IHI National Forum, December 2012
C3: Early Lessons from the Beacon Communities

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Agenda

• Introductions
• Overview of HITECH
• The Beacon Community Program
• Reflections on the first 18 months of learning
• Example site experiences:
  – Bangor Beacon Community
  – Colorado Beacon Community
  – Southeast Minnesota Beacon Community
  – Tulsa Beacon Community
• Sustainability
• Looking Ahead—“Big Ideas” for 2012-2013
• Questions and Discussion
ONC Strategic Plan

- The Office of the National Coordinator for Health IT (ONC) is implementing the HITECH Act, part of the American Recovery and Reinvestment Act of 2009

HITECH
Unprecedented investment in HIT

- Beacon Communities
- State Health Information Exchange
- Health IT Extension Centers
- SHARP (Strategic HIT Advanced Projects)
- Community College Consortia to Educate HIT Professionals
- Curriculum Development Centers
- Program of Assistance for University-based Training
- Competency Examination for Individuals Completing Non-degree Training
Beacon Community Program

- $265 million over 3 years to 17 communities that focus on specific and measurable improvement goals in quality, cost-efficiency, and population health
- Core aims of the Program:
  - Build and strengthen health IT infrastructure as a foundation to improve quality of care, health outcomes, and cost efficiencies;
  - Demonstrate that health IT-enabled interventions and community collaborations achieve concrete cost/quality performance improvements;
  - Test new innovations to improve health and health care

Beacon Communities
<table>
<thead>
<tr>
<th>Lead Organization</th>
<th>Location</th>
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</thead>
<tbody>
<tr>
<td>Community Services Council of Tulsa</td>
<td>Tulsa, Oklahoma</td>
</tr>
<tr>
<td>Delta Health Alliance</td>
<td>Stoneville, Mississippi</td>
</tr>
<tr>
<td>Eastern Maine Healthcare System</td>
<td>Brewer, Maine</td>
</tr>
<tr>
<td>Geisinger Clinic</td>
<td>Danville, Pennsylvania</td>
</tr>
<tr>
<td>Greater Cincinnati HealthBridge</td>
<td>Cincinnati, Ohio</td>
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<td>HealthInsight</td>
<td>Salt Lake City, Utah</td>
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<td>Indiana Health Information Exchange</td>
<td>Indianapolis, Indiana</td>
</tr>
<tr>
<td>Inland Northwest Health Services</td>
<td>Spokane, Washington</td>
</tr>
<tr>
<td>Louisiana Public Health Institute</td>
<td>New Orleans, Louisiana</td>
</tr>
<tr>
<td>Mayo Clinic College of Medicine</td>
<td>Rochester, Minnesota</td>
</tr>
<tr>
<td>The Regents of the University of California, San Diego</td>
<td>San Diego, California</td>
</tr>
<tr>
<td>Rhode Island Quality Institute</td>
<td>Providence, Rhode Island</td>
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<td>Rocky Mountain Health Maintenance Organization</td>
<td>Grand Junction, Colorado</td>
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<tr>
<td>Southeastern Michigan Health Association</td>
<td>Detroit, Michigan</td>
</tr>
<tr>
<td>Southern Piedmont Community Care Plan</td>
<td>Concord, North Carolina</td>
</tr>
<tr>
<td>University of Hawaii at Hilo</td>
<td>Hilo, Hawaii</td>
</tr>
<tr>
<td>Western New York Clinical Information Exchange</td>
<td>Buffalo, New York</td>
</tr>
</tbody>
</table>

Beacon Community Timeline

- **2010**
  - Governance
  - Infrastructure
  - Interventions logic models

- **2011**
  - First wave of interventions
  - Innovation networks

- **2012 & 2013**
  - Interventions
  - Innovation
  - Dissemination
Beacon Community Program

What Are They Doing?

- **Transitions of Care**
  - Information flow; hospital discharge process improvement and standardization; transitions coordinators (work with patients on medication reconciliation and self-care plans through transitions); includes PCPs, hospitals, specialty practices, and long-term care settings
- **Care Management**
  - Trained individuals using standardized protocols for identifying and managing high risk patients and others needing follow-up and services, and working with patients and PCPs in creating self-care plans, including medication management.
- **Computerized Clinical Decision Support**
  - Embedded within EHR and/or HIE systems and Utilized by multiple members of the care team (e.g., physicians, care managers, etc.)
- **Physician Data Reporting & Performance Feedback**
  - QI reports informing providers of actionable items to maintain the highest standard of care in their patient population (e.g., guidelines and/or specific cost, quality, population health measure outcomes and/or analytics)
- **Public Health Registry-Based Management**
  - Registries could target preventative services and could be disease-based; often in partnership with public health departments
- **Others (e.g., PHRs, telemedicine, telehealth)**
### Summary of “Core” Interventions in 2011

<table>
<thead>
<tr>
<th>Intervention</th>
<th># of BCs</th>
<th>“# of patients “touched” in 2011</th>
<th>“# of providers &quot;touched&quot; in 2011</th>
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<tbody>
<tr>
<td>Transitions of Care</td>
<td>12</td>
<td>250,000</td>
<td>~50 settings (including hospitals, SNFs, etc.)*</td>
</tr>
<tr>
<td>Care Management/PCMH</td>
<td>13</td>
<td>300,000</td>
<td>2,500</td>
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<tr>
<td>Computerized Clinical Decision Support</td>
<td>13</td>
<td>350,000</td>
<td>1,800</td>
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<tr>
<td>Physician Data Reporting and Performance Feedback</td>
<td>12</td>
<td>550,000</td>
<td>1,900*</td>
</tr>
<tr>
<td>Public Health Registry-Based Management</td>
<td>11</td>
<td>200,000</td>
<td>700*</td>
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</table>

### Beacon Community Role

- **Model** the effective community-wide use of health IT to improve patient care and population health
  - Lead by example and produce quantitative evidence that digital information can move measures
- **Pilot** different approaches to health IT implementation that will be relevant for achieving broader goals of health care reform
  - Be the “canary in the coal mine” of major health information exchange
Beacon Community Program Aims

- Build and Strengthen
- Improve
- Innovate

Varied Starting Points

- Build on HIT foundation
  - New Orleans
  - Mississippi
  - Indiana

- Build on Quality Improvement
  - Detroit
  - Western NY
  - Inland NW

- Balance between HIT and QI
  - Hawaii
  - Utah
  - Cincinnati

- Catalyze New Governance
  - San Diego
  - SE Minn
  - Bangor

- Adapt Existing Governance
  - Tulsa
  - Keystone
  - Colorado

- Leverage Existing Governance
  - North Carolina
  - Rhode Island

High quality, cost efficiencies, patient-focused health care, and population health
Complexity in Beacon Nation

- Broad spectrum of partners with both aligned and conflicting agendas
- Webs of interdependency
- Surprises (opt-out vs. opt-in)
- Current state is hard to know—e.g. practices with EMRs may not use them well

Zone of Complexity

Ralph Stacey, Complexity and Creativity in Organizations 1996
Beacon Examples

- Bangor
- Colorado
- Tulsa
- Southeast Minnesota

Bangor Beacon Vision

- The Bangor Beacon Community is improving the health of people with chronic conditions such as diabetes, chronic obstructive pulmonary disease, congestive heart failure, and asthma.
- We will meet this goal by building on our strong foundation of care management, collaboration, and connected health records.
Domain 2: Health IT and Meaningful Use Overview of Technologies (Pre-Beacon)

Bangor Beacon Community

All Bangor Beacon Community hospitals and practices have EMR, much of it live with CPOE. Hospital EMR vendors include Cerner (EMMC hospitals and specialists) and Siemens (St Joseph). Physician Practice EMR vendors include Centricity (PCHC and EMMC Primary Care) and an in-house system (St Joseph). Currently only EMMC feeds HealthInfoNet and uses Kryptiq for secured emails. Only a subset of community technologies represented here.

Bangor is connected to the Statewide Health Information Exchange with some two-way interfaces. Expanded secure email among providers. Expanded use of Telemedicine and Telehomecare. Chronic condition database.
High Risk/ High Cost Patients

Clinical Outcomes

Patient Reported Outcomes

High Risk/ High Cost Patients

Preventive Measures Outcomes

Healthcare Utilization (Financial Outcomes)

<table>
<thead>
<tr>
<th>Measure</th>
<th>Baseline</th>
<th>6 months</th>
<th>p-value</th>
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<tr>
<td>1 QUALITY OF LIFE EQ5D Health Score</td>
<td>375</td>
<td>62.2</td>
<td>67.8</td>
</tr>
<tr>
<td>2 MEDICATION ADHERENCE MMS Knowledge</td>
<td>415</td>
<td>2.64</td>
<td>1.36</td>
</tr>
<tr>
<td>3 MEDICATION ADHERENCE MMS Motivation</td>
<td>415</td>
<td>2.64</td>
<td>1.36</td>
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<tr>
<td>4 SELF EFFICACY CDSES</td>
<td>415</td>
<td>6.81</td>
<td>7.17</td>
</tr>
</tbody>
</table>

Healthcare Utilization (Financial Outcomes):

- ED visits
- Hospital Admissions
- Urgent care visits

Primary Care Chronic Condition Patients

Achievements in 12 months:
- 50 measures tracked
- 74% of measures reached or excided NCQA or community target goals
- 14% of measures are within the 95% percentile
Primary Care Chronic Condition Patients

90 Day Plans

Disease Dashboard

Provider review

BB Diabetes HGBA1C less than 8
(Target >=70%)

Colorado Beacon Consortium

- One of seventeen HHS/ONC “Beacon Communities”, charged with demonstrating the effect of investment in HIT in improved process and outcomes.

- Longstanding, but informal, community collaborators in Western Colorado (Grand Junction & surrounding rural & frontier regions).

- Community-wide consortium, sponsored by four (4) independent partners: Rocky Mountain Health Plans, Quality Health Network (HIE), Mesa County Physicians IPA, and St. Mary’s Hospital and Regional Medical Center.
The Western Slope

Population
- 320,000 Total Residents
- 30% < 250% FPL
- 25% Adults (18-64) Uninsured

Providers:
- 107 Primary Care Groups
- 12 Hospitals
- 3 Large IPA / PHO Orgs
- 827 total practitioners (all specialties and mid-levels)

Payers
- Rocky Mountain Health Plans
  - 60% Medicaid
  - 40% Medicare
  - 40% Commercial
- Aggregate Risk Shared with IPAs & PHOs
- Other FFS and Gov Payers

Expanded Care Model

Clinical Measure Set

Pediatric
Phase I
- Asthma – Appropriate Medications for Persistent Asthma
- Immunizations – Up to date by age 2

Phase II
- Child Weight Assessment & Counseling

Adult
Phase I
- Diabetes (BP & HbA1c)
- IVD (Lipid screen and control)
- Depression Screening (Diabetes & IVD)

Phase II
- Adult Weight Assessment & Counseling
- Breast Cancer Screening
- Tobacco Ask & Counseling

Diagnosis specific ER and Avoidable Admission measures at the Program Level
What have we accomplished?

- Started 3 Cohorts—35 Practices Total
- Just starting our last Cohort approx 15 additional practices
- Monthly Clinical reporting from 29 practices
- MU Upgrades—6 practices
- Achievement of Baseline Measures—5 practices
- Supported 2 Regional FQHCs in HRSA Funding
- Developed a Web and Action Series to promote QI skill building for sustainability
- Intangibles.....
  - Practices are creating community with each other
  - Learning QI tools and processes
  - Learning more about their technology and measurement
  - The work is tough but the feedback is “We will never go back!”

LEGEND
- Circles denote zip codes
- = 0 physicians / 1000 citizens
- = 0-2 physicians / 1000 citizens
- = 2-10 physicians / 1000 citizens
- = 10+ physicians / 1000 citizens
- = Indian Hospital or Clinic
- = Veteran Hospital or Clinic
- = Critical Access Hospital
- = Federally Qualified Health Ctr
  (red = participating) (green = participating)
Basic Framework for Health Improvement using MyHealth Interventions

- Health Information Exchange
- Single-sign on
- Context Management
- Patient portal

Community-wide Health Data

Tools to Address Care Opportunities

Analysis and Synthesis of Care Opportunities

- Clerk2Clerk Care Transition Management
- Doc2Doc Care Coordination
- eRx
- Performance Reporting
- DocSite Care Management

- Archimedes
- Community Analytics Platform (Pentaho)
- DocSite Analytics

U.S. Variations in Child Health System Performance: A State Scorecard

Source: The Commonwealth Fund calculations based on state's rankings on access, quality, cost, healthy lives, and equity dimensions.
The Opportunity

- Lack of care coordination, especially surrounding care transitions
  - Relationship between PCP and specialists has eroded
  - Volume drives workflows on both sides
  - Non-clinical personnel drive much of the referral process
  - Significant numbers of unnecessary visits happen, and important necessary visits are delayed or missed entirely
  - No effective way to monitor quality surrounding care transitions
  - New regulations place particular emphasis on care transition management
    - ACOs
    - JCAHO
    - NCQA

Visit Requests (Referrals) require 25 unique states

<table>
<thead>
<tr>
<th>Status</th>
<th>Description</th>
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<tbody>
<tr>
<td>Accepted by Receiving Provider, Awaiting Scheduling</td>
<td>Receiving provider to notify patient.</td>
</tr>
<tr>
<td>Accepted by Receiving Provider, Awaiting Scheduling</td>
<td>Sending provider to notify patient.</td>
</tr>
<tr>
<td>Awaiting Insurance Authorization</td>
<td></td>
</tr>
<tr>
<td>Awaiting More Information from Sending Provider</td>
<td></td>
</tr>
<tr>
<td>Awaiting Receiving Provider Response</td>
<td></td>
</tr>
<tr>
<td>Cancelled</td>
<td></td>
</tr>
<tr>
<td>Cancelled by Receiving Provider</td>
<td></td>
</tr>
<tr>
<td>Cancelled by Sending Provider</td>
<td></td>
</tr>
<tr>
<td>Complete per Sending Provider</td>
<td></td>
</tr>
<tr>
<td>Doc2Doc Consult Pending Draft</td>
<td></td>
</tr>
<tr>
<td>Failed Appointment</td>
<td></td>
</tr>
<tr>
<td>Patient to Manage</td>
<td></td>
</tr>
<tr>
<td>Pending Send to Receiving Provider</td>
<td></td>
</tr>
<tr>
<td>Rejected by Receiving Provider</td>
<td></td>
</tr>
<tr>
<td>Request sent to Receiving Provider, Response Not Expected</td>
<td></td>
</tr>
<tr>
<td>Scheduled, Patient Notified</td>
<td></td>
</tr>
<tr>
<td>Scheduled, Pending Patient Notification</td>
<td></td>
</tr>
<tr>
<td>Scheduled, Pending Patient Notification</td>
<td>Sending provider to notify patient.</td>
</tr>
<tr>
<td>Visit Complete - Report Pending</td>
<td></td>
</tr>
<tr>
<td>Visit Complete - Report Received</td>
<td></td>
</tr>
<tr>
<td>Visit Complete - Report Sent</td>
<td></td>
</tr>
</tbody>
</table>
ALL Observed Transitions Between Visit Request Statuses

Symbol Interpretations
• Arrows represent transition from one consult status to another
• Arrow thickness is proportional to # of transitions
• Status color represents relative length of time consults remain in each status (compared to others in this subset): red = longest; green = shortest
• Status states are abbreviated

Doc2Doc Care Transitions Process

- All communications electronic and logged
- Status of referral events clear to all involved parties
- No faxes, no printing: All records sent electronically to receiving provider
- Sending providers given the software, trained in 0.5 days
- Enables sending and receiving provider to meet meaningful use for care coordination, with or without an HIE
Unanticipated Results

- Variety of Specialties participating with good results
- Success of consult system in specialties seems more dependent on the comfort-level of the individual specialist than the specialty itself
- Relationships develop between PCPs and specialists
- PCPs learn from each interaction, fewer unnecessary consult requests over time
- Improved access: those who needed care got it sooner
Consists of Eleven Counties in SE MN
Dodge, Fillmore, Freeborn, Goodhue, Houston, Mower, Olmsted, Rice, Steele, Wabasha, Winona

Asthma
Consists of 47 school districts in the eleven counties in SE MN.

Diabetes
Consists of Home health facilities and nursing homes for example:

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

Communities of Practice
To Whom & Why is SE MN Beacon Important

- **Patients (Asthma/Diabetes)**
  - Groundwork for better use of health data to improve health
  - Reduce inappropriate healthcare utilization and cost
  - Improve ability of individuals to follow disease treatment plans

- **Health Professionals**
  - Consistent efforts for improving care; improved clinical work flows
  - Support efforts for adoption of technology in “meaningful manner”
  - National visibility as a practice providing “high value” primary care
  - New payment mechanisms
  - Advance and undertake clinical research efforts

- **Local Public Health**
  - $ 1.7 million investment for more effective secure data exchange
  - Better data to support LPH community health needs assessment
  - Addresses LPH responsibilities of Community Health Boards

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Health Information Exchange

[Diagram showing Health Information Exchange]
HIE
Accomplishments & Status

Mayo Clinic / Mayo Clinic Health System (GE/Cerner)
• MIRTH / Aurion 4.0 up; interfaces being wired
• Asthma Action Plan conversion software in development
• Connectivity test performed Oct 2011; Live 12/31/2011

Olmsted Medical Center & Winona Health
• EHRs currently generate CCD
  • WH – Cerner Exchange Live
  • OMC – NwHIN Exchange in testing; Live 12/31/11

Public Health (Ph-Doc)
• MIRTH/ NwHIN gateway’s established in all 11 counties
• CCD consumption & parsing tested; Live 12/31/2011

Asthma Care Coordination
Includes processes of care coordination with providers, public health and schools

Asthma Care in Action
Asthma Action Plans (AAP) in Schools

• 176 Asthma Management Plan Toolkits distributed to 47 school districts
  • Consent forms & workflow processes
  • AAP examples
  • Communication Templates
  • Emergency Response Posters & quick cards

• Olmsted PCP Mass Mailing Intervention:
  • Last school year: 25% / 400 AAP
  • School YTD: 40% / 638 AAP +
  • Next School Year Target: 75% / 6K Regionally

Immunization Coordination

Phase 1:
• Partner with SEMIC
• Identify data gaps

Phase 2:
• Pharmacy & Employer data entry
• School Reporting

Phase 3:
• Pediatric Population area clinics

Vaccination of children in school is one strategy to reduce the spread of influenza in households and communities.

6 Rochester Schools (Olmsted County):
20% participation rate / 776 Children

4 Goodhue County Schools:
20% participation rate / 400+ Children

September 12, 2011 Clinic Video
Sustainability Framing

- What are communities doing (or what do they want to do) that they need to sustain? Examples:
  - Community based care managers or health coaches
  - Setting up a health information exchange
  - Other technology-based services (e.g. remote monitoring, patient portals, etc.)
- How can communities/delivery systems collaborate with interested payers to sustain these initiatives?
  - Medicare: cost saving or quality improvements that are budget neutral
  - Medicaid: interventions that target specific population
  - Commercial payers: cost savings and collaboration opportunities
- Focused on how communities can identify sustainability strategies that are possible today or in the very near future as payment reform options emerge
Selling to provider groups

Sustaining a “Public Good”

Mapping the Sustainability Landscape

Focus of Beacon “Cost Containment” Work Stream

1. Are we able to adequately sustain a particular service/product/activity under existing models of payment?
   - Yes
   - No

2. Can you demonstrate an economic value case to plans/payers? (E.g. downstream cost savings from better diabetic control in a population)
   - Yes
   - No

3. Can you demonstrate an economic value case to providers / provider groups? (E.g. downstream cost savings from better diabetic control in a population)
   - Yes
   - No

4. Is there a willing payer for a “public good”?
   - Yes
   - No

- Not a “three-part aim” intervention
- Work with plans/payers on payment:
  - Demonstrate economic value
  - Develop incentives / payment structures that will sustain activities
- Can models be implemented without major policy changes?
  - Yes
  - No

- Disseminate learning and results
- Describe and share existing and potential models
- Stop work for now

Moving toward Sustainability: Framework Components

Step 1: Understand and leverage Key external environmental dynamics

Step 2: Alliance between payers and delivery system

Demonstrate value and sustain initiatives with payers, delivery systems and communities

Step 4: Impact measurement and data collection

Step 3: Feedback to key stakeholders
Guiding Principles for the Framework

**Understand and leverage key environmental factors**
- Understand payer market characteristics, payer mix and spending variation
- Examine provider market (primary care vs. specialists) and existence of integrated system
- Assess EHR adoption & connection to community HIT resources
- Understand the impact of health care legislation and payment reform initiatives

**Alliance between payers and delivery system**
- Engage in conversations with payers to identify opportunities for value-added services and quantify potential reimbursement mechanism
- Lay out details of clinical interventions (clinical focus, care pattern changes and timeframe)
- Map out the integration between clinical process and information

**Impact measurement and data collection**
- Agree on impact analysis plan with payers and other stakeholders: comparison group, target population versus total population, short/long term metrics on cost, utilization, quality and outcome, and implementation cost.
- Agree upon analytical methodologies regarding denominator, risk adjustment, prediction, and attribution.
- Track non-claim data on quality, operation, patient/provider feedback, and inform implementation team
- Track claims data (needs payer contribution) and inform implementation team

**Feedback to key stakeholders**
- Conduct analysis, calculate gains/losses, and provide feedback to payers, employers and other stakeholders
- Deliver value proposition for additional funding
- Adjust operations to maximize financial gains

Reflections on the Beacon Journey

- Widely varying “starting states” can be successful—all sites have assets and challenges
- Governance is key—sites using existing governance have had faster start-up trajectory
- Adaptive strategies are crucial when circumstances change (e.g. HIE plans slow down)
- There’s no substitute for good improvement skills
Big Ideas #1 & 2: FQHC/Beacon Alignment and State Leadership Roundtable

Opportunity: Align federal initiatives at the local level and provide incremental support to safety net providers to accelerate achievement of Beacon goals.

Plan: FQHCs in Beacon catchment areas work with local partners to create plan that aligns with Beacon goals. $100k awarded per FQHC to support QI efforts or technology deployments (as per individual agreements)

Launched September 2011

Opportunity: Help state leaders “connect the dots” and think through how their Beacon might serve as a proving grounds for testing new ideas and achieving broader state-wide aims

Plan: Convene 8 State leaders to better understand local stories of change within Beacon Communities, opportunities to scale local solutions and identify innovative strategies to accelerate statewide improvement.

September 17, 2011

Big Idea #3: A Beacon-designed mobile health project

Opportunity: Create a multi-community diabetes campaign by using a shared mobile platform that is customized by community

Plan: Work with single vendor, and specific partners at the community level to develop content, publicity and outreach

To be launched January 2012
Building Blocks | Ttxt4health Modules

System collects:
- HEIGHT
- WEIGHT (BMI)
- AGE
- GENDER
- FAMILY HISTORY
- SMOKING STATUS

User sends HEALTH to 311 411
User sends MYHEALTH to 311 411

Enrollment

Development of Profile (Risk Categorization)

System categorizes:
- HIGH RISK
- LOW/ MEDIUM RISK
- UNDERWEIGHT
- AT WEIGHT
- OVERWEIGHT
- OBESE

Goal Setting/Tracking (Weight & Exercise)
Education/Motivation (According to Risk)
Local Connections (Care & Activities)

© 2011

Big Idea #3:
A Beacon-designed mobile health project

New Orleans Overview
(Crescent City Beacon Community)
- 60% of adult residents in New Orleans have at least one risk factor for type 2 diabetes (CDC, BRFSS, 2009)
- Formation of Consumer Advisory Group to inform campaign
- Public/private partnerships (e.g., BCBSLA, Walmart)
- Public speaking opportunities (e.g., Tackling Diabetes Summit, American Academy of Pediatrics Meeting)
- Comprehensive outreach campaign (LA BCBS advertisement sample on right)
Big Idea #4:
Real-time CMS Data Analytics for Improvement

Opportunity: Provide Beacon Community leaders and “implementers” with real-time, community-wide data to inform improvement work.

Plan: Provide the 17 Beacon Communities with their Medicare performance data results (refreshed quarterly) on a select set of quality measures to help the communities examine and analyze performance over time.

Launched September 2011

For each measure and quarter a Community can compare their performance to other Beacon Communities.

Diabetes Short-term Complications Admissions Rates; Risk-adjusted rates

Diabetes Long-term Complications Admissions Rates; Risk-adjusted rates
Big Idea #5:
Beacon Palooza: Care Transitions and HIT

Opportunity: Bring together Beacons and "Beacon-like" implementers from all disciplines in the world of care transitions to drive focus and momentum around what works today, and where innovation is needed.

Plan: Host "working meeting" of 200 who’s who on the policy, tech, provider, vendor, advocacy side of this story. Invitation only.
- “Advanced ONC grantees” featured along with other national leaders.
- Partners included select foundation, ONC, CMMI and Kaiser.
- Paper to be released early next year.

October 14, 2011

NEXT TOPIC: IT and PCMH, Q1 2012

Big Idea #5:
Beacon Palooza: Care Transitions and HIT

- Remarkable convergence from stakeholders around top priorities for an IT-Transitions agenda
  - Vision of a plan of care, that spans time and setting, incorporates social and medical factors, reflects patient goals and is accessible to all care team members
  - Effective and efficient medication reconciliation continues to evade even the most sophisticated providers
  - IT-enabled feedback loops are underdeveloped, and are critical to ensure safe care and self management
  - Shifting from the hospital centric model is the most important factor for spread and uptake

Of the priority problem statements that emerged from the break out sessions, the three most important are:

- “There is no care plan…”
- “…provider ability to inform/manage plan…”
- “…effective feedback loops”

Of the innovation opportunities that would address the most difficult challenges in care transitions discussed in the break out sessions, the THREE that will likely yield the most impact are:

- “Feedback loops…”
- “…merged medication record…”
- “…optimization of existing technologies”
Big Idea #6:
Health 2.0 Exchange & a Project on Bending the Cost Curve

Opportunity: Beacon Communities want to find innovative technology solutions for health challenges, but don’t know how to find the right partners.

Plan: Create a Beacon “Innovation Exchange” at the national Health 2.0 meeting, where communities write a their problem statements, Health 2.0 screens and arranges for match-ups

September 25, 2011

Opportunity: Educate payers and actuaries about mechanics of Beacon interventions, and help Beacons receive input on intervention design and measurement to support sustainability.

Plan: Share details behind interventions of 3 Beacon Communities with actuaries from CMS, CBO and leading health plans, and technical assistance from Brookings and Booz Allen
• "Roundtable to Promote Value in Healthcare"
• Tulsa, Geisinger and Colorado Beacons
• Output: Brookings paper summarizing key lessons learned

October 28, 2011

Big Idea #7:
Performance Measurement in the Real World

Opportunity: Performance measurement in the digital world has many challenges. What can we learn from each other today to overcome roadblocks, and where is innovation most needed?

Plan: On Day 1, invite Beacon measurement and analytics staff and experts to share best practices and create a shared agenda to accelerate progress. On Day 2, share agenda with Electronic Health Record Association to agree on shared priorities for the year, and strategies for risk mitigation

November 8-9, 2011

Our mission: Decrease the noise for very busy people
• Provide top 3 priorities to E.H.R.A based on Beacon Community experiences
• Establish “Beacon” point of contact for high priority vendors to accelerate progress
• Share an innovation agenda to ensure long term goals can be achieved
• Next steps -- share learnings and priorities with other stakeholders
Your Feedback

• What are you looking to the Beacon Communities to share?
  – Make a spoken suggestion
  – Write a comment on paper
  – Email to Christina Markle at HHS: christina.markle@hhs.gov

• Do you want to receive periodic updates on Beacon activities and developments?
  – To join Listserv email Christina Markle at HHS: christina.markle@hhs.gov