Progress Report to Our Community

Addressing Community Health Needs

Fiscal Year 2017

2019

2018

2017

EMHS
Access to Quality Healthcare℠

Blue Hill Memorial Hospital

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Blue Hill Memorial Hospital

EMHS MEMBER

Progress Report to Our Community

Blue Hill
Memorial Hospital
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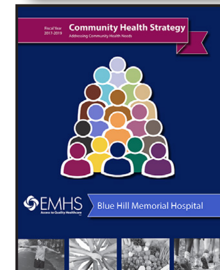

John Ronan, MBA, FACHE
President, Blue Hill Memorial Hospital

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 Blue Hill Memorial Hospital have our own unique set of priorities that we are addressing including:

- Obesity (Physical Activity and Nutrition)
- Drug and Alcohol Abuse
- Transportation

We are also working together with other EMHS members throughout the state to prevent and treat Opioid addiction and to improve access to healthy food for patients, families and communities.

The information contained in the following pages demonstrate 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,

John Ronan, MBA, FACHE

President, Blue Hill Memorial Hospital

Priority #1: Obesity (Physical Activity/Nutrition)

Rationale:

To increase the screening in our care delivery model of the overweight and obese population and provide the opportunity for education in the clinical setting and collaboration with community resources for weight loss and physical activity in an effort to improve the health condition of this population in our community.

Intended action to address the need:

1. Explore options to engage in evidence-based programs such as "Let's Go!" (for pediatrics)
2. Screening at PCP and Specialty Practice visits with BMI plan that includes referrals for diet and exercise counseling
3. Weight management classes
4. Transition from healthcare based services to community based wellness programming
5. Include more Maine Care patients diagnosed with Obesity in the Health Homes Portal
6. Group visits for obesity

Programs and resource allocation:

1. Space
2. Utilities
3. Staff
4. Marketing

Planned collaborations:

1. "Let's Go" would be a collaboration with MCMH, MDI and Downeast Community Hospital
2. Collaboration with Healthy Peninsula on their food insecurity programs such as the Magic Food Bus and Gleaning
3. Healthy Acadia and Healthy Peninsula – Double Your SNAP Benefit sponsorship – encouraging healthy food choices
4. Collaboration with Blue Hill YMCA

Population of focus:

Obese children and adults

FY 2017 Progress Report Priority 1: Obesity (Physical Activity and Nutrition)	
Objective	Obesity - Increase the percentage of current BMI management plans among PPC ACO patients with abnormal body mass index (BMIs) for age from 91% to 94% by September 1, 2017.
Status	In Progress
Approaches taken and resources used	In fiscal year 2017 (FY17), we offered high quality weight-related community health programming including an annual Women's Wellness event, 5K Fun runs, and programs offered by hospital departments throughout the year. Changes with internal reporting mechanisms posed challenges for the originally identified metrics to be tracked. However, BHMH continued its efforts to engage patients in BMI management plans who exhibited abnormal BMIs.
Partners engaged	Blue Hill Memorial Hospital partnered with the following entities on this priority to improve obesity related outcomes in our area: • Eastern Maine Medical Center's Way to Optimal Weight (WOW) • Let's Go 5210 • Healthy Acadia • Healthy Peninsula • Beacon Population Health • Maine CDC (Downeast Public Health Council) • YMCA • EMHS information systems in our efforts
Highlights	Highlights for FY17 in weight-related programming were the 5K Race Series (co-sponsored with YMCA) and the Women's Wellness June event.
Outcome Measure	55.8% BMI management plans among PPC ACO patients with abnormal BMIs (in the past year) at the time of their last office visit.
Project lead	Zoe Tenney, FNP, Primary Care Clinical Quality Director Mark Hankinson, VP Operations
Next Steps	In FY18, BHMH plans to continue tracking this metric through our Population Health program (Beacon ACO contracts). However, we plan to change our obesity focus to a collaborative effort with other community health organization in the Blue Hill Peninsula region in order to engage community members in upcoming obesity related efforts.

Priority #2: Drug and Alcohol Abuse

Rationale:

To develop a consistent screening and referral process for both outpatient clinics and the emergency department including counseling resources in an effort to improve the identification of those in need and increase referrals to the appropriate support services.

Intended action to address the need:

1. Substance abuse counselor @ BHFM, CCHS, IFM
2. Implement SBIRT (Screening, Brief intervention, and Referral to Treatment) in Primary Care Practices
3. Explore nurse case management in the ED
4. Collaborate with ED providers and hospitalists to develop a workflow and communication pathway for patients admitted with drug and alcohol problems
5. Identify and discharge plan for this patient population that includes support services and referrals

Programs and resource allocation:

1. Screening protocols
2. Evidence based workflow development in the outpatient and ED setting
3. Allocated staff for substance abuse prevention skills training
4. Staff to review and identify community based resources for this population
5. Drug take back programs / Needle Disposal

Planned collaborations:

1. Maine Coast Memorial Hospital, Mount Desert Island Hospital, and Acadia Hospital
2. Eastern Area Agency on Aging
3. Alcoholics Anonymous Program
4. Community Resource Guide with Healthy Peninsula
5. Collaboration with Healthy Acadia and Healthy Peninsula on "Hungry Heart" showing and community panel discussion
6. Maine Association of Substance Abuse Programs
7. Open Door

Population of focus:

Primary Catchment Area

FY 2017 Progress Report Priority 2: Drug and Alcohol Abuse	
Objective	Drug and Alcohol Abuse - All non-exempt opioid treated patients will be weaned down to < 100 MME by July 1, 2017.
Status	Completed
Approaches taken and resources used	In FY17, BHMH Primary Care practices in Blue Hill, Castine, and Stonington, committed to taking an organized, proactive, and compassionate, approach to helping our patients gradually taper down on opioid doses where appropriate. For patients taking greater than 100 morphine milligram equivalents (MME) per day, Maine State Law requires that doses be reduced to under 100 MME unless a valid exemption was identified (such as a patient on hospice care). During this process of helping patients safely taper, we pursued a number of strategies to encourage success in this challenging effort including: Monthly review with feedback to PCPs and managers regarding patients who need tapering plans put in place, extensive PCP and MA education re: opioid prescribing and laws, comprehensive PMP review program in all sites, completion of a comprehensive revision and update of the BHMH Controlled Substance Management policy, collaboration with Maine Coast Memorial Hospital and other affiliates to share best practices and policies, monthly emailed reminders to employed prescribers detailing Opioid-related CME opportunities, utilization of Licensed Clincal Social Worker and Nurse Practionertelepsychiatry resources to support patients, and supporting two additional PCPs in getting their suboxone/MAT training.
Partners engaged	Blue Hill Memorial Hospital partnered with the following entities on this priority: • Maine Medical Association • Acadia telepsychiatry NP • Maine Coast Memorial Hospital • Hancock County Regional Medical Group • Frenchman's Bay Orthopedics • Maine Medical Association • Maine Quality Counts • Acadia Hospital • Beacon Health
Highlights	We decreased our opioid prescribing by nearly 17,000 morphine milligram equivalents PER DAY over the course of FY17.
Outcome Measure	By the end of FY 2017, all non-exempt paients on opioid medications had been tapered to meet the requirements of Maine state law.
Project lead	Zoe Tenney, FNP, Primary Care Clinical Quality Director
Next Steps	In FY18, BHMH plans to retire the focus of the tapering program's objective and plan to focus on the opioid crisis through provider opioid education.

Priority #3: Transportation

Rationale:

Transportation is a major barrier for many in our community and has a negative impact on their health. We hope to identify those patients specifically in need and connect them with transportation resources to improve health outcomes for residents.

Intended action to address the need:

1. Screening at check out for Blue Hill Memorial Hospital Family Medicine (BHMHFM) appointments to identify patients with transportation needs
2. Provide transportation resources to Blue Hill Memorial Hospital patient community
3. Collaborate with Chamber of Commerce regarding potential transportation resource development

Programs and resource allocation:

1. Healthy Acadia transportation brochure in all patient exam rooms
2. Staff training regarding transportation resources
3. Develop referral process at check out for patients that need transportation prior to their next visit

Planned collaborations:

1. Friends in Action (new coordinator in Deer Isle)
2. At Home Downeast
3. Community Resource Guide – Healthy Peninsula
4. Eastern Area Agency on Aging
5. WHCA
6. Friendship Cottage
7. Meals for Me
8. Healthy Acadia

Population of focus:

Primary Catchment Area

FY 2017 Progress Report Priority 3: Transportation	
Objective	All patients will be asked two questions about their transportation needs when they check out after a visit with their provider in all family practice clinics. Results will be tabulated monthly to document the percent of our patient population with transportation needs and to identify opportunities for further resource development.
Status	In Progress
Approaches taken and resources used	In FY17, BHMH developed a community Transportation Resource Guide. We reviewed existing local transportation resource guides from other community organizations and websites. Some of these had been developed in the past but not updated recently. We reached out to each listed Transportation provider to verify that the information was accurate and up to date, and developed a current, complete list which is now available on paper for patients.
Partners engaged	Blue Hill Memorial Hospital partnered with the following entities on this priority: • Healthy Peninsula • Healthy Acadia • BHMH Community Relations, and practice managers • Over 15 local transport providers
Highlights	Completion of an accurate, comprehensive Transportation resource.
Outcome Measure	BHMH intended to track patient population in need of transportation options. In doing so, it was determined that there was a need for an updated resource guide. One accurate and compreshensive transportation resource guide was developed.
Project lead	Zoe Tenney, FNP, Primary Care Clinical Quality Director Mark Hankinson, VP Operations
Next Steps	In FY18, BHMH will continue working on our transportation objective by implementing the use of the resource guide across our hospital sites including primary care, emergency department, specialty settings, and the online “Community resource Guide” (hosted on the BHMH website).

Priority: Opioid Harm Reduction - Provider Education

Rationale:

Improving the way opioids are prescribed through clinical practice guidelines can ensure patients have access to safer, more effective chronic pain treatment while reducing the number of people who misuse, abuse, or overdose from these drugs.

Intended action to address the need:

Identify baseline
Develop an action plan: schedule med staff CME, circulate online opportunities, assist prescribers in tracking
Develop protocols for tracking and maintenance
Create tracking inventory of provider training and competency needs
Integrate database into system for tracking
Maintain database
Establish training protocol and timeline
Track attendance at trainings

Programs and resource allocation:

Provider educator
Staff time
Educational materials – Caring for ME

Planned collaborations:

EMHS and Maine Quality Counts

Population of focus:

Patient population in need of chronic pain management

FY 2017 Progress Report Systemwide Priority: Opioid Harm Reduction - Provider Education	
Objective	By 9/30/2017, increase the number of EMHS 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).
Status	In Progress
Approaches taken and resources used	In March 2017 BHMH sent out a baseline survey asking all providers if they have completed their three opioid continuing medical education (CME) hours. A follow up survey was done in July. Each month, email reminders were sent to all employed prescribers regarding the CME deadline reminder. The email also contained links to and information about available opportunities to complete their required hours. All information was also been shared with emergency department and hospitalist directors, although they are not formally included in this group of employed prescribers.
Partners engaged	Blue Hill Memorial Hospital partnered with the following entities on this priority: • BHMH Medical Staff office • BHMH primary care and specialty managers • Beacon Health • Maine Quality Counts and Maine Medical Association (content) • Maine Coast Memoral Hospital colleagues
Highlights	Maine Quality Counts and the Maine Medical Association have been proactive in making high quality training readily available around the State. The medical staff has been atively engaged in opiod prescribing issues, and hospital and practice administration has been supportive. Collaboration between local hospitals has been outstanding. And most importantly, the majority of patients have done very well with gradual tapers.
Outcome Measure	42% (11 of 26 possible)
Project lead	Zoe Tenney, FNP, Primary Care Clinical Quality Director
Next Steps	In FY18, BHMH plans to continue with this objective to focus on the opioid crisis through provider opioid education.

Priority: Healthy Food Access - Food Insecurity Screen and Intervene

Rationale:

According to the USDA, Maine ranks fourth in the nation and first in New England for very low food insecurity. Lack of access to nutritious foods greatly increases a number of health risks such as those associated with chronic disease and developmental issues among youth. Screening patients for food insecurity and connecting them with reliable food assistance resources can remove a barrier to good health, improving health outcomes for children, families and older adults who are at greatest risk.

Intended action to address the need:

Integrate food insecurity screen into EMR
Educate providers and MA staff on the use of the tool
Capture and report screening intervention evaluation using the Clinical Research Center's protocol established through Partnerships to Improve Community Health (PICH)
Develop food insecurity packet for patient distribution and referral to community resources
Positive score found in the office, patients offered a week's worth of dry food goods and information to have resources/assistance contact the patient

Programs and resource allocation:

Staff time

Planned collaborations:

Healthy Peninsula
Eastern Area Agency on Aging

Population of focus:

Food insecure patients at Blue Hill Family Medicine, Island Family Medicine, Castine Community Health Services

<table>
<tr><th colspan="2">FY 2017 Progress Report
Systemwide Priority: Food Insecurity - Screen and Intervene</th></tr>
<tr><td>Objective</td><td>Increase the number of patients screened for food insecurity from 0 to 50% of family practice patient population with office visits.</td></tr>
<tr><td>Status</td><td>Completed</td></tr>
<tr><td>Approaches taken and resources used</td><td>In FY17, BHMH took the following approaches on this objective:
1. Successfull integration of a food insecurity screening into our standard office visit process at all three BHMH primary care locations. We now screen nearly all patients presenting for care, far above the 50% initial goal. Patients who screen positive are given information regarding local resources, and an emergency box of non-perishable food if appropriate. These boxes are provided by the Eastern Area Agency.
2. BHMH also provided the electricity to power temp-controlled storage (located in a large truck trailer housed on our campus) of food from the Healthy Acadia gleaning project and the Healthy Peninsula Magic Food Bus (programs that supply free food to local people in need).
3. Our Castine primary care site started a garden behind their clinic this summer, and fresh produce is given away to anyone in need
4. BHMH hosted (provided food and employee volunteers) a free community meal once per month, all year, at the “Simmering Pot” held at the Blue Hill Congregational Church (this is a year round weekly community supper program). We served an estimated 1750 free meals during FY2017.</td></tr>
<tr><td>Partners engaged</td><td>Blue Hill Memorial Hospital partnered with the following entities on this priority:
• Healthy Peninsula
• Eastern Area Agency on Aging (provides emergency food boxes for patient/ family in need, distributed directly from our sites).
• “Simmering Pot” free meal each Monday (coordinated and provided by a local coalition including Blue Hill Congregational Church, Blue Hill Food Coop, Tree of Life Food Pantry and others)</td></tr>
<tr><td>Highlights</td><td>Emergency food boxes distributed to people with acute food insecurity, Simmering Pot meals, and the development of the Castine garden.</td></tr>
<tr><td>Outcome Measure</td><td>2948 visits, 2380 screenings (81%)</td></tr>
<tr><td>Project lead</td><td>Director of Family Practice, Chief Medical Officer, Practice Managers</td></tr>
<tr><td>Next Steps</td><td>In FY18, BHMH will retire the tracking of this objective as it has now been “hard-wired” into our normal processes. We will focus on improving the nutritional content of food options offered at our foodservice venues at BHMH.</td></tr>
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Conclusion

Blue Hill Memorial Hospital 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.

Blue Hill Memorial Hospital will engage in another Shared CHNA in 2019 and looks forward to ongoing community participation in these important efforts.