Acknowledgement

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

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Purpose

The purpose of this report is to describe MaineGeneral Health’s (MGH) progress in addressing its annual Community Health Implementation Plan (CHIP) for Fiscal Year 2018. These priorities were developed in collaboration with the other major health care systems in the state, the Maine Center for Disease Control and Prevention (Maine CDC), and through a series of community forums designed to reach the public, including the underserved and vulnerable populations. MGH’s FY17-FY19 Community Health Needs Assessment (CHNA) priorities are:

- Chronic Disease Prevention and Management
- Obesity Prevention
- Tobacco Use and Exposure
- Substance Use Disorder
- Access to Care

The Executive Summary provides an overview of Maine’s key health indicators and MGH’s accomplishments and progress in each of these areas. The second section of this report details each strategy in MGH’s FY2018 CHIP. While the MGH overall CHIP covers three years, this report focuses on one year: FY2018, July 1, 2017 through June 30, 2018. The County Health Profile Data shared in the Executive Summary is overall Maine data. County-specific data on these health indicators is addressed in the text.
Executive Summary

Chronic Disease Prevention & Management

Chronic diseases continue to plague our communities with high rates of cancer, diabetes and heart disease, most of which are preventable. This leads to poor quality of life, increased health care costs, and premature death. Over the past five years, cancer incidence and mortality have been relatively consistent in Maine. Kennebec County has seen a decrease in adults with high cholesterol; however, a significant increase in adults with high blood pressure has occurred in the same period. Deaths due to cardiovascular disease, coronary heart disease and heart attacks are significantly higher than the state average. To address this, MGH:

- Expanded centralized Hub staff to increase access to essential services.
- Improved capacity for clinical staff outpatient education, offering an additional 146 multi-disciplinary trainings to nearly 2,000 staff.
- Provided evidence-based education programs such as diabetes prevention, tobacco cessation, and chronic disease self-management to community members.
- Increased lung cancer screenings for the at-risk population. MGH leads the state in low-dose computed tomography (LDCT) screening.

Source: Maine Shared CHNA 2018, Kennebec County Health Profile.
Obesity Prevention

In Maine, obesity among adults and youth continues to increase. In Kennebec County, the percentage of obese adults decreased slightly over time, while the percentage of obese high school students increased slightly. To address this, MGH:

- Designed and implemented a food insecurity screening project at two primary care practices.
- Piloted an enhanced Diabetes Prevention Program to include skills-based culinary cooking.
- Implemented a Cooking Matters program for families who may be food insecure.
- Increased physical movement class participation by 26%.
- Launched quarterly Kennebec Explorer health education messaging boards.
- Provided 15 free Diabetes Prevention Programs to 171 patients at risk for diabetes.
  - Program participants lost an average of 6.9% of their body weight and decreased their risk of developing type II diabetes by 58%.

Source: Maine Shared CHNA 2018, Kennebec County Health Profile.
Tobacco Use & Exposure

While adult tobacco use declined from 2011-2016, it increased slightly within the last two years. Tobacco use continues to be the leading cause of preventable death nationwide and in our communities. Lung cancer is the leading cause of cancer death in the country, in the state of Maine, and in Kennebec and Somerset Counties. To address this, MGH:

- Screened about 800 individuals for lung cancer via LDCT. (MGH leads the state in LDCT scans in the at-risk population).
- Deployed Community Health Workers (CHWs), who reached out to more than 1,000 patients and helped 125 individuals take a lung cancer risk reduction action such as lung cancer screening (LDCT), tobacco cessation, or radon or arsenic testing and mitigation.
- Referred 159 patients to tobacco cessation services through primary care.
- Supported five Prevention and Healthy Living (PHL) staff in completing the Center for Tobacco Independence training to provide cessation services.

Source: Maine Shared CHNA 2018, Kennebec County Health Profile.
Substance Use Disorder

Substance Use Disorder (SUD) is defined as the recurrent use of alcohol and/or drugs, which causes clinically and functionally significant impairment, such as health problems, disability, and failure to meet major responsibilities at work, school, or home. This includes illicit drugs, alcohol, tobacco, and opioids. With the increase of Opioid Use Disorder (OUD) and deaths related to drug overdoses, MGH has focused much of its efforts on harm reduction and increasing access to treatment for OUD. In Kennebec County, drug-induced deaths nearly doubled between 2007 and 2011 and between 2012 and 2016, a significant increase, from 12.1 to 21.7. This is slightly higher than the state overall. To address this, MGH:

- Developed and offered quarterly chronic pain programs to 40 patients.
- Expanded the needle exchange program to the Thayer Center for Health (TCH) in Waterville.
- Expanded HIV and Hepatitis C testing availability.
- Distributed 75 naloxone (a life-saving opioid overdose reversal medication) kits in primary, intensive outpatient, outpatient plus and the emergency department.
- Trained nearly 200 MGH staff on drug overdose prevention.
- Increased the number of primary care providers trained to treat patients OUD from about 150 to 230.

Source: Maine Shared CHNA 2018, Kennebec County Health Profile.
Access to Care

Living in rural Maine creates many challenges and barriers to access the care individuals need to live a healthy life. Some of the major access to care issues in Kennebec County involve primary care, dental services, behavioral and mental health services and treatment for OUD. Major contributing factors include lack of transportation, financial barriers, and insurance status.

In Kennebec County, the percentage of residents who are unable to obtain care due to cost remained steady from 2014 to 2018 at 10%, which is on par with the state percentage. The percentage of patients who have seen a Primary Care Provider (PCP) in the past year increased from 71.1% to 73.6%, now higher than the state overall. Additionally, Kennebec County has seen a slight decrease in MaineCare enrollment. In FY18, MGH:

- Enhanced the multi-faceted approach to improve access to care, which includes lung cancer navigators at the Harold Alfond Center for Cancer Care; financial counselors who serve all of MaineGeneral; PHL’s deployment of CHWs to reach at-risk, vulnerable populations and the centralized Hub linking patients to primary care (referrals to the Hub doubled this year).
- Expanded reach of CHWs, providing education to more than 2,000 individuals, and helping 584 people take an action to improve their health and quality of life.
- Linked 1,433 patients without a medical home to a primary care practice.

Source: Maine Shared CHNA 2018, Kennebec County Health Profile.
Priority: Chronic Disease Prevention & Management

Strategy: Expand clinical community linkages to include screening for social determinants of health

PHL and primary care leadership discussed opportunities to expand screening for food insecurity. Together, PHL and primary care leaders developed a pilot program to screen and refer for food insecurity. Elmwood Primary Care and Winthrop Pediatrics launched this six-month pilot project in June in partnership with the Good Shepard Food Bank.

MGH’s primary care leadership supports expanding the screening program system-wide in FY19, and has budgeted for emergency packs for all MGH primary care practices.

Because clinical/community linkages are an overarching strategy, more details on the centralized Hub and CHW linkages can be found throughout this document.

Strategy: Extend centralized Hub reach within the Central Public Health District

The centralized Hub model serves patients and community members by connecting people to services that meet their needs – whether it’s finding a primary care provider, reducing the risk of developing Type II diabetes, learning how to cook healthy food, reducing the risk of overdose or connecting to a local community resource such as a walking program.

PHL partnered with community organizations and developed a process to link people to community-based services and programs offered by Spectrum Generations, Kennebec Valley YMCA, HealthReach Community Health Centers and MGH Employee Health Promotion.

With the expansion of Hub services, a call management database was developed to accurately and efficiently track and follow up on Hub services and support. This database, Call Resource Management (CRM), allows for future growth and also supports a comprehensive reporting system. By implementing CRM, the team was able to expand clinical/community linkage to outside partners. Additionally, the Hub has expanded to link patients with substance use disorder to harm reduction services.

Strategy: Partner with community-based organizations to expand health education delivery sites throughout the Central Public Health District

PHL continues to work collaboratively to expand health education sites in Kennebec and Somerset Counties. Through partnerships with diverse stakeholders including Healthcentric Advisors, HealthReach, Kennebec Valley YMCA, the Maine CDC, Somerset Public Health, and Spectrum Generations, PHL and its partners deliver health education at 70 locations in the Central Public Health District.

Strategy: Develop an outpatient clinical staff education plan addressing the skills needed to implement population health strategies

MGH’s Outpatient Education team educated 1,988 staff through 146 trainings, ranging from population health to professionalism to pharmacology.
Priority: Obesity Prevention

Strategy: Expand and sustain evidence-based health cooking and physical movement programs

PHL conducted outreach to at-risk populations to increase their enrollment in healthy cooking and physical activity classes. In efforts to increase capacity in healthy cooking classes, PHL piloted a demonstration class that allowed for 25 participants to receive nutrition education, learn healthy cooking techniques, and have access to new recipes. This format maximizes class capacity from the traditional limit of 12 for the hands-on cooking classes.

PHL offered Cooking Matters for families who receive food and income assistance. PHL hosted three classes with a total of 31 participants.

The number of people who registered for physical movement classes increased by 26%. PHL continues to introduce new types of physical movement classes to reach new participants and to diversify classes by age and background. New classes included: Introduction to Karate, Group Personal Training, Nordic Walking, and Hula Hooping.

Strategy: Develop and implement a three-year communication plan targeting medical staff, business, insurers, governmental leadership, social service agencies and the public regarding the benefits of local physical movement and healthy eating policies programs and services

PHL developed a communication workgroup to align with the health priority areas of MGH’s CHIP including 1.) chronic disease and obesity; 2.) tobacco use and exposure; 3.) access to care; and 4.) substance use disorders. The purpose of the communication workgroup is to identify audiences who could benefit
from PHL programs, develop effective social marketing strategies and collaborate internally to align with MGH’s broader communications and marketing strategy. The communications workgroup created health messages to be displayed on the Kennebec Explorer transit system, which serves low-income residents of Kennebec and Somerset Counties and expanded the reach of these messages by partnering with the Central Public Health District Coordinating Council and its partner organizations.

**Strategy: Expand and sustain efforts to increase enrollment of at-risk children in WIC programming**

Each month, the MaineGeneral WIC Nutrition program serves 2,817 clients. Of that number, more than 2,000 are infants and children. WIC provides supplemental nutrition benefits, education, and breastfeeding support. In addition, MaineGeneral WIC partners with community organizations including Maine Families and Maine CradleME Program to offer education, child development, and community support to expecting and new mothers. WIC also shares resources and promotes programming to local community coalitions.

Thirty percent of all infants enrolled in MaineGeneral WIC are breastfeeding and 71% of all breastfeeding babies are exclusively breastfeeding. Additionally, the MaineGeneral WIC program engaged clients in the local farmers’ markets through clinic education and outreach reminders, and achieved a 79.7% rate of fruits and veggie voucher redemption this fiscal year, higher than the overall state average of 79%. MaineGeneral WIC partnered with Healthy Northern Kennebec’s SNAP-ED and connected with the PHL oral health CHW to provide additional services and education.

**Strategy: Increase collaboration with community agencies such as The Alfond Youth Center (AYC), YMCA and Spectrum Generations to assure obesity prevention programs are sustained in the community**

In partnership with the AYC, PHL received funding from three private foundations, totaling $45,000, to expand healthy food access to children and families who are experiencing food insecurity. The AYC’s Backpack Program offered supplemental food for children and families who may not have enough to eat over the weekends or during school vacations, distributing 3,978 backpacks filled with healthy supplemental snacks and meal items each weekend to 147 families. PHL and the AYC increased funding for the Backpack Program to include healthier food options, recipe cards, and taste testing.

PHL partnered with the Kennebec Valley YMCA and Somerset Public Health to achieve National Diabetes Prevention Program recognition. All three locations are recognized for delivering this evidence-based and life-saving program, thereby building community capacity around obesity and diabetes prevention.
**Priority: Tobacco Use and Exposure**  
*Strategy: Expand tobacco exposure screening and referrals to increase lung disease risk reduction and screening services via primary care and community outreach*

MGH performed 798 LDCT scans for patients at risk for lung cancer. Screening detects cancers earlier when treatment is more beneficial for patients. MGH is detecting more lung cancers earlier with this new, more accurate technology.

Staff participate in the Maine Lung Cancer Coalition (MLCC), a statewide multi-stakeholder group established to decrease the burden of lung cancer in Maine through prevention, early detection and treatment. This CHW program, along with the MLCC, is supported with funding from the Bristol-Myers Squibb Foundation, the Maine Cancer Foundation, and the Maine Economic Improvement Fund.

*Strategy: Implement use of CHWs in pilot primary care practices to reach at-risk patients identified by practices. Also mobilize CHWs to educate low-income communities about lung cancer risk and link people at risk to cessation, primary care, prevention services, and lung cancer screening*

Four MGH primary care practices are participating in a lung cancer risk-reduction pilot involving the testing of various workflows to see which works best at encouraging the at-risk population (55-80, current or former smokers) to take a lung cancer risk-reduction action. Risk reductions include: lung cancer screening (LDCT), tobacco cessation, and radon/arsenic testing and mitigation.

The participating practices are: Gardiner Family Medicine, Oakland Family Medicine, Winthrop Family Medicine and Four Seasons Family Practice. In FY 2018, 125 patients took 232 lung cancer risk-reduction actions, an average of 1.8 actions per patient. Examples of individual actions include shared decision making conversation, LDCT screening, radon or arsenic testing, tobacco cessation discussion or quit attempt.

CHWs conducted community-based outreach to rural, low-income Central Maine residents and tracked lung cancer risk-reduction actions taken. Ten community events were held and attended by 113 people. Of the 113 who attended, 19 took a lung cancer risk-reduction action.
Strategy: Outreach to primary care practices by a team including thoracic surgery, pulmonology, and cancer navigators to educate and improve awareness of our lung cancer screening program and the resources and follow up/support provided, including smoking cessation

An interdisciplinary team of the medical staff conducted Lung Cancer Screening Lunch and Learns at four MGH primary care practices:

- Augusta Family Medicine
- Elmwood Primary Care
- Winthrop Family Medicine
- Gardiner Family Medicine

In addition, a CHW provided tobacco cessation counseling and referral at the Harold Alfond Cancer Center Cancer Screening day.

Strategy: Standardize primary care workflows, screening/referral and documentation for tobacco treatment and cessation

A multi-disciplinary MGH team consisting of PHL, pulmonology, primary care, cancer navigators and the EHR quality team developed and implemented the lung cancer screening workflow, which went live in June. This workflow is optional and is intended to simplify the lung cancer screening process by incorporating CMS guidelines for eligibility criteria and the shared decision making visit. These guidelines must be met prior to the LDCT being scheduled. The information covered in the shared decision making visit is included in the summary provided at the end of a patient’s visit.
Priority: Substance Use Disorder

Strategy: Establish a comprehensive medical staff plan for opiate prescribing, pain management, and risk reduction, opiate treatment of patients and prescription of naloxone

A MGH interdisciplinary team developed a chronic pain class taught by medical staff from the Maine Dartmouth Family Medicine Residency. Initially, this free class was held monthly due to the volume of medical staff referrals and is now offered quarterly. The class provides basic education about what chronic pain is, an expectation of living with chronic pain, and a review of all treatment modalities. Four chronic pain workshops were attended by 40 patients, and seven Living Well with Chronic Pain classes were held with 89 participants.

With funding from the Stephen and Tabitha King Foundation, PHL purchased 75 naloxone kits which were distributed to high-risk patients at specific primary care practices, Seton Intensive Outpatient Program, Outpatient Plus Program, and MaineGeneral Physiatry. Additionally, MGH held four Medication Assisted Treatment (MAT) Waiver Trainings for medical staff interested in providing treatment for OUD.

Strategy: Implement an outreach plan for medical staff education on guidelines for safe opioid prescribing, use of Maine Prescription Drug Monitoring (PMP) system, screening and referral for opiate dependence services

MGH held 24 trainings on Maine’s Prescription Monitoring Program (PMP) and on a substance use screening tool called “Screening, Brief Intervention and Referral to Treatment” (SBIRT) attended by 34 medical staff. In addition, PMP and SBIRT education was added as part of the new employee orientation for all prescribers. Trainings include an overview of the state law (PL Chapter 488) prescribing requirements. PHL’s harm reduction program provided seven overdose prevention and naloxone trainings to 192 staff.

Strategy: Implement a public education campaign on MGH standards of care for pain management, and commitment to prevention and treatment

Through the Opiate Steering Committee, educational materials were developed for medical staff, clinicians and patients. These documents were disseminated through the primary care Share Point site and the Kennebec Region Health Alliance (KRHA) website. The education information includes materials on acute pain, chronic pain clinical tools and references, opioid law information, patient education material, and the promotion of the Next Step Needle Exchange/Harm Reduction Services expansion to TCH in Waterville.
Members of the Opiate Steering Committee include: Louisa Barnhart, MD; Julia McDonald, DO; Bob Croswell, MD; Ben Brown, MD; Richard Fein, DO; Amy Madden, MD; Roy Miller, MD; Alane O’Connor, DNP; Tim Pieh, MD; Emilie van Eeghen; James Wilson, MD, LeeAnna Lavoie; Shane Gallagher; Darren Ripley; Nate Bowling, MD; Kathleen Webster, DNP; Jeff Janell, LCPC CCS; Joy McKenna; Chief Joseph Massey; and Rick Petrie.

**Strategy:** Implement overdose prevention and naloxone education in all MGH clinical settings targeting patients and families at increased risk

The Harm Reduction team distributed more than 4,500 materials and brochures on overdose prevention, naloxone use, safe storage/disposal, and harm reduction in all MGH clinical settings. The program provided 12 monthly overdose prevention classes at Seton Intensive Outpatient Program (IOP) to 77 participants.

**Strategy:** Complete feasibility study to expand integrated harm reduction services to Waterville area

With support from the Stephen and Tabitha King Foundation, MGH expanded the needle exchange program to Waterville following the completion of a feasibility study. The Waterville Harm Reduction site opened at TCH and is open four hours a week, offering services on Fridays between 10 a.m. and 2 p.m.

**Strategy:** Expand MAT capacity by providing medical staff and primary care office staff training

MGH held five MAT waiver trainings and 31 medical staff attended. Thirty-four medical staff members across 15 KRHA member practices reported at a point in time treating about 767* patients (this does not include IOP, OPP or physiatry).

*This is self-reported estimates, currently there is no report to determine number of patients being treated for OUD.
Priority: Access to Care

Strategy: Expand the integration of mental health services in primary care settings

MGH has maintained integration of mental health services in each of its primary care practices. Mental health services have also expanded coverage in primary care by increasing the number of hours offered in each site.

Strategy: Expand PHL Hub staffing to support linking Emergency Department (ED), Express Care (EC), and Care Management patients with no PCPs to appropriate follow up and primary care

PHL hired its first Hub-assigned CHW whose role is to research and collect data on patients who are linked from the Emergency Department and Express Care, to primary care.

Strategy: Expand use of CHWs to address access to care barriers related to medical care and oral health

MGH hired an additional 1.5 FTE CHWs who primarily serve community members seen in MGH’s ED or EC who do not have a medical home. In FY18, MGH was able to sustain staffing for pediatric oral health education, colorectal cancer screening and lung cancer risk reduction. PHL continues to seek grant funding to support future work.

A CHW helped 182 patients get screened for colorectal cancer by colonoscopy or Fecal Immunochemical Test (FIT), and provided education on screening to 263 patients. MGH’s Oral Health Pediatric CHW educated 493 pregnant women and families with young children on the importance of oral health, linking 277 pregnant women and children 9 and under to a dental home. Please see page 10 for additional details on the team of lung cancer risk reduction CHWs.
Strategy: Implement collaboration strategies and referrals between oral health service medical staff and primary care to assure dental health service access to children up to age 9 and pregnant women

PHL has four programs which address the health care needs of pregnant women and their children ages 0-9. These programs are: Women Infants and Children (WIC) Nutrition Program, Before the First Tooth, From the First Tooth, and outreach supported by the Maine Oral Health Funders to link at-risk children to dental care.

Before the First Tooth aims to improve the oral health of pregnant women and infants through education, collaboration and the integration of oral health into prenatal and primary care. There are three pilot sites participating in the program, including Centering Pregnancy, Maine Dartmouth Family Practice and MaineGeneral OB/Midwifery.

At the pilot sites, each pregnant woman completes an oral assessment and is provided with oral health educational resources. If the patient does not have a dental home, she is referred via the EHR or fax to a CHW. The CHW will reach out and provide additional oral health education, well water testing for fluoride and/or assist in scheduling a dental appointment.

From the First Tooth program collaborated with the Outpatient Education team to add oral health education and competency checks to the Medical Assistant (MA) curriculum.

Conclusion

In summary, MGH continues to be a leader in Maine on addressing community health needs throughout our service area. There is much work to be done and our challenges continue to be around funding for prevention and community health. MGH leadership continues to develop strategies and identify grant opportunities to sustain many efforts listed throughout this report.

Additionally, MGH along with the rest of the state is in the process of completing the next three-year Community Health Needs Assessment. In Fall 2018 the community health engagement forums were held. In early 2019, MGH leadership will identify community health priorities for the next three-year cycle. By participating in this process, MGH has an opportunity to make adjustments based on any new emerging public health issues that have arisen.