Achieving Success through Innovative Partnerships

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Common Goals for the Medical Community and AAA’s

- High Quality, Coordinated Care
- Improved Access
- Reduced Avoidable Cost
- Unnecessary Hospital Re-admissions
- Follow up on Chronic Conditions
- Patient Satisfaction and Activation
Partnership Opportunities

• Care Transitions
  – Merrimack Valley Care Transitions Program
• Evidence Based Programs:
  – Healthy Living Center of Excellence
• Medical Care Coordination for Medical Homes
The Expanded Chronic Care Model

Replicated from www.improvingchroniccare.org

COMMUNITY

- Public Health Policy
- Create Supportive Environment
- Strengthen Community Action

Health Systems

- Self-Management Development
- Develop Personal Skills
- Information Systems
- Decision Support
- Delivery System Design / Re-orient Health Services

Activated Community

Informed Activated Patient

Prepared Proactive Practice Team

Prepared Community Partners

Population Health Outcomes/Functional Outcomes
Healthy Living Center of Excellence

COMMUNITY

Elder Services of the Merrimack Valley
Healthy Living Center of Excellence
Regional Disease Management Coalitions
Care Transitions
Medical Care Coordination

Health Systems

Hebrew Senior Life
Hospitals, FQHCs, PCP
Health Plans, SCOs, ACOs, PCMH
VA, VNA, Home Health Care

Executive Office of Elder Affairs, Dept of Public Health

Aging Service Network Providers
Healthy Aging Communities and Programs Committees
Massachusetts Health Policy Forum

Informed Activated Patient
Activated Community
Prepared Proactive Practice Team
Prepared Community Partners

Population Health Outcomes/Functional Outcomes
Merrimack Valley Care Transitions Program

Elder Services of the Merrimack Valley, Inc.
Choices for a life-long journey

Lawrence General Hospital

Holy Family Hospital

Saints Medical Center

Anna Jaques Hospital

Merrimack Valley Hospital
Our Model and Unique INTERVENTIONS

- Enhanced Coleman Model
- Medical Interpretation
- Mental Health supportive services
- Evidenced Based Chronic Disease Self Management Programs
- One Time Basic Necessities to address critical unmet needs
- Nutritional Coaching and Assessment
- Enhanced Home Health including Telehealth
- Rapid response in-home services
- PCP follow up

ESMV Community services -
(services not paid by CCTP but existing and to be fully utilized)
Community Partners

- Acute Rehab Hospitals
- CHHA’s (Certified Home Health Agencies) & VNA’s
- Contracted providers of community based services
- SNF’s (Skilled Nursing Facilities): 37 in MA, 6 in NH
- Community Health Centers
- Pharmacies
- PCP’s
COMMUNICATING WITH HEALTH CARE PARTNERS

COMMUNITY CARE TRANSITION PROGRAM
Workshop Voucher

Patient Name: ___________________________________________
Doctor Name: ___________________________________________
Coach Name: ___________________________________________
MD Referral:  Yes  No

Please join us for one of the following No Cost six week workshops!

☐ MY LIFE, MY HEALTH: CHRONIC DISEASE SELF-MANAGEMENT PROGRAM
☐ MI VIDA, MI SALUD: TOMANDO CONTROL DE SU SALUD (Spanish My Life, My Health)
☐ DIABETES SELF-MANAGEMENT PROGRAM
☐ SPANISH DIABETES SELF-MANAGEMENT PROGRAM

Workshop Information

Date: ___________________________________________
Time: ___________________________________________
Place: ___________________________________________

*Please submit this voucher to your leader at the workshop.

For More Information contact Susan Poludniak at 978-946-1355 or visit www.healthyliving4me.org

Elder Services of the Merrimack Valley, Inc.
Hebrew SeniorLife
Affiliated with Harvard Medical School

In partnership with Anna Jaques Hospital, Holy Family Hospital, Lawrence General Hospital, Merrimack Valley Hospital, Saints Medical Center.
The Model: The Healthy Living Center of Excellence will promote the integration of evidence-based self-management programs held in diverse community settings within the health care delivery system through collaboratives which include the community based organizations, health care providers and plans, government, foundations, and for-profit partners.

Founding Partners: Elder Services of the Merrimack Valley and Hebrew SeniorLife

Advisory Team: Executive Office of Elder Affairs, Department of Public Health, Tufts Health Plan Foundation, Heller School of Brandeis University, Massachusetts Councils on Aging

Key Features:

* Training Center and Technical Assistance for 14 Evidence Based Programs
* Diabetes Self-Management Reimbursement under Medicare
* Integration of CDSMP as a funded intervention under CTTP (3026)
* CDSMP integration in medical home pilots
* Diversification of funding for sustainability (HMO, ACO, Foundation, etc)
* Six (6) regional collaboratives, maintaining local sensitivities
* Multi-program, multi-venue, across the lifespan approach
* Focus on workforce development and retention
* Online self-management programs
Local Collaboratives

THE COMMUNITY WHEEL

Adapted from Marin Institute – Community Organizing Action Pack (www.marininstitute.org)
Multiple Program Menu
Multiple Venue Approach
“One-stop” Coordination
Program Calendar
Leader Portal

The Healthy Living Center of Excellence is an innovative collaborative between Elder Services of the Merrimack Valley, Inc., a community based organization and Hebrew Senior Life, a medical provider with a goal of helping seniors remain independent and in the community as long as possible. By combining our expertise in the aging service and medical networks, the collaborative encourages older adults to become active partners in managing their health.
Diabetes Self Management Pilot

• Partnership with Hebrew Senior Life (Medicare Provider) to provide DSMP

• Benefits from the providers perspective working with AAA’s
  – Access to non-medical/non-traditional services for their patients
  – Access to the aging network and partnership opportunities

• DSMP is an eight week intervention designed to provide each participant with an individual assessment and education plan that has been developed collaboratively by participant and instructor

• Includes the six (6) week Stanford Diabetes Self-Management Training Program, given 2½ hours per week

• Workshops are facilitated from a highly detailed manual by two trained leaders, one or both of whom are peer leaders with diabetes themselves
Medical Care Coordination for Medical Homes

• Outcomes:
  – Better health care quality
  – Improved involvement of patients in their own care
  – Reduced avoidable costs over time
  – Improved Access
  – Improved Patient Self-Management through Evidence-Based Programming
  – Enhanced Incentives for Practitioners
  – Care Coordination that:
    • Reduces Incidence of avoidable hospitalizations
    • Improves overall patient experience
    • Increases practitioners satisfaction
Questions?

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