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News for Older Adults, Caregivers, & Partners in Supporting Health & Independence

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Rosemarie, a retired paralegal (pictured below left), is happy to be living independently in her own home following an unexpectedly challenging stretch that started with a double hip replacement. The resulting weakness and loss of mobility led to multiple hospital admissions and eventually a recommendation that she consider assisted living. In April, during Rosemarie's stay at Newton Wellesley Hospital, Maggie Gosen, Springwell's Hospital to Home Liaison (pictured below right), knocked on her door.

"Maggie listened to me and responded to my desire to sit everyone down and create a plan around what I wanted to have happen."

Last year, the MA Executive Office of Health and Human Services awarded Springwell and Newton Wellesley Hospital a two-year grant to pilot a Hospital to Home partnership. This unique and innovative program embeds a Springwell staff member on-site at the hospital to assist older adults with discharging and transitioning home. Typically, when patients are preparing for discharge, they are simply provided with contact information to set up support services like meal provision, medical transportation, and caregiver education. For older patients who live alone and lack a strong support network, this approach often results in referrals for these services being dropped. This can lead to a cycle of readmission, which the Hospital to Home program mitigates through the one-on-one, personalized approach of a liaison who provides support and coordination during the key transitional period following discharge to ensure that non-medical services start and in-home care needs are met.

Rosemarie was initially skeptical of any referrals for in-home supports. Still, she met with Maggie a few times before her discharge, and Maggie explained to her what kind of services might be possible. When Rosemarie was re-admitted two weeks later, she was happy to see a familiar, trusted person and was eager to work with Maggie to create a plan that would address some of the challenges of living independently with her current mobility issues.

According to Rosemarie, what Maggie did was not only coordinate all the different people who needed to be involved and services that needed to be set up, but she also listened to and prioritized Rosemarie's plan for what she wanted to have happen. Maggie also provided an important link and sense of continuity for Rosemarie, meeting with her both in the hospital and then on her first day at home, establishing a bridge to her new home-based services.

Today, Rosemarie is successfully living at home and managing her ongoing health care needs without unnecessary trips to the emergency room. She has a dedicated Springwell Care Manager and the support she needs to live on her own with the in-home services that are right for her.

New Supportive Housing Sites

building community

Springwell Care Coordinator Lea Tzimoulis with residents of Heritage Village in Northborough during a morning coffee (left), residents of Hudson's Norma Oliver Village at a pizza party organized by Care Coordinator Melissa Holland (center), and Hudson residents Annette Begin and Michael Haggerty (right).

This year, Springwell's Supportive Housing Program, funded by the Massachusetts Executive Office of Elder Affairs, has expanded into Northborough housing sites at Colonial Village and Heritage Village, and to Hudson housing sites at Brigham Circle and Norma Oliver Village.

Supportive housing partnerships like these offer adults aged 60 and older, as well as people with disabilities, a range of services on-site to promote healthy aging in place. Each location has a dedicated Springwell Care Coordinator offering regular office hours for residents, as well as activities to promote community and socialization. Twenty-four hour a day emergency coverage is also provided to residents through a contracted vendor. Finally, integral to the program is a congregate meal site which provides on-site lunch Monday through Friday and a 'to-go' option for the weekends.

"On-site supportive services enhance the quality of life for residents and provide access to programs and benefits that help them to remain as independent and self-sufficient in their homes for as long as possible," says Cristina Bryant, Springwell Housing Program Manager. "Care Coordinators are an accessible, friendly link for residents to support their physical, social, and mental well-being. We are thrilled to be offering these services in Hudson and Northborough."

Care coordinators are available to help residents access community resources such as home care or personal care and Medicare counseling for public health benefits. They also plan social, health, and wellness activities for residents and arrange congregate meals. The coordinators help to foster stability and a sense of community at each property and provide an important link between the tenants and the housing authority. There is no cost to residents for the Care Coordinators' services.

On recent visits to Heritage Village and Norma Oliver Village, residents were enthusiastic about the program coming to their housing development. One resident shared that, "Springwell has been wonderful. Lea is so accessible and has brought so many opportunities for me to get out and socialize." Another shared that the meal site has been a positive addition, noting that, "the food has been surprisingly good!" Residents Annette Begin and Michael Haggerty, pictured above, are long-time sweethearts who met at Norma Oliver Village. They are enthusiastic about any activity that they can do together.

Springwell has Care Coordinators at nine senior housing sites across our greater Boston and MetroWest service area through other supportive housing and congregate housing contracts with the Executive Office of Elder Affairs, as well as through our Care Connections program working directly with housing sites.

partners

Springwell is grateful to the housing entities that make our Supportive Housing, Congregate Housing, and Care Connections Programs possible. If you are interested in bringing supportive housing services to your community, contact Cristina Bryant, Springwell's Care Connections Program Manager.

Hudson Housing Authority
Marlborough Senior Housing
Mission Springs Housing
Needham Housing Authority
Northborough Housing Authority
Waltham Housing Authority
Watertown Housing Authority

CEO Notes

reaching out

Springwell is one of 24 Aging Service Access Points (ASAPs) across the Commonwealth, all contracted with the Massachusetts Executive Office of Elder Affairs, that provide programs and services designed specifically to support adults aged 60 and older and their caregivers. Most ASAPs, including Springwell, are also Area Agencies on Aging (AAAs), a federal designation that means we offer a variety of services funded through the Older Americans Act, including information, resources, and options counseling, making it possible for people to choose which services help them age in the community of their choice.

As the Area Agency on Aging for 22 communities in greater Boston and MetroWest, every four years, **Springwell is responsible for surveying older adults and caregivers in these communities.** If you are an older adult or caregiver, what do you think the needs are in your community? Are your concerns focused on technology, transportation, social isolation, or something else? To make your voice heard, **please take a few minutes to complete the short survey, explained below.**

-Trish Smith, Springwell CEO

We Want to Hear From You!

needs assessment

Every four years, the Massachusetts State Plan on Aging is revised, based on the needs of older adults (age 60+) and family caregivers. The Plan serves to shape the policy development and programs that the Executive Office of Elder Affairs will pursue to promote independence, empowerment, and well-being so that those in need will have resources to thrive in every community.

The first step in creating the Plan for federal fiscal years 2026-2029 is to hear from older adults and caregivers about their top needs. To make your voice heard this year, Springwell is hoping you will participate in our anonymous, secure survey, which you can access on our website or by scanning the QR code to the bottom right.

Printable surveys can be downloaded on our website. They can also be obtained by contacting Springwell's Director of Community Services, Donlyn Cannella, at dcannella@springwell.com or 617-926-4100.

Printable surveys are available in the following languages:

English	Portuguese
Spanish	Arabic
Khmer	Vietnamese
Haitian Creole	Russian
Traditional Chinese	Luganda
Simplified Chinese	Hindi
Armenian	Cape Verdean Creole

Scan the QR code to take this year's Massachusetts State Plan on Aging Needs Assessment Survey.

Community Transitions Liaison Program

bringing you home

A meeting of the Community Transition Liaison Team at Springwell (left), Donna Murray, Springwell's Community Transitions Liaison Supervisor (center), and Heather Berry, Director of Social Services at the Timothy Daniels House (right).

Over the next eight years, the Commonwealth of Massachusetts has committed to ensuring that 2,400 residents of long-term care facilities, like 71-year-old Jeanine at Timothy Daniels House, will get the help they need to transition back into the community. In June, with the help of the Community Transition Liaison Program at Springwell, Jeanine happily moved back in to her own home.

The Community Transition Liaison Program (CTLP), launched by the Massachusetts Executive Office of Elder Affairs in 2023, offers accessible, professional support including individually tailored discharge plans, connections to state program and local supports, and dedicated advocacy for nursing facility residents who want to return to the community. CTLP services are free for all nursing facility residents aged 22 and over, regardless of insurance status.

Transitioning to the community can mean returning to a family home, moving into accessible housing, or finding a residential facility that better meets a resident's care needs. Each situation is unique, and the program tailors its response accordingly.

For Jeanine, the personalized attention of the CTLP program made all the difference. Jeanine's case required a complicated coordination of a number of services. In April, understanding the challenges Jeanine would face in achieving her goal to move home, Heather Berry, Director of Social Services at Timothy Daniels House (pictured above right), connected Jeanine to Donna Murray, Springwell's CTLP Supervisor (above center).

Donna looped in Springwell's Community Transitions nursing team to do the clinical assessments that determine the services that would be possible and then got to work coordinating all the moving pieces. The CTLP program prioritizes developing seamless partnerships between providers to improve outcomes for residents. In this case, Donna lined up Jeanine's MassHealth re-enrollment and her qualification into the Personal Care Attendant Program. She also brought in the Money Follows the Person Program to fund the equipment Jeanine would need at home. Finally, she facilitated the timeline for services to begin with Jeanine's local Aging Service Access Point, HESSCO, since Jeanine's home was outside Springwell's service area.

Jeanine, her family, and the staff of the Timothy Daniels House were delighted with the process and the outcome. According to Heather Berry, without the CTLP Program, Jeanine would not have been able to move back home.

springwell

307 Waverley Oaks Road, Suite 205
Waltham, MA 02452

33 Boston Post Road West, Suite 510
Marlborough, MA 01752

www.springwell.com

Tel 617.926.4100
Tel 508.573.7200

Solutions in Support of Health and Independence

Springwell is an independent, non-profit organization dedicated to helping people who need long-term services and supports to remain independent and healthy in the setting of their choice. Services are made possible in part by contracts with or grants from the Massachusetts Executive Office of Elder Affairs, the Federal Administration for Community Living, MassHealth, insurance providers and health care entities. Generous philantrhopic support from individuals and institutions is also critical to our success.