Progress Report to Our Community

Addressing Community Health Needs

Fiscal Year 2017

EMHS
Access to Quality Healthcare SM

Beacon Health

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Progress Report to Our Community

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Making our communities healthier - It may sound like a simple goal, but doing it right, involves hard work, commitment, and collaboration. Many factors can influence the health of people in our communities including income, poverty, employment, education, and household environment.

In 2016, EMHS partnered with three other large healthcare systems and the Maine Center for Disease Control and Prevention, an office of the Maine Department of Health and Human Services, to create a Community Health Needs Assessment. We used that assessment and public input to develop a three-year strategy to improve the health and well-being of the communities that we serve.

The following is a progress report for our community health improvement plan for fiscal year 2017. As a member organization of EMHS, we at Beacon Health have our own unique set of priorities that we are addressing including:

- Access of Behavioral Care/Mental Health Care
- Transportation
- Mental Health
- Depression

The information contained in the following pages demonstrates our commitment to our communities and show the steps we have taken to reach our benchmarks. Thank you for taking the time to review these materials. We appreciate and value your partnership in this endeavor. Together we are achieving success and supporting vibrant and healthy communities across the regions where we work and serve.

Sincerely,

Michael Donahue, MBA

President, Beacon Health

Priority #1: Access of Behavioral Care/Mental Health Care

Rationale: Anticipated impact statements provided below.

Intended action to address the need:

- Develop state-wide, multi-stakeholder high value network of behavioral health providers
  - Anticipated impact - Improved coordination and measurement of quality outcomes for behavioral healthcare
- Develop infrastructure to promote the delivery of tele-psychiatry services
  - Anticipated impact – Improved access to services in rural health settings
  - Anticipated impact – Minimized delay in diagnosis and treatment
- Optimize ongoing utilization of Community Care Team
  - Anticipated impact – Continued connection of patients with available services in the community
  - Anticipated impact – Improved identification and integration of comorbid behavioral and chronic medical conditions (whole-person care)
- Sustainability plan for Community Care Team post Patient Centered Medical Home (PCMH) pilot
  - Anticipated impact – Continuation of critically important home- and community-based services after funding ends
  - Anticipated impact – Anticipated integration into current Population Health service contracts
- Improved support of mental health in primary care settings
  - Anticipated impact – Improved integration of mental health services in primary care settings currently accessed by the patients
  - Anticipated impact – Improved patient experience by reducing barriers in utilization of mental health services
  - Anticipated impact – Enhanced mental health knowledge and support to the primary care provider

Programs and resource allocation:

- Beacon Health Community Care Team
- Beacon Health Care Coordination Program
- Next Generation ACO Telehealth benefit enhancement program
- Beacon Health's Population Health Committee
- Behavioral Health In-system Performance Improvement group

Planned collaborations:

- Existing MOUs with Area Agencies on Aging within the State, and the City of Bangor Public Health
- Beacon Health Preferred Provider agreements with Acadia Hospital, Sweetser, and Spurwink

Population of focus:

- ACO contracts and attributed lives, Medicare, Mainecare, EMHS Medical Plan

FY 2017 Progress Report Priority 1: Access of Behavioral Care/Mental Health Care	
Objective	Access of Behavioral Care/Mental Health Care: Improve by an average of 10% three Access measures (quantity of In System providers, number of identified beneficiaries with unmet needs, and reduced provider needs for access) by 12/31/17.
Status	Completed
Approaches taken and resources used	In FY17, Beacon Health discussed and planned for a semi-annual survey related to access. In addition, Beacon Health established a focus group to review, discuss and plan for improved use of behavioral health data to improve outcomes. The Medicare ACO programs MSSP and Next Generation, and the EMHS Employee Health Plan data were the focus. This group monitored use, access, actions, and outcomes. Beacon Health's Data Analytics team identified additional ways to use its data to make targeted referrals to the Community Care Team (CCT). This resulted in at least 30 new, appropriate referrals being opened to CCT during the first data run. These referrals continue and grew throughout the remainder of the year. The Population Health Committee continued to address depression screening and improved diagnosis at its monthly meetings (x2 in 2017). EMHS member organizations developed strategies to implement process improvements, and are reporting success.
Partners engaged	Beacon Health partnered with the following entities on this priority: • Acadia Hospital to make tele-psychiatry services available to Next Generation Medicare and EMHS employee plan beneficiaries. Efforts have been made to educate and promote utilization of this service. • Acadia Hospital, Aroostook Medical Health Center, Spurwink, and Sweetser to the preferred provider listing and the Behavioral Health In System Program Improvement Committee (BHIPI), with clinic locations across much of Maine
Highlights	Traditionally, behavioral health data access has been very limited. Beacon Health has been successful at identifying the need for this information and planning for its appropriate use and access. In partnership with the BHIPI committee, Beacon Health established an agreed upon data set by which in system and in network behavioral health providers will be assessed for outcomes and quality of services.
Outcome Measure	496 Behavioral Health Preferred Providers are part of the Beacon Health Network. The various electronic medical records used by each partner have different reporting and tracking capabilities, which complicated the measurement of standardized outcomes.
Project lead	Steve Ryan, Director, Network Management (no longer at Beacon)
Next Steps	In fiscal year 2018 (FY18), Beacon Health will continue to provide behavioral health case management for the EMHS Employee Health Plan. Additionally, the BHIPI group will continue its efforts. However, Beacon Health will not pursue this goal on its own in 2018 as it is part of a larger strategic effort, and the objectives contained herein are included in other community health efforts.

Priority #2: Transportation

Rationale: Anticipated impact statements provided below.

Intended action to address the need:

Optimizing Community Care teams to bring services to the patients and improve patient experience
- Anticipated impact – Improved patient engagement and self-management
- Anticipated impact– Improved identification, diagnosis, and treatment

Develop infrastructure to promote the delivery of post-discharge home visits
- Anticipated impact – Reduced emergency department visits and hospital admissions
- Anticipated impact – Improved follow-up visit occurrence by reducing transportation barriers

Develop infrastructure to promote the delivery of tele-health services
- Anticipated impact – Improved access to services in rural health settings
- Anticipated impact – Minimized delay in diagnosis and treatment

Resource coordination to facilitate patient access to community transportation
- Anticipated impact – Increased utilization of available transportation resources
- Anticipated impact – Improvement patient experience and engagement with service provider

Programs and resource allocation:
- Beacon Health Community Care Team
- Beacon Health Care Coordination Program
- Next Generation ACO Telehealth and Post-Discharge Home Visit benefit enhancement programs
- Beacon Health's Population Health Committee

Planned collaborations:

Existing MOUs with Area Agencies on Aging within the State and the City of Bangor Public Health
Collaboration with other Community Action Program agencies
Preferred Provider agreements with local healthcare providers

Population of focus:

ACO contracts and attributed lives, Medicare, Mainecare, EMHS Medical Plan

FY 2017 Progress Report Priority 2: Transportation	
Objective	By the end of FY 2017, patients who identify transportation as a barrier to accessing appropriate care will be connected with the Community Care Team for assessment and intervention to improve access to reliable, available sources of transportation for medical appointments, including specialty. Additionally, we will bring care to the patient, when possible, by launching post discharge home visits, telehealth, and home visiting completed by the Community Care Team or other community agency.
Status	In Progress
Approaches taken and resources used	In FY17, Beacon Health recognized that a transportation waiver could expand transportation options for Medicare beneficiaries. Discussions continue regarding the use of this waiver and ability to use/implement. However, all Center for Medicare and Medicaid Innovation (CMMI) waiver capacities (transportation, Post Discharge Home Visits, telehealth, etc.) will cease on 1/1/2018 due to exit of Next Generation program. Beacon Health and partners identify value in these services and are currently cooperating and partnering with compliance/legal to determine next appropriate steps in FY18 to continue patient care in this area. Despite this significant shift, Beacon Health's Community Care Team (extended case management, including home/community visitation) will continue to provide home visits to patients in their programs.
Partners engaged	Beacon Health partnered with the following entities on this priority: • Acadia Hospital • eHealth Advisory Committee and Beacon Health are collaborating on business case development
Highlights	The infrastructure is now in place for successful home visiting with Beacon Health. This will continue to be explored in a new regulatory environment.
Outcome Measure	In FY17, Beacon Health successfully launched the CMMI waiver service for Post Discharge Home Visits. In just two reporting quarters, Beacon Health Community Care Team staff performed visits for nearly 90 patients who were at risk of readmission to a hospital. Additionally, staff also provided home visits for hundreds of more patients who had difficulty accessing healthcare services. Staff bring healthcare services to the patient, eliminating the transportation barrier, and ensuring that home assessment information is communicated to and coordinated with the patient's primary care team.
Project lead	Tori Gaetani, VP, Nursing and Patient Care Services Jamie Rogers, LCSW, Director, Community Care and Behavioral Health
Next Steps	In FY18, Beacon Health will continue to work with patients who identify transportation as a barrier to accessing appropriate care by connecting them with the Community Care Team for assessment and intervention to identify improved access to reliable, available sources of transportation for medical appointments, including specialty.

Priority #3: Mental Health

Rationale: Anticipated impact statements provided below.

Intended action to address the need:

Develop state-wide, multi-stakeholder high value network of mental health providers
- Anticipated impact - Improved coordination and measurement of quality outcomes for mental healthcare

Optimize ongoing utilization of Community Care Team
- Anticipated impact – Continued connection of patients with available services in the community
- Anticipated impact – Improved identification and integration of comorbid mental and chronic medical conditions (whole-person care)

Improved support of mental health in primary care settings
- Anticipated impact – Improved integration of mental health services in primary care settings currently accessed by patients
- Anticipated impact – Improved patient experience and quality of life by reducing barriers in utilization of mental health services
- Anticipated impact – Enhanced mental health knowledge and support to the primary care provider
- Anticipated impact – Improved provider experience

Programs and resource allocation:

Beacon Health Community Care Team
Beacon Health Care Coordination Program
Behavioral Health In-System Performance Improvement group
Beacon Health's Population Health Committee

Planned collaborations:

Multi-disciplinary care teams, across the continuum of care
Primary Care Practices
Beacon Health Preferred Provider agreements with Acadia Hospital, Sweetser, and Spurwink

Population of focus:

ACO contracts and attributed lives, Medicare, Mainecare, EMHS Medical Plan

FY 2017 Progress Report Priority 3: Mental Health	
Objective	By the end of FY17, a preferred behavioral health network will be recognized and utilized throughout the Beacon footprint. Data measures will be agreed upon and collection will have begun. Primary care providers will express improved satisfaction with the level of access for behavioral health services they/their patients have access to, and they will also report improved communication with this preferred provider network. Additionally, the Community Care Team will routinely review, screen, and intervene with high risk patients to reduce exacerbated/untreated mental health symptoms from driving costly care (i.e. ED/admissions, non-adherence to medical treatment plans/medication etc.).
Status	In Progress
Approaches taken and resources used	In FY17, Beacon Health's Community Care Team (CCT) services were available throughout the EMHS footprint. Efforts to continue mental health integration with medical care were engaged and preferred provider networks were expanded.
Partners engaged	Beacon Health's Preferred Provider Network expanded significantly and spans statewide through the behavioral health in system program improvements, which includes, for the first time ever, agreed upon data sets, which are shared amongst the group for ongoing process and quality improvement initiatives. This represents a community collaboration which has not been popular among competing behavioral health organizations in the past.
Highlights	Preferred provider network expanded significantly in quarter three of FY17
Outcome Measure	1. Number of preferred providers covering all regions = >440 2. The various electronic medical records (EMRs) used by each network partner have different reporting and tracking capabilities, which complicated the measurement of standardized outcomes. In addition, the way that these programs/services have been integrated into practice delivery include a variety of ways a referral can be made, which complicates tracking/measuring. 3. Number of mental health screens completed by CCT = 100% of patients with Post Discharge Home Visits had the PHQ9 screenings completed, with approximately 20% screening positive.
Project lead	Jaime Rogers, LCSW, Director, Community Care and Behavioral Health Services Will Seavey, PharmD, Director of Care Delivery
Next Steps	Beacon Health will not pursue this goal on its own in 2018 as it is part of a larger strategic effort, and the objectives contained herein are included in other community health efforts.

Priority #4: Depression

Rationale: Anticipated impact statements provided below.

Intended action to address the need:

Improve depression screening rates and documentation of intervention with positive screens

- Anticipated Impact – Improved identification, diagnosis, and treatment of depression
- Anticipated Impact – Improved ACO and other Value-based programs quality performance

Develop state-wide, multi-stakeholder high value network of mental health providers

- Anticipated impact - Improved coordination and measurement of quality outcomes for depression

Improved support of depression identification, diagnosis, and treatment in primary care settings

- Anticipated impact – Improved integration of depression treatment in primary care settings currently accessed by patients
- Anticipated impact – Improved patient experience and quality of life by reducing barriers in utilization of depression treatment
- Anticipated impact – Enhanced knowledge and support for the primary care team, including Beacon Health care coordinators, regarding depression identification, diagnosis, and treatment
- Anticipated impact – Improved provider experience

Programs and resource allocation:

Beacon Health Care Coordinators Beacon, Health Community Care Team Beacon Health, Population Health Committee

Planned collaborations:

Multi-disciplinary care teams, across the continuum of care
Primary Care Practices
Beacon Health Preferred Provider agreements with Acadia Hospital, Sweetser, and Spurwink

Population of focus:

ACO contracts and attributed lives, Medicare, Mainecare, EMHS Medical Plan

FY 2017 Progress Report Priority 4: Depression	
Objective	By the end of FY 2017, at least 60% of ACO patients will be screened for depression using the PHQ9 screening tool. At least 40% of positive screens (i.e. >9), will be referred for behavioral health intervention (i.e. CCT, LCSW, PMH-NP, other). Training and education will be provided to practice teams to enhance their willingness and ability to positively engage patients in discussing and intervening with depressive symptoms.
Status	In Progress
Approaches taken and resources used	In FY17, Beacon Health's Population Health Committee continued to address depression screening and improved diagnosis at its monthly conference (x2 in 2017). EMHS member organization's developed a strategy to implement process improvements, and is reporting success. All initial Post Discharge Home Visits (PDHV) included a depression screening using PHQ9.
Partners engaged	Beacon Health invited and supported Acadia Hospital to share their integrated approach to embedded services in primary care at several Population Health Committee Conferences. Additionally, the Behavioral Health In Network Program Improvement (BHIPI) committee was established to begin reviewing standards of integrated care, to ensure a responsive and effective referral network, is available when screening results in the need for intervention.
Highlights	EMHS member organizations and members of the Behavioral Health In System Performance Improvement (BHIPI) Committee were very supportive and embraced improvements surrounding screening and intervention for depression.
Outcome Measure	100% of ACO patients who have a Post Discharge Home Visit (waiver) are screened using the PHQ9 for depression. Approximately 20% of these screens are positive, indicating possible major depressive disorder.
Project lead	Jaime Rogers, LCSW, Director, Community Care and Behavioral Health
Next Steps	In FY18, Beacon Health plans to continue this goal and will expand to include successful intervention with positive screens.

Conclusion

Beacon Health continues work on identified priorities through the Community Health Strategy and is thankful for the participation and support of our community members and many area organizations for contributing their knowledge of local community health needs related to our priorities of action. Through existing and future partnerships, collaborative efforts are essential in addressing the identified community health strategies prioritized within.

Beacon Health will engage in another Shared Community Health Needs Assessment in 2019 and looks forward to ongoing community participation in these important efforts.

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