Community Health Implementation Plan

January 2023—December 2025

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 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 MaineGeneral Health (MGH) mission, vision and values.

The Maine Shared CHNA is a collaborative effort among the four largest health care systems in the state and the Maine Center for Disease Control and Prevention. MGH developed its Community Health Implementation Plan (CHIP) following a review of 2021 Health Profile Data and qualitative input from Community Forums in 2022.

Based on this review, the MGH Senior Leadership Team recommends the priorities in the table below. The priorities, goals and strategies of the MGH 2023-2025 CHIP were reviewed and endorsed by the Quality Council and the Community Health Improvement Committee of the Board of Directors. MGH project teams developed the CHIP's three-year goals, strategies and measures of success after a series of meetings convened in the summer of 2022. The table below outlines the proposed CHIP health priority areas with identified responsible departments/entities and individuals within MGH.

Proposed MGH Community Health Implementation Plan

2023-2025 MGH Priorities	Prevention and Support for Chronic Disease	Social Determinants of Health		Mental Health and SUD		Cancer	Physical Activity
		Food Insecurity	Transportation				
Unit	Primary Care Steering	Addressed in Prevention and Chronic Disease	Administrative Directors	Behavioral Health Service Line	Addiction Medicine practice	Cancer Center	Sports Medicine, Pediatrics and PAPHLC
Individuals	Drs. Laura Arnold, Jason Brown, Rebecca Brown, Alyssa Finn, and Amanda Iantosca; Anne Conners, Venus Gilley, Jess Nalesnik, Ben Ramsdell		Rick Boudreau, Ericka Deering, Victoria Jewett-Smith, Shelley King, Margaret Naas	Drs. Bob Croswell & Nick Gallagher; Karen Dostie, Shane Gallagher, Shelley King, Nikki Poulin, Jen Riggs		Deb Bowden, Arlene McLean, Sandra Neptune, Kim Smith, Barb Wiggin	Drs. Steve Diaz & Lara Walsh; Anne Conners, Rich Garini, Jill Haskell, Alicia Rice, Chris Sementelli, Steve Tosi

Goals, Strategies, Measures

Each project team noted above met between June and November 2022 to develop goals, strategies and measurements.

Prevention and Support of Chronic Disease/Food and Nutrition: This workgroup identified diabetes and chronic pain as its focus areas with two main goals: integrating registered dietitians and hands-on skill development for patients with the practices; and engaging medical staff in learning experiences on nutrition, food preparation and motivational interviewing. Examples of some strategies to achieve these goals: developing a teaching kitchen curriculum and related engagement strategies focused on diabetes and chronic pain; and delivering CME nutrition education to MGH medical staff.

Behavioral Health/Substance Use Disorder: This workgroup identified the following goals: keeping people in treatment to improve outcomes; reducing stigma; working with external partners to optimize resources; and ensuring treatment is available to those with SUD/OUD and alcohol use disorder. Examples of strategies to achieve these goals include developing a transportation system to help people keep appointments and maintain treatment; increasing educational opportunities for leaders to coach teams on stigma and bias; and using the SUD and BH collaboratives to engage external partners for a community-based continuum of care.

Physical Activity: This workgroup identified youth (ages 7-14) and non-competitive sport as the focus area with the following goals: promoting physical activity among youth participating in youth-oriented community organizations; promoting alternative physical activity and healthy behavior while youth are at school; and promoting physical activity directly to parents. This approach will leverage existing relationships MGH has with schools and community-based organizations and will require Healthy Living staff to be redirected to serve more youth. Examples of strategies to achieve goals are adding alternative physical activity and healthy behavior resources in partner schools to engage youth not involved in organized sports; and integrating 5-2-1-0 Let's Go into all primary care well-child visits to engage medical staff, parents and youth.

Transportation: This workgroup's two goals focused on optimizing the current Delta transport program for inpatient and ED patients transitioning to the next level of care; and expanding the transportation program to include rides to ambulatory care visits to reduce no shows, ED use and hospital readmission. A program coordinator was identified as needed to achieve these goals.

Cancer: This workgroup focused on the need to increase screening for cancer and continue engagement efforts with Farmington and Skowhegan to serve rural residents. The goals developed are improving access for rural residents to cancer and hematology services; reaching more people with cancer screenings and expanding the types and methods of screenings people get; and developing a whole-person approach to cancer care that integrates non-traditional care into medical treatment and supports people on their journey. Examples of strategies include expanding clinical trials to Farmington and Skowhegan to better serve those communities and decrease cancer burden; expanding virtual health; strengthening relationships with primary care to increase cancer screenings; increasing community and workplace screening events to reach those who may not have a PCP; and developing holistic and non-traditional care to offer in the expanded cancer center.

Implementation

These goals and strategies were developed with engagement of leaders in existing clinical and administrative units. A leader will be assigned for each priority area, and teams will report to the senior leadership team twice per year on their progress toward achieving the goals of this community health implementation plan.