Administration on Aging
Affordable Care Act Training
Building Community Technology Systems to Support Care Coordination
May 31, 2011
2:00 - 3:30 pm Eastern

Coordinator: Thank you for standing by.

At this time all participants are in a listen only mode until the question and answer of today's conference. At that time you may press star 1 if you'd like to ask a question.

I'd like to inform all parties this call is being recorded. If you have any objections you may disconnect at this time.

I now will turn the call over to Ms. Marisa Scala-Foley. You may begin, ma'am.

Marisa Scala-Foley: Thank you so much, Lori. Good afternoon everyone, good morning to those of you on the West Coast. My name is Marisa Scala-Foley. And I work in the Office of Policy Analysis and Development at the Administration on Aging in Washington, D.C.

We thank you so much for joining us today for our latest - AOA's latest, our sixth actually -- in a series of webinars 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.

As you know if you've been with us on past webinars our focus has been on the important topic of care transitions, patients or clients going from one care setting to another from hospital to home, from hospital to skilled nursing facility, from skilled nursing facility to home and more.

So these webinars are really designed to provide the Aging Network with the tools that you need to help to develop care transitions work in your area.

We actually developed today's webinar in response to some of the past webinar chat comments to us that asked us to take a look at the role of technology in care coordination and care transitions.

This is the first in a two part series and we'll continue it in June. That will examine this important topic.

So before we - right now let me go through a couple of housekeeping announcements before I introduce our speakers. If you have not yet done so please use the link that was included in your email confirmation from WebEx to get onto WebEx so that you can not only follow along with the slides as we go through them but also ask your questions when you have them through chat which will be the main way through which we will take questions throughout the course of this webinar.

If you - for some reason you don't have access to the link that was emailed to you you can also go to www.webex.com, again that's www.webex.com. Click

on the Attend the Meeting Button at the top of the page and then enter our meeting number which is 669837936. Again that's 669837936 to get onto WebEx and to be able to follow along with us as we move through the slides and so forth.

If you have any problems with getting into WebEx, please do call WebEx Technical Support at 1-866-569-3239, again that's 1-866-569-3239 to report any problems that you may have getting into WebEx.

As Lori mentioned all participants are in a listen only mode right now. However we do welcome your questions throughout the course of this webinar. There are two was you can ask your questions. First, as I mentioned before through the web using the Chat Function or the Q&A Function in WebEx. You can enter your questions and we'll sort through them and answer them as best we can when we take breaks for questions after each presenter or group of presenters goes.

In addition after the presentations wrap up we'll offer you the chance to ask your questions through the audio line. When that time comes Lori will give you instructions as to how to queue up to ask your questions.

If there are any questions we can't answer during the course of the webinar, we will follow-up to make sure that we get your questions answered. And if you think of any questions after the webinar you can also email them to us at affordablecareact@aoa.hhs.gov, again that's affordablecareact@aoa.hhs.gov.

All of these email addresses are included in the PowerPoint slides that are the basis for this webinar.

And we always get a lot of questions about this. You can't print out the webinar slides from WebEx at this point. We will post them on the AOA web site along with a recording and transcript from this webinar likely within about a week after this webinar concludes.

So we will - and if you need them sooner you can also email us at that affordablecareact@aoa.hhs.gov email address.

So I think that's just about - oh, one last thing is as Lori mentioned we are recording this webinar. And that will as I mentioned be posted on our web site within the next week or so.

So now let me go ahead and introduce our - we have a wonderful panel of speakers with us today. We - and let me introduce in the order in which they will speak.

The first speaker will be Janhavi Kirtane who's Director of Clinical Transformation with the HHS Office of the National Coordinator for Health Information Technology.

Second will be Lauren Capizzo, Senior Manager of Health IT and Practice Improvement with Quality Partners of Rhode Island. She will be teaming up for a presentation with Joe Russell who's a Business and Systems Analyst with the Rhode Island Quality Initiative.

After the team from Rhode Island goes we will have Corinda Crossdale who's the Director of the Monroe County Office for the Aging in Rochester, New York.

And our final presenter will be Dr. Victor Hirth who is the Medical Director for Geriatric Services at Palmetto Health and Professor and Chief of the Division of Geriatrics at the University of South Carolina.

So with that I will turn things over to Janhavi to kick things off by introducing us to the Beacon Communities. Go ahead, Janhavi.

Janhavi Kirtane: Thank you. Good morning or good afternoon everyone. And Marisa, can I advance my slides or will you do that for me?

Marisa Scala-Foley: I will do that for you.

Janhavi Kirtane: Okay, great. So I wanted to start us off with a picture before we get into the details. We were just in Mississippi a few weeks. And it was so exciting from their perspective, from our perspective and to quote from Ricky who works for the Department of Health in Mississippi said we have a moment.

And before there had been so much hard work continually underway from community workers, social workers, physicians, nurses, families to try to make sure that our system does the best that it can for everyone who's participating.

And the before picture if you will is what happens when the wind is not at our sails.

And the after and the excitement in Mississippi was that we have a moment with what several of us across the country and in Washington are trying to do to try to support and align incentives to really weave together a lot of the wonderful work that has already been underway.

And it was an exciting story in Mississippi and I wanted to share that with you all.

But with that let's shift gears and talk a little bit about the ONC at a high level before I get into the details of the Beacon Program.

So last year a lot of the ONC and that's the Office of the National Coordinator for Health Information Technology for those of you all who are less familiar with it, released a series of programs that we considered foundation building around information technology in the healthcare space.

And that began with Meaningful Use, support for Meaningful Use Incentive Payments coming out this year. And then it transformed forward with those four - three boxes in red around regional extension centers which is helping bring primary care physicians up to Meaningful Use, a lot of work on state Health Information Exchange and then the Beacon Community Program.

And the key message here rather than talk about the detail of every program is how to fundamentally bring investments and health information technology forward. But then use those as a mechanism to really transform and improve and modernize our healthcare system.

I'm going to talk in more detail about the Beacon Community Program but I do want to just mention and perhaps we can pursue this on another call, there's a lot of terrific work happening across our agency. Within the Health Information Exchange Program there are several challenge grantees who are focused exclusively on long-term care and there's a lot of regional extension center work when practices are being assisted getting to Meaningful Use that will also touch many folks in the aging community.

So with that let's transition to the Beacon Community Program. This is if you consider those other programs spreading like peanut butter across the country, the Beacon Community Program is looking at 17 communities specifically on average getting about $50 million over three years.

And there are three core aims. Build and strengthen again that foundational HIT investment that's really in the interest of improving quality, cost and population health.

And then we also want to number two, demonstrate the impact on these interventions. So not investments in HIT for the sake of it, we want to say what is the actual IT enabled intervention?

Was it clinical decision support?

Was it helping a care manager actually use information in a different way to do his or her job better?

And then third most importantly in some ways is to test and disseminate these innovations to improve health and healthcare. One of the things that we say a lot here is that yes, we're focused on our three years with the 17 Beacon Communities.

But we are a country full of Beacons and we are just as concerned of what's happening in communities 18 through 50 and beyond because the country needs to kind of it's a Beacon Nation Movement if you will.

Next slide please.

So this is a visual for you as to where across the country our Beacon Communities are. You'll see that they're everywhere from Hawaii to Maine. We're excited to have our Rhode Island Beacon Community on the phone as well.

But the interesting part not only just the geographic, the diversity that's represented here, the structure of the Beacon Communities is very different. The partners involved span from hospitals to primary care physicians to social work organizations to state departments of health to advocacy organizations.

So if you've seen one Beacon you've just seen one. But there are a lot of common threads that interdisciplinary partnership and the commitment to the triple aim goals being just a few of them.

Next slide please.

So I wanted to spend a little bit more time on the next couple slides drilling down into specific interventions. And again as we think of that first aim of IT that foundational HIT investment, these are what we've been calling those interventions.

So how are people actually using the IT investments to reach those quality costs and population health goals?

Number one, not a surprise to folks on this call, transitions of care. We have every community is working on transitions broadly defined. I know that people in the healthcare world these days think of transitions of care very specifically or broadly.

But every single community is looking at how patients and families move through our system. There are quite a few focused on care management whether that's care management centered in an emergency department, in a primary care setting or as the discharge is happening.

And there's quite a few actually looking at a more leveraged model of in rural communities you can imagine, what is the opportunity for a more community-based care manager who maybe doesn't reside in an actual setting of care?

Community, sorry, computerized clinical decision support, so we have many communities that have already made investments in HIT and what are they actually doing to make sure that the triggers for physicians or nurses or medical assistants in the offices are actually helping them manage their at risk population more effectively?

To date this has been happening more in physician offices and hospitals but we've heard a little bit more of exploring what could be possible with post-acute providers, physician data reporting and performance feedback.

So an example of this is where we have information on how a set of providers might be performing. How does providing that information back to these physician practices help them actually manage their patients better and improve their own quality improvement processes?

Public health registry-based management so an example of this would be what is a community doing to use immunization registries for example and embedding those with the Department of Health? There's a couple communities exploring interventions like that.

Then the final catchall, I mean I don't - again one Beacon is just one Beacon. But there are several examples of using mobile health technology, telemedicine, personal health records and other kind of more consumer engagement tools to try to again see what's possible in terms of the known intervention space. But potentially also explore what might be innovative.

So next slide please.

This is a quick overview of some numbers. Our latest estimates are suggesting that our Beacon Communities are touching about 2.5 Medicare lives. But here's a set of what we're estimating might be happening this year.

Each Beacon Community was requested to include what their target populations are and a geographic catchment area. And we're hoping and excited for a very expansive story which I think these numbers suggest.

Next slide please.

Now let's talk a little bit about the transitions focus since that's why we're all here. Dr. Joanne Lynn, we're very fortunate to be working with her as part of our Technical Assistance Team also led by IHI on the Clinical Transformation side. Twelve of 17 communities are focusing in a very deep way on care transitions.

And you'll see in here we've kind of broadly defined that as reducing hospital utilization but in terms of the target population it's not just the elderly.

So we have quite a few who are looking at - it could be Medicaid or uninsured or commercially insured patients who have a higher risk for readmission.

And we're also looking at pediatric populations potentially specifically around asthma quite often.

Now one of the things that we're doing is not only just looking at the interventions that I described on the prior page and we'll get into it a little bit further but we are very much looking at how can we codify a lot of what we're learning within the communities, develop toolkits around some of these interventions and then share with groups like the folks that are on this phone to try to spread and connect with some of the national initiatives underway.

Next slide please.

So a few specifics about the interventions and again I'm excited to hear about the two community stories because we'll able to get into a lot more detail.

So if we look at that aim of readmissions to hospitals but then also avoidable ED visits, these are the core interventions that are showing up here. Providing that hospital discharge information whether it's a medication or labs to the next handoff point be that a provider or a post-acute provider, sorry, physician provider, a post-acute provider or anybody else actually in the community who could benefit from that information.

We are seeing some communities looking for a much stronger link between their emergency departments and specifically PCPs in the community or again other community organizations that could benefit from knowing who the frequent users of emergency rooms are.

We're also looking at more communication between PCPs and specialists to try to again help with use of how specialty referrals are actually being - I'm

sorry, actually being used in communities but then also close that feedback loop.

And then as I mentioned before with mobile health and personal health records we are seeing a lot more exploration on community and family engagement.

The one piece I wanted to bring up specifically, we have what we've called internally as a kind of a uniting of the tribes. There has historically been such a bright line between quality improvement and health improvement and HIT. And our aspiration is to really bring together these stories of improvement and technology to best serve the interests of patients and the providers who are working in the system.

Next slide please.

So I wanted to share a little bit of what we've learned and I'll attribute this to Carol Beasley from IHI who's been leading a lot of our clinical transformation work. There's a big question of what have we learned and how are we going to get this done?

And the cartoon as it says here, there's this complicated math equation and somehow to get to the other side of the bridge this miracle occurs.

And there is no miracle as I'm sure many of you on the phone have been working at this for a long time. The miracle, focus and hard work is what we've discovered after one year.

And I put forward four challenges. I'm sure maybe Rhode Island could speak a little bit more to these specifically.

But this is a community wide story. And nurturing how a community can begin to take on a topic like transitions of care is certainly something that's challenging. And we've had - we've learned quite a lot about different communities on how they've taken on that journey and what's taking - what it's taking to stay successful and stay focused.

Third, I'm going to jump to three because we did mention focus, scaling the interventions is really - it's great to talk about moving from three provider practices and then all of a sudden hitting 60.

But actually being able to learn and do and move across the boundaries of organizations is much easier said than done. And of course along the way after your three the money goes away, so making sure that payers, employers, and others in the community who can really think about sustainability has been something that's top of mind.

Next slide please.

So as I close one thing I wanted to kind of put a call out to everybody on this - everybody who's listening today. The Beacon Communities are about demonstrating what's possible in the 17 communities but there is a mandate of ours to serve as testing grounds for whatever the latest and greatest could be to try to advance the care for people using HIT.

And we would love to hear from you. As you think about those geographies that are on the map and maybe some of your experience about how to use HIT of what you think might be possible.

And we would love for you to be as creative as possible. Those, you know, social network, community workers, really leveraging technology in a new and exciting way is something we would love to hear about.

So that is it. Thank you, Marisa, (unintelligible) information there.

((Crosstalk))

Marisa Scala-Foley: Janhavi, great. We actually got one quick question that I think we can take right now.

We got that from Elizabeth, who asked can - on the slide that talked about challenge number three, she wanted to know what you meant by scaling interventions.

Janhavi Kirtane: Okay. So basically I described before that each Beacon Community was asked to define a geography and a population that they wanted to focus on.

And if we use an intervention like deploying care managers to try to better manage high risk patients, the way the communities have taken that on is they'll say we have a target diabetic population that we estimate to be high risk of 25,000. I'm just making this up.

And so how does one begin to think about? And those patients are seen by multiple different providers across multiple different systems.

And so the challenge of scale becomes I need to get from zero to 25,000 patients. How do I begin to organize around that, right, so both from a just operational standpoint but then also from a governance standpoint because every organization wants to do this differently and it involves interfacing with

several different types of physicians and nurses and again governance bodies to make - to really make community change real.

Does that explain it better?

Marisa Scala-Foley: I think that helps a lot. Elizabeth, if you have any further questions please do enter them via chat.

With that I think we will move along and move to Rhode Island as a matter of fact. And allow our next set of presenters to go who we have Joseph Russell from the Rhode Island Quality Institute and Lauren Capizzo from Quality Partners of Rhode Island.

So Joe and Lauren, I will turn things over to you.

Joseph Russell: Thank you very much. This is Joe Russell. And before we begin talking about our project I thought we'd give you an understanding of who we are.

I work for the Rhode Island Quality Institute which is a not-for-profit organization founded in 2001. It has a statewide multi-stakeholder collaborative with the mission of improving quality, safety and the value of healthcare.

Our Board consists of many different types of people, physicians, consumers, health insurers, professional business people and state government.

And it goes beyond the Board. We have a wide range of collaborative reach with other entities and other projects that we're doing as well as other entities are doing out there in the State of Rhode Island.

So with that said as Janhavi has pointed out, the Rhode Island Quality Institute was the only award winner for all three grants. One for the regional extension center, one for the statewide Health Information Exchange and one for the Beacon grant.

And that's what we're here to talk about today is one of the many projects that the Rhode Island Quality Institute is working on and that's in our Beacon Communities Program, that if you can go to the next slide for me, and what we're covering is and Janhavi basically had pointed out these high points. Demonstrating the health IT, supporting lasting innovation networks through our wide range of stakeholders and to provide lessons, implementation, insights, and best practices.

So she already covered the program objectives. So let's just go jump right into our actual long-term care HIE rollout project.

One of the things we noticed is that a lot of times we don't put on the front burner our long-term care facilities. So in Rhode Island we wanted to reach out and complete the loop of data sharing amongst our Beacon providers by helping 100% of our long-term care facilities in the State of Rhode Island access current care which is our state HIE. We want to be able to ensure that our treating physicians in the nursing home or in a specialist office or in the emergency room have timely and accurate information at the clinical point of care.

We want to be able for these facilities to perform onsite technical assessments so what we're doing is we're sending someone out there. We're going to look at their technical - their capabilities as far as desktop computers, wiring and taking that back.

Then we're going to purchase and install all the necessary computer equipment that nursing home or long-term care facility will need. Once that's been placed then we're going to provide training and guidance on using current care to improve patient safety.

So what are the benefits of targeting our long-term care facilities?

Next slide please.

We want to increase our care coordination and communication between primary care physicians and the broader community. This gives us the opportunity to address care coordination for our patients who as a group are likely to have significantly higher comorbidity as we all know, and they pose a greater challenge in care coordination.

Hopefully, you know, as there's a potential decrease in hospitalization utilization, because we will be able to give the long-term care facilities easier access to clinical information regarding the residents and patients and allow them to have if they did go to the hospital the communication or discharge papers electronically through our HIE.

Now that is a big benefit. And to help us get to our benefits and realize our goal we are partnering with Quality Partners of Rhode Island and Lauren Capizzo is going to take over and explain what they've done up to this date.

Lauren Capizzo: Thank you so much, Joe. Yes, my name is Lauren Capizzo. I'm the Senior Manager of Health IT and Practice Improvement at Quality Partners. We're very excited to be working with Joe and Quality Institute under the Beacon Community Project.

Joe shared with you some of the benefits and the goals of the project. I'm just going to share with you how we've delivered this message of the value of current care to our long-term care community, where we stand today and a little bit of our lessons learned.

So I'm going to tell you a little bit quickly about Quality Partners. We are the Quality Improvement Organization for the State of Rhode Island. That's the QIO. We manage CMS's QIO contracts.

Through our CMS sponsored work as a QIO from 2003 and 2006 we were the QIO Support Center nationally for the long-term care community also known as the QIOSC.

Starting in 2005 we were selected to facilitate nationally the Advancing Excellence Campaign which works with nursing home facilities to bring about systems change both around clinical quality improvement work and individualized care.

Rhode Island, not only did we facilitate this project, but Rhode Island was actually the first state to voluntarily achieve 100% participation in advancing excellence and we're still one of only a few select states to have this distinction. I think that that is very helpful to kind of bridging this gap and starting with the Beacon Project.

So if we could go to the next slide please.

Using our model of spread and collaboration that was so successful in advancing excellence we developed this call to action. So let's be the first state in the nation to have 100% of its nursing homes participating in the statewide HIE, the brand name known as Current Care.

In Rhode Island we have approximately 85 nursing home facilities. And at the point of introducing this call to action it was this past January, 2011, we had about 23% participation rate of long-term care facilities as enrollment partners.

So I'm just going to share with you if we go to the next slide, how we increased the participation using this as our driving message so this is just a little bit about our strategy.

The first thing that we did that was really important was to secure the commitment of some critical long-term care stakeholders. I think we're very fortunate in Rhode Island to have strong relationships with the State Long-Term Care Ombudsman as well as the two nursing home trade associations, Leading Age Rhode Island and the Rhode Island Healthcare Association.

And when we began this recruitment campaign, you know, one of the first things we did was to have some Strategic Planning Meetings with this group to get their endorsement of the project, to help them understand, you know, the mission and the vision and also to co-brand whenever possible.

And I think hearing the support from the trade leadership has been very helpful in our campaign.

Building awareness number two, in the long-term care community via traditional. This tiered communication campaign included traditional marketing and communication methods like web sites, press releases and whatnot.

But we also did other things. Communication through the trade associations that I mentioned, sending some information out on some listservs that we manage and sponsoring Current Care tables at conferences that we knew nursing home administrators would be there just to really solidify the brand in this community.

Number three, we had the state agencies, the Department of Health, the Department of Health and Human Services and under the Department of Health it was the HIT Coordinator and the Survey and Certifications Team. They co-authored a letter of support for Current Care and endorsing or encouraging nursing homes to participate.

And I think that that was very helpful. You know Quality Partners' work both as a QIO on the Beacon Project and other whether grant or private projects has given us an opportunity to really work deeply with the long-term care community so encouraging participation, you know, at any appropriate touch point.

Lastly, we convened a Current Care Summit in March of this year. We hosted this to gather the whole community together to let the colleagues that were already participating share their experience with those that might be interested and tell them a bit more about the project and also to tell them about the funding that Joe mentioned to support computers at the clinical point of care.

If you want to go to the next slide, this is just a quick snapshot of our recruitment timeline. As I mentioned we have approximately 85 LTCs. In March of last year we had 8 long-term care facilities that were participating in the pilot.

In November we upped that number by 12 to 20 and as a result of the call to action in March right after the Breakfast Summit we had 52 nursing homes participating. Now we have 60 and we have 25 more to go.

If you want to move to the next slide, this is a brief lessons learned.

So I'm not going to go into every single one in detail. We talked a lot about the leadership and number one, building off the existing relationships has been critical especially because these nursing homes have so many conflicts, competing priorities, and asking them to do one more thing is just a real challenge. So I think that that's been helpful to have those relationships.

Number three, it talks a little bit about what Janhavi was mentioning, setting measurable goals and timelines. In Rhode Island we have an opt-in model so it's important to have everybody enroll individually as a member of the Current Care System and so working with nursing homes to make those goals of increasing the enrollment of their residents, you know, that are eligible to enroll across the nursing home in a measurable way I think is really important and setting reasonable timelines with them.

Making the delivery model flexible; we will go out and work with them off shift. We'll go early morning. We train them locally onsite or, you know, we've hosted group trainings. We really try to do anything to help establish this process as part of their workflows. And we make - we take the recommendations that they've offered us.

So number five to that point, providing a vision and letting the long-term care community be part of the process. I think Quality Institute and the team of people who have been developing Current Care for awhile have really opened up the opportunity for these long-term care facilities to share their perspective

of things that are important to them so that they are really part of this and the ultimate goal of this tool is very useful to them.

So if we want to go to the last slide, I just wanted to share with you the resident's perspective.

So this is a picture of (Mary Crockett). She is one of our local elders. She's a resident at Jeanne Jugan Little Sisters of the Poor. And she's also a member of Current Care.

Little Sisters of the Poor was one of our first enrollment partners who had participated out of those eight original pilot homes starting a few years back.

And they were the first home to achieve 100% of enrollment of their eligible residents across the facility.

This is a picture of Mary signing up. And her quote says you know it's such a relief to know that if I go to the emergency room the doctors and nurses will have access to the labs and tests done at the nursing home by - and by any of my specialists. It's a load off my mind.

And, you know, I think it speaks to the message that Little Sisters have been able to share with their residents. And also the message overall about what this project is about and who this project is for.

You know Little Sisters as well as Mary's treating providers can have access to her critical health information at the right time and be able to make the best decision possible with the, you know, the information that's available.

So I just wanted to share that as well. Thank you.

Marisa Scala-Foley: Okay. We got a couple of questions in Joe and Lauren via chat. The first one actually came from a couple of people and Joe I saw that you posted something in the Q&A but maybe you can also answer this over the audio line as well.

And we ask - got a couple questions from a couple people about what is Current Care? Could you describe it in just a little bit more detail?

Joseph Russell: Absolutely. Current Care is our state Health Information Exchange. As Lauren has explained you can opt-in. It's not mandatory. It's not statewide. If you - you have three options. You can have your medical records sent all of it or you could only have information sent to our state HIE if it's an emergency situation or you can select the doctors that'll have access to the information or which doctors will report your information into the state HIE.

So Current Care is just the name of the state HIE.

Marisa Scala-Foley: Okay. And along similar lines we actually got two questions in from Jennifer, but the first one relates really well to what we were just talking about with regard to Current Care.

And she asks; in Rhode Island do all healthcare provider systems use the same IT System? How does Current Care sort of interface with that?

And is there any - just using the Current Care System result in any sort of duplicate entry of information if facilities sort of have their own individual systems, IT Systems?

Joseph Russell: They do have their own IT Systems. And they have their own EHRs, electronic health record applications.

And we had to develop interfaces so that information can download into the state HIE.

So yes; so there was 20 - I think right now we're up to number six. There's six different HIE vendors at least in our Beacon Community that we are developing interfaces to the HIE.

And as new ones come on we'll have to build interfaces so they can access the HIE. And that'll prevent duplication.

Lauren Capizzo: And one thing too is that you do not necessarily have to have an electronic health record to access the system. So it is via a web portal, a secure web portal that treating providers can access the health information of their specific patients. You do not have to have an EHR.

Marisa Scala-Foley: Great. Okay, one more question from Jennifer, and then I think we'll turn things over to Corinda.

And that is she asks will you be including assisted living or other community providers sort of non-nursing facility providers in your program at some point?

Joseph Russell: That is - there is a particular long-term care facility here that has skilled and independent living that we have incorporated into this project. It is a possibility that we will go down and look at just the different, you know, assisted living and independent living to be incorporated.

But right now we're just basically focused on our long-term care facilities.

Marisa Scala-Foley: Okay. And actually we will take just one more quick question. And that came from Rachel.

And who asks was the Beacon Award used to assist nursing homes to develop their electronic health records or did they already have EHRs?

Lauren Capizzo: No. It's completely separate. And they don't necessarily have an EHR to be participating in the project. So no, it's just - it's a separate bucket of funding.

Marisa Scala-Foley: Okay, great. I think we did get some other questions coming in but we'd like to keep things sort of moving along right now. We will come back to other questions as time permits toward the end or we'll follow-up with the presenters to get your questions answered.

But with that I think we'd like to hear about Rochester's story in terms of developing community wide technology systems.

And for that we will turn to Corinda Crossdale who's the Director of the Monroe County Office for the Aging. Go ahead, Corinda.

Corinda Crossdale: Okay, thank you very much, Marisa. I'm going to start off with a little background of how we got started here in Monroe County. And I promise you in the end it'll all come together.

In 2006 our then Governor Pataki implemented a restructuring of our long-term care system. And he entered this with three goals in mind. He wanted to implement a nursing home transition diversion waiver. He wanted to create a

point of entry system across all of New York State and he also wanted to create what's called a restructuring waiver or mega waiver.

The nursing home transition diversion waiver is just what it sounds like. It diverts individuals from skilled nursing facilities or transitions them out of skilled nursing facilities and then it puts in place services that wrap around that individual to keep them safe and in the community.

Skipping down to restructuring waiver, that was a similar program where individuals who were in need of nursing home care would receive services regardless of what their disability was and be allowed to remain in the community and have services wrapped around their needs.

Here in New York we did implement the nursing home transition and diversion waiver as well as the POE but we did not implement the mega waiver.

One of the reasons that Governor Pataki wanted to create this restructuring is based on the growth of our aging population. I had a chance to look at the registrants and I saw a lot of individuals who were involved in the Aging Network so it's no surprise that there's a large increase based on the Baby Boomer generation of older adults especially the frail older 85 and over.

So we recognized this in New York State and the Governor and his team said if we don't do anything within the next ten years the system as we know it here in New York State was pretty much going to be unaffordable.

So our charge, next slide please, our charge here in New York State was to implement this point of entry keeping in mind the Olmstead Decision which

states that individuals should receive long-term care services in the most integrated system available.

Next slide please.

And we looked at that and what we did was we created a system throughout all of New York State that promotes self determination. It meets the individual needs of the consumer. This is not a cookie cutter model. The services that are provided are based on individual needs.

And even though we were concerned about cost our first priority was making sure that we provided the highest quality of care. So we didn't necessarily point people in a direction of least cost but what was going to be the best option for them in regards to care.

Next slide please.

One of the other charges that we had across New York State is that POE or point of entry was to create a Long-Term Care Council. Now these Long-Term Care Councils were created in each county throughout all of New York. And their goal was to advise the elected official, the Commissioner of Social Services and the Director of the Area Agencies on Aging about the long-term care system in those particular communities.

The reason we had Long-Term Care Councils set up in each county is because the needs in each county were so different. And the state recognized that. So what one Long-Term Care Council found is gaps and barriers in one county may not have been the same in another county.

Next slide please.

Here in Monroe County we decided to look at our long-term care population empirically. So we wanted to see what the trend said not only from anecdotal information but also what did the data tell us based on what our long-term care or recipients were facing.

Next slide please.

So we asked ourselves the following four questions.

Who are our long-term care users?

What are their primary issues?

And what gaps and barriers were keeping them from moving to the right level of care at the right time?

And how can we change the system to eliminate those barriers and/or gaps?

Next slide please.

So what we did is an alternative level of care study. We looked at our alternative level of care beds in our hospitals and those are the beds where individuals were placed in the hospital but for some reason they're not able to move to the right level of care at the right time.

So we wanted to profile those customers and also identify what gaps were preventing them from moving on and then the council was going to provide recommendations on how we can rebalance or restructure that system.

Next slide please.

Out of that study came 11 recommendations. And the number one recommendation was that we enhance communication between our hospitals and community-based providers.

We have an electronic reporting system here in Monroe County for all our aging services under Peer Place.

Next side please.

So this was an existing relationship that Monroe County had. And through this system we're able to provide referrals to and from Aging Network providers and also collect statistical information.

Next slide please.

This is a web-based system. And it's used by professionals and administrative staff. And it tracks all kinds of services from a simple meal to a full case management type service.

Next slide please.

And this connection was through one integrated system so we all pretty much work off the same system here in Monroe County in regards to aging services. And it also helps us collaborate in regards to service provision.

As I mentioned this is a web-based system that we also use to track all of our services and it supports direct and contract services.

Next slide please.

And under this system we create one master client database. We use universal referral so everybody uses the same referral system.

And we also use the same tracking system so all of us work on the same tracking system.

So what we talked about doing was linking our hospitals up to this Peer Place System so that they were able to see the same things that the Aging Network saw. So if one of our seniors ended up in a hospital in the emergency room the emergency room staff would be able to go into this Peer Place System and pull up the same information that our Aging Network was looking at.

Next slide please.

And these are just some quick screenshots of what the system looks like. We have basic demographic information which we call our client profile.

Next slide please.

Our referral system and these are our universal screenshots. No matter what service provider is linked up to the system would have these same consistent pieces of the system that they would use.

Next slide please.

Those more in-depth systems like case management would have a case file that would be included in the system.

Next slide please.

And also an assessment so no matter where the individual entered the aging system on this computer, they would receive an assessment. Whichever provider took the information they would enter into this system and anybody else in the Aging Network who worked with that same client would be able to access that assessment information.

Next slide please.

We also included service information so all of the services that an individual who was connected up with our network was receiving would show up on this service listing. So if somebody was receiving a meal from the Home Delivered Meals Program and they also ended up in our Case Management Program the case manager would see that that individual is also receiving home delivered meals.

Next slide please.

Now we already had this Peer Place System established. The Rochester Electronic Health Information System also known as the RHIO came to our area and they work in a nine county area here in upstate New York. And they were creating the health information system where they were going to be exchanging information electronically between healthcare providers.

So the RHIO did approach us and they wanted to work with us but at the time we weren't sure how we were going to be able to connect them with our Aging Network.

Next slide please.

Now our RHIO is one of 300 Health Information Exchanges nationwide. And they started off with a grant of $4.4 million and then leveraged another close to $2 million from local businesses, hospitals and health insurers to really get this project going.

Next slide please.

And as I mentioned we're in a nine county region so I just highlighted that piece for you so you can see where our particular RHIO works.

Next slide please.

Just like our Peer Place System the RHIO would allow that exchange of healthcare information electronically between providers. So as a couple of the previous presenters spoke about those medical records would be exchanged between those medical providers electronically so we would have those electronic health records.

Next slide please.

So we thought instead of just connecting our Peer Place System up with the emergency rooms at the hospital why not just connect it up to the RHIO and then all healthcare providers can access that same information that we were offering to the emergency room hospital staff.

Next slide please.

So that's just what we did. We got authorization from New York State Department of Health to make this connection. And we created what's called a Community Care Summary for our healthcare providers.

Next slide please.

And what this provides is a status of what's going on with those seniors in the community. So they're able to get home support information, emergency contacts, any kind of services that they were receiving from the Aging Network would now be available, that information would now be available to the healthcare providers.

Next slide please.

And in the RHIO System it's just the click of the button for the healthcare provider. So this is a screenshot of RHIO.

And what they would do was click on that button right next to the big green arrow of the Community Care Summary.

Next slide please.

And up comes all of that same information that's in our Peer Place System. So they're able to get that demographic information.

Next slide please.

Any kind of basic medical information, encounter histories, any program that they touched on in regards to the Aging Network. They're able to pull up on the RHIO program history, who their case managers are.

Next slide please.

And also that list of services that the individual might be receiving, that's now accessible to any healthcare provider.

Next slide please.

And any kind of support that the individual might be receiving in the community, if somebody ends up in the ED or even if they go see their primary care physician those healthcare providers may not be aware that they have somebody else in the community who's assisting them. Now they'll have access to that information.

Next slide please.

Any kind of assisted devices that the individual is using, if someone is taken to the hospital via ambulance we might not be aware that they use a cane or a walker but the case manager who works with them in the community might be aware and they include this information in our system which is now accessible by healthcare providers.

Next slide please.

Any kind of benefits that they're receiving that all comes up; if the case manager is aware we'll make sure that that's in the system. They also get an assessment of what's going on with that senior in the home so have they had a fall in the last week or two.

Are they suffering from any kind of emotional problem such as depression? All of that comes up on this Community Care Summary.

Next slide please.

Any kind of legal information, any medical information that we're privy to we include in the system.

Next slide please.

And also nutritional information, how are they doing at home? Are they eating well?

Do they have any special dietary needs such as a diabetic diet?

Next slide please.

Any psychosocial information and again a nutritional screening, are they are at high risk, low risk for poor nutrition? The healthcare provider is able to pick up on that information as well.

Next slide please.

Just like any other medical information, this information is not released without the patient's consent. So the patient has to sign off before any healthcare provider can access the Community Care Summary just as if they were accessing any other healthcare information.

We do have a break the glass backup so that if anybody is incapacitated and they really need this information where it's going to really save somebody's

life we do have that break the glass one time and then you can access anything that's in the RHIO including the care summary.

Next slide please.

So our goal for making this connection was to have better transitions of care for the patient so that if there is a stop gap in the system where they're not moving to the right level of care at the right time, there might be something in that Community Care Summary that can either have somebody else intervene to help out with that transition or there might be some valuable information in there to help move that person forward.

Information is easily shared and the patients don't have to repeat their story over and over again because all of that information is already in the system.

Patient information is included allowing for more engagement of patients in their healthcare. So the patient can go in here and look at this information the same as a care manager can or the same as a healthcare provider can.

So we really wanted to create a holistic system that really included everybody in the decision making on this individual's health and also the main goal, moving the person to the right level of care at the right time.

So again I know I went through that really fast understanding I only had 15 minutes.

Marisa Scala-Foley: Okay, we've gotten several questions, Corinda, so we'll take as many of them as we can and then the rest we'll try to come back to hopefully at the end.

So we've got a question from Don, who asked is it possible have you had any consumers opt-out of this system, is it voluntary? How does that work?

Corinda Crossdale: Initially when we started creating this we did try to do voluntary but because there were so many patients in that system, it was impossible to allow people to opt-out.

So the DOH, Department of Health here in New York State just made sure that we had enough stop gaps in there so that you can't access that information without the patient's consent.

And surprisingly enough we did think that we would get pushback from some community providers especially the HIV community but everybody was really supportive of putting this project together.

Marisa Scala-Foley: So then this system does include information about other age groups other than seniors?

Corinda Crossdale: Yes, any - because here at the AAA we're starting to work with individuals who needed long-term care that was one of the initiatives that were part of the point of entry.

So if someone is receiving care management who's in long-term care and they're under the age of 60 they would be included in our system as well.

Marisa Scala-Foley: And we've gotten, you know, several questions along these lines.

How is the information in the system updated?

Corinda Crossdale: This is real time information. So every time anybody has contact with a client they update the information. Both systems are web-based.

So the screenshot that the healthcare provider sees is real time information. If that care manager changed something within the last two minutes that comes up on the screen in the care summary.

Marisa Scala-Foley: Great. Lynn asks, you know, she said you talked about that the hospital or the ER could access the network. You know healthcare system staff are all very busy and have a hard time keeping some of this necessarily on their radar screens that they can actually access this.

You know what has been sort of the use rate? Are they actually accessing it?

What's been the reaction?

Corinda Crossdale: Actually it was the EDs that we got the biggest response from. And they're the ones who say that they love it the most.

They don't have to make those multiple phone calls to different agencies trying to figure out what's going on with that patient. They can go right into the RHIO, click on that care summary and pull up all of that information.

And as busy as they are, they tell us that this has made their job easier.

Marisa Scala-Foley: That's great. We got a question in from Marybeth, who asks is a medication list also included and the person, the individual's primary support person so family member or a guardian or significant other?

Corinda Crossdale: Both of those pieces of information are included. And I apologize. I know I went through those screenshots really, really fast. But when this gets posted on the Internet if you go back and take a look at those screenshots you'll see that it does have contacts in there for support and it lists all of the medications.

So if the care manager is aware of certain medications which sometimes they're more aware than different healthcare providers because they go out to the home, they list that information in our system and that all comes up on the care summary.

Marisa Scala-Foley: Okay. I think we're going to take one more question right now and then hopefully we'll be able to come back to some of the others a little bit later on.

And that is several people asked, you know, is this sort of a one way system? Are you receiving information? Is your area agency on aging at this point or your office on aging receiving information from medical providers through this system as well?

Corinda Crossdale: Right now it is a one way flow. So the Aging Network at this time is not receiving information. Our primary goal was to just get the two systems linked up and we honestly thought that the New York State Department of Health was going to say no.

So as soon as they said yes, we just moved forward very quickly to get the linkage. We are going to start working on getting the flow to come back towards the AAA.

Marisa Scala-Foley: All right. I know we have gotten several other questions. And we will do our best to answer them a little bit later on, but I want to make sure we sort of

stay on time. We should have some time at the end of this as well for - to take additional questions that come in via chat as well as through the audio line.

But with that thank you so much, Corinda. I would like to turn things over to Dr. Victor Hirth. Victor, I'll turn things over to you.

Victor Hirth: Thank you, Marisa. Good afternoon, everyone. So I'm going to take a little bit different perspective in terms of the technology and we'll cover some of the issues in terms of the application of the technology and procurement and those kinds of things.

It would be nice if you could just go to Staples and buy these things. But that's not the situation.

You can go ahead and leave it at the next slide there Marisa.

And basically what I've done is broken this down into three tiers of integration of the technology. And these are basically principles that we want our technology and our applications that are enhancing our ability to provide transitional care across the continuum to work in all these instances.

So the first bullet here is health records need to be accessible and consistent across all care settings so that they're compatible and integrated with existing systems and that we have access to things such as lab, micro-radiology as well as nursing notes, physician notes, really across all the disciplines so everyone has access to everyone else's information.

Ideally you want to a single point of access for all providers as opposed to some people logging onto system A and other people logging onto system B

and hoping those systems are compatible and integrated and they communicate with each other.

So ideally having a common record which was nicely outlined with the Monroe County and the Rochester folks, I mean they have a single point of entry where people can look at records.

And then also the issue of access across devices; as many of you know there really a number of different devices that provide access to electronic health information much of which is moving now away from desktop/laptop to more tablet type or even more often smartphone types of applications.

Next slide please.

The second tier of - I'm sorry. So what does this mean for you?

So if you're involved in negotiating a contract with a software provider you need to make sure that the contract states that your product will be compatible with your existing systems. Rarely are you purchasing something that is replacing all of your IT infrastructure. It's usually another add-on. So you have to make sure that those things are going to be compatible and work with your existing systems.

Data transfer can be one way or two way. For example we have a system now that will transfer data into our health record for the practice.

But unfortunately if the data is incorrect we are unable to correct their insurance information. We have to go back to the people who did the entry in the first place.

And then backward compatible, as you can imagine there - the age of these systems and when they were designed and deployed has an impact on whether it's compatible with the latest programming language or integration system. So you also want to keep in mind does this work again with your existing system?

Single logon or multiple logon, for those of you who have had the annoyance of having to logon through two or three different servers to get to the application that you want that can be frustrating and time consuming.

And then finally how many types of devices will it run on?

Again this issue of if the software only runs on a server type of application how many different types of devices will allow you access to that information?

Next slide.

So tier two is kind of the protocolize and standardize so again we've had some discussion of specific applications of these things but really again we want our assessments and our communication flow to be integrated and to flow across disciplines regardless of where you are or who you are.

And also we're also interested in things and now I'm specifically speaking more as it relates to aging into kind of non-typical assessments. So things like fall risk, delirium, re-hospitalization and others that in geriatrics such as gait speed, time to up and go aren't generally in the realm of the standard applications or what joint commission or other accrediting bodies want us to do.

But again that's valuable information that if there's opportunity to integrate those into your systems that'll add value over time.

And then consequently that these assessments once they're integrated it's not just the assessment has been done and someone's identified as a high risk but then that starts a protocol or standard order set or an approach in which these risk factors are now utilized as part of a care plan to minimize the risk for some kind of outcome.

And then the last bullet piece - point there on the bottom is that all of these systems are integrated in a way that data can be collected and monitored and tracked for outcomes over time.

So next slide.

What does this mean for you?

Again can you add these extra features or function in the context of what Joint Commission, College of American Pathologists, Medicare or other requirements are, again I think in our experience the difficulty has been for example just to use nursing is that they have so many standard types of assessments they have to do on our patients that ask them to do another thing on top of everything else ends up being onerous.

So look for opportunities where you can substitute for something that perhaps meets the requirement for your accrediting or credentialing body but also adds additional information.

And bullet number two, you know, generally what we want is different than the typical organ-based or financial billing reporting systems.

And so you want your vendor to be able to show well if this is a capability that's not currently in the system is it something I can add? Can it be - that function be added without excessive cost as it relates to programming other things?

So things again that we're interested in geriatrics include activities, daily living, time to up and go, gait speed.

Again I think the Rochester folks and Monroe County nicely pointed out that they had the opportunity to really describe the social network. Who are the caregivers? Who are the financial resources? Those are things that many of you know are extremely important in the care of our old adults. Cognitive function, depression, availability to transportation. You know if you can't get to the doctor it's hard to get your healthcare.

So again systems that report these things to make it accessible to the caregivers will ultimately really enhance your ability to provide care.

Next slide.

And then the third tier is really the whole data tracking and monitoring across all environments including home. And this is where things are going I think from both a regulatory and a financial reimbursement standpoint that ultimately we're going to have to know what's going on with our patients, our clients wherever they are.

So as many of you know there's already physiologic health monitoring that can be done almost everywhere. But honestly I don't find that terribly interesting. I think it's helpful for some disease states and conditions.

But there's going to be more monitoring that will be available in the future and I'll show you some examples of that in a few slides down where we can really track changes over time and understand the variability of a given individual.

And by understanding that variability to really have a prediction model which can tell you how someone is doing that particular morning, that particular day.

So if someone has a routine say for example of in the morning they generally get up at 7:00 in the morning. They go to the kitchen. They fix some coffee. And they then go about their routine in the house. That if there's a deviation from that that that might indicate as an early, early sign that something is not quite right maybe even before they feel necessarily ill.

And also I'm not really talking about Big Brother types of things where you would have a video camera which is monitoring each of these activities and then saying aha, you know, here's something that they're doing that's contrary to a good health behavior.

Next slide.

So again we really have a convergence of lots of things. And again this wireless network that surrounds much of what we do.

So on the left hand panel the network is really the infrastructure provided by your hospital, your healthcare system, your integrated health management company. And then that infrastructure provides access to your mobile devices so that ultimately again regardless of where you or your client is that you have

the applications available and in hand to provide the services that you want to do in an efficient manner.

Next slide.

So this is just a slide of all the companies, not all the companies but many companies that are interested in these systems. As you'll see there's really not one predominant system that is available again because our health systems are different. Our service needs vary across patient populations.

But I can guarantee you each of these guides is looking for, you know, what is going to be the ultimate most flexible and viable application that enhances the care. So again this is something that's being looked at continuously.

Next slide.

So to use an example, how would we enhance an existing electronic project because many of you have access or know providers who have electronic medical records but we want it to be a little bit more than what we already have so again simple things like integrating the care management plan into an electronic health record. And maybe that's a misnomer. It's not necessarily simple but ultimately that's what we want to go to.

So for example that when the pharmacist does a med review and provides recommendations that that's integrated in the system that if a provider writes for a drug the system already knows what's on formulary and what's easily accessible or affordable, etcetera.

And again also that it knows what the patient is currently taking so that if you're prescribing a medication that might have an interaction with another

drug or there might be a drug disease interaction that the system would say hey, that might not be the best choice. Do you want to think about something else?

And again as I mentioned earlier the opportunities to really have other allied health professionals be able to provide notes and assessments and integrate that into the medical record as well.

Also messaging so that, you know, there's this importance of having communication flow really across not only providers but and locations but in terms of the circumstances so that if someone is having a home health physical therapy evaluation and a physician is seeing them in office and the person is discussing how difficult - difficult time they're having with mobility that again that note would be available and that an action plan could be developed by the physician who might need to write a durable medical equipment order. But again has that information available.

And then all the home monitoring and self management types of things where we would have an understanding of how people are doing in their home or living environment and again send that information into the health record.

Next slide please, Marisa.

So let's just talk in general now in terms of where technologies are going. There are more and more applications for wireless sensor technology both in or near the person to provide monitoring.

Next slide.

So some of these things include so on this top panel here is an implantable wireless pressure sensor device that can tell you the intracardiac pressure of the heart or an intra-aortic pressure upon an aortic aneurysm repair which can again if things are exceed certain thresholds it notifies the system that hey Mr. (Jones)' blood pressure is quite high. He has a AAA repair. Someone needs to take some action to lower his blood pressure.

The cardiac - I think I'm going to talk a bit more about the next slide if you can just advance it. Well I guess not. Let me just back up a slide if you could.

So this is a mechanism by which previously when someone needed a halter monitor you went in the doctor's office. You got hooked up. You wore it for 24 hours and then you came back. Here's a system now where UPS can deliver this package. It comes with simple instructions that says here's where you put the patches on. The device that they're showing there is actually the equivalent of a cell phone.

So it monitors the heart rhythm continuously. Sends that data over to the cardiologist office. When you're done with your monitoring interval you pack it all up. You put it back in the box. You put the UPS return label back on. They come and pick it up. And you never left your home.

Next slide please.

Targeted drug therapy, so now are coming mechanisms by which drug patches which many of you are familiar with can be now remotely controlled in terms of drug release.

So say you have someone who has severe chronic pain and it's difficult to get them into the office that, you know, probably you don't want to do this

unsupervised but maybe the home health nurse comes in, does an assessment and determines that yes, pain control is not very good.

Call the doctor's office and then remotely through microchip or ray can increase the dose of medication administered.

Tablet PCs and tablet applications for remote mobile clinics have been around for awhile but are becoming more widespread.

Next slide.

Medication management,so this is an interesting one. So we already have medication reminding systems that tell people when to take their drugs or automated pill dispensers that can be placed in the home or in assisted living facility that alarm when it's time to take a drug.

But you actually don't know if that medication is going down the hatch. Well here's a new system and these are in the order of now a penny a tablet.

And what you're seeing a picture of are ghost tablets where you can put the medication inside. The little gray thing is a chip in the middle. And when that tablet is ingested the stomach activates a battery. That battery then sends a signal to the hub in the home that says that medication was actually ingested.

So ultimately that really gives you a tremendous view of patient compliance particularly for drugs that might be lifesaving or necessary for their health and wellbeing.

Activity monitors so these bracelets and bands that you see on the bottom for monitoring Alzheimer's Disease patients who are prone to wandering, these

things can be programmed so that you can set a parameter in their area of walking and when they go beyond it, it alarms and then the caregiver would say hey, you need to track the person down.

Next slide.

So in conclusion really wireless technology is moving medical care away and out of the hospital and the practice and really into the community including home. The problem we have is that reimbursement is really not consistent with modern capabilities. And what that means is right now in general for Medicare to pay there's a requirement for face-to-face interaction.

And for those of you in home health now know that for recertification there's also a requirement now for another face-to-face interaction again technology is really moving us away from that. And that remote monitoring and remote control of medical devices is close and coming soon. And the devices themselves are ready but the applications need to be developed.

So you'll see technology that's available in the retail market and you might wonder well what exactly is this, what problem is this fixing?

And I think it's best if we think about the problem first and develop technology around that.

And really system integration and communication is paramount. And I think that's really highlighted by all the talks we've had previously.

And that's my last slide.

Marisa Scala-Foley: All right, thank you so much, Victor. We've got Victor's contact information up here as well as, you know, you've seen the contact information for all of our presenters throughout.

As always we have included, I'm going to talk a little bit about our resources and our next training. And then we'll try to take some more of the questions that came in through chat. And also open up the lines for questions.

But as always if you've been on our webinars before you know that we like to include different lists of resources associated not only with care transitions as you'll see on this page, but we've also got resources related to and again by no means are these meant to be exhaustive lists of resources. Just some resources that we found to be helpful as we were sort of putting all of this together.

But certainly not an exhaustive list. But we thought lists of resources related to care transitions, health information technology as well as some resources related to the Affordable Care Act.

As I mentioned at the beginning this is the first in a two part series that we're doing looking at technology and care coordination and care transitions. Next time we'll hone in a little bit more specifically on care transitions and have the best speakers from the Center for Technology and Aging as well as some of their grantees who are taking a closer look at the use of technology in Aging and Disability Resource Centers as it relates to care transitions.

That webinar will be Tuesday, June 21st from 2:00 to 3:30 pm Eastern.

And so please do watch your email for registration information about that.

And as always, we welcome your questions. If you think of a question, you know, two hours from now or two days from now we welcome your questions, your feedback.

If you have stories about your community's work whether it's in implementation of technology related to care coordination or care transitions or just about your community's care transition story in general we'd love to hear it. Please do email those to affordablecareact@aoa.hhs.gov.

Also we're always looking for suggestions for future webinar topics. We got a request in to show the resources slides again, you know, if you - rather than try to copy down all these complicated URLs, simply feel free to email us at the affordablecareact@aoa.hhs.gov and we can send you a PDF version of these slides if you need them before they get posted on our web site next week.

So with that I think, Lori, if you want to give people instructions about how they go ahead and queue up on the audio line for questions. Then we'll take - while they're queuing up we'll take a couple more questions from chat and then we'll open up the audio lines.

Coordinator: I certainly will. If you'd like to ask a question or make a comment please press star 1 and record your name. Your name is required to introduce your question. To withdraw a request you press star 2.

One moment while we wait for that question.

Marisa Scala-Foley: Okay. So we got a question actually, and we'll take questions for all of the presenters at this point.

We got a couple questions for the folks from Rhode Island. Someone asked how did you interface with pharmacies in your - in the work that you're doing right now?

Joseph Russell: Okay. That would be more of a Beacon question.

Marisa Scala-Foley: Okay.

Joseph Russell: Rather than the long-term care. But we are with the HIE which is Current Care, we are receiving labs and incorporating pharmacy information into the HIE which the doctors can through the connection go through their EHR.

Marisa Scala-Foley: Janhavi, did you want to add to that at all in terms of how other Beacon Communities are interfacing with pharmacies, any sort of specific examples on that?

Janhavi Kirtane: Yes. I would say it's definitely several communities are pursuing exactly the Rhode Island strategy of labs. There are a couple and this is very much in pilot who are trying to figure out how to reach out to kind of the actual Walgreen's and retail world. I think I would place that in the innovation lane.

And then there's others who are selectively I think looking at Allscripts as another option. And but also focusing mostly I think as use cases on the diabetes side.

I would say this is one where there's a huge area of focus and there continues to be and I'm suspecting from the question a little bit of challenge trying to build out all of the various interfaces.

We'd be interested if people are wanting to focus more on this to follow-up because I think we've got some exciting projects but a lot of challenges to work through.

Marisa Scala-Foley: Great. Janhavi, another question for you. You mentioned engaging patients and families. Can you talk a little bit more specifically about how some Beacon Communities are seeking to do that in their work?

And certainly Joe and Lauren, if you want to add to what Janhavi starts out with that would be great.

Janhavi Kirtane: Sure. So one example is I'll give, it varies tremendously, but Southeast Minnesota has actually a very interesting model where they've gone out to the community and pretty much as interventions begin they've gone out asking how best to form the interventions.

And there's I would say that's a aspirational model. It's very inspiring as well to try to say if we want to take care of our pediatric asthma patients what does the community want.

So they have very actively from the grassroots level tried to organize patients and families and community members to define the interventions.

And then we have other I guess ways of doing which I'll describe as engagement through governance. So where there are active community groups, advocacy groups or faith-based organizations who are part of the Beacon governance body so in addition to leaders from hospitals and provider groups they have actually included key stakeholders who represent "The community voice" in a very specific way.

And then third we have introduced and encouraged and have several examples of Beacons again where they are designing test solutions. They're very much engaging the patient voice as part of that.

Now on the technology side I mentioned the patient portals and really trying to figure out how to best get either mobile technology or through the EHR and visibility to the patient and family in decision making as a key technology enabled kind of consumer and patient and family engagement tool.

Marisa Scala-Foley: Joe and Lauren, did you have anything you wanted to add?

Joseph Russell: No. We're doing the very as Janhavi had mentioned, we are taking the patient in consideration. We are working with other initiatives within the state and getting not only physician feedback, nurse feedback but the patient feedback as well as far as our interventions and how to proceed and looking at best practices for measurement.

Lauren Capizzo: And the only thing that I would add to Joe's comment is that in the long-term care community we are working with the individual nursing home facilities. If there's elder families that have questions or concerns or want to know a little bit more about the Current Care System before, you know, working with the elder to enroll we do facilitate Friends and Family Night where we've gone numerous times to different Friends and Family Nights to present about the project and answer some questions that they might have.

Marisa Scala-Foley: Okay, great. Lori, do we have any questions in the queue?

Coordinator: I have no questions at this time. Again if you'd like to ask a question please press star 1 and record your name.

Janhavi Kirtane: Marisa, I actually wanted to add one more thing around medication because this is a topic I think if we have time for it.

Marisa Scala-Foley: Yes, go right ahead.

Janhavi Kirtane: Okay, great. So we have as you can imagine, there's a lot of the Beacon Communities they're making incremental investments in HIT but a lot of these communities already were ahead of the curve in terms of investments.

And so there's a big question around what can be done with communities who already have ePrescribing around sophisticated med req. and med adherence.

So we are seeing more around kind of new ways of measuring medication adherence and then new ways of using that data to try to deliver a targeted intervention.

So I'll give an example in Mississippi where there is information about electronically medication lists available and a little bit of history on adherence. They have an intervention that's looking at remote phone calls coming out from their school pharmacy to try to target those patients who might best benefit from a higher touch intervention.

So kind of a creative one and I think we're interested and they actually have a few pretty decent results already underway.

Marisa Scala-Foley: Okay, great. And perhaps this one is probably for the team from Rhode Island as well as Corinda. Marlene asks, you know, that the interface across different software systems or different IT systems that are used by different organizations can be certainly a huge issue.

Could you both speak to your approach to how you sort of got past that barrier or how you're dealing with that barrier right now?

Joseph Russell: This is Joe from Rhode Island. And as Lauren Capizzo had suggested as far as our long-term nursing - long-term care facilities they're using a web base. So they'll have a LAN ID and a password. And they'll be based on how many people sign up in their situation in their community. They'll have access to those records. So they don't even have to have an EHR like Lauren had said.

But when it comes down to downloading the patient's information into the HIE we are working with the various EHR vendors for compatibility reasons so the data flow can go back and forth.

But for our long-term care facilities as Lauren has spoken previously they don't even have to have an EHR. It's not necessary because it's all web-based.

And what they'll access is, you know, they'll look for admissions, discharge and transfers from the hospital as well as the patient - direct patient information.

Lauren, did you want to add something?

Lauren Capizzo: No. I would say that's correct.

Joseph Russell: Okay.

Marisa Scala-Foley: Corinda, how about you?

Corinda Crossdale: We're also web-based. The Health Information Exchange System is web-based as is Peer Place so same here. You just need an access code to access either system.

The only (new build) that we did when we connected the systems is the Community Care Summary. And that was just esthetically so it would look like it made sense to the healthcare provider. It didn't look like our system. But that's the only thing that we built in that was different.

Marisa Scala-Foley: All right. We got a question Corinda also for you from (Lynn) who asks, you know, you mentioned that the emergency departments once they sort of saw the benefit in this, you know, they tended to use it a little bit more.

How did you sort of get them started, you know, how did you sort of get this on their radar screen initially?

Corinda Crossdale: One of the recommendations of the Long-Term Care Council was to put the hospitals on the Peer Place System. We have three major hospitals here in Monroe County. We met with each hospital individually before we even made the RHIO connection to just connect up with the EDs at the various hospitals.

And it wasn't going to cost them anything. All they had to do was logon to look at the information. Being that it was free and easy to use it was a simple sale. Expanding it out to RHIO didn't really change our initial conversations with the hospitals. They could still logon the same as if we just went through them initially.

The fact that they were part of RHIO just made it that much easier for them. So not only are they able to see healthcare information that they would have

been looking at anyway through the RHIO they just had to click one button to look at that Community Care Summary.

Marisa Scala-Foley: Okay great. Lori did we get any questions in the queue?

Coordinator: I do. I have one. And that is (Peter Dirksen). Your line is open, sir.

(Peter Dirksen): Hello?

Coordinator: Go ahead.

(Peter Dirksen): Yes, thank you. We're interested in how we might empower our seniors and the caregivers to adopt home monitoring and self management devices that you talked about in your presentation. Do you have any strategies in mind for doing that?

Victor Hirth: Is that directed towards Victor?

Marisa Scala-Foley: I think it sounds like it is, Victor.

Victor Hirth: It's a good question. It's - you know I don't have a good answer for that. I think the issue is in terms of, you know, obviously our folks want to be independent in the home as long as possible.

And if we have devices and technology which can enhance the ability to do that I think in general our patients are very in favor of that.

In terms of, you know, how currently most of the home monitoring particularly the stuff that's monitoring activity levels and some diabetes

monitoring and that kind of stuff in the absence of the home health chronic disease type of monitoring application is private pay.

So that's part of the reason why you don't see the really large companies, the Siemens, the Bosch, the Philips and others out there marketing systems because no one's made the business plan that either caregivers or old adults themselves need to go out and buy these systems because of a proven benefit.

So I think there are a number of reasons. Number one, lack of data showing proven benefit.

Number two, the issue in terms of how does it enhance your ability to remain independent.

Number three, there's not a payment mechanism for most of these things so you can't get insurance to cover it.

Now in Canada and in some parts of Europe these systems are being paid for.

And then the fourth item is for a lot of my own patients they say what - you know I have 80 year-old patients who tell me that's for old people so they don't recognize a utility for themselves. But they can envision that this might be helpful for other people.

So kind of a roundabout way of answering your question but we, you know, ultimately we don't know how this is going to be deployed and how you convince people to adopt the technology.

(Pete Dirksen): I won't take your time now but a group of us out here with the University of Utah, Gerontology Department has some ideas on business models that might facilitate quicker adoption of these kinds of things.

And offline here I'll try to get hold of you and see if I could follow-up with you.

Victor Hirth: Sure, that sounds great.

(Peter Dirksen): I presume your address will be in the PDF that I can send for.

Victor Hirth: I believe so. Is that correct Marisa?

Marisa Scala-Foley: Yes. All the email addresses that were included will be in the slides.

Victor Hirth: Okay.

(Peter Dirksen): (Perfect). It was a wonderful (discussion) you guys. Thank you very much.

Marisa Scala-Foley: All right. Thank you so much. And on that note we have reached the end of our time. Actually we've gone slightly over so we would just want to thank, first of all thank all of our speakers for wonderful thought provoking presentations. And thank all of you who are on the phone and on the web for such wonderful questions and for your time today.

Again if you have additional questions or suggestions for us on future webinar topics please do email us at affordablecareact@aoa.hhs.gov. We thank you for joining us and we'll hope you'll join us for future webinars. Thanks so much.

Joseph Russell: Thank you. Bye-bye.

Coordinator: This concludes today's conference. We thank you for your participation. You may disconnect your lines at this time. Have a great day.

END