

Mount Desert Island Hospital- Community Health Needs Assessment

MDI Hospital | 10 Wayman Lane, Bar Harbor, ME 04609

Report to the Community – IMPLEMENTATION overview

Community health needs assessment steering committee 12.2020

2020

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Community Health Needs Assessment

Executive Summary

# **Planning Team**

Community Health Needs Assessment (CHNA) Core Planning Team

Chrissi Maguire, *Chief Operating Officer/Senior Vice President, Mount Desert Island Hospital;* Elsie Flemings, *Executive Director, Healthy Acadia;* Maria Donahue, *Community Health Director, Healthy Acadia;* and Shoshona Smith, *Development Director, Healthy Acadia*

CHNA Steering Committee

Alf Anderson, *Executive Director, Bar Harbor Chamber of Commerce;* Alfred May, Jr., *DownEast District Public Health Liaison, Maine Center for Disease Control (in an advisory capacity);* Allie Bodge, *Operations Director, Mount Desert Island and Ellsworth Housing Authority;* Chrissi Maguire, *Chief Operating Officer and Senior Vice President, Mount Desert Island Hospital;* Crystal DaGraca, *Principal, Swan’s Island School;* Elsie Flemings, *Executive Director, Healthy Acadia;* Ingrid Kachmar, *Executive Director, Harbor House;* Jo Cooper, *Executive Director, Friends in Action;* Julie Meltzer, *Director of Curriculum, Assessment, and Instruction, AOS 91;* Karen A. Mueller, *Chief Nursing Officer, Mount Desert Island Hospital;* Kelli Casey, *Employee Engagement Coordinator,* *Mount Desert Island Hospital;* Lani Naihe, *Director of Advancement, Mount Desert Island Hospital;* Lindsay Eysnogle, *Principal, Frenchboro School;* Lynn Leighton, *Director of Care Management and Outpatient Services, Mount Desert Island Hospital;* Maria Donahue, *Community Health Director, Healthy Acadia;* Marc Gousse, *Superintendent, AOS 91 (in an advisory capacity);* Margaret Snell, *Assistant to the Director of Island Health Services, Maine Seacoast Mission;* Michelle Hackett, *Practice Manager for MDI Orthopedics, Mount Desert Island Hospital;* Michelle Smith, *Director of Fiscal Services, Mount Desert Island Hospital;* Micki Sumpter, *Executive Director, Mount Desert Chamber of Commerce;* Rev. Robert Benson, *Pastor,* [*Bar Harbor Congregational Church*](https://barharborucc.org/)*;* Shoshona Smith, *Development Director, Healthy Acadia;* and Tommy Parham, *Executive Director, MDI YMCA*

# **Overview and Introduction**

The Community Health Needs Assessment (CHNA) and Action Plan for the Mount Desert Island Service Area serves as a framework and guide for Mount Desert Island Hospital and Healthy Acadia in developing and strengthening our programming to fulfill community needs. Each organization prioritizes elements of the CHNA and Action Plan for implementation. The Plan is also available to all local organizations and citizens to support efforts to address and coordinate community health improvement.

MDIH promotes the distribution and sharing of this report through dissemination partnerships with local municipalities, non-profits, community agencies, schools, and municipalities to share the strategies and tactics collated during this process to support a healthy and vibrant community and service area.

MDIH, a 501(c)(3) non-profit, state-of-the-art rural healthcare organization, serves the close-knit island and surrounding communities. Formed in 1897, MDIH has grown into a premier rural healthcare organization with a retirement community and eight regional health centers, including a full-service behavioral health center and a dental clinic.

Mount Desert Island Hospital’s mission is to provide compassionate care and strengthen the health of the community by embracing tomorrow’s methods and respecting time-honored values. MDIH is committed to providing the care that community members need, close to their homes. They foster and appreciate opportunities to hear from their community through bi-annual community forums and through a community health needs assessment every three years.

Healthy Acadia (HA) is a 501(c)(3) non-profit organization dedicated to empowering people and organizations as they build healthy communities together. They serve Washington and Hancock counties, and provide additional community health support and leadership across Maine, with work across a broad range of collaborative community health initiatives within six areas of focus: Strong Beginnings, Healthy Food for All, Active and Healthy Environments, Healthy Aging, Substance Prevention and Recovery, and Health Promotion and Management. Healthy Acadia envisions vibrant communities where people thrive, and healthful resources are easily accessible. They prioritize creative, collaborative efforts that respond directly to community health needs which arise as priorities in a variety of regularly convening community committees, twice yearly Advisory Council meetings, and various community health needs assessments including this broader MDI region assessment in collaboration with MDIH.

This Plan focuses on the nine-town service area of MDIH. These towns include Bar Harbor, Cranberry Isles, Frenchboro, Lamoine, Mount Desert, Southwest Harbor, Swans Island, Tremont, and Trenton. This nine-town area is the focus of this Plan. It is referred to here as the “Local Service Area” (LSA).

Note for Use

Community health is multifaceted, hard to comprehensively measure, dynamic, and ever changing. This 2019-2020 broader MDI region CHNA and Action plan is a snapshot of the LSA and provides a framework for Mount Desert Island Hospital, Healthy Acadia, and partners to collectively address health concerns and to work to build an area that is “...home to vibrant communities where people thrive and healthful resources are easily accessible” as outlined in the vision statement. It is the sincere hope of CHNA Coordinators and Steering Committee members that this tool is used in countless creative ways to better the community.

# **Vision, Timeline and Process**

Community Vision

Our area is home to vibrant communities where people thrive, and healthful resources are easily accessible.

Process for Development of Vision

During the need’s assessment process of 2008-2009, committee members worked to develop a vision statement that would reflect the ideal future for the LSA in terms of broad-based community health. This statement was also used during the 2015-2016 process. In 2019, at the onset of this Community Health Needs Assessment Process, our Core CHNA Planning Team spent time reviewing the vision and decided to again uphold this vision statement for the 2019-2020 process.

CHNA and Action Plan Timeline

|  |  |
| --- | --- |
| **TASK** | **TIMELINE** |
| Form a CHNA Steering Committee and collectively define community | September 2019 |
| Conduct interviews, group dialogues, surveys (print and electronic) to develop the Community Themes and Strength Assessment | October 2019 - December 2019 |
| Conduct Health Status Assessment (gather, collate, analyze external data) | October 2019 - January 2020 |
| Conduct Forces of Change Assessment | November 2020 |
| Organize community data into themes, summarizing strengths and challenges (to finalize Community Themes and Strength Assessment) | January 2020 |
| Hold Theme Team meetings | February - March 2020 |
| Share results of Assessments with Steering Committee and solicit feedback | March 2020 |
| Core Planning Team/Steering Committee final review and Covid-19 Assessment | June 2020 |
| Building on all Assessments, complete written “Community Health Assessment and Action Plan” | June 2020[[1]](#footnote-1) |
| MDI Hospital develops an Implementation Plan. | July 2020 |
| Publication and dissemination of “Community Health Assessment and Action Plan” | July 2020 |

***Process for conducting the Community Themes and Strengths Assessment:***

The Community Themes and Strengths Assessment provides largely qualitative data on existing community health strengths, challenges, needs, and opportunities. For this assessment, CHNA Coordinators spent four months collecting community input through an electronic and paper survey. Thousands of community members within the LSA were asked to answer broad-based questions about community health. Respondents were asked about area community health concerns and strengths, suggestions for needed services, supports, and spaces, issues they would like to see more public discussion, education, and action around, and what they would like to see happen to build greater community health[[2]](#footnote-2). We received 402 surveys from community members living, working, and/or receiving services in the LSA. The resulting data was organized into themes that greatly informed the final CHNA theme areas. It was shared with Theme Teams and highlights are included within the Themes sections of this report, under ‘key findings.

Through the surveying process, significant efforts were made to ensure that survey participants constitute a broad spectrum of the LSA, with representation proportionate to the LSA population demographics as much as possible. This was fulfilled through a diverse survey dissemination effort and frequent evaluation of respondent demographics. Data on zip code, gender, age, race and ethnicity, and healthcare payment methods were collected through the survey process, which enabled us to evaluate the success of the assessment’s reach. In similar future assessment processes, CHNA Coordinators would recommend careful reconsideration of whether to collect income data and a source from which the survey was accessed, (neither were collected during this process out of respect for privacy) as well as clarifications to the question “*How do you pay for healthcare?*”. In the future, this question might benefit from space to indicate employer provided insurance or privately purchased insurance, two categories which were not differentiated in the 2019-2020 survey.

While greater representation is always to be strived for as part of every needs assessment, CHNA Coordinators and Steering Committee Members feel confident that we heard from a largely representative group of community members with a range of interests and opinions regarding the health of their communities and the efforts needed to increase community health.

Data was collected predominantly using a Google Forms survey. Paper surveys were also disseminated. One unanticipated challenge arose when school regulations disallowed high school student participation via survey dissemination or in-class discussions, which resulted in very few under-18 respondents and represents a gap in perspective. Future CHNA processes would benefit from further efforts to increase representation by this age group, as well as strategic outreach to community members who identify as Black, Indigenous, and people of color (BIPOC), lesbian, gay, bisexual, pansexual, transgender, genderqueer, queer, intersexed, agender, asexual (LGBTQIA+), disabled or having disabilities, all essential workers, unemployed and underemployed individuals, and others who are traditionally underrepresented in these types of processes to ensure that their voices and unique perspectives are best represented.

***Process for conducting Community Health Status Assessment:***

The Community Health Status report provides quantitative data on demographics and health indicators that are significant in clarifying the landscape of community health needs initially presented through the Community Themes and Strengths Assessment and broadened by the Forces of Change Assessment.

This quantitative data, which was shared with Theme Teams and is included within the Themes sections of this report under ‘key findings’, has been sourced from the Hancock County Health Profile 2018: Maine Shared Community Health Needs Assessment (Maine Shared CHNA, 2018) unless otherwise noted. This tool includes health data from over 30 sources, representing the most recent data available as of March 2018[[3]](#footnote-3) and most local data available[[4]](#footnote-4). Data is used to illustrate significant trends impacting community health in the LSA and is not comprehensive.

***Process for conducting Forces of Change Assessment:***

There are always ‘forces of change’ (events, trends, and factors in the broader environment) that are occurring or might occur and affect the health of the LSA. These forces are beyond local control but may require local awareness and response. The Forces of Change Assessment explores current forces and possible threats, or opportunities generated because of these forces.

This assessment was completed by the CHNA Steering Committee through a member survey and group discussion. The Steering Committee identified numerous forces, as well as various threats and opportunities posed by each force. Highlights of this data was provided to Theme Teams and are included within the Themes sections of this report under ‘key findings.

***Process for conducting Theme Team Meetings:***

At the close of 2019, CHNA Coordinators worked together to review data from the three assessments outlined above. All efforts were made to maintain the breadth and depth of Community Themes and Strengths Assessment survey responses while collating data into community health topic areas. This assessment played a key role in the determination of CHNA theme areas, with the Health Status Assessment data and Forces of Change Assessment results complementing and informing our definitions of each theme area.

Five unique themes were initially determined to encompass the data. These were 1) Accessibility, Affordability, and Quality of Healthcare, 2) Acute and Chronic Disease and Conditions, 3) Mental Health and Community Connectedness, 4) Social Determinants of Health, and 5) Substance Use.

Theme Teams were convened to discuss these five initial themes through a selection process that included invitations to Community Themes and Strengths Assessment survey respondents who indicated interest in involvement in the broader assessment; participants in Theme Teams during the 2015-2016 CHNA cycle, all of whom are considered experts in unique areas of community health; and additional community members and health experts with unique expertise and experience relevant to one of the five initial themes. In a format that differed from that of the previous CHNA assessment, Theme Team invitees were provided an opportunity to self-select the Theme Team or Theme Teams in which they wanted to participate. While this allowed invitees to join one or more given Theme Teams based on their interest and schedule availability, it also effectively resulted in less curated Theme Team participant groups. In similar future assessment processes, CHNA Coordinators would recommend careful reconsideration of whether to restructure this invitation process to ensure a balanced mix of perspectives and representation in each Theme Team.

Theme Team meetings were held as one two-and-a-half-hour meeting per each of the initial five themes. Participants joined in person and remotely, all in a Bar Harbor community location. Some meetings were rescheduled due to weather conditions. Preexisting snow dates, and more diverse meeting locations spread across the LSA would be advisable for future processes. During Theme Team meetings, participants were asked to review highlights from both qualitative and quantitative data sets and to use that information as well as their own professional and lived experiences to compile lists of theme-specific community health strengths and challenges. These lists then informed action-item list creation, including the initial framing of the goals and strategies listed on subsequent pages under the Themes, Goals, and Strategies section of this report.

After Theme Team meetings, it became clear that integrating Acute and Chronic Disease and Conditions content into the Accessibility, Affordability, and Quality of Healthcare was a reasonable and appropriate next step; the groups found that one Theme could not be discussed without simultaneously addressing the other. This left us with the following four Theme areas: 1) Accessibility, Affordability, and Quality of Healthcare, 2) Mental Health and Community Connectedness, 3) Social Determinants of Health, and 4) Substance Use.

***Process for conducting Covid-19 Community Health Impacts and Priorities Assessment:***

In June 2020, the CHNA Steering Committee participated in an additional assessment process to compile relevant Covid-19 specific content and facilitate necessary updates and additions to content generated by the Community Themes and Strengths, the Community Health Status, and the Forces of Change assessments and the Theme Team meetings.

The Steering Committee outlined Covid-19 related community health strengths, challenges, needs, and opportunities within each of the four Theme Areas. Strong consideration was also given to whether some CHNA relevant Covid-19 content might not be encompassed by the four Theme Areas and it was determined that these four Theme Areas are able to accurately contain relevant Covid-19 additions.

All content generated through this Covid-19 Community Health Impacts and Priorities Assessment was integrated into this report, including in ‘additional Covid-19 considerations’ sections within the ‘key findings’ of each Theme section, as well as throughout the Goals and Strategies content of each Theme section, with footnotes highlighting these.

***Assessment and Theme Team Processes, in conclusion:***

Data from these assessments and Theme Team meetings collectively provide a detailed picture of the current community health landscape in the LSA, are represented in the ‘key findings’ under each of the following Theme areas, and are the foundation of the subsequent goals and strategies in each Theme area.

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# **Themes, Goals and Strategies**

**1-Theme One: Accessibility, Affordability, and Quality of Healthcare**

*Theme One Guiding Question*: **How can we promote and increase access to quality, affordable healthcare, and prevention resources for all?**

**(Resources are broadly defined as services, supports and spaces)**

* **Additional Covid-19 Considerations**
  + Coronavirus disease 2019 (Covid-19) is an infectious disease caused by severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2). It was first identified in December 2019 in Wuhan, [China](https://en.wikipedia.org/wiki/Central_China), and has resulted in an ongoing pandemic. Maine first felt the impacts of the virus in March 2020, when mass shutdowns occurred in efforts to prevent its spread.
  + As of the publication of this report, Hancock County has had 16 known positive cases of Covid-19.
  + Severe testing and protective equipment supply chain issues have contributed to challenges in testing and resulted in poor tracking of the virus.
  + At the state level, Blacks account for 1.7% of the population but 3.7% of the infections. (Maine CDC, April 29, 2020) These numbers represent significant racial inequities of Covid-19 in Maine.

Impacts of the Covid-19 pandemic are extensive and not fully clear at the time of this publication. The virus has caused or exacerbated numerous challenges to accessibility, affordability, and quality of healthcare in the LSA and has also brought about or highlighted a few strengths related to accessibility, affordability, and quality of healthcare in the LSA

*Goal 1:* Increase awareness of available healthcare and prevention resources.

*Goal 2:* Make healthcare and prevention resources more affordable

*Goal 3:* Overcome obstacles to accessing healthcare and prevention resources.

*Goal 4:* Increase resources to empower individuals to prevent and manage health issues and be active in the development and execution of their health plans.

| **Implementation** | **Theme Goal(s)** | **Resources** | **Strategic** | **Operational** |
| --- | --- | --- | --- | --- |
| Covid-19 Testing | Overcome obstacles to accessing healthcare and prevention resources | Nurses, Allied Health Professionals, Medical Assistants and Administrative Support |  | Provide a standard and reliable platform for testing facility for ongoing testing. |
| Covid-19 Testing | Increase resources to empower individuals to prevent and manage health issues and be active in the development and execution of their health plans. | Donor funding, private funding, State of Maine funding.  Clinical Resources and consulting partnerships. |  | External testing of large employers, front facing workers and AOS-19 school district  Public and Private support of asymptomatic and sentinel testing of staff, front facing workers and large employers to ensure the mitigation and detection of community spread of COVID-19 |
| Substance Use Disorder | Overcome obstacles to accessing healthcare and prevention resources. | Medical Director, MAT Provider | Provide Mental and Behavioral Health Services | Support and staff the DownEast Treatment Center |
| Integrated Care Team | Increase resources to empower individuals to prevent and manage health issues and be active in the development and execution of their health plans. | Health Coaches and Community Educators |  | Healthy Lifestyles Nutrition and exercises  Diabetes Prevention Education  Tobacco Cessation Education  Senior Exercise Sessions  Parkinson’s Exercise Programs  Weight Management  Stress Reduction education and techniques  Community Flu Vaccines |
| Integrated Care Team | Increase resources to empower individuals to prevent and manage health issues and be active in the development and execution of their health plans.. | Diabetes Nurse Educators |  | Diabetes education.  Diabetes Self-Management Education and Support classes.  Insulin pump education and support. |
| Integrated Care Team | Increase resources to empower individuals to prevent and manage health issues and be active in the development and execution of their health plans. | Certified COAG Nurse Educators |  | Anticoagulant Medication Management and educational support. |
| Integrated Care Team | Increase resources to empower individuals to prevent and manage health issues and be active in the development and execution of their health plans.. | Register Nurse Care Coordinators |  | Chronic Disease management and education support.  Medication management support and education.  Integrated plan of care  Referrals to community health resources and daily living resources  Advocacy support for health and daily living resources |
| Integrated Care Team | Increase resources to empower individuals to prevent and manage health issues and be active in the development and execution of their health plans. | Licensed Clinical Social Workers  (LCSW) |  | Social Service Support  Financial Assistance Navigation  Referrals to community health and daily living resources.  Advocacy support for health and daily living resources  Short Term Counseling  Transportation alignment support  Home Safety Assessments |
| Integrated Care Team | Increase resources to empower individuals to prevent and manage health issues and be active in the development and execution of their health plans.. | Integrated Care Team Registered Nurses |  | Hospital to Home visits  Telemonitoring Program  Chronic disease education and management  Medication reconciliation and education programs  Referrals to community health and daily living resources.  Patient advocacy  Home Safety Assessments |
| Cancer Patient Navigator Program | Increase resources to empower individuals to prevent and manage health issues and be active in the development and execution of their health plans. | Registered Nurses and Licensed Social Workers |  | Cancer screening education  Education, support, and guidance throughout the continuum of cancer care.  Patient and family advocacy. |
| Palliative Care Program | Overcome obstacles to accessing healthcare and prevention resources.  Provide access and resources for individuals to manage health issues and focus on prevention. | Palliative Care Team |  | Improvement in quality of life for patients with life limiting illnesses.  Prevention and relief of physical, social, and spiritual aspects of suffering.  Symptom management and support.  Goals for care and quality of life aspirations.  Advanced Directive Education and Assistance with completion.  Advocacy for patient care and access.  Financial and Social Services support. |
| Outpatient Quality Improvement Team | Breast Health | 3-D Mammography  Beacon-ACO Comparatives and resources |  | State of Maine Partnership to promote employee breast health |
| COVID-19 Community Vaccine Efforts |  |  |  |  |
| Outpatient Quality Improvement Team | Colorectal Health | MDI Health Centers |  | Exceed benchmark standards |
| MDI Behavioral Health Center | Access Improvements |  | Explore additional resources necessary to improve access to Behavioral Healthcare, embedded care in Primary Care Practices, and Telehealth Services. |  |
| MDI Health Centers | Telehealth Services | Internal development of programs and access | MRHC Collaboration for specialty services |  |
| MDI Behavioral Health Center | Medical Director- Acadia Family Center | Psychiatrist | Provide resources committed to the provision of mental healthcare and wellbeing in the MDIH service area. |  |
| MDI Hospital | Educational Materials, Forums, and Classes  Downeast COVID-19 Task Force | Health Coaches online classes,  Social Media Awareness Campaigns |  | Integrated Care and Public Affairs, OB Department, Prevention communications focused on COVID-19 |
| MDI Hospital | Educational Town Halls | Public Health Expertise, Epidemiology Expertise, Infection Prevention, Psychiatry, and Integrated Care Management. |  | Information sessions for community to develop an understanding or the disease, mitigation of spread and prevention measures. Information sessions on coping with COVID-19 for physical and mental health effects. |
| MDI Hospital | Recovery Coaching | Partnership with AmeriCore/Healthy Acadia and MDIH |  | MDI Behavioral Health Center |
| MDI Hospital | Certified Application Counselors | Internal resources trained to assist with finding resources and health insurance |  | Patient Access |
| MDI Hospital | 1st Dose Program | Providing Subutex to patients seeking recovery |  | Emergency Department Team |
| Pricing Transparency | Public facing Pricing tools in association with payer contracts, machine readable pricing database | Patient Access, Revenue Cycle,  External resources |  | To make available MDIH pricing information on our public website with a price estimation tool |
| Accountable Care Organization  Quality Program | Quality and Value based initiatives | Northern Light Beacon ACO |  | Exceed Meaningful Use Metrics, Value Metrics, QHIP and Leapfrog . Continue to reduce variation, readmissions less that XX%. |

**2-Theme Two: Mental Health and Community Connectedness**

*Theme Two Guiding Question:* **How can we promote and increase access to quality mental health resources and to positive social environments that facilitate a sense of connectedness for all?**

* **Additional Covid-19 Considerations**

Impacts of the Covid-19 pandemic are extensive and not fully clear at the time of this publication. The virus has caused or exacerbated numerous challenges to mental health and community connectedness in the LSA and has also brought about or highlighted several strengths related to mental health and community connectedness in the LSA.

*Goal 1:* Increase awareness about available mental health resources and social opportunities.

*Goal 2:* Make mental healthcare more affordable.

*Goal 3:* Overcome obstacles to accessing mental healthcare and prevention resources.

*Goal 4:* Increase resources to empower individuals to prevent and manage mental health issues and be active in the development and execution of their mental healthcare.

*Goal 5:* Increase access to safe, positive social environments and spaces, and opportunities for positive social engagement for all.

| **Implementation** | **Theme Goal(s)** | **Resources** | **Strategic** | **Operational** |
| --- | --- | --- | --- | --- |
| Media Campaign | Increase awareness about available mental health resources and social opportunities. | Social Media, Town Hall Forums,  Profile providers in local media platforms. |  | Awareness of programs, providers, resources  Continue the provider profiles, highlight access to services and resources. |
| Access to Licensed Clinical Social Workers | Increase resources to empower individuals to prevent and manage mental health issues and be active in the development and execution of their mental healthcare. | LCSW and Integrated Care Management |  | Provision of care within our Primary Care Network for counseling and connectivity  Increase access to clinicians embedded in MDIH Primary Care Health Centers to provide services, counseling, and support for social and mental healthcare needs. |
| Downeast Substance Use Treatment Network | Overcome obstacles to accessing mental healthcare and prevention resources | Economic support and provision of clinical staff |  | Continued efforts to improve access, reimbursement, and awareness for treatment options. |
| Diversity, Equity, and Inclusivity Program | Increase resources to empower individuals to prevent and manage mental health issues and be active in the development and execution of their mental healthcare. | External expertise on culture awareness and education.  Internal sponsor and steering committee. | Develop a program built on education, understanding, accountability and culture.  Create an internal awareness and understanding of DEI among leadership, governance, and medical staff. |  |
| Mental Health Awareness | Increase resources to empower individuals to prevent and manage mental health issues and be active in the development and execution of their mental healthcare. | Licensed Clinical Social Workers | Develop partnerships and funding sources to accommodate embedded integrated *se*rvices. |  |
| Mental Health Resources | Overcome obstacles to accessing mental healthcare and prevention resources | Using telehealth or MRHC Partnerships to access Child and Adolescence Psychiatry Services | Develop a framework of resources, inventory needs and develop funding models for provision of service.  Evaluate Child and Adolescence Psychiatry |  |
| Advocate for Mental Health Coverage and Reimbursement | Overcome obstacles to accessing mental healthcare and prevention resources | Using the MRHC, MHA and AHA Promote |  | Advocate for improved access and reimbursement to providers in a sustainable way. |
| Community Engagement Campaign | Increase awareness about available mental health resources and social opportunities. | Partnerships with Health Acadia, AOS-91 and MDIH |  | Develop awareness campaign with engaged community members and spokespersons |
|  |  |  |  |  |

**3-Theme Three: Social Determinants of Health**

*Theme Three Guiding Question:* **How can we promote positive social, economic, and environmental conditions that encourage health and well-being for all?**

* **Additional Covid-19 Considerations**

Impacts of the Covid-19 pandemic are extensive and not fully clear at the time of this publication. The virus has caused or exacerbated numerous challenges to social determinants of health in the LSA, including health disparities, food insecurity due to remote learning and has also brought about or highlighted several strengths related to social determinants of health in the LSA.

*Goal 1:* Increase awareness of available positive social, economic, and environmental resources.

*Goal 2:* Foster a culture of civic engagement and volunteerism.

*Goal 3:* Increase access to safe, positive social environments and spaces, and opportunities for positive social engagement for all.

*Goal 4:* Increase access to positive employment and economic conditions for all community members.

*Goal 5:* Increase access to affordable healthy food.

*Goal 6:* Increase access to physical activity.

*Goal 7:* Increase access to convenient, safe, and affordable transportation.

*Goal 8:* Increase efforts to reduce bias, discrimination, inequality, inequity, stigma, and shame.

*Goal 9:* Increase access to safe and affordable housing.

*Goal 10:* Increase awareness of household and community sustainability efforts and opportunities.

| **Implementation** | **Theme Goal (s)** | **Resources** | **Strategic** | **Operational** |
| --- | --- | --- | --- | --- |
| Leadership Team | Foster a culture of civic engagement and volunteerism. | Connecting with Community Groups | Engagement with leadership team to develop key goals of community interests and schedule events quarterly to “Step Up” initiatives. | Dedicated Civic and Volunteerism Projects  Acadia National Park Clean-up, community participation in Halloween events, American Red Cross Blood Drive, Marathon Medical Tent, & Community Flu Clinics. |
| Community Partnership with Good Shepard Food Bank | Increase access to affordable healthy food. | Public Affairs, Integrated Care Team, and RN’s within Health Centers at MDIH |  | Expand shelf stable food packets to those in need. Establish access to fruits and vegetables during the seasons.  Using Pilot Program at Community Health Center to expand to all health centers at MDIH. |
| Support local access to food through partnerships with food pantries | Increase access to affordable healthy food. | MDIH Facilities Department |  | Provide access to space during weekends for community members to have a central place for food distribution. |
| Social Calling Program | Increase awareness of available positive social, economic, and environmental resources. | Partnership with Healthy Acadia and MDIH Integrated Care Department |  | Calling community members to check in with them for connectivity and connectiveness  Outreach to community members who are feeling isolated due to the Pandemic and stay at home orders |
| Promote physical activity | Increase access to physical activity. | Integrated Care Department |  | Develop awareness campaign of local resources and community health coaches at MDIH  Continue to advocate for community health programs, partner with the Schools, YMCA, and Healthy Acadia for healthy options both virtually and in person. |
| Reduce inequity, bias, stigma, and shame. | Increase efforts to reduce bias, discrimination, inequality, inequity, stigma, and shame. | Leadership Team, Board, and External Consulting | Implement an awareness and education campaign for MDIH/BBRV about Diversity, Equity, and Inclusion. |  |
| Community COVID-19 Testing Access | Increase awareness of available positive social, economic, and environmental resources. | COVID-19 Testing Pavilions |  | Provide resources to test community members no matter their financial status, health status or locality. |
| Educational Campaign – Remove stigma of COVID-19 | Increase efforts to reduce bias, discrimination, inequality, inequity, stigma, and shame.. |  |  | Promote awareness to testing, prevention and access to care without bias or disparities. |

**4-Theme Four: Substance Use**

*Theme Four Guiding Question:* **How can we reduce stigma and promote and increase access to quality substance use disorder prevention, treatment, and recovery resources?**

* **Additional Covid-19 Considerations**

Impacts of the Covid-19 pandemic are extensive and not fully clear at the time of this publication. The virus has caused or exacerbated numerous challenges to substance use disorder prevention, treatment, and recovery in the LSA and has also brought about or highlighted a number of strengths related to substance use disorder prevention, treatment, and recovery in the LSA.

*Goal 1:* Increase awareness about available substance use disorder prevention, treatment, and recovery resources.

*Goal 2:* Make substance use disorder prevention, treatment, and recovery resources more affordable.

*Goal 3:* Overcome obstacles to accessing quality substance use disorder prevention, treatment, and recovery resources.

*Goal 4:* Reduce risks and substance use in the community.

*Goal 5:* Increase resources to empower individuals to prevent and manage substance use disorders and be active in the development and execution of their treatment plans and recovery.

| **Implementation** | **Theme Goal (s)** | **Resources** | **Strategic** | **Operational** |
| --- | --- | --- | --- | --- |
| DownEast Treatment Center Support | Overcome obstacles to accessing quality substance use disorder prevention, treatment, and recovery resources. | Clinical MAT Provider and Medical Directorship | Advocate for continued regional support of treatment for substance use and Medication Assisted Therapy**.** Continued support of the access to substance use treatment. |  |
| MDIH Medical Staff Commitment to Substance Use Treatment as spokes | Make substance use disorder prevention, treatment, and recovery resources more affordable.  Overcome obstacles to accessing quality substance use disorder prevention, treatment, and recovery resources. | Promote primary care clinicians to support and become certified for care provision of medication assisted therapies. |  | Developing primary care network of spokes to manage patients in recovery for medication assisted treatment. |
| Naloxone Distribution | Increase resources to empower individuals to prevent and manage substance use disorders and be active in the development and execution of their treatment plans and recovery. | Pharmacy, Public Affairs, Health Centers, Emergency Department | Promote and provide access to substance use disorder prevention and recovery, promoting and providing Naloxone to patients, families, and community in partnership with the State of Maine. |  |
| 1st Dose Program |  | Emergency Department, Downeast Treatment Center |  | Promote recovery through 1st Dose of Subutex through ED  Provide the 1st Dose of Subutex to patients seeking recovery through MDIH Emergency Department |
| Opioid Stewardship | Reduce risks and substance use in the community | Pharmacy, Medical Staff, Health Centers |  | Create an Opioid Stewardship Program at MDIH that develops an awareness of Opioid Stewardship, education and alternatives among our community and medical staff, led by MDIH Pharmacist. |
| Recovery Coaching | Increase resources to empower individuals to prevent and manage substance use disorders and be active in the development and execution of their treatment plans and recovery. | MDIH Emergency Department and Health Centers in partnership with Healthy Acadia | Commence, promote, and expand MDIH Recovery Coach Program Increase resources to empower individuals to prevent and manage substance use disorders and be active in the development and execution of their treatment plans and recovery. |  |
| DownEast Substance Use Treatment Network | Reduce risks and substance use in the community | MDIH Leadership Team |  | Continue to actively support and participate in Network Meetings to promote regional access to treatment, funding, and advocacy. |
| Advocate for improved reimbursement for services and | Reduce risks and substance use in the community | Leadership Team, Governance, Advocacy & Local Representation. |  | Explore the continued awareness and advocacy for access and improved reimbursement for mental healthcare and substance use disorders. |
| Alcohol Use Disorder | Access to treatment and resources for treatment and recovery. | Clinical resources, Integrated Care Team and Community Outreach. |  | Support community efforts for AA Meetings and education tools for patients and families. |
| Tobacco Use Disorder | Increase awareness about available substance use disorder prevention, treatment, and recovery resources. |  |  | Health Coaches trained in providing cessation services to patients and community.  Quality Metrics to measure tobacco use |
| Behavioral Health Room- Emergency Department | Increase resources to empower individuals to prevent and manage substance use disorders and be active in the development and execution of their treatment plans and recovery. | Emergency Department Team |  | Develop a “safer room” that functions for patient in crisis to be provided a safe space, harm free that is an environment for compassionate and respectful care. |
| Behavioral Health Services embedded in the Inpatient Multidisciplinary Teams | Increase resources to empower individuals to prevent and manage substance use disorders and be active in the development and execution of their treatment plans and recovery. | MDI Behavioral Health Center Care Teams |  | To embed within the multidisciplinary approach to comprehensive care for our inpatients access to mental and behavioral health specialists for effective patient care. |
| MDI Behavioral Health Center | Increase resources to empower individuals to prevent and manage substance use disorders and be active in the development and execution of their treatment plans and recovery. | MDI Hospital economic support and workforce. | Explore further innovative access and recruitment of Psychiatrist, counselors and specialist for mental healthcare and treatment options. | Embedded access to primary care providers to mental healthcare for their patients through “drop-in” visits during regular primary care encounters, promoting seamless transitions of care and warm handoffs. |
| Embedded Counseling within MDI Health Centers | Increase resources to empower individuals to prevent and manage substance use disorders and be active in the development and execution of their treatment plans and recovery. | Licensed Clinical Social Worker’s |  |  |

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# **MDI Hospital Implementation Process**

1. Convene Implementation Steering Committee
   1. Cross representative of the organization and community
      1. Leadership
      2. Integrated Care
      3. Financial
      4. Clinical
      5. Public Affairs
      6. Employee Welfare
2. Review Plan Summary
   1. Prioritize goals
      1. Alignment with Mission, Vision and Values of MDIH
3. Inventory
   1. Strategic Goals
   2. Operational Goals
4. Identify current initiatives, relationships and systems that align with CHNA Strategies
5. Develop Implementation Plan
   1. Establish routine meeting schedule
   2. Timelines & Deliverables
   3. Responsible Team Members
   4. Process Checks
6. Reporting Plan and Publication Timeline
   1. Planning Committee
   2. Public Website

1. [↑](#footnote-ref-1)
2. [↑](#footnote-ref-2)
3. [↑](#footnote-ref-3)
4. [↑](#footnote-ref-4)