Mass General Brigham
Martha's Vineyard Hospital

2025

Community Health Implementation Plan

Martha's Vineyard Hospital Community Health Implementation Plan (CHIP) 2026-2029

Through the work of community input, regional collaboratives and our own internal process, the priorities approved and adopted by our Community Advisory Committee (CAC) are:

Health Priorities:

- Alcohol Use Disorders
- Cardiometabolic Disease Prevention:
  - Hypertension Control
- Cancer Prevention:
  - Colon Cancer Mortality
- Access to Care:
  - Primary care and Urgent needs
  - Behavioral Health and SUD support

Social Risk:

- Access to Transportation
- Access to Healthy Food and Food Security
- Mental Health, Chronic Stress and Isolation

Emerging Needs:

- Tick-borne illnesses

Overall Goal: Improve access to services with a focus on Alcohol Use Disorder, Behavioral Health, Primary/urgent care needs, and improved cancer screenings and Cardiovascular prevention

Objectives

1. Increase MH and AUD services, in conjunction with community partners, especially for special populations: older adults, people with intellectual disabilities and Brazilian Portuguese speakers
2. Increase access to primary care by raising awareness of efforts to "modernize primary care" by utilizing advanced practice providers, virtual appointments, patient gateway messaging, same day access, and provider recruitment.
3. Improve mortality rate by increasing cancer screenings and cardiometabolic disease prevention measures.

Strategies

1. Provide education for staff regarding AUD and BH, with a focus on older adults and people with intellectual disabilities.
2. Inventory BH/SUDs services available in the community.
3. Develop communications plan outlining available primary care services.
4. Add new clinic location for urgent needs
5. Expand Cardiovascular services

Metrics (Process & outcome measures) – Reviewed annually

1. New Patient referrals to MVH BH/Psych and community BH/Psych services: Increase by 5%
    a. New patient referrals to MVH BH/Psych: Baseline FY25 412 patients
    b. Referrals to MVCS Open Access Program) : Baseline (waiting on data from MVCS)
    c. Referrals to SUD Team from Primary Care- new service.
2. Improve Patient perception of access to care through NRC question "Appointment as soon as Needed." Increase by 2%
    a. Baseline 68.8%.
3. Increase patient access as measured by dashboard:
    a. # Same day visit/template utilization for Primary Care and PEC.
    b. # of unused slots
    c. # of new patients seen in the PEC
    d. # Care Connect utilization.
    e. # of visits offered at WT site
    f. Reduction in waitlist for primary care
4. Increase Colon cancer screening by 3%
    a. Baseline 84%
5. Improve BP control for all patients with hypertension by 3% and for black patients by 3%
    a. Baseline all patients 77%
    b. Baseline Black patients 68%

Overall Goal: Increase access to transportation and other resources for health care on and off-Island.

Objectives

1. Increase off-island transportation options to support access to medical services.
2. Improve identification of patient SDOH needs for increased referrals within Hospital and to Community Partners.

Strategies

1. Evaluate workflow for SDOH identification and referral system.
2. Explore partnerships with the specialty health centers and community partners, such as the Lurie Center, MVCS, HAMV, IGI, IHI, etc.
3. Develop a communication plan
4. Develop a Steamship relationship that supports improved access to off-Island appointments.

Metrics (Process & outcome measures) – Reviewed annually

1. Increase in # of days/week transportation provided for off-island appointments.
2. Reduce positive screens for SDOH questions related to transportation and food security.

Overall Goal: Develop a Plan to address Health Issues and public awareness related to Vector Borne diseases and syndromes

Objectives

1. Increase public awareness about tick borne diseases
2. Support research efforts aimed at early identification of tick disease, reduction of health impacts and development of common protocols to be shared widely.
3. Partner with Island organizations to ensure comprehensive community approach to reducing incidents of tick disease

Strategies

1. Establish/Support an Alpha Gal Working Group with multidisciplinary experts
2. Develop a communications plan to inform and educate residents and visitors about the dangers and prevalence of ticks.
3. Develop a tick-bite clinic and hotline
4. Coordination with Island nutrition experts
5. Participate/collaborate in community –wide tick initiatives, including Public Health, VNA , Tick Free MV

Metrics (Process & outcome measures) – Reviewed annually

1. Distribute DEET or other tick deterrent products across the Islands.
2. Establish clinical protocols for the diagnosis and treatment of various tick-borne diseases and syndromes
3. Referrals to allergy and nutrition consults to support patients with Alpha Gal Syndrome: Develop a process for allergy referrals and track nutrition consults and collaboration.
4. # of visits to the Tick clinic

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