



Progress report on
*Community Health
Needs Assessment
Implementation Strategy*

fiscal year

2019 2020 2021

(October 1, 2019 – September 30, 2020)

Maine Medical Center



Maine Medical Center
MaineHealth

CHNA Implementation Plan 2019-2021

Maine Medical Center

The following report outlines progress on the Maine Medical Center Implementation Strategy on key health priorities identified in the **2018 Maine Shared Community Health Needs Assessment**.

The vision of the Maine Shared Community Health Needs Assessment is to help to turn data into action so that Maine will become the healthiest state in the United States. Its mission is a dynamic public/private partnership that creates Shared Community Health Needs Assessment Reports, engages and activates communities and supports data-driven health improvements for Maine people. To access the MaineHealth 2019 Community Needs Assessment Reports, visit: <https://mainehealth.org/healthy-communities/community-health-needs-assessment>.

A member of the MaineHealth system, Maine Medical Center has a set of health priorities including:

- Adverse Childhood Experiences (ACEs) and Mental Health
- Substance Use
- Social Determinants of Health
- Physical activity, nutrition, weight
- Healthy Aging

About Maine Medical Center

Maine Medical Center is a complete health care resource for the people of greater Portland, the entire state of Maine, and northern New England. Incorporated in 1868, MMC is the state's largest medical center, licensed for 637 beds and employing more than 9,600 people. Maine Medical Center's unique role as both a community hospital and a referral center requires an unparalleled depth and breadth of services, including the state's only allopathic medical school program, through a partnership with Tufts University School of Medicine, and a world-class biomedical research center, the Maine Medical Center Research Institute.

Our care model includes the state's largest multispecialty medical group, Maine Medical Partners. Maine Medical Partners provides a wide range of primary, specialty, and subspecialty care delivered through a network of more than 40 locations throughout greater Portland.

Maine Medical Center is the flagship hospital of MaineHealth, which is an integrated health network comprising 12 local hospital and other health facilities that touch central, southern, and western Maine and eastern New Hampshire. The collaboration of MaineHealth's local organizations allows greater availability to community health improvement programs, access to clinical trials and research, and shared electronic medical records.

The strength of the health system, anchored by Maine Medical Center, enables each organization to invest in shared programs and services that improve the quality of care while reducing costs whenever possible. As a nonprofit institution, Maine Medical Center has provided more than \$200 million annually in community benefits, delivering care to those who need it, regardless of their ability to pay.

MaineHealth System Overview

MaineHealth is a not-for-profit integrated health system consisting of nine local hospital systems, a comprehensive behavioral healthcare network, diagnostic services, home health agencies, and more than 1,700 employed and independent physicians working together through an Accountable Care Organization. With more than 22,000 employees, MaineHealth is the largest health system in northern New England and provides preventive care, diagnosis and treatment to 1.1 million residents in Maine and New Hampshire.

In keeping with the health system's vision and mission, MaineHealth organizations work together to offer a wide range of community programs focused on disease management, prevention and population health, free of charge, and no one is ever denied care because of inability to pay. In 2019, the MaineHealth system provided over \$487.5 million in community health programs or services without reimbursement or other compensation.

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Please highlight progress made from **October 1, 2019 - September 30, 2020** for strategies and actions taken to address the priority areas your organization selected as part of the 2018 Community Health Needs Assessment (CHNA) process. The strategies that your organization recorded in the 3-year Implementation Strategy section of your CHNA report are listed below. In addition, you are encouraged to include progress made for any additional strategies you implemented.

MaineHealth Member Organization: Maine Medical Center

Date: October 1, 2019- September 30, 2020

2019 CHNA Priority Selected	2019 Implementation Strategy / Planned Actions to Address Priority of Focus	If Action Implemented - Describe actions taken, impact from those actions, and collaborating partners If NO - Provide a reason why no action was taken
ACEs/ Mental Health	<p>Actively participate in the Developmental Screening Community Initiative of Cumberland County (DSCI) to improve communications and referrals between community partners and the medical home.</p> <p>Action Implemented? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No Continuing in FY21? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No</p>	<ul style="list-style-type: none"> DSCI meets bi-monthly and includes numerous medical and community partners from Child Developmental Services, Maine Families, Portland Public Health Nursing, Hearing and Speech and others. MMC Physician Champion Dr. DiGiovanni regularly attends. MMP will be presenting in early FY21 about the opportunity of the Aunt Bertha platform and the MMP strategic goal around increasing utilization and community engagement.
	<p>Increase the percentage of patients aged 0- 18 years with a positive aPTSDRI screen who are referred to or are already being treated by a Behavioral Health clinician from 50% to 65%.</p> <p>Action Implemented? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Continuing in FY21? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p>	<ul style="list-style-type: none"> This strategy was completed in FY19 and is no longer being tackled beyond 9/30/2019 because the workflow has become part of routine process of care.
	<p>Maintain or increase screening rates for all 4 ACEs screening tools at defined MMP Primary Care well-child visits, measured by meeting targets:</p> <ul style="list-style-type: none"> Increase trauma screening rate target to > 80% for patients from birth to age 17. Increase Survey of Well- being of Young Children (SWYC) developmental screening rate target to > 75% for patients aged 12 months to 35 months. Increase ACEs number screening rate target to > 40% for patients age 3 to 17. Increase food insecurity screening rate target to > 60% for patients from birth to age 11. <p>Action Implemented? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No Continuing in FY21? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No</p>	<ul style="list-style-type: none"> Despite the impact of COVID, all screening rates remained above target in FY20 except for the developmental SWYC. <ul style="list-style-type: none"> Trauma screening rate for patients from birth to age 17 (Target = 80%): 93.7% Survey of Well-being of Young Children (SWYC) developmental screening rate for patients aged 12 months to 35 months (Target = 75%): 56% ACEs number screening rate for patients age 3 to 17 (Target 40%): 78.5% Food insecurity screening rate for patients from birth to age 11 (Target 60%): 93.2%

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Healthy Eating Active Living (HEAL)/ Obesity Prevention	<p>90% of MMP primary care practices that care for children will have fully implemented the Let's Go! Program.</p> <p>Action Implemented? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No Continuing in FY21? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p>	<ul style="list-style-type: none"> • This objective was met in FY20. 100% of MMP primary care practices that care for children will have fully implemented the Let's Go! Program.
	<p>Achieve MH ACO targets to decrease percentage of patients with HbA1c. > 9.0 in accordance with system targets.</p> <p>Action Implemented? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No Continuing in FY21? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No</p>	<ul style="list-style-type: none"> • This metric remains steady and without improvement. We continue with our standard outreach to contact patients who are overdue for A1c testing or with an elevated A1c, as well as encouraging use of the RN-led insulin titration protocol that was expanded last year. Due to the Covid-19 outbreak, patients were not able to be seen in the office, making it difficult to implement these improvements. Some sites implemented innovative solutions such as drive thru A1c testing options. As of October 2020, 19.5% of MMP patients had HbA1c > 9.0 (634 patients with HbA1c >9.0 and 205 patients with untested HbA1c, out of 4,297 total patients diagnosed with diabetes).
	<p>At least 50% of all school districts in Cumberland County will commit to partnering with Let's Go! Program to work to improve healthy eating and active living for all students in their district.</p> <p>Action Implemented? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No Continuing in FY21? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No</p>	<ul style="list-style-type: none"> • 50% (8 of 16 schools) of all school districts in Cumberland County signed the Let's Go! Partnership Form, committing to partnering to work to improve healthy eating and active living for all students in their districts. Reaching over 13,400 students and 1,800 staff! This work will continue in FY21 with increasing the number of schools partnering.
Social Determinants of Health (including access to care)	<p>Increase patients screened for food insecurity.</p> <p>Action Implemented? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No Continuing in FY21? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No</p>	<ul style="list-style-type: none"> • Epic added SDOH questions on MyChart to be pushed to patient to complete prior to a scheduled appointment. Overall MMP/MMC reported an increase with a total screening rate of 2.6% in October 2019 to 9.77% in September 2020. The pediatric team champions this work with a 93.2% food insecurity screening rate for pediatric patients. Providers at Westbrook Internal and Family Medicine were trained on food insecurity screening best practices.
	<p>Of those patients who screened positive for food insecurity, increase the number who are offered food access resources and/or provided an emergency bag of food.</p> <p>Action Implemented? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No Continuing in FY21? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No</p>	<ul style="list-style-type: none"> • MMP distributed 537 emergency food bags and provided food access resources to 88 people during FY20.

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Social Determinants of Health (including access to care)	<p>Address the unmet healthcare needs (access to primary care, behavioral health services and referral to specialists) of vulnerable homeless populations in Portland by participating in the MMC- Preble Street Learning Collaborative.</p> <p>Action Implemented? <input checked="" type="checkbox"/>Yes <input type="checkbox"/>No Continuing in FY21? <input checked="" type="checkbox"/>Yes <input type="checkbox"/>No</p>	<ul style="list-style-type: none"> • In FY20, at-risk clients received short-term targeted case management via the Learning Collaborative. Preble Street shelters responded to COVID by maintaining screening and isolation precautions at latest standards and to collect data to monitor trends, working closely with infectious disease and Preventive Medicine fellows.
	<p>Increase awareness and impact of SDOH on health outcomes among MMP Population Health Care Managers.</p> <p>Action Implemented? <input checked="" type="checkbox"/>Yes <input type="checkbox"/>No Continuing in FY21? <input type="checkbox"/>Yes <input type="checkbox"/>No</p>	<ul style="list-style-type: none"> • The MMP Population Health Department holds regular team meetings where SDOH topics are discussed and tracks SDOH documentation as a department KPI. A SDOH training curriculum (including utilization of the social services module Aunt Bertha) was developed and is delivered to all new care manager/coordinator staff during their orientation process. In FY20, all care managers completed SDOH training.
Substance Use Disorder	<p>Develop workflows and training for Screening, Brief Intervention and Referral to Treatment (SBIRT) and launch a pilot focused on adolescent preventive health visits at two outpatient primary care clinics with 100% of providers at pilot sites trained in the new workflows.</p> <p>Action Implemented? <input checked="" type="checkbox"/>Yes <input type="checkbox"/>No Continuing in FY21? <input checked="" type="checkbox"/>Yes <input type="checkbox"/>No</p>	<ul style="list-style-type: none"> • This objective was met in FY20. All providers at pilot sites completed the SBIRT training requirements. Two pilot sites: South Portland and Portland Peds. Workflow has been developed and put on hold due to shifting attention to COVID19 response efforts. This work will continue in FY21 expanding the goal across additional primary care and pediatric practices.
	<p>Increase access to treatment through Integrated Medical Assisted Therapy (IMAT) using hub/spoke model.</p> <p>Action Implemented? <input checked="" type="checkbox"/>Yes <input type="checkbox"/>No Continuing in FY21? <input checked="" type="checkbox"/>Yes <input type="checkbox"/>No</p>	<ul style="list-style-type: none"> • As of September 30, 2020 MMC had 38 waived and prescribing providers and 189 substance use disorder patients. MMC participates in ED referrals/intakes to MAT as well as the State of Maine's Opioid Health Home Program.
	<p>Provide affordable care for uninsured patients with Opioid Use Disorder by implementing the State of Maine's Opioid Health Home (OHH) program in identified MMP Primary Care practice sites, which includes offering peer recovery support to each OHH patient.</p> <p>Action Implemented? <input checked="" type="checkbox"/>Yes <input type="checkbox"/>No Continuing in FY21? <input checked="" type="checkbox"/>Yes <input type="checkbox"/>No</p>	<ul style="list-style-type: none"> • The OHH contract was resigned with the State of Maine in September 2020 to continue providing OHH services for uninsured patients, including peer recovery services via a partnership with Maine Behavioral Healthcare. Current sites are Scarborough, Westbrook, Portland and the Adult Clinic. In FY20 this program served an average of 7 patients each month in various stages of recovery (maintenance and stabilization).

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2019 CHNA Priority Selected	2019 Implementation Strategy / Planned Actions to Address Priority of Focus	If Action Implemented - Describe actions taken, impact from those actions, and collaborating partners If NO - Provide a reason why no action was taken
Substance Use Disorder	<p>Provide resource information to > 95% of OHH patients who indicate a need for housing, vocational or peer recovery support to social service and community-based programs to support recovery in designated MMP Primary Care practice sites.</p> <p>Action Implemented? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No Continuing in FY21? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No</p>	<ul style="list-style-type: none"> In FY20 all MMP OHH sites attained this goal reported quarterly to the State of Maine. Often patients received housing/vocational assistance via the MaineHealth Patient Assistance Line. 5 patients received housing support/resources, 1 patient received vocational support/resources, and 1 patient received peer recovery support services.
Older Adult Health/ Healthy Aging	<p>Document Advance Care Directives, POLST, or Serious Illness Conversations in Epic with at least 40% of MMP primary care patients age 65 or older.</p> <p>Action Implemented? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No Continuing in FY21? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No</p>	<ul style="list-style-type: none"> Successful completion of FY20 goal for Provider to have a Serious Illness conversation with 25% of high risk patients identified. Work continues around spread of these workflows, particularly around the Serious Illness Question which is important in the initiation of advance care planning.