



HomeHealth Connections

Healing Hearts at Home

HomeHealth Visiting Nurses has partnered with other home care agencies in the region to implement the *"Healing Hearts at Home"* program. Maryanna Arsenault, CEO of HomeHealth Visiting Nurses, is chair of the home care committee to lead this effort that includes Androscoggin Home Health and Hospice, CHANS, Healthreach, Miles Home Health and Hospice, St. Andrew's Home Care and SMMC Visiting Nurses.

This program seeks to improve heart failure care and outcomes across the MaineHealth system by adopting national evidence-based heart failure treatment guidelines.

There is a strong clinical rationale for prescribing an angiotensin converting enzyme inhibitor (ACEI) or angiotensin receptor blocker (ARB) or a beta blocker in stable patients with current or prior symptoms of heart failure. Several large clinical trials have demonstrated the efficacy of these medications in reducing heart failure morbidity and mortality. In addition, there is considerable evidence that patients often discontinue prescribed medications, particularly during transition from inpatient facilities to home.

In an effort to identify patients who could benefit from treatment, HomeHealth Visiting Nurses will send a *"Healing Hearts at Home"* Fax Back Form to physicians if his/her heart failure patient does not appear to be using either an ACEI/ARB or a beta-blocker.

By completing and returning the Fax Back Form, the physician will inform home health agencies about recommended ACEI/ARB or beta blocker medication, current heart failure medications, contraindication to these medications or plans to discuss options with the patient at the next office visit.

Please feel free to contact Maryanna Arsenault, CEO or one of our Provider Relations Representatives at 1-800-660-4867 with any questions or for more information about the *"Healing Hearts at Home"* program.

New Logo Revealed



We are delighted to introduce our new logo to the health-care community. As you can see, we have brought to the forefront our connection with the Visiting Nurse Association.

Our history as visiting nurses goes back over 100 years, and we are proud to honor and continue that tradition even as we move our organization into the future with innovative programs like Telehealth, ReACH and *"Healing Hearts at Home."*

Our new shades of blue will enhance our visibility and recognition in the community. We hope you enjoy our new look and agree that it better reflects our agency's goals and history.

Chronic Disease and Success with Telehealth

Chronic disease management is a growing challenge for home care nurses and health care professionals across the nation. More than 90 million Americans live with chronic illnesses. In Maine, the leading cause of death among adults 65 and over is chronic heart disease. Seventy-five percent of Maine people die from one of the four major chronic disease groups: cardiovascular, cancer, lung or diabetes. Health care costs related to these chronic conditions are about \$2.5 billion per year. (D. Mills, Public Policy Review)

Throughout the nation, forward-thinking home health agencies have deployed various forms of Telemedicine programs aimed at reducing costs and improving outcomes for chronic disease patients. HomeHealth Visiting Nurses was the first agency in Southern Maine to implement Telehealth using American Telecare's interactive technology. This equipment allows a specially trained nurse to conduct live, interactive, video "home" visits from a central station at agency headquarters. Telehealth patients can actually see and hear the Telehealth nurse by using a small, lightweight monitor installed in the home. Clinicians are able to track vital signs such as blood pressure, heart and lung sounds, oxygen saturation, glucose levels and wound status using peripheral medical equipment.

For the 6-month period of October 1, 2005 – March 31, 2006, Homehealth Visiting Nurses admitted 51 new patients to the Telehealth Program. Consistent with program admission criteria, patients had cardiac conditions to include congestive heart failure, myocardial infarction, pulmonary edema, chronic obstructive pulmonary disease and post surgical cardiac problems as their primary and/or secondary diagnoses. Patients ranged in age from 44 to 101 years and received a total of 230 Telehealth visits in this 6-month period.

Our findings demonstrated the following:

- 47% of our Telehealth patients got better at taking their medications correctly, compared to the national average of 40%
- 3% of Telehealth patients needed urgent, unplanned medical care compared to 21% of the national average
- 12% of Telehealth patients required hospital admission compared to the national average of 28%

Our Telehealth program is a valuable tool for improving the health and safety of at-risk cardiac patients. If you have any questions or have a patient who may benefit from Telehealth services, please call Cathy Patnaude, RN, Telehealth Coordinator at 800-660-4867.

HomeHealth Visiting Nurses Joins National Project to Reduce Hospitalizations

Selected as one of only 72 agencies nationwide, HomeHealth Visiting Nurses is collaborating on a national demonstration project to reduce hospitalization rates for home health patients.

This two-year initiative, "Reducing Acute Care Hospitalization" (ReACH), provides partners with breakthrough improvement methods, training and technical assistance to reduce hospitalization rates. The Centers for Medicare and Medicaid Services (CMS) cites that 28% of all home care patients in the United States were hospitalized in 2005. A significant percentage of these hospitalizations were related to cardiac conditions, respiratory problems and falls.

The ReACH initiative aims to reduce avoidable hospitalizations of home health patients to a rate of 23% by August 2007 versus the current 28% hospitalization rate.

"Our agency is dedicated to improving the care that all our patients receive in their home. Reducing avoidable hospitalizations of our home health patients is a top priority and we are dedicated to this goal," said Maryanna Arsenault, CEO of HomeHealth Visiting Nurses. "We are pleased to join home health agencies across the country to work on this important project. We believe the ReACH initiative will provide an important opportunity for collaboration with other agencies committed to achieving significant reductions in acute care hospitalizations nationwide."

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Interview with Charles M. Belisle, MD on a Medical Director's Role in Home Health Care

By Mia Millefogle, Vice President Development and Marketing



Dr. Belisle graduated from the University of Vermont Medical School in 1971 and completed his residency at the Navy Hospital in Portsmouth, Virginia and in Jacksonville, Florida. In 1977, he left the Navy and returned to Maine, where he opened a family practice center. Today, he is a practicing physician with the Family Practice Center at MMC and also serves in the Maine Air National Guard.

I recently had the pleasure of interviewing Dr. Charles Belisle about the rewards and challenges of his role as Medical Director for HomeHealth Visiting Nurses.

What brought you to serve as Medical Director for HomeHealth Visiting Nurses?

Dr. Robert McArtor was then the Chief of Family Medicine and the former Community Health Services needed a director so he asked for names ... I gave names and I got the hint he thought I should do it – so I did! With the merger, I rolled into HomeHealth – Visiting Nurses of Southern Maine.

As Medical Director for HomeHealth Visiting Nurses, you are primarily responsible for assuring the provision of quality home care and serving as liaison to the medical community. How do you meet this responsibility?

I insist on knowing the various departments of HomeHealth Visiting Nurses and how they work. It is important to make regular home visits with rehabilitative therapists, social workers, and nurses. For difficult cases, I meet with clinical managers and provide guidance from a physician's perspective. Sometimes, we encounter communication problems and part of my role is to interface with physicians. I will call the physician to discuss the case, the relationship and the communication. For medication questions and issues, I constantly connect the staff with our pharmacist and serve as a link to the resources within Maine Medical Center. My role is to learn the physician perspective, interject the agency's concerns and find common ground. Pleased to say, we have always managed to work out the issues and serve the patient together.

What have you learned from the experience of visiting patients in the home?

Nothing really replaces seeing what it is really like for patients in the home setting where you see behaviors, dynamics, food preferences and the physical environment. The home care team is truly the "eyes and ears" of our profession.

From a physician's perspective, do you feel there are opportunities for home health care and physicians to work more closely in care plan development?

I think we are on the front edge of collaborating on several MaineHealth initiatives to include our joint replacement program and work with orthopedic groups, the "Healing Hearts" program and cardiologists, and the AH Asthma Program. The future is that we are going to deliver more care as a team. Everyone has to feel empowered to help promote the medical objectives of a particular patient and by working together we will improve outcomes. We all have a role and we are all as good as the rest of the team.

As our liaison to the medical community, do you have any advice to our physicians?

Don't be afraid to call your front line home health staff. Be willing to dialogue as they have a lot to offer on your patient's progress. The home care staff is experienced and can make the physician's life easier. And remember, nothing is as remarkable as going into the home. Get out there!

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HomeHealth Visiting Nurses formed an Outcome Based Quality Improvement (OBQI) team of 11 nurses and therapists to participate in the ReACH collaborative. This team collects patient data, reports findings monthly to the collaborative and participates in regular on-site learning sessions and trainings. "Patients want to stay home," said Mary Harmon, RN, OBQI Team Leader. "If we can understand why 28% of patients go to the hospital, usually within the first two weeks of care, and implement strategies to avoid hospitalization whenever possible, our patients will be able to enjoy their independence in the comfort of home."

Did You Know?

Our services include:

Nursing Care

Home Health Aides

Telehealth

Physical Therapy

Occupational Therapy

Speech Language Pathology

Pre- and Postoperative Program

Parent and Child Health

Counseling and
Emotional Support

Community Health
and Wellness

Lifeline Emergency
Response System

Pre- and Postoperative Program

HomeHealth Visiting Nurses is one of the leading providers of pre- and postoperative programs in Southern Maine. Our "Joint Effort" program has demonstrated improved quality outcomes for patients who have elected joint replacement surgery.

While the federal Office of the Inspector General has recently scrutinized the provision of free preoperative visits, we are pleased to let you know that we have carefully reviewed the Advisory Opinion and, in conjunction with MaineHealth compliance attorneys, have concluded our program does not violate any regulatory statutes.

HomeHealth Visiting Nurses' "Joint Effort" program verifies insurance benefits, receives authorization for service, submits bills and receives reimbursement for all preoperative services. In addition, we obtain physician orders prior to assessment, inform patients about the options to choose other providers for postoperative care, and provide a fee schedule for those without insurance.

We are committed to strengthening and expanding this important service for our patients and remain available to answer any questions.

Return Service Requested

The MaineHealth Family

(800) 660-4867 • www.homehealth.org

15 Industrial Park Road • Saco, Maine 04072



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