2022 Community Health Needs Assessment

FY23–FY25 MAIN LINE HEALTH IMPLEMENTATION PLAN

Main Line Health®

FY23-FY25 MLH CHNA IMPLEMENTATION PLAN PRIORITY AREAS

7 MLH Implementation Plan Priorities*

19 MLH System-level Initiatives

9* of the **12 priority areas identified in the Regional CHNA (rCHNA) are addressed within the FY23-FY25 MLH CHNA Implementation Plan*

FY23-FY25 MLH CHNA Implementation Plan – # of Initiatives by Proposed Priority Areas:		**Initiatives**
MLH CHNA Implementation Plan Priority Areas	**Access to Care**	**3**
	Behavioral Health	**3**
	Chronic Disease Management	**4**
	Diversity, Respect, Equity and Inclusion	**5**
	Maternal Health	**2**
	Senior Care	**1**
	Social and Economic Conditions	**1**
	Total	**19**

rCHNA Identified Needs and MLH Implementation Plan

9 of 12 priority areas from the rCHNA will be addressed in the MLH Implementation Plan

2022 rCHNA Priority Areas	2022 MLH CHNA Priority Areas
▪ **Mental Health Conditions** ▪ **Substance Use and Related Disorders**	▪ **Behavioral Health** (addresses Mental Health Conditions and Substance Use and Related Disorders)
▪ **Access to Care**	▪ **Access to Care**
▪ **Chronic Disease Prevention and Management**	▪ **Chronic Disease Prevention and Management** ▪ **Maternal Health** ▪ **Senior Care**
▪ **Racism and Discrimination in Healthcare**	▪ **Diversity, Respect, Equity & Inclusion** (addresses Racism and Discrimination in Healthcare)
▪ **Healthcare and Health Resources Navigation** ▪ **Socioeconomic Disadvantage** ▪ **Food Access** ▪ **Housing**	▪ **Social and Economic Conditions** (addresses Food Access, Housing, and Socioeconomic barriers)

Areas Not Addressed in the MLH Implementation Plan

1. Culturally and Linguistically Appropriate Services, 2. Community Violence, 3. Neighborhood Conditions

ACCESS TO CARE

Community Health Need(s) identified in CHNA:	MLH System Initiative to address:	Outcome Metric(s) or Milestone(s):	FY22 Baseline *(if outcome metric identified)*	FY23-FY25 Estimated Targets *(if outcome metric identified)*	MLH Service Line(s) & Entities to be involved
Utilization of Community Health Centers	Expand and enhance access to MLH health centers through a number of system initiatives to add primary care and specialty care practices, as well as operational strategies to improve ease of access, including: • Collaborating with MLHC to establish a primary care and specialty practice in West Philadelphia with community-based partners, to address issues related to disparities of access to quality healthcare. • "One contact does it all" access initiative	West Philadelphia practice space and facility exploration 'One Contact Does it All initiative: Implement CTI (Computer Telephony Integration) Technology to enhance caller and agent experience	N/A	To complete identified milestones and track visit volume, patient satisfaction and other related access metrics, over time	Lankenau Medical Center, MLHC

ACCESS TO CARE

Community Health Need(s) identified in CHNA:	MLH System Initiative to address:	Projected Outcome Metric(s) or Milestone(s):	FY22 Baseline *(if outcome metric identified)*	FY23-FY25 Estimated Target: *(if outcome metric identified)*	MLH Service Line(s) & Entities to be involved:
Adults 19-64 years old with Medicaid	Increase the number of medical staff accepting Medicaid	Require providers, who are reimbursed by MLH to provide clinical services, to accept Medicaid	Will be determined based on inventory by specialty of providers that take Medicaid	>=75% of new and renewed medical provider contracts have this requirement/ provision, and/or >=75% of physicians in medical leadership roles meet this provision	Across service lines
Emergency Department utilization and High Utilizers	Assess opportunities on ED High Utilizers and implement initiatives to address needs.	Reduction of proportion of patients with 4 or more visits to the ED (treat and release only, not admitted patients)	3.1%, (2,963 patients)	Will be explored in the first year of the initiative	ED, MLHC, SDOH

BEHAVIORAL HEALTH

Community Health Need(s) identified in CHNA:	MLH System Initiative to address:	Outcome Metric(s) or Milestone(s):	FY22 Baseline *(if outcome metric identified)*	FY23-FY25 Estimated Targets *(if outcome metric identified)*	MLH Service Line(s) & Entities to be involved
Poor Mental Health Days **Adolescent Depression and Mood Disorders** **Social isolation for Older Adults**	Increasing outpatient access to behavioral health	• Volume of patients utilizing behavioral health services by setting • Continue to integrate behavioral health in primary and specialty care • Consolidate call center to allow easy access for behavioral health services	As of May'22: • 10 providers 24 integrated behavioral health (IBH) practices across primary care, OB and pain management as of • 3,126 visits completed across practices Baseline exploration of 'conversion rate' (*patients that call schedule first appointment with BH outpatient*) will be conducted in Q2 of FY23 with the launch of Epic BH module to evaluate to work towards call center consolidation	In FY23: • 3 providers and 7 integrated behavioral health practices to be added • Launch dedicated MLH Behavioral Health services outpatient therapy practice in Q2 of FY23 By end of FY25: • Integrate behavioral health into 100% of MLHC primary care practices • Achieve 10%/year visit volume for Mirmont Treatment center	Behavioral Health, Ambulatory, Women's Emotional Wellness Center, Mirmont Treatment Center

BEHAVIORAL HEALTH

Community Health Need(s) identified in CHNA:	MLH System Initiative to address:	Outcome Metric(s) or Milestone(s):	FY22 Baseline: *(if outcome metric identified)*	FY23-FY25 Estimated Target: *(if outcome metric identified)*	MLH Service Line(s) & Entities to be involved
Drug Overdose Hospitalization Rate **Drug Overdose Mortality Rate** **Adult Binge Drinking Rate**	Increase % of patients identified with a drug/alcohol-related behavioral health diagnosis who are referred from hospital EDs (MLH or external ED) to be connected to care at Mirmont Treatment Center	% of patients being referred to Mirmont by hospital EDs (MLH or external ED)	30% of referrals to Mirmont are from from hospital EDs	5% increase of referrals to Mirmont from hospital EDs per year	Behavioral Health, ED, Mirmont Treatment Center
Opioid/Substance Use Hospitalizations **Opioid Related Mortality Rate**	Evaluate disparities in care related to opioid utilization	Complete initial analysis of potential disparity areas Create CEW workgroups to develop action plans Complete comparison to baseline year	Baseline exploration in Q1 of FY23: procedures with a high utilization of regional anesthesia intraoperatively to evaluate disparities in practice and resulting opioid consumption (e.g. joint replacements)	Targets to be defined based on baseline exploration of procedure data	Surgery, Behavioral Health

CHRONIC DISEASE MANGAGEMENT

Community Health Need(s) identified in CHNA:	MLH System Initiative to address:	Outcome Metric(s) or Milestone(s):	FY22 Baseline: *(if outcome metric identified)*	FY23-FY25 Estimated Target: *(if outcome metric identified)*	MLH Service Line(s) & Entities to be involved:
Colorectal Cancer Screening Rate **Mammography Screening Rate** **Major Cancer Incidence Rate *(breast, colorectal, lung)*** **Major Cancer Mortality Rate *(breast, colorectal, lung)***	Identify & study gaps in cancer screening engagement in our community populations.	Increase cancer screening rates in the community.	Breast cancer screening: 66.4% of 44,409 MLHC patients *(FY22, as of Apr'22)* Colorectal cancer screening: 59.9% of 82,955 MLHC patients *(FY22, as of Apr'22)* Lung cancer screening: 2105 screenings total *(FY22, as of Apr'22)* *Screening rates by demographics (race/ethnicity, payor, etc.) will be explored during FY23*	5% increase each for breast and colorectal screening rates for MLHC patients 3-5% increase for lung cancer screenings	Cancer, MLHC
Diabetes Prevalence **Diabetes-related Hospitalization Rate**	Improve diabetes care.	Increase % of patients meeting Diabetes Control target of HbA1c of less than 8	65.9% of 12,081 MLHC patients *(FY22, as of Apr'22)*	5% increase of patients meeting Diabetes Control target of HbA1c of less than 8	MLHC

CHRONIC DISEASE MANGAGEMENT

Community Health Need(s) identified in CHNA:	MLH System Initiative to address:	Outcome Metric(s) or Milestone(s):	FY22 Baseline *(where applies)*	FY23-FY25 Estimated Targets *(where applies)*	MLH Service Line(s) & Entities to be involved
Premature Cardiovascular Disease Mortality Rate	Develop and implement preventative cardiology programs in underserved patient populations	Improve women's heart health through increasing risk assessment screenings, cardiac educational opportunities, and % of women who have engaged with MLH providers post-assessment.	Baseline to be explored in Q1 of FY23 to understand cardiovascular disease prevalence and related risk factors among women within MLH patient population	Initial target for intervention: 5-10 completed risk assessments from MLH Mammography Suite at Lankenau and other pop-up venues in the community per month in FY23 Increase # of completed risk assessments by 10-20% per year through FY25	Cardiology, Mammography suite at Lankenau (for pilot) then spread across campuses
30-Day Readmissions Rate	Decrease overall readmissions and improve care transitions.	Reduce 30 day readmission rate for Medical MSDRG Medicare patients	14.4%, (2,977 readmissions)	12.4%	MLHC Medicare patients, DVACO

MATERNAL HEALTH

Community Health Need(s) identified in CHNA:	MLH System Initiative to address:	Outcome Metric(s) or Milestone(s):	FY22 Baseline: *(if outcome metric identified)*	FY23-FY25 Estimated Target: *(if outcome metric identified)*	MLH Service Line(s) & Entities to be involved:
Late or Inadequate Prenatal Care	Reduce peripartum racial and ethnic disparities	SDOH screening compliance: Substance Use Disorder (SUD), Opioid Use Disorder (OUD) screening compliance	SUD & OUD compliance = 88.7% *(FY22, as of Apr'22)*	FY23 target = 91.8% By end of FY25 target = 100%	OBGYN
Maternal Mortality Rate	Decrease the Primary C esarean Section (c-section) Rate across the system including Nulliparous women with a term, singleton baby in a vertex position (NTSV)	Reduction of primary c-section rate	Primary c-section rate = 28.6% *(FY22, as of Apr'22)*	FY23 target = 22.5% By end of FY25 target = 18.8%	OBGYN

SENIOR CARE

Community Health Need(s) identified in CHNA:	MLH System Initiative	Outcome Metric(s) or Milestone(s):	FY22 Baseline *(where applies)*	FY23-FY25 Estimated Target *(where applies)*	MLH Service Line(s) & Entities to be involved
Falls in Older Adults	Reduce the number of older adults experiencing falls at the acute inpatient hospitals.	Reduce falls in older adults.	277 falls in older adults *(FY22, as of Apr'22)*	10% decrease by end of FY25	Senior Services

SOCIAL AND ECONOMIC CONDITIONS

Community Health Need(s) identified in CHNA:	MLH System Initiative	Outcome Metric(s) or Milestone(s):	FY22 Baseline *(where applies)*	FY23-FY25 Estimated Targets *(where applies)*	MLH Service Line(s) & Entities to be involved
Food Insecurity **Households Receiving Food Assistance**	Achieve a greater understanding of our patients' SDOH needs (through screening) and an enhanced coordination of efforts to address them	Design a scalable process and workflow to assess for SDOH needs	Baseline to be obtained through pilot in June 22 in ambulatory setting	>= 90% of all patients or 90% of subpopulation (e.g. Medicaid) to be screened for SDOH needs. Targeted interventions based on SDOH needs to be identified and developed	Pilot with Ambulatory, Inpatient and OBGYN service lines prior to roll-out across all settings

DIVERSITY, RESPECT, EQUITY & INCLUSION

In addition to addressing several community health needs in our next CHNA cycle, MLH will continue enhancing our system efforts to meet the needs of the diverse communities we serve through the following initiatives:

MLH System Initiative	Outcome Metric(s) or Milestone(s):	FY22 Baseline *(where applies)*	FY23-FY25 Estimated Target *(where applies)*	MLH Service Line(s) & Entities to be involved
Increase access to LGBTQ inclusive care and services *(e.g. LGTBQ practices in primary care, gender affirming services, spread of LGBTQ inclusive care training for employees)*	• Increase visit volume across LGBTQ primary care services and gender affirming surgical services • Increase visibility of LGBTQ-identified employee workforce • Spread of LGBTQ education for clinicians and greater employee workforce	Average of >100 LGBTQ primary care visits per month *(Nov'20-Apr'22)* across 23 providers in 5 MLHC practices Over 100 new patient office visits and 29 surgeries for Gender-affirming program	10% growth/year for LGBTQ and Gender-affirming program office visits and surgeries	MLHC, Acute care hospitals
Hire and promote to reflect the diversity of the communities we serve.	Increase the diversity of our leadership ranks (defined by % of managers and above)	15.7% *(FY22)*	17-18% *(for FY23)*	Across service lines and Acute care hospitals.
Continue expansion of diversity, respect, equity and inclusion awareness and education among our employee workforce to provide the best care to the diverse communities we serve.	• % DREI training completion for new employees • % Employee Resource Groups (ERG) growth • Additional DREI education curriculum development based on needs	Over 40% training completion for new employees ERGs - in development	100% completion of DREI training for new employees each year	Across service lines and Acute care hospitals.

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MLH System Initiative	Outcome Metric(s) or Milestone(s):	FY22 Baseline *(where applies)*	FY23-FY25 Estimated Target *(where applies)*	MLH Service Line(s) & Entities to be involved
Coordinate current system to embed equity into service line-level Clinical Equity Workgroups (CEWs)	100% of the 15 CEWs establish to identify metric and action plan to address identified disparity opportunity	10 CEWs-- have metric established 6 CEWs (of 10) have metric and action plan	100% of 15 CEWs will have action plans with identified metrics	Across service lines
Track and monitor progress around MLH Anti-racism collaborative commitments	Achieve progress as measured by individual outcome metrics and milestones across each of the 9 Anti-Racism collaborative commitments	Varies by collaborative commitment	Varies by collaborative commitment	Across service lines and Acute care hospitals.