Beacon Community Program

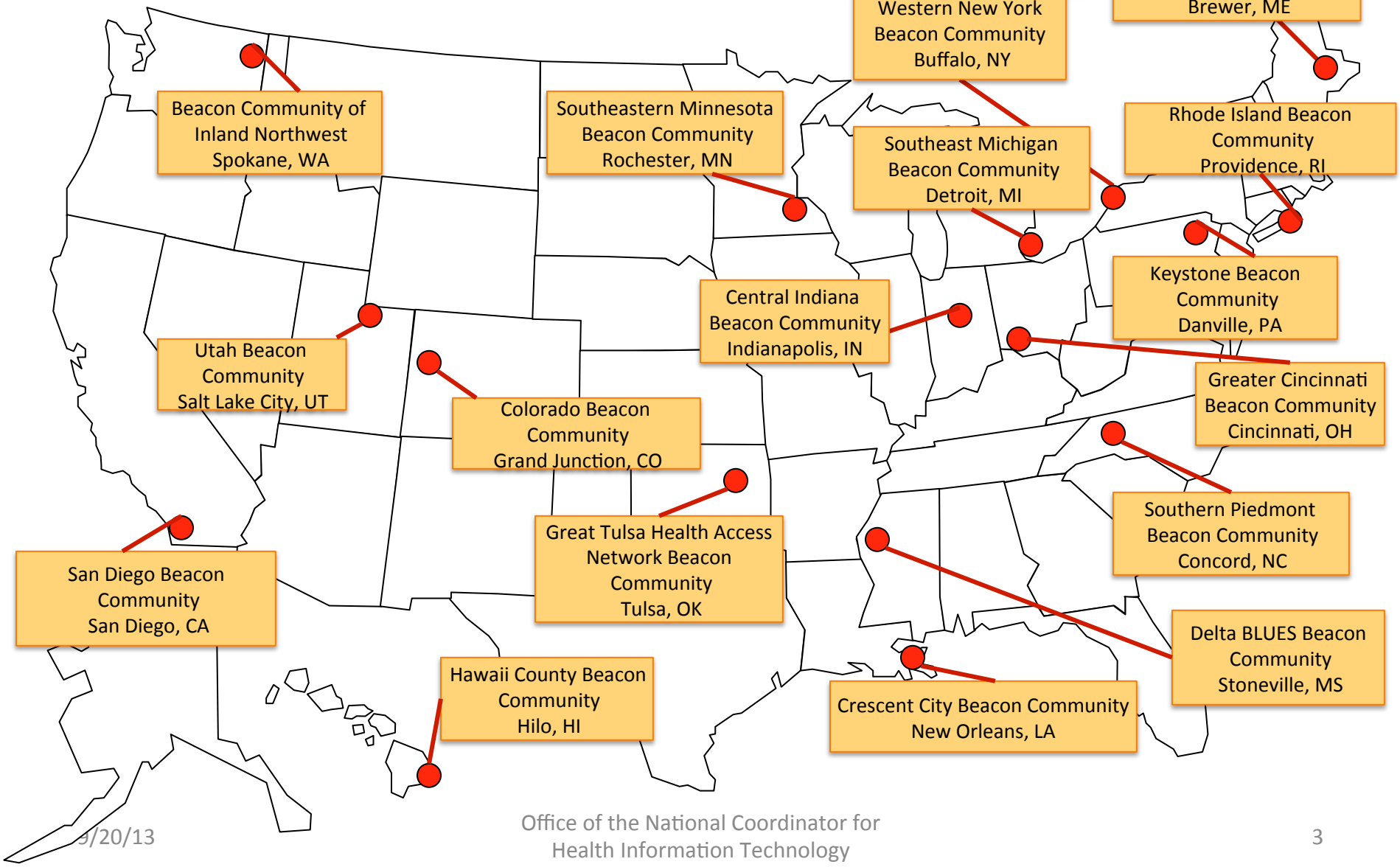
The Office of the National Coordinator for Health Information Technology

Shining on through Health IT Lessons Learned and Looking Forward with the Beacon Communities

Today's Agenda

Agenda Item	Speakers
Beacon Program Overview/Beacon Nation Overview	Janhavi Kirtane Fritz
Greater Cincinnati Beacon presentation	Trudi Matthews
Southeast Minnesota Beacon presentation	Lacey Hart
Question and Answer	All

17 Beacon Communities



Through the Beacon Community Program, HITECH Comes to Life

17 diverse communities each funded ~$12-16M over 3 years to:

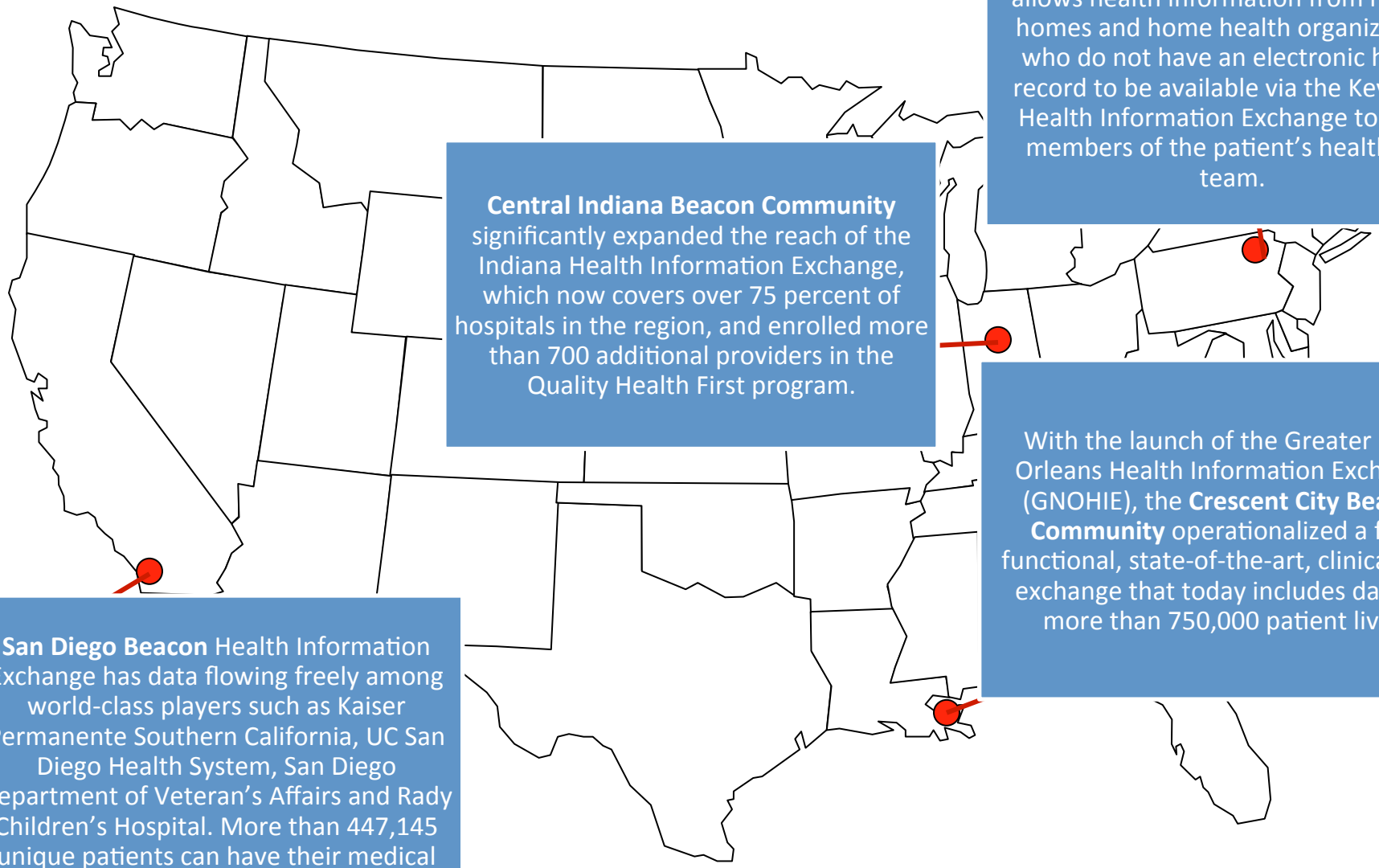
Build and strengthen health IT infrastructure and exchange capabilities - *positioning each community to pursue a new level of sustainable health care quality and efficiency over the coming years.*

Improve cost, quality, and population health - *translating investments in health IT in the short run to measureable improvements in the 3-part aim.*

Test innovative approaches to performance measurement, technology integration, and care delivery - *accelerating evidence generation for new approaches.*

EHR Adoption and Meaningful Use as the Foundation

Bright Spots from the Beacon Communities: Building and Strengthening Health IT



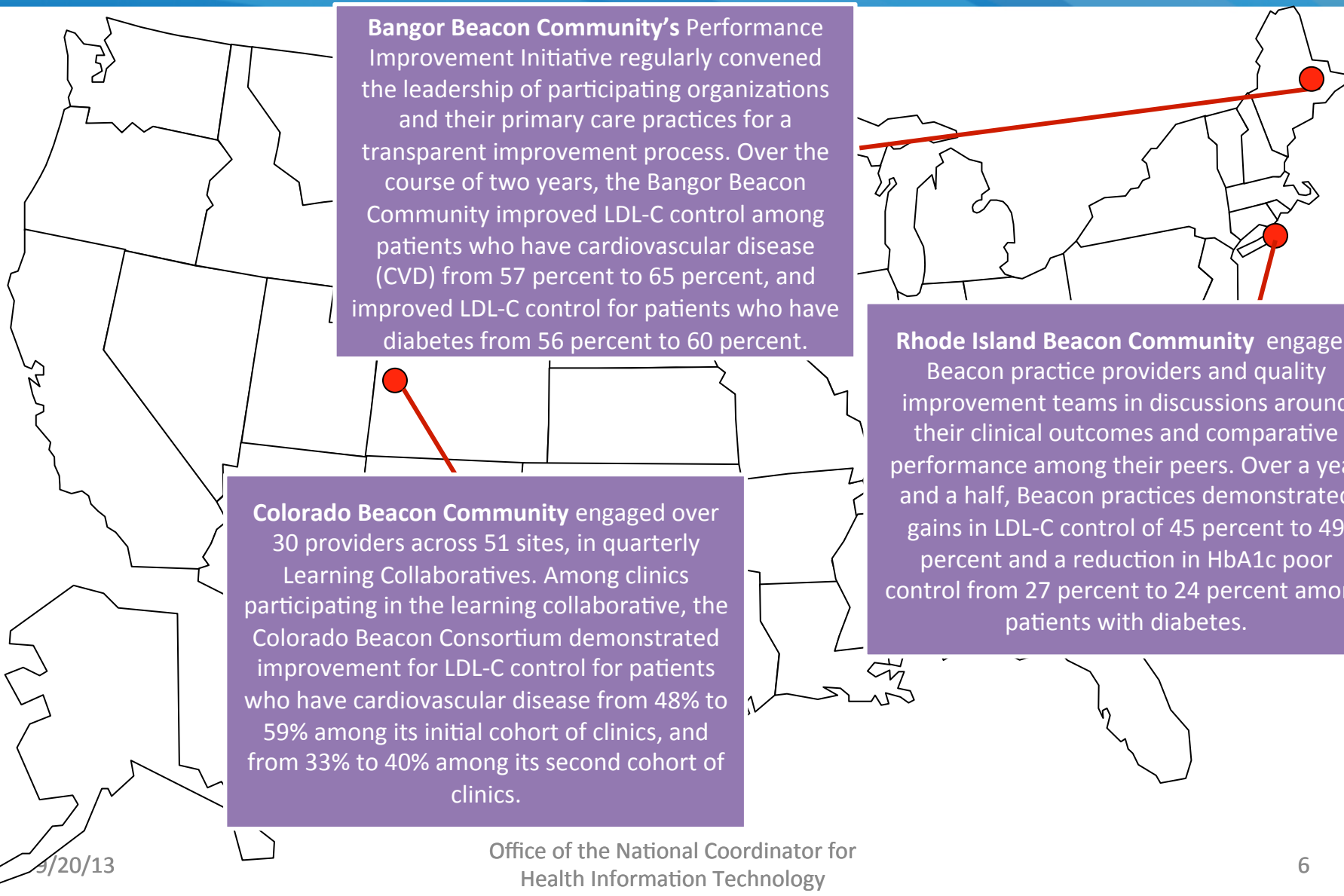
Keystone Beacon Community launched KeyHIE Transform, a low cost tool that allows health information from nursing homes and home health organizations who do not have an electronic health record to be available via the Keystone Health Information Exchange to other members of the patient's healthcare team.

Central Indiana Beacon Community significantly expanded the reach of the Indiana Health Information Exchange, which now covers over 75 percent of hospitals in the region, and enrolled more than 700 additional providers in the Quality Health First program.

With the launch of the Greater New Orleans Health Information Exchange (GNOHIE), the **Crescent City Beacon Community** operationalized a fully functional, state-of-the-art, clinical data exchange that today includes data on more than 750,000 patient lives.

San Diego Beacon Health Information Exchange has data flowing freely among world-class players such as Kaiser Permanente Southern California, UC San Diego Health System, San Diego Department of Veteran's Affairs and Rady Children's Hospital. More than 447,145 unique patients can have their medical records accessed in an emergency.

Bright Spots from the Beacon Communities: Improving Cost, Quality and Population Health



Bangor Beacon Community's Performance Improvement Initiative regularly convened the leadership of participating organizations and their primary care practices for a transparent improvement process. Over the course of two years, the Bangor Beacon Community improved LDL-C control among patients who have cardiovascular disease (CVD) from 57 percent to 65 percent, and improved LDL-C control for patients who have diabetes from 56 percent to 60 percent.

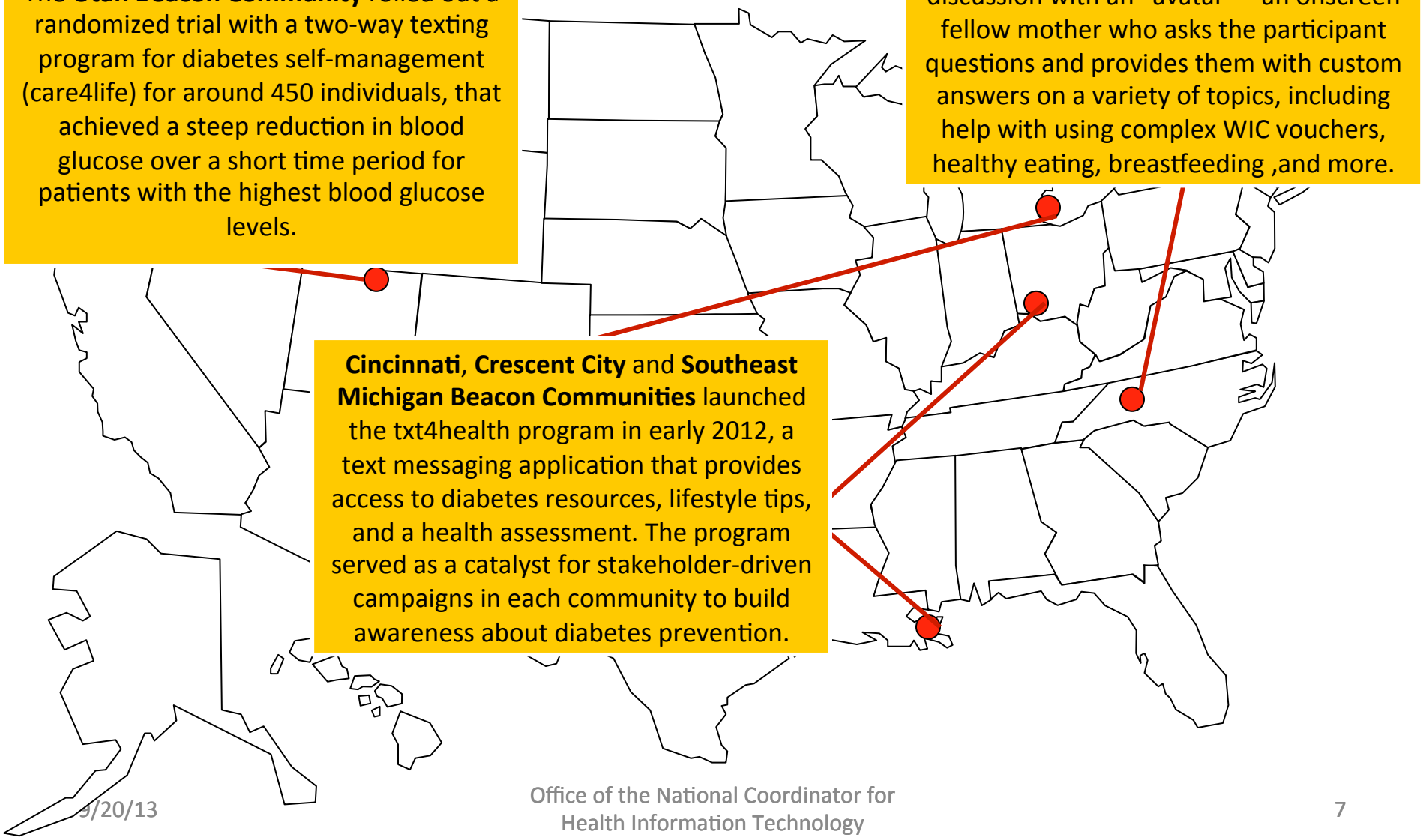
Rhode Island Beacon Community engaged Beacon practice providers and quality improvement teams in discussions around their clinical outcomes and comparative performance among their peers. Over a year and a half, Beacon practices demonstrated gains in LDL-C control of 45 percent to 49 percent and a reduction in HbA1c poor control from 27 percent to 24 percent among patients with diabetes.

Colorado Beacon Community engaged over 30 providers across 51 sites, in quarterly Learning Collaboratives. Among clinics participating in the learning collaborative, the Colorado Beacon Consortium demonstrated improvement for LDL-C control for patients who have cardiovascular disease from 48% to 59% among its initial cohort of clinics, and from 33% to 40% among its second cohort of clinics.

Bright Spots from the Beacon Communities: Testing Innovative Approaches

The **Utah Beacon Community** rolled out a randomized trial with a two-way texting program for diabetes self-management (care4life) for around 450 individuals, that achieved a steep reduction in blood glucose over a short time period for patients with the highest blood glucose levels.

In **Southern Piedmont Beacon Community**, the ANNA module, an interactive digital kiosk offers a virtual discussion with an "avatar"—an onscreen fellow mother who asks the participant questions and provides them with custom answers on a variety of topics, including help with using complex WIC vouchers, healthy eating, breastfeeding ,and more.

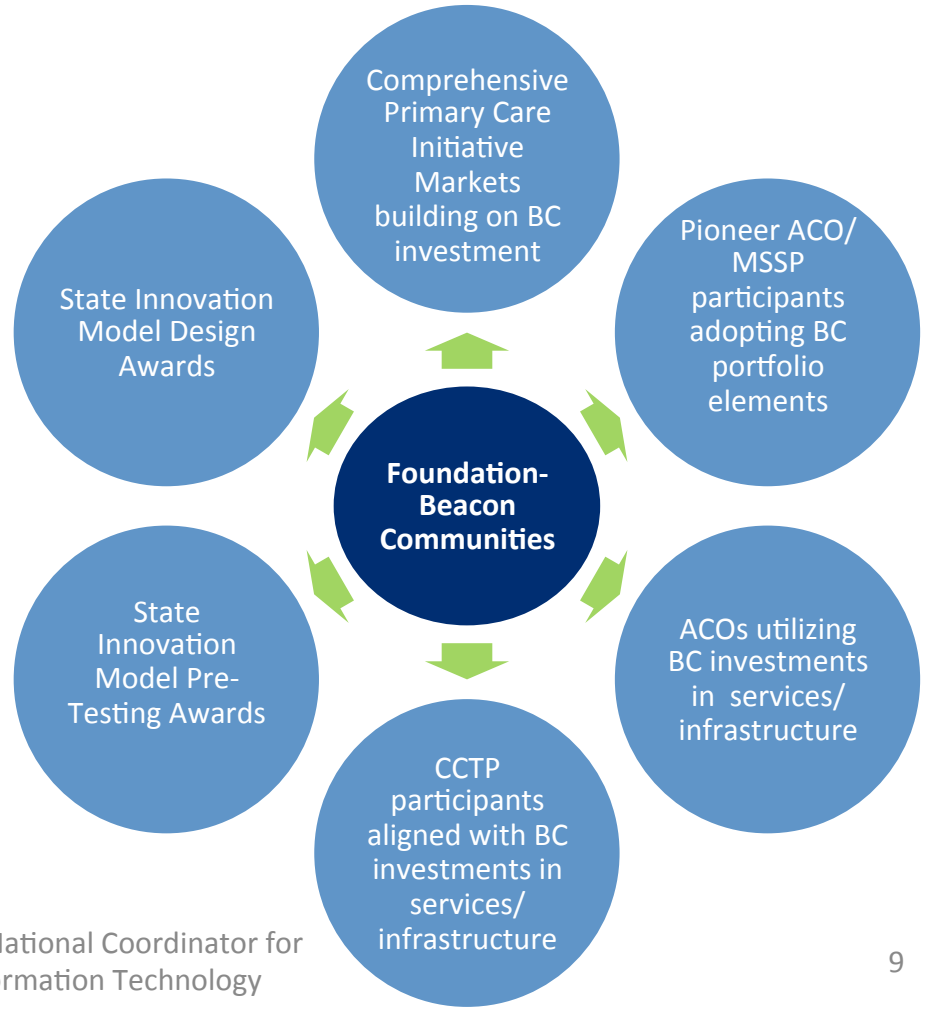


Cincinnati, **Crescent City** and **Southeast Michigan Beacon Communities** launched the txt4health program in early 2012, a text messaging application that provides access to diabetes resources, lifestyle tips, and a health assessment. The program served as a catalyst for stakeholder-driven campaigns in each community to build awareness about diabetes prevention.

The Next Chapter Begins

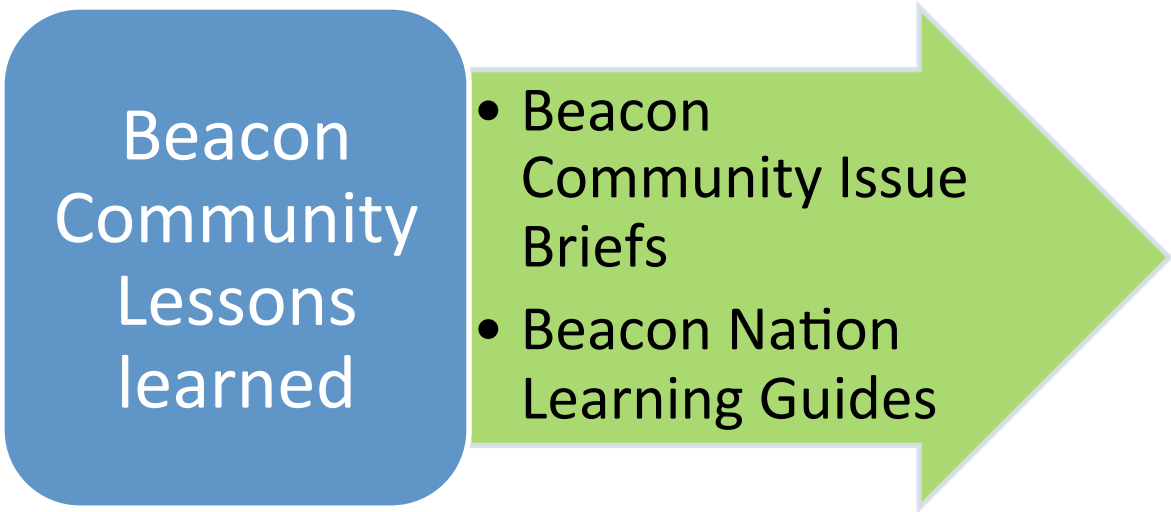
Beacon Communities: Building the Foundation for Future Initiatives

The Beacon Communities proved that organizations can advocate changes to how healthcare is paid for by working with payers and providers, while improving quality and safety at the same time — lessons learned locally but applicable to the entire nation.
-Dr. Farzad Mostashari, Director, ONC



Sharing Knowledge and Best Practices from Beacon Communities: The Next Phase

A lot of times it's easy to just be consumed by the challenges and the next generation of work ahead of us. But, really, the learnings, the experiences, the networking and the trust fabric that's been built over the last three years is incredible…I do believe that those kinds of experiences are universal … and certainly not limited to any particular community.
-Patrick Gordon, program director of Colorado Beacon Consortium



What are Learning Guides?

Learning Guide: A Learning Guide describes a promising IT-enabled intervention that can be deployed in a community to accelerate health care transformation.

- Improve Hospital Transitions and Care Management Using Automated Admission, Discharge and Transfer Alerts
- Strengthening Care Management with Health Information Technology
- Capturing High Quality Electronic Health Records Data to Support Performance Improvement
- Enabling Data Exchange Strategies to Support Community Goals
- Health Information Technology Capabilities to Support Clinical Transformation in a Practice Setting (September, 2013)
- Building Technology Capabilities for Community-wide Population Health Measurement and Analysis (September, 2013)

Collaborating around Shared Learning

"We have received many positive remarks about the visit and especially the webinar on Friday. Our participants have shown tireless commitment to CCHIE and the communities they serve and your visit was a validation that we are on the right track."
-Yvonne Hughes, MPA
Chief Executive Officer
Coastal Carolinas Health Alliance

"The opportunity to discuss Health Information Technology with such extraordinary leaders and experts on the telephone alone was a considerable privilege for our group, let alone the extraordinary opportunity for an on-site visit in which we shared lessons learned not only in our home market, but with like-minded subject experts from across the nation."
-Charles G. Cox
Director, MetroChicago HIE
Metropolitan Chicago Healthcare Council

Transforming Care Through Connectivity and Collaboration:

Greater Cincinnati Beacon's Population Health Improvement Efforts

Trudi Matthews

Sept. 19, 2013

HealthBridge

HealthBridge Overview

- One of the nation's largest, most advanced and successful health information exchange organizations (HIE)
- Provides HIE connectivity for Greater Cincinnati since 1997 and also four other HIEs
- **Connection Statistics**
  - Participants: 30+ hospitals, 7500 physicians, 800 practices
  - Delivers 3-5 million clinical messages per month
  - Clinical information for 3+ million unique patients
- Home to **Tri-State Regional Extension Center and Greater Cincinnati Beacon Collaboration**

Diabetes Improvement: Community Measurement

YourHealthMatters

Visit YourHealthMatters.org

Performance information for 500+ Primary Care Providers and 23 Hospitals

Diabetes Improvement: Comprehensive Care

Medical Home + Meaningful Use + Exchange + Payment

Lesson: Transformation can happen more quickly than you think.

- 🗁 Paper-based in 2011
- 💻 EHR live in Sept. 2011
- 💰 Meaningful use attestation in Dec. 2011
- ☑ Selected for CPC in Aug. 2012
- 🏠 Level 3 NCQA Medical Home in Nov. 2012
- ★Your Health Matters Public Reporting – above average in 6 of 10 quality measures

Dr. Mark Fraser and Leah Brunie, ANP of Summit Family Physicians

HealthBridge

Three organizations working together with stakeholders on health transformation.

Trudi Matthews
Director of Policy
HealthBridge
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Care Transitions and Communities of Care Perspectives from SE Minnesota Beacon

PCPCC Webinar

September 19

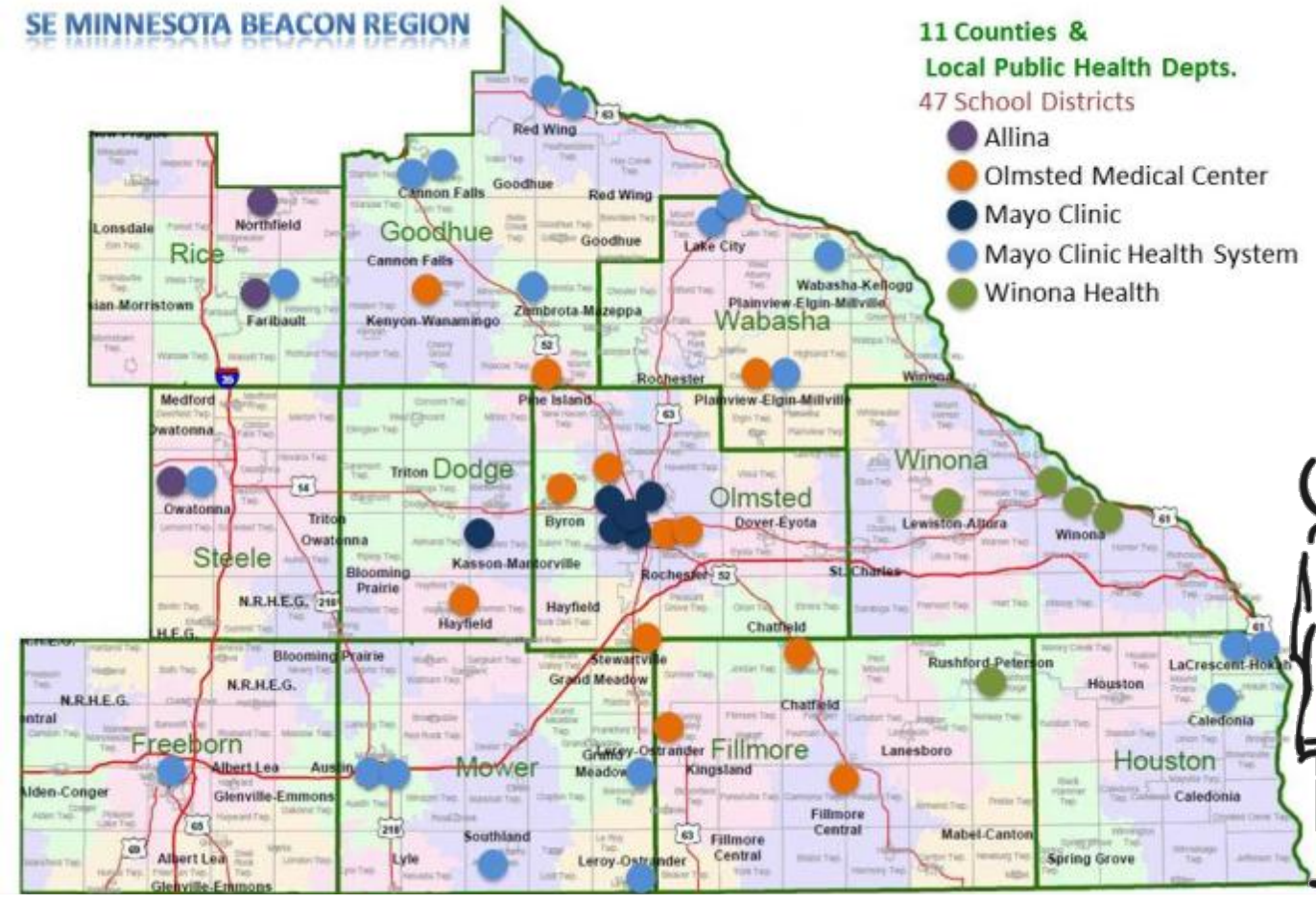
11:30-1pm EST

Lacey Hart, MBA, PMP®

Conflict of Interest Disclosure:
Speaker has no real or apparent conflicts of interest to report.

SE Minnesota Beacon Program

Working Together to Improve Health Care



Community of Practice focusing upon delivering High-value community-based care delivery model

SE Minnesota Beacon Community www.semnbeacon.org

Communities of Practice

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- Allina Health
- Mayo Clinic Health System
- Mayo Clinic
- Olmsted Medical Center
- Winona Health

11 Public Health Departments

Dodge, Fillmore, Freeborn, Goodhue, Houston, Mower, Olmsted, Rice, Steele, Wabasha, Winona

47 school districts in the 11 counties in SE MN

Home health facilities and nursing homes

3 Levels of Exchange Partners

- Valuable Health Data
- Robust Infrastructure Capacity
- Meaningful Use Funding

- Valuable Health Data
- Limited Infrastructure Capacity
- No Meaningful Use Funding

- Valuable Health Data
- Limited Infrastructure Capacity
- No Meaningful Use Funding

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SOUTHEAST MN

www.semnbeacon.org

Center for the SCIENCE of HEALTH CARE DELIVERY

SE MN Beacon Cooperative Agreement 12.5M Investment

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- Health Information Exchange (HIE)
- Continuity of Care Documents (CCD)
- Meaningful Use (MU)
- Transitions of care in schools
  - Asthma Action Plan (AAP) & School Portal
- Diabetes Tools
  - Patient Reported Outcomes & Quality of Life Tool (PROQOL) & Decision Aids
- Telemedicine Technologies
- Clinical/Community Data Repository (CDR)
- Transitions of care in Public Health

KEY- Engaging Citizens

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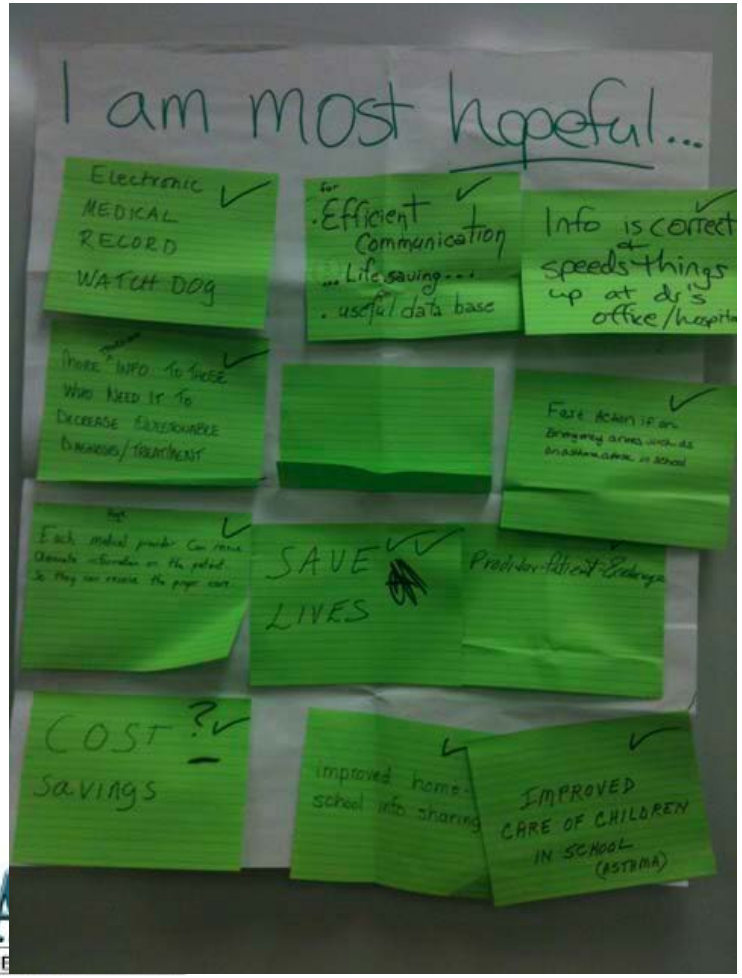
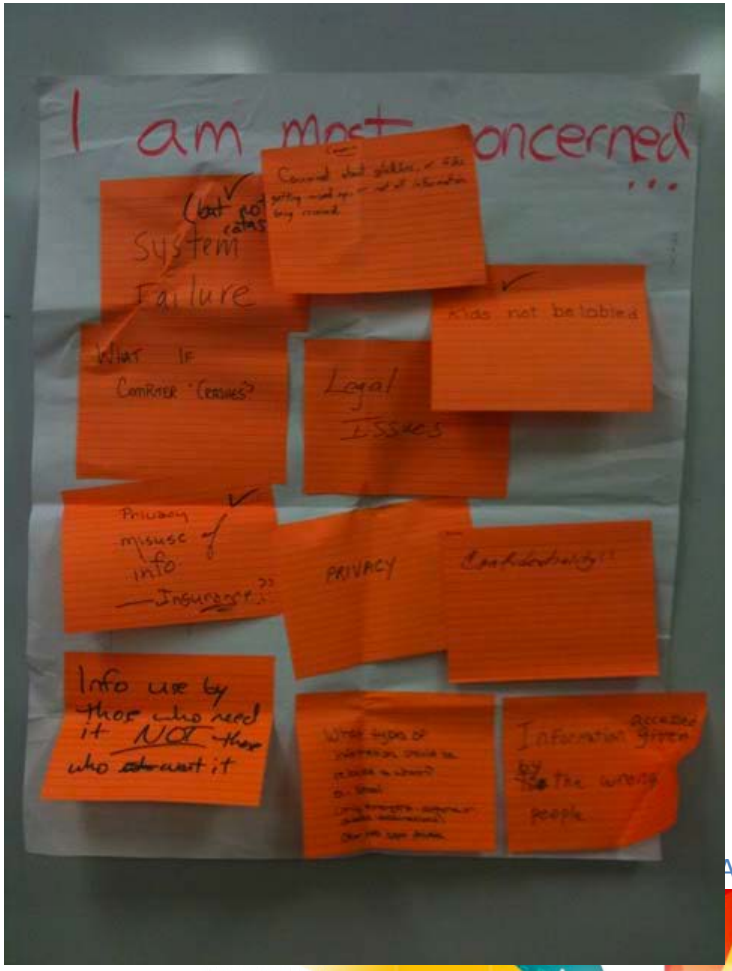
Ensuring the values and preferences of informed patients are brought into our program through meaningful conversation.





KEY - ENGAGING PATIENTS

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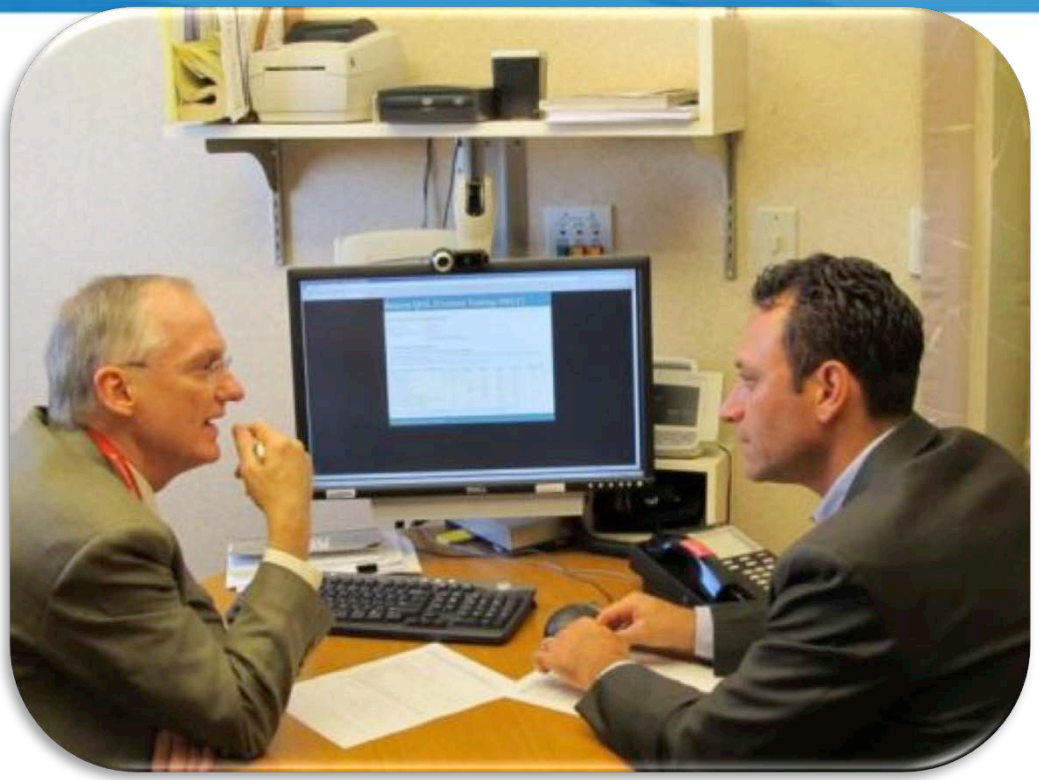

Patent
Reported
Outcomes

"It is about time we were asked about these things beyond just glucose & A1C levels."

(Type I diabetes patient for over 30 years)

Network Collaboration

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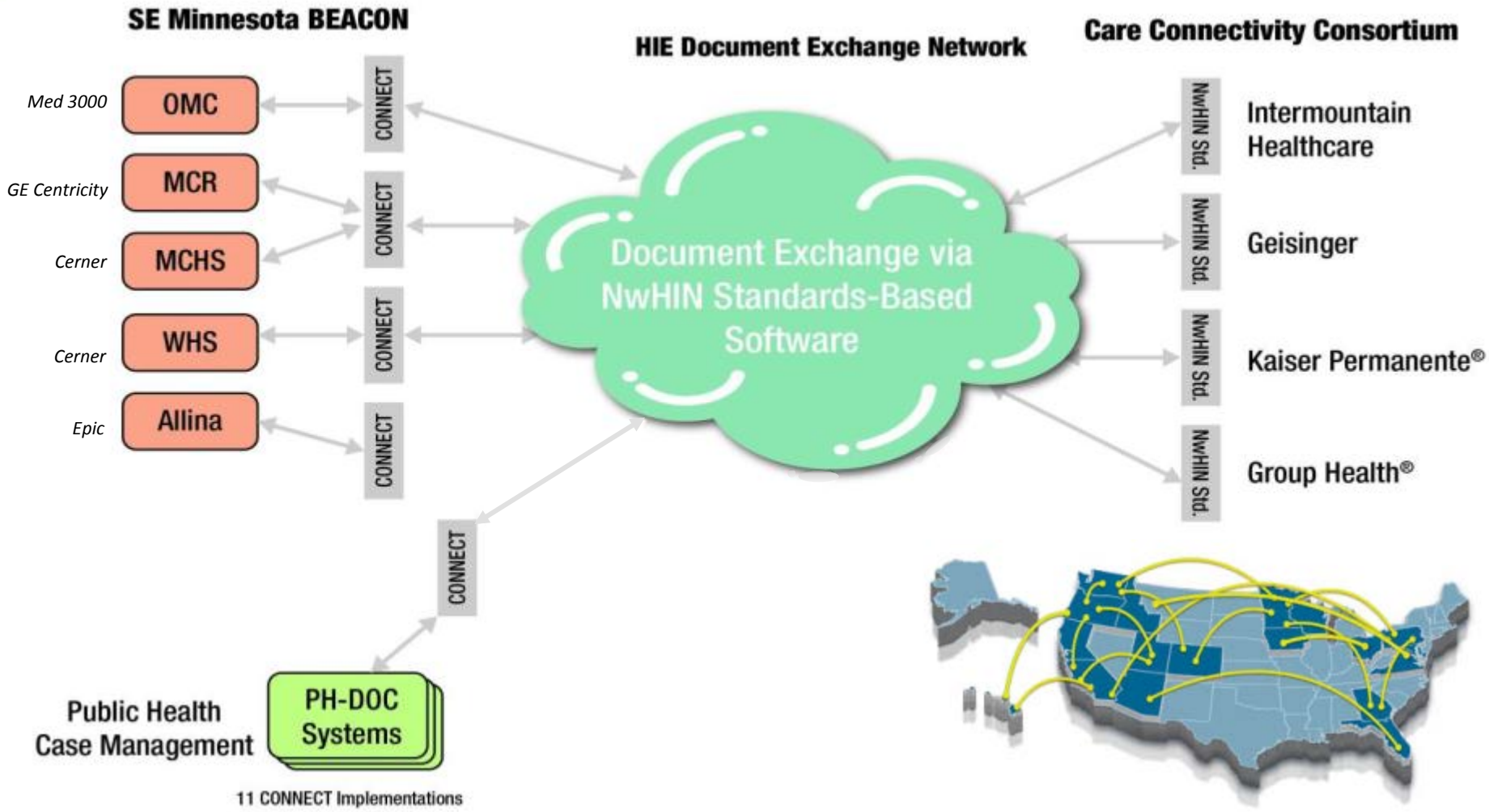

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Transitions of Care: ED/Hospital Alerts

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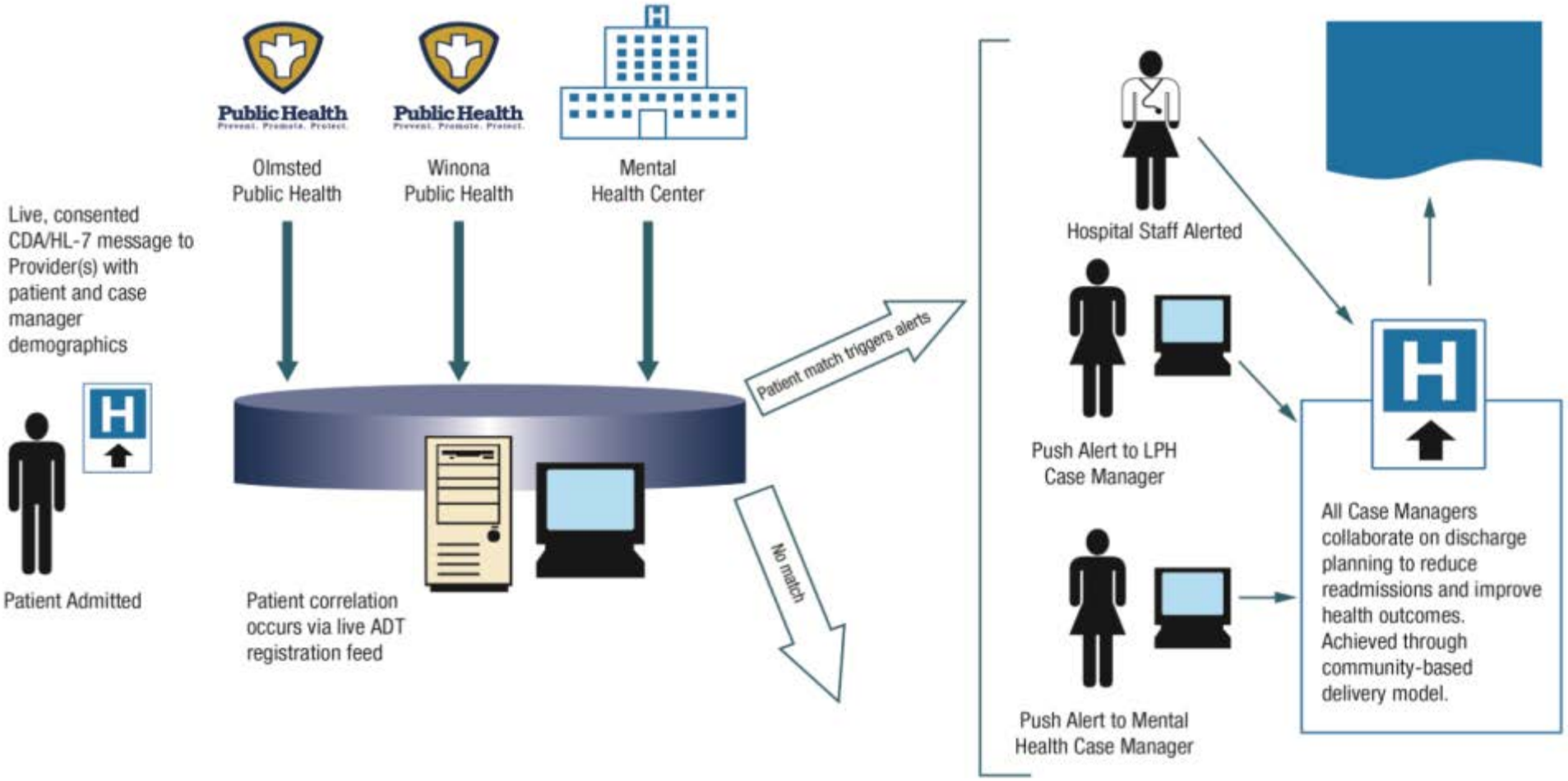

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‘Community’ Data Repository

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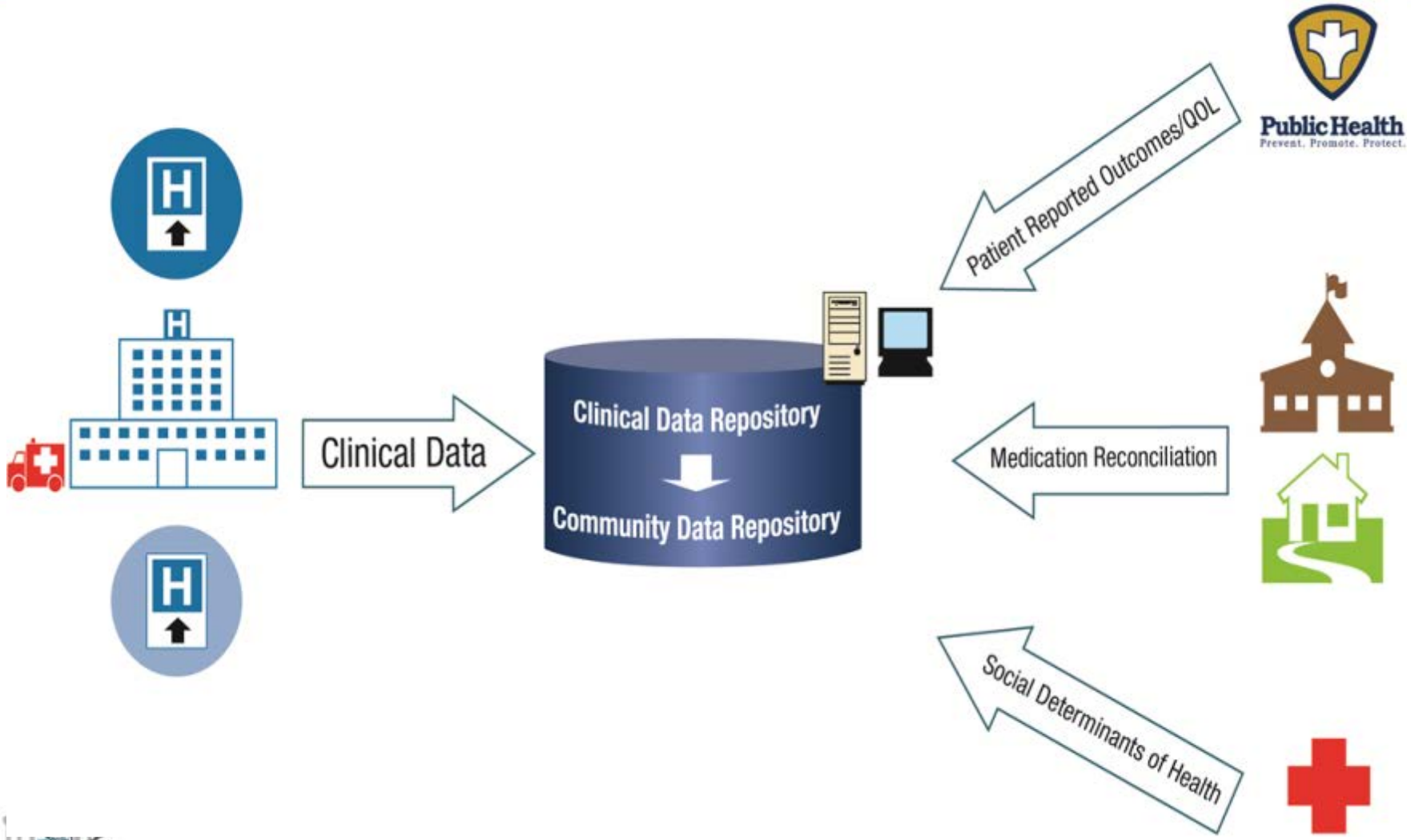

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Minnesota Research Authorization (MRA)

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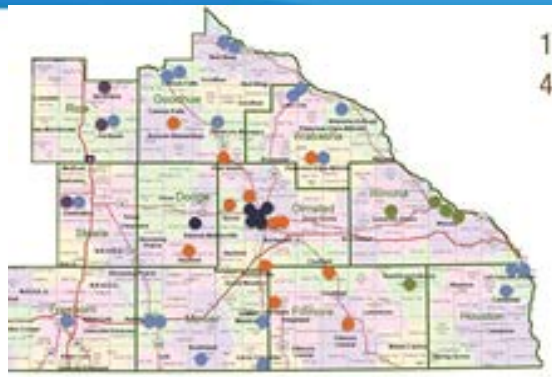

11 Counties & Local Public Health Depts.
47 School Districts
- Allina
- Olmsted Medical Center
- Mayo Clinic
- Mayo Clinic Health System
- Winona Health

With signed MRA, Beacon Governance approval and IRB approval: Client data combined, de-identified, and presented with minimal necessary for research

Mayo Silo

OCPHS Silo

OMC Silo

MRA+

MRA+

MRA-

CDR Research Result

With MRA refusal or indecision at OCPHS: Client data sent to OCPHS CDR silo but not used in any research

Public Health
Prevent. Promote. Protect.

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Asthma Care Coordination

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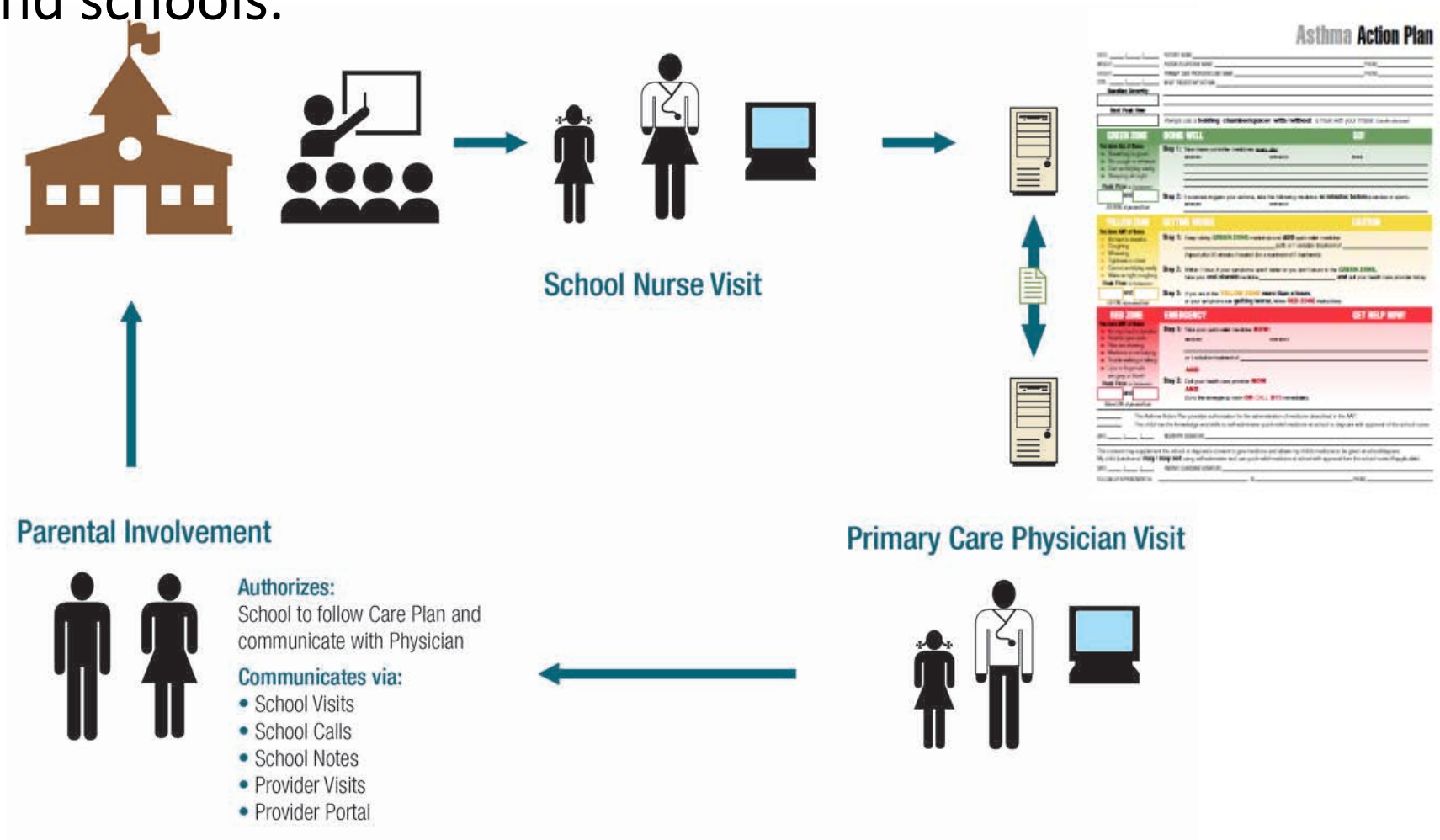
Care Coordination between parents, providers, public health and schools.



Key's to our Journey

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From provider centric to **patient-centric** with **community-driven** commitment is found woven into the very fabric of our program.

- Community Governance Model
- Deliberative Democracy Community Engagement
- Communities of Practice (Healthcare, Local Public Health, Schools, Long-term Care, Mental Health Centers)
- Technology & Health Delivery solutions enables sustainable community driven approach
  - NwHIN, School Portal, Patient Tools – Action Plans, PROQOL, Population Health Repository

The lenses we wear…

- Patient-Centric
  - Patient Reported Outcomes with Quality of Life measurements proactively allow chronic disease management and transitions of care between LPH and PCP's.
- Community-Centric
  - School portal allows sharing of action plans and chronic condition management between schools, PCP's and parents.
  - For asthma this has resulted in reduction of ED utilization from around 5% to less than .5%.
  - For influenza (ages 5-12) has increased vaccination rates, and reduced cost of delivery with school clinics.

Legal Considerations

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- Business Associate Agreements between
  - Between or among Beacon participants
  - Beacon consortium and data repository
- Privacy Compliance:
  - Health Insurance Portability and Accountability Act (HIPAA)
  - Family Educational Rights and Privacy Act (FERPA)
  - Public Health Agency State Data Practices Act (DPA)
- Consent & Authorization Compliance:
  - Minnesota Standard Consent Form to Release Health Information
  - Minnesota Research Authorization statute
  - Federal protection of human subject research regulations
- Regional Exemption Obtained for State Certificate of Authority:
  - Health Information Exchange, Health Data Intermediary, Record locator service

24 JD's

Southeast Minnesota Beacon Program

Eleven Minnesota counties working to improve health care and health delivery systems.

Home | Community Engagement | Schools | Asthma | Immunizations | Diabetes | Decision Aids | Admit2Discharge | Technology | Telemedicine | Community Connections | Partners | News | Blog

Welcome to Beacon

Beacon is a community-based program to spotlight a variety of "best practice" approaches to improving health and health care delivery in the United States. Funded by the U.S. Department of Health and Human Services, through the Office of the National Coordinator for Health Information Technology, the Beacon Communities [see the Beacon videos] are a series of medical practice and research coalitions focusing on specific health conditions in their areas and utilizing and developing efficient systems based on their foundational expertise.

Overall, each Beacon program seeks to:

- Improve quality, safety, efficiency, and reduce health disparities
- Engage patients and their families in their health care
- Improve health care coordination
- Improve public health and the health of the community's population
- Ensure privacy and security protections for personal health information

Search

Recent Posts

- Beacon is beginning

Archives

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Categories

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Project Team Wiki

- Project Team Wiki

Questions?

- **Access** Beacon Nation Learning Guides at www.beaconnation.org
  - Learn first hand about pathways and strategies for key health IT tools and infrastructure
  - Share with interested stakeholders
- **Learn more** about the Beacon Community Program by contacting: Janhavi.Kirtane@hhs.gov