

Community Health Strategy

Addressing Community Health Needs Fiscal Year 2020-2022

**Northern Light
Beacon Health**



**Northern Light
Health**SM

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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 Beacon Health 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 Beacon Health 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 Beacon Health

Northern Light Beacon Health is located 797 Wilson Street in Brewer, Maine however, we have employees across our statewide network embedded in primary and specialty practices supporting the highest quality patient care. As the population health member of Northern Light, Beacon Health is partnering with patients, providers, employees, businesses, and payers to transform the delivery of healthcare.

Northern Light Beacon Health is a leader in merging data analytics with clinical care. We're here to support comprehensive and proactive care across our statewide network of provider partners, as together we move away from the fee-for-service payment model to an approach that rewards patient outcomes and engagement with a focus on quality, efficiency, and population health. Beacon Health has the demonstrated leadership, experience, and innovation needed to help navigate the waters of change. We are dedicated to helping our communities and patients live longer, healthier, and more productive lives.

Definition of Community Served

Northern Light Beacon Health service reach extends to all member organizations of Northern Light Health. However, the largest number/concentration of patients served are located in Penobscot county. Therefore, Northern Light Beacon Health is using the Shared Community Health Needs Assessment results from Penobscot county to guide its Community Health work. However, Northern Light Beacon Health's efforts outlined in this

strategy will be implemented and shared at all Northern Light Health service locations where Beacon Health provides and oversees Population Health services.

Demographic Data		
PENOBSCOT COUNTY		
	Percent	Number
American Indian/Alaskan Native	1.1%	1,751
Asian	1.1%	1,724
Black/African American	0.8%	1,174
Hispanic	1.2%	1,895
Some other race	0.2%	258
Two or more races	1.7%	2,571
White	95.1%	145,472
County population	152,978	

Social Determinants of Health Data	
PENOBSCOT COUNTY	
Median household income	\$45,302
Unemployment rate	4.3%
Individuals living in poverty	16.3%
Children living in poverty	18.3%
65+ living alone	44.5%
People living in rural areas	57.7%
Food insecurity	16.2%

For the purpose of this strategy, Northern Light Beacon Health presents data from its primary county of service, Penobscot. However, please note, the priorities identified in Penobscot 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 Beacon Health. 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 Beacon Health.

Northern Light Beacon Health 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 Beacon Health 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 Beacon Health's Community Health Strategy team included individuals representing the following positions:

- Jaime Rogers, LCSW, MBA – Director, Community Care & Behavioral Health Services
- Dr. Ed Gilkey – Senior Physician Executive
- Will Seavey – AVP, Population Health
- Tori Gaetani, RN – VP Nursing & Patient Care Services
- Andy VanEss – Wellness Manager

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 Beacon Health experts and local partnership experts in various priority areas
- Feasibility: Northern Light Beacon Health 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 Beacon Health 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 Beacon Health'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 Beacon Health'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 Beacon Health 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 Northern Light Health.

Intended action to address the need

Northern Light Beacon Health will provide education, resources, referral assistance, and EMR development support to improve Northern Light Health system providers to be better equipped to screen for and intervene with Social Determinants of Health. Beacon Health Care Management and Community Care Teams will provide referral support, and risk stratified patient intervention which will be aligned with ongoing Beacon Health contracts.

Anticipated impact of these actions/expected outcomes

There will be system leadership and support, technology capability, and workflows that support both effective screening and intervention for/with social determinants of health. Primary care practices will be better equipped and more comfortable to complete routine screening. EMR will support screening and referral processes.

Programs and resource allocation

Northern Light Beacon Health's Care Management and Community Care Teams will be an integral part of screening and intervention for the most vulnerable populations. Directors of Quality, Community Care, Behavioral Health, and

the associate vice president of Population Health will also have important roles in supporting practices, sharing best practices, and collecting outcomes. Beacon Health will also collaborate with Northern Light Health member organizations, primary care practices, the Population Health Committee, Northern Light Health Medical Group, and integrated care management programs.

Planned collaborations

Northern Light Beacon Health plans to collaborate with other facilities or organizations to address identified social needs. Community resource information will be collected and distributed for available community resources. Beacon's Care Management and Community Care Team programs already collaborate with all/most community mental health organizations, Area Agencies on Agency, CAP agencies, Municipalities, Crisis Intervention, and others who are equipped and adept at meeting social needs.

Plan for measuring impact

Northern Light Beacon Health 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.

System selection of screening tool and integration of tool into EMR. Training and education will be provided, aimed at increasing awareness use of tool and responses to positive screenings. Beacon Health Care Management and Community Care Teams will receive referrals for interventions, when appropriate. Referrals to community providers will be directed for intervention when there are positive screens.

Population of focus

Medical Group/Primary Care and Technology Support

Priority #2: 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, 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 Beacon Health Community Health Strategy team recognizes that addressing mental health needs is a priority for our community. There are substantial local community assets and Beacon Health 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.

Intended action to address the need

Northern Light Beacon Health will use its Care Management and Community Care teams to provide support and intervention for qualified patients with mental health conditions, which are affecting their overall health.

Specifically, Beacon's Community Care Team will advance behavioral healthcare management program for targeted populations, as described. Beacon Health will also work with Northern Light Health member organizations and employees to normalize mental health by increasing educational efforts to raise awareness, readiness, and access to mental health services.

Anticipated impact of these actions/expected outcomes

Northern Light Beacon Health's Community Care Team will have a fully operational, integrated Behavioral Health Care Management program to support patients aligned under Beacon contracts and support primary care. Employee health plan preferred behavioral health provider network will be sufficient to meet needs for the plan. This preferred network will meet regularly, with a clear charter and goals, and capable to report agreed upon quality measures/outcomes.

Programs and resource allocation

Northern Light Beacon Health's Care Management and Community Care teams; Senior Physician Executive; Director, Employee Health Plan; Behavioral Health Preferred Provider Network; and Director, Quality.

Planned collaborations

Behavioral Health Preferred Provider Network

Plan for measuring impact

Northern Light Beacon Health 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.

Beacon Health will track and report the number of preferred behavioral health providers in the Employee Health Plan network, the number of Behavioral Health employee referrals made to behavioral healthcare management, and monitor outcomes and quality reporting for Preferred Behavioral Health Network. Performance improvement plans for this group will be logged and monitored. Quality data will be shared with appropriate groups.

Population of focus

Beacon Direct and Northern Light Health Employee Health Plan

Priority #3: Physical Activity/Nutrition/Weight

Rationale

Being physically active, eating a balanced diet, and maintaining a healthy weight are all essential for promoting good health and well-being. Good nutrition and regular physical activity can reduce the risk of developing serious health conditions such as diabetes, cancer, stroke, heart disease, high cholesterol, high blood pressure. These and other obesity-related chronic diseases result in significantly higher rates of healthcare utilization and costs, and cause poorer health outcomes and decreased quality of life. A comprehensive approach to improving physical activity and nutrition, including environmental approaches, healthcare system interventions, and community programs, can support healthy choices and behaviors and improve access to healthier options within communities.

Physical activity and nutrition has been identified by the Beacon Health Community Health Strategy team as a priority need for our region. Beacon Health has resources available to be leveraged in support of this need, as well as the ability to use the support and assets of our community partners. There are numerous opportunities for

implementing effective evidence-based strategies in a variety of settings that will improve physical activity and nutrition options and behaviors for our community members.

Intended action to address the need

Beacon Wellness will continue to work with Northern Light Health Benefits and Beacon insured/members to create, implement, monitor, and collect results for employees and plan members related to physical activity, nutrition, and weight.

Anticipated impact of these actions/expected outcomes

Northern Light Beacon Wellness will support plan members and employees to maintain and/or improve healthy habits, including physical activity, nutrition, and weight. They will offer several options for support and education, including individual and group health coaching, weight solutions classes, diabetes prevention classes, and more. These sessions will continue, and will also be expanded to additional community members. Wellness will also maintain an active wellness network of community providers who can also assist employees and health plan members to achieve goals related to physical activity, weight, and nutrition.

Programs and resource allocation

Northern Light Beacon Health Wellness staff and Northern Light Health member organizations.

Planned collaborations

Northern Light Beacon Health will collaborate with other facilities or organizations to address the priority health need.

Plan for measuring impact

Northern Light Beacon Health 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.

Northern Light Beacon Wellness will track, monitor and report number of participants in the various programs it offers.

Population of focus

Beacon Direct insured and Northern Light Health employees and health plan members

Health Priorities Not Addressed

Northern Light Beacon Health 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 Beacon Health 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:

- Substance Use - Beacon does not have the level of expertise, access to data/information, or influence in this area of care.
- Access to Care - The scope of Beacon's work is derived from and limited to the outcomes outlined in each unique contract. This work does often affect access to care; it is an indirect effect which Beacon is unable to measure.

Conclusion

Northern Light Beacon Health 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 Beacon Health will engage in another Shared CHNA in 2022 and looks forward to ongoing community participation in these important efforts.

Appendix

Evaluation of Impact

Progress report on selected priorities from Northern Light Beacon Health's last (2016) Community Health Needs Assessment.

Northern Light Health and Northern Light Beacon Health 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 Beacon Health 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



Beacon Health

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	<p>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.</p> <p>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.</p> <p>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.</p>
Partners engaged	<p>Beacon Health partnered with the following entities on this priority:</p> <ul style="list-style-type: none"> 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.

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

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	<ol style="list-style-type: none"> 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.

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.

Fiscal Year 2018

Progress report to our community

Addressing community health needs



Progress report update

FY 2018 Progress Report

Priority #1: Transportation

Objective: By the end of fiscal year 2018 (FY18), patients who identify transportation as a barrier to accessing appropriate care will be connected with the Community Care Team for assessment and intervention to identify improved access to a reliable, available source of transportation for medical appointments, including specialty. Additionally, we will bring care to the patient, when possible, by providing home visiting completed by the Community Care Team or other community agency.

Status: In Progress

Approaches taken and resources used: In FY18, Northern Light Beacon Health offered more than 600 home visits, bringing healthcare to those who had difficulty with transportation. Completing these home visits allows us to not only make accessing healthcare easier, but they also give us the unique opportunity to spend more time with patients, in their own environments. This time and personal visits allow us to truly understand the needs of the patient and bring that information back to the healthcare team so we can work together – with each patient – to meet those needs.

Partners engaged: Northern Light Beacon Health partnered with the following entities on this priority:

- Most Northern Light Health primary care teams have access to the Community Care Team’s home visiting program

Highlights: In FY18, Northern Light Beacon Health helped hundreds of patients to access transportation and travel several hundreds of miles to medical appointments and to other important locations (grocery stores, family visits, pharmacy, church, etc.).

Outcome Measure: In FY18, Northern Light Beacon Health provided home visits, especially for those patients with the greatest health and social needs. We completed more than 600 home visits, and were successful at finding transportation solutions for many of the patients we visited.

Project Lead: Tori Gaetani, Northern Light Beacon Health vice president of Nursing and Patient Care Services; Jaime Rogers, Northern Light Beacon Health director of Community Care and Behavioral Health Services

Next Steps: In fiscal year 2019 (FY19), Northern Light Beacon Health will continue to offer home visits, and will utilize evidence-based screening tools to improve screening for social determinants of health. Beacon Health will also work to integrate this screening at primary care practice locations, thus increasing the number of needs we can meet.

FY 2018 Progress Report

Priority #2: Mental Health/Depression

Objective: By the end of FY18, at least 60% of Accountable Care Organization (ACO) patients will be screened for depression using the Patient Health Questionnaire (PHQ)-9 screening tool. At least 40% of positive screens (i.e. >9), will be referred for behavioral health intervention (i.e. Community Care Team, licensed clinical social worker, psychiatric and mental health nurse practitioner, or 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.

By the end of FY18, covered beneficiaries on the Northern Light Employee Health Plan will have access to Behavioral Health case management through Beacon's Community Care Team.

Status: In Progress

Approaches taken and resources used: In FY18, Northern Light Beacon Health made use of the Population Health Committee to set screening targets, review data dashboards, and select intervention methods. Beacon Health also utilized its Community Care Team and Care Coordination programs to advance Behavioral Health case management when beneficiaries were identified with behavioral health needs.

Partners engaged: Northern Light Beacon Health partnered with the following entities on this priority:

- The Acadia Hospital, Affiliated Employee Assistance Program
- Sweetser
- Spurwink
- All Northern Light Health primary care teams in all locations across Maine

Highlights: In FY18, Northern Light Beacon Health is proud to have launched Behavioral Health case management available to Northern Light Health insureds. This program enhancement will serve plan members well as Northern Light Beacon Health works to continue to improve behavioral health integration and knowledge and skill building for continued growth and development.

Outcome Measure: In FY18, Northern Light Beacon Health exceeded our goal: 60% of our ACO patients to be screened for depression. Northern Light Beacon Health screened more than 70% of our Medicare, MSSP patients and launching of behavioral healthcare coordination available for beneficiaries on the Northern Light Employee Health Plan.

Project Lead: Jaime Rogers, LCSW, MBA, director Community Care and Behavioral Health Services; Will Seavey, associate vice president, Population Health; Krissy Brasslett, MHA, RN, CPHQ, CPC, director, Quality Improvement

Next Steps: In FY19, Beacon Health will continue to work with our Northern Light Health partners to improve behavioral health screening and intervention for all patients.

FY 2018 Progress Report

Priority #3: Obesity (Physical activity/nutrition)

Objective: By the end of FY18, Northern Light Beacon Health will increase the number of locations where we offer our National Diabetes Prevention Program from zero to two.

Status: Completed

Approaches taken and resources used: In FY18, Northern Light Beacon Health used biometric data to confirm that interested employees were in fact eligible for the program. Northern Light Beacon Health sent out a communication to all Northern Light Health Home Office employees explaining the new wellness program specific to diabetes prevention. The response was immediate and overwhelming.

Partners engaged: Northern Light Beacon Health partnered with the following entities on this priority:

- Northern Light Health Home Office employees
- Northern Light Total Health Team, Home Office
- Northern Light Health Home Office Benefits department

Highlights: By rewarding annual biometric screening participation, our Northern Light Employee Health Plan is able to offer programs tailored to the needs of our employee population. In FY18, Northern Light Beacon Health identified employees who would be eligible for the NDPP by using the annual biometric screening information. One email to employees and a day later our inaugural class was filled. We will take the lessons learned from our first year and continue to grow our program and locations to best help our employees reach their health and wellness goals.

Outcome Measure: In FY18, the outcome measure for this CHIP achieved by Northern Light Beacon Health was to increase the number of member organizations offering the National Diabetes Prevention Program from zero to two. We were able to increase from zero to one and enroll a full class of 12 participants.

Project Lead: Andy VanEss, MBA, Wellness Program Manager

Next Steps: In fiscal year 2019, Northern Light Beacon Health will work towards establishing more National Diabetes Prevention Programs across our statewide health system. The valuable insight we gained during our annual biometric screenings will allow us to further personalize our efforts to reach more employees. We plan to continue with our current class that was established in FY18 and learn from the pilot program to enhance our program. Our goal is to offer a comprehensive and tailored diabetes prevention program to our employees in order to engage, encourage, and guide them down their journey for a lifetime of better health and wellness.