Building Community Technology Systems to Support Care Coordination

Administration on Aging

Agenda

- Introduction/housekeeping
- The Beacon Communities
- A View from Two Communities
  - Rhode Island
  - Rochester
- Opportunities and Challenges in Building Systems
- Resources
- Next training
- Questions

Presenters

- Janhavi Kirtane, Director, Clinical Transformation, HHS Office of the National Coordinator for Health Information Technology
- Lauren Capizzo, Senior Manager of Health IT and Practice Improvement, Quality Partners of Rhode Island
- Joe Russell, Business and System Analyst, Rhode Island Quality Institute
- Corinda Crossdale, Director, Monroe County Office for the Aging, Rochester, NY
- Dr. Victor Hirth, Medical Director for Geriatric Services at Palmetto Health, and Professor and Chief of the Division of Geriatrics at the University of South Carolina

The Beacon Communities

Janhavi M. Kirtane
Director, Clinical Transformation
HHS Office of the National Coordinator for Health IT

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"We have a moment" – Mississippi Delta Blues Beacon Community

Before

After

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Overview of ONC's Major Program Areas

	Description	Funding
Meaningful Use Program (with CMS)	Provide incentive payments for eligible providers and hospitals that use certified EHR technology in a meaningful manner	▪ $27.3 billion *(high estimate)*
Regional Extension Centers	Assist at least 100,000 primary care providers in achieving Meaningful Use by 2012. Program includes 60 Regional Extension Centers covering the entire country.	▪ $643 million
State Health Information Exchanges	Give every provider options for meeting HIE Meaningful Use requirements. Priority on filling gaps in e-prescribing, labs, clinical summary exchange.	▪ ~$500 million
Beacon Communities	Demonstrate the use of health IT, in combination with other delivery interventions, to achieve improvements in cost, quality, and overall health in 17 innovation communities.	▪ $260 million

Beacon Program Aims

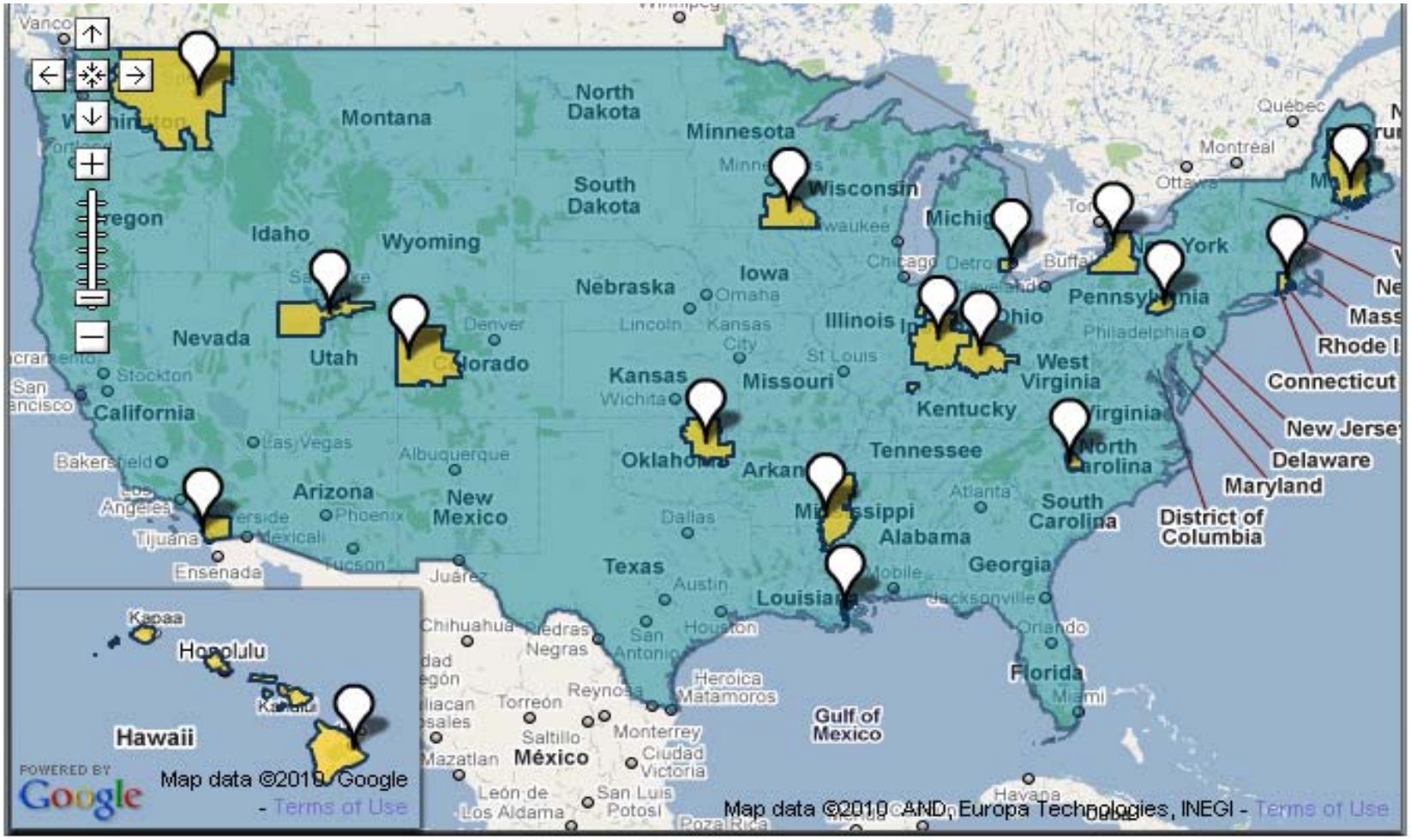
Core aims for 17 communities:

1. **Build and strengthen** community/regional health IT foundation to achieve long-term improvements in care quality, health outcomes, and cost efficiencies

2. **Demonstrate impact** from health IT-enabled interventions and community collaborations on concrete cost/quality performance improvements

3. **Test and disseminate innovations** to improve health and health care

Beacon Community Programs



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What Are We Doing?

- **Transitions of Care**
  - Information flow; hospital discharge process improvement and standardization; transitions coordinators (work with patients on medication reconciliation and self-care plans through transitions); includes Primary Care Physicians (PCPs), hospitals, specialty practices, and long-term care settings
- **Care Management**
  - Trained individuals using standardized protocols for identifying and managing high risk patients and others needing follow-up and services, and working with patients and PCPs in creating self-care plans, including medication management.
- **Computerized Clinical Decision Support**
  - Embedded within Electronic Health Record (EHR) and/or Health Information Exchange (HIE) systems and utilized by multiple members of the care team (e.g., physicians, care managers, etc.)
- **Physician Data Reporting & Performance Feedback**
  - QI reports informing providers of actionable items to maintain the highest standard of care in their patient population (e.g., guidelines and/or specific cost, quality, population health measure outcomes and/or analytics)
- **Public Health Registry-Based Management**
  - Registries could target preventative services and could be disease-based; often in partnership with public health departments
- **Others** (e.g., Personal Health Records [PHRs], telemedicine, telehealth)

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Summary of "Core" Interventions in 2011

Intervention	# of BCs	~# of patients "touched" in 2011	~# of providers "touched" in 2011
Transitions of Care	12	250,000	~50 settings (including hospitals, SNFs, etc.)*
Care Management/ Patient-Centered Medical Home	13	300,000	2,500
Computerized Clinical Decision Support	13	350,000	1,800
Physician Data Reporting and Performance Feedback	12	550,000	1,900*
Public Health Registry-Based Management	11	200,000	700*

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Beacon Communities' Transitions Focus

- 12 of 17 include a significant care transitions component (Affinity Group coached by Dr. Joanne Lynn and coordinated by our TA partner IHI)
- Aim: Reduce hospital utilization and improve health of the chronically ill, resulting from poorly managed transitions
- Target populations: Include individuals with high cost / high risk chronic conditions (e.g., adult Diabetes Mellitus [DM], Cardiovascular Disease [CVD], and pediatric asthma)
- Spread: Build on initial successes by ongoing learning with other Beacon Communities and contributing to Health Information Technology (HIT) toolkit development for national Care Transitions initiative

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Beacon Communities' Transitions Interventions

- HIT interventions are being explored to:
  - Provide hospital discharge information (e.g., medications, lab values) to next providers (e.g., nursing homes, Federally Qualified Health Centers [FQHCs], PCPs, home health providers)
  - Notify PCPs of hospital and/or Emergency Room (ER) use
  - Improve communication between PCPs and specialists
  - Better engage patients and families
- IT tools are coupled with case management (e.g., self-management coaching, risk stratification, medication reconciliation)
- Alignment of Quality Improvement (QI) with IT is a high priority area of focus

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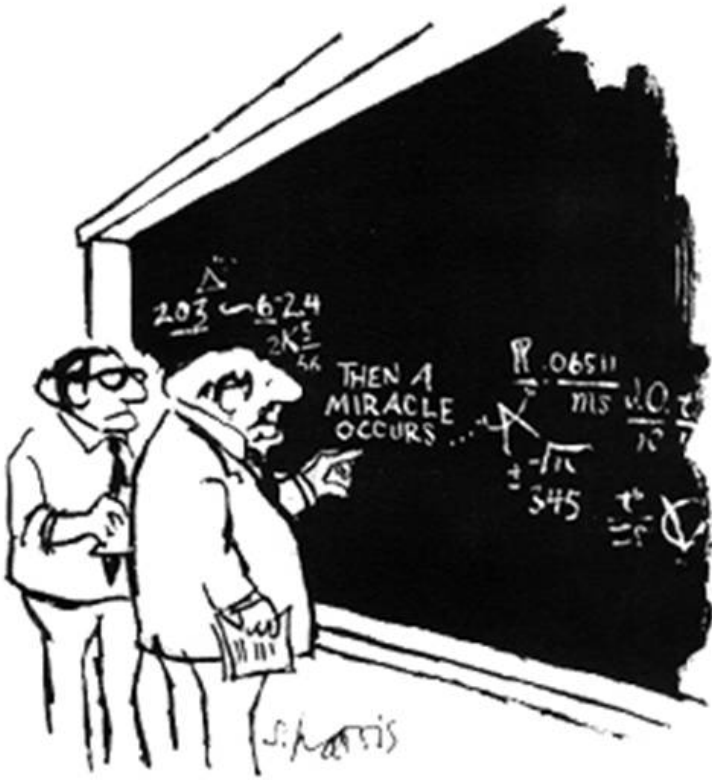
What Did We Learn in the 1st Year? The Miracle of Focus and Hard Work



"I think you should be more explicit here in step two."

- **Challenge 1:** Nurturing community-wide engagement (governance/leadership)
- **Challenge 2:** Staying focused
- **Challenge 3:** Scaling interventions
- **Challenge 4:** Keeping an eye on sustainability

(Thanks to Carol Beasley from the Institute for Healthcare Improvement!)

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We want your help: Innovation and Spread

- Beacon communities as “testing grounds”:
  - What promising practices related to HIT-enabled interventions are being used in your community?
  - What ideas do you have for new and excited ways to use technology to support
    - Patients and families?
    - Providers?
    - Social and community workers?
    - Others?

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Contact Information

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Targeted Long Term Care (LTC) Health Insurance Exchange (HIE) Rollout

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HIT and Practice Improvement
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Rhode Island Quality Institute

- Free-standing not-for-profit organization founded in 2001
- Statewide, multi-stakeholder collaborative with the mission of improving the quality, safety and value of healthcare
- Board consists of physicians, consumers and representatives from health insurers, businesses, professional associations, and state government
- High levels of participation beyond the Board and wide-ranging collaborative reach

Beacon Communities Program Objectives

- To demonstrate that health IT-enabled quality, cost/efficiency, and population health improvements are possible in diverse communities, within the program period;
- To support lasting “innovation networks” through which a wide range of stakeholders can collaborate, design, and implement new technology-enabled ideas that improve health and health care beyond the program period; and
- To provide lessons, implementation insights, and best practices for other communities eager to improve health, health care, and cost-efficiency in their communities

LTC HIE Rollout Project Purpose

1. Complete the loop of data sharing among Beacon providers by helping 100% of the Long-Term Care (LTC) facilities in Rhode Island access current*care*®.
2. Ensure treating physicians (in the nursing home, at a specialist's office, or in a Rhode Island Emergency Room) will have timely, accurate information at the clinical point of care.
3. Assist these facilities by performing on-site technical assessment of their present-day information technology (IT) system capabilities.
4. Purchase and install necessary computer equipment.
5. Provide training and guidance on using current*care*® to improve patient safety.

LTC HIE Rollout Project Benefits

1. Increased care coordination and communication between PCPs and the broader community.

2. Opportunity to address care coordination for patients, who as a group are likely to have significantly higher co-morbidity and pose greater care coordination challenges.

3. Potential decrease in hospital utilization as LTC facilities gain easier access to provider clinical information and communications.

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Quality Partners' Role and Experience

1. Quality Improvement Organization (QIO) for Rhode Island
2. National QIO Support Center (QIOSC) for Long Term Care Community 2003-2006
3. Led 100% participation in *Advancing Excellence Campaign*
4. Numerous state, federal, and private LTC projects

Call to Action

Let's be the first state in the nation to have 100% of its nursing homes participating in the statewide health information exchange

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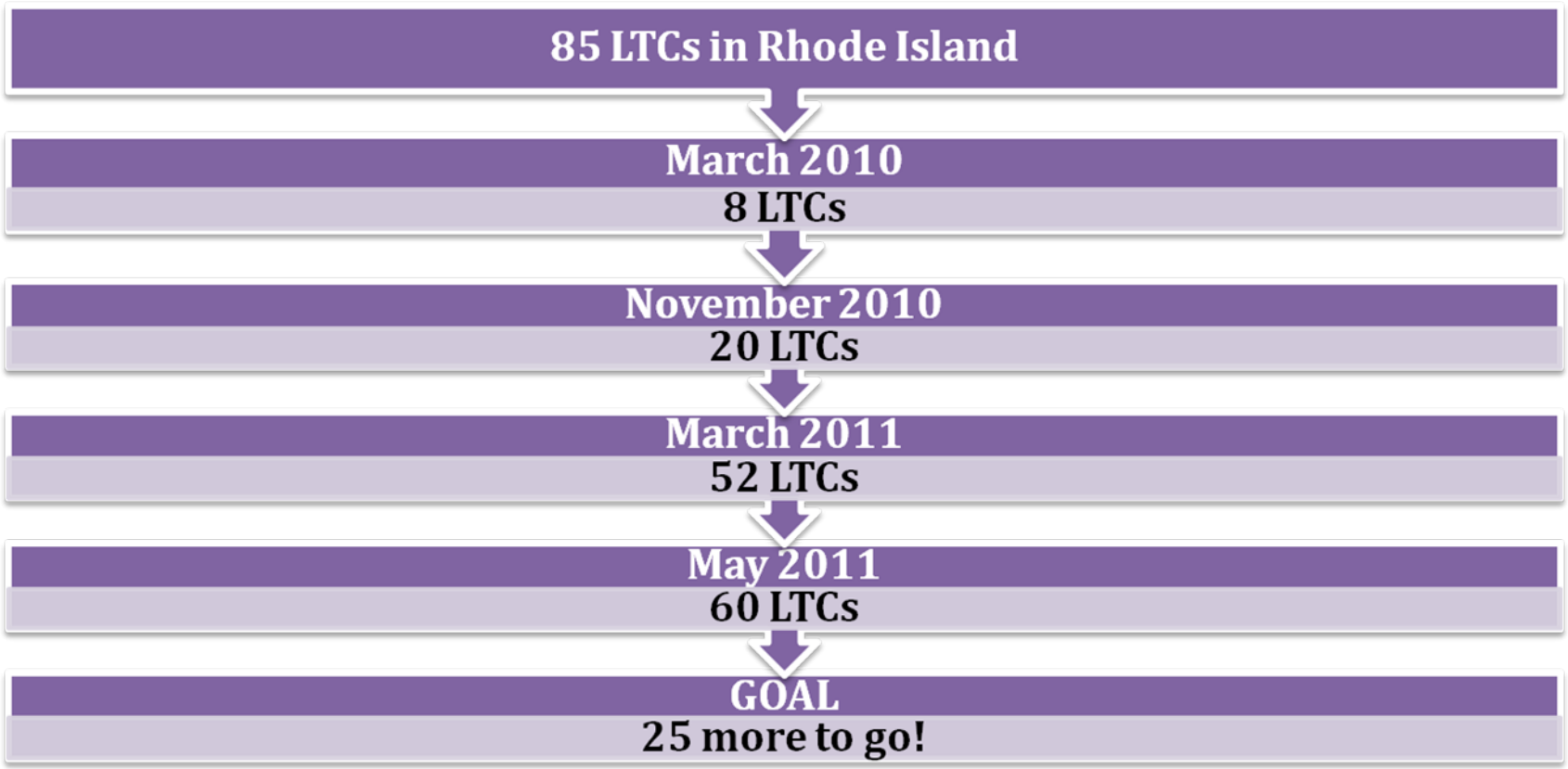
Strategy

1. Secure the commitment of critical LTC stakeholders
2. Build awareness in LTC community via a tiered communication campaign
3. Engage state agencies
4. Encourage participation at all Quality Partners appropriate touch points
5. Convene a current*care* Summit

Recruitment Timeline



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Lessons Learned

1. Get buy-in from leadership
2. Build off of existing relationships
3. Set measurable goals and timelines
4. Make the delivery model flexible
5. Provide a vision and let LTCs be part of the process

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A Resident's Perspective

- 'Residents are also looking forward to current*care* going live later this year. "It's such a relief to know that if I go to the emergency room that the doctors and nurses will have access to the labs and tests done by the nursing home and by any of my specialists," says Mary Crockett, resident at the Jeanne Jugan - Little Sisters of the Poor facility (Pawtucket, RI). "It's a load off my mind."' *Quality Partners' Press Announcement: March 1,2011*

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The Rochester Story

Corinda Crossdale, LMSW
Monroe County Office for the Aging
ccrossdale@monroecounty.gov

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How Did All of This Get Started?

In 2006 the New York State (NYS) Governor Set Out to Save the LTC System in NYS

- Governor Pataki's Agenda
  - Implement Nursing Home Transition and Diversion Waiver
  - Joint agency cooperation in establishing a Point of Entry System (POE)
  - Create Long-Term Care (LTC) Restructuring Waiver (1115 or Mega Waiver)

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Why?

- Dramatic increases in 85+ (1990-2000) rate of growth statewide was 26%.
- Accelerating phenomenon of the frail and poor
- Dramatic decline in number of workers and caregivers per elder
- Dramatic increase in 65+ beginning in the next 7-8 years
- In-migration to NYS of frail, poor elders
- Dramatic increase in minority elders which result in lower incomes and higher rates of frailty
- If we do nothing within 10 years the system as we know it will become unaffordable.

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Our Charge

- Olmstead Decision
  - Requires states to administer their services, programs and activities “in the most integrated setting appropriate to the needs of qualified individuals with disabilities.”
  - Challenges states to review intake and admissions processes to assure services are provided in the most integrated setting appropriate.

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Our Charge

- A system that:
  - Supports self-determination and Promotes Personal responsibility
  - Provides services that meet consumer needs
  - Provides high quality care
  - Ensures efficiency and affordability

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Follow the Trends

Development of the Monroe County Long Term Care Council

Charge of the Council

- Advise Monroe County Executive, Social Services Commissioner and Office for the Aging Director on long-term care issues facing Monroe County.

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Follow the Trends

- Identify and analyze community needs in the long-term care system, conduct an analysis of the system and make recommendations as may be necessary

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Data Driving Results

- Questions
  - Who are our long term care users?
  - What are their primary issues?
  - What are the gaps and barriers in addressing those issues?
  - What are our recommendations for change?

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Data Driving Results

- Alternative Level of Care Study
  - Profile of the consumer
  - Identification of gaps and barriers
  - Recommendation for adjustments/rebalancing of the Monroe County long-term care system

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Data Driving Results

- Recommendations
  - 11 recommendations
    - Number one recommendation was to enhance communication between hospitals and community based service providers. Monroe County Long Term Care Council recommended that each of the major hospitals in Monroe County, specifically their emergency and social work/care management departments become linked to PeerPlace®.

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In the Meantime

- Monroe County had an established relationship with PeerPlace®

About PeerPlace®

- PeerPlace®
  - A web-based software system that supports care professionals and their administrative staff by electronically managing workflow and information from the first point of contact through every encounter with the consumer
  - All types of services are tracked, including basic information requests to full case management functions that utilize multiple service providers across a community

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In the Meantime…

- PeerPlace®
  - Connects aging services agencies through one integrated system
  - A community-wide network enabling collaboration among professionals providing community based services
  - As a web-based client tracking system, it is designed to accommodate both direct and contracted service providers

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In the Meantime…

- PeerPlace®
  - Master Client Database - maintains unduplicated counts of people receiving services across multiple programs.
  - Care Path Workflow - comprehensive client management system from Information and Assistance through Referrals, Intakes, In-home Assessments and Care Plans. Each program area is configured uniquely for user action workflow, data validation and reporting.
  - Universal Referrals - any connected program can manage incoming and outgoing electronic referrals, providing ease of coordination across the community.
  - Service Tracking - collect all relevant data at point of service and map to proper funding sources and service types for instant reporting

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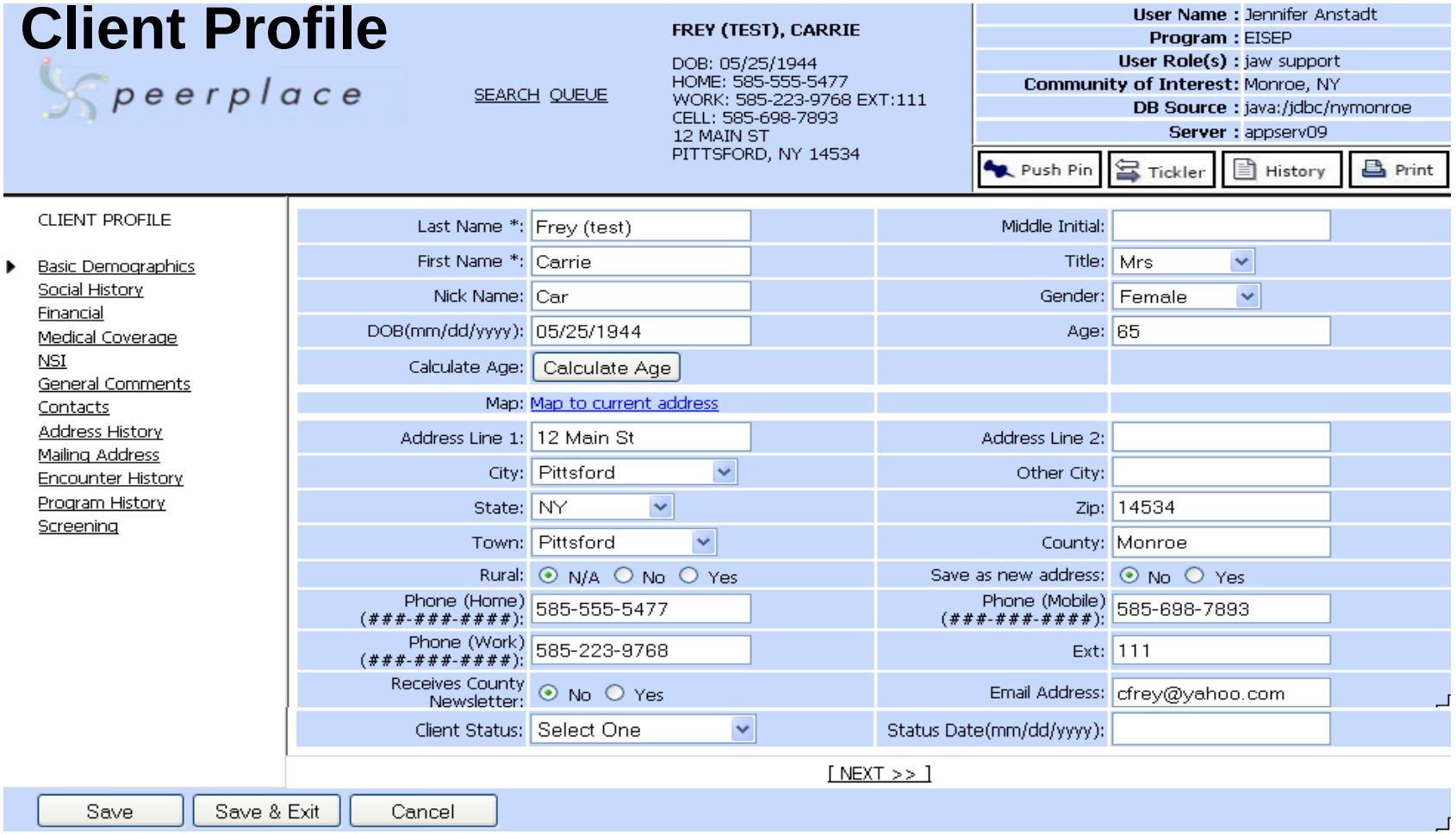
Client Data is Entered into PeerPlace®



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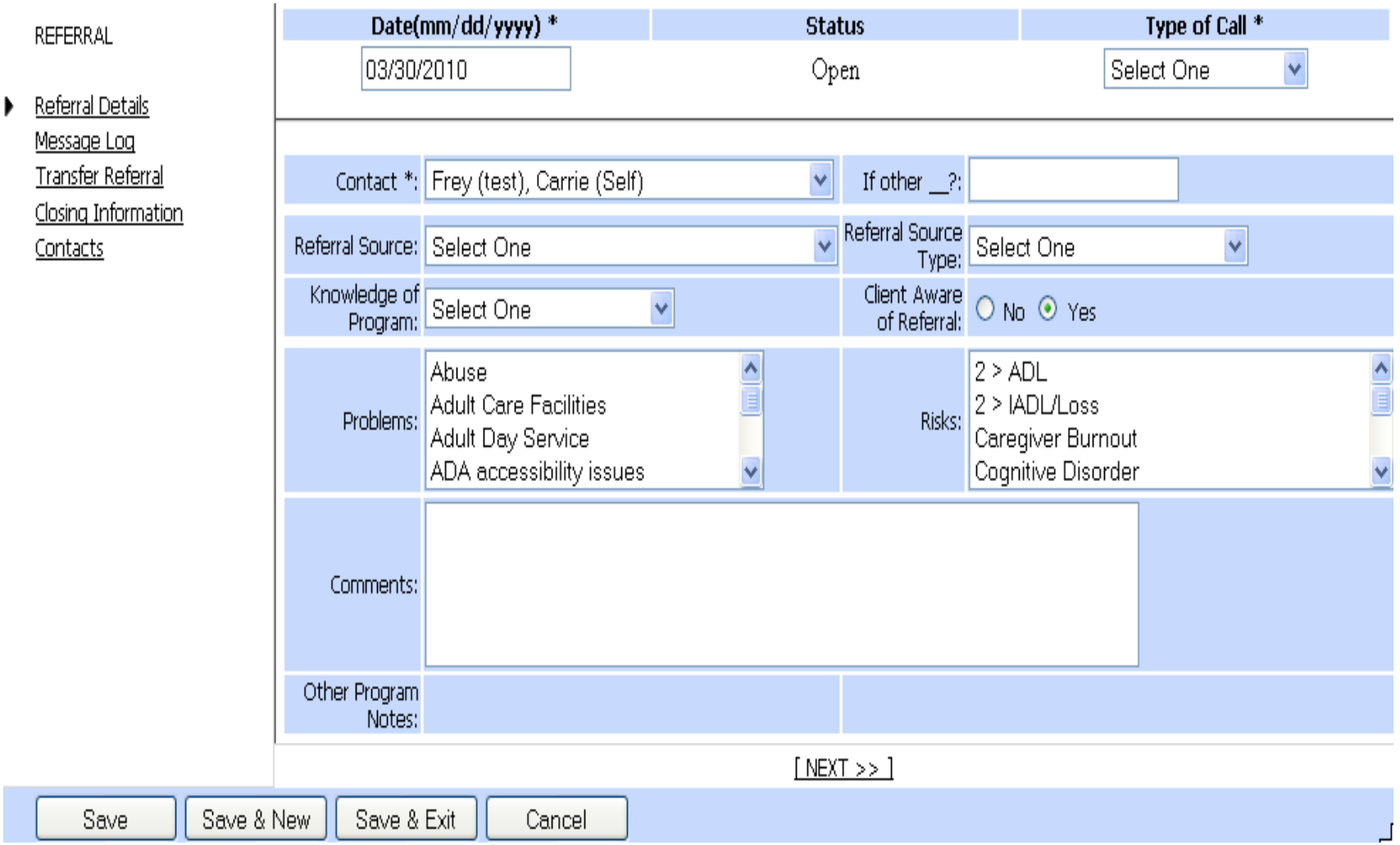
Referral


REFERRAL
Referral Details
Message Log
Transfer Referral
Closing Information
Contacts
Date(mm/dd/yyyy) *
03/30/2010
Status
Open
Type of Call *
Select One
Contact *:
Frey (test), Carrie (Self)
If other __?:
Referral Source:
Select One
Referral Source Type:
Select One
Knowledge of Program:
Select One
Client Aware of Referral:
No
Yes
Problems:
Abuse
Adult Care Facilities
Adult Day Service
ADA accessibility issues
Risks:
2 > ADL
2 > IADL/Loss
Caregiver Burnout
Cognitive Disorder
Comments:
Other Program Notes:
[NEXT >>]
Save
Save & New
Save & Exit
Cancel

Case File

CASE FILE

- Case Monitor
- Case Notes
- Assessments
- Cost Share
- Issues and Goals
- Care Plan
- Contacts
- Units Entry
- Case Reviews
- Closing Summary

Case Filed On	Case Manager	Status
01/01/1900	Peerplace Admin	Closed

Type of Case:	Case Management	Agency:	ULR
IMPORTANT DATES			
Last Assessment Date:		Next Reassessment Date:	
Next Supervisory Review Date:			
DAY PROGRAM			
Agency:	Select One	# Days per week:	Select One
Transportation Comments:		Service Start Date:	
IN-HOME SPECIFIC QUESTIONS			
In Home Status:	Select One		
Agency:	Select One	Service Type:	Select One
Total hours per week ordered:		Days and Times:	
Service Start Date:		Next Clinical Supervisory Due:	
Dates of Past Clinical Supervisory Visits:		Waitlist Comments:	
Missed Days of Service:			
SUBSIDIZED PERS			
PERS Service Started On:		PERS Service Ended On:	
OTHER INFORMATION			
Client Cost Share Percentage:	0	Maximum Monthly Fee:	
EISEP Case # :		STAR Driver:	
Initial Intake Date:		Initial Assessment Date:	
HIPAA Privacy Notice Signed:		EISEP Client Service Agreement Signed:	
Client Bill of Rights Given to Client On:		Notice of Right of Hearing Given:	
Effective Service Form Signed:		Delay Code:	Select One
Service Requested Date:		Service Started Date:	
24 Hour Service Initiation Contact Date:		15 Day Visit Contact Date:	
Incident Reports Filed On:			
Comments:			

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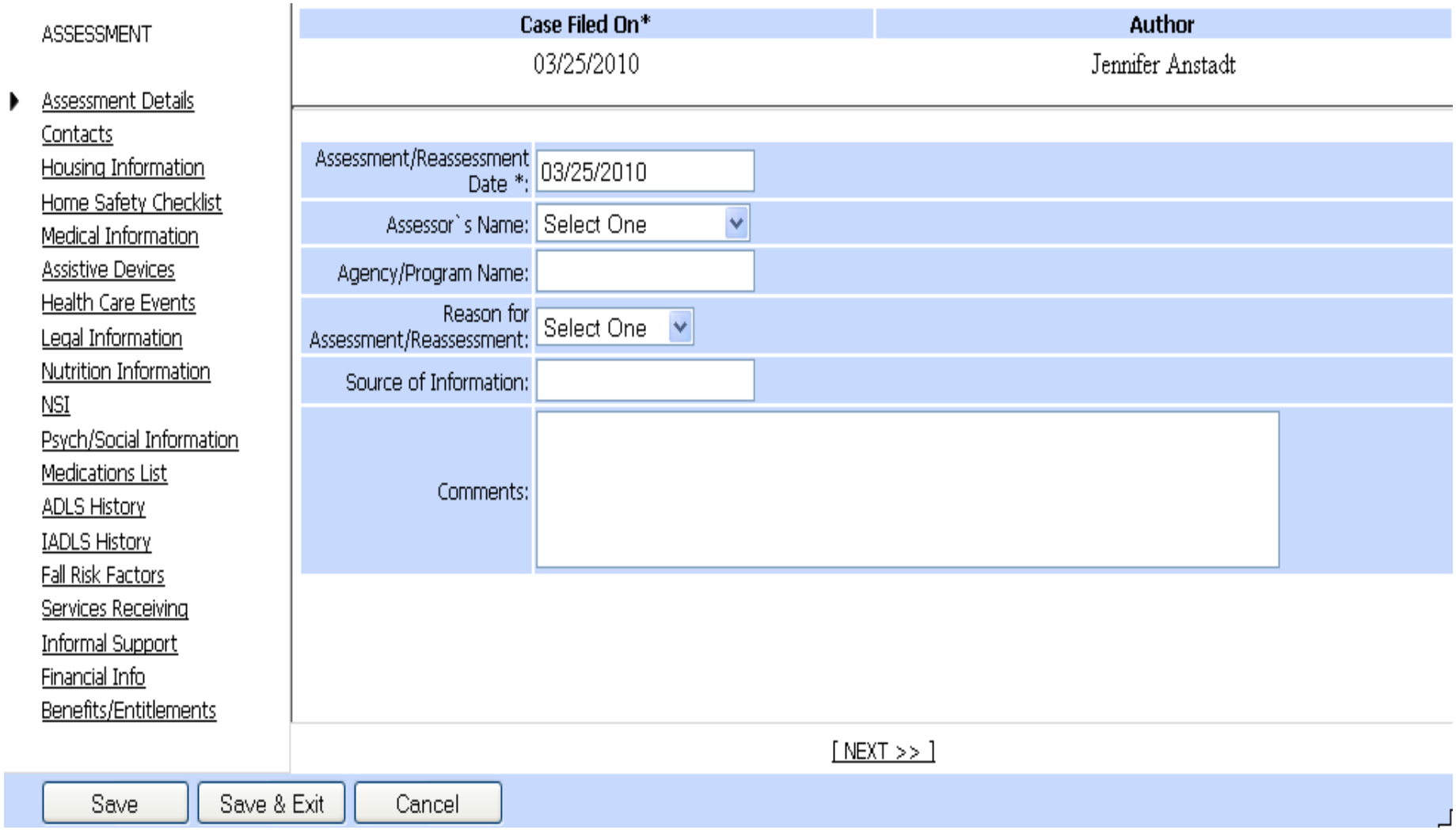
Assessment


ASSESSMENT
Assessment Details
Contacts
Housing Information
Home Safety Checklist
Medical Information
Assistive Devices
Health Care Events
Legal Information
Nutrition Information
NSI
Psych/Social Information
Medications List
ADLS History
IADLS History
Fall Risk Factors
Services Receiving
Informal Support
Financial Info
Benefits/Entitlements
Case Filed On*
03/25/2010
Author
Jennifer Anstadt
Assessment/Reassessment Date *:
03/25/2010
Assessor`s Name:
Select One
Agency/Program Name:
Reason for Assessment/Reassessment:
Select One
Source of Information:
Comments:
[NEXT >>]
Save
Save & Exit
Cancel

Services Receiving

ASSESSMENT

- Assessment Details
- Contacts
- Housing Information
- Housing Safety
- Medical Information
- Assistive Devices
- Health Care Events
- Legal Information
- Nutrition Information
- NSI
- Psych/Social Information
- Medications List
- ADLS History
- IADLS History
- Housing Falls
- Services Receiving
- Informal Support
- Financial Info
- Benefits
- OARS History

Assessment Date *	Author
01/18/2010	Jennifer Anstadt

What formal services does the person currently receive?	(Check all that apply)	Provider
None Utilized:	No	
Adult Day Health Care:	No	
Caregiver Support:	No	
Case Management:	No	
Community-Based Food Program:	No	
Congregate Meals:	No	
Equipment/Supplies:	No	
Escort:	No	
Friendly Visitor/Telephone Reassurance:	No	
Health Insurance Counseling:	No	
Home Health Aide:	No	
Home Delivered Meals:	No	
Homemaking/Personal Care:	No	
Hospice:	No	
Housing Assistance:	No	
Housekeeping/Chore:	No	
Legal Services:	No	
Mental Health Services:	No	
Nutrition Counseling:	No	
Occupational Therapy:	No	
Outreach:	No	
Personal Emergency Response System (PERS):	No	
Protective Services:	No	
Respite:	No	
Respiratory Therapy:	No	
Senior Center:	No	
Senior Companions:	No	
Services For The Blind:	No	
Shopping:	No	
Skilled Nursing:	No	
Social Adult Day Care:	No	
Speech Therapy:	No	
Transportation:	No	
Other:	No	

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In the Meantime…

- We had also established a relationship with the Rochester Regional Health Information Organization (RHIO)
- Rochester RHIO is a secure electronic health information exchange that gives authorized medical providers access to test results, lab reports, radiology results, medication history, insurance eligibility and more.
  - This nonprofit, community-run organization was created to give health care providers fast access to accurate information about patients so everyone can receive the best care possible.

In the Meantime…

- Information is only shared with the patient's doctor if the patient signs a consent form.
- Rochester RHIO is one of 300 health information exchanges in development nationwide.
- Created in 2006 with a $4.4 million state grant and $1.9 million in funds from local businesses, hospitals and health insurers.

In the Meantime…

- Healthcare providers from a nine-county (***Monroe***, *Genesee, Livingston, Ontario, Orleans, Seneca, Wayne, Wyoming and Yates counties*) service area are using Rochester RHIO.

In the Meantime…

- Health care providers can…
  - See test results as soon as they're available.
  - Avoid delays in obtaining records on referred cases, and uncertainties of patients' case histories.
  - Use e-prescribing to see medication history, add convenience, reduce errors, and increase Medicare reimbursement
  - Access information about patients from any computer, whenever and wherever its needed.
  - Have test results and patient information automatically delivered into an EHR

The Connection

- For the first time anywhere, Rochester-area health care providers are now able to see medical and social supports that human service agencies provide senior patients, alongside their clinical information.
- Data from 50 area eldercare agencies is included in the community health information exchange.

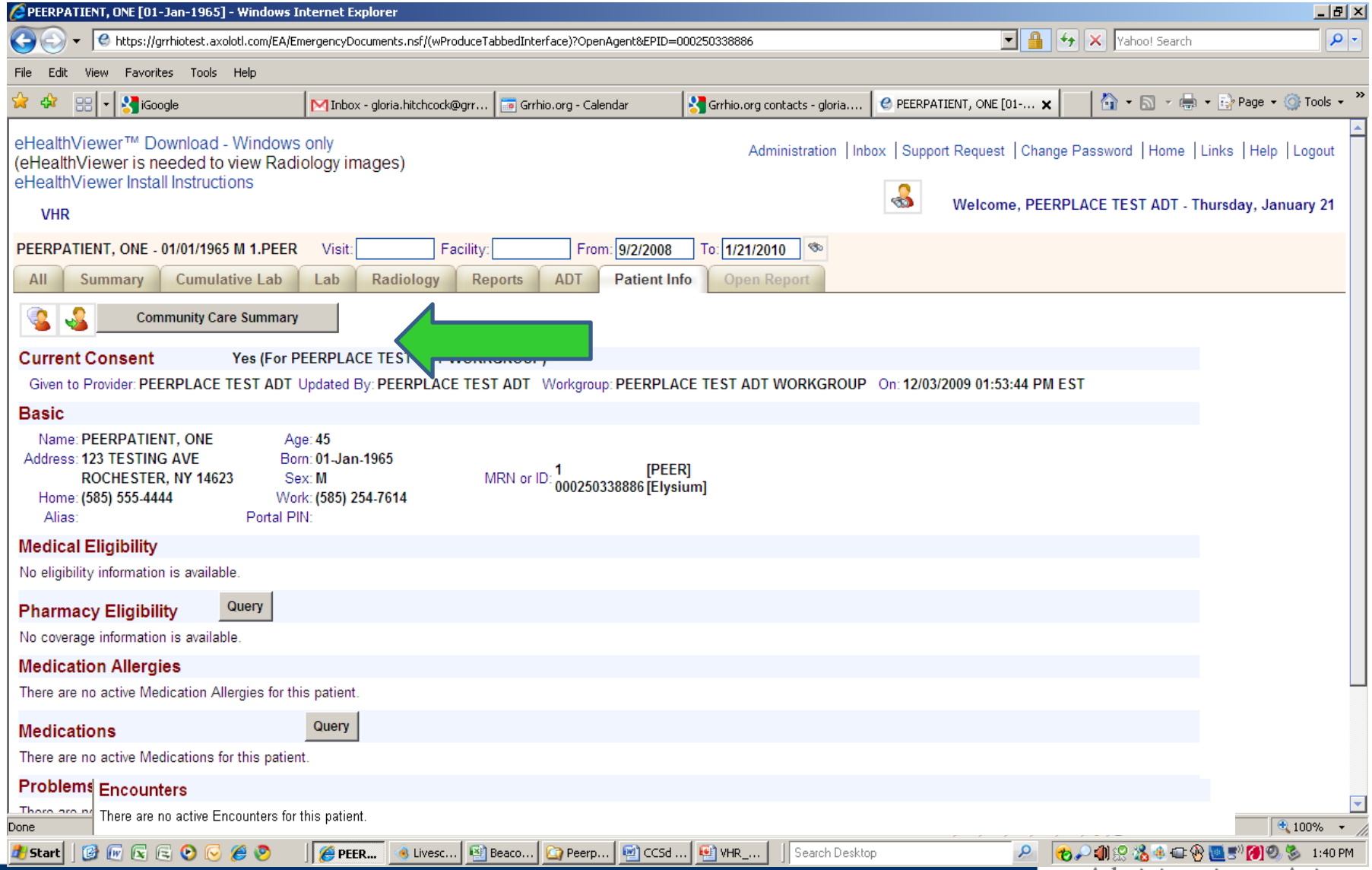
The Connection

- In partnership with PeerPlace Networks and the Monroe County Office for the Aging, Rochester RHIO developed a **Community Care Summary** that is available to authorized users of the health information exchange.
- The **Community Care Summary** is especially valuable as patients transition from the hospital to home, or between a rehabilitation facility and nursing home.

The Connection

- The Community Care Summary Indicates a patient's
  - home support status,
  - insurance information,
  - psychological/social issues,
  - emergency contacts,
  - services they currently receive such as meal supplements or equipment deliveries, medication monitoring information.

The Master Patient Index
Patient demographics are updated here by RHIO data providers.
Allergies, problems and vaccinations are populated by RHIO EMR users.



Community Care Summary

Community Care Summary

Name & Vital Information					
Client Name	Jane Smith				
Address	46 Park Drive				
City	Rochester	State	NY	Zip	14606
Home Phone	111-222-3333	Work Phone		Cell Phone	
DOB	12/22/1915	Age	93	Gender	Female

Demographics					
Marital Status	Widowed	Frail/Disabled	Yes	Vulnerable/Isolated	
Veteran	No	Lives With	Relatives	Primary Language	English
Special communication needs	Hearing impaired	Race	White not Hispanic	Ethnicity	Not Hispanic/Latino
Ancestry		US Citizen/National or Qualified Alien	Yes	Retired From/Employed By	
Other Employer		Oxygen Dependant	No	Speaks English	
Dialysis	No	Needs Interpreter		Insulin Dependant	No
Community Emergency High Risk	No	If Community Risk=Yes, Why?		Employment Status	

Assessment Details					
Assessment/Reassessment Date *	04/22/2009	Assessor`s Name	Mary Anne Angelo	Agency/Program Name	CFC

Page 1

Community Care Summary (continued)

Assessment Status

Status	Open	Assessment Date	09/28/2005	Case Last Updated On	09/28/2005

Basic Medical Information

Has Medicaid	No	Medicaid No.		Medicaid Pending	No
Date Applied (mm/dd/yyyy)		Has Medicare	Yes	Medicare No.	0123456789
Medicare Type	A and B	Prescription Coverage Provider	Medco	Eligible From (MM/dd/YYYY)	
Eligible To (MM/dd/YYYY)		Health Ins Provider	Preferred Care Gold	Health Ins. No.	A001233456

Encounter History

No.	Type	Program	Date	Case Worker	Contact	Status	Service
1	Case File	EISEP	07/06/2009	Mariel Walsh	Carpenter,Clarissa	Open	-
2	Intake	EISEP	06/29/2009	Mariel Walsh	Comenale,Rita & Louis	Casefile	-

Program History

Program	Case Manager	Status
EISEP	Mariel Walsh	Open
Eldersource	Elaine Dalconzo-Growe	Closed
STAR	Liz Fowler	Closed

Community Care Summary (continued)

Services Receiving			
Adult Day Health Care	No	Provider	
Caregiver Support	Yes	Provider	EISEP/Mary Anne Angelo
Case Management	Yes	Provider	EISEP / Mary Anne Angelo
Community-Based Food Program	No	Provider	
Congregate Meals	No	Provider	
Equipment/Supplies	No	Provider	
Escort	No	Provider	
Friendly Visitor/Telephone Reassurance	No	Provider	
Health Insurance Counseling	No	Provider	
Home Health Aide	No	Provider	
Home Delivered Meals	No	Provider	
Homemaking/Personal Care	No	Provider	
Hospice	No	Provider	
Housing Assistance	No	Provider	
Housekeeping/Chore	Yes	Provider	Through EISEP Angels
Legal Services	No	Provider	
Mental Health Services	No	Provider	
Nutrition Counseling	No	Provider	
Occupational Therapy	No	Provider	
Outreach	No	Provider	
Personal Emergency Response System (PERS)	No	Provider	

Community Care Summary (continued)

Protective Services	No	Provider	
Respite	No	Provider	
Respiratory Therapy	No	Provider	
Senior Center	Yes	Provider	Has not attended Gates Sr. Center, St. Judes in a month
Senior Companions	No	Provider	
Services For The Blind	No	Provider	
Shopping	No	Provider	
Skilled Nursing	No	Provider	
Social Adult Day Care	No	Provider	
Speech Therapy	No	Provider	
Transportation	No	Provider	

Informal Support	
Does the person have a family, friends and/or neighbors who help or could help with care?	Yes
Primary Contact Name	Angelina, Daisy (Daughter)
Degree of involvement (Type of help/frequency)	Dght is involved, and helps out as much as clt will allow.
Does the person appear to have a good relationship with this person?	Yes
Explain/Describe	
Would the person accept help, or more help, from this person in order to remain at home and/or maintain independence?	Yes
Explain/Describe	
Any factors that might limit this person`s involvement?	Family Responsibilities
Is caregiver relief needed?	No

Community Care Summary (continued)

If Yes, when?	
Secondary Contact Name	
Degree of involvement (Type of help/frequency)	
Does the person appear to have a good relationship with this person?	
Explain/Describe	
Would the person accept help, or more help, from this person in order to remain at home and/or maintain independence?	
Explain/Describe	
Any factors that might limit this person`s involvement?	
Is caregiver relief needed?	
If Yes, when?	
Overall Evaluation of Informal Support	
Can other informal support(s) provide temporary care to relieve the caregiver(s)?	No
If yes, describe.	
Does the person have any community, neighborhood or religious affiliations that could provide assistance?	No
If yes, describe who might be available, when they might be available and what they might be willing to do.	

Assistive Devices

Devices Used	Cane	Devices Needs		Client/Caregiver needs training to use devices	No
If Yes, Explain		Oxygen Dependant	No	Dialysis	No

Community Care Summary (continued)

Benefits					
EPIC	Has Benefit	LTC Insurance	Does Not Have	Medicare	Has Benefit
Medigap Insurance/HMO	Has Benefit	Food Stamps	Refuses to Apply	Medicaid	Not Eligible
Public Assistance	Not Eligible	QMB	Not Eligible	SLIMB	Not Eligible
HEAP	Has Benefit	IT 214	Has Benefit	Telephone Discount	Has Benefit
Aged STAR Exemption	Has Benefit	Veteran Tax Exemption	Not Eligible	Real Property Tax Exemption	Maybe Eligible
WRAP	Does Not Need	Railroad Retirement	Not Applicable	Social Security	Has Benefit
SSD	Not Eligible	SSI	Not Applicable	VA Benefits	Not Eligible
Reverse Mortgage	Does Not Have	Section 8 Housing	Not Eligible	Cable Discount	Has Benefit
Lifeline/PERS	Refuses to Apply	SCRIE	Not Eligible	Health Insurance	Has Benefit

Housing Falls					
Fall within past year	No	Living Alone and > 85 years old	Yes	Cognitive Impairment	No
Cardiovascular Changes	No	Sensory Impairment	Yes	Neuromuscular Changes	No
Depression	Yes	Urological Changes	No	Stress	No
Malnutrition	No	Polypharmacy	Yes	Dehydration	No
Substance Abuse/Use	No	Acute Illness	No	CVA History	Yes

Housing Safety					
Accumulated garbage?		Dirty living areas?		Bedroom-bath traffic lane has obstacles?	
Cluttered stairs/walkways?		Cords/wires across walkways?		Doorway widths are inadequate?	
Exposed wiring/electric cords?		Inadequate heating/cooling?		Inadequate hot/cold water?	

Community Care Summary (continued)

Inadequate lighting in living areas?		Insects/vermin?		Loose scatter rugs in one or more rooms?	
No access to phone/emergency numbers?		No grab bar at toilet/bathtub?		No handrails on stairways?	
No light or switch in reach of bed?		No locks on doors/windows?		No rubber mat/decals in bath tub/shower?	
No telephone near bed?		Bad odors?		Carbon Monoxide detectors not present/not working?	
Smoke detectors not present/not working?		Plumbing problem?		No lighting in bathroom or hallway?	
Stairs are not well lit?		Stairs are in poor condition?		None Apply/Satisfactory	y

Housing Information

Type of Housing	Single Family	Housing Status	Own	Is Neighborhood Safety an Issue	No

Legal Information

Power of Attorney	Yes	Power of Attorney Name	Angelina, Daisy (Daughter)	Power of Attorney Type	
Do Not Resuscitate (DNR) Request	Yes	Health Care Proxy	Daisy (Dght)	Living Will	Yes

Medical Information

Has Medicaid	No	Medicaid No.		Medicaid Pending	
Date Applied (mm/dd/yyyy)		Has Medicare	Yes	Medicare No.	1232232323A
Medicare Type	A, B and D	Prescription Coverage Plan	EPIC	Health Ins Provider	Preferred Care
Health Ins. No.		Secondary Health Ins. Provider		Secondary Health Insurance No	
Other Health Ins. Provider		Other Health Insurance No		Physician	Santiano, MD, S (Doctor)

Community Care Summary (continued)

Hospital		Primary Pharmacy Name	Sidney Hillman	Primary Pharmacy Phone	473-2555
Clinic/HMO		Medical History/Health History	Medical History/Health History	Chronic Illness/Disability	Arthritis
Possible Action	* May indicate need for assessment by nutritionist	Insulin Dependant	No	Other Diagnosis/Allergies	Clt saw orthopedic surgeon Dr. Dolan, for knee replacement surgery.
Date of last visit to Primary Medical Provider	03/01/2009	Visit Doctor less than once a year	No	Require Comprehensive Medical Exam	No

Nutrition Information

Height - Feet	5	Height - Inches	6	Weight (LBS)	150
Body Mass Index(BMI)		Possible Action	If BMI is under 20 or over 30, make referral to dietitian	Nutrition Problems	
Nutritional Challenges		If Yes to Nutritional Challenges, describe.		If Yes to Physician Prescribed Modified Diet,indicate diet type.	Diabetic
Does the person follow this modified diet?	Yes	If No to Physician Prescribed Modified Diet,indicate diet type.		Weight changes in past 6 months	No
If Yes, How Many Pounds (+ Gained/ - Lost)		Possible Action	If unplanned weight change is more than 10 pounds in a six month period, make a referral to dietitian	Number of meals taken daily	3
Does client ever go without food	No	If Yes, Explain		Does client have adequate food in home	Yes
Does client have a modified diet		If Yes, Explain		If Yes, Does client follow	

Community Care Summary (continued)

Psych/Social Information					
Cognitive/Emotional Status	Acceptance of Help	What are the client identified strengths	Clt is proud of her family and on going friendships. She is proud of her hard work throughout her life, and her independence.	Substance Abuse	No
If Yes, Explain		Problem Behavior Reported	No	If Yes, Explain	
Diagnosed Mental Health Problem	No	If Yes, Explain		History of Mental Health Treatment	No
If Yes, Explain		Mental Health Evaluation Needed	Yes	If Yes, Explain	While client might benefit from PATHS for her depression, she refuses.

Nutrition Screening Information

Program	Author	NSI Date	Total Score	Conclusion	Follow Date
EISEP	Mary Anne Angelo	04/22/2009	4	MODERATE	-
EISEP	Mary Anne Angelo	10/08/2008	4	MODERATE	-
EISEP	Mary Anne Angelo	04/23/2008	2	LOW	-
EISEP	Mary Anne Angelo	10/31/2007	2	LOW	-
EISEP	Mary Anne Angelo	04/27/2007	3	MODERATE	-
EISEP	Mary Anne Angelo	10/20/2006	4	MODERATE	-
EISEP	Mary Anne Angelo	03/31/2006	2	LOW	-
EISEP	Mary Anne Angelo	09/28/2005	2	LOW	-

The Connection

- Through Rochester RHIO, the PeerPlace® reports are made available to the patient's medical team or emergency physicians.
- As with all Rochester RHIO access, patients must first sign a consent form for their information to be viewed using the electronic health information exchange.

The Connection

- Benefits to seniors and the local health system include:
  - Better transitions of care for patients through more informed discharge planning by enabling collaboration for community support needs for safe patient discharges.
  - More informed office visits because physicians are able to see a full picture of health status, home life, and services their senior patients use.
  - Information is easily shared without patients needing to repeatedly provide documentation or verbal reports.
  - Patient reported information is included, allowing for more engagement by patients in their health care.

Application of Technology to Enhance Coordination and Care

Victor A. Hirth, MD, MHA, FACP, AGSF
Chief, Division of Geriatrics
Medical Director, Geriatric Services
University of South Carolina /
Palmetto Health
Columbia, South Carolina

Administration on Aging

Principles of Effective Technology Application
Tier 1 - Interconnection

- Health Records accessible and consistent across all care settings (compatible & integrated)
  - Lab, micro, radiology
  - Physicians, nurses, social work, PT, and others
- Single point of access for all providers
  - Common record
- Access across all devices
  - PC, laptop
  - Tablet type, smart phone

Administration on Aging

What does this mean for you?

- When contracting with software vendors/suppliers make sure that contact states the new product will be compatible with your systems
  - Data transfer one way or two way
  - Backward compatible (age of operating system)
- Single log-on or multiple, does it change what you do?
- How many types of devices will it run on?

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Tier 2 – Protocolize and Standardize

- Assessments integrated into EHR across disciplines
- Identification and assessment of high risk patients
  - Fall risk
  - Delirium
  - Rehospitalization
- Standardized approaches to patients identified as "high risk"
- Ongoing data collection and monitoring for outcomes

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What does this mean?

- Can you add what you want in the context of Joint Commission on Healthcare Organizations (JCAHO), College of American Pathologists (CAP), Medicare, and other requirements?
- What we want is “different” than usual disease, organ-based or financial (billing) reporting systems. Ask your vendor, “Can your system do this? Show me.”
  - Activities of Daily Living, Timed up and go, gait speed
  - Social support network, financial resources
  - Cognitive function, depression
  - Availability of transportation

Administration on Aging

Tier 3 – Data tracking and monitoring across all environments including home

- Physiologic health monitoring everywhere
  - Vital signs, weight, oxymetry
- Activity and “routines” monitoring
  - Track changes over time & understand variability
  - AI understanding of variability of gait speed, gait pattern, “life space,” sleep quality, food intake etc.

Administration on Aging

Convergence in the Wireless World

NETWORK EVOLUTION	MOBILE DEVICE EVOLUTION	SERVICE EVOLUTION
Co-existence of Different Access Networks for Various Needs	Convergence of Wireless Computing & Consumer Electronics	Same Rich Applications and Services in all Environments

Administration on Aging

Continua Healthcare for Consumers

Administration on Aging

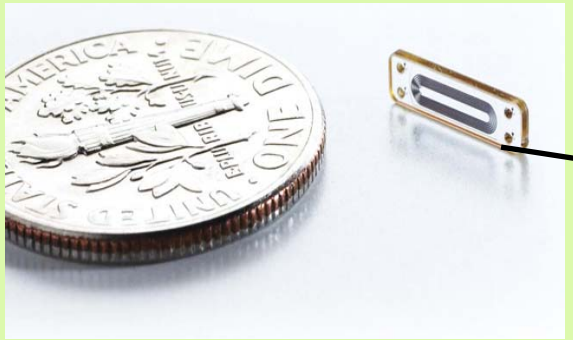
How would we enhance an existing 50% electronic project?

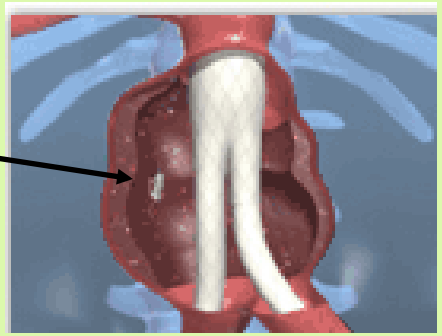
- Integrate Care Management into EHR
  - Pharmacist med review and recommendations
    - What's on formulary
    - What's affordable
    - Minimize medication related side effects
  - Occupational Therapy assessment > recommendation for assistive device to help get out of bed
- Add integrated messaging and portals for all providers
- Home monitoring and self management
  - Caregiving, medication, fall prevention, Chronic Disease

Administration on Aging

Wireless Mobile Devices and Biosensors Will Transform Healthcare

Wireless Implants





Wireless Diagnostics Devices

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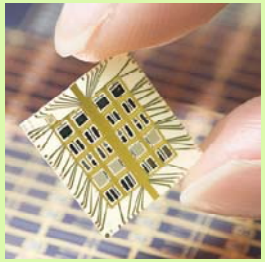
Targeted Drug Therapy

MICROCHIPS™



Remote, Mobile Clinics

Apollo Hospitals Group
touching lives

Administration on Aging

Medication Management

Proteus Biomedical

Alzheimer's

MI Medical Intelligence

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Conclusion

- Wireless technology is moving medical care into the community including home
- Reimbursement not consistent with modern capabilities (i.e. face-to-face)
- Remote monitoring, remote control of medical devices close and coming soon
- Devices are ready, but applications need to be developed, i.e. let's make sure we know what problem we're treating before throwing technology at it.
- System integration and communication is paramount

Administration on Aging

Contact information

SeniorSMART.org

Victor.hirth@palmettohealth.org

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Resources: Care Transitions

- http://www.healthcare.gov/center/programs/partnership/index.html (Partnership for Patients)
- http://www.cms.gov/DemoProjectsEvalRpts/MD/itemdetail.asp?itemID=CMS1239313 (Community-based Care Transitions Program)
- http://www.aoa.gov/Aging_Statistics/Health_care_reform.aspx (AoA's Health Reform page)
- http://www.aoa.gov/AoARoot/AoA_Programs/HCLTC/ADRC_CareTransitions/index.aspx (AoA's Aging and Disability Resource Centers Care Transitions page)
- http://www.adrc-tae.org/tiki-index.php?page=CareTransitions (AoA's Aging and Disability Resource Centers Technical Assistance Exchange care transitions page)
- http://www.cfmc.org/caretransitions/Default.htm (Care Transitions Quality Improvement Organization Support Center)
- http://www.ltqa.org/wp-content/themes/ltqaMain/custom/images//Innovative-Communities-Report-Final-0216111.pdf (Innovative Communities report from the Long-Term Quality Alliance)

Resources: Health Information Technology

- http://healthit.hhs.gov/portal/server.pt/community/healthit_hhs_gov__hitech_programs/1487 (The Beacon Communities Health Information Technology for Economic and Clinical Health [HITECH] Act programs)
- http://www.kaiseredu.org/issue-modules/health-information-technology/background-brief.aspx (Kaiser Family Foundation Health Information Technology Background Brief)

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Resources: Affordable Care Act

- http://www.aoa.gov/Aging_Statistics/Health_care_reform.aspx (AoA's Health Reform web page – where webinar recordings, transcripts and slides are stored)
- http://www.healthcare.gov (Department of Health and Human Services' health care reform web site)
- http://www.thomas.gov/cgi-bin/bdquery/D?d111:1:./temp/~bdsYKv::|/home/LegislativeData.php?n=BSS;c=111| (Affordable Care Act text and related information)

Next Training

- *Utilizing Patient-Centered Technologies to Support Care Transitions*
  - Tuesday, June 21, 2:00-3:30 pm Eastern
  - Watch your email for registration information

Questions/Comments/Stories/ Suggestions for Future Webinar Topics?

Send them to:

AffordableCareAct@aoa.hhs.gov