Progress report on Community Health Implementation Plan (CHIP)

Fiscal Year

2022 2023 2024

(October 1, 2022 – September 30, 2023)

Maine Medical Center
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:** Maine Medical Center  
**Date:** October 1, 2022 - September 30, 2023

<table>
<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>
</tr>
</thead>
</table>
| **Access to Care**          | Coordinate and improve access to primary care, behavioral health and specialized services | • 62 referrals to Living Well (with chronic conditions) & Living Well with Diabetes.  
                             |                                                                                             | • 43% referred patients enrolled in NDPP.                                                      |                                                  |
|                            | Ensure equitable access to care by supporting people with transportation and/or interpreter/translation services | • 68 standard patient education materials created in different languages.  
                             |                                                                                             | • 579 patients received transportation support: UberHealth, taxi vouchers and GPCOG Bus Ambassador program.  
                             |                                                                                             | • 100% MMC/MMP sites with iPad for video remote interpreters.                                |                                                  |
|                            | Implement PrevME Community Informed Care Initiative pilot program to better serve immigrant populations in collaboration with community partners | • 141 patients enrolled in PrevME Community Health Informed Initiative pilot program.  
                             |                                                                                             | • 468 connections to community resources/supports made by PrevME program staff.               |                                                  |
|                            |                                                                                             | • 41% enrolled patients discharged with “goals met”. (1 out 9 discharged completed their health goal, most moved out of Portland area or lost to follow up.)  
                             |                                                                                             | • 43 patients currently enrolled. 61 patients were discharged between April- September as the program was fully staffed. |                                                  |
|                            | Improve connections to community-based programs/organizations providing health and social services to address the unmet healthcare needs of vulnerable populations | • 205 Preble Street Learning Collaborative (PSLC) clients received short-term targeted case management.  
                             |                                                                                             | • 30% of clients received case management.                                                     |                                                  |
|                            |                                                                                             | • 44% closed loop connections documented to community partners.                                |                                                  |  
| **Healthy Aging**          | Improve documentation of Advance Care Directives, POLST, and Serious Illness Conversations in EPIC with patients age 65 or older | • 47% Advance Care Directives, POLST, and Serious Illness Conversations in EPIC with patients age 65 or older |                                                  |
|                            | Participate in Age Friendly Health Systems (AFHS) goals | • 17% adults 65+ assessed for 4Ms.  
                             |                                                                                             | Made progress toward achieving AFHS recognition.                                              |                                                  |
|                            | Improve health outcomes of older adults by delivering and referring to preventive services | • 72% Medicare or Medicare Advantage patients or patients age 65 or older with wellness visit in the past 12 months. |                                                  |
|                            | Increase connections to lifestyle programs among older adults | • 13 referrals to Southern Maine Agency on Aging’s Meals on Wheels & Age Well programs via FindHelp.  
<pre><code>                         |                                                                                             | • 45 CBOs added to FindHelp that serve older adults.                                         |                                                  |
</code></pre>
<table>
<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 If NO - Provide a reason why no action was taken</th>
</tr>
</thead>
</table>
| Social Determinants of Health (SDOH) | Expand FindHelp social services directory, by increasing engagement and partnerships with community-based programs/organizations | • Outreach to 51 community-based programs/organizations  
• Participation in MaineHealth Community Engagement Workgroup |
| Implement Early Childhood Specialist project to deliver trauma-informed, culturally sensitive, resilience-building supports that focus on removing SDOH barriers for families who have children ages 0-3 | • 427 families receiving services through the Early Childhood Specialist project.  
 o 89 received Tier 1 brief interventions, 173 received Tier 2 support, 18 received Tier 3  
 o 11 children moving to a lower tier of services; 1 child moved to a higher tier  
 o 33% identified one SDOH need; 52% identified two or more SDOH needs;  
 o 289 or 90% received interventions |
| Mitigate SDOH barriers by coordinating connections with internal and external resources | • 1,904 connections to community resources/supports made by Access to Care.  
• 4,829 referrals to Patient Assistance Line (PAL) and Cumberland County Care Partners.  
• 14,154 individuals served at MMC food pantry.  
• 21% well child visits where patient was given emergency diapers.  
• 83% well child visits where patient was screened for diaper insecurity.  
• 80% patients screened for food insecurity. |
| Substance Use Disorder | Increase access to naloxone by implementing MaineHealth guidelines for providers on prescribing and distributing kits to patients and family members at risk of overdose | • 223 naloxone kits supplied to Emergency Room and primary care practices for distribution to patients via Portland Public Health Needle Exchange  
• 48% patients at high risk for overdose with a current prescription for naloxone on medication list.  
• 61% patients treated for OUD with a current prescription for naloxone on medication list. |
| Increase access to treatment for opioid use disorder (OUD) using all forms of buprenorphine, including long-acting injectable buprenorphine | • 119 active MOUD providers prescribing buprenorphine.  
• 522 patients receiving buprenorphine. |
| Increase the # of pregnant and postpartum patients with SUD cared for in an integrated model | • 40 patients enrolled in MaineMOM at MMC OBGYN Clinic.  
• 10% pregnant and postpartum patients with SUD offered referral to peer recovery coaches.  
• 97% pregnant and postpartum patients with SUD screened for Hepatitis C. |