

2025

Community Health Implementation Plan



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

This Community Health Improvement Plan (CHIP) for Martha's Vineyard Hospital provides a strategic road map to improve health care access and reduce health disparities experienced by residents of Dukes County. Through the lens of community input, regional collaboratives and Martha's Vineyard Hospital's internal process, the priorities approved and adopted by our Community Advisory Committee (CAC) are:

Health Priorities:

- Alcohol Use Disorders
- Heart Disease Prevention:
 - *Hypertension Control*
- Cancer Prevention:
 - *Colon Cancer Mortality*
- Access to Care:
 - *Primary care and Urgent needs*
 - *Behavioral Health and Substance Use Disorder 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 mental health and alcohol use disorder services, in conjunction with community partners, especially for special populations: older adults, people with intellectual disabilities and Brazilian communities.
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 heart disease prevention measures, prioritizing those communities with highest disease rates and lowest screening rates.

Strategies

1. Provide education for staff regarding alcohol use disorder and behavioral health, with a focus on older adults and people with intellectual disabilities.
2. Inventory behavioral health and substance use disorder services available in the community.
3. Develop communications plan outlining available primary care services.
4. New express care clinic and tick bite care.
5. Expand cardiovascular services.

Metrics (Process & outcome measures) – Reviewed annually

1. Increase patient referrals for behavioral health & psychiatry services as measured by:
 - a. New patient referrals to MVH behavioral health and psychiatry.
 - b. Referrals to Martha's Vineyard Community Services "Open Access Program."
 - c. Referrals to substance use disorder team from primary care providers.
2. Improve patient perception of access to care as measured by patient reported survey question: "Appointment as soon as Needed."
3. Increase patient access to primary care appointments, as measured by:
 - a. The number of "same day visits" requested and completed within the primary care clinics and the PEC.
 - b. The number of unused appointments for each primary care provider.
 - c. The number of "new" patients seen in the express care clinic.
 - d. The number of patients accessing virtual primary care through new MGB platform.
 - e. The number of patients on the wait list for a primary care provider.
4. Increase colon cancer screenings.
5. Improve blood pressure control.

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 social determinant of health (SDOH) needs to increase referrals within the hospital and to community partners to support patients' non-medical needs that impact health outcomes.

Strategies

1. Evaluate internal process for gathering patient SDOH needs and improve referral processes.
2. Explore partnerships with specialty health centers and community partners.
3. Develop a communication plan that clearly articulates the services available at MVH.
4. Develop a Steamship relationship that supports improved access to off-Island appointments.

Metrics (Process & outcome measures) – Reviewed annually

1. Increase in number of days per week transportation provided for off-island appointments.
2. Track 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 Syndrome 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. Coordinate with Island nutrition experts to support patient dietary challenges related to Alpha Gal Syndrome
5. Participate and collaborate in community-wide tick initiatives.

Metrics (Process & outcome measures) – Reviewed annually

1. Distribute tick deterrent products across the Islands.
2. Establish clinical protocols for the diagnosis and treatment of various tick-borne diseases and syndromes.
3. Develop a process for allergy referrals and track nutrition consults made for tick borne illnesses.
4. Track the number of visits with a primary concern of a tick bite.



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