Fiscal Year 2021

PROGRESS REPORT TO OUR COMMUNITY

Addressing community health needs

Northern Light℠
Blue Hill Hospital

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President

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As 2021 nears an end, we approach 2022 with renewed hope, more resilience, and stronger community partnerships. Those partnerships have proven vital as the pandemic encumbered the gains we had made in Maine and nationally to address the opioid epidemic. Unemployment and food insecurity remain higher than pre-pandemic levels too.

The pandemic taught us to become even better at working together. We have renewed commitment to improving the social determinants of health, and we have better ways to reach people than ever before.

In 2019, Northern Light Health partnered with three healthcare systems and the Maine Center for Disease Control and Prevention to create a Community Health Needs Assessment (CHNA). 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.

This report is an update on the progress of our community health strategy for fiscal year 2021, representing the second year of our three-year health improvement plan. In addition to the extraordinary outreach and collaborative efforts during the coronavirus pandemic, Northern Light Blue Hill Hospital continues to engage in priority areas of work, including:

- Social determinants of health
- Substance use
- Access to care

At Blue Hill Hospital, we know that our neighbors are looking for trusted places where they can go for personalized care that is exceptional—and we want them to choose us. We are determined to be the best option for them while continuing to collaborate with our community partners. I look forward to what we can accomplish in the months ahead.

Sincerely,

John Ronan, MBA, FACHE
President, Northern Light Blue Hill Hospital

Progress report update

FY 2021 Progress Report
Priority #1: Social Determinants of Health

Objective: Increase the number of sites implementing screening and referral for health-related social needs from zero to one by 9/30/21.

Status: In progress

Strategy (approaches taken, and resources used) and highlights from this effort: In fiscal year 2021 (FY21), Northern Light Blue Hill Hospital participated in the Northern Light Health Social Determinants of Health (SDOH) system workgroup, which met bi-weekly through November 2020. The workgroup suspended meetings after this date to accommodate new system-level SDOH efforts. In January 2021, Northern Light activated four critical path project teams to plan and operationalize a system approach to identifying patients with social health needs. These groups oversaw standardization of the Cerner Social History Tool in the medical record, which will ensure patient demographics and health history are documented in a consistent fashion across all Northern Light member hospitals. The existing "Food Insecurity" form in Cerner was then updated to include six additional evidence-based questions to assess patients' housing status and safety, transportation, utilities, daily activities, and isolation. The updated screening form aligns with most of the recommendations developed by the SDOH workgroup members. Both the "SDOH Screening" form and the updated Social History Tool went live in Cerner on 5/18/21 and are now available for use. Additional efforts during this year included foundational work to operationalize the Social Vulnerability Index and developing recommendations for implementation of a social care network platform (called Aunt Bertha). These additional Cerner functions are slated to go live in fiscal year 2022 (FY22) and will provide Northern Light with enhanced ability to understand social needs by populations and geographic location and provide seamless patient referrals to community-based organizations for assistance with social needs. Moving forward, the SDOH workgroup will be re-established in FY22 as the "SDOH Team" and report to Northern Light's Quality Council and will be responsible for developing, implementing, monitoring, and evaluating the effectiveness of the system's implementation of SDOH screening and intervention.

Partners engaged: Blue Hill Hospital partnered with the following Northern Light members on this priority:

- Acadia Hospital
- AR Gould Hospital
- Beacon Health
- CA Dean Hospital
- Eastern Maine Medical Center
- Home Care & Hospice
- Inland Hospital
- Maine Coast Hospital
- Mayo Hospital
- Mercy Hospital
- Sebasticook Valley Hospital
- Information Systems
- Clinical Informatics
- Clinical Standards Group

Outcome measure: In FY21, Blue Hill Hospital and other member hospitals were unable to initiate SDOH screening and meet the projected targets. This was an accepted outcome of the Northern Light system-led SDOH efforts, which were initiated after the FY20 community health improvement plan's activities and targets had been established. Ultimately, several key system outcomes were met during this period, including standardization of how and where SDOH information is documented within the electronic health record and adoption of a standard SDOH screening form. This provides a successful foundation for SDOH efforts moving forward. While screening has occurred, as a result of inclusion on standard patient rooming workflows, the reporting capability screening rates and/or results will be completed by Information Systems following additional auditing and mapping of appropriate Cerner concepts and data.

Project leads: Dr. Mike Murnik, Senior Physician Executive; Tammy Dickey, Director of Physician Practices; Alison Billings, Director of Quality

Next steps: In fiscal year 2022 (FY22), Blue Hill Hospital will participate in SDOH system workgroup efforts to operationalize SDOH screening within practice locations, as well as contribute to development of the metrics that will be used to report and evaluate SDOH screening reach and effectiveness. Member hospitals will have a key role in supporting the implementation of Aunt Bertha, primarily through completing an inventory of existing community resources and referral partners and conducting a community resource gap analysis to identify potential weaknesses in their local community services networks. These activities are proposed Key Performance Indicators in the FY22 Annual System Goals and will inform the development of the resource directory within Aunt Bertha. Additionally, member hospitals will have an opportunity to participate in SDOH quality improvement initiatives as part of a recent award to Northern Light Health. This grant, provided through a collaboration between Pfizer, Inc., and the Institute for Healthcare Improvement, will support discrete quality improvement projects to understand and improve SDOH screening and referral workflows.

Priority #2: Substance Use

Objective: Maintain the number of Medication-Assisted Treatment options for opioid use readily available in local communities at four by 9/30/21.

Status: Completed

Strategy (approaches taken, and resources used) and highlights from this effort: In FY21, Northern Light Blue Hill maintained a focus on substance use, specifically the use of medication-assisted treatment (MAT), through educational and training offerings for providers and staff. Education allowed for new providers to become MAT trained, refresh protocols, and to reinforce the addition of the rapid access into MAT in the Emergency Department for those patients with most limited access. Blue Hill Hospital providers were also able to provide peer support and training to their Hancock County team members at Northern Light Maine Coast Hospital through Grand Rounds and shared medical staff meetings focused on substance use and treatment options for our healthcare teams to best serve our community members in need.

Partners engaged: Blue Hill Hospital partnered with the following entities on this priority:

Down East Treatment Center
Northern Light Beacon Care Management
Northern Light Emergency Care at Blue Hill and Maine Coast Hospitals

Northern Light Primary Care Medical Staff
Northern Light Primary Care Walk-in services in Ellsworth
TEAM Health Medical Staff

Outcome measure: In FY21, Blue Hill Hospital maintained the number of MAT options for opioid use readily available in local communities at four, reaching 40 unique patients for MAT intervention.

Project leads: Dr. Mike Murnik, Senior Physician Executive; Tammy Dickey, Director of Physician Practices; Nikki Robichaud, Outpatient Quality Lead

Next steps: In FY22, Blue Hill Hospital will utilize multiple strategies to address substance use and specifically access to treatment, such as continuing to recruit and train MAT prescribers at our primary care sites, and to increase provider and patient awareness of opioid use disorder, reducing stigma, and increasing readiness for treatment. Through these strategies, our goal is to maintain the number of MAT options for opioid use readily available in local communities at four throughout the fiscal year and to increase the reach to 45 unique patients for MAT intervention.

Priority #3: Access to Care

Objective: Increase the number of patients accessing non-urgent care by community paramedicine programs from 38 to 58 by 9/30/21.

Status: Completed

Strategy (approaches taken, and resources used) and highlights from this effort: In FY21, Northern Light Blue Hill Hospital utilized community partnership with Memorial Ambulance Corps and pivoted to meet the current needs of the community amidst the pandemic. Our Community Paramedicine program was impacted greatly by legislative, staffing, and financial resources, and we found our community program with one paramedicine program provider rather than five. This team, small in numbers, partnered with all available agencies and utilized any resources available to provide COVID-19 vaccinations, complete medication refill visits, vital sign checks, call patients to check in, and assist in several other ways. The team served 73 patients over the course of the year, and over 500 unique patient encounters. Whenever patients were well enough to come out of the program, paramedicine coordinators would communicate with case workers and the hospital staff to add additional patients to their roster to maximize their impact in the community. The community paramedicine team, care managers, and families also were in frequent communication of patient needs, making calls to help find resources, including volunteer programs for house repairs and Meals on Wheels to our most vulnerable patients, aligning with our brand promise to improve the health of the communities we serve.

Partners engaged: Northern Light Blue Hill Hospital partnered with the following entities on this priority:
Eastern Area Agency on Aging
Healthy Acadia
Memorial Ambulance Corps
Simmering Pot
Northern Light Blue Hill Hospital staff (primary care providers, RNs, Mas, social work, clerical staff, administration, ED director, inpatient director, population health and discharge planning)

Outcome measure: Blue Hill Hospital was able to increase the number of patients accessing non-urgent care by community paramedicine programs from 38 to 73 using one paramedicine site.

Project leads: Dr. Mike Murnik, Senior Physician Executive; Tammy Dickey, Director of Physician Practices; Nikki Robichaud, Outpatient Quality Lead

Next steps: In FY22, Northern Light Blue Hill Hospital will work to develop a Cerner referral process for community paramedicine appropriate patients, educate departments regarding paramedicine program and maintain an ongoing partnership with Northern Light Health and community partners. By implementing these strategies, Blue Hill Hospital intends to increase the number of patients accessing non-urgent care by community paramedicine programs from 73 to 80, and maintain the relationship with the community paramedicine site, Memorial Ambulance Corps.

Conclusion

Northern Light Blue Hill 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.

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