Building Clinical and Community Collaboratives through Evidence-Based Programs JOAN HATEM ROY, LICSW^{1,2}, JENNIFER RAYMOND, MBA^{1,3}, SUSAN POLUDNIAK, RD,LDN^{1,2} HEALTHY LIVING CENTER OF EXCELLENCE¹, ELDER SERVICES OF THE MERRIMACK VALLEY, INC², HEBREW SENIORLIFE³

The Model

The Healthy Living Center of Excellence (HLCE) is a partnership between a community based organization (Elder Services) and a medical provider (Hebrew SeniorLife) with a goal of integrating community social services within in the health care delivery system. Funded by the Tufts Health Plan **Health Living Center** COMMUNITY of Excellence Foundation, John A. Hartford Foundation, and **Elder Services of** the Merrimack Administration on Community Living, the HLCE Valley Health Systems Center of focuses on evidence-based health promotion programs Massachusetts Hospitals, FQHCs, PCP ixcellence Hebrew Health Policy Senior Life gional Disease Forum Management as a primary mechanism for fostering community Healthy Aging Communities THPF and other and Programs Health Plans, SCOs, and clinical linkages. Along with Partners in Care philanthropic ACOs, PCMH funding Aging Service Network Foundation, Los Angeles, California, the HLCE Providers Executive Office of Elder Affairs, Dept of Public Health seeks to build increased awareness of the benefits of integrating community based services in the health Prepareo Informed Proactive Activated Activated care delivery system. The HLCE model is derived Practice Patient Community Team Partners from the Chronic Care Model developed by Ed Population Health Outcomes/Functional Outcomes Wagner, M.D., M.P.H.

Regional Collaboratives

Through the use of six regional collaboratives covering all of Massachusetts, the HLCE embeds evidence-based programs in diverse community settings. Health care providers can refer any adult patient with one or more chronic conditions to these community programs by contacting the HLCE via one 1-800 number or email address or by submitting referrals via website, www.healthyliving4me.org

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http://www.improvingchroniccare.org.
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Key Features

• Statewide Disease Management Coalition with website and universal license. • Six (6) regional collaboratives, maintaining local sensitivities and Advisory Council. • Centralized referral, technical assistance, learning collaborative, and quality assurance.

Each regional collaborative consists of community based organizations with capacity to implement evidence-based programs in diverse settings and serving diverse populations. This allows community organizations to meet the needs of health care organizations and their patients.



- Multi-program, multi-venue, across the lifespan approach.
- Diversification of funding for sustainability (HMO, ACO, Foundation, etc).
- Diabetes Self-Management Reimbursement under Medicare.
- Integration of EBP as a funded interventions under CCTP (3026).

Health Care Partnerships

Common Goals for the Medical Community & COA's

- What's in it for me?
- High quality, coordinated care
- Improved access
- Reduced avoidable cost
- Unnecessary hospital re-admission
- Follow up on chronic conditions
- Patient satisfaction and activation

Dedham Medical Associates &

Tufts Health Plan &

Northeast Region (Elder Services of the Merrimack Valley, Inc.)

Referral Process



Hebrew SeniorLife

Dedham Medical Associates

Atrius Members High Cost/High Risk Patient Review

Hebrew SeniorLife Referral into CDSME Programs Healthy Living Center of Excellence **Tufts Health Plan** Education of Care Managers

Development of Referral Pathway

Healthy Living Center of Excellence Referral into CDSME Programs

More Information

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A Partnership with:

The Power to Redefine Aging.

Hebrew SeniorLife



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