Administration on Aging
Affordable Care Act Training
Utilizing Patient-Centered Technologies to Support Care Transitions
June 21, 2011
2:00 - 3:30 pm Eastern

Coordinator: Welcome and thank you for standing by. All participants will be in a listen only mode until the question and answer session at this end of today's presentation. At that time please press star 1 on your touchtone phone, please unmute your line and state your name clearly so that we may announce you.

Today's call is being recorded. If anyone has any objections you may disconnect at this time.

I would like to introduce your host for today's call, Marisa Scala-Foley, you may begin.

Marisa Scala-Foley: Thank you so much, Diane. And thank all of you for joining us today for AOA's latest in a series of webinars that are focused on opportunities for the aging network, both state and local agencies within the Patient Protection and Affordable Care Act, also known as the Affordable Care Act or the ACA.

If you've been with us on our webinars over the past several months you'll know that our focus has been on the critical topic of care transitions, patients or clients going from one care setting to another, whether from hospital to

home from hospital to skilled nursing facility, from skilled nursing facility to home and more.

We've designed these webinars to help provide the aging network with the tools that you need to help develop care transitions work in your area or enhance the work that you already have going on.

So, today we have the second in a two-part series that we've done these past two months in May and June examining the role of technology in care coordination and care transitions.

We developed the series in response to some of your past chat comments to us asking us to take a look at what role technology can play in all of this. While last month we took a look, a more of a systems level look in terms of what it takes to develop community-wide technology systems to support care coordination, today we'll really focus down to what it takes to support patients, and more specifically looking at how patient centered technology can enhance care transitions.

So before I introduce our wonderful panel of speakers we have a couple of housekeeping announcements. If you have not yet done so please use the link that was included in your e-mail confirmation to get on to WebEx so that you can not only follow along with the slides as we go through them, but also so that you can ask your questions when you have them through chat.

If you don't have access to the link we e-mailed you, you can also go to www.webex.com, again that's www.webex.com click on the Attend a Meeting button at the top of the page and then enter the number of our meeting, which is 663557782. Again the meeting number is 663557782.

If you have any problems with getting into WebEx please do contact WebEx technical support, you can reach them at 1-866-569-3239, again that's 1-866-569-3239.

As Diane mentioned all participants are in a listen only mode, however we do welcome your questions throughout the course of this webinar. There are two ways that you can ask your questions, first is through the Web using the chat function within WebEx, please just enter your questions, we'll sort through them and answer them as best we can when we take breaks for questions after each group presents, or each person presents.

In addition after each team wraps up we will offer you a chance to ask your questions through the audio line. When that time comes Diane will give you instructions as to how to queue up to ask your questions.

If there are any questions that we can't answer during the course of this webinar we'll be sure to follow-up so we can get your questions answered, and if you think of any questions after the webinar you can also e-mail them to us at affordablecareact@AoA.hhs.gov, again that's affordablecareact@AoA.hhs.gov.

As Diane mentioned we are recording this webinar, we will post the recording, the slides and a transcript of the webinar on the AOA Web site as soon as possible, likely within a week of this webinar.

So with that let me turn from housekeeping to talk about our wonderful panel of speakers whom we have with us today, we're thrilled to have them here. First up in terms of speaking will be Lynn Redington, who is the Senior Program Director at the Center for Technology and Aging.

Lynn designs, develops and manages several center initiatives including the tech for impact diffusion grants program, which you'll hear about today. Lynn has worked in the field of health technology and healthcare innovation for 30 years.

I'll give more bio to each of our next presenters when they speak but just so you hear the full line up initially we have Steve Kogut, Associate Professor of Pharmacy Practice at the University of Rhode Island, College of Pharmacy. Maria Gil who is the co-founder of ER Card, and Angie Hochhalter, Assistant Professor and Research Scientist with the Department of Internal Medicine at Scott and White Healthcare and Texas A&M Health Science Center, College of Medicine.

So with that I will, I'll give each of them a little more of a bio when I introduce them but the first speaker to go will be Lynn. So Lynn, I'll turn things over to you.

Lynn Redington: Thank you Marisa. And thank you, it's an honor and privilege to be here today speaking with you all and representing the Center for Technology and Aging.

So I'm going to start out the presentation by describing the Center for Technology and Aging and technologies that may help promote better care transitions, better costs, better health, better experiences of care for patients and then Steve, Maria and Angie are actually grantees of the Center for Technology and Aging and I'm thrilled that they'll tell you more details about each of their programs.

So the next slide, the next slide, there we are. A few words about the Center for Technology and Aging -- we are not a government center, we are a private non-profit resource center on issues related to diffusion of technology for

older adults. We also design, develop and manage technology diffusion grants programs such as tech for impact, that's what tech for impact is, it's a diffusion grants program that the center has sponsored and focus is on technologies for improving post-acute care transitions.

The Center for Technology and Aging was established in 2009 with funding from the SCAN Foundation and we're located at the Public Health Institute in Oakland, California. We're actually one of 72 centers at the Public Health Institute.

Our mission is to expand use of technologies that help older adults lead healthier lives and maintain their independence. So as I mentioned one of the ways we carry out our mission is to be a resource center to people that are interested in issues related to technology and aging. Another way we carry out our mission is to create these technology diffusion grants programs, such as tech for impact.

We've been in existence for a short time; it certainly seems like a short time. But we're now actually building on our experience and knowledge base and we're planning to build out a technical assistance and training group within CTA to help organizations identify appropriate technologies and implement them effectively and efficiently.

Next slide. So to speak a little bit more about our diffusion grants programs, because again that's what tech for impact is, we in general the point of our diffusion grants programs they're actually they're short grant cycles, only one year so it's really a rapid cycle community-based initiative.

We've conducted four grant programs so far, tech for impact being the third of the fourth of the four, and the point of these is to demonstrate and/or evaluate

how technologies can improve efficiency of care delivery, improve health and independence with a focus on older adults, but also it's very applicable to individuals with chronic diseases or other persons with disabilities to reduce the cost and burden of care and to improve chronic disease self management.

Again the emphasis is on diffusion, it emphasizes, our programs emphasize accelerating adoption diffusion of patient-centered technologies. You probably hear a lot about many innovation grants that promote development of new widgets; these are not about, the CTA programs are not about developing new widgets, they're about using existing technologies and using them more widely. Next slide.

So Tech for Impact, the grant, addresses the need, which you are all here interested in care transitions, about it addresses the need of avoidable readmissions, we have too many readmissions within 30 days of discharge and too many of these are preventable.

You know as Steven Jencks and colleagues published a couple years ago many statistics on this Price Waterhouse Coopers has done an updated estimate that this is a $25 billion savings potential so it's understandable why so many policy makers and payers are interested in improving care transitions and reducing avoidable readmissions.

So what do we do about readmissions? Studies have shown that by (Coleman, Nailer) and others that improving care transitions processes can reduce avoidable readmissions by as much as a third and what's involved in these interventions.

It's usually you know, let's improve care coordination, outreach, patient engagement and support, and what's interesting to note is these are all

communications and information intensive activity, so it's kind of a natural to then look at what kind of tools technologies that address information and communications, make them easier how can those help us in this process. Next slide.

So the Tech for Impact Diffusion Grants Program -- we released the RFP in September 2010. It's a one-year grant period in this calendar year. We had $500,000 in grant funds available. These are funds that the SCAN Foundation provided to us, the SCAN Foundation provides the Center's core funding as well as funds that we can re-grant.

And Tech for Impact was designed specifically basically from the conception to the program launch to compliment and supplement the AOA, CMS, ADRC evidence-based care transition program that was part of the $68 million initiative that implemented the Affordable Care Act that was launched last year.

So we've been very privileged to work closely with AOA and CMS to create this program, it's really been a wonderful, exciting public/private partnership. In terms of who was eligible, 16 states were eligible to apply for the grant, and these were the 16 states that received option D funding from AOA, CMS is part of this larger $68 million initiative.

And the 16 states were mainly state units on aging and other state entities. So 12 applied and five were selected. Just to clarify the actual implementers of the grants are the ADRCs, the Aging and Disability Resource Centers and their community partners, usually community-based hospitals.

Patients targeted in this grant were patients transitioning from hospital to home or other similar settings. So we're very privileged to work with five

outstanding states, next slide please. Oh the text came out a little funny on this. Those states are California, Indiana, Rhode Island, Texas and Washington.

And today we'll hear from grantees from Rhode Island and Texas and I just want to point out it was very interesting the four of the five states, and actually specific regions within these states are aligned with the beacon communities, which you heard about the beacons at last month's webinar.

So we have you know, San Diego, California; Central Indiana; Rhode Island and inland Washington State are Tech for Impact grantees and they just happen to be beacon communities as well.

So obviously these are areas of the country that are already forging a path towards, you know, health IT enabled care transformation, not only in large, you know, within trying to automate healthcare systems with EHRs, etc.

But reaching out into the community and to patients and seeing how they can better engage them in the care process since of course we spent a very tiny fraction of our lives in the healthcare system visiting our doctor, you know, three times a year, the rest of the time we're in our communities, in our homes.

The technology approach that these five states took tended to fall into two buckets, either it was a personal health records, PHR approach with supporting information that was California, Rhode Island and Washington. Or as in the case of Indiana and Texas it was more of an approach that was around care management, a software program that enhanced care management practices.

So today we'll hear a sampling of each of those, Rhode Island being personal health records, Texas in care management. Next slide please.

As I mentioned the Center or CTA has launched four different diffusion grants programs, technology diffusion grants programs and they're in various stages of development.

We now have 22 grantees in these diffusion grants programs and we look at them as learning laboratories and it's a collaborative learning communities, they're a very collaborative group.

We've, only four of the 22 have actually completed their grant cycle and those are in our technologies for medication optimization grants program, so I have just a couple of things to share with you today on that, and this paints, you know a broader picture of what kind of technologies can be used to optimize health and costs and care processes.

For example, and this is just to paint a picture because medication adherence is a very important problem with hospitalizations. One of our medication adherence technology grantees utilized an in-home automated medication dispenser and targeting patients that were at risk of hospitalization and declining health due to poor medication adherence.

The dispenser resulted in a 98% adherence rate, basically patients were taking the right meds at the right time in the right quantity 98% of the time fairly soon after this was installed in their home. It's about the size of a coffee pot where pills are loaded into this dispenser and it's a little machine that opens the drawer and presents, you know the next dose at the right time with either sound or auditory queues.

And this can be re-programmed remotely, so this is really more about supported self-management not just a purely consumer model.

Another medication management technology that was used in this grant program was pharmacist counseling medication therapy management via video-conferencing.

So a very unique organization located in Connecticut was able to reach out to individuals across the country that had very special needs, in this case it happened to be an organization that specialized in the health and needs of Cambodian Americans and could best address their needs for instance, or their challenges of poor literacy 90% of Cambodian Americans that sought refuge here in the 1970s today are functionally illiterate in both English and Khmer.

And then this group tends to have certain, well clients were identified as having several sort of medication problems, about six per patient and through this virtual pharmacist counseling they were able to resolve 93% of the problems, and the program was, had a strong business case with the six to one return on investment.

So that just kind of paints the pictures of the kinds of technologies that we're talking about in terms of being patient centered, medication issues obviously an important thing, I mean if you just look at the care transitions intervention and the importance of medications and Steve Kogut will talk more about that next.

But also remote patient monitoring is another technology area that is important and is, what is currently one of CTAs grant cycles we have seven grantees utilizing remote patient monitoring and messaging technologies so that people can look for those red flags, those alerts that their health condition

is declining and catch it before it really becomes so severe that they need to be hospitalized. Many of our grantees here are focusing on heart failure.

If you follow this field that tends to be a focus of many of the remote patient monitoring technology interventions because they're, they've seen great success there with being able to monitor weight and control fluids and avoid hospitalizations.

Our more recent grant program is our mobile health technologies initiative, we've just begun this with five grantees and they will be beginning their grant programs in the next month or so.

So that kind of paints an overall picture of what CTA's technology diffusion grants are about. Next slide.

And Steve, Maria and Angie will tell you more about their individual programs, but you can actually see abstracts of these 22 grant programs on our Web site at techandaging.org, it's fascinating just to read about what people are doing across the country, very innovative technology based interventions, almost all of which are addressing or trying to reduce hospitalizations.

Also at our Web site you'll see publications, we have a publication on technologies for improving post acute care transitions, which corresponded with our tech for impact program if you want to drill down and learn more about technologies that are being used in this area.

As we complete more and more, as our grantees complete more and more of their grant cycles we'll have more and more lessons learned that we'll be sharing with you all. We're also assembling tools into an adopt toolkit accelerating diffusion of proven technologies that we've gathered from all of

our grantees. Again, it's a very collaborative group and it's very exciting to learn from them and our mission is to share that learning with people like you that are interested in this area.

And if you want you can send an e-mail to me, if you want to become, if you want to receive our monthly e-newsletter. We have announcements of new initiatives, new guides, new publications and we, you may be interested in, we'll have an announcement soon of a project that we're working on with the Office of the National Coordinator to create a consumer e-health affinity group within the beacon.

So CTA will be working with ONC on this and it'll be just next month that we'll have our first affinity group meeting via webinar, via phone. So CTA grantees will be invited to that and hopefully will be fairly inclusive if other people want to track what's going on with that.

So again thank you so much for the opportunity to present to you today and I guess we'll turn it over to Steve now.

Marisa Scala-Foley: Actually let's, we got a couple of questions in Lynn that would be great if we could answer...

Lynn Redington: Okay.

Marisa Scala-Foley: ...we could talk about right now. The first one comes from (Ruth) who was asking about you had presented, and I'm going to try to go back to the slide, on the automatic medication dispensers, I think we're going to, oh, not the right slide. I'll get us there but she wanted to know who filled the automated med response dispensers.

Lynn Redington: Typically it's an informal caregiver, it could be a home health nurse.

Marisa Scala-Foley: Okay. Oh I'm sorry.

Lynn Redington: Some of the newer systems the medication dispensers hold a larger amounts of medications so I believe in, and it depends on how many pills the person is taking and how frequently you know, the dosing schedule is, but the machines have to be filled about once a month, once every 90 days, I mean it's really isn't all that frequent.

And what's nice is they can be reprogrammed from remotely. See these are all hooked up via pots, plain old telephone service so not only can they be reprogrammed in case the dosing schedule needs to be changed but also an individual's monitoring whether that person actually took the pill out of the drawer and if the don't within say 90 minutes an alert is sent to a caregiver to whomever is designated.

Marisa Scala-Foley: Okay. Thanks, Lynn. We got a question in from (Gail) who asks has there, do any of the grantees or have any of your technology programs have a focus on preventing initial hospitalization, such as for congestive heart failure patients or patients with other conditions.

Lynn Redington: Yes. Actually I know at least 20 of them are focused generally on reducing hospitalizations, catching conditions before they really become severe. So although some of these people with say heart failure probably have been hospitalized, so I mean we're not talking about an initial, initial hospitalization, but reducing hospitalizations overall yes.

Marisa Scala-Foley: All right. I think we are all caught up on questions so far, so thank you so much, Lynn. Why don't we move on to our next team? Let me introduce

first… Steve Kogut is Associate Professor of Pharmacy Practice at the University of Rhode Island, College of Pharmacy specializing in the area of pharmacoepidemiology and pharmacoeconomics.

He works with various national and local stakeholders to improve medication use among populations and his recent efforts include work for the Centers for Medicare and Medicaid Services, the Medicaid Payment Advisory Commission, the Pharmacy Quality Alliance and the American Association of Colleges of Pharmacy.

He will be teaming up on this presentation with Maria Gil who is co-founder of Professional Records, Inc., a West Warwick, Rhode Island business established in 1999 to create the ER Card, Electronic Personal Health Record, EPHR service, which you'll hear about right now, and managing partner of ER Card, LLC.

Maria was responsible for the research, software development and introduction of ER Card in Rhode Island. So with that I will turn things over to Steve and Maria and just give me a second to move our slides back up. There we go.

Steve Kogut: Terrific. Thanks, Marisa. This is Steve Kogut, I'd like to thank the Administration on Aging for hosting the webinar, certainly thank Lynn and the folks from the Center for Technology and Aging for supporting our work through the Tech for Impact Program and thank all participants for your interest today.

Our project team is the present slide Maria and I are presenting today, there are others involved with our work, (Alaina Goldstein) is a Professor of Public

Policy, she's our liaison between our states Department of Elderly Affairs and other Department of Human Services activities.

We have (Camille Charboneau) and (Anita Jackson) who are heading up the clinical pharmacy work, sort of the in the trenches work supporting patients, introduction to and use of the Electronic Personal Health Record that we'll talk about in a little bit. Next slide please.

So here's our outline, there's a little bit of context that I think is useful to review, so we'll talk a little bit about sub-optimum medication management in the community setting, talk about some health information technology solutions directed towards addressing those sub-optimal medication management issues, certainly talk about our work and some ideas for keeping things going after this work wraps up over the course of the year.

A lot to cover but I'm told this is the longest day of the year so I guess that's good. Next slide please.

So here we are prior to the medical home era and as I'm sure you all are aware medication management in the community setting is less than ideal, unlike the in-patient setting or the long term care setting there's sort of no gold standard medication list, patients visit multiple pharmacies, multiple providers and there's much less oversight of medication use in the community setting, and so there are lots of opportunities for improving how medications are used and these can impact costs and quality of care.

Sort of the issues with medication use and medication related problems can be patient related, can be system related, formulary issues, unclear instructions, lack of monitoring, need for patient education, interaction with home meds, etc., and so we think that on the personal health record coupled with some

increased involvement of folks with medication management expertise holds promise for not only reducing medication related problems but potentially readmissions to the hospital. Next slide please.

And when we think about medication related problems I think perhaps the first thing that comes to mind is medication errors and perhaps for good reason the Institute of Medicine estimates that 1.5 million preventable injuries due to adverse drug events occur annually at a cost of anywhere from three to four billion dollars when you include lost productivity, impact on quality of life, etc.

But I think what's useful is to think about the Institute of Medicine's framework of misuse, under use and over use of medicines being categories of error, and it enables us to think more broadly about how medications are used by patients during care transitions or just in the community and as we'll see in some of the information I will run through in a moment or two more commonly we identify errors of under use or sub-optimal use of medications. Next slide.

About 20 years ago (Heppler and Strand) provided a framework for considering medication-related problems. These categories can be useful for approaching a patient's medication list post discharge or really in any context and think about these various categories as being opportunities for improvement.

The first bullet here, untreated indications we're talking about perhaps the patient that has diabetes and an indication for lipid lowering therapy but wasn't prescribed or maybe the post MI patient that there is a miscommunication and aspirin wasn't continued post discharge for one reason or another so if we could have the next slide please.

We can see that these types of under use issues are as prevalent if not more prevalent than sort of the overuse issues. This was some work done a few years ago by (Steven Ash) and others that looked at medication management in the community and the percentage of patients that received recommended care.

This was sort of a roll up of about 150 quality indicators across 30 conditions, a national survey of over 10,000 patients and just trying to categorize the types of medication related issues that were common in the community setting.

And what you can see is more commonly patients were avoiding the overuse of inappropriate medication, which sort of might be the first thing that one might think of as, you know what they might expect to find in reviewing the medication list, but more commonly there was a lack of proper education, documentation, medication monitoring, patients I&R or potassium for example wasn't being monitored appropriately.

And overall 40% of patients did not receive recommended care specific to some element of medication management. So again just sort of painting the context here of broad opportunities for improving medication management, we believe that the personal health record can help address this gap and hopefully we can demonstrate that it reduces re-hospitalization as well. Next slide please.

Some of our work during the past year or so with ER Card, the company that has developed this electronic personal health record is presented here. This was again similar to some of the previous slides just describing the varied nature of medication related problems that are typically encountered.

You do see, we did determine that a number of patients did experience a drug interaction or an adverse drug event but even as common if not more common were these untreated indications where for some reason there was a miscommunication or a patient non adherence but an opportunity to use medications more effectively and see that as a big opportunity for improvement and impacting re-hospitalization. Next slide please.

This was work done by Coleman, you're probably familiar with the care transitions model looking specifically post hospital admission, post discharge, characterizing medication related problems, they're terms medication discrepancies here and you can see this break down in terms of patient associated factors or system associated factors.

Some of the big ones that stand out on the patient associated factors sort of left hand side you'd see non-intentional, non-adherence, so either a miscommunication or some lack of understanding about how to effectively use a medication or to even continue a medication as being one of the more prevalent types of medication related problems detected post discharge.

And then on the right hand side likewise, you see conflicting information from different information sources and incomplete discharge instructions or illegible, inaccurate instructions being sort of the higher prevalence issues here and I think these are important to consider and are really a platform for our project in terms of helping to understand how to support patients in being effective self managers and that includes managing their medications and using them effectively through the use of this electronic tool. Next slide please.

It was mentioned earlier in this presentation that Rhode Island has been fortunate to receive funding from a number of different initiatives, I think we might be the only state that has received all three types of federal funding for supporting development of our health information technologies, both the exchange award, the regional extension center and the Rhode Island beacon community are all down the, are all moving forward advancing in our state and it's a smaller state so we have the opportunity to be involved and to try and integrate our work within the work of those folks in that (real).

The first bullet electronic prescribing I should point out that Rhode Island was the first state to have al of its pharmacies capable of receiving electronic prescribed prescriptions, I think we're up to three out of every four docs are e-prescribing capable and I think we're on the forefront there.

And then the ER Card Electronic Personal Health Record has been, well I'll let Maria talk a little bit about the evolution of that program but it has benefited from some local state funding and partnership with the College of Pharmacy in a number of different initiatives and we're really excited about this application in terms of care transitions in this current work. Next slide please.

So medication management has been sort of in the for grains of public policy makers for awhile, certainly highlighted in the Institute of Medicine reports, but also if you look at the stage one criteria for meaningful use of electronic health records many of these functions or criteria specifically address medication management in the community, being able to transmit and communicate a medication list for example, or the third bullet on the left, implement, drug-drug, drug-allergy, drug-formulary checks.

Maintain medication allergy lists, perform medication reconciliation, these are all elements that the electronic health records when they're meaningfully used achieve, but also the personal health record as sort of managed and directed by a patient can help support these activities as well. Next slide please.

So that sort of leads us to think about well how is the personal health record different from the electronic health record, we often find ourselves trying to explain the roles of what we're doing when we communicate with providers and hospitals and other health systems.

We you know there is some confusion at times when we talk about our ER Card system or the personal health record and we have an electronic health record, you know we sort of have our own thing but you know there are some differences in terms of roles and purpose that probably worth spending a second walking through.

Certainly electronic health record is electronic by definition and the last bullet at the bottom there says the ideal for electronic health records are to promote safe, effective and efficient delivery of healthcare through the lens of providers, payers and regulators.

So there are sort of multiple functionalities of the electronic health record and it really is intended to provide a backbone resource for care delivery and clinical decision-making as well as quality improvement and all of the other aims of electronic health records.

But certainly we should recognize that there's a different focus with the personal health record really supporting patients ability to be more effective, empowered self managers of their health conditions and that's what the ER Card program does, as we'll show you in a minute or two here.

Certainly that's a narrower function but a critical one. That doesn't mean that the information in the personal health record can't connect and share with health information exchanges, there are efforts to try and couple that information.

I say data reliability is a concern with the personal health record, that's certainly a, you know a question that we commonly receive, but there are some things that the personal health record can capture that the EHR may not, we know patients visit multiple providers, they use over the counter medications, herbal supplements, so and maybe they wouldn't necessarily document PRN medications and other medications as well.

So I think maybe the union of the PHR med list and the EHR med list may ultimately get us closer to a gold standard, but we should recognize that there are at times deviations from what we would think a gold standard would be in either source. Next slide please. Thanks.

So this is our project, in a nutshell our aims are to identify and address medication related problems post discharge to accomplish that through the electronic personal health record and having a pharmacist visit with the patient post discharge to explain how the ER Card program works to help them import their medications and health information into the system.

And also in a longitudinal way to use the system to review medication lists to help answer questions, to potentially intervene when there are issues of under use or misuse of medications that are detected. We hope that this will at the end we'll measure it to, we'll measure outcomes and determine if avoidable re-hospitalizations were averted.

And certainly we want to learn more about the role of technology in supporting medication management activities during care transitions and to try to link that into ongoing efforts and see where we can build some sustainability for this model.

You see our collaborators listed here, I'll go past this slide in the interest of time. Some of the elements, the two core elements of our intervention certainly is the ER Card EPHR which we'll talk about in a moment. This PHR is augmented by various services, these are services that have been consistent or sort of associated with the program prior to this work and they're really useful in the intervention as we'll see.

The first bullet here talks about medication management frameworks or models that I think as pharmacists when we approach a patient and review a medication list perhaps it's useful to know sort of the frameworks and ideals that we bring to the table to in that process.

So I'll just highlight them here quickly, there's some links here if you want to click through or follow through for some of these resources, I think they're useful. Next slide please.

The care transitions program I'm sure is something that's very familiar to you. This isn't necessarily a model that we are incorporating into our intervention necessarily but I think it's useful to identify these pillars and just see the role of medication management and personal health records.

So you know the first pillar medication self management, second a dynamic patient centered record, primary care and specialist follow-up and knowledge of red flags, many of those red flags might be related to medication use, potential toxicities, therapeutic monitoring issues, etc.

So you know certainly we should recognize there's a lot of similarity between this model and you know our intervention. The next slide talks about medication reconciliation, there's a definition that I've pulled from an article that I think is particularly apt to the work that we're doing, there's some citations and links there.

I would just highlight the Mass Coalition for the Prevention of Medical Errors as a particularly excellent resource for learning about medication reconciliation and sort of a stepwise process for engaging in it that's there. Next slide please.

And then certainly medication therapy management is as a reimbursed service under Medicare Part D has really galvanized the pharmacy profession and these are the steps in engaging in an MTM service program and there's a link here that will provide you with a pharmacist, pharmacist.com resources for medication therapy management.

Let's move on in the interest of time, I want to get to ER Card. At this point I'd like to hand this off to my friend and colleague Maria Gil who's going to talk about the ER Card program specifically and some of the core features of it.

Maria Gil: Great. Thank you very much Steve. We're so happy to be working with the URI College of Pharmacy, we have a longstanding partnership with them, and I thank Lynn and Marisa for the opportunity to introduce the ER Card to your audience today.

But to tell you a little bit about ER Card, it's an integrative electronic personal health record that provides secure and easy access to one's up to date personal

health information at various levels of the healthcare system, but it is also a total healthcare management service which facilitates emergency retain and preventative care visits.

It's an online electronic personal health record that's available 24/7. It's secure and HIPAA compliant. The patient information is reviewed and updated by health professionals, we have pharmacists on staff, nurse practitioners and care managers and the program is being offered free to the care transitions participants. And as I mentioned we have a long-standing partnership with URI College of Pharmacy and it has been a real benefit to ER Card members. Next slide please.

The program features, care management service and little bit about that, we offer hands on assistance with enrollment, ongoing customer service support and electronic personal health record updates. We educate members regarding resources and interventions.

We place follow-up calls to our members within 24 hours whenever their information has been accessed by an EMT, a hospital, someone called into the call center, we place a follow-up call within 24 hours to see how the member's doing, see what the nature of the emergency was, if any medications were changed or a test ordered.

We also call our members regularly to remind them about preventative care visits, so it might be time for a mammogram or a PSA test or a visit with their primary care physician, and we found that the program is really invaluable to individuals with disabilities and verbal limitations.

We also offer the medication profile review and staff pharmacists will review the medication profiles of our members when they enroll in the program

trying to identify any instances of actual or potential medication related problems.

So any therapeutic duplication of generic and brand name meds, any high risk drug-drug interactions, drug therapy omissions, potentially inappropriate dosing, and then the pharmacist will call the member, let them know what they found, ask if the member would like to speak to their physician about it, would they like a letter from the pharmacist to take with them the next time they visit their doctor or would they like the pharmacist to make the call and discuss the situation with the doctor.

We also have an emergency notification system, and this is an automated system that we use for our quarterly reminder calls that we make to our members, and it allows us to simultaneously multi-device alerts and any language or voice in ten minutes or less.

So we can send a message to someone's desktop, a pager, their cell phone, their home phone, a family member if they designate someone as their primary contact, and in the event of a medication or a medical device recall or for preventative care reminders or even emergency evacuations we're able to target and prioritize calling.

So if we have people on a high rise and someone wants them to know that there's going to be a flu clinic there on Thursday we can just isolate that group and send out a message. As I mentioned we do call our members on a quarterly basis so it's just a reminder call to give us a call if they have any changes.

And then we have the EMT care link and that is for rescue vehicles that have laptop computers they have instant access to critical information when time is

of the essence, so it allows for information sharing across settings, from the rescue call to the emergency department visit and then a follow-up with a primary care physician, the medication diagnosis treatment information is there for everyone to see.

And it's also a verification of information provided by patients or family members and in an emergency a lot of times people are upset, can't remember things so the EMTs are able to access the database right on the rescue vehicle and if the person has a USB flash drive with our program on it the EMTs will plug it into their laptop. Next slide please.

Marisa Scala-Foley: Maria, we got a request for you to speak up just a little bit.

Maria Gil: Oh sure. Okay. How our, the ER Card works we have a proprietary software that provides a user friendly means to create an electronic personal health record and to share it with healthcare providers and this is just a snapshot of what the main screen looks like, and you'll see that we've included the members picture, which is really great for people who may be memory impaired but even for you know, our senior population, for children you know it's just a verification of you know, we're treating the right person here.

All of the demographic information is at the top so you see their name and address and last ER visit, blood type, whatever, and then at the bottom you'll see the tab, the first one is alerts and that's the first screen so that for any EMTs or emergency department staff they can see if there's something that needs to be relayed to the care giver.

Then the next thing is their medical conditions which provides a list of you know all of their conditions, and then there's detail in the following tabs with

allergies, their medications, we include prescribed, over the counter, herbal supplements, simple medications.

We also have a tab for advanced directives and their advanced directives can just be attached to the online record. Any tests in the last six months, their immunizations, surgeries, we really just ask about anything that's been removed or implanted, emergency contact information, their type of insurance.

We also have a home care provider section where we can list any types of durable medical equipment or any types of services that they receive, which is especially helpful to discharge planners if you're being discharged from the hospital. The pharmacy information, a lot of people have more than one place where they're purchasing their medication so we list all of the information, any attachments, so if there's lab results you know any type of test information that they'd like to attach.

And then there's the Health Data Tracking tab and that allows our members to keep track of if they want to keep track of blood pressure readings, an exercise routine, their doctor visits that are coming up, it allows them to do all of that on their own.

However not all of our members have a computer or want an online record and you know the ER Card is a program that was designed to combine technology with hands on healthcare, so our care managers will help people enroll, they'll update their information, they will print out copies, mail them to some of our senior members that you know, want a copy so that they can take it with them to the doctors, but for people who want to go online and do this themselves, or for sons or daughters of some of our members they might want to keep track of the information for their mom or dad. Next slide please.

Marisa Scala-Foley: Maria we've got about five minutes left so just to give you both a heads up on that.

Maria Gil: All right. ER Card members have a number of ways to provide caregivers with their medical information, they have hard copies of the profile, they have identification cards that have their name, the 800 number, their member number, they have key tags that also identify them as a member, window decals, EMTs had asked us for decals that they would put on the door that the EMT would use to enter their home, and the USB flash drive is optional.

Providers, next slide please, providers can access the ER Card information by calling the 800 number, by going online with a user name and password and accessing their record, the information can be faxed or e-mailed from the 24/7 call center.

Privacy and security, we have an encrypted database on a private network, licensed facilities, physicians, first responders would have a user name and password that we can supply or the member with their, keep track of their own information online.

We receive daily reports because of HIPAA we know when information is accessed so every morning we receive a report of all the records that were accessed and that's how we're following up with our members to see how they're doing, what the nature of the emergency was. And that's it for ER Card, I'm turning it back over to Steve.

Steve Kogut: Excellent. Marisa, if we could go to Slide 40 in the interest of time just wrap it up, wanted to make sure we're able, I'm sorry 39, just wanted to make sure

we had some time to talk about some ideas for how to sort of keep this going over this funding cycle.

Certainly as we mentioned Rhode Island has a number of initiatives, funded initiatives to try and reengineer our local health delivery system through information technologies and payment reforms and we hope that you know, this program is going to be well positioned as a way to not only prevent re-hospitalization and medication related problems but as sort of a way to tie together what's happening with medication use and a patient's own self-management in the community.

And we think aligns nicely with some of the initiatives locally with our large care provider groups and so you know, we're hoping to get in the mix there and find a niche for what we're doing and maybe build it out and expand it.

The fourth bullet here or the fourth item, involve community store-based pharmacist, the idea maybe as a next version of this is instead of the pharmacist having such you know, contact with the patient at home perhaps that pharmacist at the community drug store might be able to connect with the system and with patients in certain ways.

So there's different variations of this, you might be wondering about sustainability of the technology itself, I'll let Maria talk a little bit about some of what's been going on with reimbursement for the program under Part D and patient direct pay for the service.

Maria Gil: Yeah. The price for the program is $96 annually, so for an individual membership which is $8 a month, but we have found that the people who need it most can least afford it unless a family member is purchasing it for them.

So and seeking reimbursement has been a challenge, we did get our Medicare provider ID, so it was just recently so we'll soon find out what the reimbursement for the services that we offer look like, and we've also applied for Medicaid provider ID, and although we were initially refused we requested a meeting with the Rhode Island Medicaid Director and she has agreed once our state budget hearings conclude.

But we really feel that with the global waiver program here in Rhode Island there is an opportunity to reduce costs using the ER Card program, and you know the waiver is based on principles of personal responsibility, consumer empowerment, person centered solutions and options and you know the ER Card will help people live independently, provide access to hands on help when they need it, and it allows for information to be shared across many settings.

So I think the medication review process alone would minimize lessons that occur as a result of the medication misuse and so it provides an opportunity to recommend less expensive drug therapies as well. And especially in the emergency departments those visits are expensive, physicians and nurses have told us that, you know, hospital staff tends to over test and over treat because they want an opportunity to get it right.

So the medication reconciliation, just having all of that information at the caregiver's fingertips really minimizes the occurrence of delayed diagnosis or over testing and over treating. So we know that there are opportunities there and that's what we're working towards at this point. And that's it for me. All right Steve.

Steve Kogut: I think that's it for us, Marisa.

Marisa Scala-Foley: Okay great. Well, we'll take a couple of minutes, because I want to give, make sure Angie has all the time she needs for her presentation. But we did get a few questions that I think would be helpful to clarify now.

First either Steve or Maria, could you talk a little bit about what the role of the, of an area agency on aging or aging and disability resource staff is with regard to ER Card and your project?

Steve Kogut: Sure. Well, you know certainly there's an effort to offer services and programs and resources for patients as they're transitioning and you know we're connected through that, our senior centers for example are a distal conduit for making those connections.

We are working with our Department of Elderly Affairs to try and see how we can have those resources maybe augmenting what's offered through the College of Pharmacy's outreach program for example and other opportunities to try and coordinate and pull all of this together.

You know there is a lot happening in Rhode Island and you know that's part of the process as well, to demonstrate that the technology and that the pharmacist involvement works but also that it can be integrated within our health system and provide you know a resource for patients that would benefit from it.

Marisa Scala-Foley: So would AAA or ADRC staff have access to ER Card or is it purely for patients or clients and their families?

Maria Gil: No with permission, I mean you know as long as the member agrees to whoever they want to give access to with the information. Some of our members don't have family members so it's a neighbor, you know, so or it

might be someone who's a director of a senior center, you know but the point is as long as we have their permission that information can be accessed by an authorized party.

Marisa Scala-Foley: Okay. Great. We're going to take one more question now and then we'll come back to the others that came in through chat and the Q&A function in WebEx later on when we break for questions at the end. And this question comes from (Jennifer) who asks is ER Card information linked to a patient's electronic health record or is it a separate system that would have to be entered, you know, separately into an EHR?

Maria Gil: Well it has been separate, you know but now that we know what the standards are, you know, that's part of what we're working towards. We've brought in some interns from some of the local colleges that have medical informatics background, you know helping us to get our information in the standardized format so that it will be exchanged with other systems.

Marisa Scala-Foley: Okay, great. I think with that we will move on to our next presentation. Angie Hochhalter is an Assistant Professor and Research Scientist in the Department of Internal Medicine at Scott & White Healthcare and Texas A&M Health Science Center College of Medicine.

She co-leads the Patient Engagement and Safety Research Program in the College for, I'm sorry, in the Center for Applied Health Research at Scott & White Healthcare. The program pursues research on topics such as patient and family involvement during care transitions and interventions to encourage healthy behavior such as adherence to recommended preventive care.

So with that Angie just give me one minute to change over to our, to the PowerPoint slides and hopefully you can see this now. Can you see the slides okay Angie?

Angie Hochhalter: I can see them.

Marisa Scala-Foley: Okay, great. Then we're set to go. For those of, for participants we had to do a little bit of a switch because there are some, to see Angie's slides so if you do wish to enter questions in chat during this time you can, you should see a tool bar at the bottom of your screen, if you click on the one that looks like a thought button or the icon with a question mark you can enter your questions via chat and Q&A. But with that I'll turn things over to Angie.

Angie Hochhalter: Okay. Thank you so much and we really appreciate the opportunity from the Administration on Aging to talk and share what we're doing for this project and also the funding that we've received for these Tech for Impact awards.

In Texas our project is a collaboration between the Central Texas Aging and Disabilities Resource Center at Scott & White Healthcare, which is a large integrated healthcare system. And we have a history of working together, in the past we did a community living program together and during that project we included the care transitions intervention and one of the things that we found was that for coaches who were delivering that CTI intervention sometimes keeping track of everything that they're doing got to be a little bit difficult.

So our project is a very practical project, we were looking for a better way for our coaches to be able to manage information so that their time could be used really efficiently with our consumers in the community.

The other side of that is that as the evaluator for our projects I've always been really interested in making sure that how we do the CTI intervention in our communities matches how it is that it was done when it was originally tested, or if it doesn't that we understand how it changes when we take it out to our communities.

The problem was that without really knowing much about exactly how the coaches were doing the intervention we couldn't, we couldn't get to that information but we didn't want to make it so hard for the coaches that they were spending all of their time on evaluation and not enough time with our consumers.

So our project, our Tech for Impact project is to use a Microsoft access database system, so it's a system of forms and tables and that kind of thing that I'll show you in just a minute to deliver the care transitions intervention or to at least track what it is that we were doing.

Now we came across this last summer, the care transitions program, Dr. Coleman's program had used a version of this database in some of their clinical trials and happened to have it up on their Web site, we came across that and decided that it might be really useful for our coaches but that some of the things in it were designed much more for nurses and our coaches were not nurses.

So this grant has allowed us to really edit what Dr. Coleman's group had done initially with his permission and collaboration, and get it into a form that our coaches are now using, they're on their second project using this and they really very much prefer using this over trying to track things on paper and in a bunch of different databases.

So before I go on I just want to let everyone know that part of our mission for this project is not only to make this useful for our Texas project but also to make it available freely to anyone else who's interested in using it. So if you're doing the care transitions intervention and anything in here looks like something you would like for your coaches to try using in terms of tracking please my e-mail address will be at the end, we want to know that part of what we were trying to do here is get this out to people who might find it useful.

So today I'll talk about kind of what we've done with that tool, again what we're trying to do is facilitate high quality coaching, we're trying to integrate coaching and evaluations so that our coaches don't feel like they're doing more paperwork than they need to, and we're trying to improve our ability to manage our CTI project so that we really understand how the intervention's being delivered. Next slide.

So what I'm going to do is go through some of the forms that are in this tool and you'll see that there are some things that are pretty Texas specific. We've intentionally make it Texas specific for our coaches, we also did a version for California, which is doing CTI for their AoA project right now so they're using something very similar, but I'll talk you through kind of the main features.

This is designed so that coaches can just enter the data into fields as they come up. So this first one is to track who gets referred to us, who actually enrolls in the project and then if they are re-hospitalized or need to withdraw from the CTI program for any reason we capture that.

So you see over on the left hand side site information which is where a particular coach is and the county where the consumer lives. In the middle you see referral and enrollment so we know who referred the person to us, when

that was, when we were able to determine whether they were eligible and when we determined whether or not they enrolled.

And I'll show you later some of the reports that this systems can produce so that some of this make more sense, why do we really care the date they were eligible for example.

Then you can also see that we track a change in status and if somebody's re-hospitalized. You know each new consumer is in our case assigned an ID, we assign them that ID in the top left hand corner you'll see that, and then we can go back at any time and find that consumer and go back into their records, so all of our coaches work off of one file so that all of our consumers are saved in the same place and they can go in and work with them for a little while in the database and then go out.

Let's go to the next slide. One thing our coaches really wanted was a place to put contact information. Some of our coaches are enrolling people right in the hospital setting, they're embedded in the hospital and so they wanted to make sure they could enter the medical record number because they need that for some of their screening work.

They get the caregiver information and the home address, and really this form is designed specifically for the coach, nothing on here is used for evaluation purposes, but the coaches need this information to be able to stay in contact with the consumers. The next slide.

So for each of the CTI visits, the hospital visits, the home visit and the phone calls there's a tab with forms specific to that visit. So you'll see here we're looking at the hospital visit and sometimes we'll need to visit someone in the hospital more than once so in sort of the middle left hand side you'll see

where it says visit date and time spent, we can track each time we go to see someone in the hospital and how long it took us to do that and write any notes.

Now on the bottom you'll see that there are columns for medication management, the personal health record, medical care follow-up and red flags. These are corresponding to the four pillars and all we do, we very much understand that part of the CTI intervention is that you do not use checklists to develop it, that's not what this is for, this is just for the coaches to say what it is that they did when they were in that hospital visit.

What it allows us to do on the back side is just to get an idea of whether or not all four pillars are actually being delivered over the course of most of our visits.

We have another column which allows us to document our enrollment paperwork and that kind of thing very specific to the Texas project. But that's the kind of thing that's easily customized for any site. The next slide.

This slide shows what we document for a home visit. Now one of the things that you'll up on the top is that we write down the goal that the consumer sets at the home visit in the consumers own words.

What this allows the coach to do is have this information available to them so that when they later do the phone calls they can say, "Well hello Mr. Martinez. I see that last time we talked you said you wanted to feel good enough to play with your grandchildren. How is that going?"

They've got it written in the consumer's words right in front of them when they go to do the phone call later and it also helps them to track progress. On

the evaluation side what it allows us to do is get an idea of how often people are actually setting goals and the quality of those goals.

So each of these forms we're going to talk about is set up just like the first one so you have a column for each of the four pillars and then some other things that sometimes coaches will do that don't necessarily fall into the four pillars. So something like sometimes we'll discuss whether or not home health services that were ordered are there and if not help work with the consumer to problem solve how to do that.

These are just examples of the kinds of things that coaches would document. Again this allows us to know what it is that the coaches were actually doing. For our Texas version we ask a few questionnaires over the course of some of the contacts, and so you'll see that we have a questionnaires button, it allows us to go to and fill in the answers that someone gave us. Next slide.

Here's an example of what our phone call page looks like, again very similar, you've got the goal in front of you, each of the four pillars has a column so we can document what we did, you'll see on the bottom left hand side there's a button that will take us directly to our medication discrepancies form.

There's some of the data that was shown in the previous presentation was talking about some of the medication discrepancies that Coleman has documented in previous studies, we use the same form as they use and this would be apparent to the coach in the home visit page as well, I'm just showing it here for you.

But the basic idea is the same, it's simple, all we want people to do is to kind of write down what they did so they can remember, they can follow-up but also so we know for evaluation purposes. Next slide.

We find that sometimes there are phone calls that happen that don't, aren't designed for content delivery like a care giver is trying to call us to get a hold of us or a coach calls to arrange a time to go out for a home visit. So we have a page just for that so that we can get an idea of how many additional phone calls are happening, we're not necessarily delivering the four pillars but there's been some sort of contact with the coach or the caregiver or the consumer. Next page.

Here's an example of the medication discrepancy form that we were just talking about, again there's a button, we fill these out actually on paper at the home visit because we don't want the computer to get in the way of the relationship with the consumer, but then to have that information in a way that's easy for us to use we bring it back to the office and just coaches quickly enter it into this form. Next page.

Here are some examples we have different tabs that you can select for whatever questionnaire you want to enter the data for. So we have things like demographics, we use the Coleman care transitions measure, we ask them health literacy questions so coaches would ask these either on the telephone calls or in the home visit and then just go and enter those data so that we have them. Next page.

And here is an example of the patient activation checkout, if you're familiar with the patient activation assessment you'll see those questions on the bottom so there are ten yes or no questions, the coaches write these to get an idea of how activated the patients were during the time that you were coaching them. the questions on the top were left over from some of the original clinical trials, they were in the original version we found of Coleman's and that we actually liked them so we kept them.

Again coach rated how activated were consumers on each of the four pillars and then we added activation on the goals because we're particularly interested in the goals. Next page.

We also added a measure that Connecticut is using and they said that we could borrow too. This is again just another tab that we've customized for Texas because were collecting it but our coaches rate what were kind of some of the problems that consumers were facing in terms of their transition. Next page.

Now all of these data that coaches are entering, even though they see the forms that you've just seen, they're all being saved in the background in data tables so that those people who are doing the evaluation later can go in and collate the data that they want.

So there are a bunch of data tables that are behind this that the coaches never have to worry about or be bothered by the data, the pages we've seen so far, the pages that the coaches see. But in terms of what happens to that information and can we use it for something the answer is it's all going into tables that could be easily exported to excel and put into statistical packages or manipulated however it needs to be done for the evaluation side. Next.

And then this is just an example, the system is able to make, to spit out some reports that we can use for project management, so this is an example of a report that just tells us for people who were enrolled are they finishing all of the visits that we want them to finish.

So it tells us the date when everything happened. There are several reports that are built in there now, more can be customized at any time, and we're just

kind of working through that on our own but it could be customized to any other site as well. Next slide.

So that's a quick overview of this tool that we've been able to develop with this funding, which we really appreciate in terms of our own working with the CTI intervention and our coaches it's been really very helpful in terms of getting all the information into one place.

Like I said before part of our goal for this project is to get this tool into the hands of others who are doing CTI if they think it would be useful for their coaches. So my e-mail address is there, I am happy to share this freely, it does not belong to us, obviously CTI belongs to the Care Transitions Program in Colorado but we've worked with them from the beginning to say that we wanted to be able to distribute it freely to people.

So it certainly isn't an option and for the duration of this grant period, so for the next few months we also have some capacity to be able to customize it to other groups needs or to help with training on how to use it. We're developing a user manual for it right now just to kind of help facilitate the delivery of CTI across the country.

And that's what I have.

Marisa Scala-Foley: All right. Thank you so much, Angie. Before we've gotten a few questions in specific to your presentation so but before we do that I'd like to quickly go through the last couple of slides about resources and our next training and then we'll see if we can have people queue up on the audio line as well as take the questions that came in through chat for you. Let's see, there we go. Just give me a second to move to the end.

Okay. So as always we have included in the slides lists of resources on care transitions as well as on the Affordable Care Act and on health information technology that we found to be helpful in putting together and thinking about the topic and putting together this presentation and that we think might be helpful to you in some of your work.

I know we've got a lot of links here and you certainly can't, some of them are very complicated so it's really not possible to write them all down now, but as I've posted in chat we will be posting these slides online on the AOA Web site on our health reform page you'll see the, an icon for health reform on the right hand side of the AOA.gov Web site and they should be posted there within the week, and or if you need them sooner you're welcome to e-mail us at affordablecareact@AoA.hhs.gov.

Our next training actually will be coming up fairly quickly. We will be doing our next training and we'll continue our webinar series next month, we'll look at the Medicare/Medicaid, we'll look at Medicare/Medicaid enrollees and the work of CMS's Medicare/Medicaid coordination office to their alignment initiative which seeks as the name would indicate to align, to better align the Medicare and Medicaid problems.

We're looking to do that webinar on Tuesday, July 5th because they do have a comment period on that alignment initiative that closes on July 11th so we want to make sure that you all can get as familiar with it as possible and hopefully make comments on it if need be.

So that training will be Tuesday, July 5th from 2:00 to 3:30 Eastern and e-mail should probably go out later this week which will contain registration information, so please do keep your eyes peeled for that. And as always if you

have questions, comments, stories or suggestions for future webinar topics please do e-mail us at affordablecareact@AoA.hhs.gov.

So with that Diane why don't you go ahead and give the instructions for people to queue up on the audio line and while people are queuing we'll take a couple of the questions that came in for Angie during the, while she was presenting.

Coordinator: Thank you. If you would like to ask a question from the phone lines please press star 1 on your touchtone phone. Please unmute your line and state your name clearly so that we may announce you. To withdraw your question, please press star 2. Once again to ask a question, please press star 1. One moment please.

Marisa Scala-Foley: Okay. While people are queuing up let's take a couple of questions that came in through chat. Angie the first one came from (Gail) who asks does your database have any connection or ability to import data from a hospital's EMR? If so what was required for the hospital to allow that?

Angie Hochhalter: Our database does not have that functionality right now. We wanted to design it so that it could be used by ADRCs out in the community so we haven't focused on getting that capacity together.

Also the way that we, we have arranged in Texas is that all of our coaches are hired at the hospital so they have access to the electronic medical record. So we didn't have a need here to have things imported from the record, it's the kind of thing that would be really nice to be able to do but we have not pursued it here.

Marisa Scala-Foley: How do they work, how do they interface, you mentioned that you designed it for the ADRC, how does it work with triple A or ADRC care management systems?

Angie Hochhalter: It works separately from the care management systems at this point. We have a couple of things that we have built in to make sure that we remind our coaches to enter their, like for example we want demographics entered into the ADRC care management system. So there is a place in the current version that says check here when you've entered into the care management system.

But again we have not worked on interoperability with the ADRC system and the reason for that is partly because we wanted to it be able to be used across ADRCs and partly because in our previous project we actually used the ADRC care management system, and what we found here locally was just that getting the data out of that in a timely manner used a lot more personnel time than we wanted to have to use and so we here designed the system separately because it was, gave us faster access to the data and was more efficient for us.

Marisa Scala-Foley: Okay. Before we let Diane allow people to ask their questions through the audio line we got a couple of questions about this, a lot of interest in seeing how they might be able to get a version of this database Angie, should people contact you or is there someone else who they should contact?

Angie Hochhalter: People should contact, if you e-mail me directly we would love to know who is interested. I am happy to send it in its current version and then to have conversations with different groups about if you need some changes to it some tweaks that are not major while we're in this grant period we're happy to provide that service.

I will say that our user manual is still in development so I would want to stay in touch and just make sure you got that eventually too but contacting me directly is the best way to do it right now.

Marisa Scala-Foley: All right. And I have put Angie's e-mail address back up on the screen, also you're welcome as I mentioned before to e-mail us for the slides. So with that Diane have, do we have any questions on the audio line?

Coordinator: You have no questions from the audio portion, ma'am.

Marisa Scala-Foley: Okay. All right. Well then we'll take a few more of our chat questions that we received, just bear with me for a moment while I scroll up, and these will, I'll queue you presenters because these will be for, these could be for any of you so I'll let you know who they are for.

First question came from (Kate) and Steve I think this question is for you, on the slide where you listed some of the issues that come up within the transition process you mentioned the concept of duplication. Could you talk a little bit more about that and what that refers to?

Steve Kogut: Oh sure. I think mostly a consequence of formulary issues between maybe a patient's Medicare Part D plan and then the hospital's formulary, and so there may be you know, one ACE inhibitor that's covered under the Part D plan, that's switched off when the patient is in the hospital and then the discharge instructions you know list the hospital ACE inhibitor and the patient has the old one at home and continuing to take both, those sorts of issues are what I meant by duplication, hope that answers the question.

Marisa Scala-Foley: That's great. If not (Kate) let us certainly please do let us know via chat. Another question from (Renee) and this one's for Angie, or actually for any of

you but could you talk a little bit about has data been collected to the point, to this point that shows if these technologies have an impact on preventing unnecessary re-hospitalizations and if so could you share some of the early results?

Angie Hochhalter: Well this is Angie and I'll start with that. We are not comparing delivery of CTI with and without this tool we're, partly because once our coaches started using it they really, really preferred it over us trying some more clunky systems where we were just having them enter data into places.

So for us it's really an issue of efficient delivery of what's already an evidence-based intervention, so I can't comment other than that other than to say that our coaches experience has been that this is really helpful for them versus what we were having them do before, which was kind of keeping track of who was screened and who was enrolled and when their contacts were and separate databases and that was not working.

Marisa Scala-Foley: Okay.

Steve Kogut: This is Steve, I would...

Marisa Scala-Foley: Okay.

Steve Kogut: ...just add to that and maybe refer to maybe some of the work done with the chronic care model and (Ed Wagner's) group that used registries as a way to manage perhaps heart failure for example where re-hospitalizations may be avoided through systems, technology systems where the medication management functions may not be that dissimilar from a personal health record.

Marisa Scala-Foley: Great. Thank you. Diane, have any questions come in yet through the audio line?

Coordinator: We have no questions on the audio portion.

Marisa Scala-Foley: Okay. We've got about three minutes left so we'll take a couple more questions in via chat. We do have several sort of outstanding questions at this point, excuse me, so we will take a couple of them now and but for those of you who didn't get your questions answered we'll certainly follow-up with you via e-mail and I'll check in with the presenters as to the answers to those questions, we want to make sure that your questions do get answered.

Coordinator: Excuse me. We just got a call from the phone lines.

Marisa Scala-Foley: Great.

Coordinator: Okay. One moment. (Joanne Schwartzburg) you may ask your question.

(Joanne Schwartzburg): Thank you. My question is how do you get information and coordination back to the primary care physician and possibly to the specialists about what you've found through this?

Steve Kogut: Was that, yeah I'm sorry is that for Dr. Hochhalter or?

(Joanne Schwartzburg): Okay. The question is how, you're getting a lot of information from the patient, how does that information get back to the primary care physician, does it at all? Do you ask the patient to report, do you ask if you can report or is it just left up in the air?

Steve Kogut: Maria did you want to talk about some of...

Maria Gil: Actually I would, I wasn't, I'm sorry I didn't quite understand the question but if you're talking about the information that's in the ER Card program it is self reported by patients and as part of our education outreach, you know communication with our members on a regular basis we encourage them to take that copy of their profile with them to all the doctors that they visit.

Because we know one doctor may not know about the other or what they're prescribing, you know or also as part of the follow-up when someone's been in an emergency room the first recommendation we make is that they do call their primary care physician, let them know they were in the emergency room and at least, you know, have a visit with that primary care doc.

(Joanne Schwartzburg): The reason I was questioning is because I hear from physicians who are unhappy because they never get information back from the coaches, they don't know what's going on, it's very different from working with home health nurses who always refer back and tell the doctors where they're going on, but all of these transition programs the primary care docs say they aren't hearing anything, and I think it's a real problem and I wondered how you were addressing it.

Maria Gil: Well I, we're just getting started you know with our program you know...

(Joanne Schwartzburg): Right. Just (unintelligible) about it and put in a system to make sure that everybody is connected, that's all.

Maria Gil: Like I said that is part of our, the ER Card program you know the way it exists today and it always has been so that will continue.

(Joanne Schwartzburg): I was interested for Angie for the care transition.

Angie Hochhalter: So part of this is actually it's a philosophical issue for the way that Coleman's group has developed the care transitions intervention, and we try to deliver it as closely as we can to their training and to their original protocols and honestly the way that that intervention was developed was to engage patients and caregivers to do that communicating.

And so they would say, I hope that I'm not speaking wrongly on their behalf, but my understanding of the way that they would answer that question is that it's not intentionally the coach would not make that communication to the specialist or the primary care physician because the whole idea of that intervention and how it differs from some of the others philosophically is that they're intending the engage the patient and family in a way that they will improve their communication.

Now whether or not that's happening under different models I certainly can't speak to but I will say that that specific question under the coaching model would be answered that way, that the idea is to really try to empower the family and...

(Joanne Schwartzburg): Could your database include the question from the coach to the family about did they follow-up?

Angie Hochhalter: So one of the pillars is yes, to do that, is to definitely communicate with the family, with the caregiver about did you do the follow-up visit or even before that is that follow-up visit scheduled, if they have questions to encourage them to even role play how a phone call would go, for example to try to move a, try to move a visit up to be within 30 days.

And so the coach would absolutely follow-up on that and one of the things that this tool helps us do is say oh look I've got a note in here that they couldn't get an appointment within 30 days, we talked about someone now when I do the follow-up call the coach says we talked last time about trying to get an appointment earlier, have you done that, and if not problem solve why they hadn't done it.

(Joanne Schwartzburg): Okay. It still leaves the primary care doctors I think out of the loop in a very distressing way if the patients are not fully empowered, even though the coach is trying. And so it worries me that there's this gap, but I've said enough and I realize that's the Coleman model but it does have a big gap to it.

Angie Hochhalter: Yes.

Coordinator: Excuse me, we have one more question from the audio portion, did you wish to take it?

Marisa Scala-Foley: Let's go ahead and take that and then we'll close things out.

Coordinator: All right. The party's name was not recorded, your line is open but your name was not captured, please state your name and ask your question.

(Tammy Johnson): Yes. My name is (Tammy Johnson) and I'm actually one of the care transition coaches implementing the Coleman model here in Connecticut and I just want to say that what Angie had mentioned is correct about the coaches role is to facilitate patient or consumer self management as much as possible.

But again that previous woman who had the question about the gap in communication, that is true and we are finding that here as well where we are working with the consumers on the paper PHR where the consumer is actually

manipulating and navigating that personal health record by themselves if they're able to, they're writing in it themselves.

However we are finding that a lot of the consumers are choosing not to utilize that paper PHR and I was wondering if Steve and Maria had any insight as to if they have patients or consumers that choose to use the electronic PHR, which I guess is constructed by the physician or a nurse or a clinician.

Maria Gil: Well the ER Card is available both ways, it's paper and electronic.

(Tammy Johnson): Oh it is, okay.

Maria Gil: So for you know, for senior members or people who are intellectually disabled you know a family member might just want that paper copy that's hanging on the refrigerator or that they, you know, child goes off to camp or something or word during the day, you know they have a copy with them with their membership identification card, but then for people who have the electronic version and can keep it up themselves they like that so they have a choice.

(Tammy Johnson): But is it mostly that the doctors are entering information or is it the consumers and the families and doctors can enter the information?

Maria Gil: Actually this is just the patient's information.

(Tammy Johnson): Oh okay.

Maria Gil: You know I mean I've had some doctors say that they don't think what the patient wants in their alert section is appropriate, you know like if someone is severely depressed and that's what they want it to say, and I just, I have to

remind them that it's the patient's information and if that's what they want someone to know that is their choice.

(Tammy Johnson): Do you guys track any readmission data off the tool that you guys have?

Maria Gil: Not at this point, what we...

(Tammy Johnson): Okay.

Maria Gil: ...you know what we've done all along is try to keep people, you know out of the emergency rooms and that kind of thing, but we're just getting started with our program so we'll have that data shortly.

(Tammy Johnson): Oh okay. Thank you.

Marisa Scala-Foley: All right. With that we are definitely out of time. I wanted to thank our presenters for a wonderful stimulating session today and thank you to all of our participants who are still on the line and on the Web. We appreciate all of your questions. If you had a question that you entered into WebEx that did not get answered we will follow-up with the presenters to make sure that we get your questions answered and we'll e-mail those answers to you.

Thank you all for being here and we hope you'll join us next month. Thank you very much.

Coordinator: Thank you for your participation. Your call has concluded, you may disconnect at this time.

Marisa Scala-Foley: Thank you.

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