Community Health Implementation Plan

FY2022 Annual Report

MaineGeneral Health

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From Our President & CEO, Nathan Howell

Three years ago, everything in health care — and our everyday lives — was changed by the COVID-19 pandemic. While we're continuing to "get back to normal," we want to take a moment to recognize all of the work done within our health care system, by our community partners, and our community members to adjust and re-adjust to changing times and needs. So many organizations and individuals have provided great service and comfort even if scared and unsure of what the future would hold. Every one of you reading this report has contributed in ways small and large, all of them important, to keep the fabric of our community strong and stitched together. In trying times, I want to take a moment to thank you for all you have done to keep our communities strong and resilient.

In the midst of the pandemic, our health system, along with community organizations and dedicated individuals, continued our efforts to improve community health. Despite the challenges, we were able to proceed with key implementation strategies of our FY22 Community Health Implementation Plan.

I am happy to share highlights of that plan with you in this Annual Report, which features MaineGeneral Health's commitment to meeting our community members where they are in their health journey and providing resources, expertise and support to empower them to improve their health and wellbeing.

As noted above, recent years have been especially challenging for health care systems in our country and state with the impact of the COVID-19 pandemic still lingering and affecting staffing, screening rates, and people's ability to engage with their health care teams in the usual way. I am proud that, despite these challenges, we have been able to offer an array of services to meet community needs. We are a resilient system and community and the work in this report, and the community participation in it, reflects that.

This report details our community health work from July 1, 2021 to June 30, 2022. This is our fifth 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 community 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 Community Health Fund and the Peter Alfond Foundation endowments to support our efforts to 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,

Nathan Howell
President & CEO, MaineGeneral Health

Acknowledgements

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

Anne Conners
Barbara Crowley
Amanda Doody
Melissa Emmons
Dan Feldman
Vicki Foster
Shane Gallagher
Adam Gurin
Chuck Hays
Wendy Jorgensen
Michelle King
Gillian LaPlante
Michele McCarthy
Joy McKenna
Laura Mrazik
Jessica Nalesnik
Alicia Rice
Alan Sanford
Alex Sydnor
Sarah Webster

Funding

The following funding sources made the outcomes and accomplishments in this report possible:

MaineGeneral Endowments

- 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 Center for Disease Control and Prevention
- United States Department of Health and Human Services, Health Services and Resource Administration
- United States Department of Agriculture

Private Grants

- AIDS United
- John T. Gorman Foundation
- Maine Cancer Foundation
- National Association of State and Territorial Health Directors
- United Way of Kennebec Valley

Summary

In FY22, MaineGeneral (MGH) spent $2,031,165 of its own resources on the execution of community-based health and prevention programs. In addition, MaineGeneral secured approximately $3,376,032 in federal, state and private foundation grants to fund prevention work around various community health initiatives, among them prevention of Substance Use Disorder (SUD) and overdose deaths; providing services to individuals with a diagnosis of serious mental illness, increasing access to care through telehealth; reducing the impact of complications from chronic disease through remote patient monitoring; and treating patients with SUD through Medication Assisted Treatment (MAT). MaineGeneral's community health and prevention work is supported by $1,493,698 in funding from the Peter Alfond Endowment as well as $250,376 from MGH's Community Health Fund, the source of which is MaineGeneral Health's own net assets.

Purpose

The purpose of this Annual Report is to describe MaineGeneral Health's Community Health Implementation Plan (CHIP) for fiscal year 2022: July 1, 2021 to June 30, 2022. MGH developed these priorities after participating in the state's Community Health Needs Assessment 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 as to their thoughts on system health priorities.

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

Community Health Needs Assessments Priorities FY22

Mental Health

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

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

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

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 (i.e., access to care, transportation, food security, etc.)

Substance Use

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

Highlights of FY22 Community Health Needs Assessment Priorities

This is the last report of the 2020-2022 CHIP implementation cycle. The next cycle, following the triennial Community Health Needs Assessment cycle, will cover 2023-2025. We are proud of what has been accomplished in the 2020-2022 cycle and are sharing highlights of that work in this report. This report does not feature all of the work in our system addressing the health priority areas, but rather a selection of representative work that has had high impact and met a significant community need.

Chronic Disease Prevention and Management

Goal of Health Priority

To improve the prevention and management of chronic disease in order to reduce incidence.

Objective

Identify patients with chronic conditions (Chronic Obstructive Pulmonary Disease (COPD), Congestive Heart Failure (CHF), Diabetes Management (DM) or multiple Emergency Department (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 an assistant), as well as the prescription assistance technicians and navigators at the Harold Alfond Center for Cancer Care (HACCC). The KVCCT provides short-term (3-6 months with 128 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 98 percent of all hospital discharge calls within 48 business hours and reach an average of 75 percent of these patients. Patients are offered ongoing care management services based on chronic disease and needs.

In addition to the work of the Community Care Team, in FY21, MaineGeneral launched the IMPaCT (Individualized Management of Patient-Centered Targets) Community Health Worker (CHW) model from the University of Pennsylvania. This model embraces a patient-centered approach to selecting goals the patient feels will most improve their overall health and well-being. In FY22, five CHWs made up the team and were dedicated to the work of assisting patients in developing action plans, finding resources, and following through on small steps to meet long-term health goals. The majority of patients identify goals such as losing weight, controlling diabetes, moving more and/or quitting tobacco. For most patients, this involves weekly meetings either at the patient's home, in the medical practice, in the community, or via telephone.

Since November 2020, the 110 patients who have graduated from the program spent an average of 6.5 months in the program, with 1.1 contacts with their CHW per week, on average. Of the patients who have graduated, 57% have met, or partially met, their six-month health goal. Patients have been successful at losing an average of 6.2 pounds, increasing their average activity levels by 133.8 minutes per week, decreasing their A1c (a measure of diabetic control) by 0.75 and decreasing tobacco use by 10.25 cigarettes smoked per day.

Impact in FY22

- **438** people referred to KVCCT
- At the end of FY22, 47% of patients referred were either currently active, or had successfully graduated from CCT services.
- **110** patients have graduated from the CHW program

Success Stories

CHWs walk the walk with their patients and, together, achieve impressive results.

For example, CHW Barb Hewins facilitated conversations between her patient and a local property management team to avoid eviction while assisting the patient in connecting to a daily living skills program, which will

strengthen the patient's ability to live independently and maintain stable housing. CHW Jane Allen helped a patient experiencing depression to sport new (and long overdue) eyeglasses, try chair yoga and use a tablet to connect with friends, read books and play games.

In addition, the practices have seen transformation in the health and wellbeing of their patients through participation in the CHW program.

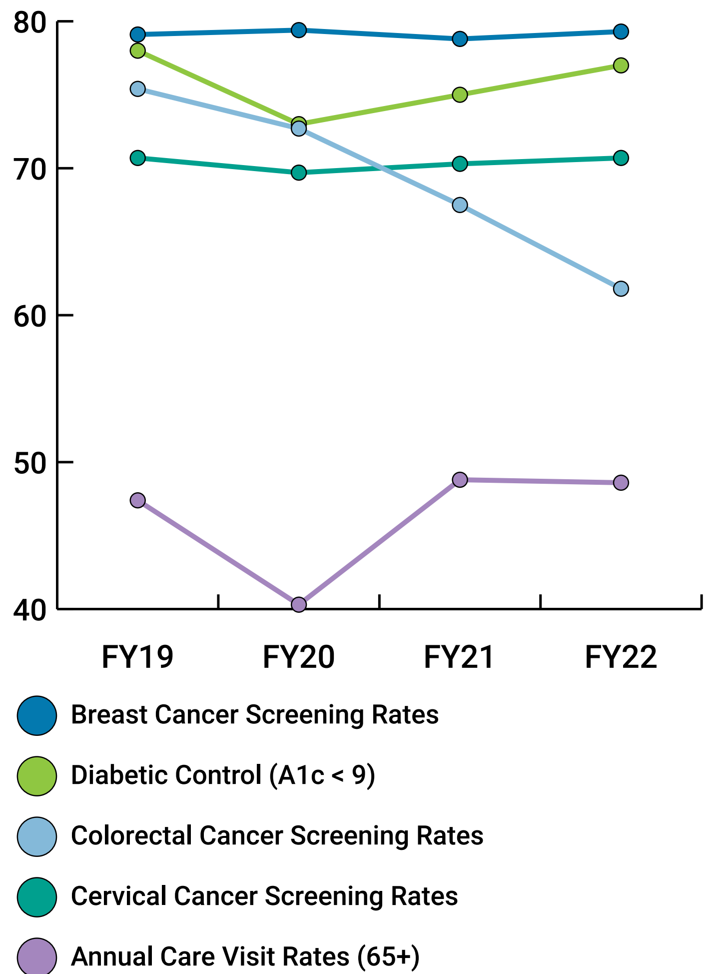
A patient at Augusta Family Medicine with a diabetes diagnosis was recently referred to the CHW program. The patient had weight-loss goals but faced several barriers around mental health and transportation. She and her CHW, Vicky Nadeau, have worked together to address these barriers. They have also made a short-term goal to exercise twice per week for 20 minutes. The patient has since exceeded that goal and is exercising three times per week for 25 minutes; sometimes the pair exercises together at their visits. Only two months into the six-month program, the patient has begun to lose weight and cried tears of happiness when she saw her most recent weight on the scale. During a recent telehealth visit, the patient reported to her clinical team that: "My CHW is a saving grace in my life, the best thing that has come into my world in a long time, and has made me believe in myself again. My CHW has helped me so much." The positive feelings are mutual. "It makes my heart happy to know that I am making a difference," said Vicky.

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

Objective

Increase compliance with colorectal cancer screening, diabetic screening for retinopathy and nephropathy (pre-visit planning, proactive outreach, etc.) and increase the number of patients 65 years old or older being seen for an annual wellness visit/annual physical.

In FY22, primary care was focused on seeing patients routinely in order to manage chronic diseases while also addressing prevention and screening. Colorectal cancer screening rates have been more heavily impacted by the pandemic, while cervical cancer screening has returned to pre-pandemic levels. Breast cancer screening has remained stable. Annual care visits (Annual Wellness Visit or Physical Exam) for the Medicare population increased as the pressures of the pandemic eased, although staffing changes and an electronic medical record transition likely affected the practices' ability to increase annual visit rates further in FY22. Diabetic control, as measured by Hemoglobin A1c values, has also returned to pre-pandemic levels.



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.

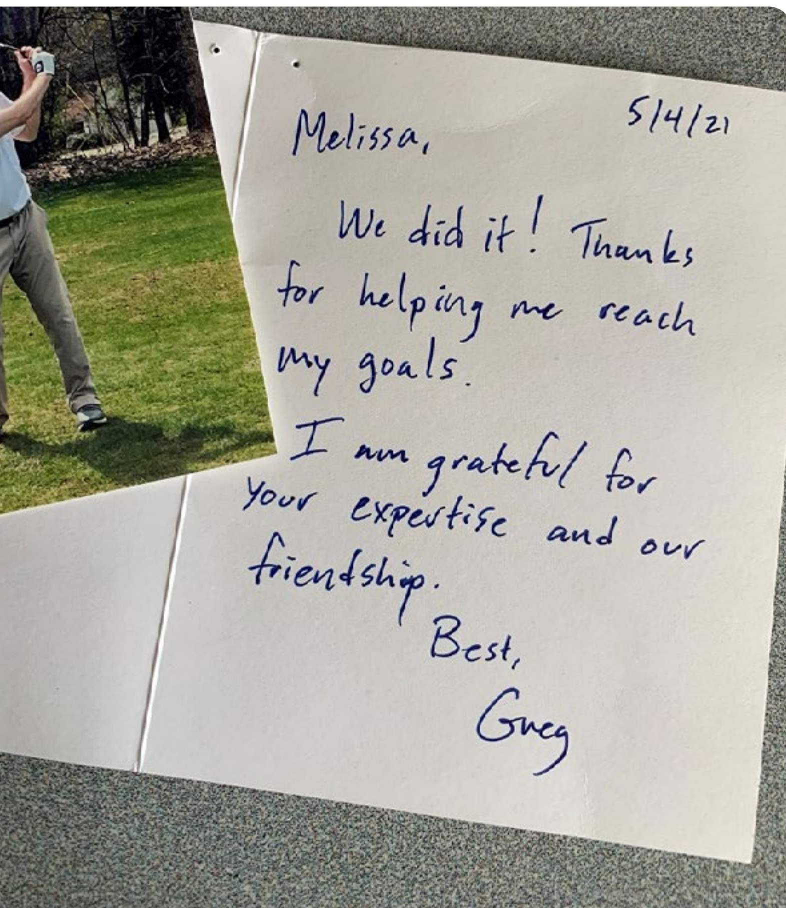
Objective

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

Through our Community Health Department, MGH offers 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 FY22

- **47** classes held
- **380** class participants
- **19** lay leaders trained


Melissa, 5/4/21

We did it! Thanks for helping me reach my goals.

I am grateful for your expertise and our friendship.

Best,

Greg

Success Story

Carol Fairfield had been heavy all her life. Her mother suffered from diabetes and she knew she was at risk of getting it herself if she didn't do something. When she retired in 2017, the 67-year-old Benton resident tried to sign up for the National Diabetes Prevention Program (NDPP) through MaineGeneral, but it was full. Carol persisted, and when she did sign up for the class, she committed to it fully. With great results!

"At my biggest, I weighed close to 300 pounds. Now I weigh 207," Carol said proudly. "I have more to go, but I'm more than pleased with where I am. I have more energy and stamina, I used to hate to exercise and could barely handle 15 minutes at the beginning. Now I've joined Silver Sneakers and can do an hour. Zumba, weights, resistance training, I love it!"

Adults like Carol at risk for developing type 2 diabetes or who have already been diagnosed with pre-diabetes can benefit from the National Diabetes Prevention Program. The program, which is free, gives people the tools to stay healthy and prevent disease. Participants meet weekly in one-hour group settings. Sessions are led by health coaches who help participants focus on gradual lifestyle changes, resulting in fat and calorie reduction and increased physical activity.

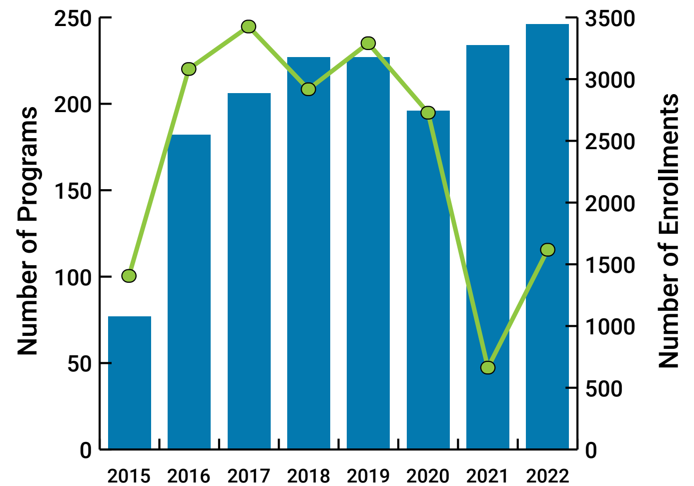
"It's easy to do, and it fits into my life," Carol said of the program. "Simple one-at-a-time things can lead to big successes. I have a lot more energy, and I feel amazing, like I am 17 again."

From July 2021 to June 2022, we offered 10 National Diabetes Prevention Programs with 142 enrollments. Of the 142 enrollments, 101 participated in the program by attending at least one session. By April 10, 2023, five of the 10 groups had concluded the year-long program, with 21 participants losing a total of 7.8% of their starting weight. The remaining five programs are still in progress at the time of the writing of this report, with 10 people continuing to participate. These programs will complete by June 2023.

In addition to our evidence-based self-management classes, we offer healthy living classes to community members and patients to help them live healthier lives and prevent chronic disease from occurring or if they already have it, to reduce its impact on their lives and wellbeing. We offer classes in physical movement, healthy cooking and eating and healthy mind/body, i.e., stress management and spiritual practice.

Impact in FY22 Healthy Living Classes

- 193 classes held
- 1,231 class participants
- 13 delivery sites
- 30 trained facilitators, coaches, leaders and instructors
- 3 contracted employer sites offering healthy living/ evidence-based classes



Of note, July 2018-June 2019 are pre-pandemic years. For FY20, the data for both programs and participants reflects three quarters of data as all spring programming was cancelled due to COVID-19. FY21 was our peak COVID impact year. While in-person class participation declined dramatically in FY21, we were able to offer more options virtually and telephonically and saw a substantial increase in participation through remote offerings. In our peak COVID year, our number of offerings increased; this was due to increased telephonic programming and a number of videos posted on the MaineGeneral YouTube channel as well as free one-on-one health coaching. During FY22, chronic disease programming was still operating under MGH COVID-19 guidelines around physical distancing and masking. The physical distancing restrictions meant that our classes were smaller. This had a direct correlation to the number of participants/enrollments.

While we are getting back to the new normal in our chronic disease self-management programs, the chart above shows the impact of the pandemic on both our enrollments and number of programs. In short, we are offering more programs with a lower enrollment as FY22 saw us increasing our participation rates, but not rebounding to pre-pandemic levels. The chart above shows total enrollments in both our evidence-based chronic disease management classes and our healthy living classes.

Physical Activity, Nutrition and Healthy Weight

Objective

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

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, Hub staff orient new medical practitioners to the programs the Community Health Department offers patients, as well as the processes for referring to evidence-based and healthy living classes and other services. In FY22, 52 medical staff received the orientation.

The chart below reflects the number of patients referred to the Hub for connection to a primary care provider, healthy living classes and evidence-based chronic disease management programs such as the National Diabetes Prevention Program.

Hub Activity	FY21	FY22
ED/Express Care/ Inpatient Referrals	1,337	1,478
Incoming/Outgoing Calls	15,028	17,046
Healthy Living Referrals	81	113
Evidence-based Program Referrals	693	366
TOTAL	**17,319**	**19,003**

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

Goal of Health Priority

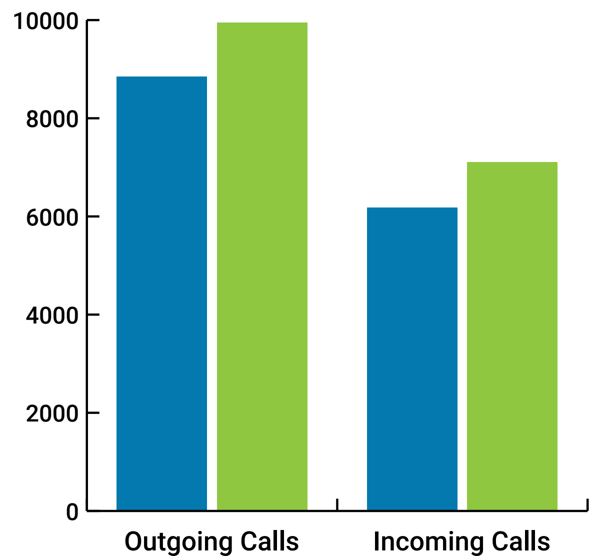
To enhance health care system capacity and community partnerships in order to address social determinants of health for populations served.

Objective

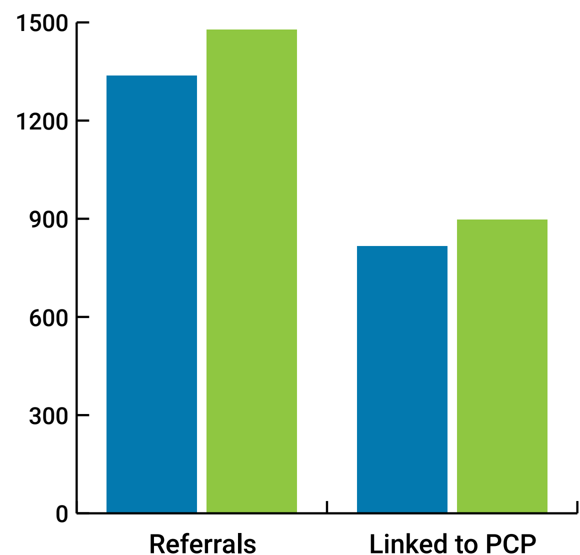
Increase the number of ED and Express Care patients without a PCP who are linked to a primary care practice.

Research tells us that having a usual source of primary care increases wellness. In FY22, MaineGeneral Resource Hub health educators received 1,478 referrals for primary care and linked 897, or just over 60%, of people to primary care. People who need primary care are referred to the Resource Hub in four ways: from Express Care, the Emergency Department, inpatient units and calls to MaineGeneral's health information line. Referrals from MaineGeneral's inpatient units increased significantly in FY22.

Outgoing and Incoming Calls



Patients Linked to Primary Care



Social Determinants of Health (access to care, food insecurity, and transportation)

Goal of Health Priority

To enhance health care system capacity and community partnerships in order to address social determinants of health for the populations served (i.e., access to care, transportation and food insecurity).

Objective

Implement Digital Health Strategy to enhance access to care for rural populations.

In FY22, MGH received $697,915 in grant awards to expand telehealth services. These funds were used to purchase remote patient monitoring equipment, telehealth staff equipment and fund a tablet loan program, among other efforts. During this time, all primary care, including the Horizon Program and the Edmund N. Ervin Pediatric Center, were onboarded to the Zoom for HealthCare program. In addition, services were enhanced for non-English speakers or those who have hearing loss through improved workflows and integrated Stratus interpreter services systems.

In FY22, MaineGeneral continued its efforts to enhance access by expanding virtual prevention and treatment options for staff, patients and community members. In FY22, MGH implemented virtual healthy living classes using Zoom for Healthcare and launched a virtual wellness coaching and Employee Assistance Program services. In partnership with Northern Light Acadia Hospital, MGH also launched virtual Emergency Department consults. This service allows patients, pediatric and adult, waiting in our Emergency Department to have early virtual access to psychiatric evaluations, medication management, follow-up visits and bed placement search. This program was developed to improve patient wait times in the Emergency Department and to ease the burden of staff shortages in the Emergency Department and surrounding behavioral health services. In FY22, MaineGeneral patients in the ED had 871 initial visits and 1,916 follow-up visits with Acadia.

In February, MaineGeneral launched a virtual satellite clinic between MaineGeneral's Harold Alfond Center for Cancer Care and Redington Fairview General Hospital, allowing oncology patients to remain in Somerset County for follow-ups while seeing the HACCC oncologist virtually. From February to June 2022, 49 visits were conducted virtually.

MaineGeneral also partnered with the National Digital Equity Center to establish a tablet loan program (for behavioral health, Horizon and Oncology patients) and completed requirements to offer on-site digital literacy courses. The Horizon Clinic serves people in nine counties who are living with HIV, using an inter-professional team approach incorporating clinical, behavioral health and case management professionals. In FY22, the Horizon Patient Advisory Group enhanced access for its members by adopting a hybrid option, using Zoom virtual support and a tablet loan program to ensure clients could access the required group sessions, regardless of transportation or other barriers.

Impact in FY22

- 2,224 virtual visits with 1,475 unique patients across outpatient practices
- 538 Telestroke/Teleneurology visits with Dartmouth Hitchcock
- 319 new patients enrolled in the Remote Patient Monitoring program, with an average of 200-225 patients actively monitored each month

Objective

Onboard all primary care practices and other specialty sites with a food insecurity screening project to provide emergency food packs to those in need.

In FY22, three additional primary care practices joined the Community Health and Hunger program where the Community Health Department and primary care practices

screen for food insecurity and partner with Good Shepherd Food Bank (GSFB) to distribute emergency food bags and a Resource Guide to those who screen positive. In total, in FY22, 11 MGH primary care practices and 12 MGH specialty practices participated in the program. In addition, four Kennebec Region Health Alliance practices were onboarded in partnership with the Community Health Department and GSFB and now operate their programs independently.

Impact in FY22

- **18,755** patients screened
- **1,867** positive for food insecurity (nearly 10% of those screened)
- **1,169** Food Resource Guides distributed
- **1,000** Emergency Food Bags distributed

The Community Health Department also worked to increase access to influenza and COVID-19 vaccination through its school-located vaccination clinic program. By bringing services into the school setting, access is improved for all, especially children whose parents may not otherwise be able to get them to a primary care practice to receive a vaccination. In FY22, 55 schools in 31 towns in Kennebec and Somerset Counties participated in the program. Of those students who received influenza vaccinations, 37% have MaineCare or are uninsured. Insurance status varies by community; for example, the majority of students in the Augusta area receiving an influenza shot are members of MaineCare while other communities, such as Winthrop, see the reverse.

Impact in FY22

- **2,361** student and staff influenza shots administered
- **1,693** COVID-19 vaccinations administered to students and school staff

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

Recruit and hire a LCSW who has a background in HIV and mental health to offer counseling to Horizon Program clients.

MaineGeneral's Horizon Program provides a complete range of quality medical and social services to all identified HIV-positive persons in central and mid-coast Maine. All services are for people infected and affected by HIV/AIDS. The Horizon program offers people identified as HIV positive one-stop access to primary care, mental health services, and case management. Services are confidential and based on a sliding scale according to income.

To better serve its patients and community, the Horizon program focused on enhancing the expertise of its team by recruiting and hiring a Licensed Clinical Social Worker (LCSW) who has a background in HIV and mental health. The LCSW started in January 2022 and has seen 48 clients since then. Overall, the Horizon program has 57 clients currently receiving mental health treatment.

Objective

Expand staffing pattern and organize daily management tasks to grow Assertive Community Treatment (ACT) program and enhance capacity.

The ACT program is an evidence-based practice serving adults with severe and persistent mental illness who may also have a SUD and often have medical complications. The team, located in Augusta and Waterville, includes a team leader, two psychiatric mental health nurse practitioners, psychiatric nurses, case managers, a substance use specialist and an employment specialist. Intensive support, at a ratio of 10 clients per staff member, is shown to reduce psychiatric hospitalizations and unnecessary ED usage. During the COVID-19 pandemic, the ACT team experienced staffing challenges; however, the team overcame these challenges and has successfully recruited and hired staff. The current census is 110 clients.

Impact in FY22

- **95%** of ACT clients had no or decreased hospitalization (goal 60%)
- **71%** of ACT clients had no or decreased emergency room visits (goal 60%)
- **86%** of referrals receive face-to-face evaluation within 7 business days (goal 60%)
- **100%** of clients had their housing and employment needs assessed

Objective

Implement Columbia Scale for suicide risk screening for all Behavioral Health Services under MaineGeneral Medical Center by July 2019.

The Columbia Risk Assessment, also known as the Columbia-Suicide Severity Rating Scale (C-SSRS), is an evidence-based questionnaire that asks a series of simple, plain-language questions to assess suicide risk.

- All adult patients treated by MaineGeneral Medical Center's Behavioral Health Services are screened for suicide using the Columbia Scale at every visit.
- The Columbia Scale is used in MaineGeneral Medical Center's Emergency Department to screen all patients presenting with a behavioral health complaint.

Objective

Implement Patient Safety Plans for patients assessed as at risk for suicide following screening and make Safety Plans available at all levels of care.

A suicide safety plan is a written set of instructions that patients create with staff assistance as a contingency plan if they begin to experience self-harm thoughts. It contains a series of gradually escalating steps to follow, proceeding from one step to the next, until the individual is safe.

- All patients admitted to inpatient behavioral health services have a Safety Plan completed during hospitalization.
- All residents in the Women's Residential program have a Safety Plan developed within the first week of treatment.
- The Safety Plans are part of the electronic medical record and are available for transitions of care.

Substance Use

Goal of Health Priority

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

MGH recognizes the impact that SUD has in our communities, including the increase in drug overdose deaths over the past three years, with Kennebec County's rate of drug overdose deaths exceeding Maine's and the nation's. MGH's response to this crisis affecting so many families in our service area is multifaceted and relies on collaboration taking place internally among MGH departments, externally with community organizations and statewide through funding from state government and collaboration with professional associations and advocacy organizations.
Our efforts span and link prevention, treatment and

residential care.

Major focus areas for FY22 centered on naloxone distribution (to reverse drug overdoses and save lives), harm reduction education (working with people who use drugs to keep them healthy and link them to recovery support) and working with internal MGH departments on naloxone distribution.

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. In FY22, staff were able to return to limited in-person trainings as well as develop videos featuring people telling their story of recovery from substance use disorder.

Impact in FY22

- 679 training sessions
- 1,000 people trained
- 3 recovery journey videos produced and disseminated

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, MGH's inpatient behavioral health unit and the Maternity and Emergency Departments.
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 is also distributed through MaineGeneral's two Syringe Service Programs (SSPs): one at the Thayer Center for Health in Waterville and one at Green Street in Augusta. During FY22, SSP staff reported 367 refills for SSP members. This indicates a trusting relationship with SSP staff and that members distributed naloxone to those in need of it and/or used it to reverse an overdose. In FY22, SSP members reported 209 overdose reversals to program staff.

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 FY22

- 123 free Naloxone kits distributed to inpatients (ED and departments at the Alfond Center for Health)
- 1,041 free Naloxone kits distributed through the Syringe Service Programs

Objective

Engage the community in overdose prevention through naloxone distribution and overdose education.

Through a contract with the state, and with the support of Dr. Steve Diaz, Chief Medical Officer, the Harm Reduction Program regularly trains community organizations in nine of the state's 16 counties who are interested in providing naloxone to community members. We provide naloxone to non-MaineGeneral medical practices, schools, jails and community nonprofits, as well as other SUD treatment organizations. We also provide general overdose prevention and harm reduction education sessions.

Impact in FY22

- 4,940 naloxone kits distributed
- 679 training sessions
- 1,000 individuals trained

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 operates two Syringe Service Programs (SSP), located in Augusta and Waterville. Members of the SSP receive harm reduction education, safe-injection supplies and HIV/HCV (Hepatitis C) 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, and access to health care and housing resources.

In FY22, the SSP collected 25% more syringes than in FY21 and distributed 2.1% percent more syringes. We believe that the increase is a result of more people seeking services at the SSPs due in part to the effects of the pandemic when COVID and isolation caused either new use or return to use. The rate of syringe return may also have been affected by two executive orders, issued during the pandemic, that lifted stipulations on how certified SSPs can operate. Most significantly, the executive orders allowed a "needs-based" distribution of syringes as compared to a 1-1 exchange (to receive a new syringe, you have to bring in a syringe). The other executive order removed geographical requirements where you could operate at a town or county level as long as a certification was for a location inside that jurisdiction. For example, our SSP could operate anywhere in Kennebec County as we have two locations in the county.

SSP membership grew significantly between FY21 and FY22 seeing an 81% jump. Unique individuals served also increased by 59%. SSP membership hovers at around 373 unique individuals.

People who inject drugs are at higher risk for transmission of the HIV and Hepatitis C viruses, and testing for both is encouraged for SPP members by the health education team. By testing members' status for HIV and HCV, members can be linked to treatment and support for improved health outcomes. In FY22, SSP HIV testing increased by 30% and HCV testing increased by 28%. We believe that this increase is due to an increase in SSP membership as well as staff training on testing. Also, the Augusta and Waterville SSPs were the only exchanges in the state to stay open during the pandemic and increased hours of operation to accommodate clients' needs. This increased trust among SSP members and staff and contributed to the higher testing rates.

Impact in FY22

- 397,914 syringes collected
- 390,453 syringes distributed
- 1,444 exchanges
- 373 unique individuals served
- 188 new members
- 66 rapid HIV tests administered
- 59 rapid HCV tests administered

Conclusion

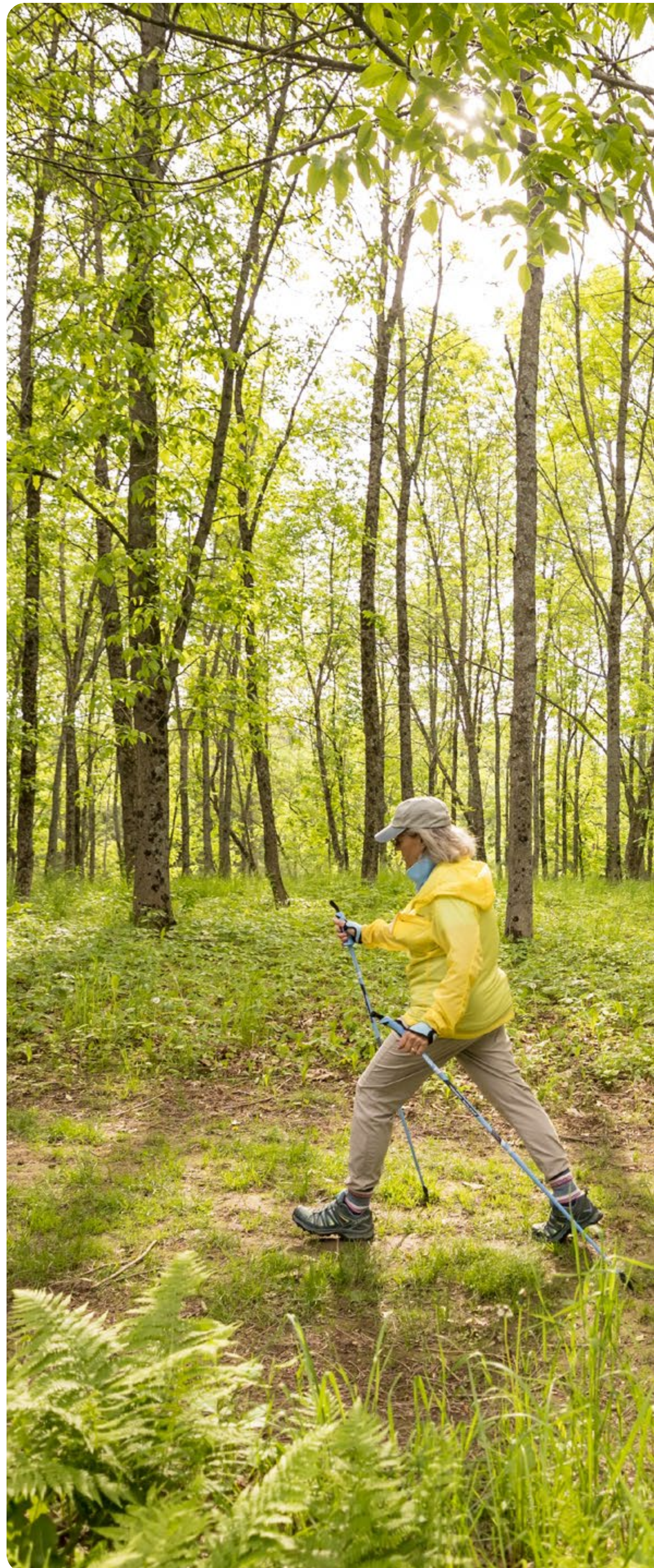
Thank you for taking the time to read this report. We are pleased to share the results of our FY22 Community Health Implementation Plan with you. While we are proud of the work that has been accomplished, we know that there is more to be done as our community faces many challenges around recovery from the pandemic, substance use and mental health, and the impact of chronic disease and social needs such as food and transportation.

Nonetheless, we know that our community members and staff are resilient and adaptive. People who never were on a video conference before are now participating in classes and programs via Zoom or telephonically.

Take Betty, a participant in a Living Well with Chronic Pain program, whose goal was to increases her fitness by walking. With several chronic health conditions, including a form of arthritis that causes constant pain, Betty has limited mobility and finds some basic functions of daily living, such as shopping and household chores, challenging. When she started the program, Betty was walking 6 minutes a day. Her goal was to increase to 7 minutes each day. During the first week, Betty exceeded her goal by walking 10 minutes a day. The following week she walked 12 minutes a day and added a routine of walking up and down stairs for 3 minutes, 3 times a day. When the stairs proved too challenging all at once, she took rest breaks and this strategy allowed her to meet her goal. By the fourth week of the program, Betty incorporated easy-movement exercises into her morning routine. She reported less pain and stiffness and more flexibility as a result.

Each of us is on a personal health journey. We are proud to support community members and patients in that journey with free and low cost resources. As Helen Keller said, “Alone we can do so little. Together we can do so much.” We look forward to continuing our health journeys with you and sharing our results, challenges and success stories.

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.



09-2023