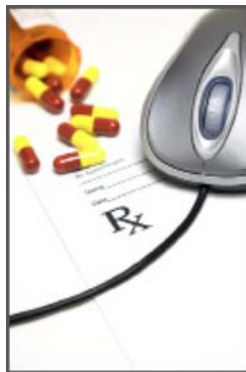


## Tech4Impact Diffusion Grants Program

*Summary of the Program and the Awardees*

*January 2011*



## Tech4Impact Diffusion Grants Program Summary

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

January 2011

### Table of Contents

Tech4Impact Program Background and Purpose .....	3
Summary of Proposals .....	5
California Health and Human Services Agency Collaborative CTI/Electronic Personal Health Records Proposal .....	6
Indiana Family & Social Services Division of Aging Collaborative GRACE Technologies Proposal...	8
Rhode Island Department of Elderly Affairs Collaborative ER-Card Proposal .....	10
Texas ADRC Proposal: Software-Facilitated Evaluation of Cross-Site Implementation and Outcomes of the Care Transitions Intervention Project .....	12
Washington State Department of Social and Health Services-Aging and Disability Services Administration Proposal .....	14

## Tech4Impact Diffusion Grants Program

### Background and Purpose

#### Recommended Tech4Impact Applicants

The Request for Proposals for the Tech4Impact Diffusion Grants Program was distributed to 16 state units on aging on September 29, 2010. A total of 12 Tech4Impact proposals were received on October 21, 2010. The Center for Technology and Aging Grant Review Committee identified five 1-year grants, totaling \$494,301, that merited immediate funding. The states represented are: **California, Indiana, Rhode Island, Texas, and Washington**. The grant cycle begins in January 2011 and ends December 2011.

#### Program Purpose

The purpose of the Tech4Impact Diffusion Grants Program is to accelerate adoption and diffusion of technologies that better enable evidence-based care transitions models, and result in a reduction in avoidable hospitalizations, improvements in health outcomes and cost of care, and an increase in the number of people that are able to safely and effectively transition from hospital to home or similar settings.

#### Tech4Impact Stakeholders

- **Program collaborators:** Administration on Aging (AoA) and Centers for Medicare & Medicaid Services (CMS)
- **Grant applicants:** State units on aging and other state entities
- **Grant program implementers:** Aging and Disability Resource Centers (ADRCs) and their community partners (e.g., community hospitals)
- **Patients/Consumers targeted:** Patients transitioning from hospital to home or other similar settings

#### About CTA's Collaboration with AoA and CMS

From program conception to program launch, CTA has worked closely with AoA and CMS to create Tech4Impact. Tech4Impact was specifically designed to complement and supplement the AoA/CMS ADRC Evidence-Based Care Transition Program which is part of a \$68 million initiative titled *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*.<sup>1</sup> On 27 September 2010, sixteen states received AoA/CMS awards under the ADRC Evidence-Based Care Transition Program. These 16 states were eligible to apply for the Tech4Impact grants program.

#### Use of Tech4Impact Funds

Funds will be used to further expand technology use in ADRCs that are implementing transitional care interventions. Two grantees are expanding use of technologies that enhance care transitions program evaluation and planning, and three grantees are expanding use of technologies that better empower patients/consumers in the care transitions process.

This report includes a summary table of the five initiatives. A more detailed description of each project, their technologies, and their goals follows.

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<sup>1</sup> For further information see page 121 of the AoA/CMS Program Announcement at <http://www.aoa.gov/AoARoot/Grants/Funding/index.aspx>, Funding Opportunity: HHS-2010-AoA-CT-1026.

## Summary of Proposals

State Applicant	Proposal	Technology	Collaborators	Target Population	Award
<b>California</b>	Activate patients to manage chronic conditions and locate resources via ePHR and Network of Care (NoC). Engage MDs/caregivers in virtual teaming	ePHR as provided on NoC website	San Diego ADRC, Sharp Memorial Hospital, Trilogy (NoC owner), SD Futures Foundation	36-50 CTI patients and 125 Sharp providers	\$100,000
<b>Indiana</b>	Enhance and evaluate GRACE processes and quality of care, improve VA's confidence in GRACE model	GRACE protocols and evaluation software customized to VA's EHR system	ADRC and VA in Indianapolis, Indiana U School of Med.	200 hospitalized Veterans at risk of readmissions and institutional LTC, in Marion County	\$100,000
<b>Rhode Island</b>	Augment health care system during patient transitions by implementing EHR coupled w/ pharmacy services to reduce medication problems post-discharge	ER-Card—which provides medication information at the point of care	ADRC for all of RI, Univ of RI College of Pharmacy, Quality Partners, ER Card	250 ADRC patients that were recently hospitalized and pass health literacy screen	\$94,414
<b>Texas</b>	Expand CTI model evaluation processes by modifying a single data collection and reporting system for CTI coaches ( <i>CT Coach System</i> )	Modified <i>Care Transitions Coach System</i> : Single data collection and reporting system (Microsoft Access) for cross-site implementations	Central Texas ADRC, Scott & White Healthcare, Texas Quality Improvement Organization, Texas Medical Foundation Health Quality Institute	540 patients 60+ y/o from Scott & White sites plus 250 patients from other project partners--all within Central TX	\$99,827
<b>Washington</b>	Expand CTI model through the use of the web-based <i>Shared Care Plan</i> PHR Platform in Whatcom and Skagit Counties and by creating a training curriculum for the Shared Care Plan	HInet's web-based <i>Shared Care Plan Platform</i> (PHR), which is integrated with Microsoft's HealthVault	HInet (Whatcom Health Information Network, LLC), Northwest Regional Council (AAA and ADRC sponsor)	180 adult patients who are not Medicare fee-for-service. Will include Medicare advantage, Medicaid, private insurance & hospital charity beneficiaries	\$100,000

Abbreviations: AAA = Area Agency on Aging, ADRC = Aging and Disability Resource Center, CTI = Care Transitions Intervention ("the Coleman Model"), ePHR = electronic personal health record, EHR = electronic health record, LTC = Long Term Care, PHR = Personal Health Record, VA = Veterans Administration

## California Health and Human Services Agency Collaborative CTI/Electronic Personal Health Records Proposal

### Project Goals

The overarching goal of this project is to support the Care Transition Intervention (CTI) by reinforcing participants' adherence to the four pillars of the CTI Model beyond the four-week project through adoption of technology. The project goals are: (1) to activate chronically ill patients to manage their chronic conditions through utilization of an electronic personal health record (PHR); (2) to engage formal and informal caregivers in supporting chronically ill patients by communicating and coordinating care through an electronic PHR; and (3) to activate patients to use a Web-based tool to locate services and resources, plan for their long term care needs, and learn how to improve their health and wellbeing.

### Technology Intervention to be utilized

The Aging & Independence Services (AIS), Network of Care (NoC) Web site, [www.sandiego.networkofcare.org/aging](http://www.sandiego.networkofcare.org/aging), is a comprehensive, Internet-based, free resource for older adults and people with disabilities, as well as their formal and informal caregivers. The site contains an electronic PHR, which is stored on a HIPPA compliant VeriSign-encrypted server; an extensive library with more than 30,000 articles; fact sheets and reports; a local service directory; a unique Long Term Care Options Counselor that facilitates long term care planning; links to fall prevention information, benefits and prescription assistance; local announcements and reports; and nationwide news.

**Rationale for selection:** The AIS NoC Web resource, together with the AIS Call Center and its partner, Access to Independence (the county's Independent Living Center), is San Diego County's Aging and Disability Resource Center (ADRC). It is a highly visible and trusted place to go to obtain information about long term care services and supports and access needed programs, services and benefits. Since its inception, this Web site has been enhanced locally to provide a warehouse of information on self-care management, healthy lifestyle choices, and other information to improve quality of life for our aging and disabled populations. In 2008, TEAM SAN DIEGO (TSD), a grass roots community health initiative to improve communication and care coordination among formal and informal care and service providers in support of activated patients with chronic conditions, was implemented. The PHR on the NoC has provided a medium for virtual teaming, improved communication and a tool to activate patients to better manage their health.

**Previous experience with this technology:** In 2004, AIS received grant funding from CMS and AoA through the California Department of Aging to establish an ADRC in San Diego. The AIS Call Center was already established as an integrated service delivery model and gateway to more than 30 different AIS programs and services. San Diego stakeholders recognized that a growing number of consumers, caregivers, healthcare and social service providers, and family members were turning to the Internet to obtain information and support. In response to the needs of our community, a partnership was formed between the owner of the NoC site, Trilogy Integrated Resources Inc., and AIS. Through collaboration, the NoC Web resource was enhanced to include supports and elements that weren't available on other Web sites. Over the years, that partnership has grown and further customization of the site has made AIS' NoC the flagship of Trilogy's websites. Dedicated AIS staff and community stakeholders continue to recommend design and functionality changes to the site which are readily implemented by Trilogy.

**Care transitions model to be utilized:** Care Transitions Intervention

**Collaborators:** AIS, the lead agency in San Diego's ADRC and the County's umbrella agency for programs and services for older adults and persons with disabilities, will carry out this project in partnership with Sharp Memorial Hospital, the largest provider of acute-care services in San Diego County and AIS' partner in the existing Care Transitions Intervention (CTI) Program.

### **Consumer/Patient Population(s) to be Targeted**

The populations that will be served include Sharp Memorial CTI participants over the age of 55 who have one or more chronic health conditions such as congestive heart failure, diabetes, respiratory disease, or others who are at high risk for readmission. In addition, special attention will be given to identify CTI participants who are Medi-Cal recipients, uninsured or don't have access to Sharp Healthcare's online health portal, *mySharp*.

A minimum of 20% of participants enrolled in CTI each month (a total of approximately 36-50 CTI patients) will receive technical support and coaching to establish a PHR on the NoC, maintain an accurate medication list, grant access to their PHR to formal and informal caregivers, and engage their "team" in supporting them through improved communication and care coordination utilizing the unique capabilities of the PHR. In addition, 125 Sharp Healthcare providers will be educated about the NoC Web resource so that they can inform chronically ill patients not enrolled in CTI upon discharge about how to locate needed services and resources and manage their health through the PHR.

### **Sustainability and Replicability Plans**

Immediate replication goals are targeted at early expansion through the Sharp Health Care System. As approved in the Option D application, San Diego's ADRC will develop a business case in 2011 for Sharp Memorial Hospital to assume full financial responsibility for the ADRC's CTI Coach position. If successful, this will ensure the sustainability of CTI. The business case will include the adoption of technology in the model. Additionally, Sharp HealthCare is interested in seeking future funding to link CTI with other existing Sharp projects, including their Remote Patient Monitoring Project, which is funded through a grant from CTA.

Team San Diego is sustainable through other funding, and can be replicated and customized. As an evidence-based model, CTI is easily replicated. All four California ADRCs (San Diego, San Francisco, Riverside, and Orange counties) are using CTI. Lastly, the NoC Web site can be easily and cost-effectively replicated because the infrastructure and many of its components (library, national links, PHR) are identical from one region in the country to another. Only region-specific components and resources for the Service Directory would require local development for replication.

### **Dissemination Plans**

Project results and lessons learned will be posted on the LTCIP Web site, [www.sdltcip.org](http://www.sdltcip.org). Results will also be shared with other ADRC Site Directors on monthly conference calls and quarterly with the ADRC Coalition and The California Community Choices Advisory Committee. As the recipient of the 2010 n4a "Leadership as Innovators in Aging Programs Award" because AIS "cultivates a creative and flexible atmosphere to foster groundbreaking programs," state and national leaders refer to AIS and the LTCIP for leadership, policy recommendations, and practice standards. The success of this project will highlight the value and cost effectiveness of CTI, the benefit of adopting technology to support this evidence-based model, and will demonstrate how persons with chronic conditions can be activated to manage their health and engage their "team" to communicate "virtually" through an electronic PHR. This innovative approach to care coordination integrates social services into the health care system model and supports the culture change required to improve health outcomes for people with chronic illnesses.

## **Indiana Family and Social Services Division of Aging Collaborative GRACE Technologies Proposal**

### **Project Goals**

To enhance current activities of care planning, tracking, and communication; and to use computer-based technologies for program evaluation ensuring fidelity to the GRACE model and measuring quality indicators.

### **Technology Intervention to be utilized**

The GRACE intervention uses technologies to aid in individualized care plan development and tracking, facilitate communication among providers, and to evaluate processes and quality of care.

**Rationale for selection:** The GRACE care transition model has demonstrated in a randomized trial to improve quality and outcomes, including reduced hospital admissions and readmissions in low-income seniors at high risk of hospitalization.

**Previous experience with this technology:** Investigators at Indiana University invented GRACE technologies and for 8 years have successfully applied to patient care including at a public safety-net healthcare system and large managed care medical group.

**Care transitions model to be utilized:** GRACE (Geriatric Resources for Assessment and Care of Elders)

### **Collaborators**

The Indiana Tech4Impact project will strengthen existing partnerships between the local ADRC (CICOA Aging and In-Home Solutions), Indianapolis VAMC, Indiana University School of Medicine, and the Indiana Family and Social Services Administration Division of Aging.

### **Consumer/Patient Population(s) to be Targeted**

- Hospitalized Veterans at risk of for hospital readmission and institutional long-term care
- Aged 65 or older.
- Marion County, Indiana
- 200 cases will be evaluated

### **Sustainability and Replicability Plans**

Indianapolis VAMC is committed to continuing GRACE and associated technologies beyond the start-up and project funding period based upon measurable success in expanding patient centered alternatives to institutional extended care. The initial grant funding will provide the needed resources to initiate the program and document patient and health system benefits providing the rationale for long-term sustainability. Outcomes from this project will be used to develop a business case to support expansion of the program to serve additional at risk older Veterans. A critical component of this business case will be the demonstration that GRACE costs will be covered through additional VERA reimbursement based on patients served by the program, combined with cost savings from reduced acute care utilization. In addition, GRACE and the associated technologies are scalable to the VA's large primary care based healthcare system and complement current geriatrics and extended care programming and the broader medical home initiative. Furthermore, the GRACE model helps optimize the roles and efficiency of primary care and geriatrics healthcare professionals, both of which are in limited supply and in need of augmentation.

### **Dissemination Plans**

This project has potential for impacting the health and independence of older Veterans well beyond those served by the Indianapolis VAMC. Findings from this demonstration will provide valuable information and tools that will facilitate GRACE dissemination and collaboration with ADRCs within Indiana and nationwide. Documented success of the GRACE technologies in transforming care transitions and integrating medical and social care for older Veterans in Indianapolis will lead to rapid dissemination nationally by the Veterans Health Administration since these technologies will be transferable to VA Medical Centers around the country all of which use the same electronic medical record. Beyond the VA healthcare system, the Indiana project team will disseminate results statewide and nationally through networking and meetings. Specifically, Dr. Counsell will present results during an invited presentation at the April 2011 American Society on Aging/Aging in America Conference in San Francisco, CA, and at the May 2011 Annual Scientific Meeting of the American Geriatrics Society in National Harbor, MD. As a 2009-2010 Health and Aging Policy Fellow, Dr. Counsell developed a national network of colleagues interested in health policy toward better integration of medical and social care in vulnerable elders, and including policy makers at CMS and the U.S. Administration on Aging.



## Rhode Island Department of Elderly Affairs Collaborative ER-Card Proposal

### Project Goals

1) To apply the ER-Card program and clinical pharmacy expertise to support medication management activities (including medication reconciliation) in reducing medication-related problems during patient transitions in care; 2) To evaluate the utility of this model with standard paper-based sources/tools in identifying and addressing medication-related problems.

The vision behind the ER-Card® program is that a patient-managed electronic personal health record, accessible by health care workers during patient interactions with the health care system, will improve the safety, effectiveness and efficiency of care delivery. The program has been operating in the state of Rhode Island and achieving these aims since 2002. However, the utility of this program has not yet been evaluated specifically within the context of patient transitions in care. As a component of an integrated care delivery system, the ER-Card program offers a solution to many of the challenges described above. It provides health care personnel with updated medication information at the point of care, thus facilitating medication reconciliation and decision making. Furthermore, the utility of the ER Card program extends longitudinally beyond the care transition episode to provide critical information to primary care providers, further connecting the program into the physician office setting through medication profile reviews and through interventions by clinical pharmacists who continually review medication profiles for medication-related problems. The ER-Card program has been supported in part by RI legislative grants to apply the program among community-dwelling seniors and patients having disabilities.

### Technology Intervention to be utilized

ER-Card program, a patient managed electronic personal health record (PHR), accessible by health care professionals during patient interactions with the health care system at all points of care transition. It is web-accessible and is also available as a USB flash drive. This application will be utilized in conjunction with in-person clinical pharmacy involvement.

**Rationale for selection:** ER-Card application provides a continually updated repository of information describing a patient's medical history and medication use, including prescription and OTC drug use. In addition to pharmacy services the software also includes a section for homecare providers and a place for documenting and tracking health data such as blood sugar results, cholesterol level, weight and blood pressure.

**Previous experience with this technology:** The ER-Card program has been operating in RI since 2003 through a strong partnership between URI-CoP and ER-Card, LLC. The pharmacy services component of ER-Card has yielded significant benefits in addressing the 5,000 enrolled patient's medication uses issues since its inception.

**Care transitions model to be utilized:** Care Transitions Intervention

### Collaborators

The Rhode Island Department of Elderly Affairs (RIDEA) in collaboration with the URI College of Pharmacy (URI-COP), Rhodes to Independence, Quality Partners of RI, ER Card, LLC as well as the network of service providers, will augment the capabilities of the health care system during patient transitions in care by implementing an electronic personal health record system coupled with clinical pharmacy services.

The College of Pharmacy has collaborated with the RIDEA and Quality Partners in numerous initiatives during the past several years with great success and amicability. Dr. Goldstein, in her

role as Director of Rhodes to Independence, has also worked closely with the RIDEA and Quality Partners, also to the great benefit of Rhode Islanders with disabilities. Leaders of the private entity that operates the ER-Card program also have strong and highly positive relationships with the involved parties. These existing relationships provide a significant benefit in allowing this initiative to ramp up quickly and operate with open and candid communication.

**Consumer/Patient Population(s) to be Targeted**

- This project will focus on THE POINT (RI-ADRC) clients who are or have recently been hospitalized.
- Eligible clients must speak English or Spanish and pass a health literacy screening, or have a family, friend, or caregiver who meets these criteria and can be coached as a proxy. Clients must have access to a computer with the Internet.
- Older adults (ages 60+) and adults with disabilities (aged 18+)
- Statewide (RI)

**Number to be served with grant**

Up to 250

**Sustainability and Replicability Plans**

If project results are favorable, the investigators will seek reimbursement for this model among local health insurers, and through participation as providers under Medicare Part D Medication Therapy Management reimbursement arrangements. ER-Card has recently received Medicare provider status.

**Dissemination Plans**

Investigators aim to present findings at national conferences within the realms of pharmacy and technology (e.g. HIMSS, ASHP, AMCP). At the local level, project findings will be shared with the RI state legislature, within the College's annual report which details the activities of the College in collaboration with the ER-Card program. Further visibility of the project will be gained through involvement in the larger Option D initiative.

## The Texas ADRC Proposal: Software-Facilitated Evaluation of Cross-Site Implementation and Outcomes of the Care Transitions Intervention Project

### Project Goals

Successful implementation of evidence-based programs such as the Care Transitions Intervention<sup>SM</sup> (CTI) in a wide range of healthcare and community settings requires site-specific adjustments to ensure integration into existing processes. It also requires sensitivity to the unique needs of communities and individual consumers. Texas anticipates that interventions will be implemented differently in “real world” community-based settings than they are in more carefully controlled research settings. Capturing data on exactly how interventions are implemented can serve two important purposes. First, data can be used to provide feedback to intervention personnel for the purposes of quality improvement and problem-solving, allowing staff to better meet consumer needs. Secondly, outcomes can be interpreted in the context of well-defined implementation patterns. This means staff can better describe consumer-coach interactions and what works best for which consumers, if they can efficiently document processes and outcomes.

The first goal of this project is to systematically evaluate implementation and outcomes of CTI in the Texas ADRC Evidence-Based Care Transitions Program using an electronic consumer management and data collection system called the *Care Transitions Coach System*. The current version, a publicly available file at [caretransitions.org](http://caretransitions.org), requires refinement for use in the various ADRC and community healthcare settings. The second goal of the project is to make the same evaluation infrastructure and support available to all ADRC project partners across Texas who are interested in conducting cross-site evaluations of CTI programs offered through “Option D” programs. The Texas ADRC Care Transitions Project leadership welcomes the opportunity to partner with the Center for Technology & Aging, AoA and the Centers for Medicare & Medicaid Services, to explore collaboration across the broader network of Care Transitions programs where applicable. Interested CTI Programs could be invited to use the tool and share their data with the Texas evaluation site, for the purpose of cross-site evaluation and improved dissemination of CTI in ways that are shown to be effective.

### Technology Intervention to be utilized

Care Transitions Coach software

**Rationale for selection:** The *Care Transitions Coach* software allows simultaneous management of CTI consumer panels and documentation of metrics needed to evaluate CTI implementation and outcomes. Integration of these functions will facilitate systematic evaluation of CTI without placing unnecessary demands for extra time/documentation on CTI coaches.

**Previous experience with this technology:** The *Care Transitions Coach* software is publicly available on [caretransitions.org](http://caretransitions.org) and was originally used in a CTI trial by Dr. Coleman’s group. Scott & White Healthcare is now using a revised version in a pilot study of CTI. Coaches find the software useful and easy to use. Researchers appreciate its capacity to capture necessary evaluation information.

**Care transitions model to be utilized:** Care Transitions Intervention

### Collaborators

The Texas Department of Aging & Disability Services will conduct project oversight and support activities, with a focus on diffusion of successful project outcomes to eight additional Texas ADRCs, (serving thirty-three additional Texas counties, which together represent a mix of urban, suburban, rural and frontier population centers).

Central Texas ADRC and Scott & White Healthcare will coordinate project implementation and evaluation. Additional Texas ADRCs and CTI: Option D grantees will be invited to collaborate.

### **Consumer/Patient Population(s) to be Targeted**

*Note that the following description applies to the Central Texas site. If other Texas ADRC sites and network CTI program partners choose to collaborate on this evaluation, their populations will be specific to their project.*

Central Texas Population Description: Six organizations are partnering on the Central Texas CTI project. Each serves different populations. Agencies, populations served and estimated number of consumers to be targeted is listed in Table 1 (below). Consumers will be children with developmental delays or special medical needs, persons with intellectual or physical disabilities, veterans with long-term care needs, and older persons with chronic conditions. To be eligible for CTI, consumers must be:

1. Admitted for an unscheduled hospitalization
2. Required (clinically) to be hospitalized for two or more days
3. Choose to receive CTI when invited
4. Eligible for ADRC services from one of the participating organizations (see Table 1, below)

Geographic locations: Central Texas ADRC service area—Bell, Coryell, Hamilton, Lampasas, Milam, Mills and San Saba Counties in Texas.

Regions served by additional ADRCs implementing CTI as part of the Texas Option D Proposal; with potential to serve thirty-three additional Texas counties, which together represent a mix of urban, suburban, rural and frontier population centers).

### **Number to be served with grant**

540 consumers hospitalized in Scott & White Healthcare hospitals plus 250 additional consumers identified in the community through partner organizations. Additional consumers will be reached by other Texas ADRCs.

### **Sustainability and Replicability Plans**

This one-year project will create the infrastructure for data reporting and sharing with the project site, and the Central Texas ADRC is willing to continue to lead any broader CTI evaluation efforts initiated during the project year, until the completion of the Option D programs. All project sites will benefit from pooled evaluation activities across a variety of communities, especially when examining whether aspects of implementation are associated with different outcomes (as measured within the tool's capacity to document outcomes of interest). Texas' plan includes delivery of a user manual for the revised coaching tool, which will be useful on other types of projects.

### **Dissemination Plans**

During the one-year project period, the Texas team will offer technical support and training on the tool, develop a revised version of the tool with feedback from users, and create a user guide. Texas has received informal confirmation from Dr. Coleman that the revised tool can be posted for public use at [caretransitions.org](http://caretransitions.org) after it is developed (pending his approval of the final product). This is the same website where the current version of the tool is available. By posting the tool at the CTI site, it will be readily available for others who choose to use it for their own evaluations.

## Washington State Department of Social and Health Services – Aging and Disability Services Administration Proposal

### Project Goals

The project's overall goal is to Advance the efficacy of Washington State's Care Transitions Intervention (CTI) model through expanded use of HInet's Shared Care Plan platform in Whatcom and Skagit Counties; and to determine how it can become an integral part of statewide ADRC expansion.

The objectives are to: (1) Develop an in-home Shared Care Plan training curriculum; (2) Expand use of the Shared Care Plan in Whatcom County; (3) Adopt and expand use of the Shared Care Plan in Skagit County; and (4) Analyze CTI participant and caregivers' experiences in use of the Shared Care Plan for determining further expansion opportunities.

### Technology Intervention to be utilized

Whatcom Health Information Network, LLC (HInet) and its Shared Care Plan Health Record Bank: A well established and web-based personal health record and communication tool. It is free to all residents of Whatcom and Skagit Counties. By the end of 2010, HInet will also have a more generic form of the PHR that will retain many core functions of the Shared Care Plan, except those specific to the local medical network, but will be available nationwide.

**Rationale for selection:** HInet is dedicated to improving quality of care and cost-effectiveness of care by using health information technology to ensure safe, effective transitions from one setting to another, and enhance patient participation in their personal care. This project expands on both the AoA Option D grant project and a currently funded contract awarded by Center for Medicare and Medicaid Services (CMS) to the QIO Qualis Health, which improves the transition of care for Medicare patients from acute care settings to home/community settings.

HInet and the Shared Care Plan Health Record Bank supports the 4 pillars of Eric Coleman's Care Transitions Intervention, incorporates the Patient Activation Measure, and facilitates improved patient self confidence for self-care management, which are integral components in Washington State's Option D Care Transitions project. In addition, HInet is close to launching, by the end of 2010, a more generic form of the Shared Care Plan (My Family Care Plan) that will be available nationally and could support expanded use by CTI participants and others in additional Washington State counties. The Shared Care Plan supports the following Tech4Impact allowable activities:

- Medication adherence
- Medication reconciliation
- Patient or caregiver access to health records and other important health information
- Home monitoring of a patient's health condition, including technologies that provide an early warning alert when a patient's health condition deteriorates
- Health risk assessments (e.g., to identify pre-discharge patients most at risk of hospital readmission)
- Communications between and among patients and informal caregivers, and formal caregivers
- Technology-based care transitions program evaluations that will guide and improve program quality

### Previous experience with this technology

HInet, a collaboration of over 15 community partners in Whatcom County, has been a national leader in making electronic personal health records (PHRs) feasible and available for patients. HInet hosts a secure web based PHR Bank, [www.sharedcareplan.org](http://www.sharedcareplan.org), that is available free of charge to all citizens of Whatcom and Skagit Counties. The Shared Care Plan PHR and Microsoft

HealthVault provide the technical infrastructure for two of the three WA Health Record Bank pilots of which Whatcom County is one. Further expansion of the Shared Care Plan as a Health Record Bank connected with the Microsoft Health Vault Platform and the State Immunization Registry, Child Profile, is currently funded through HInet by the WA State Health Care Authority with oversight by the state Health Information Infrastructure Advisory Board. HInet is an active participant in the Washington State HIE planning and development process. A CMS 9th scope of work contract with Qualis Health (the Beacon Regional Extension Center) is allowing HInet to develop a Workflow Assisted Care Transitions software module building upon the infrastructure of HInet and the Shared Care Plan.

**Care transitions model to be utilized:** Care Transitions Intervention

**Organizations Involved in Carrying out Project (Describe the following)**

1. Whatcom Health Information Network, (HInet), a limited liability company (LLC) and a secure, health care electronic communication channel (Intranet) in Whatcom County (<http://www.hinet.org>)
2. Northwest Regional Council, an Area Agency on Aging and ADRC sponsor

**Consumer/Patient Population(s) to be Targeted**

Care Transition Intervention (CTI) participants and their informal caregivers who have been invited and are interested in using the PHR, either in electronic or hardcopy format, regardless of health coverage payor, EXCEPT that in Whatcom County they cannot be Medicare fee-for-service beneficiaries as these are already being served by Qualis Health under a CMS Care Transition grant.

**Age Range:** 18 and over

**Geographic location(s):** Whatcom and Skagit Counties, Washington State

**Number to be served with grant**

180 individuals will be provided one-on-one in-home training and support to be set up and use the PHR; however it is anticipated that additional individuals will be activated to participate in the PHR as a result of community outreach and participation in the HInet drop-in sessions available to anyone in the community.

**Sustainability and Replicability Plans**

HInet is in the process of developing a more generic version of the Shared Care Plan to be available nationwide by the end of 2010. It will continue to be free to individuals and their caregivers. The proposed curriculum and videos will be available as project products and shared with current and anticipated ADRCs as well as partners across the state for replication. The training of ADRC staff to conduct individualized training and support in the expanded use of the Shared Care plan or its more generic version will be conducted through online webinars and in-person training using HInet staff.

**Dissemination Plans**

Products, progress reports, and outcomes of the Tech4Impact grant will be disseminated through AoA ADRC semi-annual and final grant reports; CTA reports and gatherings, learning collaboratives, statewide ADRC meetings, and contributions to a Tech4Impact toolkit.