Mass General Brigham
Martha's Vineyard Hospital

2022-2025
Martha's Vineyard Hospital
Community Health Improvement Plan

Martha's Vineyard Hospital is a critical access, not-for-profit, community hospital on the island of Martha's Vineyard. Committed to delivering high-quality healthcare to the community and its visitors, MVH provides acute, ambulatory, and specialty services either on-site or through its affiliation with Mass General Brigham.

Our Mission

The mission of Martha's Vineyard Hospital is to safeguard the health of island residents and visitors by providing and arranging high-quality, accessible medical care. This care will be provided to all, regardless of ability to pay, in an atmosphere that fosters equity, respect and compassion.

Our Vision

It is the vision of Martha's Vineyard Hospital (MVH) to be the trusted leader for the continuum of care for every islander. From inpatient acute-care needs to ambulatory medical care and ancillary medical services, MVH strives to be the primary resource for health and wellness on Martha's Vineyard. We will partner with those with whom we share comparable values to assure an equitable system of care that is comprehensive, minimizes duplication and meets community need.

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Introduction

Martha's Vineyard Hospital (MVH) was incorporated in 1921. Since that time, MVH has delivered high quality, compassionate medical care to the year-round and seasonal residents of Martha's Vineyard Island (MVI), as well as those who visit the island. MVH is a member affiliate of Massachusetts General Brigham, which allows MVH to provide patients with seamless access to the finest community-based medicine and most advanced specialty care in the world.

2022 Community Health Need Assessment (CHNA) and Community Health Improvement Plan (CHIP)

In 2022, MVH conducted a Community Health Needs Assessment and Improvement planning process (CHNA-CHIP) to inform community-based efforts. The CHNA fulfills the IRS Section H/Form 990 mandate to identify community health needs, strengths, and resources; describes issues affecting the community overall and within subpopulations; and provides data for planning and program development. Additionally, nonprofit hospitals are required to conduct a CHNA under the provisions of the Affordable Care Act (ACA), as well as the Massachusetts Attorney General's guidelines.

The survey tool used was recommended by Mass General Brigham for community affiliate hospitals. The survey was distributed electronically and in paper form, in both English and Brazilian Portuguese, with 455 surveys completed. Additional data was collated from secondary sources, including public data and 18 key informant interviews. The complete CHNA can be accessed here: MVH Community Health Needs Assessment 2022

This Community Health Improvement Plan (CHIP) is a road map for 2022-2025 to address community-identified public health challenges identified through the CHNA.

Communities Served

The Martha's Vineyard Hospital serves the residents and visitors of Dukes County, Massachusetts. The county includes the island towns of Aquinnah, Chilmark, Edgartown, Oak Bluffs, Tisbury, and West Tisbury and neighboring island of Gosnold. While MVH provides care to seasonal and part-time residents, the primary target for the CHNA-CHIP is the island's year-round population.

CHNA Key Findings

Demographics

The island population is comparatively older than the rest of the state and, while it is home to a lower percentage of foreign-born residents and is less racially and ethnically diverse than Massachusetts overall, the Vineyard has a larger proportion of American Indians than statewide and is home to substantial Brazilian and Jamaican populations. Traditional demographic identification data does not collect accurate data for many residents, i.e., Brazilian residents may not identify as any of the ethnic options listed. It is estimated that upwards of 25% of the Island population identifies as Brazilian.

Household incomes and labor force participation are lower than statewide and 7.5% of the island's population lives in poverty.

Survey Respondent Priorities

One-third or more of community survey respondents who are year-round residents believe that to make our community healthier, the hospital should focus on mental health services (66.3%), housing stability and home ownership (41.4%), substance misuse and the opioid crisis (38.1%), and improved care for medical conditions (36.7%). While most residents indicated that they get their medical care from a doctor's office, they also revealed that the primary barrier to accessing healthcare is the inability to get appointments, which suggests that demand for services exceeds current capacity. The community survey suggests that some residents are amenable to accessing screening services and mental health care from a mobile health van.

Key Informants and Social Determinants of Health Impacting Health Outcomes

As part of the CHNA process, eighteen community leaders were interviewed as "key informants." Key informants articulated that creating affordable housing on the island will help to alleviate stress and the difficult choices people are making between housing costs and other living and medical expenses. Additionally, if affordable housing were available, it would be easier to attract and retain primary care providers, behavioral health clinicians, and medical specialists and healthcare staff, including culturally and linguistically diverse providers and staff who are so critically needed. The hospital, according to key informants, could use its prominence and that of the MGB health system to advocate for affordable, safe, and reliable housing for hospital staff as well as for year-round middle- and low-income residents and older adults. Key informants also believe MVH should ensure that all new hires have diversity education and language skills to treat island's diverse residents, especially the Brazilian, Jamaican, and Wampanoag communities. Key informants also called for service improvements at the hospital, including increased coordination and collaboration between MVH and community-based organizations to prevent duplication of effort and conserve resources, as well as the designation of a point person at MVH for older adults. Key informants would also like to see investments to expand transportation options for older adults to travel to medical appointments on and off island, funding to expand mental health and substance abuse treatment for adults and children, and additional support for local initiatives to create sustainable food sources on the island.

Vulnerable Population and other community health needs identified

While relevant and timely secondary data were not available for all the priorities that emerged from the community survey and key informant interviews, secondary data exist to suggest that older adults comprise a large and growing segment of the island's population; there is a history of need for services to address mental health concerns and substance use disorders; and both homeowners and renters are burdened by excessive housing costs. While the secondary data offered little insight into the need for improved care for medical conditions, Islanders experience higher rates of multiple risk factors for chronic disease that, if addressed, would likely improve the health of the community. The available secondary data clarified the challenges the island faces related to housing supply and demand; the need for culturally competent and linguistically appropriate care; the remaining needs related to improved and sustained food and nutrition security; and transportation challenges, particularly to off-island services and for older adults and those with disabilities.

Social Determinants of Health Issues Addressed by this Plan

- Housing instability and Availability
  The COVID pandemic applied more pressure to a housing shortage that is now a crisis affecting the entire community. Year-round housing supply was at the lowest levels ever recorded, in large part due to seasonal homeowners taking winter rental opportunities out of the regular workforce housing supply. Additionally, many homeowners took advantage of opportunities to cash in on a volatile housing market often selling to investors who are using the properties for short-term rentals. Growth of the short-term market is evidenced by the exponential growth in short term rental tax revenue. Very limited shelter space is available – currently there is a temporary winter shelter and two transitional homes. Limited shelter space, in general, and especially for unaccompanied youth (under 18), and too few affordable housing options for everyone leads to housing-related problems such as over-crowding, unhealthy and unsafe conditions, instability, frequent relocation, and homelessness. These challenges exacerbate other social determinants, disrupt care, and contribute to the spread of COVID and other transmissible infections. The development of a Green House model project in partnership with Navigator Homes will address the need for long-term care for older adults and increase availability of workforce housing. The project will provide long-term care units for up to 70 older adults and 56 rental units for workforce housing. This project will also decrease the reliance on "travelers" thereby reducing labor costs. To better support patients experiencing housing instability, this Plan calls for increased collaboration and referrals to the Dukes County Regional Housing Authority, which support emergency funds and low-income housing support.

Barriers to Care and Service Delivery Addressed by this Plan

- Transportation
  Lack of transportation to/from medical appointments off-island and other services is a major barrier to preventive services, continuity of care, and appropriate use of emergency and ambulance services. Far too few transportation options exist, particularly those with chair cars to transport older adults to/from health care and other services. The Hospital is partnering with Health Aging MV to identify methods of transportation. Current projects underway include the use of "GoGo Grandparent", a private car program that is free to patients and underwritten by a community grant program. Hospital staff participate in a community transportation committee examining barriers to traveling off-island for appointments. This plan identifies transportation as a barrier for patients and the Hospital will participate in any system-wide committee efforts aimed at reducing transportation barriers, including addressing challenges with local ambulance services and ED take home needs.

- Lack of Care Coordination
  Several systemic barriers exist and affect access to care and effective service delivery and coordination. With a loss of emergency services provided by a community partner, ED utilization for behavioral and mental health crises increased. Pandemic emphasis reduced availability for non-COVID health care. A staffing shortage due to housing, pandemic and cost of living has increased wait times for some services. In the spring of 2022, the Hospital was forced to take over emergency mental health services, including oversight of evaluations and bed searches. With the advent of new regulations for ED provision of emergency behavioral health services, the Hospital was poised to partner with Gosnold to implement a more permanent structure for evaluations. This plan reflects

increased coordination among community partners to maximize the strengths of local community providers and MGB system support.

- Need for Increased Culturally Sensitive Care
  Cultural differences, health care literacy and linguistic barriers create unequal access to care, heavy reliance on the ED for non-urgent care, high rates of c-section deliveries and disproportionally poor outcomes for certain chronic health conditions. There is a desperate need to increase access to in-person interpreter services and to coordinate with community resources to maximize education and health literacy opportunities. This plan will explore health disparities for expectant families, increased access to in-person translation services and improvement of culturally competent new hire training. MGB financial support of the Community Ambassador Program, a program that trains medical translators and deploys translators to the Hospital and other areas of need in the community, has made the in-person translation services a reality for our patients. As part of this Plan, we will also explore the viability of providing telehealth bilingual, bicultural medical care by accessing providers within the greater MGB system.

- Limited Availability of Mental Health Providers and Services
  Post-pandemic mental health and substance use services are reduced by half at the Island's largest community services provider. Further there are no CBHC, mobile crisis units or crisis stabilization units on the Island. ED volume has increased, and workplace violence incidents associated with behavioral health patients has led to the Hospital providing 24-7 security for the first time. Under this Plan, the Hospital will hire additional behavioral health staff, including a psychiatric nurse practitioner to add to a recently hired licensed social worker. The Hospital employs a substance use disorder team that historically focused on care within the ED. Under this plan, the SUD team and the new behavioral health professionals will be a bridge between emergency needs and ongoing behavioral health management within primary care. Continuing financial support of the Counseling and Outreach to the Elderly (CORE), New Paths Recovery Program and the Red House will provide much needed stability for local community partners who provide other non-medical support to patients in common.

Identified Health Conditions and Behaviors Addressed in this Plan

- Mental Health and Substance Use
  Access to mental health and substance services were challenging prior to the pandemic and have intensified due to increase in volume, increase in severity, and reduction in services by community partners. Statewide access to beds is challenging, coupled with transportation via ferry, led to increased boarders, particularly geriatric and pediatric. It is very challenging to find a mental health clinician who is accepting new patients. This plan will help to coordinate with community partners through monthly case management meetings and Coalition meetings to collaborate on high-risk individuals and to identify training needs.

Underserved and Vulnerable Populations Served by this Plan

- Older Adults
  Behavioral health and the certain social determinants of health pose particular threats to older adults on Martha's Vineyard. Many older adults are isolated and experience increased behavioral health

issues as a result. The frequency and increased length of stay for geriatric patients at MVH required us to create a behavioral health boarding area in our acute care wing. Too few providers are comfortable and equipped to address the specific care needs of geriatric patients, which may mean end-of-life decisions are not discussed and patients are denied choice about their health care. Home-health staff shortages cause long delays in access to and inconsistent care, thus endangering homebound older adults. There is one nursing home and limited affordable housing units for older adults. Many live in unmaintained housing with unsanitary and unsafe conditions. Older adults often go without resources that would keep them safe and out of the hospital (i.e., air conditioning, grab bars, chair lifts, hospital beds) because insurance won't cover those supports. Healthy, easy to prepare and easy to eat foods are not always available, which affects blood pressure, blood sugar, and the overall health of older adults. Through continued financial support for home modification services and in-home counseling, a plan for routine dementia screenings and collaboration with councils on aging, this Plan demonstrates the Hospital's continued emphasis on improving access to health care for older adults. The expansion of specialty services will also reduce off-island transportation needs that are often difficult for older adults to navigate independently.

- Immigrants/Residents with Limited English Proficiency and/or Literacy
  Martha's Vineyard is home to a significant number of Brazilian and Jamaican immigrants. The Brazilian population is estimated to be upwards of 25% of year-round residents. Medical misinformation is pervasive in immigrant communities, especially among those who don't speak English. Newer immigrants often lack experience with, trust in, and understanding of health care, including why it's important and how to access it. Lack of understanding about the health system leads to increased ED use for non-urgent issues. The ability to navigate and utilize the health system among those with limited English is hindered by language. Many undocumented immigrants fear being turned over to immigration services by health care and other service providers. Immigrants often live in over-crowded housing. The Hospital has a vibrant local DE & I council that provides educational and other opportunities to celebrate and learn about the cultural richness of our community. This Plan will support efforts for continued education for staff, increased availability of patient-facing materials in Portuguese and increased access to video and in-person translation. Success in this area will require creative collaborations with local churches, outreach to the schools and utilization of different means of communicating, such as "What's App" and Brazilian sponsored social media sites.

Priority Health Issues for the CHIP:

The Community Affairs Committee (CAC) met September 23, 2022, to review the findings of the CHNA and health priorities for the CHIP. The CHNA revealed the need for continued emphasis in the priority areas of Behavioral health (Mental Health and Substance Use Disorder) and Improving Access to Care, both priorities were identified in the MVH 2019 Strategic Improvement Plan. For this Plan, The CAC recommends continuing with the priorities of 2019 and adding a Social Determinant of Health priority. This plan intends to align the MV CHIP priorities with Health Equity priorities set by Medicare and Mass General Brigham and the Community Benefits Guidelines established by the Attorney General.

Priority	Issues associated with the priority community health needs
Mental Health and Substance Use (Existing)	Mental health, substance use disorders, gaps in treatment
Access to and Coordination of Medical Care (Existing)	Accessibility, transportation, care coordination, navigation and culturally sensitive medical care delivery and services, especially for older adults and diverse populations.
Social Determinants of Health (New)	Housing and food/nutrition

CHIP Planning Process

CAC members, hospital staff and community members engaged in a multi-step process to develop the CHIP.

To maximize resources and avoid duplication of programs and services, the CHIP process began by inventorying existing initiatives at the Hospital and in the community that address the priority areas. The CHNA findings were presented to The Patient Family Advisory Council, The Dukes County Health Council and the MV Diversity Coalition Health Disparities Committee.

CHIP strategies were viewed through the lens of the MVH Institutional goals and the MGB Institutional priorities to ensure alignment. The CAC reviewed the existing and planned strategies. The Committee generated additional strategies and suggested additional community partners to address gaps in the identified priority areas.

Step 3: MVH leadership reviewed the strategies generated by the CAC to determine which it could support given the available resources (i.e., financial, personnel, space, partnerships).

Step 4: MVH leadership created and shared the final draft of the CHIP with the CAC on January 23, 2023. The CHIP was approved by the CAC and recommended for approval by the full Board of Trustees.

Step 5: The CHIP was revised and shared with MVH's Board of Trustees on January 27, 2023.

Primary Focus of Plan Strategies

Based upon the 2022 CHNA, MVH's 8-member Community Benefit Advisory Committee (CAC) identified three priority areas: (1) Behavioral Health (2) Access to and coordination of medical care (4) Addressing Social Determinants of Health that impact patient health. Implicit in the priorities is a goal of developing closer coordination and collaboration among MVH and community-based organizations to reduce duplication and conserve resources.

This plan includes 39 strategies (programmatic, staff resource and financial initiatives) for achieving the plan's short- term outcomes, intermediate-term objectives, and progress toward long-term goals. The tables below provide a brief description of each Priority Area and multiple strategies to support each goal. Descriptions include information about the target population served, statewide priority addressed, and the data used for measuring success. Where community collaborations are needed to achieve success, the entities are identified.

Priority 1:	**Behavioral Health**
Goal 1:	**Improve Access to Mental Health Services**
Objective1:	**Decrease the mortality and morbidity of community members with mental health needs**
Strategies:	
Strategy a:	Expand Outpatient Psychiatry Services for Primary Care, including hiring new psych NP, providing access to MVH SUD team and other community partners
Strategy b:	Refine emergency services system based on new regulations
Strategy c:	Host an "open forum" grand rounds about mental illness
Strategy d:	Continue financial support for Counseling and Outreach to the Elderly (CORE), if available
Expected Outcomes:	
	Reduced time spent on bed searches with advent of MGB bed search program
	Reduced wait time to see Mental Health Professional
	Improved coordination with community programs
Population (s):	All
Potential New Resource:	State grant funding
Current Initiatives Underway:	Gosnold partnership, MVH BH team, CORE
Collaborations:	Gosnold, McLean, MVCS, Schools, private clinicians, IHC, law enforcement/co responders
Data Sources:	ED behavioral Health evaluation data, staff hired, # of trainings conducted, # of people served in CORE and New Paths
Goal 2:	**Improve Access to Substance Use Disorder Services**
Objective 1:	**Decrease the mortality and morbidity of community members with mental health needs**

Strategies:	
Strategy a:	Expand Outpatient Psychiatry Services for Primary Care, including hiring new psych NP, providing access to MVH SUD team and other community partners
Strategy b:	Refine new emergency services system based on new regulations
Strategy c:	Monitor SUD screenings across ED, primary care, and women's health
Strategy d:	Continue to develop cooperative relationship with the Red House (post-covid)
Strategy g:	Continue financial support for New Paths program and The Red House, if available
Expected Outcomes:	
	Reduced time spent on bed searches with advent of MGB bed search program
	Diverted appropriate SUD emergencies to community resources/fewer ED admissions
	Improved care coordination for high-risk cases
Population (s):	All
Potential New Resource:	McLean, MGB doctors and clinicians who are bilingual, MVCS/Police Co-Responder program
Current Initiatives Underway:	Gosnold partnership, MVH BH team, New Paths
Collaborations:	Gosnold, McLean, MVCS, Schools, private clinicians, IHC, law enforcement/co responders
Data Sources:	ED behavioral Health evaluation data, staff hired, # of trainings conducted, # of people served in CORE, the Red House and New Paths, SUD screening data from EPIC
Priority 2:	**Access to Care and Coordination of Medical Services**
Goal 1:	**Meet the unique healthcare needs of the Island's diverse population**
Objective 1:	**Identify and reduce barriers to accessing health care services**
Strategies:	
Strategy a:	Expand Care Team Model in Primary Care to increase access to and capacity across PCPs
Strategy b:	Explore expansion of specialty services to reduce travel off-island for health needs (urology, ophthalmology, pulmonology, palliative care)
Strategy c:	Build partnership with Hospice and Palliative Care of MV to provide palliative care services
Strategy d:	Monitor use of SDOH screenings and evaluate referrals to address barriers to access (i.e., transportation, food, insurance)
Strategy e:	Implement new multilingual patient access coordinator
Strategy f:	Participate in System-wide committee to explore transportation concerns: ambulance access, ambulance take homes, off-island transport
Strategy g:	Continue financial support for MV Hospice and Palliative Care, if available

Expected Outcomes:	
	Reduced off-island travel and ED ambulance transports to home
	Reduced wait list for new patients to access a primary care provider
	Better awareness and coordination with community partners to provide support identified through SDOH screenings
Population (s):	All
Potential New Resource:	New specialty services, new Palliative Care program, dedicated staff member to support patient access needs
Current Initiatives Underway:	Ophthalmology clinic, hired new Social Worker
Collaborations:	MV Hospice and Palliative Care, Hospice of Cape Cod, Patient Family Advisory Council
Data Sources:	Statistics on SDOH screenings, new service lines implemented, PFAC minutes, wait list and panel size data for PCPs, # of patients served by new patient access coordinator
Goal 1:	**Meet the unique healthcare needs of the Island's diverse population**
Objective 2:	**Improve health care access for older adults**
Strategies:	
Strategy a:	Conduct quarterly meetings with Councils on Aging to identify barriers to care and solutions to better support older adults
Strategy b:	Increase dementia screenings
Strategy c:	Improve older adult fluency with Patient Gateway through "tip sheets", training at COAs with community partners
Strategy d:	Continue participation in Falls Prevention Coalition
Strategy e:	Increase referrals to "A matter of Balance" program
Strategy f:	Continue financial support for HAMV (home modification) and CORE (Counseling), if available
Expected Outcomes:	
	Improved alignment of Hospital system with older adult health care needs
Population (s):	Older adults
Potential New Resource:	High School digital support program for older adults; tip sheets on patient gateway geared to older adults
Current Initiatives Underway:	Healthy Aging MV House modification, counseling outreach and referral for the elderly (CORE), Age Friendly Designation
Collaborations:	MVCS, HAMV, COAs, Center 4 Living, Falls Prevention Coalition
Data Sources:	EPIC reports on dementia screenings; % provider completion of dementia trainings; deliverables for easier navigation of patient gateway, # of referrals to programs, minutes from quarterly COA meetings

Goal 1:	**Meet the unique healthcare needs of the Island's diverse population**
Objective 3:	**Become a trusted health care resource for a culturally diverse community and reflective of the community's priorities and needs**
Strategies:	
Strategy a:	Review and update new employee onboarding materials to reflect culturally competent care and expectations
Strategy b:	Continue to expand the role of the DE&I committee to bring educational and celebratory opportunities reflecting our diverse staff
Strategy c:	Research high c-section rate among Brazilian community to better understand and to promote more educational opportunities for expectant Brazilian families
Strategy d:	Improve ethnic data collection within EHR to better understand diversity of patient panels
Strategy e:	Develop an "Anti-Racism" statement for the Hospital
Strategy f:	Continue to participate in the MV Diversity Coalition Health Disparities Committee to recognize needs of underserved in our community
Strategy g:	Support provider community outreach to underserved communities, i.e., Dr. Gitlin, Dr. Browne & Dr. Mostone
Strategy h:	Explore the viability of providing telehealth bilingual, bicultural medical care by accessing providers within the greater MGB system.
Strategy i:	Continue financial support for Island Autism Group, if available
Expected Outcomes:	
	Increased trust of the Hospital by underserved communities
	Increased awareness by staff of impact of racism in health care settings
	Better health outcomes for patients who need in-person translation services; fewer medical errors due to translation mistakes
Population (s):	Underserved communities, including but not limited to: Brazilian, Wampanoag, Jamaican and patients with special needs
Potential New Resource:	MV Diversity Coalition (MVDC), "What's App" and social media
Current Initiatives Underway:	Medical Clinic on Wampanoag Reservation; Lunch and Learn educational series for staff; Mass Health Maternity Bundle initiative; CAP translation services, ADA accessibility Gap Analysis
Collaborations:	CAP, MVDC, Island Health Care, Local and MGB DE & I Councils, MVCS, schools, local church leaders
Data Sources:	Health Stream trainings: Report on CAP translation services accessed; New educational materials in Portuguese for expectant families; community focus groups/forums on health care literacy; hours served by providers in underserved community clinics/settings, facility changes made to support patients with special needs

Priority 3:	**Social Determinants of Health**
Goal 1:	**Reduce inequities in health care related to housing stability/instability**
Objective1:	**Increase availability of affordable, quality year-round housing**
Strategies:	
Strategy a:	Complete Navigator Green House Project
Strategy b:	Explore land acquisition opportunities for housing development for workforce, i.e., Tisbury land
Strategy c:	Explore housing partnerships with community partners and /or house sharing programs
Strategy d:	Support Harbor Homes efforts to build safe year-round shelter
Expected Outcomes:	
	Increased housing stability for staff and patients
	Reduced of Hospital Costs for clinical travel staff
	Increased opportunity for stable, workforce housing
	Improved care coordination for those who are homeless
Population (s):	All
Potential New Resource:	Long-term housing for older adults with Navigator Homes project
Current Initiatives Underway:	Navigator Green House, New Homeless Shelter, Housing bank funds
Collaborations:	Harbor Homes, USDA, HAMV, Dukes County Regional Housing Authority
Data Sources:	Successful completion of Green House, increase in Hospital housing inventory, # of travelers needed to support long-term care
Priority 3:	**Social Determinants of Health**
Goal 2:	**Increase access to nutritional food**
Objective1:	**Reduce health disparities based on nutrition**
Strategies:	
Strategy a:	Continue support for community programs that provide food resources and advocate for long-term solutions for food insecurity
Strategy b:	Increase awareness among providers about Fresh Connect Program fresh food program
Strategy c:	Increase cafeteria menu options that support healthy food choices, including vegetarian and vegan options.
Strategy d:	Continue financial support for IGI, if available
Expected Outcomes:	
	Increased awareness of food insecurity and sustainability of current programs.
	Improved health outcomes for people enrolled in Fresh Connect and food prescribing programs

Population (s):	All
Potential New Resource:	
Current Initiatives Underway:	Food Pantry support: meals on wheels, Fresh Connect
Collaborations:	IGI/food pantry, MGB Fresh Connect
Data Sources:	# Of enrollees in Fresh Connect and any outcome data available; data on meals served through meals on wheels