Community Health Implementation Plan

FY2020 Annual Report

MaineGeneral Health

In This Report

From Our President & CEO, Chuck Hays

2020 was a year like no other for our state, communities, and health care systems. The COVID-19 pandemic presented unprecedented challenges, but also some opportunities as we adapted and innovated to provide our services and care in light of COVID-19 precautions such as physical distancing, masking, and screening.

In the midst of the pandemic, our work on community health priorities continued, although the form changed. We cancelled in-person classes and health educators pivoted to provide telephonic and virtual support. Primary care changed its workflows and appointment structures to provide care but also keep patients safe. For a time, our health care system cancelled elective procedures.

We set up community COVID-19 vaccination clinics in partnership with the state of Maine and provided 46,275 doses to members of our community. We redeployed staff to nursing homes. We doubled down on community collaborations, distribution of meals through the Alfond Youth & Community Center and provided masks to community organizations in need.

We are proud of what we were able to accomplish in terms of community health priorities in light of the pandemic.

This report details our community health work from July 1, 2019 - June 30, 2020. This is our third annual report on goals and strategies developed through the community health needs assessment process.

Maine is unique in conducting a statewide, collaborative community health needs assessment that joins Maine's four largest health care systems and the Maine Center for Disease Control and Prevention to pool resources, develop common metrics and conduct community forums to inform the direction of our health care, prevention and public health efforts.

We are fortunate to have the support of private, state and federal grants and the Peter Alfond Foundation and Community Health Fund endowments as we address chronic disease prevention and management and substance use prevention and management.

I hope you enjoy reading this report. I am proud of the work that MGH does to enhance, every day, the health and well-being of people in the Kennebec Valley.

Sincerely,

Chuck Hays
President & CEO
MaineGeneral Health

Acknowledgements

Thank you to the following individuals who contributed to the development of this annual report:

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- United States Department of Agriculture
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Private Grants

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- Elmina B. Sewall Foundation
- Harvard Pilgrim Health Care
- Health Equity Alliance
- Institute for Healthcare Improvement
- Maine Cancer Foundation
- Maine Economic Development Fund
- Maine Health Access Foundation
- Maine Oral Health Funders
- Stephen and Tabitha King Foundation
- United Way of Mid-Maine
- United Way of Kennebec Valley

Donations

- MaineGeneral's Farms, Forks & Friends annual fundraiser

Summary

In FY20, MaineGeneral spent $989,508 on the execution of community-based health and prevention programs. In addition, MaineGeneral secured approximately $2 million in federal, state and private foundation grants to fund prevention work around opioid use disorder, drug overdose and harm reduction. MaineGeneral's community health and prevention work is supported by $819,400 in funding from the Peter Alfond Endowment as well as $264,780 from MGH's Community Health Fund, the source of which is MaineGeneral Health's own net assets.

Purpose

The purpose of this report is to describe MaineGeneral Health's implementation of its Community Health Implementation Plan (CHIP) for FY 2020 (July 1, 2019 to June 30, 2020). MGH developed these priorities in collaboration with the other major health care systems in the state; the Maine Center for Disease Control and Prevention; and through a series of community forums designed to reach the public, including underserved and vulnerable populations.

By compiling this report, we are holding ourselves accountable for the impact we have on community health in our region. We also hope this information is useful to our community partners in their efforts to improve the health and well-being of people in the Kennebec Valley.

Community Health Needs Assessments Priorities FY20

Health Priority: Chronic Disease Prevention and Management (Cancer, Diabetes, Heart Disease, Tobacco)

Goal of Health Priority: To improve the prevention and management of chronic disease in order to reduce incidence

Health Priority: Social Determinants of Health (Access to Care, Food Insecurity, Transportation)

Goal of Health Priority: To enhance health care system capacity and community partnerships in order to address social determinants of health for populations served

Health Priority: Mental Health

Goal of Health Priority: To further the integration of mental health and physical health to increase well-being and quality of life

Health Priority: Substance Use

Goal of Health Priority: To improve the prevention, screening, management and treatment of substance use within an integrated care delivery network

Health Priority: Physical Activity, Nutrition and Healthy Weight

Goal of Health Priority: To improve access to prevention programs throughout the community to reduce the incidence of chronic disease

Highlights of FY20 Community Health Needs Assessment Priorities

MaineGeneral Health is a large and diverse system. Many departments and individuals within MaineGeneral collaborated on these community health needs priorities. Not all of that work is reflected in this document. What follows are highlights of the work of FY20. These health priorities are a part of the triannual community health needs assessment process. As a system, MGH will be working on these priorities until FY22. We plan to share annual reports, success stories and barriers addressed and overcome as we proceed with this work.

Health Priority: Chronic Disease Prevention and Management

Objective

Identify patients with chronic conditions (Chronic Obstructive Pulmonary Disease (COPD), Congestive Heart Failure (CHF), Diabetes Management (DM) or multiple ED visits/admissions who may be eligible for Kennebec Valley Community Care Team (KVCCT) or practice-based care management services.

The Outpatient Care Management Department consists of the KVCCT, RN Care Managers, social workers and remote patient monitoring staff (RN and assistant). The KVCCT provides short-term (3-6 months with 72 days on average) care management services to the highest risk and most vulnerable patients who have multiple admissions, and/or ED visits, and uncontrolled chronic conditions. The care managers assist these patients in creating an individualized care plan to overcome barriers and meet goals as well as connect them to resources.

Care managers complete an average of 88 percent of all hospital discharge calls within 48 business hours and reach an average of 83 percent of these patients.

Impact in FY20

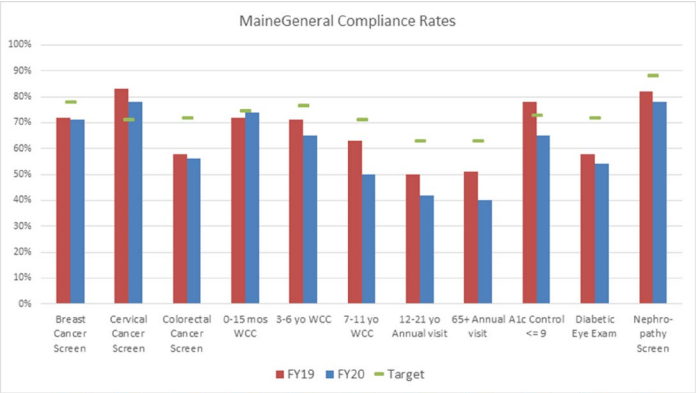
360 people referred to KVCCT

Success Stories

One patient resided in her car through the winter months with limited food/nutrition as she did not have a way to store or prepare food. The KVCCT was able to connect this patient with resources and the patient obtained an apartment.

A young man was referred to the KVCCT as he had a recurring infection due to uncontrolled diabetes (his A1C was 11.3). The KVCCT care manager developed a care plan with this patient, worked with him on weight loss and his A1C came down to 7.2, with no further hospital admissions or ED visits from enrollment to graduation.

Impact of COVID-19 on Chronic Disease Prevention and Management



Unfortunately, FY20 saw a decline in almost every measure related to chronic disease management, including compliance rates with preventive screenings, annual well child checks and physical exams, and diabetic quality measures. The pandemic certainly played a large role in this decline. On a positive note, the rate of WCC for 0-15-month-old patients actually increased, and the percent decrease in the 3-6-year-old range was less significant than the other age groups. This reflects the prioritization that occurred in the practices to get children in for necessary vaccines, despite COVID-19 precautions.

Health Priority: Chronic Disease Prevention and Management

(Cancer, Diabetes, Heart Disease, Tobacco)

Objective

Expand Chronic Disease Self-Management Programs to high-risk populations, including people living with HIV.

MaineGeneral is the first organization in Maine certified to facilitate the Positive Self-Management Program, offered to clients of the Horizon Clinic, which treats people positive for HIV.

We continue to offer a robust roster of chronic disease programming to our patients and community members including the National Diabetes Prevention Program, Living Well with Diabetes, and Living Well with Chronic Pain. MGH offers these self-management programs free to interested patients and community members.

Impact in FY20

560 referrals to chronic disease self-management programs by primary care, self-referrals

- 17 classes held
- 190 class participants
- 13 lay leaders trained

Success Story

Matt Axtell is a man with a plan. The 27-year-old from Oakland is a full-time student at Kennebec Valley Community College and plans to study biomedical engineering after he graduates and build a career designing prosthetics for those who have lost limbs to illness or injury. He is also determined not to succumb, literally, to what he calls the "Axtell Curse" – both his father and grandfather died at age 59 of heart issues, and there is diabetes on both sides of his family. When his doctor suggested Matt sign up for the National Diabetes Prevention Program (NDPP) through the Community Health Department, he wanted to sign up, but transportation was an issue for him.

Transportation wise, Matt disclosed that he would have difficulty continuing to attend NDPP after his second week of class. Thankfully, the Community Health Department has funding available through the MaineGeneral Education Transportation Program which provides rides through KVCAP to educational classes. "I am very glad I could take this class," Matt says. "My sugar and cholesterol levels are better. I have learned to count fat grams in addition to calories. I know how much fiber my diet should include. I am eating better and feel a lot healthier."

Matt says he was the youngest member of the year-long diabetes prevention program, but he was fine with that. "I hope that developing healthier habits when I'm younger will make it easier to keep them up later on," he says. "I think this is a great class for people of all ages."

Despite the pandemic, cancellation of classes and a launch of smaller classes when classes could resume in person, our participation in the National Diabetes Prevention Program remained constant. Offering this vital programming for free is a service to our community members and provides our primary care partners with an action step for those struggling with chronic disease.

From July 2019 to June 2020, we offered seven programs with 99 participants. At the end of the year-long program, participants lost 4.95 percent of their starting weight. Over a seven-month period, July 2020 to February 2021, MGH offered six programs with 48 participants who lost 2.81 percent of their weight.

Health Priority: Mental Health

Goal of Health Priority: To further the integration of mental health and physical health to increase well-being and quality of life

Objective

Implement Columbia Scale for suicide risk screening for all Behavioral Health services under MGMC, by July 2019

The mental health focus for FY20 was on key suicide prevention measures and training. All MGH behavioral health services (inpatient, outpatient psychiatry and IOPs) implemented the Columbia Scale for Suicide Risk Screening. Through cross-system collaboration, primary care practices adopted the evidence-based, validated tool in the Electronic Health Record (EHR). Community Health Department staff also developed a primary care prevention toolkit. MGH Human Resources added the suicide risk training as required annual training for all staff.

Health Priority: Physical Activity, Nutrition & Healthy Weight

Goal of Health Priority: To improve access to prevention programs throughout the community to reduce the incidence of chronic disease

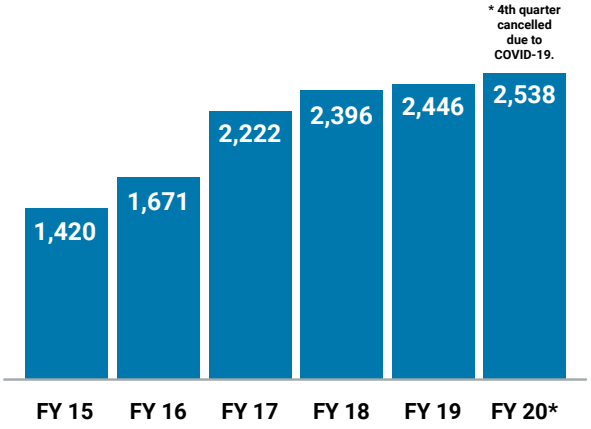
Objective

Increase the number of people enrolled in evidence-based programs and healthy living classes, including fall prevention programs

Despite COVID-19, the number of participants in evidence-based chronic disease prevention programs and healthy living classes increased, even with all fourth-quarter FY20 classes cancelled due to the pandemic.

The class enrollment chart below includes quarterly events such as employer cooking demonstrations and culinary classes for medical students. It reflects overall enrollment and is not broken down by content area.

Class Enrollment by Year



Health Priority: Physical Activity, Nutrition & Healthy Weight

Objective

Increase referrals to healthy living classes by providing education/feedback to practice and medical staff.

MGH is unique in its Resource Hub service. The Resource Hub is staffed by a team of health educators who manage referrals received from medical and practice staff and attempt to

connect patients to health care, community-based organizations and other services and resources. In addition, staff spend an hour orienting new medical staff to the programs the Community Health Department offers patients, as well as the process for referring to evidence-based and healthy living classes and other services. In FY20, out of 49 new medical staff hired, 44 received the orientation.

The chart below reflects the number of patients referred for healthy living classes and evidence-based programs such as the National Diabetes Prevention Program and chronic disease self-management programs as well as primary care.

Hub Activity	FY19	FY20
ED/Express Care/Inpatient Referrals	1,425	1,446
Incoming/ Outgoing Calls	16,051	16,971
Healthy Living Referrals	27	97
Evidence-Based Program Referrals	633	554
TOTAL	**18,166**	**19,086**

Health Priority: Physical Activity, Nutrition & Healthy Weight

Objective

Increase the number of health education programs offered in community-based and employer settings

Healthy cooking classes are one of the Community Health Department's most popular offerings. To engage more members of our community who may not have experienced a class, the Community Health Department partnered with Workplace Health to deliver classes and activities for area employers, including, Huhtamaki, Maine Veterans Homes, the Boys & Girls Club of Kennebec Valley, and the Maine Department of Transportation.

In addition to these new service sites, more than 50 representatives from local businesses participated in employer forums where the Teaching Kitchen demonstrated services they might access to increase the wellness of their employees. Future plans include the promotion of a menu of services for local employers.

Impact in FY20

- 196 participants in healthy living programs/classes
- 23 delivery sites
- 19 trained facilitators, coaches, leaders and instructors
- 12 employers offering services

Health Priority: Social Determinants of Health

(Access to Care, Food Insecurity, Transportation)

Goal of Priority: To enhance health care system capacity and community partnerships in order to address social determinants of health for populations served

Objective

Increase the number of ED and Express Care patients without a PCP who are linked to a primary care practice

Research tells us that having a usual source of primary care increases wellness. In FY-20, MaineGeneral Resource Hub health educators responded to nearly 3,500 calls and faxed referrals, seeing a 37 percent increase in individuals needing primary care. People who need primary care are referred to the Resource Hub in three ways: from Express Care, the Emergency Department and calls to MaineGeneral's information line. Working directly with people who need the access to care, health educators connected 86 percent of the individuals they talked with to a primary care practice.

Health Priority: Substance Use

Goal of Health Priority: To improve the prevention, screening, management and treatment of substance use within an integrated care delivery network.

MGH's response to substance use disorder and drug overdose is multifaceted with collaboration taking place internally among departments, externally with community organizations, and statewide with state government, professional associations and advocacy organizations. Our efforts span and link prevention, treatment and residential care.

Major focus areas for FY20 were on naloxone distribution, harm reduction education and safe injection supplies, and training medical staff in X-waiver Medication-Assisted Treatment (MAT).

Objective

Deliver drug overdose trainings throughout the communities and in high-risk settings (Intensive Outpatient Program, homeless shelters, treatment facilities, jails, law enforcement, soup kitchens, recovery communities, etc.)

The Harm Reduction Program's team of health educators provides drug overdose trainings to community members and organizations throughout MaineGeneral's service area. Health educators provide trainings to community members at high risk of overdose, staff of organizations served, community members, as well as family members and friends. Due the emergence of COVID-19, staff transitioned from in-person trainings to developing topic-specific videos, which were published through the Harm Reduction Program's Facebook page and the MaineGeneral Health Youtube channel.

Impact in FY20

- 309 trainings
- 3,180 materials distributed
- 1,046 people trained

Objective

Train medical staff in the X-waiver MAT training to increase OUD treatment capacity

The Harm Reduction Program coordinated a series of "half and half" waiver trainings for medical staff over the past year. This included setting the date/time/location, arranging for the instructor, and providing necessary materials for participants to complete the in-person portion of the training. Our team also coordinated with participants to complete the necessary paperwork of continuing education credits.

Impact in FY20

- 10 medical staff trained
- 53 medical staff treating patients for Opioid Use Disorder
- 8 MaineGeneral primary care practices offering MAT services

Objective

Provide easy access to naloxone through clinical and community settings to decrease drug overdose deaths

The Harm Reduction Program coordinates a robust naloxone distribution program. Through that program, naloxone is distributed to primary care practices, specialty practices and the Emergency Department for distribution to patients in need. For instance, when a patient with an opiate use disorder is discharged from 3 South, they are provided with a naloxone kit. Also, if a patient from the IOP program is receiving MAT services through MaineGeneral, they also receive a naloxone kit or a prescription for one.

Naloxone kits are provided to community members through public events and needle exchange programs as well. In addition, administration trainings and free naloxone are provided to community organizations interested in offering naloxone to community members.

Impact in FY20

- 117 free kits distributed to patients
- 326 kits distributed at the Needle Exchanges

Objective

Engage community in overdose prevention through naloxone distribution and overdose education

Through a contract with the state, the Harm Reduction Program regularly trained community organizations, within and beyond our service area, who were interested in providing naloxone to community members. The Program arranged for the ordering and delivery of naloxone to organizations and trained staff on how to educate individuals and respond to an overdose.

- 2,668 naloxone kits distributed
- 54 trainings
- 588 individuals trained

Objective

Increase rapid access to MAT treatment through the emergency department induction program with follow-up in the Outpatient Plus (OPP) MAT program

Our community members struggling with opioid use disorder can be started on suboxone in the Emergency Department. On the next business day,

they are seen in the OPP for follow-up treatment.

Impact in FY20

- 66 patients who visited the Emergency Department were enrolled into the Outpatient Plus (OPP) MAT program.
- 2,994 visits to Outpatient Plus (OPP)/Medication-Assisted Treatment (MAT) programs
- 165 active patients

Objective

Offer Intensive Outpatient Program (IOP) level of treatment for individuals with co-occurring disorders

Located in Waterville and Augusta, IOP services specialize in focused co-occurring (mental health and substance use disorder) treatment as a step-down from inpatient (reducing Length of Stay) or alternative to inpatient (reducing need for more beds). Counselors and psychiatry provide care; treatment is 4 – 6 weeks, four days per week. Team-based care is the standard. Trauma-informed practices in combination with co-occurring treatment of mental health and substance use disorder are essential. The goal for IOP intake for MaineGeneral's inpatient behavioral health unit referrals is within three days of inpatient discharge. The IOPs also take referrals from primary care offices, counselors and other lower levels of care. During the pandemic, the IOP Program at MaineGeneral ran at capacity and has continued to provide on-site services.

Objective

Offer Residential Treatment, which can include MAT

In FY20, MGH's residential care for substance use disorder transitioned from serving men and women to serving women. Capacity doubled from eight beds to 16 beds. MGH's residential program provides a comprehensive nine-month treatment program, providing co-occurring treatment and based on understanding the biopsychosocial dimensions of the whole person.

Treatment is individualized for each resident based on her unique needs and preferences, which may or may not include MAT. During FY20, MAT/suboxone was provided to 8 residents. If a resident has an opiate use disorder, she is prescribed Narcan. Approximately 25 residents were discharged with a Narcan kit.

Objective

Provide harm reduction education and safe injection supplies to people who inject drugs to decrease preventable infections and diseases such as Hepatitis C, HIV, sepsis and cellulitis

The Harm Reduction Program continues to operate two needle exchange programs, located in Augusta and Waterville. Community members receive harm reduction education, safe-injection supplies and HIV/HCV rapid testing. Health educators screen exchange members for social determinants of health and provide referrals to appropriate programming based on our clients' needs. This includes transportation, food insecurity, access to health care and housing resources.

Impact in FY20

- 740 exchanges
- 197,745 syringes disposed
- 57,874 supplies provided
- 24 rapid HIV tests administered
- 26 rapid HEP C tests administered

Conclusion

MGH is proud to share this work with you, acknowledging that we need to do more to address community health priorities within our system, county and state. By documenting the work of FY20, we are holding ourselves accountable to you, our community partners, and sharing our success and barriers in the hopes that future collaboration will take us forward to making a collective impact on the health needs in the greater Kennebec Valley.

In doing this work, we strive to keep community members foremost in our minds and to think of opportunities to engage people for prevention, access to care and treatment. We are mindful of our impact on our communities and that engagement with community members and patients can take many forms. In FY20, we received a letter from a patient who had attended an event where a giant inflatable colon was on display. Community members could walk through and also received information about cancer screenings and colonoscopies. After the inflatable colon caught his eye, the community member followed up with his primary care provider. He was found to have early-stage colon cancer. He said that encounter with the giant colon was a "life saver." He wrote: "Please know that you are making a difference."

Together we can make a difference. Thank you for reading this report and for all you do to make our communities healthier and happier places to be. If you would like to join with us to improve the health of your community or to share your thoughts on health priorities, please reach out to us at 872-4102 or phl@mainegeneral.org.


MaineGeneral Health