2019

COMMUNITY HEALTH **IMPLEMENTATION PLAN**

Main Line Health Acute Care Hospitals

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OVERVIEW OF THE IMPLEMENTATION PLAN

Main Line Health (MLH) is pleased to share the July 2019 through June 2022 (FY20 to FY22) Community Health Implementation Plan (CHIP). MLH would like to thank community members and leaders for participating in this CHNA process and providing great insights to inform our future work. MLH's Center for Population Health Research (CPHR) and PHMC conducted a series of focus groups and surveys to understand the health needs in the community. Focus groups were conducted with MLH patients, MLH employees, community, business and government leaders, and social services organizations. Meetings were held with MLH physicians to learn their perspective on how MLH is doing in the community and what MLH should focus on to improve the health of people in the community. PHMC leveraged a variety of quantitative datasets, with their 2019 Southeastern Pennsylvania Household Health Survey as a central source. The CHIP work group—consisting of leaders in Community Health and Equity (formerly Community Health Services), the MLH CPHR, and Planning and Business Development—also contacted leaders throughout MLH to learn about internal capabilities and initiatives related to community health.

PHMC's findings from the community outreach and quantitative analyses identified the following needs:

1. Chronic disease management
2. Mental health care
3. Access to affordable health care and prescription medication
4. Older adult well-being
5. Health behaviors
6. Health inequities in the broad community

A summary of PHMC's findings are provided in the next section. The valuable information provided by community members and leaders were a key input when developing the CHNA and priorities for MLH to focus over the next three years. To address these findings from the CHNA, MLH established 8 priorities for the FY20 to FY22 CHIP. The MLH priorities and alignment with CHNA identified needs are depicted in the table below. The columns represent the top needs identified during the CHNA, the rows represent the priorities that MLH has proposed to address the identified needs, and the check marks in the cells show areas MLH has existing or planned work to address identified needs.

		Identified Needs in the 2019 MLH Acute CHNA					
		Chronic Disease Manage-ment	Mental Health Care	Access to Affordable Health Care and Prescription Medications	Older Adult Well-Being	Health Behaviors	Health Inequities
Priority for MLH Acute FY20 to FY22 CHIP	Chronic Disease Prevention and Management	✓			✓	✓	✓
	Neuro-sciences	✓					✓
	Senior Services	✓			✓	✓	✓
	Behavioral Health		✓			✓	✓
	Maternal Health		✓	✓		✓	✓
	Health Care Access and Affordability		✓	✓		✓	✓
	HomeCare & Hospice	✓					
	Diversity, Respect and Inclusion	✓	✓	✓	✓	✓	✓

The health needs were identified and prioritized by comparing the health status, access to care, health behaviors, and utilization of services for residents to results for Southeastern Pennsylvania (SEPA)—comprising Bucks, Chester, Delaware, Montgomery and Philadelphia counties—and Healthy People 2020 (HP2020) goals for the U.S. Additional data sources were considered, such as online surveys and qualitative focus groups. Input from community meetings were also used to identify and prioritize unmet needs, local problems with access to care, and populations with special health care needs. The MLH acute care service area is large and includes a diverse set of communities; this assessment found pockets of residents who have drastically different health needs and experiences with the health care system.

The MLH CHNA Oversight Committee, comprising MLH System leadership, provided oversight and active governance of the CHNA and CHIP development. Goal selection was based on programs and initiatives where MLH is in a position to make the most impact in the health of the community in alignment with the mission, values and capabilities of the organization. MLH will work closely with the MLH CPHR to develop and improve data collection tools, and provide advanced analyses and

reporting of MLH community health activity, leveraging CPHR capabilities for ongoing focus groups, subject-specific reports and data analyses throughout the CHNA cycle. Please see the appendix for more information about the CPHR.

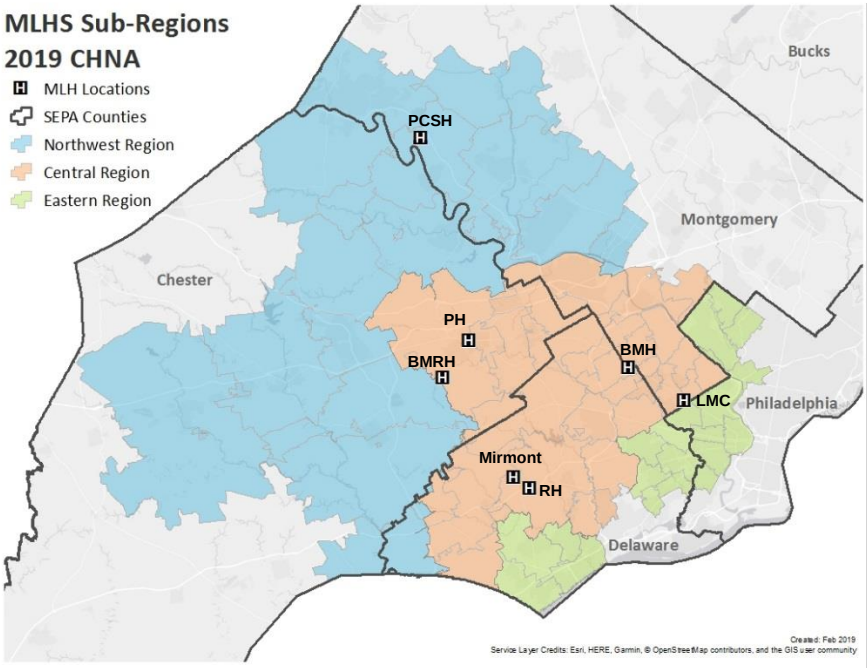
SUMMARY FINDINGS FROM THE CHNA

Community Definition

For purposes of this CHNA, the MLH community is depicted in the map below. The community comprises 69 ZIP codes that are primarily served by MLH acute care facilities. The community is divided into 3 sub-regions, (eastern, central and northwestern) for deeper analysis. Please see the appendix for the market definition.

MLH's acute care hospitals include the following:

- Bryn Mawr Hospital (BMH) (Montgomery County);
- Lankenau Medical Center (LMC) (Montgomery County);
- Paoli Hospital (PH) (Chester County);
- Riddle Hospital (RH) (Delaware County); and
- Physicians Care Surgical Hospital (PCSH) (Montgomery County, Joint Venture)



Key sub-region demographic facts:

- Eastern is home to a majority of the racial and ethnic diversity in the community
- Central has the highest median household income ($114,506); Eastern region has the lowest ($49,839)
- Northwest has the highest projected 5 year population growth (+2.4%), more than double Central and Eastern regions (+1.1% each)

Chronic Disease Management

Chronic diseases are on the rise in the US, with asthma, diabetes, obesity, as well as smoking-related health issues amongst the top 10 chronic conditions with high costs to health payers, as well as to individuals, families, and communities, particularly given comprehensive, ongoing and long-term health, social, and other needs. Chronic disease management was identified as a community health need given its disparate impact to the Eastern region and variable impact across the 3 regions. For example, more adults in the Eastern region have been diagnosed with asthma

compared to the remainder SEPA region and adults across Pennsylvania (17%). Additionally, the percentage of adults with diabetes (14%) and obesity (38%) were higher for the Eastern area compared to the remainder SEPA region (12% and 29%, respectively).

Mental Health Care

Mental health care was identified as an unmet and growing health need in the MLH service area and one of the most pressing issues impacting MLH community health as stated by MLH community constituents themselves. Approximately one quarter of the population has a behavioral health condition. Among those diagnosed, 63% are receiving treatment in the Eastern region, 62% in the Central region, and 54% in the Northwest region, compared to 60% in the MLH acute care service area and 57% in the SEPA region. The Northwest region also has the highest suicide rate (10.3 deaths per 100,000), and is the only region not meeting HP2020 goal of less than 10.2 deaths per 100,000 people.

Drug overdose is the 6th leading cause of death in the MLH acute care service area (347 deaths per 100,000 people between 2012-2016). The Eastern region drug overdose mortality rate (29.4 deaths per 100,000 people) exceeded that of SEPA (26.0 deaths per 100,000 people). Community leaders and members cite mental health problems, opioid use disorder, and aging problems as their top three most pressing health issues.

Access to Affordable Health Care and Prescription Medications

Access to health care, including prescription pain medication, remains a persistent barrier. The Eastern area adult residents are more likely to be uninsured (13%) compared with the remainder SEPA region (10%). More adults in the Eastern (15%) and Central (14%) region reported that they do not have a usual source of care compared to the Northwestern region (11%). 35% of Eastern region area residents visited the emergency room in the past year compared to 26% of residents in the remainder SEPA region

Older Adult Well-Being

Older adult well-being was identified as a health need for the MLH acute care service area since the 65+ older adult population is projected to increase 15% between 2018-2023 - underscoring the need and likely increase in demand for expansion of partnerships, services and programming focused on aging and older adult well-being. In addition, older adults are at increased risk of depression and social isolation. One indicator of social isolation, talking with friends or relatives less than once a week, was higher for the MLH acute care service area (7%) when compared to remainder SEPA region (5%). In addition, 10% of older adults (60+) in the MLH acute care service area report having four or more signs of depression.

Health Behaviors

Health Behaviors was identified as a health need given variability between regions with smoking for example, consumption of sugary beverages, and obesity. While more adults in the Northwest region report good or excellent health, have health insurance, and a regular source of care compared to the remainder of SEPA, among smokers (13% of adult Northwest region residents), 59% did not try to quit in past year and 10% used an e-cigarette in the past month compared to remainder SEPA region (48% of smokers did not try to quit in past year; 8% used an e-cigarette in past month). Smoking is a risk factor for heart disease and cancer, which are the two leading causes of death in the MLH acute care service area and nationally. In the Eastern region, 38% of adult residents are obese (BMI 30+), compared to 29% in the remainder SEPA region. Similarly, in the Eastern region, consumption of sugary beverages, such as soda, fruit drinks, or bottled tea once a day or more in the past month, by adult residents was much higher than in the remainder SEPA region (31% compared to 26% respectively).

Health Inequities

Health Inequities was identified as a health need for the MLH acute care service area given differences in and across regions, between racial groups, and income levels. For example, blacks are disproportionately impacted by cancer as well as heart disease mortality when compared to other racial and ethnic groups, according to the SEPA HHS. Relatedly, heart disease and cancer were the top two leading causes of death for the MLH acute care service area, accounting for 48% of all deaths from 2012-2016.

- The heart disease mortality rate was higher among blacks living in the MLH acute care service area (210.2 individuals per 100,000 people) compared to whites (152.1 individuals per 100,000 people, Asians (60.4 individuals per 100,000 people) and self-identified other (149.3 2 individuals per 100,000 people)
- The cancer mortality rate among blacks in the MLH acute care service area is higher than the mortality rate among whites, Latino and self-identified “other” adults, and it does not meet the HP2020 goal (161.4 individuals per 100,000 people). The black cancer mortality rate in the MLH acute care service area is also lower than the same rate across SEPA (211.4 per 100,000).

IMPLEMENTATION PLAN PRIORITIES

Chronic Disease Prevention and Management

The MLH Acute CHNA identified the MLH eastern sub-region as experiencing higher prevalence of chronic conditions such as diabetes, obesity and cancer. There is also a higher proportion of uninsured residents than the other sub-regions and the remainder of SEPA. Smoking and lung cancer are ongoing problems in the MLH community, especially in men.

MLH has targeted initiatives aimed at reaching out to communities in the eastern sub-region. MLH partners with The Food Trust and participates in their Heart Smarts Program and Healthy Corner Store Initiative. MLH health educators conduct blood pressure and BMI screenings monthly at two corner stores to access hard to reach populations in Philadelphia. The health educators notify participants of unhealthy readings and direct to primary care as necessary. The Food Trust is present during these screenings to provide additional nutrition education and vouchers for healthy food to be redeemed on site. MLH has received positive feedback from participants of this program, and a large proportion of participants are repeat visitors, which allows MLH to track blood pressure and BMI over time. MLH health educators also make follow-up phone calls to those who had high blood pressure readings to see if they were able to see a health care provider after the corner store screening as well as learn about their nutrition.

Main Line HealthCare (MLHC)—the employed multispecialty physician network of MLH—is committed to providing exceptional care to the communities they serve. MLHC is focusing on increasing health screenings and improving diabetes control of patients in communities throughout MLH's market area.

MLH has initiatives for obesity not called out in this CHIP. MLH Community Health and Equity conducts community outreach activities on an ongoing basis to promote healthy weight, such as nutrition and exercise education, and blood pressure screenings.

To further address the issues identified in the CHNA, MLH proposes the following initiatives:

Objective	Initiative	Current state	Future state	Facilities
1. Raise awareness of cancer in the community by providing screenings with the intent to discover and treat cancers early.	1a. Increase colorectal cancer screening	**60.5%**: (33,969 of 56,110) MLHC patients received screening	FY22: 68.0% of MLHC patients to receive screening	BMH, LMC, PH, RH
	1b. Increase breast cancer screening	**63.7%**: (19,130 of 30,022) MLHC patients received screening	FY22: 76.0% of MLHC patients to receive screening	BMH, LMC, PH, RH
	1c. Increase lung cancer screening	929 lung screenings	FY22: 1,750 lung screenings	BMH, LMC, PH, RH

Objective	Initiative	Current state	Future state	Facilities
2. Improve diabetes control	2a. Increase proportion of MLHC patients meeting Diabetes Control target of HbA1c of less than 8	**57.7%**: (4,847 of 8,397) MLHC patients with HbA1c under 8	FY22: 65.0% of MLHC patients with HbA1c under 8	BMH, LMC, PH, RH
3. Improve heart health in West and Southwest Philadelphia by raising awareness and education through the Healthy Corner Store Initiative.	3a. Offer screenings and education at additional corner stores and grocery stores	2 locations	FY22: 5 locations	LMC
	3b. Increase percentage of returning participants	**34.6%** (73 of 211) participants had multiple visits during calendar year 18	40.0% with multiple visits by 2021	LMC
	3c. Increase redemption rate of Heart Smart Bucks for healthy food	Minimum of 80% redemption of Heart Smart Bucks for healthy food	FY22: Aim for a 5% increase in redemption of Heart Smart Bucks for healthy food	LMC
	3d. Tracking control of blood pressure and body mass index for repeat participants	23.6% of participants had improvement in blood pressure	Calendar year 21 goal: 25.0% of repeat participants with improved blood pressure	LMC
4. Develop thoughtful evaluation and assessment of newly developed programs or existing programs to refine our understanding of populations that are touched by MLH community programming.	4a. Development of metrics by program	Inventory of all relevant MLH data in development	Inventory of relevant data ready for use in the 2022 CHNA	BMH, LMC, PH, RH, PCSH

Neurosciences

Stroke mortality rates in the MLH acute care area are higher than SEPA. The central sub-region is the only area meeting the Healthy People 2020 goal for stroke mortality rate. Stroke is also a leading cause of disability in our community and the United States. MLH is committed to not only educating communities about stroke risk, how to identify stroke, and how to lower the risk of stroke, but also educating emergency medical services (EMS) on the importance of rapid care for various types of strokes. MLH seeks to provide the full spectrum of stroke care services aimed at reducing disabilities and mortality from stroke. MLH has initiatives to reach out to senior centers as well to educate residents and their employees about the importance of urgent treatment in the event of a stroke.

Recent changes to stroke care guidelines have created an opportunity to significantly improve outcomes for stroke disability to enhance our capability. MLH will undertake the following initiatives:

Objective	Initiative	Current state	Future state	Facilities
1. MLH will continue to provide high-quality stroke care to the community while further developing advanced capabilities to offer comprehensive stroke care in our local community.	1a. Increase proportion of eligible ischemic stroke patients receiving thrombectomy (blockage removal) within 24 hours	5.1% of inpatients with ischemic stroke received thrombectomy (78 IP interventions, 1,526 IP stroke volume)	FY20: 8.0% FY21: 10.0% FY22: 12.0%	BMH, LMC, PH, RH
	1b. Develop at least one comprehensive stroke center within MLH		FY22: 1	BMH, PH
2. Develop thoughtful evaluation and assessment of newly developed programs or existing programs to refine our understanding of populations that are touched by MLH community programming.	2a. Development of metrics by program	Inventory of all relevant MLH data in development	Inventory of relevant data ready for use in the 2022 CHNA	BMH, LMC, PH, RH

Senior Services

According to the MLH Bryn Mawr Rehabilitation CHNA, seniors (65+) are projected to have the fastest growing population segment from 2018 to 2023, and 27% of older adults in the market report that they have fallen within the past year. Considering the projected growth of the older adult population to 2023, and 60% of older adults preferring to "age in place," there is a strong need for fall prevention. The CHNA found that older adults in the eastern sub-region were less likely to report being in good or excellent health, more likely to have challenges with activities of daily living (ADLs) such as walking or bathing, and more likely to have challenges with instrumental activities of daily living (IADLs), such as managing medications and transportation. Residents in the MLH acute service area generally report being in better physical and mental health than the remainder of SEPA. Social isolation is an area where the MLH acute service area performed significantly worse than the remainder of SEPA. Problems associated with aging was identified as the most pressing need in the community member survey and the second most pressing need in the community leader survey (followed by mental health and opioid use disorder).

MLH has responded to these identified needs with numerous initiatives. An example of a major initiative targeting health and wellness improvement in the eastern sub-region is Together for West Philadelphia, a coalition of organizations to improve care in West Philadelphia. MLH and the Senior Well-Being Subcommittee of Together for West Philadelphia is exploring and leading efforts to establish a coalition of providers and grassroots community leaders in West Philadelphia to identify and address gaps in access to senior services. This initiative aims to reach out to community members and create information centers in locations such as barbershops and senior centers to education on topics such as fall prevention, social isolation and food insecurity.

MLH hospitals are addressing food insecurity and integrating nutrition into health care. For example, Lankenau Medical Center (LMC) runs the Deaver Wellness Farm. Paoli Hospital (PH) provides meals to patients in need.

The top diagnoses related to admission to the trauma services at PH and LMC are related to falls among older adults. MLH is focused on reducing falls of the senior population in the community and on hospital campuses. MLH provides patient/family and staff education through falls prevention programs such as A Matter of Balance, which is an eight-session course covering thoughts and concerns about falling, exercise and fall prevention, assertiveness and fall prevention. An evidence-based approach to understanding the effectiveness of classes is being explored.

MLH Senior Services launched an initiative with the Delaware Valley Accountable Care Organization (DVACO) aimed at improving the quality of care for seniors after discharge from acute hospitals. MLH leaders meet bimonthly to provide guidance for post-acute and senior related initiatives.

MLH also recognizes the importance of advance care planning. Advance care plans provide important information to clinicians and families in the event that individuals are unable to

communicate. MLH has a committee to review current outreach and education intended to increase the rate of advance care planning among patients and families MLH serves.

MLH proposes the following initiatives to further address the needs of older adults in the community:

Objective	Initiative	Current state	Future state	Facilities
1. Target food insecurity and healthy eating in the MLHC senior population and improve access to food and education programs.	1a. Sustain the Deaver Farm healthy nutrition program by continuing to provide nutritious food to vulnerable patients and providing education on healthy living.	905 patients received produce from the farm in FY18. Approximately 20% of the recipients were over the age of 65.	Maintain the number of patients receiving produce	LMC
		26 classes held at the farm about education on healthy living	Maintain the number of education sessions offered in the community	LMC
		438 participants in education and screening programs	Maintain the number of participants in education and screening programs	LMC
	1b. Improve data collection for food insecurity.	Questions related to food insecurity are an option to be used in a patient's Electronic Medical Record (EMR)	Screening questions for food insecurity are asked with all patients	BMH, LMC, PH, RH
2. Reduce the number of older adults experiencing falls at the acute inpatient hospitals.	2a. Reduce the total number of falls in older adults (age 55 and over) in acute inpatient facilities	138 falls in older adults	10% annual reduction in number of falls	BMH, LMC, PH, RH, PCSH
3. Decrease the overall falls rate per 1,000 patient days in all acute inpatients.	3a. Reduce number of falls per 1,000 patient days	1.83 falls per 1,000 patient days	10% reduction annually in fall rate	BMH, LMC, PH, RH, PCSH
4. Reduce the percentage of seniors experiencing falls.	4a. Maintain Trauma Falls Awareness Prevention Consultation Program	186 admitted patients over the age of 65 seen by the LMC Trauma Falls Prevention Awareness Consult program	Continue to offer LMC Trauma Falls Prevention Consultation program to all patients who have falls	BMH, LMC, PH, RH

Objective	Initiative	Current state	Future state	Facilities
	4b. Maintain the falls prevention awareness class participation each year at all MLH hospitals	371 participants took the Matter of Balance class	Increase the number of participants by 15% by FY22	BMH, LMC, PH, RH
5. Improve the quality of care for seniors following discharge from MLH hospitals in collaboration with the DVACO.	5a. Reduce the number of admissions to skilled nursing facilities (SNFs) for sub-acute rehab	For the time period May 2017-April 2018 **27.5%** of patients with Medicare fee for service (FFS) were discharged to SNFs	Percentage of patients with Medicare FFS discharged to SNF will be reduced to **23%** by FY22	BMH, LMC, PH, RH
	5b. Reduce readmissions to hospital	The observed to expected ratio for 30 day readmissions to MLH hospitals for the time period April 2017- January 2018 is **0.95**	The observed to expected ratio for 30 day readmissions to MLH hospitals will be **0.91** by FY22	BMH, LMC, PH, RH, PCSH
6. Increase the number of MLH patients with an advance care plan.	6a. Increase the number of MLH and MLHC patients who are asked about their advance care plan and health care decisions	5,173 patients' advance care plans have been scanned into EMR between March 2018 and March 2019	Evaluate the feasibility and process to administer advance care plan to all patients served by MLH and MLHC Monitor number of advance care plans scanned into EMR	BMH, LMC, PH, RH
7. Develop thoughtful evaluation and assessment of newly developed programs or existing programs to refine our understanding of populations that are touched by MLH community programming.	7a. Development of metrics by program	Inventory of all relevant MLH data in development	Inventory of relevant data ready for use in the 2022 CHNA	BMH, LMC, PH, RH, PCSH

Behavioral Health

Mental health and opioid use disorder were both identified as pressing needs in the community leader survey and the community member survey.

MLH is committed to improving access to behavioral health services. MLH currently provides inpatient behavioral health care in a 20-bed unit.

MLH currently has two Women's Emotional Wellness Centers (WEWCs). The WEWCs offer services such as the women's intensive outpatient program—for women needing mental health support more than weekly, but do not require the intensity of partial hospitalization—individual therapy for parenting women and support for women and families before, during and after pregnancy or adoption.

MLH's Mirmont Treatment Center—a drug and alcohol addiction treatment facility in Delaware County—is working to increase availability of substance use disorders treatment, screening and information in order to reach more community residents in need of treatment. Mirmont is exploring a more comprehensive partnership with the Delaware County Single County Authority—an organization that provides funding for prevention, intervention and treatment of substance use disorders—to help reach more people in need and increase individual and group substance use disorder treatment at the Mirmont Outpatient Centers. To combat rise in opioid abuse, all prescribers, psychiatrists and certified registered nurse practitioners at Mirmont are obtaining their suboxone (drug to treat opioid addiction) certification. A revision of the current medication-assisted treatment program is underway.

To continue to address the significant behavioral health needs in our communities, MLH proposes the following initiatives:

Objective	Initiative	Current state	Future state	Facilities
1. Evaluate the expansion of the inpatient behavioral health unit at BMH to improve access for inpatient behavioral health services for the community.	1a. Expansion of the inpatient behavioral health unit	20 beds	FY22: 32-40 beds	BMH
2. Expand access to women's emotional wellness.	2a. Offer WEWC at additional location to expand geographic access	2 locations	FY22: 3 locations	BMH, LMC, PH, RH
	2b. Increase WEWC staffing to improve community access to services	Counselors: 5.5 FTEs; Psychiatrists and NPs: 0.9 FTEs	FY22: Counselors: 10.0 FTEs; Psychiatrists and NPs: 2.9 FTEs	BMH, LMC, PH, RH

Objective	Initiative	Current state	Future state	Facilities
3. Enhance behavioral health care coordination by integrating behavioral health services in MLH primary care practices and through increasing community screenings.	3a. Number of MLHC practices offering integrated behavioral health services	11 MLHC practices	FY22: 22 MLHC practices	BMH, LMC, PH, RH
4. Increase availability of substance use disorders treatment, screening and information.	4a. Increase in number of patients screened and treated	3,023 patients treated	FY22: 4,020 patients treated	BMH, LMC, PH, RH, PCSH
5. Increase depression screening of MLH patients.	5a. Increase the proportion of MLHC primary care patients screened for depression	34.4%	FY22: 50.0%	BMH, LMC, PH, RH
	5b. Increase the proportion of MLH inpatients screened for depression	87.8%	FY22: 93.0%	BMH, LMC, PH, RH
6. Increase the capacity to provide medicated-assisted treatment (MAT) for opioid dependence at Mirmont Inpatient and Outpatient Centers.	6a. Number of physicians and CRNPs who obtain suboxone certification	8 prescribers	FY22: 12 prescribers	BMH, LMC, PH, RH
	6b. Number of patients both inpatient and outpatient who are receiving medication-assisted treatment	44 patients	FY22: 150 patients	BMH, LMC, PH, RH, PCSH
7. Develop thoughtful evaluation and assessment of newly developed programs or existing programs to refine our understanding of populations that are touched by MLH community programming.	7a. Development of metrics by program	Inventory of all relevant MLH data in development	Inventory of relevant data ready for use in the 2022 CHNA	BMH, LMC, PH, RH, PCSH

Maternal Health

Women using prenatal care services in the first trimester of pregnancy did not meet the Healthy People 2020 goal in any of the MLH CHNA sub-regions. Black, Asian and Latina women were less likely to receive prenatal care services than white women in the MLH acute service area.

Maternal health is a major area of focus for MLH. MLH delivers more than 7,000 babies per year. To improve access to maternal care including prenatal care in our communities, MLH proposes the following initiatives:

Objective	Initiative	Current state	Future state	Facilities
1. Improve access to maternal health and prenatal care in the community, ensuring greater access for underserved communities.	1a. Add MLHC practices in targeted areas to create access for all patients including Medicaid	6 OB/GYN MLHC practices	FY22: Add 2 new OB/GYN practices in markets with underserved populations	BMH, LMC, PH, RH
	1b. Work with private OB/GYN practice leadership to expand Medicaid acceptance	Axia practices enrolled in major Medicaid plans, but no available access	FY22: Create access for Medicaid patients in 3 Axia practices	BMH, LMC, PH, RH
2. Improve the postpartum depression screening rate of outpatients at LMC's maternity clinic (LOGCC)	2a. Postpartum depression screening rate of outpatients at LMC's maternity clinic (LOGCC)	**79.5%** screening rate (194 of 244 patients)	FY22: 85.0% screening rate	LMC
3. Develop thoughtful evaluation and assessment of newly developed programs or existing programs to refine our understanding of populations that are touched by MLH community programming.	3a. Development of metrics by program	Inventory of all relevant MLH data in development	Inventory of relevant data ready for use in the 2022 CHNA	BMH, LMC, PH, RH

Health Care Access and Affordability

Access to health care was identified as an important factor for a healthy community in both the community member and community leader surveys. For both surveys, cost of health care, insurance and medications were each firmly among the top three barriers to health care in their community.

Community Health and Equity teams from each of MLH's acute hospitals conducts health screenings and educational activities throughout the MLH acute CHNA area. LMC is involved in several initiatives to provide and improve access of health services to low income and underserved communities. For example, LMC runs a Medical Student Advocate (MSA) program and is in the process of expanding the program and outreach in partnership with the Free Library of Philadelphia, the Office of the Mayor's Community Schools Initiative and federally qualified health centers in West Philadelphia. MSAs are students from Philadelphia College of Osteopathic Medicine who volunteer at LMC's facility and go out into the community to provide screenings and connect patients with community resources. MSAs conduct social needs surveys with underserved patients and community members to learn about the barriers these individuals face. They direct community members to the appropriate internal and community resources that help address community member needs.

To further help address health care affordability and access to communities throughout MLH's acute CHNA area, MLH is proposing the following initiatives:

Objective	Initiative	Current state	Future state	Facilities
1. Connect MLH vulnerable populations with resources to address unmet needs and a regular source of care.	1a. Number of needs identified (includes clinical and community based outreach)	331 social needs (e.g., transportation, childcare, food, employment) have been identified across 3 clinical sites	Explore how to leverage MLH' EMR to identify social needs in the inpatient and ambulatory setting. FY22: **Increase number of needs identified by 10%**	BMH, LMC, PH, RH
	1b. Number of needs successfully closed (includes clinical and community based outreach)	24% of social needs have been successfully resolved, based on definition of resolution	Create additional community based partnerships and explore the implementation of community based resource tools to enhance ability to successfully connect patients to community based resources. FY22: **Increase resolution rate to 30%**	BMH, LMC, PH, RH

Objective	Initiative	Current state	Future state	Facilities
	1c. Develop community based partnerships and programs to address the complex needs of ED superutilizers	Identify targeted subset of ED utilizers	FY22: Create 3 sustainable partnerships that address the needs of ED superutilizers	LMC
	1d. Explore the use of technology that can ID community based resources and be embedded within MLH's EMR	Currently using MyHealthFinder as a resource tool. Currently over 700 community based resources within MyHealthFinder across MLH service area	FY22: Explore how to enhance and/or augment with additional tool that can be embedded within MLH's EMR	BMH, LMC, PH, RH
2. Launch virtual medicine options to expand affordability and access to services to community members.	2a. Pilot virtual care models	Remote monitoring for home health	FY22: Launch virtual health capabilities for employees through pilots and evaluate expansion to vulnerable populations	BMH, LMC, PH, RH
3. Develop thoughtful evaluation and assessment of newly developed programs or existing programs to refine our understanding of populations that are touched by MLH community programming.	3a. Development of metrics by program	Inventory of all relevant MLH data in development	Inventory of relevant data ready for use in the 2022 CHNA	BMH, LMC, PH, RH

HomeCare & Hospice

According to the CHNA, heart disease is the leading cause of death in MLH's community. To improve care of congestive heart failure (CHF) patients, MLH HomeCare & Hospice offers remote monitoring for these patients.

To further enhance care for CHF patients, MLH proposes the following initiatives:

Objective	Initiative	Current state	Future state	Facilities
1. Increase remote monitoring services for MLH Congestive Heart Failure (CHF) patients to improve rehospitalization rates.	1a. Increase number of remote monitoring units	125	FY22: 137	BMH, LMC, PH, RH
	1b. Reduce rehospitalization rates for the monitored CHF population	12.1%	FY22: 11.5%	BMH, LMC, PH, RH
2. Increase the home remote monitoring utilization rate for CHF patients eligible for such services	2a. Track and improve remote monitoring patient acceptance rate for eligible CHF patients	Developing baseline (by 7/1/19) for proportion of eligible patients currently monitored	Establish process to increase home monitoring acceptance by 15% by FY22	BMH, LMC, PH, RH
3. Develop thoughtful evaluation and assessment of newly developed programs or existing programs to refine our understanding of populations that are touched by MLH community programming.	3a. Development of metrics by program	Inventory of all relevant MLH data in development	Inventory of relevant data ready for use in the 2022 CHNA	BMH, LMC, PH, RH

Diversity, Respect and Inclusion

MLH sees diversity, respect and inclusion closely intertwined with health equity. The CHNA identified health inequities as an overarching health need for the MLH acute care service area given differences in and across regions, between racial groups, income levels and within populations such as LGBTQ communities.

MLH serves communities where a number of chronic diseases are not only more prevalent, but its presentations are notably more severe because poverty and lack of access to key social determinants of health, like healthy food, exacerbate the difficulties of achieving and maintaining positive health outcomes. Health care has a significant role to play in achieving health equity. While health care organizations alone do not have the power to improve all of the multiple determinants of health for all of society, they do have the power to address disparities directly at the point of care, and to impact many of the determinants that create these disparities in our communities.

MLH is committed to Diversity, Respect and Inclusion (DRI). In 2013, MLH launched the DRI initiative with goals to increase diversity in management, board and professional positions, eliminate disparities in care, educate staff on cultural competencies, integrate diversity into all elements of MLH's strategic plan. As a result, the principles of Equity are woven into MLH leadership competencies for all employees to demonstrate in their daily work. Diversity Respect and Inclusion is also embedded within MLH's values.

Main Line Health became one of eight health care organizations across the US selected to participate in Pursuing Equity, a two-year initiative of the Institute for Healthcare Improvement (IHI) to reduce inequities and outline a blueprint for how health care can advance equity. The eight health care organizations—diverse in size, geography, and patient populations—work with IHI and learn best practice strategies and successes from one another. MLH's strategic focus on identifying and addressing disparities in care was a key driver in joining the IHI's initiative.

MLH will take a health equity lense to all priorities adopted in this implementation plan. MLH proposes the following initiatives to further address DRI needs of the community:

Objective	Initiative	Current state	Future state	Facilities
1. Increase awareness and understanding to provide a more diverse, respectful and inclusive environment to provide culturally competent care to all in our members of MLH's community.	1a. Provide classroom education to all MLH employees with a goal of completing roll out in 2021	17% of employees completed DRI classroom training 30% of all MLH employees are expected to attend by June 30, 2019	Calendar year 2021: 100% completion of all employees	BMH, LMC, PH, RH
2. Address disparities of care in our community	2a. Create a robust equity dashboard for Inpatient Medicine/Critical	Currently have 1 equity measure for Inpatient Medicine/Critical	Develop 3-4 equity measures for each CEW	BMH, LMC, PH, RH

Objective	Initiative	Current state	Future state	Facilities
	Care, Emergency Medicine, Women and Infants, Surgical Services, Rehab Services clinical environment work groups (CEWs)	Care, Emergency Medicine and Women and Infants		
	2b. Continue MLH Annual Health Care Disparities Colloquium	Since the inaugural program in 2012, 61 research projects across MLH have been presented	Complete an additional 40 disparities in care research projects by FY22	BMH, LMC, PH, RH
	2c. Expand LGBTQ centers of excellence across MLH	2 LGBTQ inclusive care offices at Paoli and Bryn Mawr campuses	Expand LGBTQ inclusive care offices to all acute hospital campuses	BMH, LMC, PH, RH, PCSH
	2d. Create sustainable partnerships that address disparities of care: Together for West Philadelphia	Together for West Philadelphia maintains 5 web-based resource guides (one guide for each of the following subcommittees for ZIP code 19139: Health Equity, Education, Food Justice, Employment, and Senior Well-Being)	Increase to 30 resource guides by expanding to 5 ZIP codes for each subcommittee (including Housing), and make resources available through a web-based app	LMC
3. Education	3a. Promote DRI culture within MLH by embedding educational learning experiences	Number of educational learning experiences conducted in last 3 years: 250	Conduct an additional 415 learning experiences by calendar year 2021	BMH, LMC, PH, RH
4. Develop thoughtful evaluation and assessment of newly developed programs or existing programs to refine our understanding of populations that are touched by MLH community programming.	4a. Development of metrics by program	Inventory of all relevant MLH data in development	Inventory of relevant data ready for use in the 2022 CHNA	BMH, LMC, PH, RH, PCSH

APPENDIX

Community Needs not Addressed in this Implementation Plan

Access to affordable health care and prescription medications was identified as an overarching need in the MLH acute hospital CHNA. MLH hospitals have a charity care policy available to assist individuals and families who need help paying for their hospital care. MLH works with community partners to help underserved communities access services they need. MLH is exploring a virtual medicine pilot to expand affordability and access to services to community members. However, MLH does 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.

The Social isolation among older adults was a need identified in the CHNA. The SEPA household health survey significance testing found that the total MLH community reported that they were likely to talk with friends and relatives less than once per week; this is significantly lower than the remainder of SEPA cohort. Social isolation is difficult to identify and address. MLH operates a senior care phone line and may direct callers to community senior centers to increase contact for individuals indicating they are lonely, but MLH has not identified any direct initiatives to address this social issue.

Initiative Hospital Facility Summary Table

The numbers represent objectives and letters represent initiatives:

MLH Acute Implementation Plan Priority	MLH Acute Hospital Facility				
	BMH	LMC	PH	RH	PCSH (Joint Venture)
Chronic Disease Prevention and Management	1a, 1b, 1c, 2a, 4a	1a, 1b, 1c, 2a, 3a, 3b, 3c, 3d, 4a	1a, 1b, 1c, 2a, 4a	1a, 1b, 1c, 2a, 4a	4a
Neurosciences	1a, 1b, 2a	1a, 2a	1a, 1b, 2a	1a, 2a	
Senior Services	1b, 2a, 3a, 4a, 4b, 5a, 5b, 6a, 7a	1a, 1b, 2a, 3a, 4a, 4b, 5a, 5b, 6a, 7a	1b, 2a, 3a, 4a, 4b, 5a, 5b, 6a, 7a	1b, 2a, 3a, 4a, 4b, 5a, 5b, 6a, 7a	2a, 3a, 5b, 7a
Behavioral Health	1a, 2a, 2b, 3a, 4a, 5a, 5b, 6a, 6b, 7a	2a, 2b, 3a, 4a, 5a, 5b, 6a, 6b, 7a	2a, 2b, 3a, 4a, 5a, 5b, 6a, 6b, 7a	2a, 2b, 3a, 4a, 5a, 5b, 6a, 6b, 7a	4a, 6b, 7a
Maternal Health	1a, 1b, 3a	1a, 1b, 2a, 3a	1a, 1b, 3a	1a, 1b, 3a	
Health Care Access and Affordability	1a, 1b, 1d, 2a, 3a	1a, 1b, 1c, 1d, 2a, 3a	1a, 1b, 1d, 2a, 3a	1a, 1b, 1d, 2a, 3a	
HomeCare & Hospice	1a, 1b, 2a, 3a	1a, 1b, 2a, 3a	1a, 1b, 2a, 3a	1a, 1b, 2a, 3a	
Diversity, Respect and Inclusion	1a, 2a, 2b, 2c, 3a, 4a	1a, 2a, 2b, 2c, 2d, 3a, 4a	1a, 2a, 2b, 2c, 3a, 4a	1a, 2a, 2b, 2c, 3a, 4a	

Previous Needs Assessment

Previous 2016 needs assessments for the MLH hospitals used quantitative information from PHMC's 2015 Household Health Survey, the U.S. Census, PA vital statistics, school nurse and MLH physician surveys, as well as qualitative information (e.g., community leader meetings and interviews) and other information to support the development of the following priority community health priority topics:

MLH Acute Hospital:

- 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

Bryn Mawr Rehab Hospital:

- Community Education and Resources for Healthy Living
- Injury Prevention
- Public Transportation
- Mental Health of Rehabilitation Patients
- 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 items
    - Met a community stakeholder interest
    - Involved a benchmark/trend needing improvement
    - Is listed as a community health benchmark
    - 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
3. Was not currently being addressed by an MLH partner

As a result of the 2016 CHNA, the MLH hospitals had a positive impact in FY17 and FY18 on the specific needs identified by the needs assessment for their community, reaching approximately 153,000 lives during this time, as shown in the table below.

FY17 to FY18 MLH Community Health Services Department CHNA Activity by Priority Topic:

MLH CHNA	MLH Priority Topic	Event Count	Lives Reached
MLH Acute Hospitals	Healthy Weight/Diabetes	649	20,373
	Heart Health/Stroke	1,395	32,991
	Cancer	147	8,398
	Smoking/Tobacco	233	8,910
	Seniors	336	9,894
	Injury Prevention	200	11,491
	Behavioral Health (Mental Health and Substance Abuse)	46	1,002
	Culture/Diversity/ Disparities of Care	427	16,535
	Subtotal	**3,433**	**109,594**
Bryn Mawr Rehab Hospital	Community Education and Resources for Healthy Living	366	3,812
	Injury Prevention	158	39,854
	Subtotal	**524**	**43,666**
Total		**3,957**	**153,260**

MLH hospital Community Health Services activity summary to meet identified needs in the 2016 CHNA:

- The Community Services Departments and MLH clinical staff at the five MLH hospitals held nearly 4,000 CHNA Implementation Plan related events that touched over 150,000 lives during FY17 and FY18
- Events include healthcare screenings, a variety of education presentations for school children, seniors and community residents, Cruisin' Smart automobile injury prevention events, healthcare clinic interventions, and counseling sessions
- More than 12,000 of these lives reached involved activities focused on Philadelphia neighborhoods
- MLH acute hospitals are on pace to meet or exceed the majority of the Community Health Services action items established during the 2016 implementation plan such as providing 27 lectures per year to over-55 communities on healthy eating and nutrition (completed 143 from FY17 to FY18, reaching approximately 4,500 people) and conducting health screenings (e.g., blood pressure, cholesterol, glucose, stroke) at 610 events per year (completed 1,355 screening events from FY17 to FY18, reaching approximately 23,000 people)
- BMRH is on pace to nearly meet or exceed the majority of the Community Health Services action items established during the 2016 implementation plan, such as averaging at least 24 education outreach activities per year (completed 52 from FY17 to FY18), sponsoring 6 "Home Safe Home' presentations per year (completed 12 from FY17 to FY18) present 100

Cruisin' Smart programs to reach approximately 20,000 students per year (presented 158 Cruisin' Smart programs to approximately 39,850 students from FY17 to FY18)

Other Priority Topic Notes:

Mental Health of Rehabilitation Patients: BMRH addressed the established goals from the prior implementation plan. BMRH has continued to provide in-house psychology services to patients and families. Suicide intervention has been a component of the BMRH in-house psychology service. Presentations were also made by the President of Behavioral Health & physician liaisons to educate BMRH staff to help identify Behavioral Health patients and available resources in MLH Behavioral Health and in the community.

Additional Behavioral Health Activity Examples: MLH's CPHR, Temple, Drexel, University of Pennsylvania, Jefferson, and PCOM came together to promote Medical Student and Resident Training related to Substance Use. Focus is on development of standardized curriculum to improve surveillance of substance use disorders and referral to treatment, prescribing practices for pain management (acute and chronic). MLH has been working with Emergency Department (ED) providers to change prescribing patterns and developed a guideline in the ED for a warm handoff for patients with opioid disorder. Narcan education is included in weekly family education at MLH's Mirmont Treatment Center, and it is open to friends/family of current patients and the public. MLH has also increased access in all EDs with TelePsych and dedicated behavioral health social workers crisis intervention specialists

Metabolic Syndrome: A whitepaper identified for this priority topic's goal has evolved into the proposed MLH Comprehensive Metabolic and Weight Management Program that was initiated in FY17. In July 2019, the first Comprehensive Weight and Wellness Program will open at MLH in Broomall, Lawrence park. This center will offer a comprehensive team approach to weight loss and overall health. The Center will offer multiple plans/pathways to fit the pts goals and life style, medical management with a bariatrician, bariatric surgery, registered dietitians, exercise physiologist, psychological support, meal replacement plans, and appetite suppressants.

Injury Prevention: MLH acute hospitals far exceeded the fall prevention program goal in FY17 & FY18, conducting more than 100 "A Matter of Balance" sessions (goal of 15 per year) reaching 1,754 older adults. Additionally, Cruisin' Smart ™ is an award-winning program developed and sponsored by BMRH. The program takes a peer-to-peer approach to educating students on the dangers of impaired and distracted driving. BMRH sponsored 158 assemblies, reaching approximately 40,000 students in FY17 & FY18. MLH hospitals sponsor "mock crashes" at several high schools each year in conjunction with the BMRH program; the "mock crash" adds a reality impact to the program. Programs are held around prom time each year. It is difficult to measure the lives saved/traumatic injuries prevented by this program; however, there are anecdotal reports of students being impacted positively by the program.

Public Transportation: BMRH team has worked with appropriate transportation officials in an attempt to improve public transportation access. As of date, no concrete changes have been made, but the MLH team continues to explore this area.

Culture/Diversity/Disparities of Care: MLH has a system-wide initiative regarding diversity, respect and inclusion and reducing disparities in healthcare that may exist in its CHNA areas. Cultural awareness and competence improve the quality of care and health outcomes. Each hospital has a Diversity & Inclusion Work Group that focuses on fostering diversity and inclusion across the campus. Hospitals continue to address any needs of sub-populations in their CHNA areas. MLH sponsors an annual “Healthcare Disparities Colloquium” where research on disparities and opportunities to address them are presented to MLH employees and medical staff. Additionally, MLH is working towards training all employees in two day (managers) and one day Diversity, Respect and Inclusion classes by 2021. As of January 1, 2019, 17% of employees have completed training.

Dental Health: A preliminary assessment was conducted. Findings are being reviewed for potential solutions for emergent patients. However, dental health is not an MLH core service line.

About Main Line Health

Founded in 1985, Main Line Health is a not-for-profit health system serving portions of Philadelphia and its western suburbs. Main Line Health's commitment—to deliver advanced medicine to treat and cure disease while also playing an important role in prevention and disease management as well as training physicians and other health care providers—reflects our intent to keep our community and ourselves well ahead. A team of more than 10,000 employees and 2,000 physicians care for patients throughout the Main Line Health system.

At Main Line Health's core are four of the region's most respected acute care hospitals—Lankenau Medical Center, Bryn Mawr Hospital, Paoli Hospital and Riddle Hospital—as well as one of the nation's recognized facilities for rehabilitative medicine, Bryn Mawr Rehabilitation Hospital.

The Main Line Health system also includes Mirmont Treatment Center for drug and alcohol recovery; Main Line Health HomeCare & Hospice, which includes skilled home health care, hospice and home infusion services; Main Line Health Centers, primary and specialty care, lab and radiology, and other outpatient services located in Broomall, Collegeville, Concordville, Exton and Newtown Square; Lankenau Institute for Medical Research, a biomedical research organization; and Main Line HealthCare, one of the region's largest multispecialty physician networks.

Main Line Health is the recipient of numerous awards for quality care and service, including System Magnet® designation, the nation's highest distinction for nursing excellence, the Mid-Atlantic Alliance for Performance Excellence (MAAPE) Excellence Award, and recognition as among the nation's best employers by Forbes magazine. Main Line Health is committed to creating an environment of diversity, respect and inclusion and has proudly embraced the American Hospital Association's #123forEquity Pledge to Act to eliminate disparities in care. We are dedicated to advancing patient-centered care, education and research to help our community stay healthy.

About Lankenau Medical Center

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. Lankenau Medical Center has been named among the top 10 hospitals in Pennsylvania and top five in the Philadelphia metro area in *U.S. News & World Report*'s Best Hospitals 2018–19, and was ranked as high-performing in in aortic valve surgery, colon cancer surgery, gastroenterology & GI surgery, geriatrics, orthopedics, heart bypass surgery, heart failure,

hip replacement, and knee replacement. Lankenau has achieved The Joint Commission's Gold Seal of Approval for stroke care and breast cancer care and is one of the nation's Top Performing Hospitals for heart attack, heart failure, pneumonia and surgical care. Lankenau has also been ranked for multiple years as one of the top 50 cardiovascular hospitals in the nation by Truven Health Analytics. Lankenau has also earned the highest distinction for excellence in nursing care, the American Nurses Credentialing Center Magnet® designation.

About Bryn Mawr Hospital

Bryn Mawr Hospital, a member of Main Line Health, is a 287-bed, not-for-profit acute-care teaching hospital dedicated to helping the community stay well ahead on the path to lifelong health. Bryn Mawr Hospital has been named as the 10th best hospital (three-way tie) in the Philadelphia region by *U.S. News & World Report*'s Best Hospitals 2018–19, and is ranked as high-performing in orthopedics. *U.S. News & World Report* also ranked Bryn Mawr Hospital as high performing in the following procedures/conditions: colon cancer surgery, heart failure, hip replacement, knee replacement and lung cancer surgery. Bryn Mawr Hospital has earned Magnet® designation for the third time for its superior nursing staff. Bryn Mawr Hospital's Neuro-Cardiac Intensive Care Unit (NCICU) has also received the 2015–18 American Association of Critical-Care Nurses (AACN) Silver-level Beacon Award for Excellence for the second time. The National Institutes of Health Commission on Cancer has accredited our Cancer Center and our 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 earned the MBSAQIP Accredited Comprehensive Center designation from the American Society of Metabolic and Bariatric Surgery. The hospital offers a full range of services, including cancer care, orthopedic care, cardiovascular care, behavioral health, maternity care, bariatric surgery, neurovascular and a level III neonatal intensive care unit, all aided by a dedicated team of health care professionals and innovative technologies. 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 unit and in the pediatric emergency department with additional board-certified, fellowship trained pediatric emergency medicine physicians.

About Paoli Hospital

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 Collegeville. Paoli has been ranked the seventh best hospital (three-way tie) in the Philadelphia region by *U.S. News & World Report*'s Best Hospitals 2018–19, and was ranked as high performing in the following areas: pulmonology, urology, colon cancer surgery, heart failure, hip replacement and knee replacement. Paoli is a multi-year recipient of the Premier "Award for Quality" and Truven Health Analytics' 100 Top Hospitals® for providing superior patient care, and has earned Magnet® designation for the third time for its superior nursing staff.

About Riddle Hospital

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, the Society of Chest Pain Centers and other health care rating organizations for its high quality patient care. For the fourth year in a row, Riddle has achieved designation from the Joint Commission as a Top Performer on Key Quality Measures®. Riddle was ranked the 10th best hospital (three-way tie) in the Philadelphia region by *U.S. News & World Report*'s Best Hospitals 2018–19, and was ranked as high performing in the specialty area of gastroenterology & GI surgery and orthopedics. Riddle Hospital was also ranked as high performing in the following Common Core specialty areas: heart failure, hip replacement and knee replacement. The hospital offers a full range of services including maternity, orthopedic care and cardiovascular care—aided by a dedicated team of health care professionals and advanced technology. Riddle Hospital recently expanded and enhanced its emergency department to better suit the growing needs of the community it serves. Health Center 4, a LEED-Certified Gold building, houses the Rothman Institute, the Wound Healing & 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.

About Physicians Care Surgical Hospital

Physicians Care Surgical Hospital (PhyCare Hospital or PCSH) was formed on October 2, 2007. Founded by community surgeons, the hospital was designed for our medical and nursing teams to take the lead, ensuring clinical quality, top-notch patient experience and safe patient outcomes. PCSH also provides among the most affordable surgical care in the country.

PhyCare Hospital performed their first surgical case on October 25, 2010 at the location 454 Enterprise Drive, Royersford, PA 19468.

Recognizing that PhyCare Hospital is positioned to achieve among the best outcomes in the country, the Rothman Orthopedic Institute joined the team of owners and attending medical staff on September 7, 2012.

Main Line Health and Jefferson Health also recognized that PhyCare Hospital would be a great complement to their own exceptional patient care goals. On May 25, 2017, Main Line Health and Jefferson Health partnered to purchase majority ownership of PhyCare Hospital.

About MLH Community Health and Equity

MLH Community Health and Equity (Bryn Mawr Hospital, Lankenau Medical Center, Paoli Hospital, Riddle Hospital, and Bryn Mawr Rehabilitation Hospital) conducted more than 1,700 activities reaching an estimated 70,000 lives on campus and throughout the communities that MLH serves during FY18. Community Health and Equity leverages a multidisciplinary team, including health educators, nurses, dieticians, social workers, and public health practitioners to create and deliver community-based wellness and prevention programming. Community Health and Equity collaborates with partners in the community who are working towards our shared vision of a culture of health and are committed to addressing the underlying drivers of chronic disease. We aim to improve the health of the community by engaging with members of the community where they live, work, play and worship. MLH Community Health and Equity is the primary resource across the System along with the MLH Center for Population Health Research for MLH's Community Health Implementation Plan.

About the MLH Oversight Committee

The MLH Oversight Committee consists of MLH leadership representing a broad range of System leaders including the CFO and General Counsel; Service Line Leaders; Physician Leadership; MLH CPHR; and the MLH Community Health and Equity team. The committee meets three times per year to monitor progress on the defined implementation plans and provide guidance on priority, objective and initiative development leading into each new CHNA cycle.

CPHR Partnership for CHNA Implementation

The Center for Population Health Research (CPHR) is available to offer assistance in:

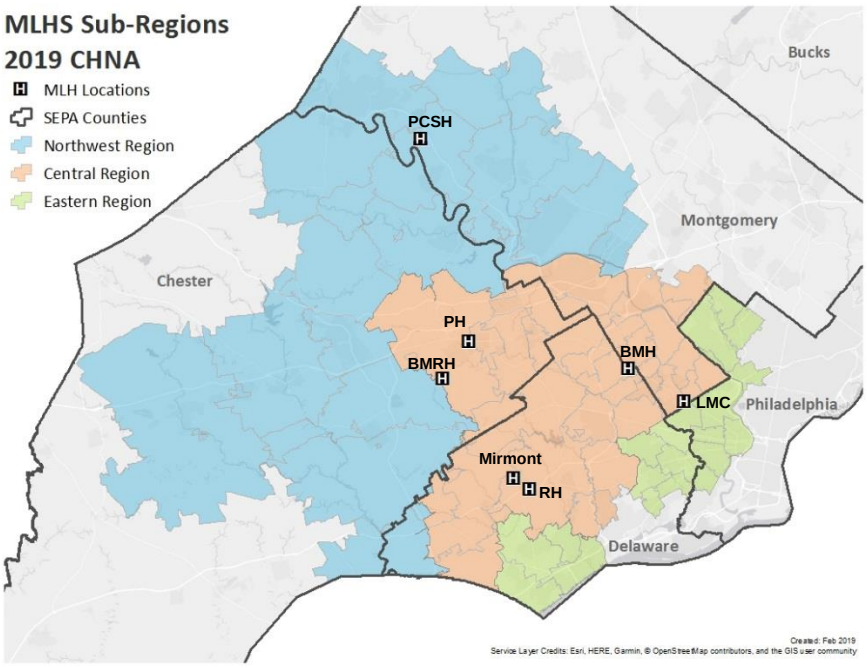
Development of assessment and data collection tools
Development of a catalog of existing measures
Development of study design to assess CHNA activities
Analysis of data in order to establish baseline measures and outcomes

Specifically, CPHR will perform the following services for ongoing CHNA tracking and reporting:

1. Develop small area estimates of population and subpopulation of the MLH service area. This will ensure that we can reasonably estimate the population "touched" by services that we deliver and relate these to reasonable estimates of the numerator served.
2. Develop or augment existing tracking instruments in order to document, with each intervention, the population characteristics of those we serve. This will involve a partnership with departments across the System to develop both:
3. Paper and pencil data collection tools for use in community and clinical settings
4. Electronic versions of the data collection tools for use in community and clinical settings
5. Where possible these will be "linkable" to patient records pending consent by patients to create these crosswalks.
6. Data collected will include the "social determinants" as well as information about current care utilization, food scarcity, location of health services in the consumer area, social resources used or required, transportation mechanisms, and brief screeners for physical health. Users of these instruments will be able to use those data collection tools relevant to the clinical or community-facing setting in order to reduce collection burden.
7. Enter paper and pencil data in a community database, merge with electronic data.
8. Begin to catalog existing data and data definitions across MLH for use in reporting.
9. Partner in the creation of quarterly data tables for use in updating relevant leadership groups on progress. Assist with populating the data tables using data collection tools.
10. Assist in collection and analysis of program activity data associated with program metrics.
11. Conduct midterm focus groups, interviews and surveys internally and in the community to prepare for next cycle.

The MLH CPHR is the primary resource across the System along with MLH Community Health and Equity for MLH’s Community Health Implementation Plan.

MLH CHNA Acute Sub-Region ZIP Codes



Service area ZIP codes included for this CHNA report included:

Central: 19355, 19008, 19060, 19073, 19373, 19087, 19010, 19083, 19301, 19312, 19064, 19063, 19003, 19342, 19333, 19041, 19081, 19406, 19096, 19004, 19072, 19085, 19066, 19035, 19428, 19319, 19444

East: 19014, 19061, 19015, 19026, 19036, 19018, 19013, 19082, 19050, 19151, 19127, 19131, 19128, 19023, 19118, 19139, 19104, 19129, 19143, 19119, 19142

Northwest: 19453, 19341, 19335, 19380, 19382, 19425, 19460, 19372, 19317, 19320, 19405, 19426, 19475, 19468, 19403, 19465, 19401, 19464, 19383, 19473