The MOMA Experience
Managing Chronic Care & Tele-Monitoring Model for enhancing integrated care

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Healthcare facing challenges

Resources
Limited
Demand for efficiency
allocated to treatment rather than prevention

Patients
Diversity
awareness
Demanding

Technology
Advanced remote care solutions
The Vision

Safety | Efficacy | Cost-Effectiveness | Professionalism
Moma, Since July 2012
Remote platform for Chronic Care Management

- Personal nurse – care integration
- Multi-disciplinary team
- 6000 patients - 20,000 since foundation
- Coordination with Primary physician
- Complementary community service
- Nationwide support, 24/7
Moma – Goals

• Continuity of care
• Patient empowerment
• Increasing treatment adherence
• Early intervention in exacerbation
• Hospitalization rate reduction
• ER referral reduction
MOMA - intervention groups

- COPD (GOLD 2-4)
- CHF (NYHA 2-3)
- Diabetes
- Oncology

- Home Care
- Fragile (3+ diseases, <3.3 Albumin, >6 drugs, >2 hospitalizations / ER visits)
- Stoma
The MOMA Treatment Model

Community Health Services

Primary Physician
Case manager

MOMA
Chronic Care Management
Nurses
Specialist Doctors
Nutritionists, Social worker
Pharmacist
Administrator

Hospitals
Moma - Technology

- Computerized Medical Protocol System
- MOMA Nurse System
- BI Control Management Panel
- Video Consultation
Computerized Medical Protocol System

Guidelines for clinical decision making - standardization
Video Consultation
Moma- Medical Transmitting Sensors

Blood glucose monitor

Electronic pill organizer
Blood glucose monitor

Yoav started MOMA program in 8/15 with HbA1C 13.8%

Medical background
- BMI-37.7 (obesity)
- Refusing for treatment and further examination

Intervention and outcomes:
- Insulin treatment with the support of MOMA
- Education about: medical treatment, glucose balancing, exercise, HVA
- Support of MOMA dietitian during weight lose
Electronic pill organizer
MOMA’s Evaluation 2015
MOMA after 3 years
Fragile, CHF, COPD & Diabetes
MOMA’s Evaluation 2015

- 3 dimensions: Clinical measures, Cost savings & Patient satisfaction
- 10%~ Hospitalization cost reduction in Frailty, Home Care & COPD patients
- 6%~ Total Cost Saving in Frailty, Home Care, COPD & CHF patients
- 14% Improvement in Hba1c level
- Significant improvement in clinical & economic parameters
Thank you