

Executive Office of Elder Affairs
 RESPECT INDEPENDENCE INCLUSION
**Hospital to Home Partnership
 Program Learning Collaborative**
July 15, 2024 11am-12pm



Agenda



- Welcome New HHPP Grantees!
- Upcoming Trainings
- Supporting Patients In-Patient and Discharge Planning: Greater Springfield Senior Services (GSSSI)
 - Brenda Labbe, Outreach Director and Supervisor for HHPP
 - Anna Randall, Community Services Director
- Program Overview: Somerville-Cambridge Elder Services (SCES) and Cambridge Health Alliance (CHA)
 - Annie Fowler, Chief Program Officer, SCES
 - Eleni Carr, Chief Care Integration Officer, CHA
- Next Steps

Welcome!

HHPP New Award Grantees

AgeSpan and Greater Lynn
Senior Services

Partner Hospital: Salem
Hospital

Elder Services of Berkshire
County

Partner Hospital:
Berkshire Medical Center

Elder Services of Cape
Cod and the Islands

Partner Hospital: Cape
Cod Healthcare

Highland Valley

Partner Hospital: Cooley
Dickinson Hospital

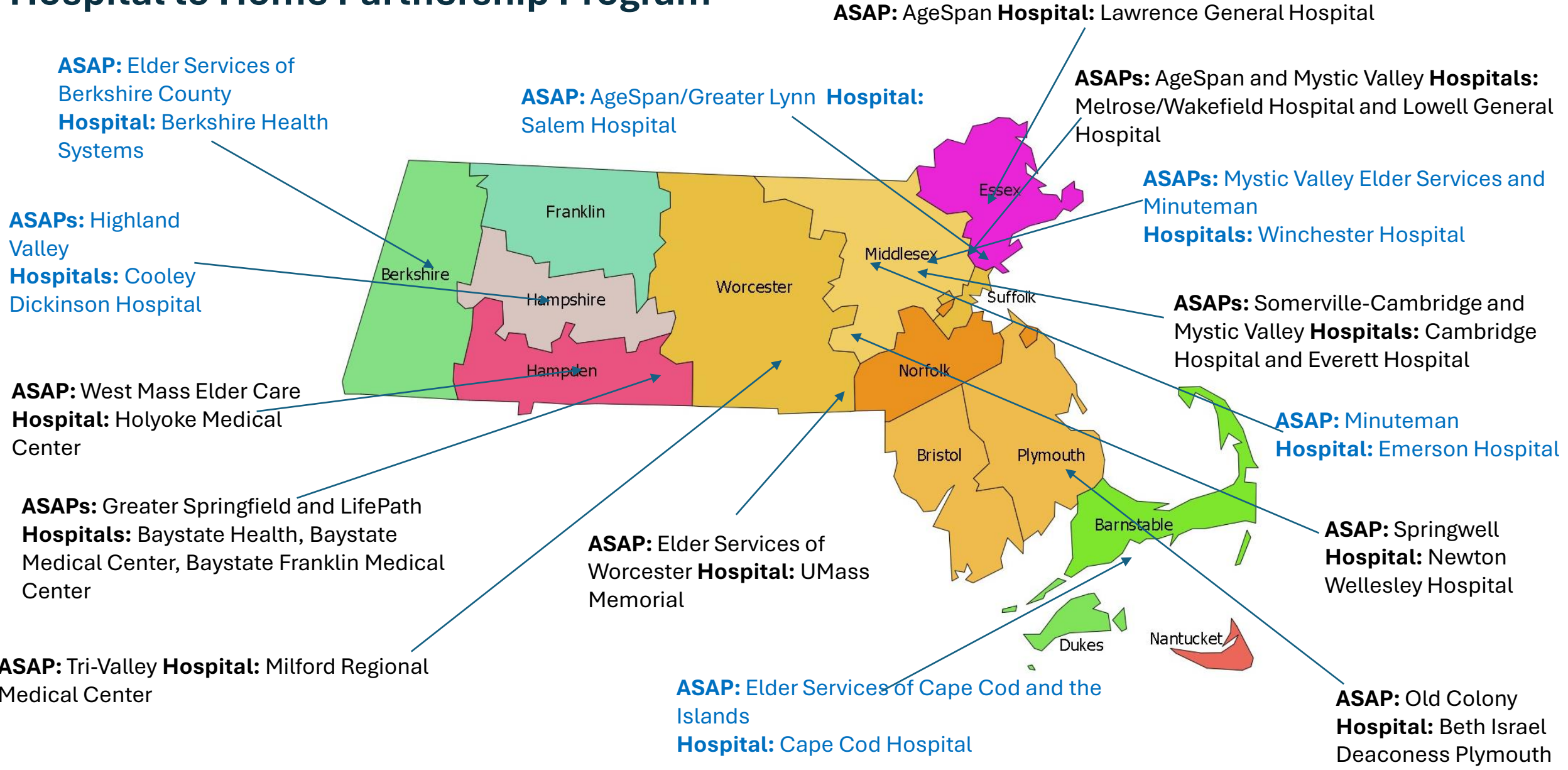
Minuteman Senior
Services

Partner Hospital: Emerson
Health

Mystic Valley Elder
Services and Minuteman
Senior Services

Partner Hospital:
Winchester Hospital

Hospital to Home Partnership Program



*For HHPP utilization only. Not for distribution.



Performance Reporting Webinar

Tuesday, August 6th from 12–1 pm

During the webinar, we will:

- Review the performance reporting requirements
- Go over the submission process
- Address program reporting questions

Notification will be sent to the primary ASAP contacts later this week and will include:

- Registration information
- User guide and FAQ (with reporting dates and deadlines)

Attendance is highly encouraged

Serving Older Adults with Limited English Proficiency

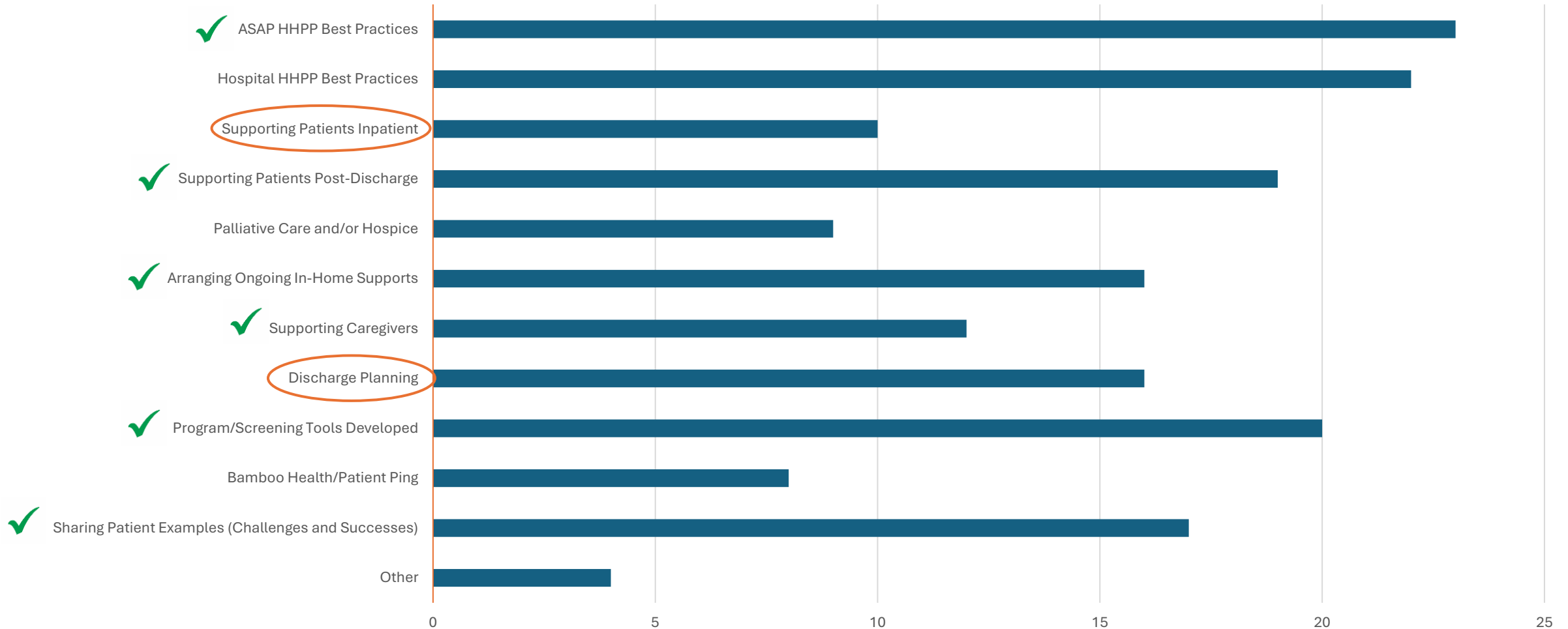
Tuesday, July 30th from 11:00am-12:00pm

This training will cover:

- Background information about older adults with LEP;
- An overview of federal language access authorities most relevant for older adult programs and services, including Title VI, select caselaw, and other federal laws; and
- Practical strategies for working with older adults with LEP, including tips on working with an interpreter, and more.

HHPP Learning Collaborative Survey Results

What topics are you interested in learning about?

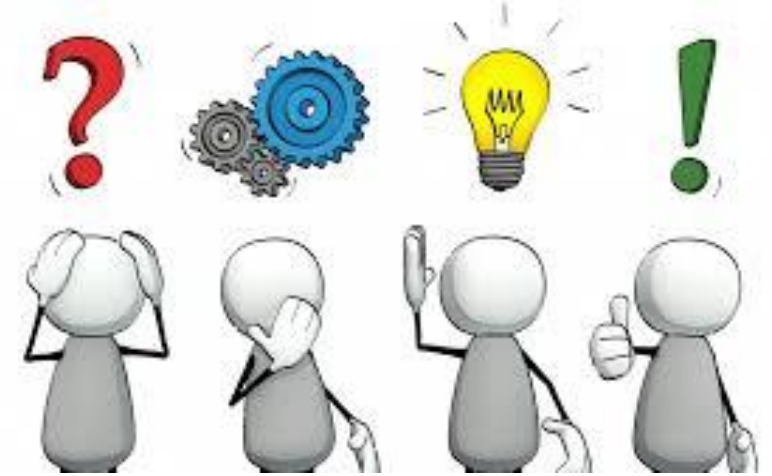


Other: Best practices for effective and efficient documentation, Careport Connect (similar to Bamboo Health), iCarol software for H2H

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Request for Topics

- Is there a topic we have not yet covered?
- A topic worth revisiting?
- Share additional best practices?
- Discuss and share patient experience stories?



Access all previous HHPP Learning Collaboratives at [Hospital to Home Partnership Program \(HHPP\) - Document Library \(800ageinfo.com\)](http://800ageinfo.com)

Supporting Patients In-Patient and Discharge Planning: Greater Springfield Senior Services Inc (GSSSI) and Baystate Health

Speakers

- Brenda Labbe (She/Her) Outreach Director and Supervisor for HHPP, GSSSI
- Anna Randall (She/Her) Community Services Director, GSSSI



**GREATER SPRINGFIELD
SENIOR SERVICES, INC.**
DIGNITY - PASSION - PURPOSE



**Baystate
Health**

ADVANCING CARE.
ENHANCING LIVES.

Program Overview: Somerville-Cambridge Elder Services (SCES) and Cambridge Health Alliance (CHA)

Speakers:

- Annie Fowler (She/Her), Chief Program Officer, SCES
- Eleni Carr (They/Them), Chief Care Integration Officer, CHA



History

- Began discussions in 2011 between:
 - Cambridge Health Alliance
 - Hallmark Health
 - Mystic Valley Elder Services
 - Somerville Cambridge Elder Services
- Granted Community Care Transitions Program (CCTP) funding in 2012
- Funding ended in 2016 (as planned)
- CHA continued to fund care transitions programs with SCES staff from 2016 – present
 - Part of ACO's Complex Care Management Team
- Received ARPA funding through EOHHS for current H2H Hospital Liaison intervention

Program Description

- Liaisons are embedded in the 2 hospitals
- On-site 3-4 days per week
 - Sit with the care teams for documentation
 - Attend rounds
 - Meet with patients
 - Consult with staff on potential referrals
- Conduct home visits within 3 days, sooner in higher risk cases
- Follow up with medical providers
- Follow up calls/home visits with patients
- Document hospital visit, home visit and closure in Epic, along with additional information relevant to care team

Successes

- Inpatient teams and Liaisons sit in the same space which has led to natural consultations and learning on both sides. Extends beyond Case Managers and includes PT, and ED staff
- Liaisons are able to alert consumers already enrolled in ASAP programs of hospitalizations so d/c planning can start earlier
- Liaisons are reporting back to inpatient teams and outpatient clinics issues in the community
 - Participation in daily safety meetings to drive change

Areas for Exploration

- Every ASAP has small differences and Liaisons cannot always speak to what will happen when d/c'd to another catchment area
- Role of Liaison is not always clear across disciplines
 - Hierarchy within the hospital and can be hard to navigate as a new Liaison coming in to an established system
- Discharge planning is complex and where patient will discharge to can change last minute either due to space, payment or patient choice
- On the fence STR vs home cases – rehab often needed due to ASAP services not being able to start same day

Case Studies

- Success
- Room for Improvement

Next Steps

Tentative HHPP Learning Collaborative Schedule



Date	Time
Wednesday, September 18, 2024	2:00pm-3:00pm
Wednesday, November 13, 2024	1:30pm-3:00pm
Tuesday, January 14, 2025	3:00pm-4:00pm
Wednesday, March 26, 2025	1:30pm-2:30pm

Questions or ideas?

- Contact Dana.Beguerie@mass.gov