Progress report on *Community Health Needs Assessment Implementation Strategy*

fiscal year

2019 2020 **2021**

(October 1, 2020 – September 30, 2021)

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://www.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 2020, the MaineHealth system provided over $662 million in community health programs or services without reimbursement or other compensation.

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Please highlight progress made from **October 1, 2020 - September 30, 2021** 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, 2020- September 30, 2021**

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	**Actively participate in the Developmental Screening Community Initiative of Cumberland County (DSCI) to improve communications and referrals between community partners and the medical home.** Action Implemented? ☒Yes ☐No Continuing in FY22? ☒Yes ☐No	• MMC Physician Champion Dr. DiGiovanni actively participates in bimonthly meetings with medical and community partners from Child Developmental Services, Maine Families, Portland Public Health Nursing, Hearing and Speech and others. MMP presented in early FY21 about the Aunt Bertha/Findhelp platform and MMP strategic goal to increase utilization and community engagement with the platform.
	Maintain or increase screening rates for all 4 ACEs screening tools at defined MMP Primary Care well-child visits, measured by meeting targets: • **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 ages 12 months to 35 months.** • **Increase ACEs number screening rate target to >40% for patients ages 3 to 17.** • **Increase food insecurity screening rate target to >60% for patients from birth to age 11.** Action Implemented? ☒Yes ☐No Continuing in FY22? ☒Yes ☐No	• Despite the impact of COVID, all screening rates remained above target except for the developmental Survey of Well-being of Young Children. ○ Trauma screening rate for patients from birth to age 17 (Target = 80%): 93.5% ○ Survey of Well-being of Young Children developmental screening rate for patients aged 12 months to 35 months (Target = 75%): 68.6% ○ ACEs number screening rate for patients age 3 to 17 (Target 40%): 78.9% ○ Food insecurity screening rate for patients from birth to age 11 (Target 60%): 93.5%
	Develop and implement a risk stratification model based on medical, behavioral and social determinants of health to identify children at risk for poor health outcomes at defined MMP Primary Care Pediatric Practices. Action Implemented? ☒Yes ☐No Continuing in FY22? ☐Yes ☒No	• This objective was met in FY20. MMP developed the risk stratification model, a report to identify children at highest risk for poor health outcomes, and began implementing the tool at defined MMP Primary Care practices that care for children in FY20.

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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
ACEs/ Mental Health	**At least 25% of pediatric patients, identified as being high risk, will be assigned an MMP care manager and have at least one outreach attempt within 30 days, at defined MMP Primary Care Pediatric Practices with an MMP employed care manager.** Action Implemented? ☒Yes ☐No Continuing in FY22? ☐Yes ☒No	• In FY20 MMP adjusted the original strategy in this CHNA priority due to COVID, and has not continued utilization of the survey report for this purpose in FY21.
	≥ 20% of primary care patients (> 18 years of age) who are referred to integrated behavioral health are screened with the ACEs tool. Action Implemented? ☒Yes ☐No Continuing in FY22? ☒Yes ☐No	• This objective was met with 31.3% of MMP primary care patients referred to integrated behavioral health being screened with the ACEs tool.
Healthy Eating Active Living (HEAL)/ Obesity Prevention	**Achieve MH ACO targets to decrease percentage of patients with HbA1c. > 9.0 in accordance with system targets.** Action Implemented? ☒Yes ☐No Continuing in FY22? ☒Yes ☐No	• MHACO updated the HbA1c annual target to 17%. • As of September 2021, 17.47% of MMP patients had HbA1c > 9.0 or no reading (866 of 4,691 patients diagnosed with diabetes). • Despite COVID, 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 and complex care management services to eligible patients who have diabetes.
	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. Action Implemented? ☒Yes ☐No Continuing in FY22? ☒Yes ☐No	• 9 out of 16 (56%) 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. This reached over 16,200 students and 2,000 staff.
	Increase # of referrals to NDDP, for patients with a diagnosis of pre-diabetes or who are at risk for pre-diabetes. Action Implemented? ☒Yes ☐No Continuing in FY22? ☒Yes ☐No	• Most MMP Primary Care practices are participating in referring patients to the National Diabetes Prevention Program (NDPP). • MMP referred 134 eligible patients to NDPP and of those, 57 (43%) enrolled in the program.

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Social Determinants of Health (including access to care)	**Implement a social services module in EPIC as a tool to address SDOH barriers identified by patients enrolled in the MMP Care Management program.** Action Implemented? ☒Yes ☐No Continuing in FY22? ☒Yes ☐No	• 100% of MMP Care Managers are actively using the Aunt Bertha/findhelp platform to make connections for patients with SDOH. • Community engagement activities resulted in new partnerships with community-based organizations and more programs being listed and receiving direct referrals through the platform, indicating the ability to better serve patients with a variety of social needs.
	Increase patients screened for food insecurity. Action Implemented? ☒Yes ☐No Continuing in FY22? ☒Yes ☐No	• Overall MMP/MMC reported an increase in SDOH screening, with a total screening rate of 12.5% in September 2021 (patients with one or more SDOH questions answered). • EPIC added SDOH questions on MyChart for patient to complete prior to scheduled appointments, which contributes to these rates. • Food insecurity screening trends, with overall SDOH screening, with 2.33%positive in September 2021. • Food insecurity screening was at its highest point in July 2021, at 4.39% of patients screened positive
	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. Action Implemented? ☒Yes ☐No Continuing in FY22? ☒Yes ☐No	• The MaineHealth Patient Assistance Line routinely screens callers for food insecurity and provides local resources and information regarding applying for SNAP (food stamps) by delivering education and sending applications. ○ Out of all of the MaineHealth patients who contacted the Patient Assistant Line looking for food sources, 327 were helped. • MMP/MMC ordered 720 emergency food bags, each containing 10lbs of food, which equates to about 8 meals per bag.
	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. Action Implemented? ☒Yes ☐No Continuing in FY22? ☒Yes ☐No	• 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 collected data to monitor trends, working closely with infectious disease and Preventive Medicine fellows.
	MMP and ACO employed care managers will document a Social Determinants of Health (SDOH) assessment in Epic for ≥ 85% of newly enrolled patients in MMP care management services. Action Implemented? ☒Yes ☐No Continuing in FY22? ☐Yes ☒No	• Both MMP and MHACO employed Care Managers follow the best practice EPIC SDOH documentation workflow. • The MMP Population Health Department actively monitored this performance via a monthly KPI in FY21, however discontinued this at the end of 2020 after continuous success.

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Substance Use Disorder	**Increase access to treatment through Integrated Medical Assisted Therapy (IMAT) using hub/spoke model.** Action Implemented? ☒Yes ☐No Continuing in FY22? ☒Yes ☐No	• MMC increased the number of patients in MAT treatment from 228 to 313 as of September 30, 2021. • MMC participates in ED referrals/intakes to the MAT program as well as the Opioid Health Home program.
	Increase access to naloxone by implementing MaineHealth guidelines for providers on prescribing naloxone to patients and family members at risk of overdose. Action Implemented? ☒Yes ☐No Continuing in FY22? ☒Yes ☐No	• Naloxone is regularly prescribed for many MMP/MMC patients. • As of September 30, 2021, 63% (196 of 313) IMAT patients in treatment and 37% (598 of 1,624) of all at-risk patients had a naloxone prescription. ○ This work is driven by our physician champion Dr. Silvia who created a naloxone toolkit and provider education series.
	Provide resource information to >95% of Opioid Health Home 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. Action Implemented? ☒Yes ☐No Continuing in FY22? ☒Yes ☐No	• All MMP OHH sites attained this goal, reported quarterly to the State of Maine. • Often MMP's OHH patients received housing/vocational assistance via the MaineHealth Patient Assistance Line. Three patients received housing resources, one patient received vocational resources, and one patient received peer recovery services when requested.
Older Adult Health/ Healthy Aging	**Develop and pilot the Age Friendly Health Systems 4 M's Model as a framework to identify gaps and strengths for targeted interventions to improve health outcomes for older adults in the inpatient setting.** Action Implemented? ☒Yes ☐No Continuing in FY22? ☒Yes ☐No	• MMC's Age Friendly Health System metric was reviewed in the context of related initiatives like increasing the proportion of primary care patients who complete an annual wellness visit and other quality initiatives. • The updated Annual Wellness Visit template incorporates prompts to assess the 4 M's integrated into the workflow. ○ The report request is in process, submitted on 5/28/21, to track the 4 M's with breakdown by practice and physician. • MMC submitted the application for Age Friendly Health System participant recognition on 9/10/21 to complete this metric for FY21 and will continue this work as a strategic goal for FY22 in partnership with our Primary Care sites.
	With a goal of supporting goal concordant care & improving the quality of end of life experience, providers strive to engage patients with advanced chronic disease in serious illness conversations. We will focus on increasing the frequency of these conversations at defined MMP PCP Action Implemented? ☒Yes ☐No Continuing in FY22? ☐Yes ☒No	• The surprise question reached goal for documentation in Epic for >50% of the patients identified as high risk by Care Management. • Serious Illness Conversation reached goal for documentation in Epic for >25% of the patients for whom the answer to the surprise question was 'no'.