Community Health Strategy

Addressing Community Health Needs Fiscal Year 2020-2022

Northern Light Home Care & Hospice

Northern Light Health℠

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Introduction

Northern Light Health and our more than 12,000 employees care deeply about our neighbors and communities. Northern Light Health member organizations work hard to understand and address priority needs. We meet regularly with community partners to plan and implement local solutions that make it possible for people in our communities to lead healthier lives. By working together, we promote a culture of stewardship and foster vibrant communities.

Northern Light Home Care & Hospice is committed to shaping health improvement efforts in its service area based on sound data, personal and professional experience, and community need. Through collaborative efforts, Northern Light Home Care & Hospice creates healthier communities through the provision of services, resources, and programs within and beyond the walls of our organization.

About Northern Light Health

At Northern Light Health, we're building a better approach to healthcare because we believe people deserve access to care that works for them. As an integrated health delivery system serving Maine, we're raising the bar with no-nonsense solutions that are leading the way to a healthier future for our state.

A statewide integrated healthcare system serving Maine. We provide care to people from Portland to Presque Isle and from Blue Hill to Greenville. We are comprised of nine member hospitals with 584 long-term beds, a single physician-led medical group, eight nursing homes, five emergency transport members, 37 primary care locations, and we employ more than 12,000 people in Maine.

About Northern Light Home Care & Hospice

Northern Light Home Care & Hospice is the trusted choice for healthcare at home in Maine. We are experts in managing patient needs and work as a team to coordinate a continuum of care from hospital or rehabilitation facility to home.

Home Health: Our Home Health Program provides skilled care focusing on recovery, quality of life and independence, reducing emergency room visits and hospital readmissions.
Services include: Skilled Nursing, Physical/Occupational/Speech Therapy, Social Work, Wound Care Management, Dietician Services, Chronic Disease Management, Telehealth, Home Health Aides, all from the comfort of a patient's home.

Palliative Care: Our Palliative Care Program provides an extra layer of support and helps keep the patient and family at the center of care. Palliative Care focuses on quality of life and everything that influences that quality. Palliative Care is appropriate at any age and any stage in a serious illness, and can be provided along with curative treatment.
Services include: Advance Care Planning, Establishing Patient Centered Goals Of Care, Symptom Management and Addressing The Stresses Of A Serious Illness.

Hospice: Our Hospice program provides compassionate end-of-life care to those who are no longer seeking curative treatment for a terminal diagnosis. Our hospice team works in partnership with patients and their

families to coordinate a care plan based on patients' unique needs and wishes. Hospice can be provided anywhere the patient calls home.
Services include: Hospice Care Registered Nurses, Physicians & Nurse Practitioners, Physical/Occupational/Speech Therapy, Social Work, Spiritual Care, Hospice Aides & Trained Volunteers, as well as Bereavement Support for loved ones.

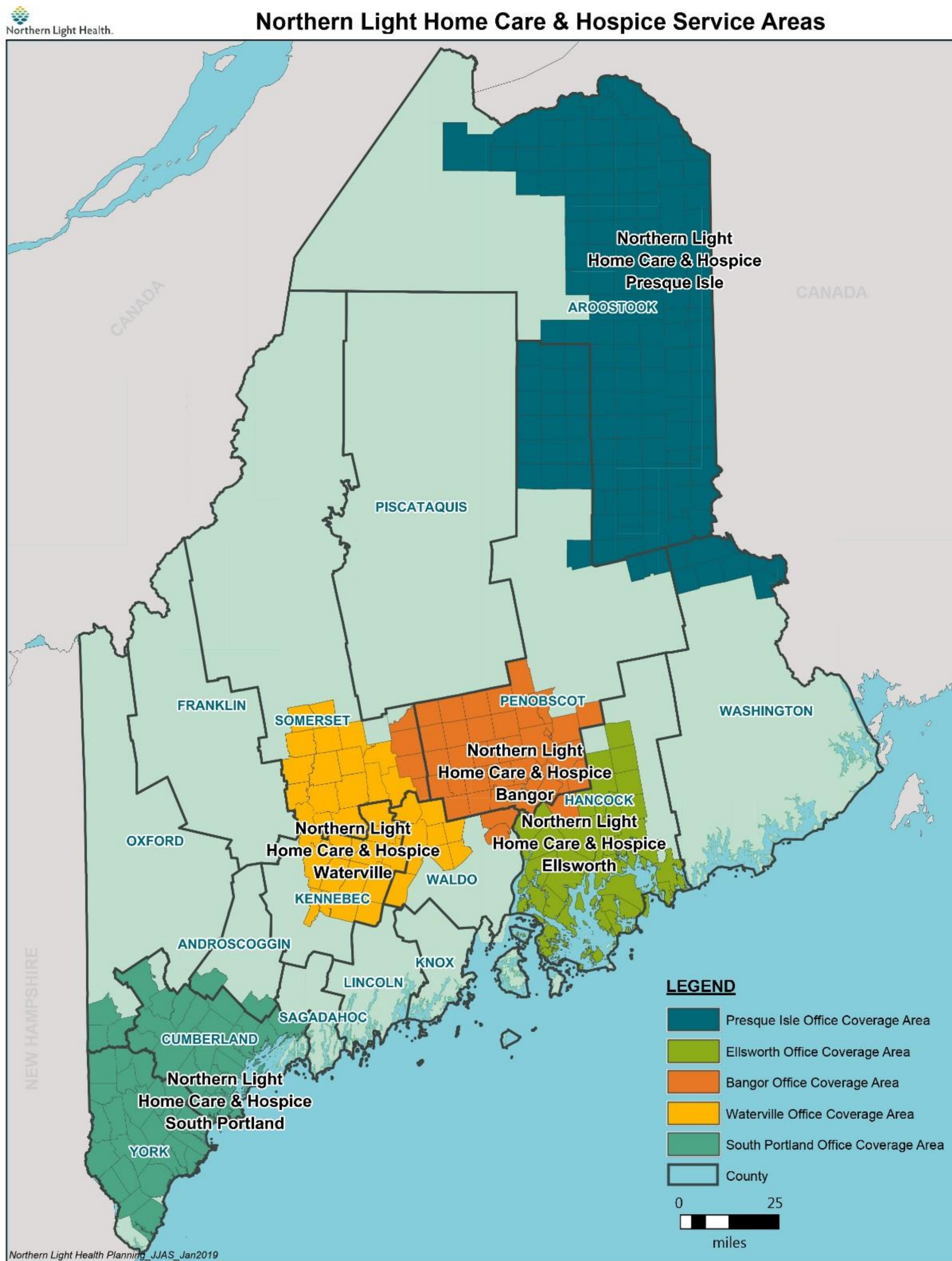
Northern Light Home Care & Hospice also provides Community Wellness Programs in the counties we serve. Services include: School Based Vaccination Clinics, Hypertension Clinics, Senior Wellness Clinics, Caregiver Education Seminars, LiveSafe Emergency Call Services and Telehealth for those managing a chronic illness.

Agency Locations: South Portland, Waterville, Bangor, Ellsworth, Presque Isle

Counties Served: Cumberland, York, Kennebec, Somerset, Penobscot, Hancock, Aroostook

Definition of Community Served

With offices in South Portland, Waterville, Bangor, Ellsworth, and Presque Isle, Northern Light Home Care and Hospice provides home care, companionship and private duty care, palliative and hospice services to residents throughout the state of Maine. Patients served are seeking support to stay safe in their own homes, recovering from illness and surgery post hospitalization, dealing with chronic health conditions, or are choosing to remain in their home after discontinuing curative treatment or while facing a terminal diagnosis.



Demographic Data		
CUMBERLAND COUNTY		
	Percent	Number
American Indian/Alaskan Native	0.2%	650
Asian	2.0%	5,899
Black/African American	2.7%	7,833
Hispanic	1.9%	5,538
Some other race	0.4%	1,132
Two or more races	2.3%	6,768
White	92.3%	265,918
County population	288,204	

Social Determinants of Health Data	
CUMBERLAND COUNTY	
Median household income	$61,902
Unemployment rate	2.9%
Individuals living in poverty	11.1%
Children living in poverty	13.3%
65+ living alone	46.4%
People living in rural areas	36.1%
Food insecurity	14.0%

For the purpose of this strategy, Northern Light Home Care & Hospice presents data from its primary county of service, Cumberland. However, please note, the priorities identified in Cumberland County closely parallels the state's identified priority of needs.

Addressing Community Health Needs

Shared Community Health Needs Assessment

In 2019, Maine's four largest healthcare systems – Northern Light Health, Central Maine Health Care, MaineGeneral Health, and MaineHealth – as well as the Maine Center for Disease Control and Prevention, an office of the Maine Department of Health and Human Services (DHHS) partnered to research and publish a shared Community Health Needs Assessment (Shared CHNA). The Shared CHNA provides a comprehensive review of health data and community stakeholder input on a broad set of health issues in Maine. The Shared CHNA data were made widely available to the public, as community engagement forums were held across the state, gathering additional feedback on priority issues and opportunities for community health improvement. These reports and the community input received are fundamental to achieving our goal of partnering with community, public health entities, and accountable care networks to improve the health and well-being of the communities we serve.

Results of the 2019 Shared CHNA along with community input were used to inform the development of this three-year Community Health Strategy by Northern Light Home Care & Hospice. The efforts identified within help demonstrate our commitment to our community, as we provide benefits reflective of our mission and tax-exempt status. These benefits include a focus on the clinical, social, and environmental factors that influence the ability of people to lead healthier lives.

Community Health Strategy

This Community Health Strategy was developed with input from community stakeholders including those who serve priority populations, local Public Health District Liaisons, local business leaders, and community advocates.

Priorities were selected after weighing the severity of each priority area, availability of known and effective interventions, determination that the priority area was un-addressed or under-addressed, and community collaborations underway with Northern Light Home Care & Hospice.

Northern Light Home Care & Hospice reserves the right to amend this Community Health Strategy as circumstances warrant. For example, certain community health needs may become more pronounced and require enhancements or a refocus to the selected priorities of focus.

Process and Methods for Priority Selection

The community health strategy was developed by a planning team consisting of members both internal and external to our organization. The planning team included representatives with knowledge and insight of the communities served. Northern Light Home Care & Hospice selected key priorities and strategies based on the county CHNA report, which includes quantitative health profile indicators and qualitative prioritization of need derived from a community engagement process. In addition, shared system-wide priorities were identified in the areas of Substance Use and Social Determinants of Health for all Northern Light Health members. These priorities were identified as shared priorities based on a selection process which considered a review of county level priorities across the state as well as local readiness and capacity to address these needs in partnership with local communities.

Members of Northern Light Home Care & Hospice's Community Health Strategy team included individuals representing the following positions:

- Billing and Reimbursement Lead
- Central Intake Coordinator
- Chaplain
- Clinical Services Coordinator (Also LPN)
- Director of Revenue Cycle (also PT)
- Director of Clinical Operations
- Director of Home Health and Specialty Services
- Manager - Hospice Services (also LCSW)
- Occupational Therapist - Lead
- Physical Therapist
- Provider Relations Liaison
- Registered Nurse - Home Health
- Registered Nurse - Hospice Outreach
- Registered Nurse - Lead
- Speech Language Pathologist
- VP Finance and Business Operations
- VP Nursing and Patient Care Services

The following criteria were used for the health need selection process:

- Shared CHNA prioritization: How the health priority rank in the Shared CHNA
- System-wide priority areas of work as determined by the Community Health Council
- Ability to leverage local community assets: Identification of potential community partnerships to engage in order to address the priority need, or to build on current programs, emerging opportunities, or other community assets
- Expertise: Northern Light Home Care & Hospice experts and local partnership experts in various priority areas
- Feasibility: Northern Light Home Care & Hospice has the ability to have an impact given the community benefit resources available

Annually, our internal team will convene to determine if changes need to be considered in order to best address the priority health needs of our community.

NOTE: There were no written comments received related to the most recently conducted CHNA and Community Health Strategy for inclusion in this report.

Evaluation Efforts

Northern Light Home Care & Hospice will monitor and evaluate the strategies related to this priority area of work for the purpose of tracking the implementation of those strategies as well as to document the anticipated impact. Through internal quarterly reporting practices we plan to document and track measures, approaches and resources used, partners engaged, and highlights related to this priority area of work. These quarterly reports will inform our fiscal year-end Progress Report to Our Community that will be made publicly available on our community health strategy web page.

Feedback Opportunity

Contact communitybenefits@northernlight.org with feedback on this report.

Approval from Governing Board

Northern Light Home Care & Hospice's Community Health Strategy and Community Health Needs Assessment (CHNA) were reviewed by the organization's governing board and a resolution was made to approve and adopt both the Shared CHNA and the Community Health Strategy on May 16, 2019.

Selected Priorities of Focus

Priority #1: Social Determinants of Health

Rationale

A community's health can be determined in part by access to social and economic opportunities, the safety and cleanliness of environments, and the resources available in homes, neighborhoods, and communities. These social determinants of health are the conditions in which people are born, live, work, and play, and affect a wide range of health and quality of life outcomes. Examples of social determinants include socioeconomic status, availability of safe housing, education, access to healthcare services, and food insecurity. Over the past two decades, a large and compelling body of evidence has revealed that these factors play a powerful role in shaping health. This has resulted in a greater understanding that medical care is not the only influence on health and suggests that traditional healthcare models may not be enough to adequately improve health outcomes or reduce health disparities without also addressing how people live.

The Northern Light Home Care & Hospice's Community Health Strategy team has identified Social Determinants of Health as a priority need for our community. There are substantial local community assets and Northern Light Home Care & Hospice has assets available to be leveraged in support of this need. Also, there are many evidence-based or promising approaches to address the need for interventions on the many facets of Social Determinants of Health. Finally, Social Determinants of Health rated as a high priority to the community and our Northern Light Health system.

Intended action to address the need

Increase the number of patients screened for food insecurity and referred to community resources.

Anticipated impact of these actions/expected outcomes

The goal of Northern Light Home Care and Hospice is to expand our food insecurity assessments and responses through educating staff, enhancing access to resources, seeking grant funding to expand existing programs and

fund new ones, and identifying and mitigating barriers to patients seeking out, and ultimately accessing, key community resources that may improve their health status.

Programs and resource allocation

Northern Light Home Care and Hospice will maintain and provide patients with information to access resources, such as food delivery services and food banks. We will work to enhance and expand our highly successful food box program, which has been primarily focused in Aroostook County, by expanding it statewide, which will require new funding sources and collaboration with our Northern Light Foundation partners. We will also provide ongoing education to staff about our food insecurity screening process, and methods to expand patient's willingness to reach out to, and ultimately access, key community resources. This will require enhanced and early social work involvement, and a continued focus on holistic case management.

Planned collaborations

Northern Light Home Care and Hospice will collaborate with food banks, community action programs, food delivery services, grant resources, and our internal subject matter experts.

Plan for measuring impact

Northern Light Home Care & Hospice will monitor and evaluate the strategies related to this priority area of work for the purpose of tracking the implementation of those strategies as well as to document the anticipated impact. Through internal quarterly reporting practices we plan to document and track measures, approaches and resources used, partners engaged, and highlights related to this priority area of work. These quarterly reports will inform our fiscal year-end Progress Report to Our Community that will be made publicly available on our community health strategy webpage.

We will measure our impact through tracking food insecurity screenings, tracking referrals to resources, assessing the number of patients that are receiving a form of assistance (such as grant-funded food boxes) and tracking of staff education.

Population of focus

Any patient receiving our services that is identified as food insecure

Priority #2: Substance Use

Rationale

Substance Use, including alcohol, tobacco, and other drugs, have a major impact on individuals, families, and communities. Alcohol misuse, smoking and tobacco use cause or increase risk of many diseases, such as cancer, heart disease, diabetes, and respiratory conditions. The effects of substance use often result in social, physical, mental, and public health problems, including domestic violence, child abuse, accidents, crime, and suicide. Substance use is now understood to be a complex disease of the brain and body, requiring long-term attention and treatment just like any other chronic illness. There are many effective evidence-based strategies that communities, including healthcare organizations and providers, may employ to prevent, identify and treat substance use disorders.

The Northern Light Home Care & Hospice's Community Health Strategy team determined it was feasible to address this need. There are substantial local community assets and Northern Light Home Care & Hospice has assets available to be leveraged in support of this need. Also, there are many evidence-based or promising approaches to address the need for substance use interventions. Finally, substance use rated as a high priority to the community and our Northern Light Health system.

Intended action to address the need

Northern Light Home Care & Hospice, in recognition of the public health crisis presented by the opioid epidemic, will ensure patients, staff, and families are trained on recognition and avoidance of drug diversion. During the three years of implementation activities, we intend to engage in several initiatives such as:

- Train our hospice patients and their families on proper disposal of opioids, and methods to avoid diversion by family members
- Educate our post-surgical patients on proper use of narcotics for pain, and ensure they understand the dangers of opiate addiction
- Partner with Drug Free Communities to establish a "train the trainer" program, to facilitate our staff being trained in communicating safe opioid practices, and to help identify risks
- Enhance the availability of medication disposal bags, to be funded through philanthropic efforts. Based on successes with the hospice program, Northern Light Home Care and Hospice will consider expanding the medication disposal bag program to other patient populations we serve.

Anticipated impact of these actions/expected outcomes

Through the implementation of this goal, we anticipate our patients having better access to training and education, medication disposal bags, and be able to articulate the resources available to them to prevent misuse of medications.

Programs and resource allocation

Northern Light Home Care & Hospice resources will be allocated to enhanced staff training, including staff time and materials. Additionally, medication disposal bags will be purchased through anticipated grant or philanthropic funding for this effort.

Planned collaborations

Northern Light Home Care & Hospice will partner with the Drug Free Communities programs in the areas we serve, to form best practices for our staff and patients. We will ensure notification and access to drug take-back programs. We will collaborate with our own physicians to ensure they have access to, and receive training, on safe prescribing. We will also collaborate with internal stakeholders, such as Northern Light Acadia Hospital.

Plan for measuring impact

Northern Light Home Care & Hospice will monitor and evaluate the strategies related to this priority area of work for the purpose of tracking the implementation of those strategies as well as to document the anticipated impact. Through internal quarterly reporting practices we plan to document and track measures, approaches and resources used, partners engaged, and highlights related to this priority area of work. These quarterly reports will inform our fiscal year-end Progress Report to Our Community that will be made publicly available on our community health strategy web page.

Measurement may include staff training (initial and ongoing), distribution of medication disposal bags, and analysis of patient and family education and training.

Population of focus

Hospice and post-surgical patients, and their families

Priority #3: Older Adult Health/Healthy Aging

Rationale

The aging population in Maine and throughout the United States is increasing rapidly, which will contribute to

higher demands for healthcare, in-home caregiving, and assisted living facilities, resulting in increased costs for these services. Older adults experience higher rates of chronic disease, including heart disease, cancer, diabetes, and Alzheimer's disease, with many managing two or more of these conditions. Additionally, many seniors experience disability, transportation challenges, social isolation, and unsafe housing, creating additional barriers to good health and quality of life. Research has shown that disability and decline are not always inevitable consequences of aging, and that health may be preserved through promotion of healthy lifestyles and appropriate preventive care. Older adults, particularly those in rural communities, may also be supported through aging in place strategies that integrate health and social services.

The Northern Light Home Care & Hospice Community Health Strategy team has identified elder care and healthy aging as a priority need within our community. In addition to an established and capable network of community partners, Northern Light Home Care & Hospice has resources available to be leveraged in support of this need. There are many options for evidence-based approaches for integration of healthcare and community services that will keep seniors healthy and safe in their homes for as long as possible.

Intended action to address the need

Northern Light Home Care & Hospice will increase education and training regarding Advance Care Planning and Advance Directives in the communities in which we serve. Furthermore, we will assist our own patients in being more informed about the benefits of palliative care, where appropriate. To accomplish this, staff will need to have a deep understanding of the palliative care philosophy, and the appropriate applications of it. Additional targeted work will be done to assist our own employees, both at Home Care & Hospice and throughout Northern Light Health, in becoming more familiar with, and having access to, advance care planning. Part of this will be accomplished through distribution of our own internal advance directive form, and events focused on staff awareness.

Anticipated impact of these actions/expected outcomes

Northern Light Home Care & Hospice will seek to decrease hospitalization, improve health in the home, improve quality of life through focus on receiving the right care, at the right time, and in the right place, and work to help patients more comfortably accept the discussions around palliative care and end of life planning. We will continue building on system-level education that the palliative care program has been offering. Internally, targeted work will be done with clinical groups beginning with our social worker staff.

Programs and resource allocation

Northern Light Home Care & Hospice will continue, and expand our community-based trainings on palliative care and advance care planning. In addition, we will expand internal training and education to equip all clinical providers with the tools they need to effectively have discussions about palliative care and advance care planning.

Planned collaborations

Northern Light Home Care & Hospice will collaborate with internal partners to continue refining training and education resources that can be used internally and externally. In addition, we will partner with community organizations that will facilitate provision of community-based education programs. We will partner with internal colleagues, such as the new Northern Light Health Medical Group, to ensure our physicians are informed and educated about palliative care.

Plan for measuring impact

Northern Light Home Care & Hospice will monitor and evaluate the strategies related to this priority area of work for the purpose of tracking the implementation of those strategies as well as to document the anticipated impact. Through internal quarterly reporting practices, we plan to document and track measures, approaches and resources used, partners engaged, and highlights related to this priority area of work. These quarterly reports will inform our fiscal year-end Progress Report to Our Community that will be made publicly available on our community health strategy webpage.

We will measure advance care planning in place within 30 days of admission into any of our services, and we will work to measure our ability to integrate these into a patient's broader medical record. We will also measure the quantity of, and the effect of, community-based trainings on advance care planning, which are accomplished through community forums and panels. Critical to this will be ensuring patients in all of our geographies have access.

Population of focus

Any member of our community who will benefit from Advance Care Planning and/or Palliative Care

Priority #4: Mental Health

Rationale

Mental health conditions, including depression, are leading causes of injury, illness, and disability in the United States and around the world. These illnesses are common and are caused by a complex combination of biological, psychological, social, and environmental factors. Untreated mental illness can result in severe health problems, including but not limited to heart disease and other chronic conditions, weakened immunity, social isolation, legal and financial problems, self-harm and harm to others, poverty, and homelessness. There is also a strong connection between mental illness and substance use, with more than one in four adults experiencing these co-occurring disorders. Limited healthcare options, lack of support, and fear of stigma may prevent individuals from seeking help, indicating an ongoing need to increase mental health awareness and address barriers to accessing mental healthcare.

The Northern Light Home Care and Hospice Community Health Strategy team recognizes that addressing mental health needs is a priority for our community. There are substantial local community assets and Northern Light Home Care and Hospice has resources available to be leveraged in support of this need. Furthermore, there are many options for evidence-based mental health interventions and services that promote appropriate and effective prevention, identification, and treatment for mental illnesses. Mental health is a co-morbidity and is a predictor of mortality. Many patients are treated with medications but are not receiving treatment focused on non-medication-based therapies. We also know that depression affects patient's enthusiasm and adherence with rehabilitative therapies. Behavioral health concerns can also exacerbate cognitive impairments.

Intended action to address the need

Northern Light Home Care & Hospice will develop and provide staff education focused on available resources for patients with behavioral health needs as well as best practices for working with these patients. Social work will be leveraged in our approach to caring for patients with behavioral health needs. Staff will be further educated on working with patients who are expressing acute mental health symptoms. We will strive to become a trauma-informed agency, which means understanding the effect that traumatic life experiences have on a patient's ability to actively participate in their plan of care. We will also develop a checklist, to ensure that patients with histories of mental illness are offered opportunities to work with social work, or are referred to their physician, for further treatment after discharge from home health or hospice.

Anticipated impact of these actions/expected outcomes

Northern Light Home Care & Hospice staff will gain a further understanding of where to find and how to access resources for patients experiencing mental illness. Patients should feel more supported and less alone. These efforts should also lead to staff feeling more supported, and ultimately lead to better engagement and higher retention.

Programs and resource allocation

Northern Light Home Care & Hospice will involve social work in development of programs and resources. We will also work with the resource center of Integrated Care Management to catalogue available resources. In order to be

successful in this area, staff training hours will be dedicated, and a workflow will be developed for managing patients expressing acute mental health concerns.

Planned collaborations

Northern Light Home Care & Hospice will collaborate with Northern Light Acadia Hospital, including working to develop a partnership for telepsychiatry and telepsychology programs. We will also create pathways for patients who may be accessing resources in other health systems. The American Foundation for Suicide Awareness has a Maine Chapter with whom we will also collaborate.

Plan for measuring impact

Northern Light Home Care & Hospice will monitor and evaluate the strategies related to this priority area of work for the purpose of tracking the implementation of those strategies as well as to document the anticipated impact. Through internal quarterly reporting practices we plan to document and track measures, approaches and resources used, partners engaged, and highlights related to this priority area of work. These quarterly reports will inform our fiscal year-end Progress Report to Our Community that will be made publicly available on our community health strategy webpage.

We will measure staff familiarity of resources pre- and post-education. Patients will also be evaluated at the start of care and at discharge to evaluate improvements (screening is currently done at admission, but not at discharge). Hospice patients are not currently assessed and creating an assessment mechanism for that population will also be pursued.

Population of focus

Internal staff education, and all patients served by Northern Light Home Care & Hospice. This will also include our Pathfinders participants, which is a support group for grieving children and their families.

Health Priorities Not Addressed

Northern Light Home Care & Hospice considered all priorities identified in the Shared CHNA, as well as other sources, through an extensive review process. While the full spectrum of needs is important, Northern Light Home Care & Hospice is currently poised to focus only on the highest priorities at this time. Priorities not selected, due to a variety of reasons are listed below:

- Access to Care - It was determined that access to care will be addressed through our selected priority of needs. In addition, Northern Light Home Care & Hospice is engaged in a number of current initiatives focused on improving access to care through our home health services and other efforts that are ongoing and part of our continual mission to improve access to care.

Conclusion

Northern Light Home Care & Hospice is thankful for the participation and support of our community members and many area organizations in the Shared CHNA process and for contributing their knowledge of local community health needs. Through existing and future partnerships, collaborative efforts will be essential in addressing the identified community health strategies prioritized within.

Northern Light Home Care & Hospice will engage in another Shared CHNA in 2022, and we look forward to ongoing community participation in these important efforts.

Appendix

Evaluation of Impact

Progress report on selected priorities from Northern Light Home Care & Hospice's last (2016) Community Health Needs Assessment.

Northern Light Health and Northern Light Home Care & Hospice are committed to promoting a culture of community stewardship, and partnering together with community stakeholders to address high priority health issues. In order to do so effectively, we regularly monitor the impact of our community health efforts, and make this information widely available to our communities in the form of annual Community Benefit statements, and this triennial Community Health Strategy report. The following annual Progress Report to Our Community provides a summary evaluation of impact of the actions taken by Northern Light Home Care & Hospice to address community health priorities adopted in 2016.

Measuring and reporting on progress is critical to making a difference in the communities we serve, and in the lives of those we care for. The following annual Progress Reports to Our Community are provided for:

- Progress Report to Our Community FY17
- Progress Report to Our Community FY18
- Progress Report to Our Community FY19 (will be included upon availability)

For additional information, visit https://northernlighthealth.org/Community-Health-Needs-Assessment/2016-CHNA-Reports/Community-Health-Strategy

Progress Report to Our Community

Addressing Community Health Needs

Fiscal Year 2017

2019

2018

2017

VNA Home Health Hospice

FY 2017 Progress Report Priority 1: Preventive Care	
Objective	Flu immunization - VNA Home Health Hospice will continue its leadership role providing flu immunizations in the community and will engage in a point of dispensing (POD) drill by the end of FY17.
Status	Completed
Approaches taken and resources used	VNA Home Health Hospice (VNA) completed the 2016-2017 flu season through vaccination efforts in a number of schools, as well as senior living sites and workplaces VNA also worked collaboratively with the Maine Centers for Disease Control and Prevention to engage in a drill, located at the University of New England, as an emergency point of dispensing (POD) site for distribution of medicinal items in a public health emergency.
Partners engaged	VNA Home Health Hospice partnered with the following entities on this priority: • City of Portland • Schools in Cumberland and York Counties • University of New England • Employers • Senior living sites
Highlights	A significant number of people were vaccinated against the flu in schools, workplaces, homes, and clinics. VNA exceeded its target measure to vaccinate 6,000 individuals by 2,673, ultimately vaccinating 8,673 individuals.
Outcome Measure	8,673 influenza shots given 2018 Flu Season Planning Completed
Project lead	LeighAnn Howard RN, MSN, CHFN-K, Director of Home Health and Specialty Programs; and Catherine Bean RN, Community Health and Wellness Coordinator, VNA Home Health and Hospice
Next Steps	In FY18, VNA Home Health Hospice is planning for the 2017-2018 flu season in Cumberland and York counties. In addition, VNA plans to engage the Penquis District Public Health to discuss opportunities to offer flu clinics in Penobscot and Piscataquis counties. VNA is also currently working with the City of Portland to coordinate another POD drill.

FY 2017 Progress Report Priority 2: Senior Health	
Objective	Senior blood pressure and wellness clinic - Implement one wellness/blood pressure clinic in Aroostook County for seniors.
Status	Completed
Approaches taken and resources used	VNA Home Health Hospice (VNA) established three clinics at senior sites in Aroostook County at Fort Kent Senior Center, Sargent Family Community Center, and Ricker Plaza. In addition, VNA also started three blood pressure sites at Fort Kent Senior Center, Sargent Family Community Center and Houlton Rec Department for community residents to come test their vitals on their own time. The blood pressure checks are supported by VNA staff.
Partners engaged	VNA Home Health Hospice partnered with the following entities on this priority: • Fort Kent Senior Center • Sargent Family Community Center • Houlton Rec Department • Ricker Plaza
Highlights	ADPHIP (Aroostook District Public Health Improvement Plan) - we applied for a received a grant to purchase needed equipment to set up three more sites in Fort Kent Senior Center, Sargent Family Community Center and Houlton Rec Department where patients can self-test their vital signs. The data is then sent to a VNA nurse for review.
Outcome Measure	Three blood pressure clinics offered in Aroostook County
Project lead	LeighAnn Howard RN, MSN, CHFN-K, Director of Home Health and Specialty Programs; and Katherine Cropley RN, Mental Health Visiting Nurse VNA South Portland
Next Steps	In FY18, VNA plans to finalize grant funding and implement software needed to use telemonitoring devices for monitoring remote blood pressure in one senior site in Aroostook County.

Priority #3: Tobacco Use

Rationale:

Many of the patients served by VNA Home Health and Hospice struggle with nicotine addiction. Providing staff with the much needed education and certification will be essential to help patients work through their addiction. The final desired outcome being that patients have a lowered risk of disease and hospitalization and a more positive impact on their health.

Intended action to address the need:

1. Supporting visiting staff in tobacco education and certification through the Tobacco Free Maine program
2. Train the trainer approach
3. Implementing educational and assessment programs for our staff and patients

Programs and resource allocation:

Clinical staff will attend education and certification classes. Those trained are available to visit patients with tobacco dependence and as a resource to other clinical staff.

Planned collaborations:

Tobacco Free Maine

Population of focus:

Home health patients and wellness clinic participants

FY 2017 Progress Report Priority 3: Tobacco Use	
Objective	Tobacco certification - VNA Home Health Hospice (VNA) will assist at least one employee achieve Tobacco certification through the Tobacco Free Maine program.
Status	Completed
Approaches taken and resources used	VNA identified one staff member to receive training and certification through Tobacco Free Maine. The staff member completed the required education in 2017. Post certification, the staff member has gathered and developed resources for VNA clinicians to use with patients for Tobacco Cessation.
Partners engaged	VNA Home Health Hospice partnered with the following entities on this priority: • Maine Tobacco Help Line resources
Highlights	Completion of the training and certification through Tobacco Free Maine. Education of clinical staff has begun.
Outcome Measure	One employee achieved certification through the Tobacco Free Maine program
Project lead	LeighAnn Howard RN, MSN, CHFN-K, Director of Home Health and Specialty Programs; and Jessica St. Peter, Manger of Clinical Services, Aroostook
Next Steps	In FY18, VNA will host an educational seminar (scheduled for October 2017) for clinicians to learn how to use tobacco cessation materials and refer patients. VNA will also build a library of patient resources related to tobacco cessation for staff use.

FY 2017 Progress Report Priority 4: Obesity/Diabetes	
Objective	Diabetes education - VNA staff member will complete diabetes education training to be a resource to home care clinicians.
Status	Completed
Approaches taken and resources used	VNA identified one staff member to receive diabetes education training. The employee successfully completed the required course through the American Diabetes Association and has started to develop a diabetes teaching aid for home care clinicians to use as a resource when working with patients in need of diabetes education.
Partners engaged	VNA Home Health Hospice partnered with the following entities on this priority: • American Diabetes Association
Highlights	Valuable knowledge gained from the American Diabetes Association's training has proven to provide beneficial insight for other VNA staff when working with patients with diabetes.
Outcome Measure	One employee trained
Project lead	LeighAnn Howard RN, MSN, CHFN-K, Director of Home Health and Specialty Programs; and Catherine Bean RN, Community Health and Wellness Coordinator, VNA Home Health and Hospice
Next Steps	In FY18, the trained staff will finalize the diabetes resource guide through the identification of additional diabetes resources to be used by VNA staff for education purposes.

FY 2017 Progress Report Systemwide Priority: Opioid Harm Reduction - Provider Education	
Objective	By 9/30/2017, increase the number of VNA Home Health providers receiving education on Maine's new opioid prescribing law (LD 1646, An Act to Prevent Opiate Abuse by Strengthening the Controlled Substances Prescription Monitoring Program) by five.
Status	Completed
Approaches taken and resources used	Provider education/training and inventory of competency needs on Maine's new opioid prescribing law was provided by Eastern Maine Medical Center to all five VNA providers.
Partners engaged	VNA Home Health Hospice partnered with the following entities on this priority: • EMHS • Hospice council • Maine Family Practice Conference
Highlights	All five provider attended opioid education.
Outcome Measure	5 providers received education on Maine's new opioid prescribing law (LD 1646, An Act to Prevent Opiate Abuse by Strengthening the Controlled Substances Prescription Monitoring Program)
Project lead	LeighAnn Howard RN, MSN, CHFN-K, Director of Home Health and Specialty Programs
Next Steps	In FY18, VNA plans to roll-out patient education materials surrounding prescription drug safety at two provider sites.

FY 2017 Progress Report Systemwide Priority: Healthy Food Access - Food Insecurity Screen and Intervene	
Objective	Increase the number of patients screened for food insecurity to 250 by 9/30/2017.
Status	Completed
Approaches taken and resources used	In FY17, VNA integrated food insecurity assessments in the home care electronic medical record. All physician practices, nursing homes, skilled nursing facilities, and hospitals were given in services on our program and were asked to help by identifying potential food insecurity at time of referral. Patient education was also created for hospitals and skilled nursing facilities. In addition, VNA successfully added questions to the screen and intervene intake that assessed access to food pantries and clinics. When needed, delivery options were arranged through formalized partnerships with local food banks, delivery services, and local agency on aging teams.
Partners engaged	VNA Home Health Hospice partnered with the following entities on this priority: • EMHS • Aroostook County Action Program • Food delivery organizations • Food pantries
Highlights	Although our EMR build, formal screening to every homecare client on our service, and formalized follow-through pathways are "big wins" – we believe the biggest "win" of this project so far is the increased number of inspired local food insecurity screening champions. Over seven month period in FY17 we met with over 70 physician practices, hospitals, and facilities. Approximately 280 in-person meetings, food insecurity was discussed to increase awareness. Care managers, physicians, MAs, nurses, med techs, and administrators are now thinking more about food insecurity, patients who are potentially food insecure, and the value of proper screening and placement into support programs. Inspiring local champions and enhancing partnerships is the key to sustainable change. We have started this relationship building process.
Outcome Measure	78% of VNA's patients were screened
Project lead	Mathew Collins, Provider Relations Liaison LeighAnn Howard RN, MSN, CHFN-K, Director of Home Health and Specialty Programs
Next Steps	In FY18, VNA Home Health Hospice will no longer report on this objective. However, VNA has a long standing mission to meet the needs of our patients including food needs. VNA will continue to informally monitor for food insecurity and when needs are identified foods will be donated and or purchased through mission funds.

Fiscal Year 2018

Progress report to our community

Addressing community health needs

Northern Light
Home Care & Hospice

Progress report update

FY 2018 Progress Report
Priority #1: Preventive care

Objective: Meet with Penquis District Public Health Liaison to discuss flu immunizations in Penquis district.

Status: Completed

Approaches taken and resources used: In fiscal year 2018 (FY18), Northern Light Home Care & Hospice met with Penquis District's Public Health Liaison, covering Penobscot and Piscataquis Counties (Penquis District) to discuss needs in that district.

Partners engaged: Northern Light Home Care & Hospice partnered with the following entities on this priority:

- Maine Public Health District 6

Highlights: In FY18, Northern Light Home Care & Hospice worked with the Penquis Public Health District to expand access to vaccination programs. The greatest need was in administration of Hepatitis Vaccine, which proved difficult to obtain. Unfortunately, no Hepatitis A clinics were able to be held. There were several flu clinics held in the district, however, including:

- Corinth Schools
- Freightliner
- Gross Minsky
- Country Villa
- Miller on the Square
- Ellen Leach Home
- Porvair
- New England Kenworth

Outcome Measure: In FY18, the outcome measure for this objective achieved by Northern Light Home Care & Hospice was meeting with the Penquis District Health Liaison and establishing several flu clinics for the region.

Project Lead: LeighAnn Howard, RN, MSN, CHFN-K, director of Home Health and Specialty Services; and Cathy Bean, RN, community wellness coordinator

Next Steps: In fiscal year 2019, Northern Light Home Care & Hospice will increase the total number of flu vaccines administered state wide from the 2017-2018 baseline of 7,050.

FY 2018 Progress Report
Priority #2: Senior health

Objective: Implement telehealth remote blood pressure monitoring in one senior site in Aroostook County.

Status: Completed

Approaches taken and resources used: In FY18, Northern Light Home Care & Hospice deployed two telehealth remote blood pressure monitoring systems in Aroostook County. This uses Honeywell Telehealth Monitoring equipment similar to that which is used in patient homes. Patients voluntarily participate in the program which tracks and trends their blood pressures.

Partners engaged: Northern Light Home Care & Hospice partnered with the following entities on this priority:

- Fort Kent Senior Center
- Sargent Family Community Center

Highlights: In FY18, Northern Light Home Care & Hospice was able to deploy telehealth monitoring equipment in two senior centers in Aroostook County. Monitoring has begun and patients are able to voluntarily participate in the program which tracks and trends their vital signs.

Outcome Measure: In FY18, the outcome measure for this objective achieved by Northern Light Home Care & Hospice was deploying two telehealth monitoring stations.

Project Lead: LeighAnn Howard, RN, MSN, CHFN-K, director of Home Health; Jessica St. Peter, manager of Clinical Services

Next Steps: Additionally, we intend to embark on a new target, which is increasing the percentage of patients with advanced directives or Professional Orders for Life-Sustaining Treatment or POLST documents, which are reviewed within 30 days of initiation of palliative care. The increase will be based on a baseline of 89%.

FY 2018 Progress Report
Priority #3: Tobacco use

Objective: Hold one Tobacco Education Session for employees sponsored by the Tobacco Free Maine program.

Status: Completed

Approaches taken and resources used: In FY18, Northern Light Home Care & Hospice hosted an in-service with the educator from the Tobacco Free Maine program. Clinicians and leadership from all offices attended the meeting. Many materials were also supplied to all offices. These materials will be used by visiting staff.

Partners engaged: Northern Light Home Care & Hospice partnered with the following entities on this priority:

- Maine Tobacco Helpline and our tobacco educator

Highlights: In FY18, Northern Light Home Care & Hospice now has great tools and access to other resources to help our patients who have tobacco dependence.

Outcome Measure: In FY18, the outcome measure for this objective achieved by Northern Light Home Care & Hospice was 30 or more employees attended the tobacco education session sponsored by the Tobacco Free Maine program.

Project Lead: LeighAnn Howard, RN, MSN, CHFN-K, director of Home Health and Specialty Programs; Kathy Cropley, RN, Home Health

Next Steps: In fiscal year 2019, Northern Light Home Care & Hospice will continue to partner with Tobacco Free Maine to identify resources for patients for smoking cessation. The suggested resources will be incorporated in to the admission books for patients.

Furthermore, we will survey staff to assist in identification of specific needs for focused patient cessation programs.

FY 2018 Progress Report
Priority #4: Obesity/diabetes

Objective: Increase by one, the development of a diabetes resource guide to be used by staff by September 2018.

Status: Completed

Approaches taken and resources used: In FY18, Northern Light Home Care & Hospice worked with new-graduate resident nurses to create a diabetes resource guide to help both patients and staff identify resources to assist with managing their disease. The two "resident" RNs spent 120 hours working on this project.

Partners engaged: Northern Light Home Care & Hospice partnered with the following entities on this priority:

- University of Southern Maine new-graduate residents

Highlights: In FY18, Northern Light Home Care & Hospice created a diabetes resource guide to be used to assist patients in getting connected to the best resources possible to assist with managing their disease and improve quality of life.

Outcome Measure: In FY18, the outcome measure for this objective achieved by VNA was the creation of the resource guide.

Project Lead: LeighAnn Howard, RN, MSN, CHFN-K, Director of Home Health and Specialty Programs; Kristine E. Rogers, Manager of Clinical Education.

Next Steps: In fiscal year 2019, Northern Light Home Care & Hospice will work to make this guide available across all of the regions that we serve, including (but not limited to) Aroostook, Penobscot, Kennebec, Waldo, Cumberland, Sagadahoc, and York counties. In addition, this work will be shared externally through Kris Rogers' MSN teaching at the University of Southern Maine.

FY 2018 Progress Report
Systemwide priority: Opioid harm reduction – provider education

Objective: By September 30, 2018, increase by two the number of provider sites providing patient education materials surrounding prescription drug safety.

Status: Completed

Approaches taken and resources used: In FY18, Northern Light Home Care & Hospice worked with staff to increase access to opioid education for patients.

Partners engaged: Northern Light Home Care & Hospice partnered with the following entities on this priority:

- ABIM Foundation

Highlights: In FY18, Northern Light Home Care & Hospice exceeded the goal of two sites providing opioid education. All four Northern Light Home Care & Hospice primary offices are offering the education materials.

Outcome Measure: In FY18, the outcome measure for this objective achieved by Northern Light Home Care & Hospice was implementing patient education at all sites for opioid use.

Project Lead: Leah Wright, vice president of Quality, Compliance and Informatics; LeighAnn Howard, RN, MSN, CHFN-K, director of Home Health and Specialty Programs

Next Steps: In fiscal year 2019, Northern Light Home Care and Hospice will establish a baseline measurement for providing opioid education to patients. In 2018, the education material was made available – now we will measure its use with patients.

FY 2018 Progress Report
Systemwide priority: Healthy food access – food insecurity - screen and intervene

Objective: Increase the number of screenings for food insecurity from zero to 500 by September 30, 2018

Status: Completed

Approaches taken and resources used: In FY18, Northern Light Home Care & Hospice educated staff members and implemented food insecurity screening questions.

Partners engaged: Northern Light Home Care & Hospice partnered with the following entities on this priority:

- Internal staff

Highlights: In FY18, Northern Light Home Care & Hospice had a 15% screening rate in the first four months of the fiscal year with eight people (0.02%) identified as potentially food insecure. For the next eight fiscal periods, more targeted efforts were implemented as well as an improved data collection mechanism. In the last eight months, 87% of admissions were screened for food insecurity. 5% of those admissions (221 patients) were identified as food insecure. 4% of the total was referred to local food banks, and 3.5% were referred to social work.

Outcome Measure: In FY18, the outcome measure for this objective achieved by Northern Light Home Care & Hospice was exceeded. The goal was to document 500 food insecurity screenings. In fact, 4,962 food insecurity screenings were completed, with referrals to resources completed where appropriate.

Project Lead: LeighAnn Howard, RN, MSN, CHFN-K, director of Home Health and Specialty Programs

Next Steps: In fiscal year 2019, Northern Light Home Care and Hospice will strive to increase to 90% the number of patients with food insecurity screenings, and additionally will increase the number of referrals to either food banks or social work. Furthermore, staff will receive education on ways to enhance referrals and capture documentation.