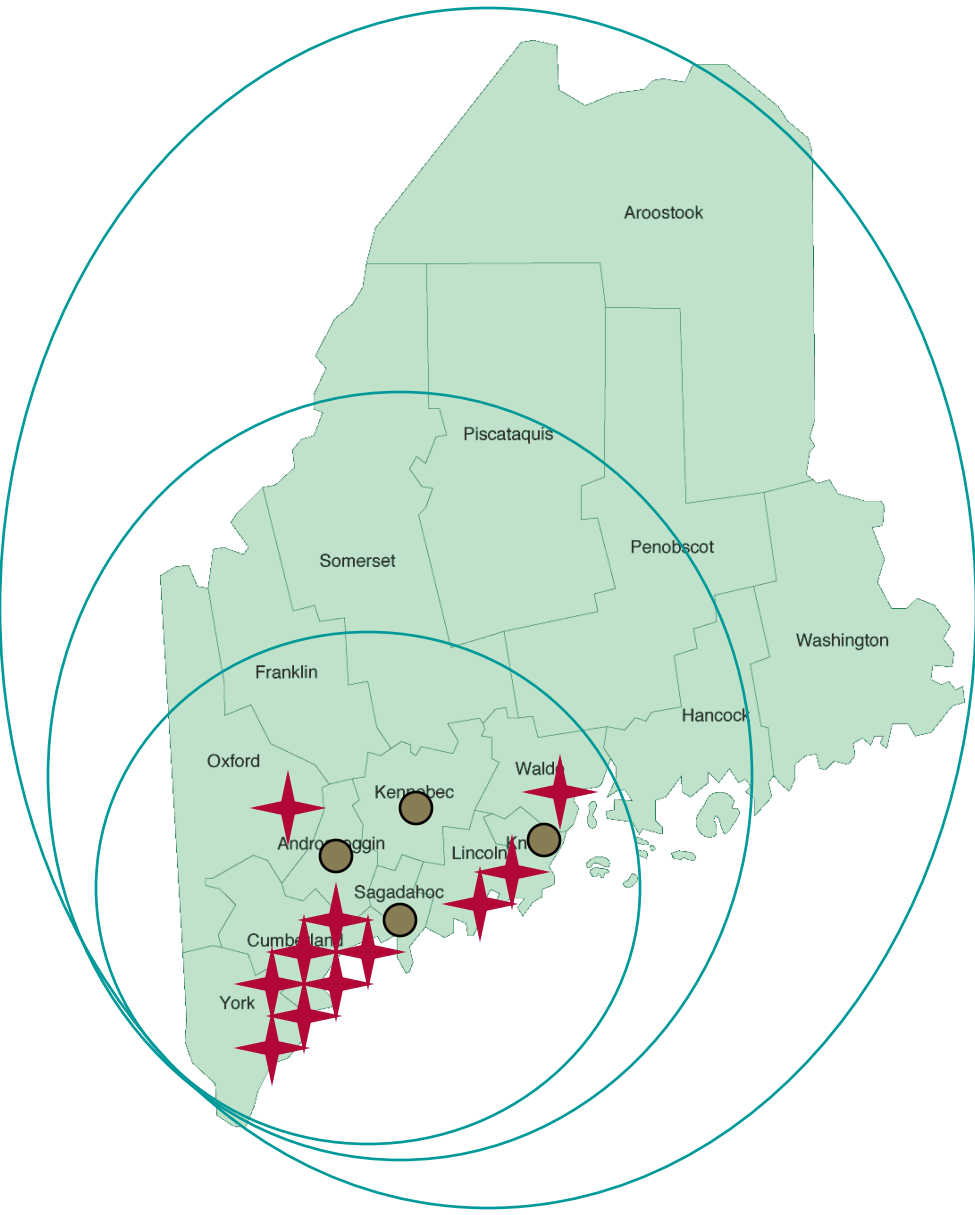


MaineHealth

A nationally-recognized family of leading healthcare providers working together to ensure our communities are among the healthiest in America



Members

- Maine Medical Center
- Southern Maine Medical Center
- Spring Harbor Hospital
- Miles Memorial Hospital
- St. Andrews Hospital
- Stephens Memorial Hospital
- Waldo County General Hospital
- HomeHealth Visiting Nurses
- Synernet
- NorDx
- Maine PHO

Affiliates

- MaineGeneral Medical Center
- St. Mary's Regional Medical Center
- Mid-Coast Hospital
- Penobscot Bay Medical Center

A Matter of Balance Class

Designed to benefit community-dwelling older adults who:

- Are concerned about falls
- Have sustained a fall in the past
- Restrict activities because of concerns about falling
- Are interested in improving flexibility, balance and strength
- Are age 60 or older, ambulatory and able to problem-solve

During 8 two-hour classes, participants learn:

- To view falls and fear of falling as controllable
- To set realistic goals for increasing activity
- To change their environment to reduce fall risk factors
- To promote exercise to increase strength and balance

Outcomes: significant improvement in falls control, falls management, falls efficacy, increased exercise levels

Project Enhance

EnhanceWellness

Nursing and Social Work support

- Health review and functional assessment
- Development of Health Action Plan
- Motivational interviewing
- Health Mentors and Support Groups
- Customized software program – WellWare

Outcomes: 63% reduction in hospital admissions, 69% reduction in ED visits, and 79% reduction in restricted activities

EnhanceFitness

- low-cost, highly adaptable exercise program
- offering levels challenging for active older adults to safe enough for near frail

Outcomes: improved physical and social functioning, reduced incidence of pain, fatigue, and depression

The Care Transitions Program

- A patient-centered intervention designed to improve quality and contain costs for older patients with complex care needs as they move from hospital to home.
- During the 28 day intervention, a nurse transitions coach:
 - ◆ provides patients with tools and support that promote knowledge and self-management of their health conditions.
 - ◆ encourages direct communication between the patient/caregiver and the healthcare team.
- Built on Four Pillars
 - ◆ Use of a patient-centered record- Personal Health Record (PHR)
 - ◆ Medication self-management
 - ◆ Primary care and specialist follow-up
 - ◆ Knowledge of “red flags”- signs and symptoms to be reported
- Outcomes: reduced re-hospitalizations, greater knowledge and confidence in self-management skills.

Evidence - Based Program Sites

Legend

- △ Living Well (CDSMP) Host Organizations
- ▲ Living Well (CDSMP) Implementation Sites
- Matter of Balance Master Trainer Sites
- EnhanceFitness Sites
- EnhanceWellness
- Care Transitions
- Healthy IDEAS - statewide 8.7.09

