Appendix C

PRMC/MAC, Inc. Population Health Partnership: Bridging the Gap

Leigh Ann Eagle – Executive Director
Sue Lachenmayr – State Program Coordinator
MAC, Inc. Living Well Center of Excellence

Why Prevention and Behavior Change Strategies Matter

- Since January 1, 2011 every day for the next 19 years, 10,000 baby boomers turn 65. The aging of this huge cohort of Americans dramatically changes the composition of the country.[1]

- 70% of physical and mental decline associated with aging is due to poor lifestyle behavior.[2]

- Older adults at any age can and do learn to make healthy behaviors and even modest lifestyle changes can produce big results when people are empowered and supported to cultivate health and longevity.[3]

Impact of Baby Boomers and the Elderly on the Health Care System

- 91% of people over 65 have one or more chronic conditions; 73% of 65+ have 2 or more chronic conditions.
- Over 1.7 million Americans die of a chronic disease each year.
- In 2009, the federal and state governments spent over $250 billion on health care benefits for 9 million low-income elderly or disabled people jointly enrolled in Medicare and Medicaid.

Dual-Eligible Beneficiaries of Medicare and Medicaid: Characteristics, Health Care Spending, and Evolving Policies, Congressional Budget Office, June 2013

Why These Programs Work

- People with chronic conditions have similar concerns and problems.
- People must deal not only with their disease, but also the impact these have on their lives and emotions.
- People with chronic conditions are more likely to identify with and trust leaders who have had similar experiences.

How We Started

- Training of hospital staff as Master Trainers/Leaders and implementation of workshops at the hospital and workshops and leader trainings at MAC;
- Hospital team participation in Living Well Eastern Shore Advisory Committee
- Multiple Letters of Support/Commitment by both partners for grant opportunities
- Focus on expanding access to evidence-based programs (CDSME, Stepping On, PEARLS)
- Collaboration on Community Health Worker pilot and development of webinar and resources highlighting MAC's home and community-based programs
- Department of Health and Mental Hygiene "Million Hearts" funding to support implementation of the Living Well with Hypertension Module; develop processes for referral across Community Health Workers, CDSME and other services

Healthy Aging/Disease Management Programs for Older Adults

Living Well Stanford University Self-Management Programs

- Living Well with Chronic Conditions
- Living Well with Diabetes
- Living Well with Chronic Pain
- Living Well: Cancer - Thriving and Surviving
- Living Well Home study chronic disease toolkit
- Living Well with Hypertension (Recruitment session)

Other Healthy Aging/Disease Management Programs for Older Adults

Living Well Evidence-based Programs

- Stepping On (Falls Prevention)
- EnhanceFitness (Exercise)
- PEARLS (Depression Screening)
- DPP (Diabetes Prevention Program)

MAC Inc. Living Well Center of Excellence: Delivering Evidence-Based Programs and Services Across the Continuum

- Statewide License for Stanford CDSME programs (Chronic Disease, Diabetes, Pain, Cancer)
- Training and technical assistance for CDSME and other evidence-based programs (DPP, Stepping On falls prevention, EnhanceFitness, PEARLS Depression intervention)
- Centralized referral with tracking and feedback to providers; certified workforce, community-based locations, quality assurance measures, HIPAA compliant
- Statewide calendar, quarterly reporting to partners on demographics, participant retention, feedback on patient activation, engagement and long-term goals

Initial Partnership Tools and Resources

- Participant Registry Shared Across Partner Agencies
- Provider Referral Forms
- Reporting Tool for Community/Clinician Referral Forms
- Client Information and Tracking
- Plan of Care Process Flow/Feedback Loop
- Blood Pressure Action Plan and Protocol
- Webinar on Community Services
- CDSME Courses access across PRMC Services Region
- Contribution in Staff and Supervision to Support Effort
- CHW Assessment

Building the Partnership

- Hospital staff trained as Master Trainers/Leaders and implementation of workshops at the hospital and workshops and leader trainings at MAC
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PRMC supports a Multi-Faceted Approach to Meet Client and Health Care Partner Needs

- **Evidence-Based Programs**: CDSME (CDSMP, CPSMP, CTS, DSMP, Stanford CDSMP Home Toolkit), EnhanceFitness, Tai Chi for Better Balance, Stepping On, Hypertension Recruitment Module, PEARLS
- **Referral and Plan of Care Process Loop**: evidence-based programs, provider, homecare-based CHW for monitoring of clinical outcomes, AAA-based CHW for home and community-based services
- **Hospital services provided at MAC:** staff support for evidence-based program implementation, cancer (support and navigation, organic garden, teaching kitchen), weight loss center (monitored exercise, nutritional counseling, teaching kitchen)

What We're Doing Now

- PRMC budget line item support for CDSME, Stepping On, PEARLS workshop delivery; staff support for implementation, administration
- ACO measures include requirement to refer to CDSME; face to face visits with providers
- Care Transitions Team utilizes online HIPAA compliant Autofill referral
- Cancer Thriving and Surviving provided within a wide array of Cancer Survivor services (community garden, tasting kitchen, weekly organic vegetable, EnhanceFitness boot camp, support groups co-located at MAC in partnership with PRMC
- Outreach workers on PRMC Wellness Van and in the community to recruit high risk hard-to-reach CDSME participants

What We're Doing Now

- In June, the PRMC Weight Loss Center opened at MAC, 75+ participants
  - PRMC clinical staff
  - DPP and/or Enhance Fitness as ongoing benefit for individuals
- Targeting ACO Providers' patient panels for referrals to CDSME based on diagnosis
- Linking CDSME and other evidence-based program participants back to hospital to track health care utilization and document value of EBPs

Plans for the Future

- Co-locate Diabetes nonclinical services at MAC utilizing a referral process to prioritize and ensure the appropriate level of diabetes resources
- Apply for a HRSA Rural grant using multiple providers and partners in Somerset, parts of Worcester and northern Virginia to:
  - Expand telehealth services in rural, isolated areas
  - Embed CDSME and other evidence-based behavior change programs as part of routine delivery of services
  - Expand use of PRMC and MAC CHWs to do assessments, track engagement and provide an array of in-home services

MAC, Inc. Area Agency on Aging Home and Community-Based Services

- MAP (Maryland Access Point Information & Assistance)
- Advocacy and Assistance Programs
- Caregiver Resource Center
- In-Home Services
- Assisted Transportation
- Nutrition (Meals on Wheels and Congregate Meals)
- Senior Centers
- Volunteer Services
- 50+ Network for Creative Engagement
- Community Outreach

Nationally recognized MAC (Maintaining Active Citizens), founded in 1972, is the designated Area Agency on Aging and Disability Resource Center for Dorchester, Somerset, Wicomico and Worcester Counties. MAC's mission is to preserve a dignified quality of life for our older adults through services that maintain healthy independent living, and helps them manage challenges as they become frail.

Phone:
410-742-0505
www.macinc.org

MAC's Programs and Services

Maryland Access Point(MAP): *Your link to health and support services.*

- Call MAP for information and assistance about long-term care services and planning future needs for aging and disabled adults.

Advocacy and Assistance Programs

- Legal services
- Ombudsman services (advocacy for nursing home and assisted living residents and their families)
- Guardianship
- Senior Health Insurance Program (SHIP), which includes Medicare counseling
- Income tax preparation assistance
- Assisted living subsidies
- Senior Community Services Employment Program

Wellness Center

- State-of-the-art gym (memberships available)
- Health and fitness programs, including aquatic, Yoga, Tai Chi, and Zumba
- Chronic disease, chronic pain, diabetes and fall prevention programs
- Susan G. Komen for the Cure (life after breast cancer, a return to independence)

In-Home Services

- Senior Care
- Caregiver Support Services
- Older Adults Waiver Services
- Money Follows the Person (from nursing home back to home program)
- Hospital Discharge Planning (linking patients going home to community resources)

Nutrition

- Meals on Wheels (home delivery to homebound adults 60+)
- Meals served in senior centers in four counties

Senior Centers

- MAC operates a network of senior centers throughout the Lower Shore, offering social, educational and recreational programs, and meal

Day Center *(for the memory impaired)*

- The Parsons Day Center offers families respite from the challenging 24/7 care of a loved one suffering from dementia.
- Alzheimer's support groups

Volunteer Services

- Retired and Senior Volunteer Program
- Neighbor to Neighbor
- Telephone Reassurance Program (phone calls to seniors living alone)

Plans for the Future

- Discussion underway to pilot 'high touch' in-person ongoing home and community-based services and frequent monitoring/assessment/engagement of highest risk individuals (Dual Eligibles - Medicare and Medicaid) by maximizing utilization and reimbursement across multiple programs
- Reimbursable programs include: TCM (Transitional Care Management), CCM (Chronic Care Management), PRP (Wrap-around Psychological Rehabilitation Services), Medicaid Waiver and Veterans' VA Choice
- Explore MFP (Money Follows the Person) to reduce SNF rehabilitation length of stay

Questions ??????

CONTACT INFORMATION

Leigh Ann Eagle, Executive Director
MAC, Inc. Living Well Center of Excellence
LAE2@macinc.org 410-742-0505 x 136

Sue Lachenmayr, State Program Coordinator
bslach@earthlink.net 908-797-5650