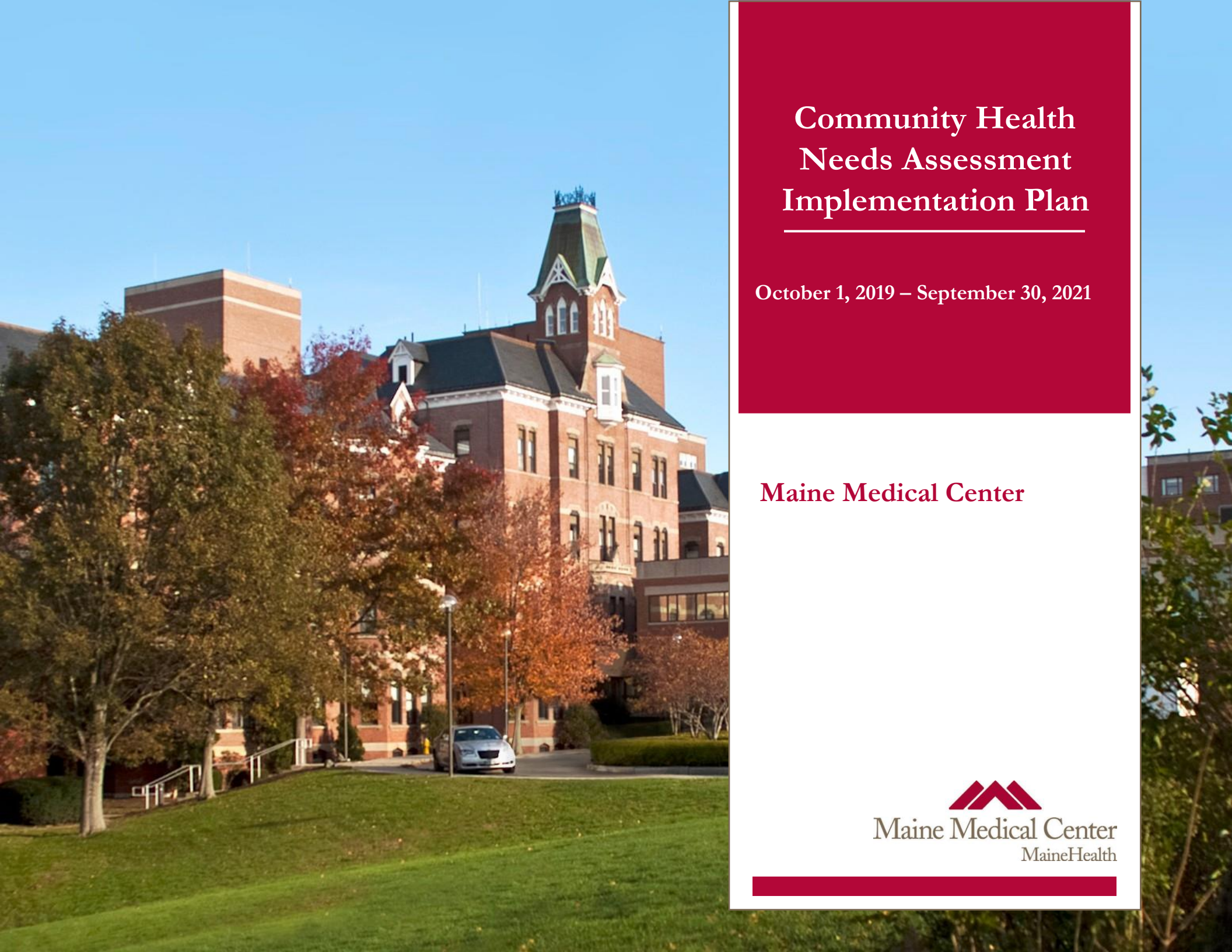

Community Health Needs Assessment Implementation Plan

October 1, 2019 – 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 2018 Community Needs Assessment reports, visit: http://www.mainehealth.org/chna

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, Maine Medical Center is the state's largest medical center, licensed for 637 beds and employing nearly 8,700 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 eight local hospital systems, a comprehensive behavioral healthcare network, diagnostic services, home health agencies, and more than 1,600 employed and independent physicians working together through an Accountable Care Organization. With more than 19,000 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 2018, the MaineHealth system provided $477 million in community health programs or services without reimbursement or other compensation.

Implementation Plan for Community Health Needs Assessment 2019-2021

MaineHealth/Affiliate Hospital: Maine Medical Center

County: Cumberland

Health Priority: ***Substance Use***

Goal of Health Priority: To prevent and improve health outcomes for patients with substance use disorders.

Strategies for: Substance Use	Dedicated Resources	Metrics/What are we measuring?	Partners/External Organizations	Accountable	Year of Work (1-3)
Strategy 1: 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.	• MMC Primary Care & Community Service Line • MMP IMAT program • MMP Population Health	• Number of practices implementing OHH program. • Number of uninsured patients served by OHH program.	• Maine Behavioral Healthcare • State of Maine Value-Based Purchasing	• Debra McGill, Director MMP Population Health	Year 1
Strategy 2: 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.	• MMC Primary Care & Community Service Line • MMP Quality Analytics • MMP App Support	• Screening workflows developed, training complete and pilots launched at defined MMP Primary Care practice sites. • Percent of providers at pilot sites trained in the new workflows.	• Maine Behavioral Healthcare	• Dr. Beth Wilson, Physician Champion • Dr. Rob Chamberlin, Physician Champion	Year 1

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Strategies for: Substance Use	Dedicated Resources	Metrics/What are we measuring?	Partners/External Organizations	Accountable	Year of Work (1-3)
Strategy 3: 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.	• MMC Primary Care & Community Service Line • MMP IMAT program • MMP Population Health	• Number and percentage of OHH patients referred to housing, vocational and/or peer recovery support services.	• Maine Behavioral Healthcare	• Debra McGill, Director MMP Population Health	Years 1-3
Strategy 4: Increase access to naloxone by implementing MaineHealth guidelines for providers on prescribing naloxone to patients and family members at risk of overdose.	• MMC Primary Care & Community Service Line • MMP IMAT program	• Naloxone Toolkit developed. • Provider education module with CME developed. • Number and percentage of providers who complete provider education module. • Patient education resources developed. • EPIC prompts in place. • Naloxone prescribing rate.	• MaineHealth Center for Health Improvement • MaineHealth - EPIC	• Dr. Kristen Silvia, MMC Physician Champion	Years 2-3
Strategy 5: Increase access to treatment through Integrated Medical Assisted Therapy (IMAT) using hub/spoke model.	• MMC Primary Care & Community Service Line • MMP IMAT program	• Number of patients receiving MAT for opioid addiction. • Number of x-waivered providers able to prescribe MAT.	• MaineHealth Center for Health Improvement • Maine Behavioral Healthcare	• MaineHealth Center for Health Improvement	Years 1-3

Implementation Plan for Community Health Needs Assessment 2019-2021

MaineHealth/Affiliate Hospital: Maine Medical Center

County: Cumberland

Health Priority: ***Mental Health (ACEs)***

Goal of Health Priority: To improve integration of mental and physical health to improve overall health.

Strategies for: Mental Health (ACEs)	Dedicated Resources	Metrics/What are we measuring?	Partners/External Organizations	Accountable	Year of Work (1-3)
Strategy 1: 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 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.	• MMC Primary Care & Community Service Line • MMP/MMC Quality Improvement • MMP Quality Analytics	• Trauma screening rate for patients from birth to age 17. • Survey of Well-being of Young Children (SWYC) developmental screening rate for patients aged 12 months to 35 months. • ACEs number screening rate for patients age 3 to 17. • Food insecurity screening rate for patients from birth to age 11.	• MaineHealth - EPIC • MaineHealth Center for Health Improvement	• Dr. Steve DiGiovanni, MMC Physician Champion	Years 1-3

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Strategies for: Mental Health (ACEs)	Dedicated Resources	Metrics/What are we measuring?	Partners/External Organizations	Accountable	Year of Work (1-3)
Strategy 2: 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.	• MMC Primary Care & Community Service Line • MMP/MMC Quality Improvement • MMP Quality Analytics	• Risk stratification tool developed. • Risk stratification tool implemented at defined MMP Primary Care practices that care for children.	• MaineHealth - EPIC	• Dr. Steve DiGiovanni, MMC Physician Champion	Years 2-3
Strategy 3: 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.	• MMC Primary Care & Community Service Line • MMP/MMC Quality Improvement • MMP Quality Analytics • MMP Population Health	• Number of patients who are identified as high risk who are assigned an MMP Care Manager and who have at least one outreach attempt within 30 days at MMP Primary Care pediatric practices with an MMP employed care manager.	• MaineHealth - EPIC	• Dr. Steve DiGiovanni, MMC Physician Champion • Debra McGill, Director MMP Population Health	Years 2-3
Strategy 4: 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%.	• MMC Primary Care & Community Service Line • MMP/MMC Quality Improvement • MMP Quality Analytics	• Number 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.	• MaineHealth - EPIC	• Dr. Steve DiGiovanni, MMC Physician Champion	Year 1

Implementation Plan for Community Health Needs Assessment 2019-2021

Strategies for: Mental Health (ACEs)	Dedicated Resources	Metrics/What are we measuring?	Partners/External Organizations	Accountable	Year of Work (1-3)
Strategy 5: ≥ 20% of primary care patients (> 18 years of age) who are referred to integrated behavioral health are screened with the ACEs tool.	• MMC Primary Care & Community Service Line • MMP/MMC Quality Improvement	• Number and percentage of adult patients (> 18 years of age) referred to and seen by the integrated behavioral health clinician (BHC) who are screened with the ACEs tool by the BHC.	• MaineHealth - EPIC • MaineHealth Center for Health Improvement • Maine Behavioral Healthcare	• MMP Clinical Transformation Project Team	Years 2-3
Strategy 6: Actively participate in the Developmental Screening Community Initiative of Cumberland County (DSCI) to improve communications and referrals between community partners and the medical home.	• MMC PCCSL Clinical Transformation project work	• Number of providers/staff attending DSCI meetings. • Number of DSCI meetings attended. • Engage in one quality improvement initiative with at least one community partner	• MaineHealth • DSCI • Portland Public Health Nursing	• MaineHealth Center for Health Improvement	Year 1

Implementation Plan for Community Health Needs Assessment 2019-2021

MaineHealth/Affiliate Hospital: Maine Medical Center

County: Cumberland

Health Priority: ***Physical Activity, Nutrition, Weight (obesity)***

Goal of Health Priority: To reduce the prevalence of obesity and burden of related chronic conditions.

Strategies for: Physical Activity, Nutrition, Weight (obesity)	**Dedicated Resources**	**Metrics/What are we measuring?**	**Partners/External Organizations**	**Accountable**	**Year of Work (1-3)**
Strategy 1: Achieve MH ACO targets to decrease percentage of patients with HbA1c. > 9.0 in accordance with system targets.	• MMC Primary Care & Community Service Line • MMP Population Health • MMP Specialty Care practice teams	• Number and percentage of MMP patients with HbA1c > 9.0.	• MH ACO	• Dr. Rob Chamberlin, Physician Champion	Years 1-3
Strategy 2: 90% of MMP primary care practices that care for children will have fully implemented the Let's Go! Program.	• MMC Primary Care & Community Service Line • MMP/MMC Quality Improvement	• Percent of MMP primary care practices that care for children will have fully implemented the Let's Go! Program.	• Let's Go! Program	• Dr. Tory Rogers, MMC Physician Champion	Year 1

Implementation Plan for Community Health Needs Assessment 2019-2021

Strategies for: Physical Activity, Nutrition, Weight (obesity)	Dedicated Resources	Metrics/What are we measuring?	Partners/External Organizations	Accountable	Year of Work (1-3)
Strategy 3: 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.	• Let's Go program	• Number of school districts committed to partnering with Let's Go! Program. • Number of schools, out of school and childcare programs and healthcare practices that fully implement the Let's Go! Program.	• Let's Go! Program • Cumberland County school districts	• Dr. Tory Rogers, MMC Physician Champion	Years 1-3
Strategy 4: Increase # of referrals to NDDP for patients with a diagnosis of pre-diabetes or who are at risk for pre-diabetes.	• MaineHealth Center for Health Improvement	• Number of referrals to NDPP for patients with a diagnosis of pre-diabetes or who are at risk for pre-diabetes.	• MaineHealth Center for Health Improvement	• MaineHealth Center for Health Improvement	Years 2-3

Implementation Plan for Community Health Needs Assessment 2019-2021

MaineHealth/Affiliate Hospital: Maine Medical Center

County: Cumberland

Health Priority: ***Older Adult Health/Healthy Aging***

Goal of Health Priority: To improve health outcomes and health-related quality of life for patients age 65 or older.

Strategies for: Older Adult Health/Healthy Aging	Dedicated Resources	Metrics/What are we measuring?	Partners/External Organizations	Accountable	Year of Work (1-3)
Strategy 1: Document Advance Care Directives, POLST, or Serious Illness Conversations in Epic with at least 40% of MMP primary care patients age 65 or older.	• MMC Primary & Community Care Service Line • MMP/MMC Geriatrics • MMP/MMC Palliative Medicine • MMP Population Health	• Number of patients with documented Serious Illness Conversations in EPIC.	•	• Dr. Rob Chamberlin, Physician Champion	Year 1
Strategy 2: 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.	• MMC Primary & Community Care Service Line • MMP/MMC Geriatrics	• Age Friendly Health System implementation plan developed. • Number of departments with established Age Friendly Health System in place.	• MaineHealth Center for Health Improvement	• Dr. Heidi Weirman, Physician Champion	Years 2-3

Implementation Plan for Community Health Needs Assessment 2019-2021

Strategies for: Older Adult Health/Healthy Aging	Dedicated Resources	Metrics/What are we measuring?	Partners/External Organizations	Accountable	Year of Work (1-3)
Strategy 3: With a goal of supporting goal concordant care and 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 Primary Care practices, with the goals of ensuring that: o The *surprise question* will be documented in Epic for ≥ 50% of the patients identified as *high risk* by Care Management. o There will be documentation in Epic of a *serious illness conversation* for ≥ 25% of the patients for whom the answer to the *surprise question* was 'no'.	• MMC Primary & Community Care Service Line • MMP/MMC Geriatrics • MMP/MMC Palliative Medicine • MMP Population Health	• Number of patients with documented Serious Illness Conversations in EPIC.	•	• MMC Primary & Community Care Service Line • Dr. Isabella Stumpf, Physician Champion	Years 2-3

Implementation Plan for Community Health Needs Assessment 2019-2021

MaineHealth/Affiliate Hospital: Maine Medical Center

County: Cumberland

Health Priority: ***Social Determinants of Health (including access to care)***

Goal of Health Priority: To identify and address social determinants of health (SDOH).

Strategies for: Social Determinants of Health (SDOH) ***Including access to care***	**Dedicated Resources**	**Metrics/What are we measuring?**	**Partners/External Organizations**	**Accountable**	**Year of Work (1-3)**
Strategy 1: Increase awareness and impact of SDOH on health outcomes among MMP Population Health Care Managers.	• MMP Population Health	• SDOH training developed. • Number of care managers who complete SDOH training.	•	• Debra McGill, Director MMP Population Health	Year 1
Strategy 2: 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.	• MMP Population Health	• Number of patients in the care management program who have an SDOH assessment by an MMP/MHACO care manager.	• MaineHealth - EPIC • MHACO employed Care Managers	• Debra McGill, Director MMP Population Health	Years 2-3
Strategy 3: Implement a social services module in EPIC as a tool to address SDOH barriers identified by patients enrolled in the MMP Care Management program.	• MMP Population Health	• Social service resource module built in EPIC. • Number of MMP care management staff actively using/accessing EPIC module.	• MaineHealth - EPIC • MaineHealth Center for Health Improvement • Aunt Bertha customer support team	• Debra McGill, Director MMP Population Health	Years 2-3

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Strategies for: Social Determinants of Health (SDOH) ***Including access to care***	**Dedicated Resources**	**Metrics/What are we measuring?**	**Partners/External Organizations**	**Accountable**	**Year of Work (1-3)**
Strategy 4: 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.	• MMC Department of Family Medicine and Adult Medicine Service Line	• Number of Learning Collaborative clients receiving short-term targeted case management.	• Preble Street	• Dr. Beth Wilson, MMC Physician Champion	Years 1-3
Strategy 5: Increase patients screened for food insecurity.	• MMP/MMC Quality Improvement	• Number of providers trained on food insecurity screening best practices. • Number and percentage of patients screened at Well Child Visits.	• MaineHealth Center for Health Improvement • Good Shepherd Food Bank • Local food pantries • Maine Hunger Initiative • Local food councils • SNAP-Ed	• MaineHealth Center for Health Improvement	Years 1-3

Implementation Plan for Community Health Needs Assessment 2019-2021

Strategies for: Social Determinants of Health (SDOH) *Including access to care*	Dedicated Resources	Metrics/What are we measuring?	Partners/External Organizations	Accountable	Year of Work (1-3)
Strategy 6: 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.	• MMP/MMC Quality Improvement	• Number of patients screened positive for food insecurity. • Number of emergency food bags distributed. • Number of patients offered food access resources.	• MaineHealth Center for Health Improvement • Good Shepherd Food Bank • Maine Hunger Initiative • Local food councils • SNAP-Ed	• MaineHealth Center for Health Improvement	Year 1-3

Implementation Plan for Community Health Needs Assessment 2019-2021

MaineHealth/Affiliate Hospital: Maine Medical Center

County: Cumberland

Health Priority: ***Priorities Not Selected***

Goal of Health Priority: N/A

Health Priority:	Reason Not Chosen:
Tobacco Use	• Tobacco screening is built into standard workflows in ambulatory and inpatient settings, and tobacco cessation referrals are measured in the MaineHealth System Quality Dashboard. • The ongoing needs around tobacco use is also being addressed by the MaineHealth Center for Tobacco Independence, a formal partnership with MMC. • Tobacco cessation for COPD patients is included in the system improvement work at the ACO. • MMC continues annual work to achieve Maine Hospital Association's Tobacco Free Hospital Network's Gold Star recognition program.
Cardiovascular Disease	• Cardiovascular disease is an area of concern and MMC has workgroups tasked to improving quality and patient outcomes related to cardiovascular disease prevention and management. • Blood pressure and hypertension screenings are built into standard workflows in ambulatory and inpatient settings. • Avoidable admissions for congestive heart failure patients is a part of system improvement work at the ACO which MMC is directly involved with.
Chronic Disease	• Chronic disease, including cancer, is a complex priority area and fully aligned with the overall strategic priorities of the entire organization and measured in the MaineHealth System Quality Dashboard. • MMC is addressing chronic disease in other selected CHNA priorities (colorectal cancer and mammogram screenings in Health Aging priority; HbA1c control in Obesity priority) • MMC has incorporated disease-specific standard workflows in ambulatory and inpatient settings. • Examples of other disease-specific activities include: targeted outreach for colon cancer screenings, HbA1c control, referral to care management for diabetes management and COPD action plans.