Update on Selected Priorities and Activities since the 2016 Community Health Needs Assessment - Penobscot County

In response to the 2016 Community Health Need Assessment (CHNA) along with community input, hospitals and local districts developed their own three-year strategies and plans. Below are these organization's updates on their selected priorities and activities since the 2016 Community Health Needs Assessment. One full year of implementation has taken place to date in 2017, 2018 implementation work is currently underway with 2019 work on the horizon for implementation activity on these identified priorities.

For a number of organizations listed in this document priority work spans across multiple counties throughout Maine though their physical location may be in one county.

Priority	Activities	Partners	Key Accomplishments
Organization – **Penquis District Public Health Improvement Plan**			
Drug & Alcohol Abuse, Tobacco Use	In 2017, no applications were received for work in this area	Not applicable	Not applicable
	In 2018, no funding for this goal in 2018	Not applicable	Not applicable
Food Security, Obesity, Physical Activity, & Nutrition	In 2017, 1. Collaborated with established school, community, and worksite garden partners to construct modular greenhouses and integrate an evidence-based gardening curriculum within Penobscot county. The project focused on food insecure population. 2. Constructed three raised vegetable gardens in strategic partner locations where the population is low-income and food insecure; support committees of affected community members to lead and tend to each garden; organize workshops to teach skills associated with gardening, cooking/preserving, and shopping for healthy food on a fixed budget; develop leadership at each garden site so that each garden can sustainably continue and be more autonomous. 3. Sustained the Giving Hope Garden, a 15-raised bed organic garden in Bangor, Maine. This project will provide nutritious produce and food security to vulnerable populations in the broader Bangor community	1. Sebasticook Valley Health, Bangor Public Health and Community Services, Penquis DCC 2. Food AND Medicine, Bangor Public Health and Community Services, Penquis DCC 3. PCHC, Food AND Medicine, Bangor Public Health and Community Services, Penquis DCC	1. Constructed six modular greenhouses and integrated the Edible School Yard curricula at school and community locations. 2. Constructed and planted three raised vegetable gardens; Supported committees of 3-8 to lead each garden project. 3. Developed a sustainable garden plan at the Hope House.
	In 2018, funding was not available for this goal in 2018. The District Coordinating Council worked with an intern to develop an eco-map that demonstrated the connections of all the food work going on in five distinct regions in Penobscot and Piscataquis county.	Bangor Public Health and Community Services and the Penquis District Coordinating Council	Completed eco-map for food related work including names, locations, connections.
Poverty	In 2017, this goal was integrated into the work of the other goals as there was no funding to address the topic.	Not applicable	Not applicable
	In 2018, this goal was integrated into the work of the other goals as there was no funding to address the topic.	Not applicable	Not applicable

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Priority	Activities	Partners	Key Accomplishments
Access to Behavioral Health/Mental Healthcare	In 2017 1. Increased education and access to behavioral health resources by creating a behavioral health resource guide for the Sebasticook Valley region. 2. Offered Mental Health First Aid Trainings to increase awareness and deliver concrete skill-building opportunities to the residents of Penobscot and Piscataquis Counties. The project aimed to certify residents in this national, evidence-based training and includes the provision of both the Adult and Youth models.	1. Sebasticook Valley Health, Bangor Public Health and Community Services, Penquis DCC 2. NAMI, Bangor Public Health and Community Service, Penobscot Nation, Penquis DCC	1. Inventory existing behavioral health resources. Created local resource guide; printed and distributed guide. The Guide distributed at the following locations: Schools, Civic organizations, Primary Care and specialty provider offices, and behavioral health providers 2. Conducted eight Adult and/or Youth Mental Health First Aid Trainings in Piscataquis and Penobscot Counties. One training occurred at the Penobscot Nation.
	In 2018, no funding for this goal was available	Not applicable	Not applicable
Additional information on the Penquis District Public Health Improvement Plan priority activity can be found at: http://www.maine.gov/dhhs/mecdc/public-health-systems/lphd/district6/district-public-health-improvement-plan.shtml Contact: Jessica Fogg, Penquis District Public Health Liaison 207-561-4421 or Jessica.Fogg@maine.gov			
Organization - **Acadia Hospital**			
Drug and Alcohol Abuse	In 2017, Acadia Hospital prepared and trained two to four primary care providers to start delivering Suboxone to patients in their practices.	City of Bangor ,Eastern Maine Medical Center, St. Joseph Hospital	Upon completion of the Suboxone certification, providers started treating patients.
	In 2018 , Acadia Hospital will focus on increasing the number of patients served in Suboxone Daily Dosing Program.	Outreach at this time has not been needed as there is a steady stream of referrals for this program.	Results available at the end of the year and posted on our Progress Report to Our Community.
Mental Health, and Access to Behavioral Care/Mental Healthcare	In FY17, Acadia Hospital engaged in ongoing emergency department tele-psychiatry evaluations, integrated care encounters and tele-psychiatry to home through Acadia's Restorative Health practice	EMMC's Internal Medicine & Family Medicine, Pediatrics and Cancer Care of Maine , Blue Hill Memorial Hospital, Sebasticook Valley Health Family Care, Mercy Hospital, Charles A. Dean Memorial Hospital, Inland Hospital, Maine Coast Memorial Hospital, Down East Community Hospital, Bucksport Regional Health Center, Katahdin Valley	During FY17, Acadia Hospital was able to bring more integrated sites and emergency departments on board for this initiative.

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Mental Health, and Access to Behavioral Care/Mental Healthcare	In FY18, Acadia Hospital is working to increase the number of people who receive behavioral health and substance abuse services in Maine through tele-psychiatry appointments and behavioral health integrated encounters and telemental health encounters.	15 rural hospital emergency departments, 21 primary care practices from eight organizations.	Results will be available at the end of the fiscal year and posted on our Progress Report to Our Community.
Additional information on Acadia Hospital's priority activity can be found at: http://www.emhs.org/Community-Benefit/CHNA/2016-EMHS-Community-Health-Strategies.aspx Contact: Rick Redmond, Associate Vice President of Access and Service Development, Acadia Hospital 207-973-6811 or rredmond@emhs.org			
Organization - **Bangor Public Health and Community Services**			
Additional information on Bangor Public Health and Community Service's priority activity can be found at: http://www.bangorpublichealth.org/ and http://www.bangormaine.gov/ Contact: Patricia Hamilton, Public Health & Community Services Director, 207-992-4550 or patty.hamilton@bangormaine.gov Jamie Comstock, Health Program Manager, 207-992-4466 or jamie.comstock@bangormaine.gov			
Organization - **Beacon Health**			
Information on Beacon Health's priority activity can be found at: http://www.emhs.org/Community-Benefit/CHNA/2016-EMHS-Community-Health-Strategies.aspx Contact: Jaime Rogers, Director of Community Care Services and Behavioral Health, Beacon Health 207-973-6491 or jbrogers@emhs.org			
Organization - **Eastern Maine Medical Center (EMMC)**			
Substance Use Disorder	In Fiscal Year 2017 (FY17) , Eastern Maine Medical Center (EMMC) looked to increase the number of primary care practices that have fully implemented prescribing protocols	EMMC shared ideas with Community Health Leadership Board members as the project rolled out.	EMMC ensured all providers were educated and enrolled in the prescription monitoring program database.
	In FY17 , EMMC to complete full evaluation of post-procedure prescription practices in specialty practices and identify improvement tactics to implement in FY17 and FY18.	EMMC partnered with the Community Health Leadership Board (idea sharing) for this priority.	Discussions have occurred between the chief medical officer and service chiefs. Together, they have developed a better understanding of current state. Chiefs have had discussions with their surgeons, and they have brainstormed ideas.
	In Fiscal Year 2018 (FY18), EMMC will develop specific, measurable, realistic goals for tracking that will be put into place to ensure continued compliance.	Community Health Leadership Board (idea sharing)	Results will be available at the end of the fiscal year and posted on our Progress Report to Our Community.

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Priority	Activities	Partners	Key Accomplishments
Obesity	In FY17 EMMC revamped their cafeteria menu to emphasize the Mediterranean diet characterized by high consumption of plant-based foods, whole grains, nuts, and legumes	EMMC enhanced partnerships with local foodservice vendors.	Successful completion of project to implement new menu.
	In FY18, EMMC is working to remove all beverages that have 40 or more calories per serving from all State Street hospital campus-based foodservice and retail environments.	Pepsi, Lori's Gifts, Miller Drug, Casco Bay Vending	Results will be available at the end of the fiscal year and posted on our Progress Report to Our Community.
Health Literacy	In FY17, EMMC worked to increase the number of referrals from EMMC primary care practices, Beacon Health care managers, and EMMC Diabetes, Endocrine, and Nutrition practice to Literacy Volunteers of Bangor	EMMC partnered with Literacy Volunteers of Bangor.	Information was distributed to key points of service for patients, visitors, and primary care staff. EMMC accepted Literacy Volunteers of Bangor's 2017 Champion for Literacy Award for its efforts.
	In FY18, EMMC continues to work to increase referrals to Literacy Volunteers of Bangor	Literacy Volunteers of Bangor, Fox News and our practices	Results will be available at the end of the fiscal year and posted on our Progress Report to Our Community.
Additional information on Eastern Maine Medical Center's priority activity can be found at: http://www.emhs.org/Community-Benefit/CHNA/2016-EMHS-Community-Health-Strategies.aspx Contact: Helen McKinnon, Vice President, Support Services, Eastern Maine Medical Center 207-973-7842 or hmickinnon@emhs.org			
Organization - **Health Access Network (HAN)**			
Drug and Alcohol Abuse	In FY17, Health Access Network initiated a Medication Assistance Treatment program (MAT). The program integrated Medical services with Behavioral Health services in order to reduce substance use disorders.	Save-A-Life is a key partner	Education to the community regarding prevention and awareness.
	In FY18, Health Access Network, Penobscot Valley Hospital, and Save-A-Life expanded the MAT program services in the community by offering free trainings to individuals to become certified Recovery Coaches.	Save-A-Life and Penobscot Valley Hospital are key partners	Recovery Coach training
Obesity	In FY17, HAN initiated a educational program at all office visits with both Adult and Children focusing on Obesity and Health Nutrition awareness. Educational materials and resources were offered to all patients at risk and currently exceeding the recommended BMI levels.	Local food banks; school systems	Efforts to educate and provide health resources HAN was able to reduce Obesity rates by 10% among the patient population at risk between 2017/2018.
	In FY18, HAN maintained and reinforced educational program.	Local food banks; school systems	
Physical Activity and Nutrition	In FY17, HAN initiated a educational program at all office visits with both Adult and Children focusing on Obesity and Health Nutrition awareness. Educational materials and resources were offered to all patients at risk and currently exceeding the recommended BMI levels.	Local food banks and School systems	Due to efforts to educate and provide health resources HAN was able to reduce Obesity rates by 10% among the patient population at risk between 2017/2018.
	In FY18, HAN maintained/reinforced educational program	Local food banks; school systems	

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Mental Health	In FY17, Health Access Network increased it capacity to serve patients with Mental Health disorders by employing a 7th Behavioral Health Counselor and offering substance use disorder treatment.	Save-A-Life	Reduced waiting list from 80 patients to 60 patients.
	In FY18, Health Access Network purchased equipment to offer Tele-health services through Acadia Hospital for Psychiatric Medication Management and Counseling in order to address the needs of the community.	Acadia Hospital	Reduced waiting list from 120 patients to 50 patients.
Additional information on Health Access Network's priority activity can be found at: www.hanfqhc.org Contact: Nicole Morrison, Chief Executive Officer, Health Access Network 207-794-6700, and nmorrison@hanfqhc.org			
Organization - **Millinocket Regional Hospital (MRH)**			
Hunger/Food Security	In FY17, MRH began screening for food insecurity in the two Rural Health Clinics (Family Medicine and Primary Care Offices) and in the Emergency Department. Through the Community Health and Hunger Pilot Project, GSFB provided MRH emergency food bags to give patients self-reporting food insecurity. Thrive Penobscot developed a local food resource guide that is shared with patients.	Good Shepherd Food Bank (GSFB). Thrive Penobscot, a Thriving in Place(TiP) Collaborative funded by MeHAF.	Food Insecure patients are identified and provided with local resources .
	FY18 – Millinocket Regional Hospital has continued Screening for food insecurity in the established locations and has added the Walk- In Clinic in East Millinocket.	Same partners as in FY17	Food Insecure patients are identified and provided with local resources . Additional funding secured through GSFB to sustain efforts to provide emergency food bags for another year.
Obesity	In FY17, Classes held for families at local school – sponsored by MRH. MRH Lifestyle Changes Class, designed for people identified as having pre-diabetes or who are at risk for developing diabetes, open to public. MRH has maintained Gym and therapeutic pool with open membership.	Local Nutritionists, schools	Knowledge for families on how to create healthy menu/meals on a budget; Increased awareness and improvement in Physical Activity and Nutrition; Increased Physical Activity in Adults, and in High School Students; Increased Fruit and Vegetable Consumption.
	In FY18, MRH Display of LETS Go! 5-2-1-0 posters in waiting areas cafeterias and restrooms; Eliminated sugar drinks	Together with the Maine Hospital Association, participate in "Triple Aim" projects	Improve "Population Health" and create/increase awareness among patients, staff and visitors; Improve availability of Healthy Food.
Chronic Disease	In FY17, MRH offered the CDC's National Diabetes Prevention Program (NDPP) to community members.	Maine Diabetes Prevention and Control Program	MRH has 2 trained Lifestyle Change Coaches on staff to facilitate the NDPP.

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Chronic Disease	FY 18- Millinocket Regional Hospital offered the CDC's National Diabetes Prevention Program to community members.	Maine Diabetes Prevention and Control Program	MRH earned Full Recognition for the diabetes prevention program from the National Center for Disease Prevention & Health Promotion, CDC
Mental Health Services	In FY17, implementation of Community Care Partnership of Maine's screening protocol for depression.	Community Care Partnership of Maine, ACO and Medicare Shared Savings Program, and the Maine Rural Health Innovations Network (MRHIN)	Early detection and treatment of depression. Provides a Treatment plan option for patients and community.
	In FY18, development of a model for assessing and providing treatment options for Behavioral Health issues. (MRHIN)		
Access to Care	In FY17, establish walk-in available to care for all ages, clinic located in East Millinocket.		Increase presence in immediate service area; Increase access to care; decrease strain on Emergency Department Resources.
	In FY18 MRH implemented availability of same day appointments	All Primary Providers	Improved timely access to care – decrease unnecessary ED visits
Preventable Hospitalizations	In FY17, the Hospital has developed a process that includes assessing patients risk for readmission and implemented early follow up care for those at highest risk to be readmitted. (Using LACE tool)	MRH Clinical and Medical Staff with cooperation from all Primary Care offices in the area.	Decreased # and rate of readmissions
	In FY18, participation in Better Living – Better Breathing Program – providing support to COPD patients.	MRHIN Collaborative	Increased resources for Chronic Disease Patients and families
Maintain a Community Based Hospital	In FY17, joined an Accountable Care Organization (ACO) and Medicare Shared Savings Program. Partnered with 5 hospitals in collaborative to identify opportunities to save and share services and or service contracts. Made investments in Information Technology and Electronic Medical Record	CCPM, ACO and MSSP	Improved clinical outcomes, access to care, reduce costs, and patient' experiences of care. More efficiently keep track of quality metrics, deliver optimum care for patients, and capture charges and bill for services.
	In FY18, MRH continued to make large investments in Information Technology and Electronic Medical Record. Continued participation in ACO and the Collaborative	Health Centric Advisors, Evident, CMS	Improved competitive position and participation in MCR programs to prevent decreased reimbursement (MIPS)

Additional information on Millinocket Regional Hospital's priority activity can be found at:
www.mrhme.org
Contact: Missy Martin, Vice President of Quality, Millinocket Regional Hospital 207-723-5161 or mmartin@mrhme.org

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Priority	Activities	Partners	Key Accomplishments
Organization - **Penobscot Community Health Care (PCHC)**			
Drug & Alcohol Abuse, Tobacco Use	In FY17: Maintained Controlled Substance Initiative (CSI) committee, opened specialized recovery program/MAT for homeless individuals, opened specialized recovery program/MAT for incarcerated individuals, opened additional recovery programs/MAT in primary care sites and reduced wait time, maintained CHAMP program (for babies born effected by mother's substance use), continued to implement multi-organizational prescription protocol revisions, highly active member of CHLB (Community Health Leadership Board). Provided trainings to multiple PCHC and non-PCHC audiences around SUD, stigma, and "Addiction as a Brain Disease". Began pilot project around screening and brief intervention for SUD. Began hepatitis C screening and treatment initiative.	CHLB, Penobscot County Jail, State of Maine, Wellspring, Bangor Police Dept. (PD), Brewer PD, local parole officers, BARN, Attorney General Office, Penobscot County Sheriff, Health Equity Alliance, Maine Quality Counts, Maine Medical Association, DHHS, Maine Primary Care Association, variety of other health centers such as Sebasticook Family Doctors, Bucksport Regional Health Center, and Health Access Network, Maliseet Tribe, Micmac Tribe	Provided MAT to 300+ unique patients, over 100 educational outreach sessions presented by PCHC providers/leaders throughout community, increased number of waivered providers and number of patient groups offered.
	In FY18: Continued all of the above. In March Dr. Nesin announced a new program in which PCHC will provide naloxone prescriptions to any person in Maine requesting one. Provided naloxone to Transitions Team (clinical staff who go to patient homes and provide hospital follow-up services). Conducted numerous trainings in community re: naloxone administration. Collaborated on the opening of a social detox center, and PCHC providers conduct medical rounds at the center. Use of HIN predictive analytics tool to identify those in hospital or ER that had an overdose. Reviewing cases in Controlled Substance Stewardship Committee and trying to engage those patients in substance use disorder treatment.	Continued with all of the above	Year to Date (Jan – June) we have provided MAT to 424 unique patients, which already meets our projected goal for 2018.
Obesity	In FY17: Clubhouse facilitated InSHAPE program to improve wellness through nutrition and physical exercise. All primary care practices screen 2-17 year olds for BMI percentile and provide counseling on nutrition and exercise. Primary care sites screen adults for obesity, check BMI, and make BMI plan if overweight. Hired a dietician who provides assistance in weight management and travels to three sites to provide better access.		28 Clubhouse members participated in InSHAPE. 83% of children screened for BMI and counseled, 53% of adults screened for BMI and counseled if out of range.
	In FY18: All primary care practices continue to screen 2-17 year olds for BMI percentile and provide counseling on nutrition and exercise. Primary care sites continue to screen adults for obesity, check BMI, and make BMI plan if overweight.		85% of children screened for BMI and counseled, 57% of adults screened for BMI and counseled if out of range.

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Physical Activity & Nutrition	In FY17: Clubhouse facilitated InSHAPE program to improve wellness through nutrition and physical exercise. All primary care practices screen 2-17 year olds for BMI percentile and provide counseling on nutrition and exercise.		28 Clubhouse members participated in InSHAPE. 83% of children screened for BMI and counseled, 53% of adults screened for BMI and counseled if out of range.
	In FY18: All primary care practices continue to screen 2-17 year olds for BMI percentile and provide counseling on nutrition and exercise.		85% of children screened for BMI and counseled, 57% of adults screened for BMI and counseled if out of range.
Health care insurance	In FY17: Outreach & Enrollment Dept. assists people during open enrollment and throughout the year in obtaining insurance coverage. During open enrollment period we hire extra staff to assist.		
	In FY18: Continued activities listed above. Began running a report of all patients with no insurance who have a mental health diagnosis, then reaching out to those patients to assist them in signing up for MaineCare disability coverage. Also run report of those without insurance and reach out to them to assist in signing up for income-based MaineCare if they meet a certain income range.		511 people assisted in obtaining insurance during the open enrollment period of 2018.
Poverty	In FY17: PCHC serves individuals regardless of insurance or economic status (more than 35% of PCHC patients fall below 200% of Federal Poverty Guidelines). We offer assistance through our Affordable Care Program, Medication Assistance Program, and we have staff on hand to assist people with insurance applications. We provide emergency shelter as well as a transitional living program for homeless individuals, and a variety of other services. In 2017 we increased the number of housing navigator staff to help individuals find permanent housing and to support individuals in personal finances, finding employment, etc. PCHC expanded case management services to help assist patients-both children and adults. Care managers actively screen patients for social determinants of health and assist patients in overcoming these barriers and brokering services. Embedded LSW's in each practice.	PCHC participates in "Caring Connect" meetings in which a group of many organizations across the region meet monthly to review patients and identify potential resources to assist those patients.	Provided approx. $5million in uncompensated medical care via our Affordable Care Program. Pharmacy Dept. assisted patients in accessing over $3.5million in free medications via our Medication Assistance Program. Hope House served approx. 52,000 meals and provided emergency shelter to 624 individuals, totaling 22,725 bed nights.
	In FY18: Continued activities listed above.		As of Feb 2018 Hope House served almost 1500 meals per week.
Access to Behavioral Health/Mental Healthcare	In FY17: Hired a Pediatric Psych NP, continuing to hire additional LCSWs and Psych NPs across organization. Expanded mental health services in Seaport practice. Increased number of SUD counselors.		
	In FY18: Continue to recruit for more providers, as outlined above.		

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Employment	In FY17: PCHC is 6th largest employer in Penobscot County. Clubhouse program assists members in finding jobs and furthering education. Hope House navigators assist homeless or housing-insecure individuals in finding employment.		46 competitively paying jobs found for Clubhouse members. Provided 49 micro-scholarships for members to further their education.
	In FY18: Continued activities listed above.		
Additional information on Penobscot Community Health Care's priority activities can be found at: www.pchc.com Contact: Sarah Dubay, M.Ed., MMEL, Chief Communications and Public Affairs Officer, 207-249-2597, sdubay@pchc.com			
Organization - **Penobscot Valley Hospital**			
Substance Use	In FY17, PVH is designing and implementing and after care treatment policy to include available support systems for patients following inpatient care with PVH & HAN senior leadership teams and providers; Participate in Save a Life Task Force ; Monthly meetings between staff at HAN and PVH to identify issues and barriers; participated in grant with HAN to identify needs of community surrounding substance use	Health Access Network ; Penquis Regional Linking Project; Save a life Task Force; PVH Medical Staff; Partnership for a Healthy Northern Penobscot; Acadia Hospital; Lincoln Police dept.; F.A.C.T; NOE; Full Circle Wellness	Offered support for training of Save a life task force recover coaches
	In FY18, Continue to update prescribing policies; provide medical staff development and education on new prescribing law for both PVH & HAN providers; Participate in Save a Life Task Force; Continue monthly meetings between providers at HAN & PVH	Health Access Network ; Penquis Regional Linking Project; Save a life Task Force; PVH Medical Staff; Partnership for a Healthy Northern Penobscot; Acadia Hospital; Lincoln Police dept.; F.A.C.T; NOE; Full Circle Wellness	Identifying areas for the Recovery coaches from the save a life task force to integrate within the community as a resource; Obtained data from grant participation with HAN to use to identify next steps
Obesity	In FY17, PVH offers community fitness center and independent gym to the public for a nominal monthly fee; Created free Healthy Me weight loss program to teach the community about healthy eating and safe exercising; worked with HAN to disseminate 5210 Let's Go materials; PVH provides healthy meals for patients and staff in the cafeteria; PVH collects healthy food items for the Lincoln Regional Food Cupboard's weekend backpack program; participates with the THRIVE Penobscot activities; participated in RSU #67 Wellness Fair and offered free screenings for diabetes and fitness challenges.	HAN; THRIVE; Lincoln Regional Food Cupboard; RSU #67; SAD 31 & 30	Promoting community fitness center; active participation of community in free Healthy Me class; Promotion of 5210 Lets go; Over 100 community members attended RSU #67 Wellness Fair

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Priority	Activities	Partners	Key Accomplishments
Obesity	In FY18, PVH offers community fitness center and independent gym to the public for a nominal monthly fee; Continue to dissemenate with HAN 5210 Let's Go materials; PVH provides healthy meals for patients; PVH collects healthy food items for the Lincoln Regional Food Cupboard's weekend backpack program; participates with the THRIVE Penobscot activities; participated in RSU #67 Wellness Fair and offered free balance and strength screenings	HAN; THRIVE; Lincoln Regional Food Cupboard; RSU #67; SAD 31 & 30	Promotion of 5210 Lets go; Over 100 community members attended RSU #67 Wellness Fair and received wellness screenings
Mental Health Services	In FY17, Expanded access to mental health services through a psychiatric telemedicine program and a crisis prevention program in the emergency department; host monthly case management luncheons to coordinate efforts with agencies noted in partner column; assist HAN in promoting their school based health centers at Lee Academy and Mattanawcook Academy, where counseling services are provided to high school students	HAN; Acadia Hospital; Behavioral HealthCare Program; Community Care; Community Health & Counseling; Full Circle Wellness Center; NOE; Turning Points and Maine Suicide Prevention Program	Increase use of tele-medicine; enhance public health activities
	In FY18, recruitment of additional mental health providers at HAN; enhance tele-psychiatry services at PVH; continue all FY 17 efforts	HAN; Acadia Hospital; Behavioral HealthCare Program; Community Care; Community Health & Counseling; Full Circle Wellness Center; NOE; Turning Points and Maine Suicide Prevention Program	Address disparities in health status among different populations
Cardiovascular Disease	In FY17, PVH participates in the Breathe Easy Coalition and Maine Tobacco Free Hospital Network programs and implements best practices for a smoke-free campus through Gold Star Standards of Excellence program; Partners with Tobacco-Free Maine CDC program offering resources to public through helpline; PVH implemented Community Relations Committee to provide education in School systems; working with MRHIN health collaborative to implement best practices in diabetes and congestive heart failure and treatment and prevention	HAN; Town of Lincoln; Maine Rural Health Innovation Network; Maine Tobacco Free Hospital Network; Maine Tobacco Helpline; Partnership for a Tobacco Free Maine; RSU#67; SAD 30 & 31	Gold Star Award Winner for 2017 for Gold Star Standards of Smoke-free campus; Increased use of Maine tobacco helpline
	In FY18, Continue efforts from FY 2017 and increase education opportunities in local schools	HAN; Town of Lincoln; Maine Rural Health Innovation Network; Maine Tobacco Free Hospital Network; Maine Tobacco Helpline; Partnership for a Tobacco Free Maine; RSU#67; SAD 30 & 31	Seek to receive Gold Star Standard for 2018
Additional information on Penobscot Valley Hospital's priority activity can be found at: www.pvhme.org			

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Organization - **Sebasticook Valley Health (SVH)**			
Hunger/Food Insecurity	In fiscal year 2017 (FY17), SVH worked with six family practice locations (three SVH and three Hometown Health Practice locations) to implement food security screening at patient visits. Patients were asked two food insecurity questions during intake. Results were recorded in the electronic medical records (EMR) and flagged for provider to follow up with the patient and provide a referral to care management for follow-up. In addition, food resource guides were given to the patient by their provider. SVH established community gardens and increased fruit and vegetable availability at local food pantries and soup kitchens.	SVH Family Care , Hometown Health Practices, Good Shepard Food Bank, Pittsfield Food Pantry, Palmyra Baptist Food Pantry, Clinton Community Food Bank, Middle Schools, Pittsfield Public Library, Elementary Schools, High Schools. For a complete listing, visit website below.	SVH trained clinicians in six practice offices. 2,864 resource guides were distributed to 12 sites. 11 community gardens established
	In fiscal year 2018 (FY18), SVH worked on increasing the number of school and community gardens that donate to food partners as well as creating school pantries	Warsaw and Sebesaticook Valley Middle Schools, Nokomis High School, RSU19 Alt. Ed; for complete listing, visit website below	Results will be available at the end of the fiscal year and posted on our Progress Report to Our Community
Substance Abuse	In FY17, SVH engaged the community through presentations and trainings specific to substance abuse. Presentations were offered at a variety of school settings that focused on the Maine Integrated Youth Health Survey (MIYHS) data and tobacco cessation information for attendees to discuss, reflect upon, and connect with others. Also, SVH ensured that Prescription Drug Safe Storage and Disposal Brochures were made available at a number of locations throughout our service area.	SVH Emergency Medical Staff, Pittsfield Police Department, Somerset County Sheriff Department, RSU 19 school district, MSAD 53 school district, Maine State Police Troop C	Through MIYHS, interest amongst community members increased along with the need for advocacy for prevention efforts related to substance misuse in our service area. In addition, 32 sites received safe drug storage and disposal education information.
	In FY18, SVH is working to increase the number of community education sessions that present and discuss substance abuse data for Sebasticook Valley residents in addition to increasing safe drug storage and disposal education.	Results will be available at the end of the fiscal year and posted on our Progress Report to Our Community	Results will be available at the end of the fiscal year and posted on our Progress Report to Our Community
Mental Health	In FY17, SVH increased educational and partnership opportunities with local providers through lunch and learn programs were offered to reduce the stigma of mental health issues. In addition, created a resource/referral guide to include local, regional and statewide resources.	Nokomis Regional High, Sebasticook Valley Middle School, Maine Central Institute, NAMI, EMHS	Four educational and partnership opportunities with local providers engaged and 18 classes offered with referral to resources
	In FY18, SVH is working to increase the amount of community organizations, healthcare partners, and local pharmacies that provide safe drug storage and disposal education information	Results will be available at the end of the fiscal year and posted on our Progress Report to Our Community	Results will be available at the end of the fiscal year and posted on our Progress Report to Our Community
Additional information on Sebasticook Valley Health's priority activity can be found at: http://www.emhs.org/Community-Benefit/CHNA/2016-EMHS-Community-Health-Strategies.aspx Contact: Sherry Tardy, Director, Business Development, Sebasticook Valley Health 487-4085 or stardy@emhs.org			

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Priority	Activities	Partners	Key Accomplishments
Organization - **St. Joseph Hospital**			
Drug and Alcohol Abuse	In FY17- Trained six providers to provide Suboxone treatment. Trained employees on skills to deal with patients dealing with substance use disorder. Supported BARN and other local agencies with their recovery efforts. Provided support to HEAL to supply Narcan to the law enforcement and primary responders. Educated faith community leaders on the effects of substance use disorder.	Community Health Leadership Board, Bangor Area Homeless Shelter, Bangor Area Recovery Network, Health Equity Alliance, Faith Communities from all religions.	6 providers trained to provide suboxone treatment. Supported recovery efforts through the BARN and Wellsprings. Provided Narcans to law enforcement and first responders. Greater awareness to the community.
	2018- Started Social Detox Program at St. Joseph ED, partnered with local faith communities to conduct a Community Healing Service. Educated the community at large through faith communities. Supported BARN in efforts to provide recovery residences for Women in Recovery.	BARN, HEAL, Law enforcement and primary responders, Faith Communities	A care continuum plan was put in place who approached the ED with the desire for recovery. Supported Harm reduction efforts of HEAL. 300 plus people from all faiths and walks of life gathered for a Community Healing Service
Mental Health	In FY17- Trained staff with skills to deal with persons with mental illness. Established a .5 FTE Psychiatric nurse to support the existing Psychiatric Doctor with rounds and consults.		Improved care for persons with mental illness.
	In FY18- Focused attention to persons with mental illness and substance use disorder in the ED.		Added attention to people with mental illness and substance use disorder
Obesity	In FY17- Expanded the hours of Dietician and nutritionist to support patients at risk, referred by the provider. Additional Diabetic educator was hired and a Diabetic Education program started. Stayed active in the social media to provide education in areas of obesity and diabetes	Social media, local TV and Radio channels	Focused attention to patients at risk especially due to obesity and diabetes. Social media awareness building reaching to many thousands of viewers.
	In FY18- Food Security Project was launched and food provided to anyone identified insecure. Continued Vegetable stand providing healthy vegetables to anyone in need. Supported local homeless with nutritious food once a month.	Good Shepherd Food Pantry, Covenant Health Grant, Bangor Area Homeless Shelter	Additional resources added to provide food for anyone identified food insecure at the Hospital and our Primary Care offices. Additional grant money utilized to expand the project to the ED also.
Aging Problems	In FY17- Educated staff on the local resources. Referred seniors who are financially struggling to sign up for the Food Commodity Program with Eastern Area Agency on Aging. Conducted Being Mortal educational evens to prepare the community to talk about advance care planning.	Hospice Foundation of America, Eastern Area Agency on Aging, local Faith Communities	A updated resource list was prepared and provided to employees assisting discharge planning. Awareness created regarding Advance Care Planning and literature and forms distributed.

Update on Selected Priorities and Activities since the 2016 Community Health Needs Assessment - Penobscot County

Priority	Activities	Partners	Key Accomplishments
Aging Problems	In FY18- "Being Mortal" Advance Care Planning Workshops conducted. Additional resource guides were provided to patients and families. Created a committee to enhance the Hospice and Home Care Program	Hospice Foundation of America, Eastern Area Agency on Aging, local Faith Communities	Two additional awareness building workshop sessions were conducted. Provided updated resource list to everyone discharged from the hospital.

Additional information on St. Joseph Hospital's priority activity can be found at:

www.stjoeshealing.org

Contact: Fr. Augustine Nellary, Vice President of Mission Integration, St. Joseph Healthcare 207-907-1700 or augustine.nellary@sjhhealth.com

Organization - **United Way of Eastern Maine**

Information related to United Way of Eastern Maine's priority activity can be found at:

https://www.unitedwayem.org/

Contact: Meredith Alexander, Community Initiatives Manager, 207-941-2800 or mereditha@unitedwayem.org

Organization - **VNA Home Health Hospice**

Information on VNA Home Health Hospice's priority activity can be found at:

http://www.emhs.org/Community-Benefit/CHNA/2016-EMHS-Community-Health-Strategies.aspx

Contact: Joe Kellner, VP, Emergency Services and Community Programs, VNA Home Health Hospice 207-973-4702 or jkellner@emhs.org