

Progress Report to Our Community

Addressing Community Health Needs

Fiscal Year 2017



2019



2018



2017



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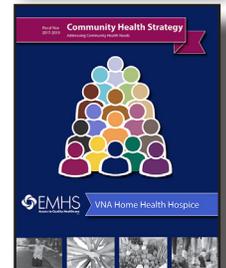
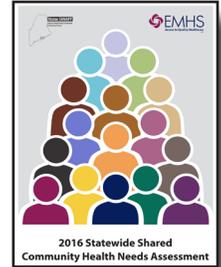
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Progress Report to Our Community



Colleen Hilton, RN
President, VNA Home Health Hospice



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 VNA Home Health Hospice have our own unique set of priorities that we are addressing including:

- Preventive Care
- Senior Health
- Tobacco Use
- Obesity/Diabetes

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 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,

Colleen Hilton, RN

President, VNA Home Health Hospice



Priority #1: Preventive Care

Rationale:

Providing school based immunization provides easy equal access for all children, prevents the flu, prevents death from complications, and protects seniors who come in contact with children from possible flu exposure.

Intended action to address the need:

VNA has provided school based influenza immunization clinics in eight school districts primarily in Cumberland and York Counties since 2009, immunizing over 7,000 in 2015. In 2016, initial plans (pending state provided vaccines) is to expand our collaboration with School Districts to at least one school district in Penobscot County, adding the City of Portland and others as requested in Aroostook and Hancock Counties.

1. VNA will continue its leadership role in the Cumberland and York County Flu Task Force; and seek opportunities to partner in other regions.
2. VNA will continue to work with the Maine CDC as an emergency POD site for distribution of medicinal items in a public health emergency.

Programs and resource allocation:

1. Per Diem Staffing resources will need to be added to cover additional sites.
2. Grant/donation funding to offset non-funded resources, and to allow VNA to continue and expand our community benefit of covering the cost of vaccines for those without medical coverage.

Planned collaborations:

Partnerships with identified schools Districts (Portland, SAD 64), community centers, shelters, and senior housing sites; continued partnership with Maine CDC.

Population of focus:

Ages six months and up.

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: <ul style="list-style-type: none"> • 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.

Priority #2: Senior Health

Rationale:

Seniors living in senior sites will have access to blood pressure screening clinics. The desired action will be to help identify those with heart disease early and assist in connecting them with needed resources in the community.

Intended action to address the need:

1. Implement at least one wellness/BP clinic in Aroostook County for seniors.
2. Work as a member of EMHS on implementation of targeted pilots as determined by the Healthy Aging Task Force.

Programs and resource allocation:

1. Staff to assess vital signs and provide health education regardless of insurance.
2. Staff/volunteers as required by the Healthy Aging Task Force.

Planned collaborations:

1. Regional senior housing, meal sites and wellness centers.
2. CAP agencies, Public Health councils, Patient Centered Medical Homes.

Population of focus:

Seniors

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: <ul style="list-style-type: none"> • 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: <ul style="list-style-type: none"> • 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.

Priority #4: Obesity/Diabetes

Rationale:

Targeted staff education will help to improve the quality of life for patients with obesity and diabetes. These trained staff members will work to develop evidenced based home care practices and education. Reducing obesity rates will also decrease incidences of diabetes and affect quality out comes such as hospitalizations and ER visits.

Intended action to address the need:

Clinical staff will attend diabetes education classes to achieve certification as Certified Diabetes Educator (CDE). Those trained will work to develop evidenced based home care practices and education. The CDE will be available as a resource.

Programs and resource allocation:

1. Dedicated staff to attend and complete the CDE education program
2. Cost of CDE courses

Planned collaborations:

Collaboration with primary care offices and others involved in the patient's health (Member hospitals, Beacon ACO, Patient Centered Medical Homes, Health homes)

Population of focus:

Home health patients with diabetes

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: <ul style="list-style-type: none"> 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, CHFNP-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.

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:

- Assess areas of need
- Develop an action plan
- Develop protocols for tracking and maintenance
 - Create tracking inventory of provider training and competency needs
- Establish training protocol and timeline
- Track attendance at trainings

Programs and resource allocation:

- Staff time and educator
- Educational materials – Caring for ME

Planned collaborations:

None noted

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 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: <ul style="list-style-type: none"> • 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.

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:

- Initial meeting with system community health staff to offer resources and technical assistance
- Integrate food insecurity screen into EMR
- Educate providers on the use of the tool
- Develop a site specific referral process

Programs and resource allocation:

- Staff time

Planned collaborations:

- None noted

Population of focus:

- Food insecure patients

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: <ul style="list-style-type: none"> • 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, CHFNP-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.

Conclusion

VNA Home Health Hospice 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.

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

