Spotlight on the Beacon Communities: Western New York & Southeast Michigan

Presented by:
- Jason Kunzman, Senior Project Officer, ONC
- Terrisca Des Jardins, Director, Southeast Michigan Beacon Community
- Dan Porreca, Executive Director, HEALTHeLINK
Advisory Council

- **Holt Anderson** – North Carolina Health Information and Communications Alliance, Inc. (NCHICA)
- **David Baker, MD** – Northwestern University
- **William Bernstein, JD** – Manatt
- **Michael Bice** – Kent State University
- **Pam Cipriano, RN, PhD** – Institute of Medicine
- **Adam Clark, PhD** – FasterCures
- **Gwen Darling** – Healthcare IT Central
- **Gwenn Darlinger** – BlueCross and BlueShield Association
- **Arthur Davidson, MD** – Denver Health
- **Mary Jo Deering, PhD** – Office of the National Coordinator for Health IT
- **Charles Friedman, PhD** – University of Michigan
- **Mark Frisse, MD** – Vanderbilt University
- **Lilee Gelinas, RN** – VHA, Inc.
- **Mary Rita Hyland** – SSI Group, Inc.
- **Regina Holliday** – Consumer HIT activist
- **Linda Kloss** – Kloss Strategic Advisors
- **Dianne Lee** – St. Louis Community College/Region C Community College Consortia
- **Patricia MacTaggart** – George Washington University
- **Chuck Parker** – Continua Health Alliance
- **Andrea Sodano, PhD** – School of Management, Boston University
- **Timothy A. Swope** – Personalized Medicine Coalition
- **Steven Waldren, MD, MS** – American Academy of Family Physicians
- **Chantal Worzala, PhD** – American Hospital Association
NeHC University provides unique opportunities for interested stakeholders to learn about multiple health IT initiatives, programs, and trends all in one place.

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Spotlight Learning Series: Consumer Engagement in Health IT

This series will feature a series of case studies and discussions on the benefits of engaging consumers.

Upcoming Webinars

- The Patient’s Role in Improving the Quality of Information in EHRs
- Best Practices for Health IT and Patient-Centered Care

Mark Your Calendar

- Making Collaborative Care Work
  - Faculty:
    - Dr. Charles Kennedy, Director of ACO Initiative, Aetna
    - Dr. Ralph Korpman, CEO, CentriHealth
  - Date: Monday, April 23, 2012 1:00PM-2:30PM ET

- Improving Patient-Provider Communication: Update on the OpenNotes Project
  - Faculty:
    - Tom Delbanco, OpenNotes Project
    - Dave DeBronkart, Patient Advocate
    - Danny Sands, Society for Participatory Medicine
  - Date: Tuesday, April 24, 2012 2:00PM-3:30PM ET
Spotlight Learning Series: HIE Leadership and Sustainability

Executives give valuable insight into the successes and challenges of maintaining HIE sustainability.

Spring case studies will include:
- Coastal Carolinas Health Alliance
- Dignity Health

Mark Your Calendar

- Update on the Care Connectivity Consortium
  - Date: Monday, April 30, 2012
    1:00PM-2:30PM ET

Register now at:
http://www.nationalehealth.org/HIELeadership
Spotlight Learning Series: Beacon Communities

This series will provide in-depth case studies of the Beacon Community grantees’ projects as they work to further build and strengthen their health IT infrastructure and exchange capabilities.

Mark Your Calendar!

- Spotlight on San Diego and Utah
  - Faculty:
    - Christie North, Vice President of Utah Programs – HealthInsight
    - Anupam Goel, Co-Principal Investigator – San Diego Beacon Collaborative
  - Date: Thursday, May 24 1:00PM-2:30PM ET
Presentation slides are available now!
http://www.nationalehealth.org/BeaconSEMichWNY

Recorded webinar will be available in 24 to 48 hours
Full transcript will be available in approximately 7 to 10 days

Want more?

Check out the supplemental materials available on the NeHC website!

You can also continue today’s discussion by joining the HIE Leadership & Sustainability group in NeHC’s online community:
http://www.nationalehealth.org/collaborate/groups/hie-leadership-sustainability
Please enter your questions or comments in the Q&A window at the bottom right of your screen.

You can also send us an email at university@nationalehealth.org, tweet a question using hashtag #NeHC, or comment on our Facebook page at www.facebook.com/nationalehealth
Beacon Community Program
Build and Strengthen
Improve
Test innovation

Jason Kunzman

HIMSS 2012
The Beacon Community Program: Where HITECH Comes to Life

Regional extension centers

Workforce training

Medicare and Medicaid incentives and penalties

State grants for health information exchange

Standards and certification framework

Privacy and security framework

Adoption of EHRs

Meaningful use of EHRs

Exchange of health information

BEACON

- Improved individual and population health outcomes
- Increased transparency and efficiency
- Improved ability to study and improve care delivery

Research to enhance HIT

*Taken from: Blumenthal, D. “Launching HITECH,” posted by the NEJM on 12-30-2009.*
“The community at large has multiple agendas, projects and competing goals. Having an understanding of what the other community projects are, how they impact your project and where there is competition for scarce resources, how you can align with other projects to achieve synergy and avoid competition, is vital.”

Western New York Beacon Community
Beacon: What is it about?
Beacon Community Aims

17 grantees each funded ~$12-15M over 3 yrs 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.
Create a sustainable path for near-term success and on-going improvement

Near Term Success: The Beacon Communities Are Using One Voice to...

• Highlight critical issues to state policy makers and align major initiatives (Policy Roundtable with State Leaders in September 2011)

• Prioritize needs of safety net providers (HRSA joint funding opportunity, releasing $100K to each FQHC in a Beacon catchment area, September 2011)

• Pilot community-level dashboards to drive improvement using Medicare data (CMS, Brandeis, Buccaneer)

• Establish a workgroup (6 vendors, 17 Beacon Communities) to develop a standard CCD that can be automatically exported to an HIE upon a pre-defined trigger by mid-Q2 2012
Create a sustainable path for near-term success and on-going improvement

On-going Improvement: Identify how high-value infrastructure and innovation can be sustained

- Payment pilots – local and national (IN, ME, MI, OH, NY, OK, CO)
- System and infrastructure for community-wide measurement and population analytics
- Governance structure to support execution of the community health agenda
- Purchaser engagement: payers and employers
- National and local spread and dissemination: learning collaboratives, trade associations, etc.
Southeast Michigan Beacon Community Collaborative (SEMBC)

• Vulnerable Population
  – Detroit, Highland Park, Hamtramck, Dearborn, Dearborn Heights
  – Population Flight
  – Physician Flight

• Considerations
  – Unemployed
  – Uninsured
  – Limited access to healthcare
SEMBC: Part of a Health Care Quality Revolution

- Guiding Principles:
  - Building and strengthening health IT infrastructure and exchange
  - Driving measurable improvements in cost, quality, and population health
  - Testing innovative, evidence-gathering approaches to improve health care performance measurement, technology integration, and delivery
HIT-Enabled Clinical Transformation: Target Goals and Measures

1. A 5% increase in the proportion of diabetic patients who receive standard recommended testing and examinations.

2. A 5% reduction in the proportion of non-urgent Emergency Department utilization among diabetic patients.

3. A 5% reduction in the proportion of diabetic patients having disparity ratios for quality of care and population health measure disparities related to gender, insurer, or race.
SEMBC Interventions

Physician data reporting and performance feedback
• Establish a network of physicians who are committed to process change and data exchange.

Care Coordination - Ambulatory
• Utilization of patient navigators to help patients adhere to treatment plans.

Clinical Decision Support
• Targeted alerts, reminders, and decision support information.

Care Coordination - Hospital Emergency Departments
• Partnerships with ED that helps identify, treat, and coordinate care of diabetic patients.

Patient Engagement
• Partnerships with community and faith-based organizations that extend the reach of SEM BC.

Telehealth
• Use mobile and other messaging options to identify diabetes within the SEM BC.
SEMBC Domains

- Information Technology and Security
- Evaluation & Measurement
- Clinical Transformation
- Sustainability
- Stakeholder Engagement & Participation
Domain Focus

Domain

1. Stakeholder Engagement and Participation
   - Establishing Beacon strategic direction; fostering collaboration and joint accountability across Beacon Communities; interfacing with national leadership on key strategic objectives

2. Information Technology and Security
   - Achieving meaningful use goals; promoting interactions with RECs, State HIEs, and other ONC resources; testing and documenting new technologies

3. Clinical Transformation
   - Identifying and accelerating best practice care delivery innovations; leveraging HIT for performance improvement; disseminating insights and evidence

4. Evaluation & Measurement
   - Developing robust performance measurement and feedback capabilities; testing new measurement approaches; interfacing with national measurement organizations

5. Sustainability
   - Strategic planning and implementation activities focused on payment reforms to sustain performance improvements and support infrastructure developed under the Beacon Program
Health Information Exchange
BeaconLink2Health

• Building and strengthening HIT infrastructure and exchange capabilities in Southeast Michigan
  – Community-wide collaboration from conceptual development to implementation
  – Bold, game-changing resource
BeaconLink2Health Strategy

- Platform neutrality
- Two-vendor solution
  - Covisint
  - Medicity
- Trusted, secure PHI sharing and exchange
- Population-based analytics at all levels
Building a Foundation: Provider and Patient Engagement

- Quality Scores and Care Metrics
- Engaged Providers
- Clinical & Process Interventions
  Improvement
  Plans/Strategies
- Patient Navigators
- Engaged Patients
- txt4health

Building a Foundation: Provider and Patient Engagement
Clinical Transformation Enabled by HIT & HIE

- Engaged Providers
- Quality Scores and Care Metrics
- Clinical & Process Interventions Improvement Plans/Strategies
- Patient Navigators
- Engaged Patients
- txt4health
Clinical Transformation: Meaningful Use Driving Quality Improvement

- Engaged Providers
- Clinical & Process Interventions
- Improvement Plans/Strategies
- Patient Navigators
- Engaged Patients
- Quality Scores and Care Metrics
- txt4health

Meaningful Use

Improved Quality
Better Patient and Population Outcomes: Clinical Transformation Supported by HIT & HIE
Txt4health Background

• Use technology to reach vulnerable populations
• “Reverse” the upward trend for digital technology
• Increased awareness of diabetes, the risks of diabetes, and how to manage diabetes
• Get people into a healthcare setting sooner rather than later
• Public-facing intervention vs. provider intervention
What is txt4health?

- Interactive, personalized 14 week text-based program that:
  - Assesses risk for developing diabetes
  - Sets goals, tracks weight and activity levels
  - Sends tailored educational and motivational messages
    - Encourage healthy diet
    - Increased exercise
  - Connect to local resources
Voxiva: text4baby

- Largest mHealth service in the US
  - 180,000+ Moms
  - 13,000,000+ messages
  - 500 partners in 50 states
Messaging Content

• Based on recommendations and guidelines of
  – US Preventive Services Task Force
  – National Diabetes Education Program’s Small Steps, Big Rewards program partnership:
    • The National Institutes of Health
    • The Centers for Disease Control and Prevention
    • The American Diabetes Association
Txt4health Service Area in Southeast Michigan

- Seven counties:
  - Wayne
  - Oakland
  - Macomb
  - Washtenaw
  - Monroe
  - Livingston
  - St. Clair
Marketing

• “Fighting D in The D’
  – Micro-targeted hotspots
  – Defiant, pro-active attitude
  – Grass-roots community-based campaign
  – Ideally-suited for Southeast Michigan
Campaign Kickoff: Wednesday, February 22, 2012

Kickoff Event: The Fight Against Diabetes. We’re All In.

- Regina Benjamin, M.D., Surgeon General of the United States
- Community Roundtable
  - 25+ Healthcare, business, and community leaders
- Kickoff Luncheon
  - Over 225 attendees
- Enormous Press Coverage
Campaign Kickoff: Thursday, February 22, 2012

- PSA Takeover
  - Over 4,000 PSAs
  - Radio
  - Online
  - Television/Cable
Campaign Kickoff: Friday & Saturday February 24-25

• Street Teams
  – Friday: Detroit
  – Saturday
    • Pontiac
    • Royal Oak
    • Birmingham
    • Rochester
    • Rochester Hills
Campaign Extensions

• Community Outreach
  – 60+ Locations
  – Community Centers
  – Neighborhood Service Organizations
  – Soup Kitchens
  – Faith-Based

Cass United Methodist

Gleaners Community Food Bank of Southeastern Michigan

Lighthouse of Oakland County

NSO Neighborhood Service Organization

Fighting in the D
Detroit can beat diabetes.

txt4health

Beacon Community
Campaign Extensions

- Exhibitor at 20-30 Project Healthy Living events across Southeast Michigan
Campaign Extensions
Txt4health Evaluation and Measurement

• Extensive User Data
• Connections to Care
• Direct User Research
Thank you!

Contact Information:
Terrisca Des Jardins
Director
Southeast Michigan Beacon Community
(313) 638-2156
htdocsjardins@semha.org

www.sembc.org
HEALTHeLINK Background

:: Culmination of more than 10 years of collaborative efforts by region’s 4 major hospitals and 3 health plans

:: Founded in June 2001, HEALTHeNET provides fast, secure access to administrative information to assist providers

:: Stakeholders formed HEALTHeLINK, Western New York’s clinical information exchange in 2006

:: HEALTHeLINK data began to flow in mid-2008

:: Significant local, state and federal investment to date in exchanging health information and connecting hospital systems, health care organizations and physician practices throughout eight counties of Western New York
WNY Beacon Mission & Objectives

:: Mission: Improve clinical outcomes and patient safety through the use of health information technology and health information exchange, focusing on diabetes care management.

:: Main Objectives:

- Utilize EHRs to achieve meaningful use and optimize diabetes control

- Reduce emergency department visits, hospitalizations and readmissions for individuals with diabetes through preventative measures such as medication reconciliation and telemonitoring

- Implement clinical decision support systems in relevant PCPs and specialists to ensure monitoring and reduction of health disparities for minority, rural and underserved populations
Technical Infrastructure

:: Capability

- Leverage current HEALTHeLINK (HIE for Western New York) investments by expanding data sources and adding technology to support long term care, home health and telemonitoring sources.

- Adding clinical decision support tools, medication reconciliation support and increase number of hospitals and providers connected to HIE.

:: Value

- Support improvement of quality of care and outcomes for diabetics, improve provider/patient communication, improve patient engagement through telemonitoring utilization while supporting the decrease costs through decreased hospitalization and ED visits in patients with diabetes.
Capabilities that support provider HIT and MU requirements

:: Clinical reports delivery
   - 90% of lab reports and 80% of radiology reports generated in WNY flowing through HEALTHeLINK and delivered directly into participating physicians’ EHRs.
   - Over 68 million reports available with 1.9 million added monthly
   - Nearly 1,000 providers getting reports delivered direct to their EHR

:: EHR to EHR clinical data transfer
   - 500 physicians able to send bidirectional discrete patient information for referral purposes with.

:: Clinical reports search – Patient Record Lookup (VHR)
   - 650% increase in use of VHR access to patient data from December 2010 to December 2011.
   - Over 350,000 consents received to date – 95% yes!

:: E-prescribing
   - An estimated 51% of all prescriptions written in Western New York were sent to pharmacies electronically (17% in 2009).

:: Clinical Transformation Services
   - Have assisted nearly 300 providers in 64 practices in achieving NCQA PCMH level 2 or 3 certification
Beacon Clinical Transformation Focus

Partner with Catholic Medical Partners and P2 Collaborative of Western New York to offer:

- Health IT support to provider practices including:
  - Results delivery
  - Interoperability
  - Patient record lookup

- Targeted intervention and preventative focus. Continuous monitoring of the health condition, before it becomes a bigger issue and/or requires hospitalization.
  - Standing up effective use of registries
    - 47 practices stood up to date
    - 29,752 diabetic patients in these practices
    - 24 additional practices scheduled up by end of April
  - Clinical decision support
  - Process and workflow support
  - Assistance in meeting MU requirements
Improving coordination & transitions

- ADTs from all major hospitals, including discharge alerts from emergency departments available with our Patient Record Lookup function (Virtual Health Record)

- Continue to connect long term care and home health agencies to HEALTHeLINK to exchange patient data.

- Each component of the Beacon project addresses proactive and preventative measures to improve care coordination:
  - Registries
  - Telemonitoring
  - Medication History
  - Medical Practice Language / Literacy Assistance
  - Personal Health Record
Telemonitoring

:: Connects home health care agencies and primary care providers to provide high-risk patients with in-home monitors to submit glucose, blood pressure and weight readings.

:: Working with Catholic Health’s McAuley Seton Home Care, Kaleida Health’s Visiting Nurses Association of WNY and Advantage Telehealth to support services with home interventions when needed.

:: Physicians identify high-risk patients pre-hospitalization and enroll them in project.

:: Nurses and other health care professionals interpret readings and report critical information for treating physician to see.

:: Data is displayed in concise and easy to read manner for the physician to view within their own EHR, avoiding “data overload.”
  - Aggregated data also available via Patient Record Lookup “pull” function
Telemonitoring Successes

:: Currently have 110 participants with a goal of 150 in coming months.

:: Successes to Date

- Physicians requesting that more of their patients be enrolled due to success they have seen with current participants.

- 71-year-old diabetic female, congestive heart failure; Three months after joining pilot, reduced her glucose/HbA1C levels from 9% to 5.2% and physician took her off of diabetic medication.
Medication History

:: Real-time alert system notifies PCP with updated medication history when his or her patient has been seen in an ED or discharged from hospital/long term care facility.

- Long term care pharmacy data added to HIE to improve medication reconciliation between hospitals & community providers.

:: Consulting pharmacists perform comprehensive medication review for high risk diabetic patients’ data and recommend any medication regime modification necessary for the patient to meet standard of care.

:: Launching pilot later this spring/summer.
Medical Practice Language/Literacy Assistance

:: Standalone web-based tool that generates medical instructions that are simpler, easier to read, easier to understand and in the patient’s preferred language. Drawings also included to illustrate time of day to take medication.

:: 10 health care centers and/or pharmacies that have multi-language barrier issues currently participating in pilot.

:: Medical instructions available in 16 languages for non-English speakers.

:: English also available for older population who may need easier to understand and/or larger font instructions.
Lessons Learned

:: Things never go as fast as you want - we are dealing with change

  - Identify and work very closely with clinician “believers”

:: Clearly define and manage expectations early for all partners.

:: Need to have knowledgeable people for clinical decision support to assist in incorporating health IT into practices.

:: The best technology in the world will not work properly or deliver expected results if not used in an effective way.

  - Don’t underestimate the process and workflow component!
Thank You!

Questions?

HEALTHeLINK & WNY Beacon Project

716-206-0993 x311

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Didn’t get your question answered? Join the HIE Leadership & Sustainability group in NeHC’s online community to continue the discussion:
http://www.nationalehealth.org/collaborate/groups/hie-leadership-sustainability

Questions or Suggestions? Send us an email at university@nationalehealth.org
Thank you for your participation!

National eHealth Collaborative
1250 24th St. NW, Suite 300
Washington, DC 20037
(877) 835-6506
info@nationalehealth.org
www.NationaleHealth.org

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