Center for Technology and Aging

Using IT Tools to Enhance ADRC-based Care Transitions Programs
Stories from the Tech4Impact Program

Background

The Center for Technology and Aging (www.techandaging.org) sponsored the Technologies for Improving Post-Acute Care Transitions, Tech4Impact, grant program with support from The SCAN Foundation. Five state units on aging were awarded a total of $500,000 in grants, the purpose of which were to encourage ADRCs to utilize information technologies to enhance evidence-based care transitions initiatives. The Tech4Impact grant program was designed and launched in collaboration with AoA and CMS and complemented Option D grants awarded through "Implementing the Affordable Care Act: Making it Easier for Individuals to Navigate their Health and Long-Term Care through Person-Centered Systems of Information, Counseling and Access." The grant cycle began in January 2011.

Two states are expanding use of technologies that enhance care transitions program evaluation and planning and three states are expanding use of technologies that better empower consumers in the care transitions process.

- California: This project enables patients to manage chronic conditions and locate resources via a personal health record (PHR) and Network of Care (NoC) online resources. The collaborators include: San Diego ADRC, Sharp Memorial Hospital, Trilogy Integrated Resources and the San Diego Futures Foundation.
- Indiana: This project will enhance and help evaluate the "Geriatric Resources for Assessment and Care of Elders," GRACE, model of care in order to improve the Veteran Administration's (VA) confidence in this model. The effort includes participation by the Indianapolis ADRC and VA Medical Center, the Indiana University School of Medicine, and the Indiana Family and Social Services Administration Division of Aging.
- Rhode Island (RI): This project seeks to reduce medication problems following a patient's hospital discharge by implementing an electronic health record (EHR) that is coupled with pharmacy services. Participants include the RI Department of Elderly Affairs and statewide ADRC, in collaboration with the University of RI College of Pharmacy, Rhodes to Independence, Quality Partners of RI, and ER Card.
- Texas: This project expands the Care Transitions Intervention (CTI) model evaluation process by modifying a single data collection and reporting system for CTI coaches in the Scott & White Healthcare system. The Texas Department of Aging & Disability Services will conduct project oversight and support activities, and the project will be implemented by several Texas ADRCs.
- Washington: This project expands the CTI model through the use of the web-based Shared Care Plan PHR platform used in Whatcom and Skagit Counties, and by creating a training curriculum for the Shared Care Plan. Participants include the Whatcom Health Information Network, and the Northwest Regional Council.

Patient/Family Stories

The California Tech4Impact Program: Using Web Resources and Personal Health Record Technology to Help Activate Patients and Caregivers

This family story illustrates how an ADRC used IT tools to help empower family members to support a recently hospitalized patient: Tien is a chronically ill, 75 year-old, monolingual, Chinese female. Her primary caregiver is her granddaughter, Connie. The family looks to Connie to oversee her grandmother's health management. Connie is in her 20's, has a laptop and is very tech savvy. She is very knowledgeable about her grandmother's medications, diagnoses, and red flags. In fact, she had created her own medication spreadsheet and was about to create other spreadsheets to organize her grandmother's health information when she was informed about the Tech4Impact Project. She was thrilled when the CTI Coach told her about the Network of Care (NoC) Web resource and the electronic personal health record (PHR). She immediately enrolled in the Tech4Impact Project. During the CTI Coach's home visit, Connie established a PHR account for her grandmother and entered one medication into the electronic PHR. When the Technical Coordinator made his home visit, Connie was coached to enter her grandmother's other medications into the PHR and was educated about how she could use the PHR to organize health information and share the PHR with other family members. She was very excited about the pop ups that linked her to information about her grandmother's medications and health conditions. She created an emergency card for her grandmother to carry with her, and she learned how to find needed services and resources in the Service Directory. She also learned how to research health topics in the Library. Connie was very impressed with the NoC Web resource and said that she hadn't found anything like it in her Internet searches. She was ecstatic that she no longer had to create spreadsheets to stay on top of her grandmother's health. The NoC Web resource was going to make her job as the primary caregiver for her elderly grandmother much easier.

The Indiana Tech4Impact Program: Using IT Tools to Promote Evidence-Based Care and Follow-up

This patient story illustrates the power of IT to help ensure quality care in a care transitions initiative that included an ADRC, a university, and a Veterans Health Administration site: Jim was an older Veteran with frequent falls and hospitalizations, who was frustrated and suspicious of providers as he couldn't communicate effectively with them. He was thought by providers to have cognitive impairment and to be taking his medications improperly. The GRACE technologies including the electronic assessment tool and care planning protocols aided the GRACE nurse practitioner and social worker in providing a comprehensive evaluation. It was discovered that Jim had profound hearing loss previously unrecognized. The GRACE protocols for hearing impairment and medication management were triggered including several interventions for better care and outcomes. Specifically, the GRACE team typed out questions and always used written communication during visits. Per Jim's daughter, Jim grew to really enjoy the GRACE team visits because he felt like they were listening to him. Extensive medication management using written communication led to Jim's using a pill box, not taking dangerous over-the-counter medications, and better understanding and adhering to his medication regimen. Jim was not found to have cognitive impairment but only profound hearing loss which makes him seem confused at times. Jim has had no further falls or hospitalizations since the GRACE team got involved with his care.

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Program Stories

The Texas Tech4Impact Program: Using an IT Tool to Streamline CTI Care Planning, Management, and Evaluation

An ADRC and health care system in Central Texas recognized the need for a streamlined IT tool to document Care Transition Intervention (CTI) coaching activities while gathering information for evaluation purposes. (CTI is largely paper based). With support from the Center for Technology and Aging, the ADRC has further developed the tool and promoted its benefits to ADRCs nationwide.

This Tech4Impact program demonstrates the need and interest among ADRCs in "putting IT into care transitions. In just ten months, 38 sites in 18 states began using or evaluating the tool. The tool was also introduced to 29 coaches from 12 new Texas sites.

The California Tech4Impact Program: Sustaining a Program that Uses IT Tools to Help Activate Patients and Caregivers

A California ADRC is putting plans into place in order to continue their Tech4Impact program well beyond the grant period. San Diego's ADRC has received funding from the San Diego Beacon Community Collaborative to sustain and expand the CTI and Tech4Impact programs through April 2013 to three hospitals. Additionally, San Diego's ADRC is partnering with 4 large health systems that are comprised of 13 hospitals to apply for the CMS Community-based Care Transitions Program (CCTP). The ADRC care transitions intervention that will be provided to high-risk Medicare beneficiaries includes the adoption of technology into the CTI evidence-based practice.

The Tech4Impact program is well aligned with initiatives being carried out by the HHS Office of the National Coordinator (ONC). Tech4Impact grantees in the San Diego area, central Indiana, and Rhode Island have had the benefit of riding the coat tails of Beacon Community initiatives, which have much larger funding bases. Moreover, since the Center for Technology and Aging has been working collaboratively with ONC, the Tech4Impact grant has opened the door for grantees to provide input into ONC agendas and activities, including the Consumer eHealth initiative and the Putting IT into Care Transitions initiative.