Progress report on Community Health Implementation Plan (CHIP)

Fiscal Year

2022  2023  2024

(October 1, 2022 – September 30, 2023)

Franklin Memorial Hospital/ Franklyn Community Health Network
Please highlight progress made from **October 1, 2022 - September 30, 2023** for strategies and actions taken to address the priority areas your organization selected as part of the 2022 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:** Franklin Memorial/FCHN  
**Date:** October 1, 2022 - September 30, 2023

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<thead>
<tr>
<th>2022 CHNA Priority Selected</th>
<th>2022 Implementation Strategy / Planned Actions to Address Priority of Focus</th>
<th>If Action Implemented - Describe actions taken, impact from those actions, and collaborating partners</th>
<th>If NO - Provide a reason why no action was taken</th>
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| **Access to Care**         | Advocate and educate for increased broadband access as a community health strategy. (mental health, SDOH) | • 31 towns and townships participating in Broadband planning.  
• 147 individuals reached through Digital Literacy Program. | |
|                           | Identify and establish a systematic approach to meet urgent ambulatory care needs | • Established Task Force to develop a plan for same day primary care access.  
• Explore feasibility of ED Expansion - not yet underway.  
• Identify implementation Plan - not yet developed | |
|                           | Increase access to evidence-based programming through referral and enrollment in NDPP to prevent diabetes. | • 3% eligible patients referred to NDPP.  
• 46% referred patients enrolled in NDPP. | |
|                           | Increase access to Health Care/Wellness services in rural towns via the HCC Mobile Health Unit | • 118 mobile health unit events.  
• 2,235 people served on Healthy Community Coalition (HCC) Mobile Health Unit. | |
|                           | Increase the number of people in Franklin County who are insured | • Identifying process for people to work with ACA navigators.  
• 92% Franklin County residents with health insurance. | |
| **Social Determinants of Health (SDOH)** | Explore opportunities for identification and referral to address SDOH | • 7 community-based organizations (CBOs) who claim their program on FindHelp.  
• 1,436 211 encounters.  
• 73 211 encounters with mental health specialists.  
• 697 connections on FindHelp.  
• 588 referrals to HCC | |
|                           | Increase Food Security in Franklin County | • 5,500 individuals served at food pantry.  
• 85% patients screened for food insecurity. | |
|                           | Pilot Food As Medicine (FAM) program at FCHN | • 14 people completed FAM.  
• 46 health care referrals to FAM.  
• 72 people enrolled in FAM. | |
| **Mental Health**          | Engage community partners and stakeholders in youth mental health initiatives. | • 1 community partner participating in Advisory Task Force.  
• 4 organizations engaged in town hall meetings.  
• 4 town hall meetings.  
• 12 individuals became certified program facilitators for Youth Mental Health First Aid | |
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<td>Mental Health</td>
<td>Increase the number of adults in the community with the knowledge and skills to address a youth experiencing a mental health challenge and to promote help-seeking behaviors.</td>
<td>• 43 adults were trained in Youth Mental Health First Aid &lt;br&gt;• 3 Healthy Communities Coalition (HCC) staff trained in the Youth Thriving Guide and Implementation</td>
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<td>Link services to improve care coordination within the FCHN system and with community resources in order to assist with discharge planning and care coordination</td>
<td>• Created EPIC referral system with in FCHN to refer patients to HCC &lt;br&gt;• Developed communication tools with care managers, providers and behavioral health to coordinate care. &lt;br&gt;• HCC facilitates monthly meetings with access to care, lend a hand and our CHW team to coordinate care. &lt;br&gt;• HCC expanded the role of CHW to SUD Navigation &lt;br&gt;• Reinvigorated the FCHN IMAT steering committee</td>
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<td>Pilot a school-based wellness program that focuses on root causes of mental health.</td>
<td>• 16 schools engaged. &lt;br&gt;• 806 students reached. &lt;br&gt;• 43.8% youth who report feeling that they matter.</td>
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<td>Substance Use Disorder</td>
<td>Increase access to Evidence-Based SUD treatment services</td>
<td>• 21 MOUD prescribers. &lt;br&gt;• 3 patients who received rapid access/buprenorphine in ED – this program started in September 2023. &lt;br&gt;• 20 patients referred to Substance Use Navigator.</td>
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<td>Increase community and health care team’s knowledge and self-efficacy to address alcohol use.</td>
<td>• 4 staff trained in Responsible Beverage Server Trainings</td>
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<td>Standardize screening and referral process for SUD</td>
<td>• 41.8% patients with an Annual Wellness Visit who had a substance use screening. &lt;br&gt;• 88.9% patients with an Annual Wellness Visit who had a tobacco use screening. &lt;br&gt;• Action plan for SBIRT training and implementation developed. &lt;br&gt;• Understand readiness for SBIRT model at Franklin - not yet completed</td>
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<td>Use harm reduction models of care delivery and treatment for those with active SUD</td>
<td>• 8 trained Peer Recovery Coaches. &lt;br&gt;• 70 individuals working with Peer Recovery Coaches. &lt;br&gt;• 20 people engaged with Peer Recovery Coaches. &lt;br&gt;• 189 patients receiving buprenorphine. &lt;br&gt;• 130 naloxone prescriptions in the community. &lt;br&gt;• 185 individuals accessing harm reduction through HCC Mobile Health Unit. &lt;br&gt;• 21 sites visited by MHU. Sites are visited monthly. &lt;br&gt;• 740 promotional materials distributed.</td>
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