

Community Health Needs Assessment Implementation Plan

October 1, 2019 – September 30, 2021

Memorial Hospital



Memorial Hospital
MaineHealth



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**.

2018 Community Health Needs Assessment reports for all MaineHealth hospitals can be found here: <http://www.mainehealth.org/chna>

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

- Mental Health
- Substance Use
- ☐ Obesity Prevention
- ☐ 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, family birthing center, sleep center, wound care center, and the Miranda Center for Diabetes. Physician practices include primary care and family medicine, women's health, orthopedics and sports medicine. The Merriman House, a 45-bed nursing home specializing in Alzheimer's and other memory disorders, is also located on the hospital campus. Together, our staff and providers are committed to meeting the health needs of the Mt. Washington Valley and surrounding communities by collaborating with community partners in the delivery of accessible, comprehensive, compassionate, and quality health care.

The MaineHealth System

MaineHealth is a not-for-profit integrated health system consisting of eight local hospital systems, a comprehensive behavioral healthcare network, diagnostic services, home health agencies, and more than 1,600 employed and independent physicians working together through an Accountable Care Organization. With more than 19,000 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 2018, the MaineHealth system provided \$477 million in community health programs or services without reimbursement or other compensation.

Implementation Plan for Community Health Needs Assessment 2019-2021

MaineHealth/Affiliate Hospital: Memorial Hospital

County: Carroll

Health Priority: Substance Use Disorder

Goal of Health Priority: To prevent and treat opioid use disorder (OUD)

Strategies for: Opioid Use Disorder	Resources/Responsible Party	Metrics/What are we measuring?	Partners/External Organizations	Year of Work (1-3)
Strategy 1: Increase access to treatment through Medical Assisted Treatment (IMAT)	Memorial Behavioral Health/Primary Care	New patients in (MaineHealth) IMAT program # providers .with x waivers # sites providing IMAT # patients seen by each provider # by site	External Primary Care Offices-Saco River Medical Group, White Mountain Community Health Center	Year 1 FY 20
Strategy 2: Implement peer recovery model	Memorial Behavioral Health/Primary Care/Emergency Department Grants IDN7 Funding	# peer recovery coaches # patients seen by peer coach	External Primary Care Offices-Saco River Medical Group, White Mountain Community Health, White Horse Addiction, Northern Human Services, North Country Health Consortium	Year 1 FY 20
Strategy 3: Increase awareness of NH Doorways Model	Memorial Behavioral Health, Primary Care, Emergency Department	# referrals made to the nearest Doorway for: - Treatment - Transportation - Housing	NH DHHS, C3PH, External Primary Care Offices	Year 1 FY 20 expand going forward
Strategy 4: Continue New Life Prenatal Program	Memorial New Life Program Team, Women's Health Primary Care Behavioral Health	# of pregnant women screened # of women participating and remaining in program, improved outcomes for infants (NAS, infants discharged to home, not removed by DHHS) # referrals from outside organizations	White Mountain Community Health Center, Area social service supports including Healthy Families of America, Children Unlimited, NHS,	Year 1 FY 20
Strategy 5: . Increase capacity to provide Tobacco Cessation consults to Inpatient Population	Population Health, Memorial Primary Care, Respiratory Health, Heart, Health & Wellness	# staff trained to provide tobacco consults # patients referred	MaineHealth Tobacco	Year 1 FY 20

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Strategies for: Opioid Use Disorder	Resources/Responsible Party	Metrics/What are we measuring?	Partners/External Organizations	Year of Work (1-3)
Strategy 6: Continue participation in Medicaid 115 waiver initiative to maintain coordinated alliance and awareness of services	Population Health, Memorial Behavioral Health	# community outreach contacts through events, PSA's or marketing # of services provided in community through collaborative efforts	Northern Human Services, White Horse Addiction, Children Unlimited, C3PH, Saco River Medical	Year 1 FY 20 Continued FY 21
Strategy 7: Reduce and identify causes of OUD stigma for providers and health care workers through regional stigma reduction training program	Population Health	Implementation of regional awareness training # of trainings	Carroll County SUD Prevention Workgroup, White Horse Addiction, Northern Human Services, MWV Supports Recovery, Community Health Collaboration, SAU9, SAU13, Law Enforcement	Year 1 FY 20 start Expand FY 21

*MaineHealth System Quality Dashboard measure

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MaineHealth/Affiliate Hospital: Memorial Hospital

County: Carroll

Health Priority: Mental Health

Goal of Health Priority: To improve integration of mental and physical health to improve overall health.

Strategies for: Opioid Use Disorder	Resources/Responsible Party	Metrics/What are we measuring?	Partners/External Organizations	Year of Work (1-3)
Strategy 1: Identify and develop access to mental health for youth	Population Health, SAU9, SAU13, Memorial Behavioral Health/Primary Care	School site based support i.e. school based clinicians	SAU9, Memorial Behavioral Health/Primary Care, Northern Human Services, White Mountain Community Health Center	Year 1 FY 20
Strategy 2: Build community capacity including schools to address ACES/trauma through community collaboration of programs	Population Health, Memorial Behavioral Health/Primary Care	# school, # of students, # of administrators/teachers trained, # sites offering trauma informed programs	SAU9, SAU13, Community Health Collaborative, Faith Based Organizations, C3PH	Year 1 FY 20 expand FY 21
Strategy 3: Screen patients 0-17 with 2 question trauma screener at well child visits	Memorial Primary Care/Behavioral Health	# of patients 0-17 screened		Year 1 FY 20
Strategy 4: .Raise awareness of ACEs and Resiliency in collaboration with community partners for parents? a. 1 community outreach event per quarter	Population Health, Memorial Behavioral Health/Primary care	# of outreach events executed # people reached	Community Health Collaborative, SAU9, Faith-Based Organizations, MaineHealth	Year 1 FY 20
Strategy 5: Increase staff & community mental health stigma education	Population Health, Memorial Behavioral Health/Primary Care,	# staff trained at hospital # staff trained at external organizations	External Primary Care Offices-Saco River Medical and White Mountain Community Health Center, Community Health Collaborative,	Year 1 FY 20
Strategy 6: Increase access to Mental Health emergency care	Memorial Behavioral Health	# APRN visits in ED # patients seen by NHS mental health worker # of patients treated # of patients receiving services from Memorial Patient Navigator (social services)	Maine Behavioral Health	Year 1 FY 20

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Health Priority: Healthy Eating Active Living (HEAL) / Obesity Prevention

Goal of Health Priority: Decrease the prevalence of obesity

Strategies for: HEAL/ Obesity Prevention	Resources/Responsible Party	Metrics/What are we measuring?	Partners/External Organizations	Year of Work (1-3)
Strategy 1: Decrease % of patients with HbA1c. > 9.0	Memorial Primary Care	% of patients with HbA1c. >9.0		
Strategy 2: 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	Population Health, Diabetes Center, Memorial Primary Care	Number of classes offered in region	MaineHealth, MWV Community Health Collaborative, Welfare Offices, Local Food Banks	Year 1 Year 1 and 2
Strategy 3: Improve provider referrals to NDPP	Population Health, Diabetes Center, Memorial Primary Care	Increase # of provider referrals through EPIC		Year 1
Strategy 4: Increase NDPP participant completion meeting CDC-established program outcomes	Population Health, Diabetes Center	# patients meeting program outcomes 80% completion rate of total class population	MaineHealth Center for Health Improvement	Year 1 and 2
Strategy 5: Increase % of patients screened for food insecurity at annual well child visits	Memorial Primary Care, Behavioral Health and Specialty Practices	# referrals to resources and referrals to NH Food Bank/Local Pantries # referrals referred to food resources and education (SNAP ED, WIC, Cooking Classes) # food bags provided to patients	Community Health Collaboration, Welfare Offices, Local Food Banks, SNAP, SAU9, SAU13	Year 1 and 2
Strategy 6: Continue WOW! partnership to maintain comprehensive on-site offerings	Population Health	# classes offered # of employees participating in programming	Community Health Collaboration, Various Wellness/Fitness Vendors within region	Ongoing

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Strategies for: HEAL/ Obesity Prevention	Resources/Responsible Party	Metrics/What are we measuring?	Partners/External Organizations	Year of Work (1-3)
Strategy 7: Continue to track Let's Go! to meet annual goals	Population Health	# sites continuing, # new sites (school, OOS, childcare)	SAU9, SAU13, Carroll County Early Childcare Coalition, Chamber of Commerce	Ongoing
Strategy 8: Expand Let's Go! outreach to include (5) provider based education visits/events at LG! sites or in community	Population Health, Memorial Primary Care, Specialty Practices	# outreach contacts by providers		Year 1 and 2
Strategy 9: Maintain and/or expand wellness program offerings to meet needs for adult/child population <ul style="list-style-type: none"> a. Year round fitness classes b. Year round health education, stress management, mindfulness and nutrition workshops 	Population Health	# classes offered # workshops offered # participants (adult/child) % of provider referrals through EPIC	Community Health Collaboration, Various Wellness/Fitness Vendors within region, SNAP/Nutrition Connections	Ongoing Year 2
Strategy 10: Train primary care practice on Small Steps and that by 12/31/19 program is implemented	Let's Go! Healthcare Team, Population Health	# staff is trained on Small Steps program # program implemented by 12/31/19		Year 1

*MaineHealth System Quality Dashboard measure

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MaineHealth/Affiliate Hospital: Memorial Hospital

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Health Priority: Healthy Aging

Goal of Health Priority: To improve overall health of aging population to age in place through early diagnosis, preventative education and planning

Strategies for: Healthy Aging	Resources/Responsible Party	Metrics/What are we measuring?	Partners/External Organizations	Year of Work (1-3)
Strategy 1: Expand capacity for Advanced Care Planning in region	Population Health	1-Train 8-10 Memorial Employees as Respecting Choices facilitators to identify patients, initiate and/or facilitate conversation 2-Provide at least one POLST training to staff and community partners 3-Build Population Health referral workflow in Epic 4-Metrics-Track referrals, # of Advanced Directives completed, survey facilitators 6 month after completing course	Visiting Home Care & Hospice of Carroll County, Community Health Collaborative, MaineHealth, Saco River Medical Group	Year 1 FY 20
Strategy 2: Expand capacity as Dementia Capable/Friendly community	Memorial Elder Health Services-Adult Day Center, Population Health	1-Increase early identification of Mild Cognitive Impairment and dementia 2-Provide resources and support for early intervention and treatment 3-Increase referrals and participation in Adult Day Center (ADC) 4-Identify and implement strategies to support caregivers and decrease caregiver stress 5-Track outcomes/benefits of attendance dependent on program offered	Visiting Home Care & Hospice of Carroll County, Community Health Collaborative, Saco River Medical Group, Gibson Center for Senior Services, ServiceLink Resource Center (SLRC), Betty Ketchum Foundation, Carroll County Coalition for Public Health,	Year 1 Fy 20 with further expansion continuing forward
Strategy 3: Increase community education related to Aging	Population Health, Memorial Elder Health Services-Adult Day Center	1-Track number of community events, programs and strategies 2 Expand Caregiver Expo (2 nd annual) and measure attendance	VNS, Community Health Collaborative, SLRC, Alliance for Healthy Aging, Alzheimer's Association,	Year 1

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Strategies for: Healthy Aging	Resources/Responsible Party	Metrics/What are we measuring?	Partners/External Organizations	Year of Work (1-3)
Strategy 4: Identify & Train Staff for Serious Illness Conversation Program	Population Health, Memorial Primary Care, ED, and Specialty Practices	1-Track number of trained facilitators 2-Track patient outcomes	External Primary Care Offices-Saco River Medical Group, White Mountain Community Health Center, Visiting Home Care & Hospice of Carroll County, Community Health Collaborative	FY end 20 and FY 21
Strategy 5: Begin development of formalized multidisciplinary Palliative Care Program	Population Health, Oncology, Primary Care	1-Identify and develop team 2-Develop written formal program with roles and responsibilities, goals, strategies, timelines	MaineHealth, VNS	FY 20 Year 1
Strategy 6: Maintain Falls Prevention Program to decrease % of falls in region	Population Health, Memorial Primary Care, Emergency Department	# classes offered in region % of participants completed program	Community Health Collaborative, External Primary Care Offices-Saco River Medical Group, White Mountain Community Health Center, community organizations	
Strategy 7: Increase Matter of Balance Coaches and Master Trainers in region to ensure capacity	Population Health	# newly trained coaches # train 1-2 new master trainers	MaineHealth Healthy Aging	FY 20 Year 1
Strategy 8: Execute chronic disease management program for 50+ population	Population Health, Memorial Primary Care	# trained coaches Train 1-2 master trainers by 8/30/2021 # classes offered (goal: 4 per year) # participants completing program	Community Health Collaborative, Spectrum Health/MaineHealth	FY 20 Year 1
Strategy 9: Expand involvement in AARP Age Friendly Community Initiative	Population Health	1-Achieve SMART community goals related to health identified in Plan. Goals include increase utilization of REAP and Good Morning program, expand Music and Memory, use of identified age friendly walking trails, support HomeShare initiative,	Community Health Collaborative, Gibson Center	

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Strategies for: Healthy Aging	Resources/Responsible Party	Metrics/What are we measuring?	Partners/External Organizations	Year of Work (1-3)
Strategy 10: Continue 50+ Fitness Offerings	Population Health	# 50+ classes offered # participants completing classes	Community Health Collaborative, Gibson Center	

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Health Priority: PRIORITIES NOT SELECTED

Goal of Health Priority: N/A

Priority:	Reason not chosen:
Priority 1: Housing	While the need for more affordable housing, housing for older adults and transitional housing for those with mental health and/or substance use disorders has been identified as a need within the region this was not selected based on other community organizations that are already addressing the issue. The scope of this work is best led by these organizations with the expertise to address and we are working closely with them to provide collaborative support and assistance.
Priority 2: Transportation	Understanding the rural landscape of the region with a lack of public transportation and many individuals without a personal vehicle which makes it difficult for individuals to access medical care we have chosen not to select this issue as a priority. However, we have addressed access to care issues with alternative routes of access, i.e. community based, development of online delivery and work very closely with regional and local organizations focused on transportation.