC, PH, RH) (Community partner – AARP)

**Resources:** Hospital accommodations and community partners

**Sponsor:** Community Health Services Manager / Director

**Goal 3: Promote fall prevention initiatives aimed at the senior population in the CHNA area with the intent to reduce the percentage of seniors experiencing falls.**

*Action Plan:*

- Continue to provide “A Matter of Balance” program to assist seniors in learning skills to avoid falls. (BMH = 3, LMC = 2, PH = 8, RH = 2)

Continue to provide the “Safer Steps” program to assist seniors and LMC staff in learning skills to avoid falls - two classes per year. (LMC)

**Resources:** Hospital accommodations; Community partners

**Sponsor:** Community Health Services Director

The MLH System entities will explore the feasibility of offering the “*Healthy Steps for Older Adults*”, an evidence based program for falls prevention, across the MLH System entities by December 2017. (System partner – Senior Services) (Community partners – Area Agencies on Aging and Surrey Services)

**Resources:** Hospital staff time; System director time; Participation of community partners

**Sponsor:** System Director – Senior Services

**Goal 4: Conduct educational programs promoting an understanding of gun safety, and violence and injury prevention to school children in the in the LMC CHNA sub-area with the intent of reducing injury and death due to guns and violence in the community.**

*Action Plan:*

- Conduct “*Home Gun Safety: Safety First*” classes for elementary school children – three classes per year. (LMC)

**Resources:** Staff time

**Sponsor:** Associate Director – LMC; Trauma Manager – LMC

- Conduct violence prevention classes (with topics including safety first, harassment hurts, and aggression, intimidation, and bullying) to school age children in the LMC CHNA area – ten classes per year. (LMC)

**Resources:** Staff time

**Sponsor:** Associate Director – LMC, Trauma Manager – LMC

**Goal 5: Conduct educational programs and community events in conjunction with community partners to promote safe pedestrian ways and bike safety in local communities to reduce injuries from accidents.**

*Action Plan:*

- Explore additional opportunities to work with the group, “Communities in Motion”, to promote safe, walkable pedestrian walkways, street crossing, etc. The first new programming will be completed by June 2017. (LMC)

**Resources:** Staff time and funding

**Sponsor:** Associate Director – LMC, Trauma Manager – LMC

- Provide programming to elementary school students on safe walking and biking to and from school at elementary schools and camps identified by the Philadelphia Department of Public Health (PDPH). Target five schools or camps; complete implementation by August 2017 (LMC) (Community partner – School administrations) (Community partner – PDPH)  
**Resources:** Staff time and teaching materials  
**Sponsor:** Associate Director – LMC, Trauma Manager - LMC
- Provide programs on safe walking elementary school children. Conduct two programs in schools or camps per year. (PH) (Community partner – Safe Kids of Chester County) (Community partner – TMAACC)  
**Resources:** Staff time and educational materials  
**Sponsor:** Trauma Program Manager – PH and Trauma Injury Prevention Coordinator – PH
- Conduct a bike safety program each year. (BMH, PH)  
**Resources:** Staff time and teaching materials  
**Sponsor:** Community Health Services Managers; Trauma Injury Prevention Coordinator – PH

**Goal 6: Reduce the number of prenatal injuries occurring to expectant mothers of the LMC CHNA area.**

*Action Plan:*

- Teach expectant moms and partners through “Safe Baby” classes at the LMC Obstetrics and Gynecology Care Center (LOGCC) on safety steps to prevent prenatal injuries. Five classes will occur each year throughout this Implementation Plan cycle. (LMC)  
**Resources:** Staff time  
**Sponsor:** Associate Administrator - LMC

**Goal 7: Provide injury prevention education and information on emergency department trauma centers to school children with the intent to encourage students to understand the risk of injuries and their impact on the community.**

*Action Plan:*

- Provide injury prevention education and information on emergency department trauma centers to 10th, 11th and 12th grade students (in inter-city schools) enrolled in the LMC Health Career Academy. The Health Career Academy will be funded on a yearly basis throughout this Implementation Plan cycle. (LMC)

**Resources:** Staff time and educational materials; Budgeted funding; Medical students participation

**Sponsor:** Chief Academic Officer - MLH , Associate Administrator – LMC; Trauma Manager - LMC

- Conduct four “911 What’s your emergency” programs for school age children with the intent to promote injury preventative behaviors. (PH) (Community partner – Girl Scouts of Southeast Pennsylvania) (Community partner – Paoli Fire Company)

**Resources:** Staff time and educational materials

**Sponsor:** Trauma Program Manager – PH and Trauma Injury Prevention Coordinator – PH

**Goal 8: Reduce the number of trauma related injuries resulting from improperly restrained infants, toddlers, and children.**

*Action Plan:*

- Conduct four child safety car seat fittings per year. (PH) (Community partner – Safe Kids of Chester County) (Community partner – Chester County Highway Safety Program)

**Resources:** Staff time and educational materials

**Sponsor:** Childbirth Education Coordinator - MLH and Trauma Injury Prevention Coordinator – PH

**COMMUNITY NEED TOPIC**  
**DENTAL HEALTH**  
**(Adults and Seniors)**

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**PRIORITY STATEMENT:** To improve the percentage of adults and seniors who maintain good oral health habits and maintain a full set of teeth; and to further include the known and suspected role of poor oral health in the risk assessment for certain systemic diseases and the overall health of the individual.

**Supporting Information / Background:**

- The National Institutes of Health, the Center for Disease Control (CDC) and WebMD recognize that poor oral health plays a role in an individual's overall health status and that research evidence suggests that chronic periodontal disease and tooth loss are associated with cardiovascular disease, bacterial endocarditic, pregnancy outcomes, and diabetes. Further, the literature suggests that tooth loss affects dietary quality and nutrition intake particularly in seniors. (Ritchie, Joshipura, Hung & Douglass, 2002)
- Community input for the MLH CHNAs suggested that poor dental health, and particularly teeth loss in seniors, affected dietary quality and nutrition intake. Dental Health was also recognized as a community health need in the 2013 MLH Hospitals' CHNAs.
- Oral health is addressed in the Healthy People 2020 under two topics: Oral Health and Diabetes. Oral Health includes 17 objectives for health improvements; Diabetes has one objective related to oral health – all diabetic patients should have at least one dental exam per year.
- In Pennsylvania, children are covered for dental services through the CHIP program. Adults, on the other hand, receive very limited coverage through Pennsylvania Medicaid. And for seniors, Medicare does not cover dental services. Research shows that dental services have the most elasticity for individual healthcare spending.
- The root cause of poor oral health is frequently linked to lifestyle behavioral choices including poor diet, tobacco use, poor hygiene, and alcohol consumption; it can be further complicated by stress and mental health status.

**Goal 1: MLH should understand the extent of need for dental health services, by type, in the MLH CHNA area adult population with the intent of increasing the percentage of adults who receive regular dental health screenings and reduce the percentage of adults and seniors with teeth loss.**

*Action Plan:*

- By June 2017, MLH will complete a more detailed community needs assessment in the CHNA area to understand the oral health needs of adults / seniors and of the available dental health services to meet those needs. (In conjunction with MLH System) (System partner – Senior Services)

**Resources:** MLH staff and resources

**Sponsor:** System Director – Planning and Business Development

- Explore a partnership with PCOM to bring dental services to a community based health center in West Philadelphia. Project completion of the facility and implementation of the practice is expected by September 2017. (LMC)

**Resources:** LMC staff and budgeted resources

**Sponsor:** Chief Academic Officer – MLH , Associate Administrator – LMC

- Establish a referral source for underinsured from LMC emergency department, LMA, and LOGCC with targeted focus on adults and seniors by June 2017. (LMC)

**Resources:** LMC staff and budgeted resources

**Sponsor:** Chief Academic Officer – MLH , Associate Administrator – LMC

**Goal 2: MLH, based on the impact that poor oral health can have on an individual's overall health status and their susceptibility to systemic diseases, engage MLH affiliated physicians and their patients to include oral health care or treatment in their patient care plans.**

*Action Plan:*

- By December 2017, MLH should encourage the MLH medical staff (PCPs and specialists) to include discussions of oral health care or treatment into their patient care plans. A patient educational brochure on the importance of oral health should be prepared and distributed to physician offices. (In conjunction with MLH System)

**Resources:** MLH staff and resources

**Sponsor:** Chief Medical Officer – MLH

**PRIORITY COMMUNITY NEED TOPIC**  
**SENIORS**

**PRIORITY STATEMENT:** Improve the quality of life and increase education, awareness and access to senior services, thereby encouraging seniors to live active and healthy lifestyles and to successfully navigate inpatient and outpatient community health services.

**Supporting Information / Background:**

- The senior age cohort is the fastest growing cohort in the CHNA area including all sub-areas. The population, age 65+ is 16% of the suburban sub-area population, 13% in NW Philadelphia and 12% in West Philadelphia. (PHMC, Nielson-Claritas database, 2015)
- The growth in the number and proportion of older adults is unprecedented in the history of the United States. Two factors, longer life spans and aging baby boomers, will combine to double the population of Americans aged 65 years or older during the next 25 years. (CDC: Aging and Health, 2013)
- More than a quarter of all Americans and two out of every three older Americans have multiple chronic conditions, and treatment for this population accounts for 66% of the country's health care budget. (CDC: Aging and Health, 2013)
- The senior population lives in a variety of housing arrangements and with varying levels of in-home support. The CHNA area has a multitude of 55+ communities, continuing care retirement communities (CCRCs) and nursing homes. PHMC data suggests that over 60% of seniors (60+) in every CHNA sub-area intends to stay in their current home for 10 or more years. (PHMC, Community Health Database / MLH CHNA, 2015)
- A review of the CHNA data suggests that seniors are impacted by most of the health needs identified in the CHNA .

**Goal 1: To engage the senior population living independently in the community, in 55+ communities and in continuing care retirement communities (CCRCs) to live active and healthy lifestyles and to navigate inpatient and outpatient community health services.**

*Action Plan:*

- MLH System will explore the feasibility to partially support and / or determine partners for two grassroots “Aging in Place” / “Aging in Community” initiatives in the CHNA area by December 2017. (System partner – Senior Services)

**Resources:** Staff time

**Sponsor:** System Director - Senior Services

If feasible, the MLH System will begin the funding / partnership of these two initiatives by FY19. (System partner – Senior Services)

**Resources:** Staff time and budgeted funds

**Sponsor:** System Director -Senior Services

- Support and strengthen partnerships with community agencies each year during this Implementation Plan cycle: (System partner – Senior Services)
  - Continue to provide financial support to ElderNet in order to support their social work staff doing in-home visits and responding to emergency needs of clients. (BMH)
  - Provide the “Your Call” referral and information support and publicize it. (BMH)
  - Continue to assist the Ada Mutch Community Resource Center and Food Pantry. (BMH)
  - Continue to support the “Quick Find Main Line” Program and the “Lock for Life” Program, both partnerships with Lower Merion Police Department . (BMH)

- Continue “File for Life” Program and “Key Fob Health Information” Program which provides clear information to physicians and first responders. (BMH)

**Resources:** Staff time and budgeted expenses

**Sponsor:** Community Health Services Director

- Continue to offer “Ask-A-Nurse” sessions at senior centers and other community sites – 270 sessions per year. (BMH)

**Resources:** Staff time

**Sponsor:** Community Health Services Director

- Provide annual influenza vaccinations at senior centers. (BMH = 5, LMC = 3, PH = 2)

**Resources:** Staff time

**Sponsor:** Community Health Services Manager / Director

- Provide “Stretch Your Limits” senior exercise program – 90 sessions per year. (BMH)

**Resources:** Staff time

**Sponsor:** Community Health Services Director

- Offer seniors from the community the opportunity to attend a hospital sponsored “*Senior Supper*” for socialization and education activities each month. (PH, RH)

**Resources:** Staff time and budgeted expenses

**Sponsor:** Community Health Services Manager

- Offer seniors from the community the opportunity to attend a hospital sponsored “*Senior Entertainment Program*” with socialization activities – four events per year. (PH)

**Resources:** Staff time and budgeted expenses

**Sponsor:** Community Health Services Manager

- Attend senior expos / health fairs per year in 55+ communities and CCRCs and participate in “*Senior Health Fairs*” sponsored by local state legislators. (BMH = 3, LMC = 2, PH = 4, RH = 4)  
**Resources:** Staff time and printed materials  
**Sponsor:** Community Health Services Manager / Director
- Present healthy living lectures at 55+ communities and CCRCs each year. (BMH = 2, LMC = 2, PH = 2, RH = 5)  
**Resources:** Staff time  
**Sponsor:** Community Health Services Manager / Director
- Provide educational program and health screenings in various senior communities. (BMH = 3, LMC = 6, PH = 2, RH = 2)  
**Resources:** Staff time  
**Sponsor:** Community Health Services Manager / Director
- Expand partnership with Abramson Center for Jewish Life and develop additional opportunities for collaboration by June 2018. (BMH, LMC)  
**Resources:** Staff time  
**Sponsor:** Community Health Services Director
- Explore developing a relationship with a senior services provider and developing a day care center for patients with Alzheimer's disease. (LMC) (System partner – Senior Services)  
**Resources:** Staff time  
**Sponsor:** Associate Director – LMC; System Director – Senior Services



- Conduct at least one senior focus group from the Paoli Hospital CHNA area during this Implementation Plan cycle. (The intent of the focus group is to continue to understand health care and community resource needs of this growing age cohort. Also, the intent is to understand any gaps in service coverage, difficulties in accessing services and overall satisfaction with health services in the CHNA community.) (PH)

**Resources:** Staff time

**Sponsor:** Community Health Services Manager; Hospital and system support staff

**Goal 2: To assist seniors and caregivers with guidance and tools to navigate the health system to ensure all appropriate care and resources are available for improving or maintaining the health and wellness for all seniors.**

*Action Plan:*

- MLH System, in conjunction with MLHC, will develop and implement a “Comprehensive Geriatric Assessment” program in two primary care practices by January 2017. (System partner – Senior Services) (System partner – MLHC)

**Resources:** Staff time; MLHC physician time to orient and implement the program

**Sponsor:** System Medical Director of Geriatric Medicine and Long Term Care

- MLH System will develop and pilot a telephone based Senior Navigation Program by July 2016. (System partner – Senior Services)

**Resources:** Staff time and budgeted funds for program staff and resources

**Sponsor:** System Director - Senior Services

If the pilot is successful, the program will be expanded throughout the MLH System by October 2016. (System partner – Senior Services)

**Resources:** Staff time and budgeted funds for program staff and resources

**Sponsor:** System Director - Senior Services

- MLH System will explore the feasibility of MLH implementing a chronic disease self-management program in partnership with local senior services organizations by June 2017. (System partner – Senior Services)

**Resources:** Staff time and budgeted funds

**Sponsor:** System Director - Senior Services

### **Goal 3: To understand food insecurity and healthy eating in the senior population and plan for addressing gaps and issues which could improve the health and wellbeing of seniors.**

#### *Action Plan:*

- MLH System will convene a series of meetings with community partners to initiate a planning effort which explores food insecurity among seniors and healthy eating, and identify ways to address needs by June 2018. (System partner – Senior Services)

**Resources:** Staff time

**Sponsor:** System Director - Senior Services

MLH will also explore the impact of poor oral health on healthy eating in the senior population during these meetings. (Also see Dental Health, Goal 1.) (System partner – Senior Services) (In conjunction with MLH System)

**Resources:** Staff time

**Sponsor:** System Director - Senior Services; System Director - Planning & Business Development

**PRIORITY COMMUNITY NEED TOPIC**  
**PRE-NATAL CARE / LOW BIRTH WEIGHT INFANTS**

**PRIORITY STATEMENT: To decrease the rate of women who receive late or no pre-natal care and to lower the rate of low birth weight infants born in the LMC CHNA sub-area.**

**Supporting Information / Background:**

- Black infants in the CHNA area are twice as likely to be low birth weight as white infants. The largest number of low birth weigh babies occur in the West Philadelphia and Lawrence Par CHNA sub-areas.
- The largest number (~1,050) of premature births (less than 37 weeks gestation) are born to black women in the West Philadelphia and Lawrence Park CHNA sub-areas.
- While the statistics indicate a need for improved outcomes for black mothers and infants as a health need in the community, community health assessment input reflected upon the underlying causes including socio-demographics, healthy diets / weights, and related systemic disease.

**Goal 1: Increase timely access to care for pre-natal women, with a targeted focus on underserved and vulnerable populations.**

*Action Plan:*

- By June 2017 explore a strategic partnership with a local Federally Qualified Health Center in West Philadelphia to support transitions in care between prenatal care and hospital delivery. (LMC)

**Resources:** Staff time

**Sponsor:** Chief Academic Officer – MLH, Associate Administrator - LMC

- Explore strategies to increase outreach to the community to improve timely access to prenatal care. Develop community based outreach strategy by June 2018.(LMC)

**Resources:** Staff time

**Sponsor:** Chief Academic Officer – MLH, Associate Administrator - LMC

**Goal 2: Expand the Student Nursing Advocate (NSA) program to support pre-natal care in the Lankenau Obstetrics and Gynecology Care Center (LOGCC).**

*Action Plan:*

- Explore the possibility of additional nursing school partnerships and increase the Nursing Student Advocate program cohort by June 2017. (LMC)

**Resources:** Staff time

**Sponsor:** Chief Academic Officer – MLH, Associate Administrator - LMC

**COMMUNITY NEED TOPIC**  
**CULTURE / DIVERSITY / DISPARITIES OF CARE**

**PRIORITY STATEMENT: To create a culturally competent health care system to improve outcomes and quality of care and contribute to the elimination of racial, ethnic and socio-economic disparities of care.**

**Supporting Information / Background:**

- Creating a culturally competent health care system helps improve health outcomes and quality of care and contributes to the elimination of racial and ethnic health disparities.
- The MLH CHNA area is a large geography covering parts of three suburban counties (Chester, Delaware and Montgomery) and NW and West Philadelphia. Overall, the suburban CHNA populations are similar in many respects with some racial and ethnic diversity and with pockets of underserved individuals. West Philadelphia, on the other hand, is racially different from the suburbs and has a larger higher percentage of medically underserved and socio-economically challenged individuals and families. It is the intent of MLH System to create a respectful, inclusive environment and to make clinical settings accessible to all patients.
- Chester and Montgomery Counties annually rank among the top five counties (for “Health Outcomes” and “Health Factors”) in Pennsylvania by the University of Wisconsin Population Health Institute’s “County Health Rankings and Roadmap” ®; Philadelphia annually ranks 67<sup>th</sup> (last among the PA counties. Delaware County ranks in the middle of the 67 counties.
- Over 80% of the Main Line Health hospitals’ medical and allied health staff is in private practice.

## Goal 1: To continue the system-wide Diversity / Respect / Inclusion (DRI) Journey toward a culturally competent health care system.

### Action Plan:

- All MLHS management and employees will complete the DRI classroom training during this Implementation Plan cycle. (BMH, LMC, PH, RH)  
**Resources:** Allocation of system and hospital resources to accommodate the training of all MLHS staff  
**Sponsor:** System executive sponsors
- Provide all MLH System managers and employees with a monthly DRI message. Each message map includes educational messages on such matters as holidays and observances being celebrated during the month, suggestion on promoting DRI among staff and patients, etc. (BMH, LMC, PH, RH)  
**Resources:** System and hospital resources to produce and distribute message maps  
**Sponsor:** Senior Vice President, Human Resources
- Engage the Hospital DRI Councils in implementing the DRI message on each campus (BMH, LMC, PH, RH)  
**Resources:** Allocation of Council members time and necessary executive leadership to implement initiatives  
**Sponsor:** Hospitals' presidents / vice presidents
- Continue to fund the Culture Vision ® software as a tool for MLH hospital staff to improve their understanding when encountering patients, families and visitors of various racial and ethnic backgrounds. (In conjunction with MLH System)  
**Resources:** Budgeted operational funds  
**Sponsor:** Senior Vice President, Human Resources



**Goal 2: Continue to sponsor the MLH System’s “Annual Healthcare Disparities Colloquium” to inform employees and medical staff about recognizing and potentially eliminating barriers or disparities in care in MLH hospitals and System entities.**

*Action Plan:*

- MLH hospitals will continue to support an annual event to present research data and discuss strategies to eliminate disparities of care. (In conjunction with MLH System)

**Resources:** Allocation of staff time to undertake research and attend annual event

**Sponsor:** Academic Medical Officer - MLH and Associate Director - LMC

**Goal 3: Assure that all medical and surgical specialties across MLH accept governmental insurance plans.**

*Action Plan:*

- Prepare a white paper on how to assure acceptance of government insurance across MLH medical and surgical specialties to adequately serve the populations in the MLH service area. Distribute the plan for discussion at senior levels of the MLH System and the medical staff. (In conjunction with MLH System)

**Resources:** Executive staff time and professional writer to prepare document

**Sponsor:** Senior Vice President, CMO

**Goal 4: Improve health care access for un- and under-insured in the community to MLH hospitals and MLH medical staff practices.**

*Action Plan:*

- PH will continue to build relationships with two free community health clinics: The Clinic (Phoenixville) and Community Volunteers in Medicine (West Chester) and allocate resources to provide appropriate specialty care to their patients. (PH)

**Resources:** Charity care and budgeted funds

**Sponsor:** Director of Finance

- PH will continue to develop a relationship with The Point at Parkesburg, a non-profit community center that offers afterschool academic enrichment, nutrition, music, recreation, life skills, Bible studies, and devotionals. The facility features skate park, gymnasium, kitchen and cafeteria, classrooms, and more. PH will provide an Ask-a Nurse program twice monthly as well as various screenings throughout this Implementation Plan cycle. (PH)

**Resources:** Charity care and budgeted funds; Community Health Services Manager

**Sponsor:** Director of Finance; Community Health Services Manager

**Goal 5: To engage young people, particularly those who live in at-risk communities, through education and career planning programs, to accept healthy lifestyles and life long learning habits with the intent to improve health status through improved social demographic status and healthful habits.**

*Action Plan:*

- The Lankenau Health Education Center will conduct programs that provide creative, hands on, learning environment that supplements the health education efforts of schools, families, and community organizations for over 7,500 children from K-12 each year during the Implementation Plan cycle. (LMC)

**Resources:** Education Center budgeted resources and staff time

**Sponsor:** Chief Academic Officer - MLH and Associate Director – LMC

- Create new and interactive Delema G. Deaver Wellness Garden programming and curriculum that can be provided year round to children across the five counties with special outreach to underserved and low-income communities. Conduct 10 garden based programs a year by June 2017. (LMC)

**Resources:** Education Center budgeted resources, and staff time

**Sponsor:** Chief Academic Officer - MLH and Associate Director - LMC

- Explore an enhanced partnership between the Health Career Academy Program and the Lankenau Health Education Center to provide programs in local middle schools by June 2017. (LMC)

**Resources:** Education Center budgeted resources and staff time

**Sponsor:** Chief Academic Officer - MLH and Associate Director - LMC

**Goal 6: Increase access to primary care in underserved communities in West Philadelphia.**

*Action Plan:*

- Explore partnership with PCOM to implement student run clinic in association with St. Barnabas Shelter for Women in West Philadelphia. Integrate with PCOM Core Clinical Campus. Complete implementation by June 2017. (LMC) (MLH partner – PCOM)

**Resources:** Budgeted resources and staff time

**Sponsor:** Chief Academic Officer, MLH and Associate Director – LMC

**COMMUNITY NEEDS**  
**Not addressed in this Implementation Plan**

Each of the following health needs were identified in the CHNA; while important, they have not been selected as a Priority Need. These needs have been addressed within other priority topics or by the MLH acute hospitals' MLH partner, Bryn Mawr Rehab Hospital (BMRH). These topics are:

- Lung Disease (Cancer)
- Arthritis (BMRH)
- Have a regular source of care (Culture / Diversity / Disparities of Care)

The MLH hospitals do not feel that availability of low cost health insurance or the cost of prescriptions is within their purview to address. It is the intent of the MLH hospitals to keep their costs as low as possible while maintaining high quality care. In addition, the MLH hospitals have available a charity care policy to assist individuals and families who need help paying for their hospital care. (See [www.mainlinehealth.org/charitycare](http://www.mainlinehealth.org/charitycare))

Pediatric care and screenings for children are available through the pediatric care partner of MLH, the Nemours Foundation / Al duPont Hospital for Children. Nemours provides emergency department care and specialized inpatient and outpatient care on the Bryn Mawr Hospital campus. Primary and specialty services are also provided by Nemours at various MLH outpatient sites.

Specialized care for the treatment of asthma is available from specialists on the MLH medical staff and well as at other community resources.

A list of available community resources is included as an appendix to the MLH Acute Hospitals CHNA document.

**MAIN LINE HEALTH SYSTEM  
AND  
COMMUNITY PARTNERS**

## **MLH Hospitals System Partners:**

### **Bryn Mawr Rehab Hospital (BMRH)**

Bryn Mawr Rehabilitation Hospital, a member of Main Line Health, is a leader in the field of physical medicine and rehabilitation. As a 148-bed, not-for-profit hospital, Bryn Mawr Rehab offers the full continuum of rehabilitation services, including acute inpatient care, as well as outpatient services for adults and adolescents. The range of illnesses and injuries treated at Bryn Mawr Rehab Hospital includes traumatic, mild traumatic and non-traumatic brain injury, stroke and other neurological disorders, spinal cord injury and amputee and orthopaedic injuries and illnesses. In addition, the Main Line Health Outpatient Rehab Network provides rehabilitation services at convenient locations in Philadelphia's western suburbs for patients of all ages. The Hospital has also achieved Magnet® designation, the nation's highest distinction for excellence in nursing care. For more information about Bryn Mawr Rehab Hospital, visit [mainlinehealth.org/rehab](https://mainlinehealth.org/rehab).

### **Main Line Health Behavioral Health Services: Mirmont Treatment Center**

Mirmont Treatment Center, part of Main Line Health, was founded in 1985 to provide inpatient and outpatient treatment for patients with drug and alcohol dependence. Mirmont is located on 33 acres in Lima, Delaware County, in a spacious facility that includes treatment areas for individual and group therapy, a fitness center, and 900-square-foot meditation hall. Treating adults age 18 and older, Mirmont's staff—including physicians, nurses, master's level therapists, and psychiatrists—provide medically monitored detoxification, inpatient and dual diagnosis rehabilitation, partial hospitalization, intensive outpatient programs. Mirmont's nationally acclaimed Valor with Integrity Program for Emergency Responders (V.I.P.E.R.) provides addiction and trauma treatment for law enforcement/police, firefighters, EMTs and combat veterans. Mirmont utilizes a foundation in 12-step recovery and trauma informed treatment complemented by holistic therapies including Mindfulness Based Stress Reduction (MBSR), meditation, yoga, supervised exercise, and nutrition counseling.

### **Main Line Health Behavioral Health Services: Mental Health Programs**

Main Line Health Behavioral Health Services cares for patients in both inpatient and outpatient settings. For substance use disorders and mental health issues, Main Line Health offers people in the community programs and services that are characterized by clinical excellence and compassionate care. For mental health patients, we offer a 20-bed inpatient psychiatric unit at Bryn Mawr Hospital that tailors treatment to each patient's clinical needs. TMS (transcranial magnetic stimulation) and ECT (electroconvulsive therapy) are treatment options for appropriate patients. Mirmont Outpatient Centers in Exton and Broomall offer comprehensive mental health outpatient care for adults and adolescents, including: psychiatric evaluation and medication management, partial hospitalization programs, intensive outpatient programs, and individual and group therapy.

### **Main Line HealthCare (MLHC)**

Main Line HealthCare (MLHC) is a multi-specialty network of employed providers with offices located in and around Main Line Health - Lankenau Medical Center, Bryn Mawr, Paoli and Riddle hospitals. MLHC provides professional practice management and operations support to our employed physicians and staff. By providing these services, our physicians get back to being doctors - doctors who are some of the most respected and accomplished physicians and surgeons in the Philadelphia area. MLHC strives to be the destination of choice for patients, physicians and health care professionals. We are committed to providing exceptional care with empathy and compassion for people at all stages in life.

The physicians of Main Line HealthCare are committed to providing exceptional health care and patient service, offering a full range of primary and specialty care services in suburban Philadelphia and beyond. Affiliated with the Main Line Health System, Main Line HealthCare represents leading physicians in the Philadelphia area who are committed to providing exceptional care throughout the communities they serve.



**MLH Hospitals System-level Resources (including):**

- Diabetes / Nutrition Management Program
- Health Career Academy
- Lankenau Health Education Center
- Lankenau Heart Institute
- Medical Student Advocates
- Nursing Student Advocates
- MLH Cancer Program
- MLH Human Resources
- MLH Marketing and Business Development
- Senior Services
- Trauma Centers – Lankenau Medical Center and Paoli Hospital
- Women's Heart Health Initiative

**MLH Implementation Plan Community Partners:**

- AARP
- Ada Mutch Community Resource Center and Food Pantry
- Alcoholics Anonymous
- Abramson Jewish Community Center
- ACAC
- Access Matters
- American Cancer Society
- American Diabetic Association
- American Lung Association
- Community Resources and Education Center at the Haverford Reserve
- ElderNet
- Food Trust
- Girl Scouts of Southeast Pennsylvania
- Healthy Kids Running Series
- Linda Creed (Mammography screenings)
- Lower Merion Police Department
- Narberth Food Bank
- Nemours Foundation / Al DuPont Hospital for Children
- Paoli Fire Company
- Philadelphia College of Osteopathic Medicine
- Philadelphia Department of Public Health
- Rails to Trails
- Safe Kids of Chester County
- Suicide Prevention Task Force (Chester, Delaware, Montgomery Counties)
- State Farm Insurance
- Susan B. Korman (Mammography screenings)
- TMAAC
- Tobacco-Free Coalition (Chester, Delaware, Montgomery Counties)
- Unite for Her
- Yellow Daffodils
- YMCA – local branches

# COMMUNITY HEALTH METRICS

## Tracking the following community health metrics:

### Percentage of: Adults (18+ ):

- Health Status (Good / Excellent)
- Adults overweight and obese
- Diagnosed with diabetes
- Diagnosed with high blood pressure
- Did not have blood pressure screen in past year
- Taking medication to control high blood pressure
- Daily servings <4 of fruits and vegetables
- Exercised fewer than 3X per week
- Did not have colonoscopy in past ten years (50+)
- Did not have Pap test in past three years (women)
- Did not have mammography in past two years (women 50-74)
- Did not have PSA or rectal exam (prostate) in past year (men)
- Motor vehicle accidents (students / young adults and seniors)
- Needs transportation service / used transportation program (seniors)
- Did not receive health care due to cost
- Did not fill a prescription due to cost
- Smokes cigarettes
- Tried to quit smoking in past year
- Receiving treatment for mental health condition
- Diagnosed with depression
- Ever had a substance abuse problem
- Currently in recovery

## Tracking the following community health metrics:

### Percentage of adults (60+):

- Health Status (Good / Excellent)
- Fall in past year
- Adults overweight and obese
- Diagnosed with diabetes
- Diagnosed with high blood pressure
- Taking medication to control high blood pressure
- Signs of depression
- Need meal or food program
- Exercise per week
- Did not visit dentist in past year
- Motor vehicle accidents (students / young adults and seniors)
- Needs transportation service / used transportation program (seniors)
- Expect to remain in current home

### Percentage of children (0-17):

- Health Status (Good / Excellent)
- Children overweight and obese
- Daily servings <4 of fruits and vegetables
- Exercised fewer than 3X per week (3+)

### Rates for all ages:

- Stroke mortality
- Diabetes mortality
- Coronary heart disease mortality
- Cancer mortality by site (breast, colorectal, lung, prostate, and female genital)
- Accidents / violence mortality
- Suicide mortality

**Any comments on this document should be in writing and sent to the following address:**

Community Health Needs Assessment – MLH Hospitals  
c/o Marketing and Business Development Office  
Main Line Health – Suite 300  
240 N. Radnor-Chester Road  
Radnor, PA 19087