Utilizing Patient-Centered Technologies to Support Care Transitions

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, ADMINISTRATION ON AGING, WASHINGTON DC 20201
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Agenda

- Background on Center for Technology and Aging (CTA) and Tech4Impact Grant Program
- Role of health technologies in reducing hospitalizations and promoting better care, better health, lower costs
- Presentations from two Tech4Impact Grantees

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Presenters

- Lynn Redington, Senior Program Director, Center for Technology and Aging
- Stephen Kogut, Associate Professor of Pharmacy Practice, University of Rhode Island College of Pharma
- Maria Gil, Co-founder, ER-Card, LLC
- Angie Hochhalter, Assistant Professor and Research Scientist II, Department of Internal Medicine at Scott & White Healthcare and Texas A&M Health Science Center (TAMHSC) College of Medicine.

Technologies for Improving Post-Acute Care Transitions ("Tech4Impact")

Lynn Redington, DrPH, MBA
Senior Program Director
Center for Technology and Aging
June 21, 2011 Webinar

Center for Technology and Aging

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About the Center for Technology and Aging

- Established in 2009 with funding from The SCAN Foundation, located at the Public Health Institute
- Mission: Expand use of technologies that help older adults lead healthier lives & maintain independence
- Independent, non-profit resource center on issues related to diffusion of technology for older adults
- Design, develop Technology Diffusion Grants Programs, e.g., Tech4Impact

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CTA Diffusion Grants Programs

Demonstrate/evaluate how technologies can:

- Improve *efficiency* of care delivery
- Improve *health* and independence
- Reduce the *cost* and burden of care
- Improve chronic disease *self-management*

Emphasis on *accelerating adoption/diffusion of patient-centered technologies*

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Tech4Impact Grant--The Need

- Avoidable Readmissions:
  - 1 in 5 patients readmitted w/in 30 days of discharge
  - 76% of readmissions are preventable
  - A $25 billion savings potential
- Need to improve care transitions
  - Better care coordination, outreach, patient engagement and support
  - Information and communications technologies

References:
New England Journal of Medicine, Jencks S, et al "Rehospitalizations among patients in the Medicare fee-for-service program" *N England Journal of Medicine 2009; 360: 1418-28.*
PricewaterhouseCoopers, 2008. The price of excess: Identifying waste in healthcare spending.

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Tech4Impact Diffusion Grants Program

- RFP released September 2010
- January-December 2011 grant period
- $500,000 in grant funds
- Tech4Impact designed to complement the AoA/CMS ADRC Evidence-Based Care Transition ("Option D") Grant to States
- 16 States eligible→12 applied→5 selected

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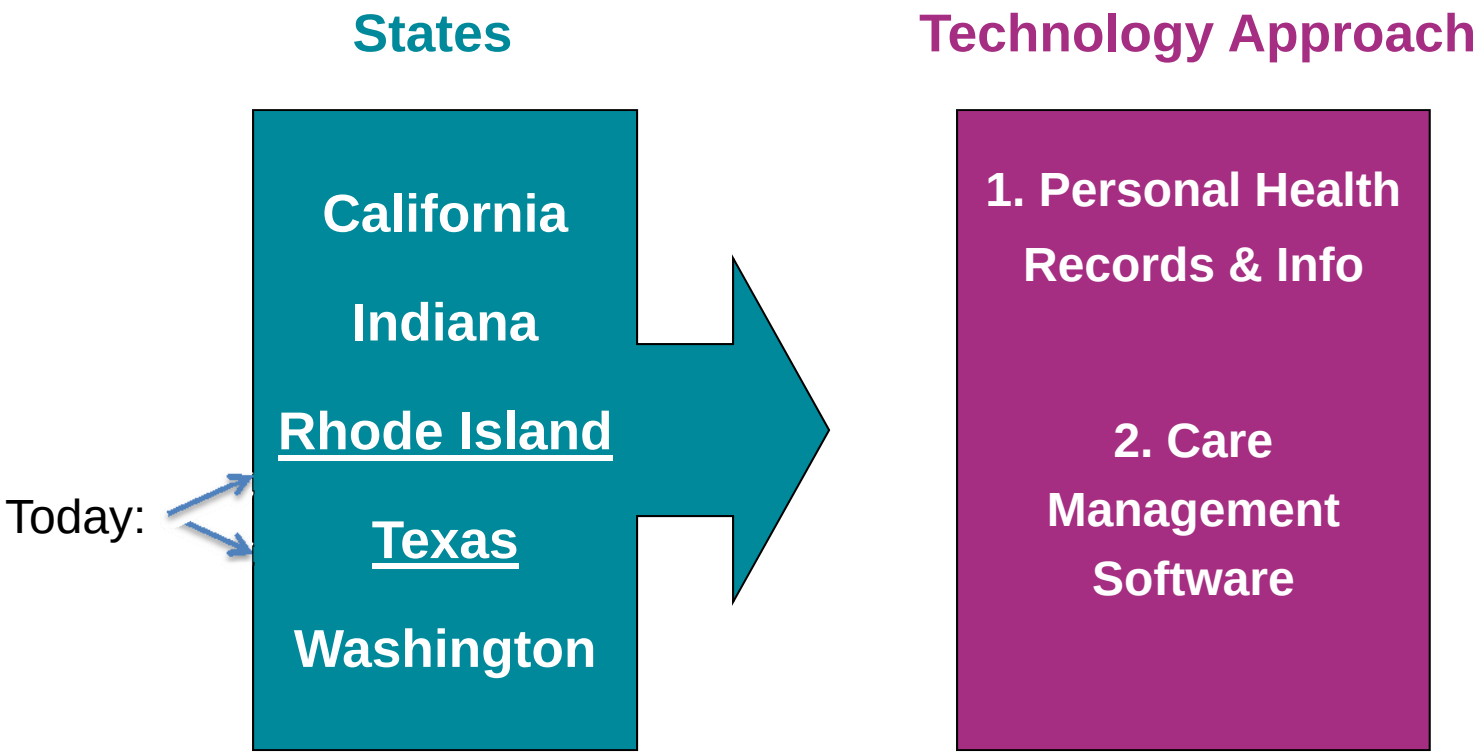
Tech4Impact Grant Awards



For more information about the 5 grant awards, see:
http://www.techandaging.org/Tech4Impact_Grants_Abstracts.pdf

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CTA's Other Technology Diffusion Grants

- 22 CTA Grantees ("learning laboratories")
- Technologies for *Medication Optimization*
  - Medication Adherence Technologies
    - In-Home Automated Meds Dispensers resulted in 98% adherence rate

  - Medication Management Technologies
    - Virtual Pharmacist Counseling identified 6 medication problems/patient, resolved 93%, 6:1 ROI

- Technologies for *Remote Patient Monitoring*
  - Heart Failure monitoring and messaging
- *Mobile Health* Technologies

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To Learn More . . .

- www.techandaging.org
  - CTA publications on technologies
  - Lessons learned from grantees
  - Abstracts on 22 grant programs
  - ADOPT (Accelerating Diffusion of Proven Technologies) Toolkit
- Contact: lredington@techandaging.org

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Improving Medication Management Post-Discharge via Pharmacist Home Visits and Use of an Electronic Personal Health Record (ER-Card®)

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Project Team

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Assistant Professor Research
URI College of Pharmacy
Executive Director, Rhodes to Independence

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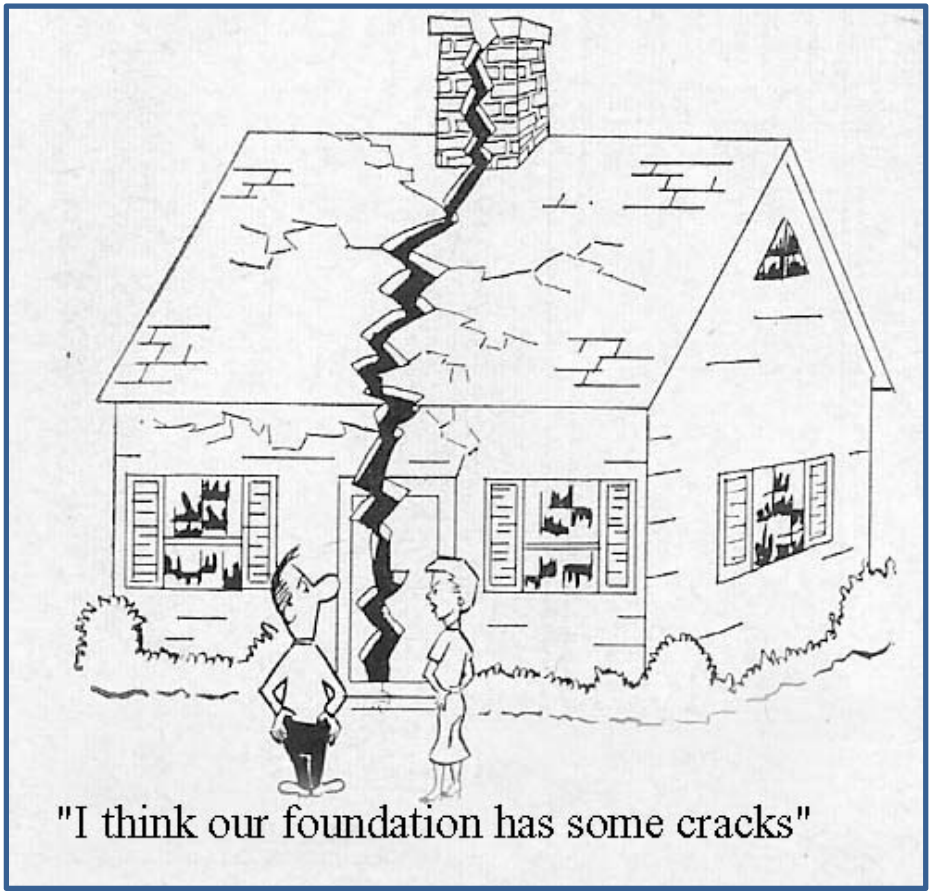
Outline

Care Transitions:

- Suboptimal medication management in the community setting
- Health Information Technology solutions
- The utility of electronic personal health records coupled with pharmacist involvement
- Sustainability and further development

…Prior to the Medical Home Era



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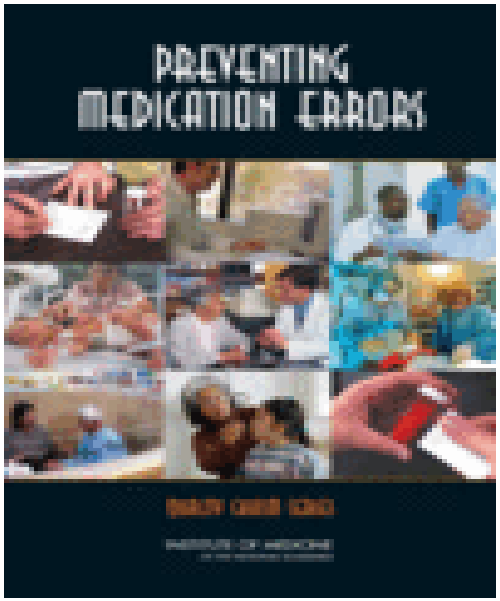
Medication Errors

- Medication errors are among the most common medical errors
- Estimated 1.5 million preventable injuries due to adverse drug events annually
- Total annual cost of at least $3.5B (2006 dollars)
- Problems of misuse, overuse and underuse



Preventing Medication Errors: Quality Chasm Series

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Medication-Related Problems

- Untreated Indications
- Improper Med Selection
- Sub-therapeutic Dosage
- Failure to Receive / Take Meds
- Over-dosage
- Adverse Drug Reactions
- Interactions
- Med Use Without Indication

Modified from Strand LM, et al. Drug-related problems: their structure and function. DICP. 1990 Nov;24(11):1093-7.

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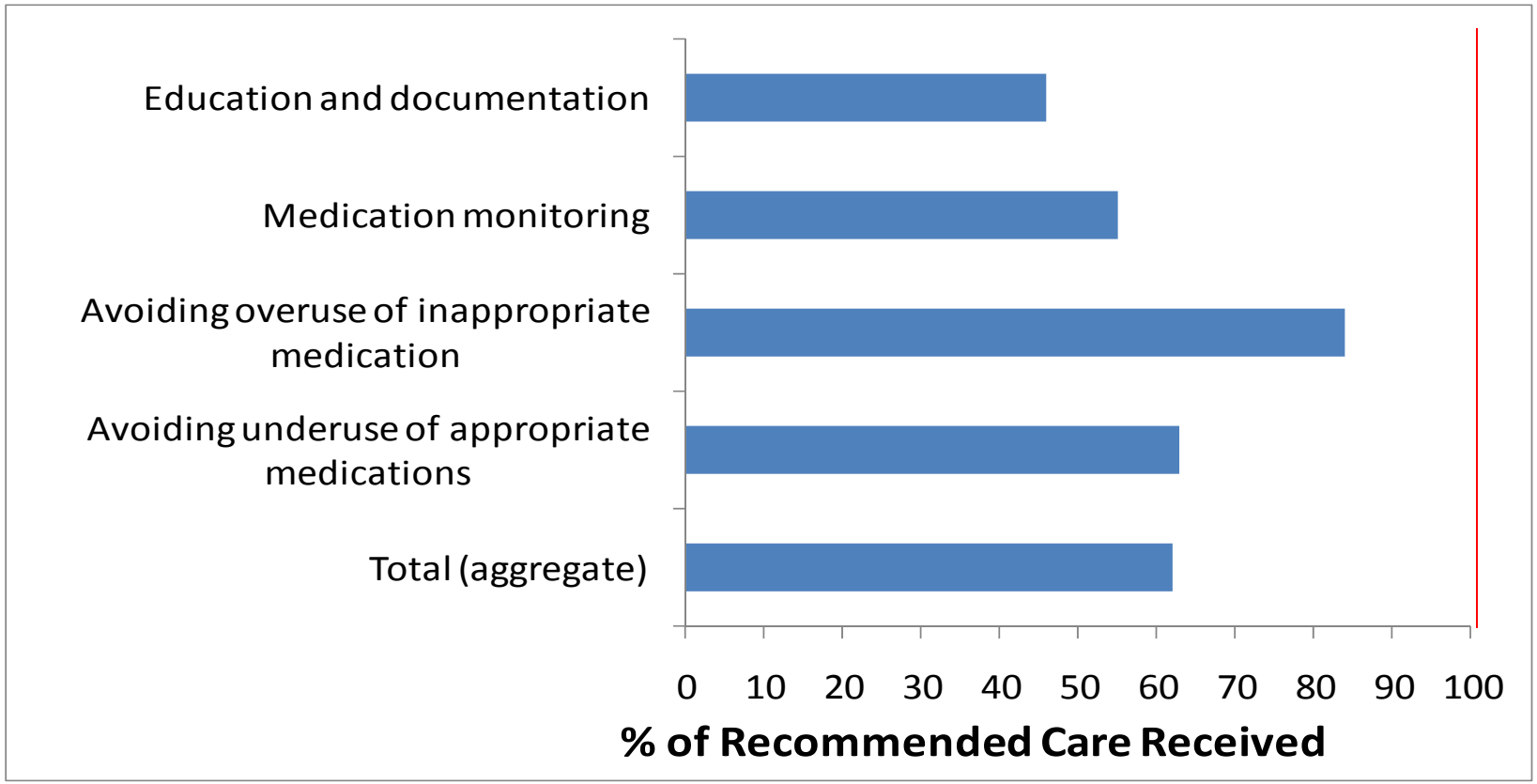
The Quality of Pharmacologic Care for Adults in the United States

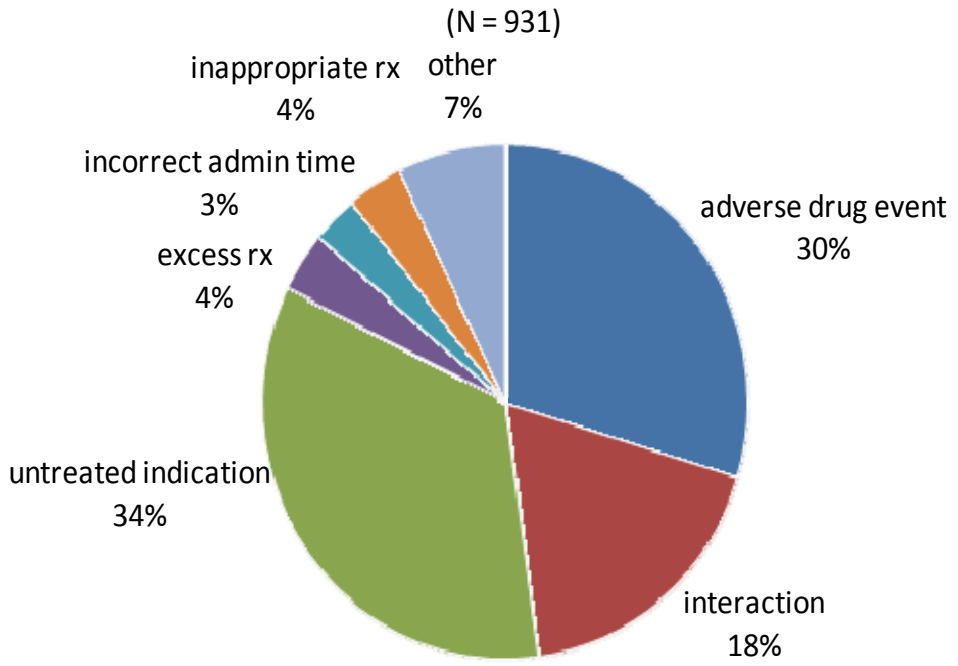
Shrank WH, Asch SM, Adams J, et al. Med Care 2006 Oct;44(10):936-45. (modified)



ER-Card®/University of RI College of Pharmacy City of Warwick, RI Employee Health Initiative

(2009, unpublished)

Types of Medication-Related Problems Identified



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Posthospital Medication Discrepancies: Prevalence and Contributing Factors

Coleman EA et al. Arch Intern Med. 2005; 165:1842-1847.

Patient-associated factors

- Did not fill prescription (4.8%)
- Did not need medication (0.8%)
- Money/financial barriers (5.6%)
- Intentional nonadherence (4.8%)
- Nonintentional nonadherence (33.9%)
- Performance deficit (0.8%)
- **Subtotal (51%)**

System-associated factors

- Rx with known allergy/intolerance (2.4%)
- Conflicting information from difference informational sources (14.5%)
- Confusion b/w brand and generic names (2.4%)
- Discharge instructions incomplete, inaccurate, or illegible (16.1%)
- Duplication (8.1%)
- Incorrect dosage (0.8%)
- Incorrect quantity (0.8%)
- Incorrect label (3.2%)
- Cognitive impairment not recognized (0.8%)
- **Subtotal (49.2%)**

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Health Information Technology Initiatives in RI

- Electronic Prescribing
- Health Information Exchange Award
  - currentcare *http://www.currentcareri.org*
- Regional Extension Center Award
- Rhode Island Beacon Community
- ER-Card ePHR (electronic Personal Health Record) program

Meaningful Use of EHRs: Selected Stage 1 Criteria Impacting Medication Management

- Exchange key clinical information (for example, problem list, medication list, allergies, and diagnostic test results), among providers of care and patient authorized entities electronically
- Generate and transmit permissible prescriptions electronically
- Implement drug-drug, drug-allergy, drug- formulary checks
- Perform medication reconciliation at relevant encounters and each transition of care
- Maintain medication / allergies list
- Generate lists of patients by specific conditions to use for quality improvement, reduction of disparities, research, and outreach.

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Electronic Health Record (EHR)

- Electronic by definition
- Data input: Clinician driven
- Multiple users
- Multi-functional
- “Gold” standard
- Gaps in information
- Ideal: promote safe, effective and efficient delivery of health care *through lens of providers, payers and regulators*

Personal Health Record (PHR)

- Electronic or paper
- Data input: Patient driven
- Patient controls access
- Narrower function
- Data reliability a concern
- Gaps in information
- Ideal: promote safe, effective and efficient delivery of health care *through lens of empowered patient as active participant in care*

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Improving Medication Management Post-Discharge via Pharmacist Home Visits and use of an Electronic Personal Health Record (ER-Card)

Funding: Center for Technology and Aging, Tech4Impact Diffusion Grants Program

Project Aims

1. To identify and address medication-related problems post discharge
   - Pharmacist home visit
   - ER-Card® Program as ePHR (plus)
2. Prevent avoidable rehospitalization
3. To learn more about the role of technology in supporting medication management activities during care transitions

Collaborators

- URI College of Pharmacy
- ER-Card
- RI Department of Elderly Affairs
- Quality Partners of RI (Quality Improvement Organization, or QIO)
- RI Department of Human Services (Medicaid)
- Kent Hospital, Warwick, RI

Intervention Elements

- Medication Management / Pharmacist
  - Overarching models / frameworks
- ER-Card® ePHR
  - Augmented by various services

The Care Transitions Program: The Four Pillars

1. **Medication self-management:** Patient is knowledgeable about medications and has a medication management system.
2. Use of a **dynamic patient-centered record**: Patient understands and utilizes the Personal Health Record (PHR) to facilitate communication and ensure continuity of care plan across providers and settings. The patient or informal caregiver manages the PHR.
3. **Primary Care and Specialist Follow-Up**: Patient schedules and completes follow-up visit with the primary care physician or specialist physician and is empowered to be an active participant in these interactions.
4. **Knowledge of Red Flags**: Patient is knowledgeable about indications that their condition is worsening and how to respond.

Coleman EA. http://www.caretransitions.org/four_pillars.asp

The Care Transitions Program℠ is based in the Division of Health Care Policy and Research at the University of Colorado Denver, School of Medicine.

Medication Reconciliation

- " … a process of obtaining a complete and accurate list of each patient's current home medications - including name, dosage, frequency, and route of administration and comparing the physician's admission, transfer, and/or discharge orders to that list."

  Wong JD et al. Medication Reconciliation at Hospital Discharge: Evaluating Discrepancies. Annals of Pharmacotherapy. Oct, 2008. Vol 42

- *Steps:* Verify > Clarify > Reconcile > Transmit

  Kliethermes MA. Medication reconciliation and the pharmacist's role. http://www.pharmacist.com

The Massachusetts Coalition for the Prevention of Medical Errors
http://www.macoalition.org/reducing_medication_errors.shtml

Medication Management/Pharmacist

Core Elements of an Medication Therapy Management (MTM) Service

1. Medication therapy review
2. A personal medication record
3. A medication-related action plan
4. Intervention and/or referral
5. Documentation and follow-up

http://www.pharmacist.com

Medication Therapy Management in Pharmacy Practice: Core Elements of an MTM Service Model Version 2.0. A joint initiative of the American Pharmacists Association and the National Association of Chain Drug Stores Foundation (2008)

- An innovative, electronic personal health record and healthcare management service (http://www.ER-Card.com)
- Online ePHR system, 24 hour accessibility
- Secure, HIPAA compliant
- Patient information reviewed and updated by health professionals
- Free to study participants
- Long-standing partnership with URI College of Pharmacy

Program Features:

- Care Management Service
- Medication Profile Review
- Emergency Notification System
- EMT (Emergency Medical Technician) Care Link

How ER-Card Works

Proprietary software provides a user-friendly means to create an electronic personal health record and to share it with healthcare providers.

Providing Medical Information

- ER-Card members have a number of ways to provide caregivers with their medical information:
  - Hard copies of their medical profile
  - ID cards and keychain tags
  - Window decals and refrigerator magnets
  - USB flash drive (optional)

Access to ER-Card Member Profiles

- Providers may access ER-Card member profiles via:
  - 24-hour access 1-800 number
  - Internet
  - Fax
  - Email

ER-Card: Privacy / Security

- Encrypted database on a private network
- Licensed facilities, physicians and first responders require username and password supplied by ER-Card
- Provide daily reports to members when records are accessed by physicians, hospitals, EMTs and when calls are received by the emergency response hotline

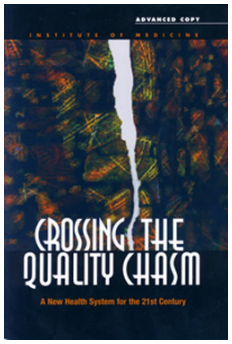
Design

- Eligibility
  - Older age (60+); Chronic disease
    - Diabetes, Coronary Artery Disease (CAD)/Congestive Heart Failure (CHF), Chronic Obstructive Pulmonary Disease (COPD)/Asthma
  - English speaking without diminished cognition
  - Max N of 250
- Outcomes
  - Medication related problems (subgroups)
  - Group comparison (with/without intervention)
    - MRPs, Rehospitalization rates
  - Participant Satisfaction
  - 12 month project duration

Anticipated Results

- Medication related problems occur commonly post-discharge
- Reduced rehospitalization rates
- Patients value the service
- Publication / awareness
  - Local media
  - Peer-reviewed journals
- Sustainability

Roles of Information Technology
(IOM, 2001)



1. Reengineer care processes
2. Manage the burgeoning clinical knowledge base
3. Coordinate patient care across providers and settings
4. Support interdisciplinary team function
5. Facilitate performance and outcome measurements for improvement and accountability
6. Information rich environments for education and training

Sustainability / Further Development

1. Involvement in local Health Information Exchange (HIE)/Person-Centered Medical Home (PCMH) initiatives
2. Publication: model and outcomes
3. Wider-scale pilot including insurers
4. Involve community (store-based) pharmacists
5. Reimbursement under Medicare Part D Medication Therapy Management (MTM) programs
6. Enrollment co-payments / fees
7. Other

Care Transitions Intervention™ (CTI) Coaching Tool

Developed in cooperation with the Care Transitions Program (caretransitions.org) for public use

Angie Hochhalter, PhD
Scott & White Healthcare
State Of Texas

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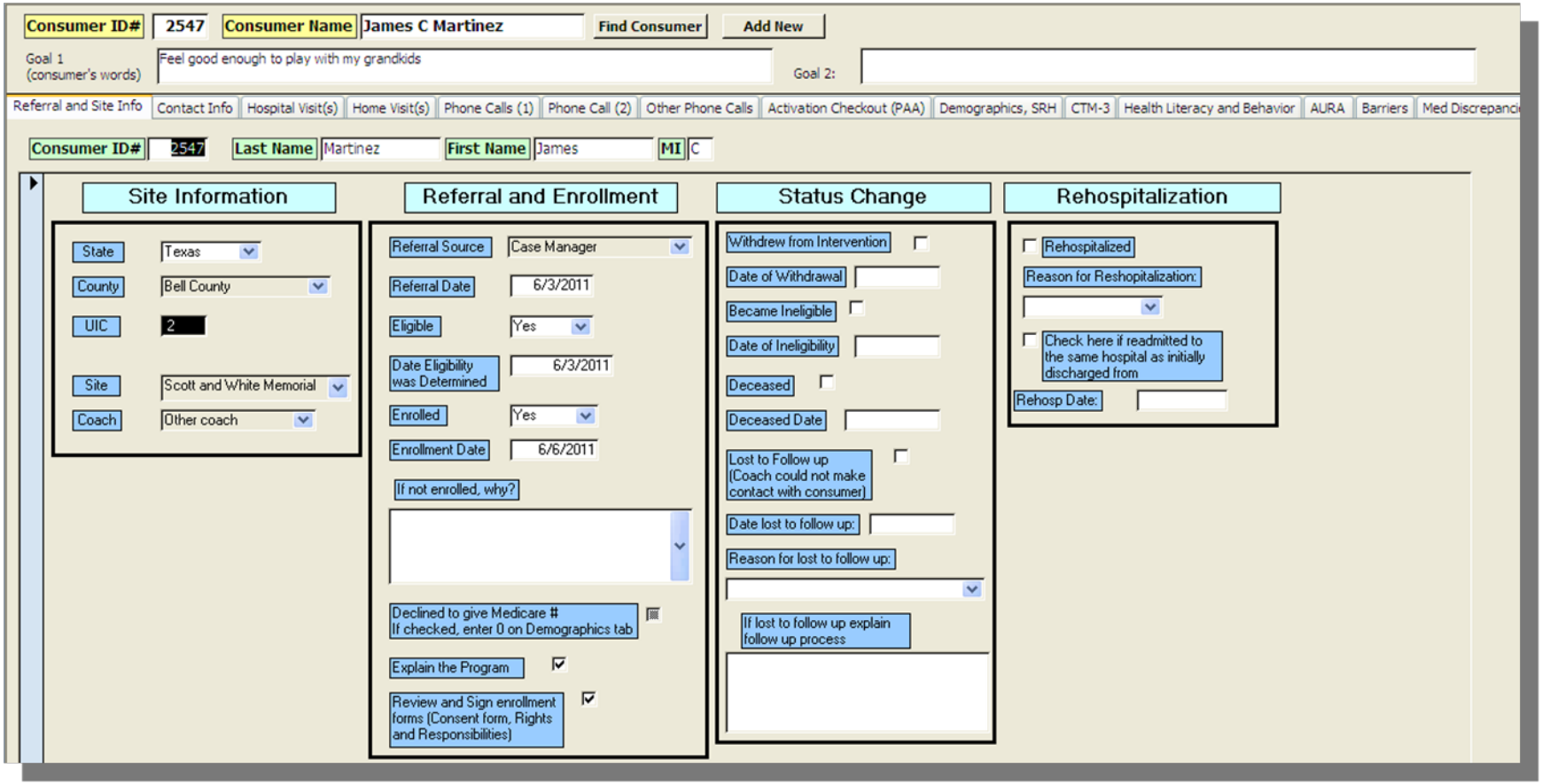
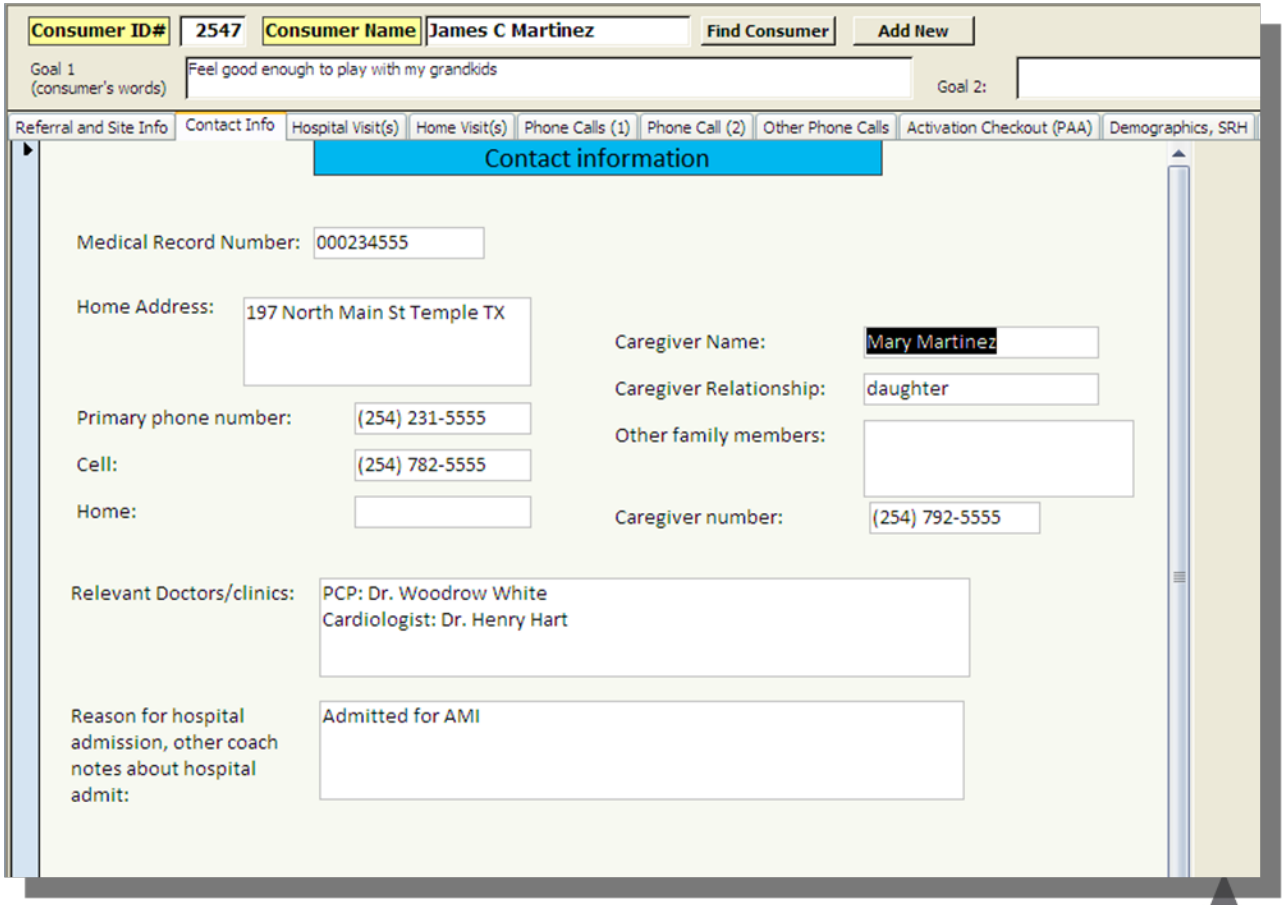
Background

- Revision of existing Care Transitions Program tool
- Freely available as Microsoft ACCESS database
- Goals
  - Facilitate highest quality coaching
  - Integrate coaching and evaluation
  - Improve project management capacity

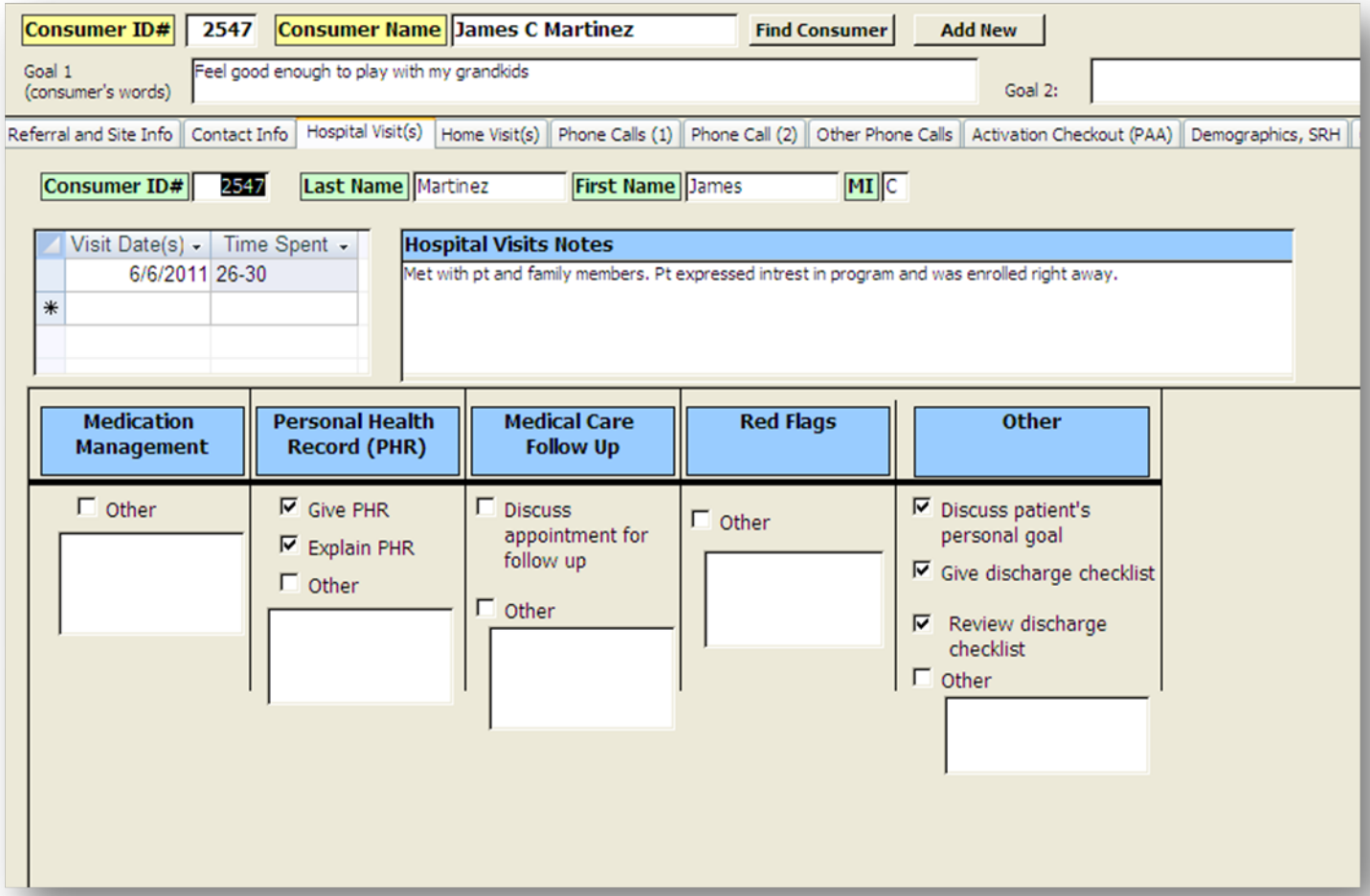
Referral, Enrollment, Project Status



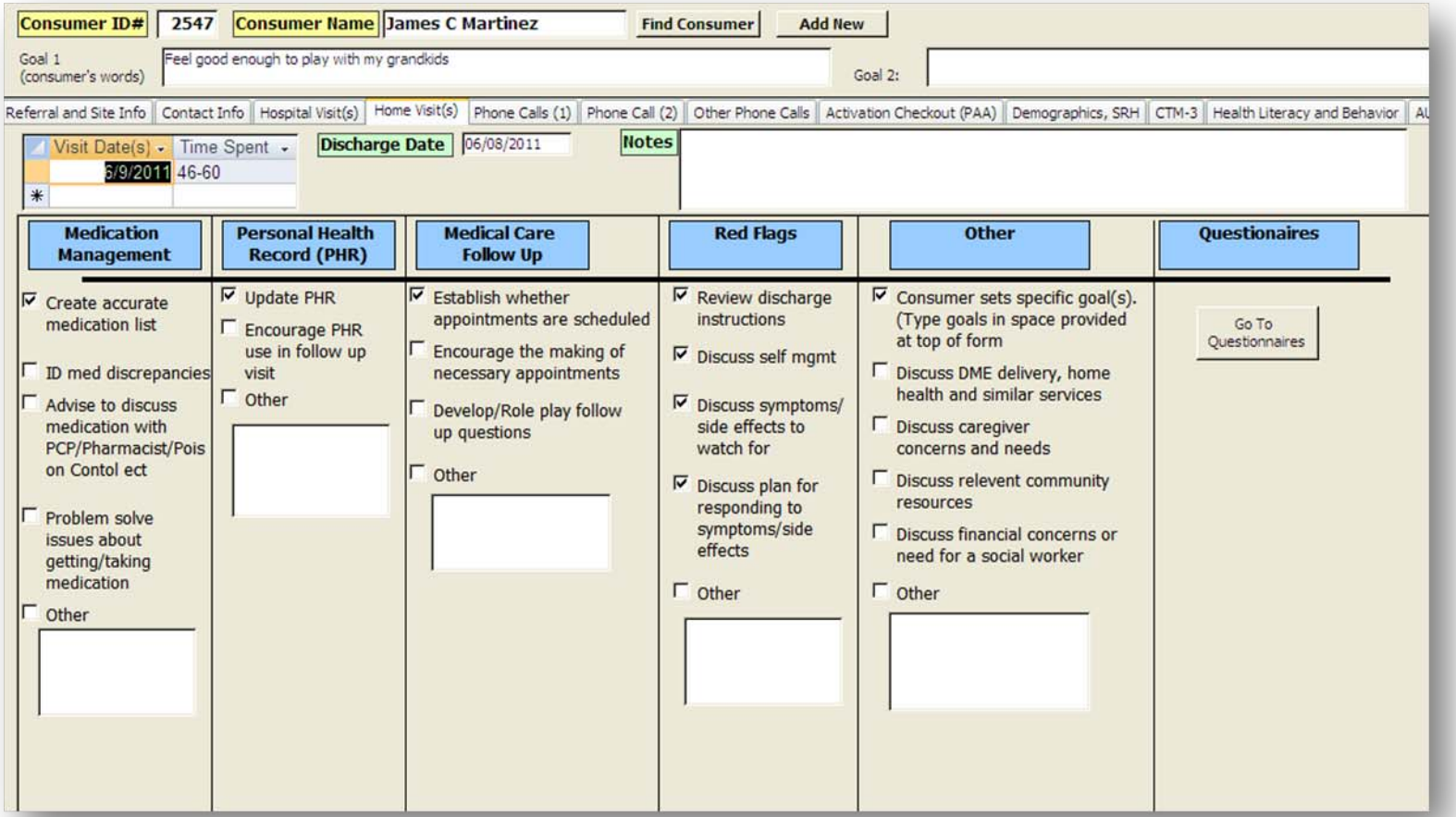
Contact Information



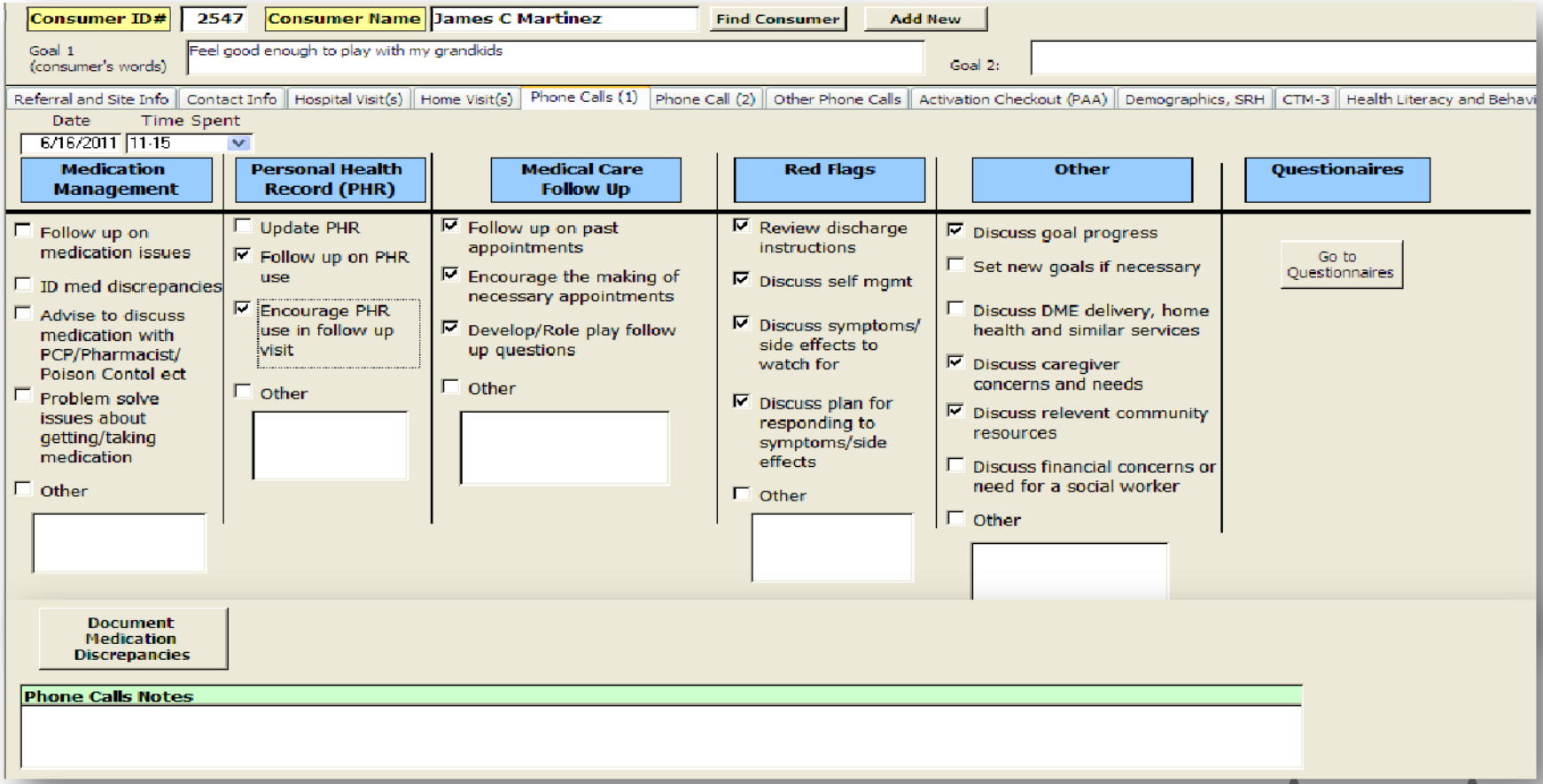
Hospital Visit



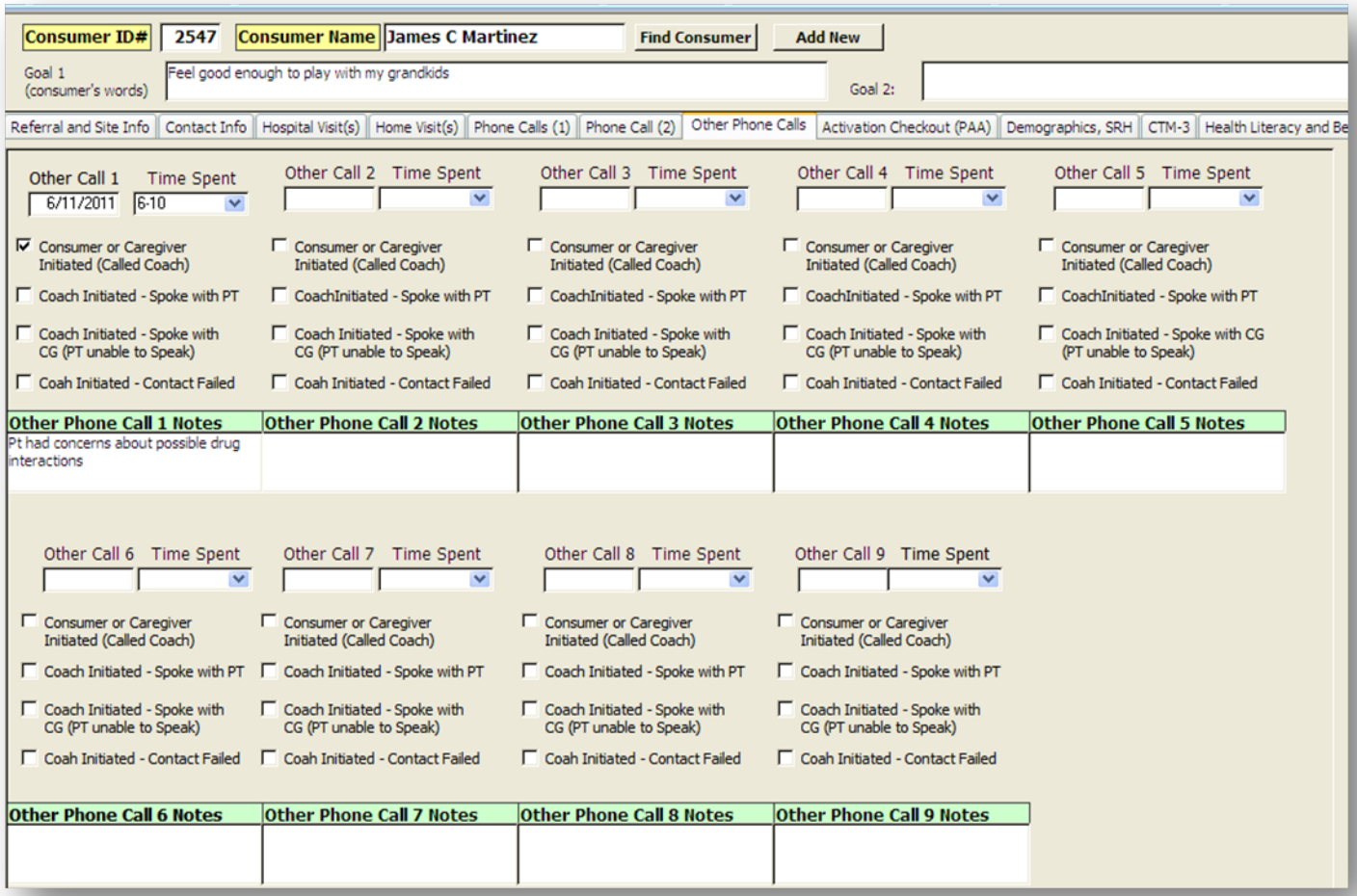
Home Visit


Consumer ID# 2547
Consumer Name James C Martinez
Find Consumer
Add New
Goal 1 (consumer's words)
Feel good enough to play with my grandkids
Goal 2:
Referral and Site Info
Contact Info
Hospital Visit(s)
Home Visit(s)
Phone Calls (1)
Phone Call (2)
Other Phone Calls
Activation Checkout (PAA)
Demographics, SRH
CTM-3
Health Literacy and Behavior
Visit Date(s)
Time Spent
6/9/2011
46-60
Discharge Date
06/08/2011
Notes
Medication Management
Create accurate medication list
ID med discrepancies
Advise to discuss medication with PCP/Pharmacist/Pois on Contol ect
Problem solve issues about getting/taking medication
Other
Personal Health Record (PHR)
Update PHR
Encourage PHR use in follow up visit
Other
Medical Care Follow Up
Establish whether appointments are scheduled
Encourage the making of necessary appointments
Develop/Role play follow up questions
Other
Red Flags
Review discharge instructions
Discuss self mgmt
Discuss symptoms/ side effects to watch for
Discuss plan for responding to symptoms/side effects
Other
Other
Consumer sets specific goal(s). (Type goals in space provided at top of form
Discuss DME delivery, home health and similar services
Discuss caregiver concerns and needs
Discuss relevent community resources
Discuss financial concerns or need for a social worker
Other
Questionaires
Go To Questionnaires

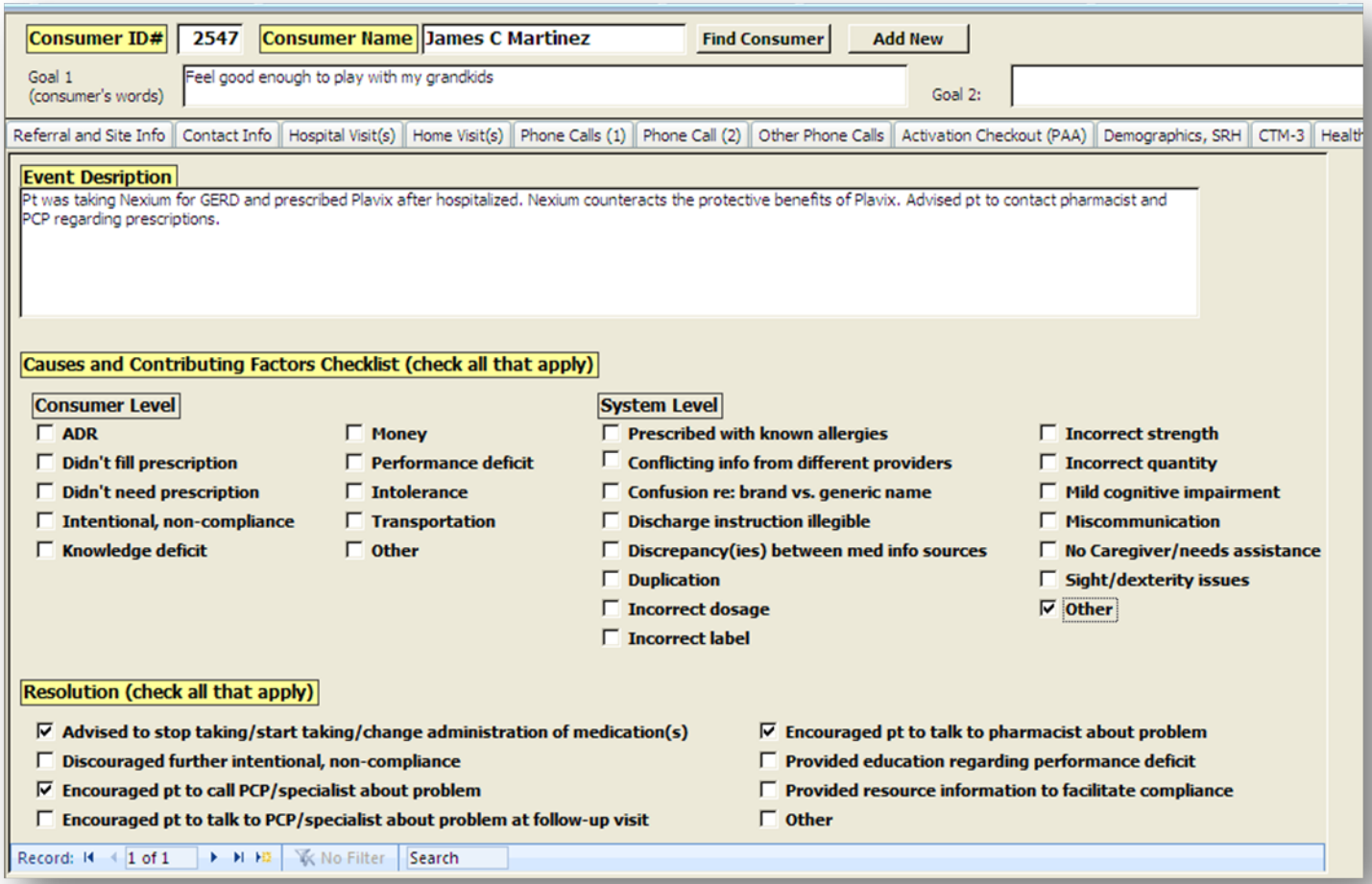
Phone Calls (with CTI content)



Phone Calls (Logistics)



Medication Discrepancy Form



Consumer ID# 2547 Consumer Name James C Martinez Find Consumer Add New

Goal 1 (consumer's words): Feel good enough to play with my grandkids

Goal 2:

Referral and Site Info | Contact Info | Hospital Visit(s) | Home Visit(s) | Phone Calls (1) | Phone Call (2) | Other Phone Calls | Activation Checkout (PAA) | Demographics, SRH | CTM-3 | Health

Event Desription

Pt was taking Nexium for GERD and prescribed Plavix after hospitalized. Nexium counteracts the protective benefits of Plavix. Advised pt to contact pharmacist and PCP regarding prescriptions.

Causes and Contributing Factors Checklist (check all that apply)

Consumer Level

- ☐ ADR
- ☐ Didn't fill prescription
- ☐ Didn't need prescription
- ☐ Intentional, non-compliance
- ☐ Knowledge deficit
- ☐ Money
- ☐ Performance deficit
- ☐ Intolerance
- ☐ Transportation
- ☐ Other

System Level

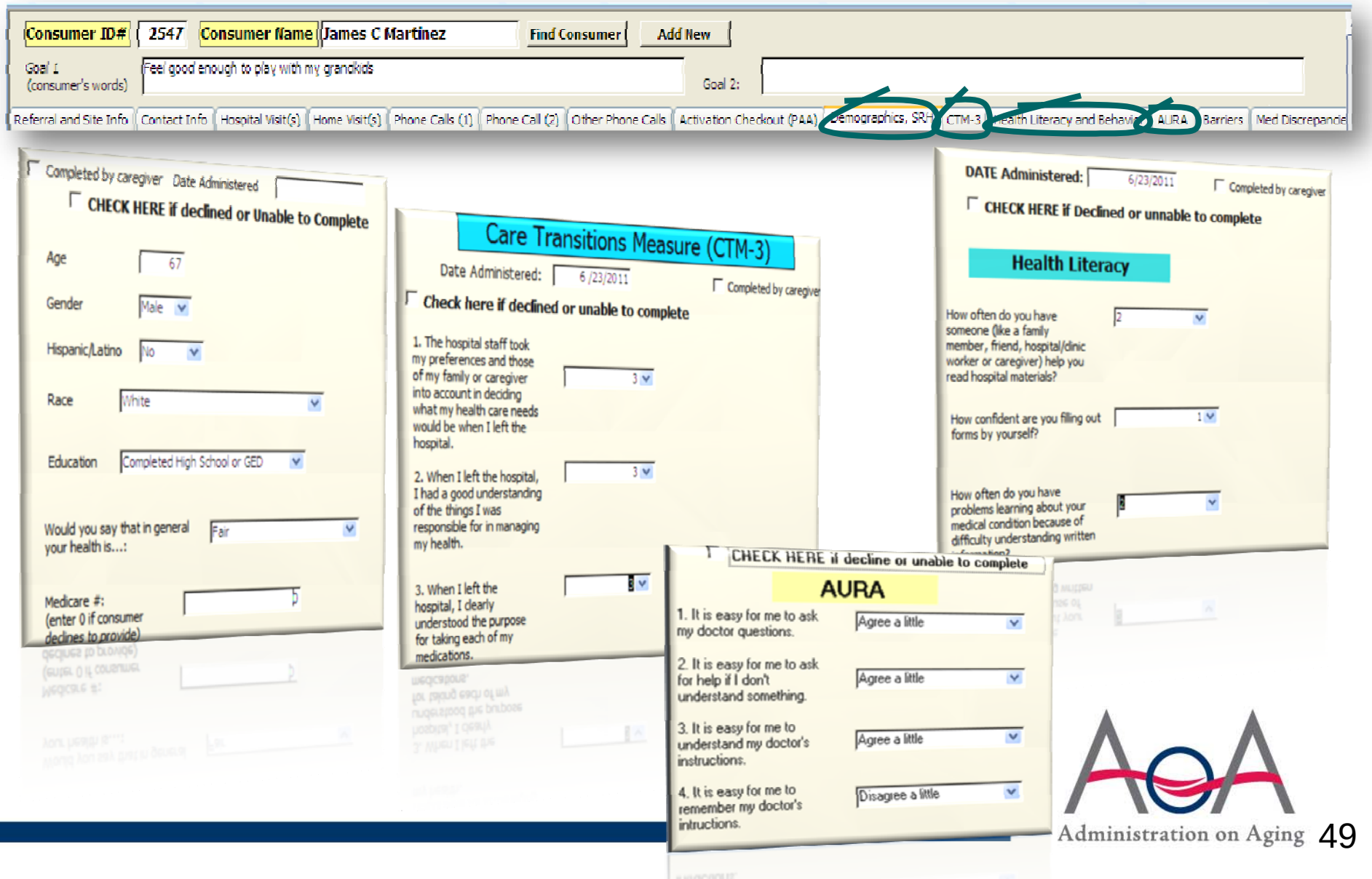
- ☐ Prescribed with known allergies
- ☐ Conflicting info from different providers
- ☐ Confusion re: brand vs. generic name
- ☐ Discharge instruction illegible
- ☐ Discrepancy(ies) between med info sources
- ☐ Duplication
- ☐ Incorrect dosage
- ☐ Incorrect label
- ☐ Incorrect strength
- ☐ Incorrect quantity
- ☐ Mild cognitive impairment
- ☐ Miscommunication
- ☐ No Caregiver/needs assistance
- ☐ Sight/dexterity issues
- ☑ Other

Resolution (check all that apply)

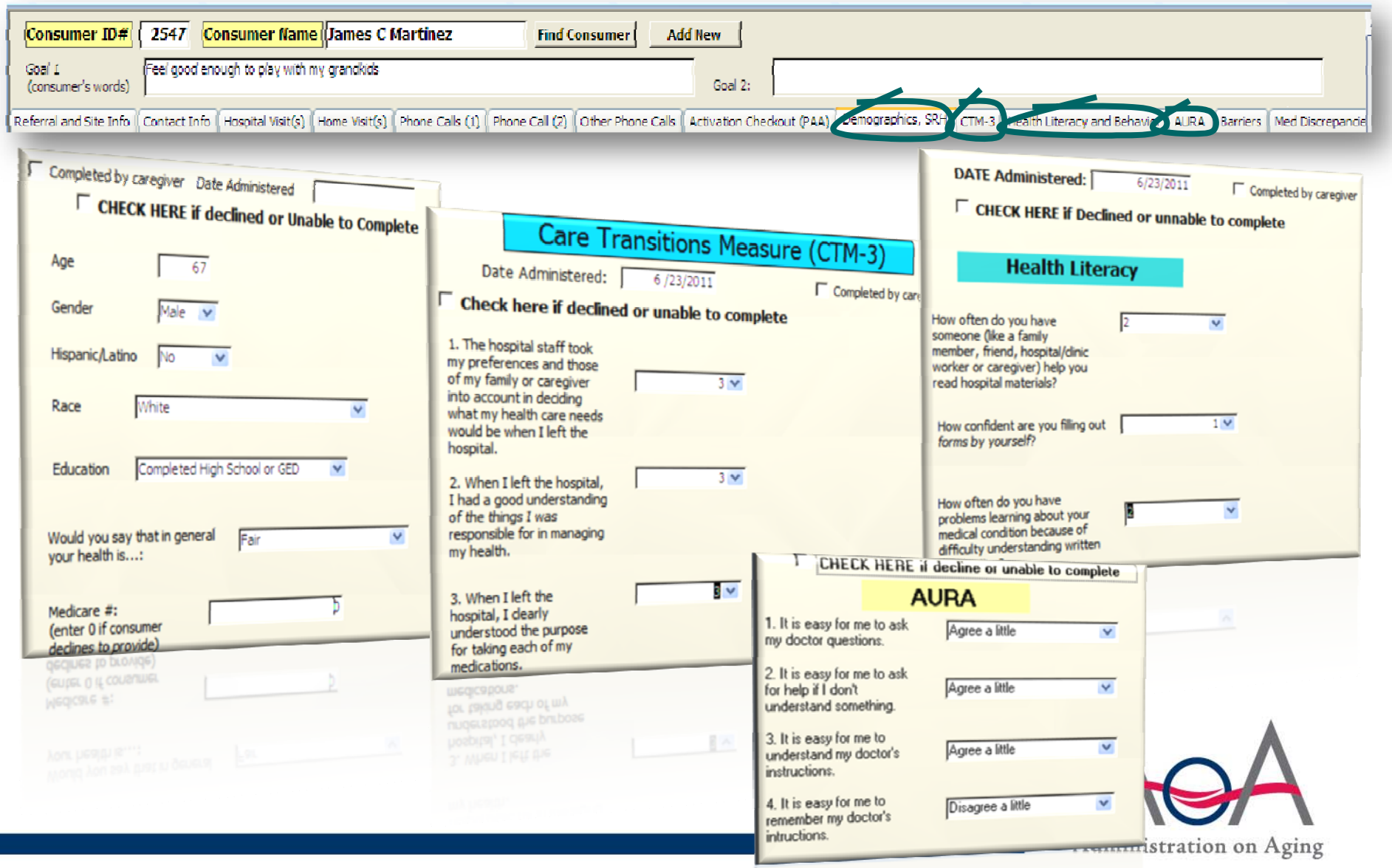
- ☑ Advised to stop taking/start taking/change administration of medication(s)
- ☐ Discouraged further intentional, non-compliance
- ☑ Encouraged pt to call PCP/specialist about problem
- ☐ Encouraged pt to talk to PCP/specialist about problem at follow-up visit
- ☑ Encouraged pt to talk to pharmacist about problem
- ☐ Provided education regarding performance deficit
- ☐ Provided resource information to facilitate compliance
- ☐ Other

Record: 1 of 1 | No Filter | Search

Questionnaires



Questionnaires



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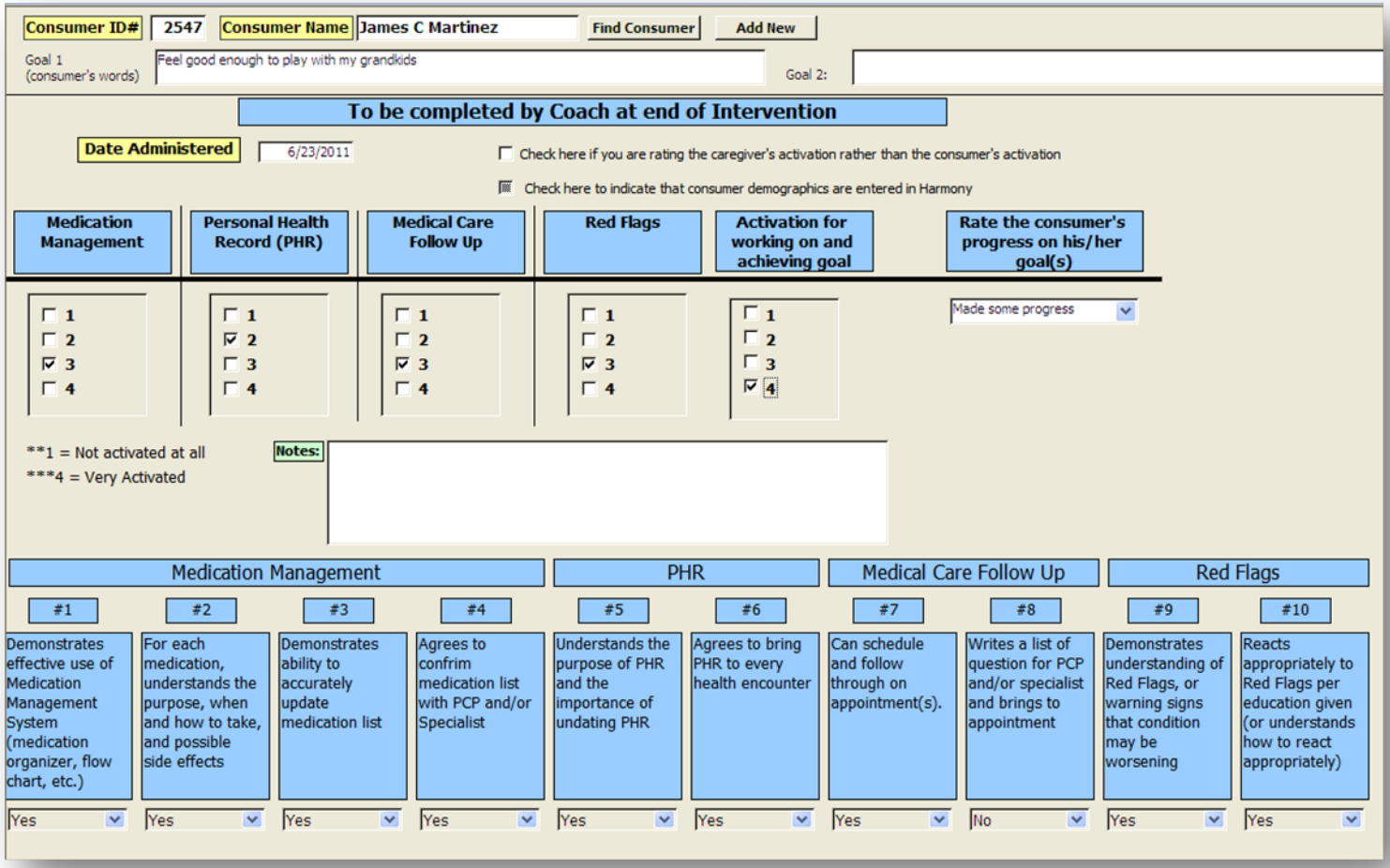
Coach-Rated Patient Activation



Consumer ID# 2547 Consumer Name James C Martinez Find Consumer Add New

Goal 1 (consumer's words): Feel good enough to play with my grandkids

Goal 2:

To be completed by Coach at end of Intervention

Date Administered: 6/23/2011

☐ Check here if you are rating the caregiver's activation rather than the consumer's activation

☑ Check here to indicate that consumer demographics are entered in Harmony

Medication Management	Personal Health Record (PHR)	Medical Care Follow Up	Red Flags	Activation for working on and achieving goal	Rate the consumer's progress on his/her goal(s)
☐ 1 ☐ 2 ☑ 3 ☐ 4	☐ 1 ☑ 2 ☐ 3 ☐ 4	☐ 1 ☐ 2 ☑ 3 ☐ 4	☐ 1 ☐ 2 ☑ 3 ☐ 4	☐ 1 ☐ 2 ☐ 3 ☑ 4	Made some progress

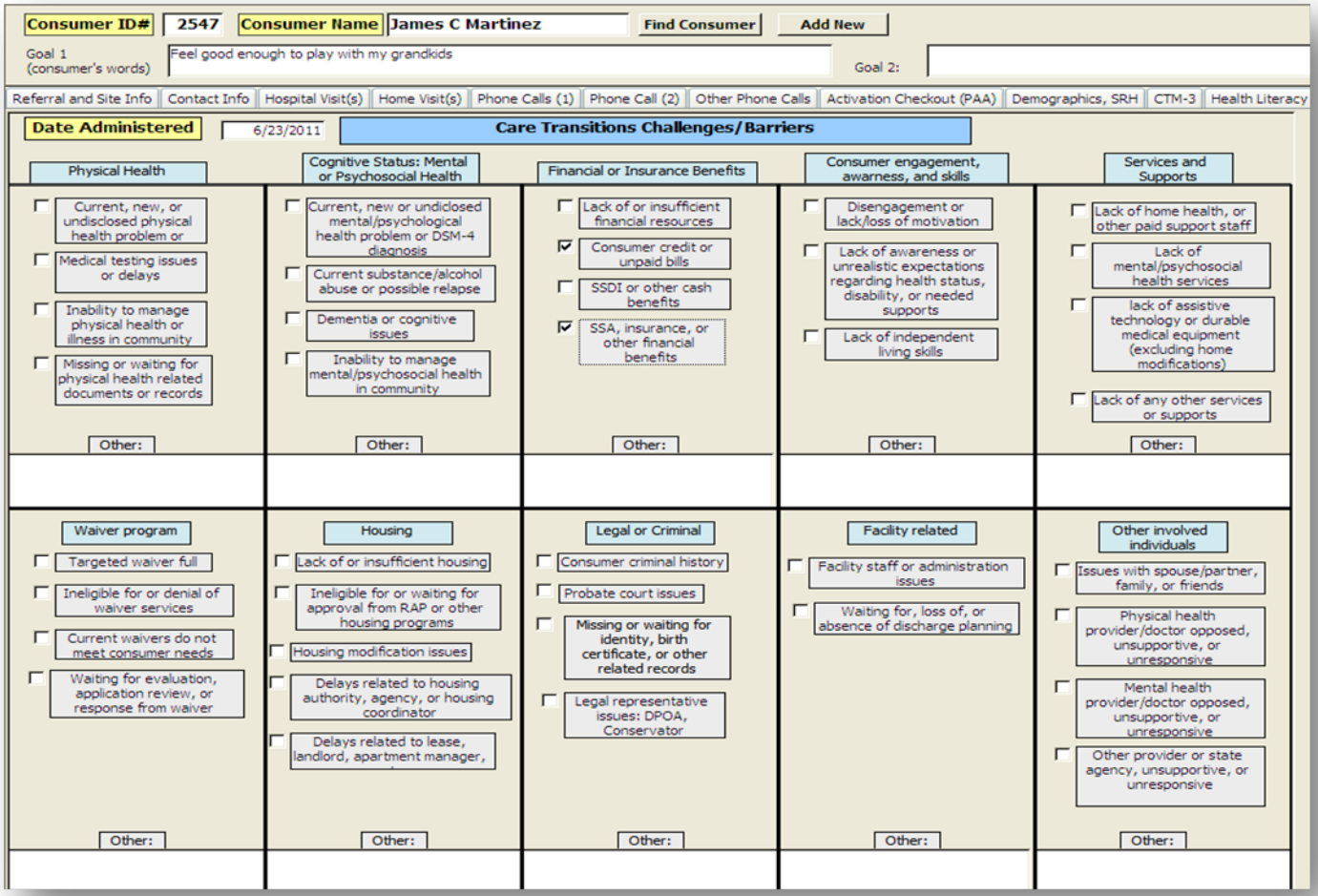
**1 = Not activated at all

***4 = Very Activated

Notes:

Medication Management				PHR		Medical Care Follow Up		Red Flags	
#1	#2	#3	#4	#5	#6	#7	#8	#9	#10
Demonstrates effective use of Medication Management System (medication organizer, flow chart, etc.)	For each medication, understands the purpose, when and how to take, and possible side effects	Demonstrates ability to accurately update medication list	Agrees to confrim medication list with PCP and/or Specialist	Understands the purpose of PHR and the importance of undating PHR	Agrees to bring PHR to every health encounter	Can schedule and follow through on appointment(s).	Writes a list of question for PCP and/or specialist and brings to appointment	Demonstrates understanding of Red Flags, or warning signs that condition may be worsening	Reacts appropriately to Red Flags per education given (or understands how to react appropriately)
Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes

Coach-Rated Barriers to Engagement (Connecticut Measure)



Consumer ID# 2547 Consumer Name James C Martinez Find Consumer Add New

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Referral and Site Info | Contact Info | Hospital Visit(s) | Home Visit(s) | Phone Calls (1) | Phone Call (2) | Other Phone Calls | Activation Checkout (PAA) | Demographics, SRH | CTM-3 | Health Literacy

Date Administered 6/23/2011

Care Transitions Challenges/Barriers

Physical Health
- ☐ Current, new, or undisclosed physical health problem or
- ☐ Medical testing issues or delays
- ☐ Inability to manage physical health or illness in community
- ☐ Missing or waiting for physical health related documents or records

Other:

Cognitive Status: Mental or Psychosocial Health
- ☐ Current, new or undiclosed mental/psychological health problem or DSM-4 diagnosis
- ☐ Current substance/alcohol abuse or possible relapse
- ☐ Dementia or cognitive issues
- ☐ Inability to manage mental/psychosocial health in community

Other:

Financial or Insurance Benefits
- ☐ Lack of or insufficient financial resources
- ☑ Consumer credit or unpaid bills
- ☐ SSDI or other cash benefits
- ☑ SSA, insurance, or other financial benefits

Other:

Consumer engagement, awarness, and skills
- ☐ Disengagement or lack/loss of motivation
- ☐ Lack of awareness or unrealistic expectations regarding health status, disability, or needed supports
- ☐ Lack of independent living skills

Other:

Services and Supports
- ☐ Lack of home health, or other paid support staff
- ☐ Lack of mental/psychosocial health services
- ☐ lack of assistive technology or durable medical equipment (excluding home modifications)
- ☐ Lack of any other services or supports

Other:

Waiver program
- ☐ Targeted waiver full
- ☐ Ineligible for or denial of waiver services
- ☐ Current waivers do not meet consumer needs
- ☐ Waiting for evaluation, application review, or response from waiver

Other:

Housing
- ☐ Lack of or insufficient housing
- ☐ Ineligible for or waiting for approval from RAP or other housing programs
- ☐ Housing modification issues
- ☐ Delays related to housing authority, agency, or housing coordinator
- ☐ Delays related to lease, landlord, apartment manager,

Other:

Legal or Criminal
- ☐ Consumer criminal history
- ☐ Probate court issues
- ☐ Missing or waiting for identity, birth certificate, or other related records
- ☐ Legal representative issues: DPOA, Conservator

Other:

Facility related
- ☐ Facility staff or administration issues
- ☐ Waiting for, loss of, or absence of discharge planning

Other:

Other involved individuals
- ☐ Issues with spouse/partner, family, or friends
- ☐ Physical health provider/doctor opposed, unsupportive, or unresponsive
- ☐ Mental health provider/doctor opposed, unsupportive, or unresponsive
- ☐ Other provider or state agency, unsupportive, or unresponsive

Other:

Data Table Examples

IDs, Names, Goals

1)ID/Name/Goals

StudyNo	PLstName	PFstName	PMidIni	Goal 1	Goal 2	Add N
2547	Martinez	James	C	Feel good enough to play with my grandkids		
2567	Howard	Neil	M	Quit smoking		
3400	Schneider	Eleanor	F	To not fall again		
6700	Faeke	Carter	J	To manage diabetes so another amputation does not happen		

Demographics and Self-Rated Health

1)Demographics/SRH

StudyNo	Age	Sex	Hispanic/Lat	Race	Highest grade completec	Refused/Un	Date	SRH	Completed by c	Medicare #
2547	67	Male	Yes	White	Completed High School or (	☐	6 /9 /2011	Fair	☐	0
2567	61	Male	No	Native Hawaiia	Some college	☐	5 /21/2011	Good	☐	
3400	81	Female	No	White	Completed High School or (	☐	4 /9 /2011	Fair	☐	
6700	55	Male	No	Black or Africar	Graduated college	☐	3 /2 /2011	Very Good	☐	

Care Transitions Measure (CTM-3)

StudyNo	Preferences	Good Understanding	Purpose of Meds	Unable/Refused	Date	Completed by caregiver
2547	Agree	Agree	Agree	☐	6/23/2011	☐
2567	Agree	Strongly Agree	Agree	☐	6/4/2011	☐
3400	Agree	Strongly Agree	Strongly Agree	☐	4/23/2011	☐
6700	Agree	Agree	Strongly Agree	☐	4/6/2011	☐

Data Can be Collated into Reports for Project Management

Report Contact Dates

StudyNo	Enrollment Date	Hospital Visit Date	Discharge Date	Home Visit Date	Ph2Date	Ph7Date	Rehospitalized	RehopsDT
987	6/5/2011	6/5/2011	06/08/2011	6/9/2011	6/16/2011	6/23/2011	☐	
2547	6/6/2011	6/6/2011	06/08/2011	6/9/2011	6/16/2011	6/23/2011	☐	
2567	5/18/2011	5/17/2011	05/18/2011	5/21/2011	5/28/2011	6/4/2011	☐	
3400	4/5/2011	4/5/2011	04/08/2011	4/9/2011	4/16/2011	4/23/2011	☐	
6700	3/22/2011	3/22/2011	03/22/2011	3/23/2011	3/30/2011	4/6/2011	☐	

Thursday, June 16, 2011

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Questions, Comments, Suggestions?

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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://*www.techandaging.org/* (Center for Technology and Aging)
- 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)

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

- *Aligning Systems to Support Medicare-Medicaid Enrollees*
  - Tuesday, July 5, 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