Community Health Implementation Plan

FY2023 Annual Report

MaineGeneral Health

Purpose

The purpose of this Annual Community Health Implementation Plan Report is to summarize MaineGeneral Health's (MGH) Community Health Implementation Plan (CHIP) for fiscal year 2023: July 1, 2022, to June 30, 2023. MGH developed these priorities after participating in the state's triennial Community Health Needs Assessment (CHNA) process, including reviewing county-level health data and reports, conducting community forums in partnership with other health care systems and organizations, and surveying our internal stakeholders on health priorities.

Summary

In FY23, MGH spent $2,099,679 of its own resources on community-based health and prevention programs. In addition, MGH secured approximately $6,434,024 in federal, state and private foundation grants to fund prevention work around various community health initiatives, including the prevention of Substance Use Disorder (SUD) and overdose deaths; providing services to individuals with a diagnosis of serious mental illness; increasing screenings and access to care through telehealth; reducing complications of chronic disease through education about food and nutrition and the importance of physical activity; working to advance regional transportation solutions; and addressing hunger through screenings at primary and specialty care practices and providing resources and emergency food bags. MaineGeneral's community health and prevention work is supported by $1,843,493 in funding from the Peter Alfond Endowment as well as $239,504 from MGH's Community Health Fund, the source of which is MaineGeneral Health's own net assets.

Funding

We would like to acknowledge the following funding sources for our Community Health work throughout Central Maine:

MaineGeneral

- The Community Health Fund
- The Peter Alfond Foundation

State Grants

- Maine Department of Health and Human Services, Office of Behavioral Health
- Maine Department of Health and Human Services, Center for Disease Control and Prevention
- Maine Department of Health and Human Services, Office of MaineCare Services

Federal Grants

- United States Centers for Disease Control and Prevention
- United States Department of Health and Human Services, Health Services & Resources Administration
- United States Department of Health and Human Services, Health Services & Resources Administration/ Rural Health Outreach and Rural Network Development
- United States Department of Health and Human Services, Health Services & Resources Administration/ Substance Abuse and Mental Health Services Administration
- United States Department of Health and Human Services, HIV/AIDS Bureau
- United States Department of Agriculture, Nutrition Education and Obesity Prevention/Healthy Hunger-Free Kids Act of 2010
- United States Treasury Department Fiscal Recovery Funds, subaward from Kennebec County Commissioners' Office

Private Grants

- AIDS United
- John T. Gorman Foundation
- Joint Plan of Reorganization of Malinckrodt PLS and its Debtor Affiliates
- Maine Cancer Foundation
- National Association of State and Territorial Health Directors
- Sheaffer Trust
- United Way of Kennebec Valley

Background

The 2010 Patient Protection and Affordable Care Act (ACA) requires tax-exempt hospitals to conduct Community Health Needs Assessments (CHNAs) and develop implementation strategies based on information learned during the process. Expenditures on programs related to meeting community health needs may be considered community benefit, according to the Internal Revenue Services (IRS) Code. Working with community partners, both individuals and organizations, is an important step in understanding the health needs in our community and aligns our work with the MGH mission, vision and values.

The Maine Shared CHNA is a collaborative effort among the stat's four largest health care systems and the Maine Center for Disease Control and Prevention. MGH developed the CHIP following a review of 2021 Health Profile Data, qualitative input from Community Forums in 2022 and internal meetings that took place in the summer of 2022 to develop three-year goals, strategies and measures of success.

Data that Informed Selection of MGH CHIP Priorities

In selecting our priorities for the fourth cycle of the CHNA (FY23-25), MaineGeneral leadership reviewed the following supporting data:

Priority	Cancer	Chronic Disease Management	Mental Health	Physical Activity & Nutrition	Social Determinants of Health	Substance Use Disorder
Supporting Data	• Smoking rates • Cancer deaths/100K • Lung cancer cases/100K • Obesity-associated cancer rates • GI screening • GI-associated cancer rates • Obesity-associated cancer rates	• CV deaths • Obesity • Diabetes • Self-reported health status • 3+ chronic conditions • High blood pressure • Stroke deaths/100K • Diabetes deaths/100K	• Suicide deaths • ACEs • BH ED rates • # of psychiatrists • Youth sadness, suicidal ideation	• CV deaths • Obesity • Diabetes • Self-reported health status • Obesity-associated cancer rates • High blood pressure • Stroke deaths/100K • Diabetes deaths/100K • Self-reported physical activity • Sedentary lifestyle • Fruit and vegetable consumption • Food insecurity rates	• Rurality 100% • % elderly living alone • 30+-mile drive to PCP • ED visits • % of residents screened as food insecure • % of residents screened as housing insecure	• Overdose deaths • ACEs • Drug-induced deaths • Narcotic doses dispensed • Overdose ED rates • Hospital ED utilization • Drug-affected infants

The priorities below, recommended by the MGH Senior Leadership Team, reviewed and endorsed by the Quality Council and the Community Health Improvement Committee, and approved by the MGH Board of Directors, are listed alphabetically. Their order does not reflect a hierarchy; all are equally important and deserving of resources and attention as part of our CHIP.

Behavioral Health and Substance Use Disorder

While evaluated separately during the data-review phase of the CHNA cycle, these health-priority areas were combined due to alignment of activities and reduction of overlap. For this priority, the goals are to keep people in treatment to improve outcomes, to promote stigma reduction, and to work with external partners to optimize resources and ensure treatment is available to those with SUD/OUD and alcohol use disorder, including promoting screening and assessment.

Cancer

The focus of the cancer-health priority is to increase screening for cancer and continue engagement efforts with Farmington and Skowhegan to serve rural communities. For this health priority, the goals are to reach more people with cancer screening, expand the types and methods of screenings people get, and develop a whole-person approach to cancer care.

Physical Activity

The focus area for this health priority is youth and non-competitive sports with the goals of promoting alternative physical activity and healthy behavior while youth are at school, and promoting physical activity to parents as well as integrating 5-2-1-0 Let's Go! into primary care well-child visits.

Prevention and Support of Chronic Disease

This priority focuses on diabetes and nutrition. Goals include integrating dietitians and skill development for patients, and engaging medical staff in nutrition education, food preparation and Motivational Interviewing.

Social Determinants of Health (SDoH)

While SDoH encompass many aspects of life such as where people live, work and play, the focus of this priority for the CHIP is on food insecurity and transportation as these factors influence access to care and health outcomes.

Community Health Implementation Plan FY23 Highlights

This is the first report of the fourth Community Health Implementation Plan cycle and covers FY23: June 1, 2022 to July 1, 2023. We are proud of what has been accomplished in this fiscal year and are sharing highlights of representative work that has had a high impact and met a significant community need.

Behavioral Health and Substance Use Disorder (SUD)

The goals for this health priority include keeping people in treatment to improve outcomes; reducing stigma and bias against people with behavioral health and SUD throughout our system and in the community; working with external partners to optimize use of limited resources; and ensuring that treatment is available to all people with alcohol; opioid and stimulant use disorders, including promoting screening and assessment.

MaineGeneral's Addiction Medicine practice strives to provide empathic, non-judgmental care to all, and to reduce gaps in care. During FY23, Addiction Medicine served 492 individuals with SUD and OUD with 5,580 visits between the Augusta and Waterville practices. Overall, the patient retention rate was 35%, exceeding the national retention rate of 30%. A snapshot shows that of 101 patients served in FY23, 35 patients had consecutive appointments in the first 90 days with no gap between appointments of more than 30 days. The remaining 66 patients had either at least one gap between appointments of more than 30 days, no second appointment, or a gap of more than 30 days between their last appointment and the end of the 90-day period.

The MGH Assertive Community Treatment (ACT) Team takes an evidence-based approach to serving adults with severe and persistent mental illness who may also have a SUD and often have a medical complication. In FY23, the ACT Team served 143 individuals. By working with clients and providing support, medication and connection to resources, the ACT Team strives to address housing and employment needs as well as decrease hospitalizations and ED visits.

In FY23:

- **91%** of ACT clients had no or decreased hospitalization
- **71%** of ACT clients had no or decreased emergency department visits
- **91.25%** of referrals received face-to-face evaluation within seven business days
- **100%** of clients had their housing and employment needs assessed

To ensure patients receive treatment and are at the right level of care for their risk level, MGH screens for a variety of mental health and substance use disorders, including depression, alcohol, tobacco, and other drugs including prescribed over-the-counter medications and illicit substances, and provides Medication Assisted Treatment (MAT) throughout its primary care system.

In FY23:

- **11.92%** of primary care patients were screened using the AUDIT screening tool if substance use screening was positive for alcohol use
- **85.61%** of primary care patients were screened for tobacco use
- **12.07%** of primary care patients were screened using the DAST tool, which is used for any positive screening for a drug use question, excluding alcohol/tobacco
- **37.48%** of primary care patients were screened for depression
- **3.74%** of primary care patients were screened for suicidality using the Columbia Screening tool
- **495** unique patients were provided with MAT services at **4,169** visits

For adolescents, **16.23%** of primary care patients ages 12-17 were screened with the CRAFFT screening tool, which is used if substance use screening is positive for alcohol or drug use.

MGH's Harm Reduction Program works to reduce stigma for people with SUD/OUD by providing outreach and education to a wide array of community organizations, including kindergarten through grade 12 schools (public and private); hospitals/medical offices; private businesses; Emergency Medical Services; nonprofit community-based organizations; recovery residential programs and recovery centers; and camps and youth agencies.

In FY23, the Harm Reduction program reached 1,993 people through community presentations.

Internally, the Harm Reduction program provides training and support to medical staff treating people with SUD/OUD. In FY23, the team trained 34 MGMC medical staff and presented information at 22 medical staff orientations, including information on how stigma affects both delivery of services and an individual's ability to engage in the same.

To decrease drug-overdose deaths and reduce stigma, the Harm Reduction program provides broad community education and outreach and coordinates a robust NARCAN® distribution program. According to the National Institute on Drug Abuse, NARCAN® is a brand name for naloxone, a medication designed to rapidly reverse opioid overdose. It can quickly restore normal respiration to a person whose breathing has slowed or stopped due to overdosing with heroin or prescription opioid medications. Naloxone can be administered via nasal spray or injection; however, NARCAN® is administered via nasal spray.

To increase access to NARCAN®, the Harm Reduction Program provides training on NARCAN® storage and administration to community-based organizations so they can have NARCAN® on site to respond to emergencies and/or distribute to their clients/community members. In FY23, the team conducted 54 NARCAN® trainings attended by 800 individuals in a nine-county service area. The team also onboarded 10 community emergency response organizations so they could leave NARCAN® behind when responding to a call.

Cancer

The focus of the cancer-health priority is to increase screening for cancer and continue engagement efforts with Farmington and Skowhegan to serve rural communities. For this health priority, the goals are to reach more people with cancer screening, expand the types and methods of screenings people get, and develop a whole-person approach to cancer care.

The Harold Alfond Center for Cancer Care (HACCC) provides cancer treatment to more than 12% of the state's population and is a critical community resource. The HACCC seeks to reach more people with cancer screenings and screening assessments, especially those in rural areas where access and transportation are barriers.

In FY23, the HACCC focused on partnering with primary care to increase low-dose lung screening referrals (LDLS). In FY23, 2,725 screenings were performed at MaineGeneral with 76% of the patients referred by a PCP compared to a 59% referral rate in FY22, which saw a total of 1,173 LDLS. The HACCC also developed a workflow to improve the monitoring of patients at high risk for lung cancer based on previous LDLS results.

To improve access for rural communities, the HACCC partnered with Redington-Fairview General Hospital in Skowhegan and Franklin Memorial Hospital in Farmington to participate in clinical trials and genetic screening. In FY23, seven patients in Farmington were eligible for clinical trials and one person enrolled. At Redington-Fairview for the same time period, six people were eligible and five people enrolled. For both Farmington and Skowhegan, 79 people were referred for genetic screening.

An additional focus area of the current CHIP cycle is developing a whole-person approach to cancer care by integrating non-traditional care into medical treatment and supporting patients throughout their cancer journey. The HACCC developed an approach to engage clinical and administrative leaders and staff in a culture of whole-person care by developing a survey to measure baseline. The HACCC also hired an oncology holistic care coordinator to begin this work and survey patients and families about their needs and concerns. In FY23, the HACCC referred 106 patients to holistic alternative care approaches at the Dempsey Center and held support groups at the HACCC in which 124 people participated. The support groups incorporated a variety of approaches, including art and meditation.

Going outside of the walls of the cancer center, HACCC staff partnered with the Peter Alfond & Center (PAPHLC) to reach people at community locations, pairing cooking demonstrations that featured cancer-fighting foods with education about cancer prevention and screening. In FY23, events were held at the Chelsea Grange, Huhtamaki and Sappi, with a total participation of 140 people.

Physical Activity

The focus area for this health priority is youth and non-competitive sports with the goals of promoting alternative physical activity and healthy behavior while youth are at school and promoting physical activity to parents, as well as integrating 5-2-1-0 Let's Go! into primary care well-child visits.

In FY23, the focus area for this health priority was identifying an appropriate intervention for youth ages 7-14 in non-competitive sports. The PAPHLC partnered with Healthy Communities of the Capital Area (HCCA) to promote the 100 Mile Club, a free to low-cost intervention where youth walk 100 miles in a defined time period. HCCA has offered the program at local schools and is partnering with MaineGeneral to expand its reach. Youth focus program offerings in FY 23 included a Create Theatre program open to teens and planning for family physical activity programming for FY24.

Promoting 5-2-1-0 Let's Go! in primary care is a way to engage the whole family in healthy behaviors. The 5-2-1-0 Let's Go! program is an initiative aimed at promoting healthy lifestyles among children and families to combat childhood obesity. It encourages daily habits of consuming 5 servings of fruits and vegetables; limiting screen time to 2 hours; engaging in 1 hour of physical activity; and avoiding sugary drinks by drinking water or low-fat milk. The program, developed by MaineHealth, offers resources for schools, childcare centers, health care practices and communities to support these healthy behaviors. MaineGeneral reviews the 5-2-1-0 program with parents during well-child visits. In FY23, 5-2-1-0 information was shared at 25.78% of well-child visits.

Prevention and Support of Chronic Disease

The focus area for this health priority is diabetes and food and nutrition. For this priority, the goals are to integrate registered dietitians (RD) and hands-on skill development

for patients within the walls of the practices and to engage medical staff in learning experiences on nutrition, food preparation and motivational interviewing.

Within this priority, the key focus area is food and nutrition given their vast impact on health and well-being. During the convening of stakeholder groups, medical staff identified the need for learning experiences on nutrition, food preparation and motivational interviewing to more effectively meet patients' needs. The need for this education was supported by a survey done by Maine Dartmouth Family Practice that showed nutrition education is an area of improvement for medical staff.

An internal workgroup consisting of two community RDs, two clinical RDs and a family medicine clinician formed to review nutrition education offered within other health care systems for medical staff. The workgroup identified the "Eat to Treat" program at Boston Medical Center as aligning with the food and nutrition focus area of the CHIP. "Eat to Treat" provides clinicians with tools to facilitate effective nutrition counseling to patients.

In FY23, the workgroup completed a plan for adaptation of "Eat to Treat" for MGMC staff to be delivered in several modalities — video; in person on site; Grand Rounds; and an interactive quarterly opportunity to complete the "Eat to Treat" curriculum, earn CEUs and participate in a cooking demonstration. Pre- and-post surveys will be developed to evaluate the impact of nutrition education on a clinician's confidence and understanding about nutrition and nutrition counseling.

Training on motivational interviewing techniques to couple with the nutrition information is underway for FY24.

Social Determinants of Health (SDoH)

While SDoH encompass many aspects of life such as where people live, work and play, the focus of this priority area for the CHIP is on food insecurity and transportation as these factors greatly influence access to care and health outcomes.

In FY23, Great Oak Family Medicine joined MaineGeneral's primary care practices and began screening for food insecurity, along with our 12 other primary care practices participating in the Good Shepherd Food Bank's Community Health & Hunger program. Also participating are 12 MGMC specialty care practice locations, where staff also screen patients for food insecurity and provide emergency food bags as well as linkage to sustainable food resources in the community. Food insecurity screening questions are now included in the SDoH screening tool and routinely assessed at each annual wellness visit. The implementation of this SDoH assessment has led to a more consistent, broader span of patients reached by the program and offered these resources when needed.

In FY23, 27,002 patients at MGMC primary and specialty care practices were screened. Of that number, 2,357, or 8.7%, screened positive. Practice staff distributed 1,327 food-resource guides to link people to ongoing food support and distributed 1,126 emergency food bags containing shelf-stable foods.

MaineGeneral's Harm Reduction Program's two Syringe Service Programs (SSPs), located in Augusta and Waterville, provide empathic services and support to reduce the negative consequences of substance use and other high-risk behaviors by promoting safety and health, naloxone distribution and linkage to community resources. In FY23, the SSPs distributed 194 emergency food bags, 586 Just-in-Time food items and 74 $10 gas cards.

In FY23, MaineGeneral addressed regional transportation and access to care through an ongoing partnership with the Kennebec Valley Community Action Program for outpatient services, as well as collaboration with regional transportation companies to ensure viable transport for in-patients with acute needs.

Conclusion

In conclusion, the successful implementation of MGH's Community Health Implementation Plan depends on the collaborative efforts of all stakeholders, including the Maine Center for Disease Control and Prevention, the Central Public Health District, our medical staff and that of other health care facilities, community organizations and residents of the Kennebec Valley. By focusing on preventive measures, enhancing access to health care services and promoting healthy lifestyle choices, we aim to significantly improve the overall health and well-being of our community.

The strategies outlined in this plan, such as health education programs, regular screenings and the promotion of physical activity and nutritious diets, are designed to address the specific health challenges identified by county-level health data as well as our internal patient population data. Continuous monitoring and evaluation will ensure these initiatives remain effective and responsive to the evolving needs of Central Maine residents.

We are committed to fostering a supportive environment that encourages healthy behaviors and reduces health disparities. Through sustained engagement, resource allocation and policy advocacy, we can create a healthier, more resilient community.

Moving forward, it is crucial to maintain open lines of communication and feedback with all participants to adapt and refine our approach. Together, we can achieve the goals set forth in this plan and pave the way for a healthier future for all community members.


MaineGeneral Health