

Progress report on
Community Health
Needs Assessment
Implementation Strategy

fiscal year

2019 **2020** 2021

(October 1, 2019 – September 30, 2020)

**Memorial Hospital** 



## **CHNA Implementation Plan 2019-2021**

### **Memorial Hospital**

The following report outlines progress on the Memorial Hospital Implementation Strategy on key health priorities identified in the **2018 Community Health Needs Assessment for Carroll County, NH.** 

2019 Community Health Needs Assessment Reports for all MaineHealth hospitals can be found here: <a href="https://mainehealth.org/healthy-communities/community-health-needs-assessment">https://mainehealth.org/healthy-communities/community-health-needs-assessment</a>

A member of the MaineHealth system, Memorial Hospital has a set of health priorities including:

Mental Health

Obesity Prevention

Substance Use

Healthy Aging

#### **About Memorial Hospital**

Memorial Hospital is a not-for-profit 25-bed Critical Access Hospital located in North Conway, NH, and is a member of the MaineHealth family. Its hospital services include a 24-hour emergency department, surgery center, clinical laboratory, heart health & wellness programs, imaging services, cardiopulmonary care, family birthing center, oncology, chemotherapy and infusion services. Practices include primary care and family medicine, diabetes care, behavioral health, women's health, podiatry, orthopedics and physical therapy. Additional Memorial facilities include The Merriman House nursing home - providing senior care services in a comfortable, home-like setting.

In 2011, Memorial Hospital celebrated its 100th anniversary.

### The MaineHealth System

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 2019, the MaineHealth system provided over \$487.5 million in community health programs or services without reimbursement or other compensation.

Please highlight progress made from **October 1, 2019 - September 30, 2020** 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: Memorial Hospital

Date: October 1, 2019- September 30, 2020

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
Healthy Eating Active Living (HEAL) / Obesity Prevention	Continue to track Let's Go! to meet annual goals  Action Implemented? ⊠Yes □No  Continuing in FY21? ⊠Yes □No	<ul> <li>Met annual LG! goal to expand sites and/or assist sites to increase recognition level.</li> <li>We currently have all schools registered but 1 (they choose not to participate in outside partnerships). Will continue to grow out-of-school and early childhood education centers. COVID-19 has halted outreach but beginning again slowly as of September 2020.</li> </ul>
	Continue WOW! partnership to maintain comprehensive onsite offerings  Action Implemented? ⊠Yes □No  Continuing in FY21? ⊠Yes □No	Ongoing wellness class offerings, challenges with incentives, wellness workshops and education about WOW! for staff through email, onsite events and monthly newsletter.
	Decrease % of patients with HbA1c. > 9.0  Action Implemented? □Yes □No  Continuing in FY21? □Yes □No	<ul> <li>New Quality Director onboarded 12/19.</li> <li>Primary care without permanent medical director until 7/20.</li> <li>Year 2: plans through collaboration with diabetes educator and pop health to decrease %. Diabetes committee established for clinical/community outreach.</li> </ul>
	Expand access to National Diabetes Prevention Program (NDPP) program within the region from 1 class to 4 classes per year;  a. Provide on site  b. Provide community locations  c. Online delivery  Action Implemented?   Yes   No  Continuing in FY21?   Yes   No	<ul> <li>National Diabetes Prevention Program centralized at MaineHealth. New coaches recruited/hired and trained during Fall 2019.</li> <li>Classes rolled out January 2020. 2 classes started; 1 completed/1 ongoing. Community locations classes scheduled when COVID-19 hit/cancelled. Program pivot to virtual delivery May 2020.</li> <li>Year 2: Local Health System service area has proven that print marketing gains best return for program registrations in combination with social media. Will work in tandem with provider education for referrals.</li> </ul>
	Expand Let's Go! outreach to include (5) provider based education visits/events at LG! sites or in community  Action Implemented? ⊠Yes □No  Continuing in FY21? ⊠Yes □No	<ul> <li>Outreach met through different avenues due to COVID-19. Pediatrician participated in SAU wellness committee meetings, 1 ACEs event, and 3 Facebook live events. Behavioral Health provider participated in ACEs event and Facebook live event for youth. No in-person access to sites. Utilizing Facebook live outreach/education and Zoom.</li> </ul>



2019 CHNA	2019 Implementation Strategy /	If Action Implemented - Describe actions taken, impact from those actions,
Priority	Planned Actions to Address Priority of Focus	and collaborating partners
Selected		If NO - Provide a reason why no action was taken
<b>Healthy Eating</b>	Improve provider referrals to NDPP	• EPIC roll out 12/18 included Population Health referrals tab, National
Active Living	Action Implemented? □Yes ⊠No	Diabetes Prevention Program included. Mid-year 2019, the program
(HEAL) /	Continuing in FY21? ⊠Yes □No	centralized referrals and providers were unaware of new process.
Obesity		Year 2: Plans for education and outreach are in progress.
Prevention	Increase % of patients screened for food insecurity at annual	• 32.91% increase of patients ages 0-17 screened. Target 60%.
	well child visits	September 2020 performance at 87.2%
	Action Implemented? ⊠Yes □No	
	Continuing in FY21? ⊠Yes □No	
	Increase NDPP participant completion meeting CDC-	Increased participation to completion by 157.1%.
	established program outcomes	Participant Goal: 35. Met: 18.
	Action Implemented? ⊠Yes □No	Multiple in-person classes cancelled due to COVID-19. Push for virtual
	Continuing in FY21? ⊠Yes □No	attendance ongoing.
	Maintain and/or expand wellness program offerings to meet	Offered in-person Bootcamp, Yoga (gentle flow, ayurvedic, Piyo, prenatal,
	needs for adult/child population:	mommy & me), HIIT, Zumba, ChiRunning (adults & kids) and healthy
	a. Year round fitness classes	eating/living and mindfulness community classes.
	b. Year round health education, stress management,	
	mindfulness and nutrition workshops	
	Action Implemented? $oximes$ Yes $oximes$ No	
	Continuing in FY21? $oximes$ Yes $oximes$ No	
	Train primary care practice on Small Steps and that by	• Practice trained 7/29/2019. Follow up training pushed off due to COVID-19.
	12/31/19 program is implemented	Looking to schedule second training Spring 2021 depending on COVID-19
	Action Implemented? ⊠Yes □No	through late fall/winter.
	Continuing in FY21? ⊠Yes □No	
Mental Health	Identify and develop access to mental health for youth	Behavioral health team in collaboration with ACEs workgroup and other
	Action Implemented? ⊠Yes □No	community healthcare partners, working to create referral network and
	Continuing in FY21? ⊠Yes □No	identification that follows confidentiality guidelines within schools/HIPPA
		compliant for medical organizations.
	Increase access to Mental Health emergency care	Contracted with community partners Northern Human Service for onsite
	Action Implemented? ⊠Yes □No	services in ED (evaluation and time w/patients); obtained privileges for our
	Continuing in FY21? ⊠Yes □No	in-house APRN-PMHNP in ED for formal consultant management (70
		consults performed)
	Increase staff & community mental health stigma education	• In-house training had been scheduled for Spring 2020, halted per COVID-19.
	Action Implemented? $oximes$ Yes $oximes$ No	Reschedule pending Spring 2021. Community Education ongoing through
	Continuing in FY21? ⊠Yes □No	Facebook Live Event and Zoom in collaboration w/community partners.



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Mental Health	Raise awareness of ACEs and Resiliency in collaboration with community partners for parents; 1 community outreach event per quarter  Action Implemented?   Yes   No  Continuing in FY21?   Yes   No	<ul> <li>Recovery Boys screening/Q&amp;A shown in Feb 2019, followed by Resilience screening/Q&amp;A in May 2019.</li> <li>Formed ACEs community workgroup, Building Resilience Mount Washington Valley to raise awareness, educate and do outreach events led by pop health manager.</li> <li>June-early fall 2019 recruitment of partners, development of framework, mission, and purpose.</li> <li>Created PR campaign and solicitation for training in January 2020. Pivot to Facebook live event through COVID-19 hosting 7 events under Building Resilience Mount Washington Valley Coalition.</li> </ul>
	Screen patients 0-17 with 2 question trauma screener at well child visits  Action Implemented?	<ul> <li>2 question screener used; kids (0-2), and the 2 questions plus the ACEs screener for 3 and up.</li> <li>Additional formal developmental screen at ages 9, 15, and 30 mos, and that screen currently includes the full ACEs screen.</li> <li>71.1% increase. Target: 80%. (October 2019 Performance 48.1% to Sep September 2020 Performance at 82.3%)</li> </ul>
Older Adult Health/ Healthy Aging	Begin development of formalized multidisciplinary Palliative  Care Program  Action Implemented?	Visiting Nurse Home Care and Hospice started community-based Palliative Care. Primary Care provider as medial director. Census increased steadily increasing within first 6 months.
	Continue 50+ Fitness Offerings  Action Implemented?	<ul> <li>Ongoing in-person fitness classes: yoga, chair yoga, ChiRunning, Zumba, Pilates. 100 Days of Wellness Challenge 5/13/2021-8/2021</li> <li>2019 included senior category/partnership with AARP/ Mount Washington Valley Age-Friendly Initiative. Classes halted during 3/2020-8/2020 due to COVID-19. September through end October resumed virtually.</li> <li>New classes began January 2021.</li> </ul>
	Execute chronic disease management program for 50+ population Action Implemented? ⊠Yes □No Continuing in FY21? ⊠Yes □No	<ul> <li>April 2020 roll out pushed to September 2020 due to COVID-19. Program allowed transition to virtual delivery. First class successful.</li> <li>Recruiting more volunteer coaches and participants for 2021/Q1 classes.</li> </ul>
	Expand capacity for Advanced Care Planning in region  Action Implemented?	<ul> <li>Two people were trained as Respecting Choice Train the Trainer with anticipation to offer local training in Spring 2020. Training delayed due to COVID-19.</li> <li>Advanced Care Planning continued with current facilitators remotely.</li> </ul>



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Older Adult Health/ Healthy Aging	Expand capacity as Dementia Capable/Friendly community  Action Implemented?	<ul> <li>Adult Day Center opened providing cognitive stimulation, socialization, engagement and physical activity to guests attending and respite to caregiver. Continued connection during COVID-19 closure via Zoom.</li> <li>Began community education programs.</li> <li>In August 2020, awarded 3 year Administration of Community Living Grant to be Dementia Capable Community.</li> </ul>
	Expand involvement in AARP Age Friendly Community Initiative Action Implemented?	Active representation on Steering Committee of Adult Family Care Initiative     Senior Kiosk at Conway Library, Health task force promoted "Good Morning Program", project for inter-generational Walkable Trails, Senior Resource Guide  On hald COVID 10 deleved training Committee of Adult Family Care Initiative  On hald COVID 10 deleved training Committee of Adult Family Care Initiative  On hald COVID 10 deleved training Committee of Adult Family Care Initiative  On hald COVID 10 deleved training Committee of Adult Family Care Initiative  On hald COVID 10 deleved training Committee of Adult Family Care Initiative  On hald COVID 10 deleved training Committee of Adult Family Care Initiative  On hald COVID 10 deleved training Committee of Adult Family Care Initiative  On hald COVID 10 deleved training Committee of Adult Family Care Initiative  On hald COVID 10 deleved training Committee of Adult Family Care Initiative  On hald COVID 10 deleved training Committee of Adult Family Care Initiative  On hald COVID 10 deleved training Committee of Adult Family Care Initiative  On hald COVID 10 deleved training Committee of Adult Family Care Initiative  On hald COVID 10 deleved training Committee of Adult Family Care Initiative  On hald COVID 10 deleved training Committee of Adult Family Care Initiative  On hald COVID 10 deleved training Committee of Adult Family Care Initiative  On hald COVID 10 deleved training Committee of Adult Family Care Initiative  On hald COVID 10 deleved training Committee of Adult Family Care Initiative  On hald CovID 10 deleved training Committee of Adult Family Care Initiative  On hald CovID 10 deleved training Committee of Adult Family Care Initiative  On hald CovID 10 deleved training Committee of Adult Family Care Initiative  On hald CovID 10 deleved training Committee of Adult Family Care Initiative  On hald CovID 10 deleved training
	Program  Action Implemented? □Yes ⊠No  Continuing in FY21? □Yes ⊠No	On hold. COVID-19 delayed training. Some internal reorganization.
	Increase community education related to Aging Action Implemented? ⊠Yes □No Continuing in FY21? ⊠Yes □No	<ul> <li>Two Reframing Aging Facilitators trained.</li> <li>Representatives on State Commission on Aging with involvement on tasks force supporting aging in community.</li> </ul>
	Increase Matter of Balance Coaches and Master Trainers in region to ensure capacity  Action Implemented?	<ul> <li>Increased coaches (2), master trainer (1); program halted due to COVID-19.</li> <li>Virtual pilot conducted since COVID-19. Rollout planned for January 2021.</li> <li>Master coaches need to be re-trained, then coaches retrained. Early February 2021 schedule start. New coaches will be recruited to augment those coaches who are not comfortable w/virtual.</li> <li>Year 2: Will be in capacity building mode, with 20% more classes scheduled.</li> </ul>
	Maintain Falls Prevention Program to decrease % of falls in region  Action Implemented?	Maintained % of falls in region, no substantial increase/decrease.
Substance Use Disorder	Increase access to treatment through Medical Assisted Treatment (IMAT) Action Implemented? ⊠Yes □No Continuing in FY21? ⊠Yes □No	<ul> <li>Additional IMAT provider hired, will move to Director of Behavioral Health.         Existing NP provider obtained IMAT credential. Currently, 4 IMAT providers who can see total of 680 patients.     </li> <li>Goal to merge New Life Program with IMAT under one umbrella. Internal addiction medicine program in development and plan to expand into community.</li> </ul>



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Substance Use Disorder	Increase capacity to provide Tobacco Cessation consults to Inpatient Population	• 10/24/19 Center for Tobacco Independence on-site to train staff for best practices "verbiage".
	Action Implemented? ⊠Yes □No	Respiratory therapy took over all consults.
	Continuing in FY21? ⊠Yes □No	• Initial increase in referrals from 10/2019 - 2/2020.
	-	• 12/2019 sync between EPIC and National Jewish was established.
	Continue New Life Prenatal Program	New Program Coordinator hired September 2020.
	Action Implemented? ⊠Yes □No	• Plans to merge with Behavioral Health under new director/one umbrella to
	Continuing in FY21? □Yes □No	stabilize program and hire primary care counselor.
	Continue participation in Medicaid 115 waiver initiative to	Finalized fund distributions to partners. Further participation halted
	maintain coordinated alliance and awareness of services	October 2020 per COVID-19/capacity.
	Action Implemented? ⊠Yes □No	
	Continuing in FY21? □Yes ⊠No	
	Implement peer recovery model	Contracted with community partners White Horse Recovery and Mount
	Action Implemented? ⊠Yes □No	Washington Valley Supports Recovery 24/7 access in ED for (23) Peer
	Continuing in FY21? ⊠Yes □No	Recovery Coaches.
	Increase awareness of NH Doorways Model	Doorway Model excludes Carroll County; requiring patients to travel 45-60
	Action Implemented? ⊠Yes □No	minutes for treatment, not feasible for many.
	Continuing in FY21? ⊠Yes □No	• Close collaboration exists among Carroll County agencies providing services.
		Local Health System and region has found Doorway impractical when
		resources are available within own county.
		Patients informed of 211, which refer to nearest Doorways, but awareness
	Deduce and identify source of OUD stigms for providers and	is limited even among staff. Regional awareness work is ongoing.
	Reduce and identify causes of OUD stigma for providers and	Behavioral health team participates in IMAT ECHO monthly calls.      FD staff training being planned.
	health care workers through regional stigma reduction	ED staff training being planned.
	training program	
	Action Implemented?	
	Continuing in FY21? □Yes ⊠No	

