

# Update on the Beacon Project for the Regional Health Information Forum

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# Current Status of Diabetes Care

- Individual physicians and hospitals working to improve care
  - Some use of diabetes registries or tools within EMRs to manage care for individuals
  - Some coordination of care within and between practices
  - Differences in available care based on size and capacity of each organization
- Gaps in patient records due to lack of information from other providers

# Beacon Community of the Inland NW

- \$15.7 million over three years
- Lead Organization – INHS
- Key Partners –
  - Outreach and Communication
    - Community Choice (Wenatchee)
    - Eastern WA Critical Access Hospital Network
  - Training and Education
    - WA Academy of Family Physicians
    - WA Department of Health
  - Technology Support
    - Science Application International Corporation
    - INHS IRM
  - Evaluation
    - INHS Center for Innovation and Quality
    - University of Washington
    - Group Health Research Institute

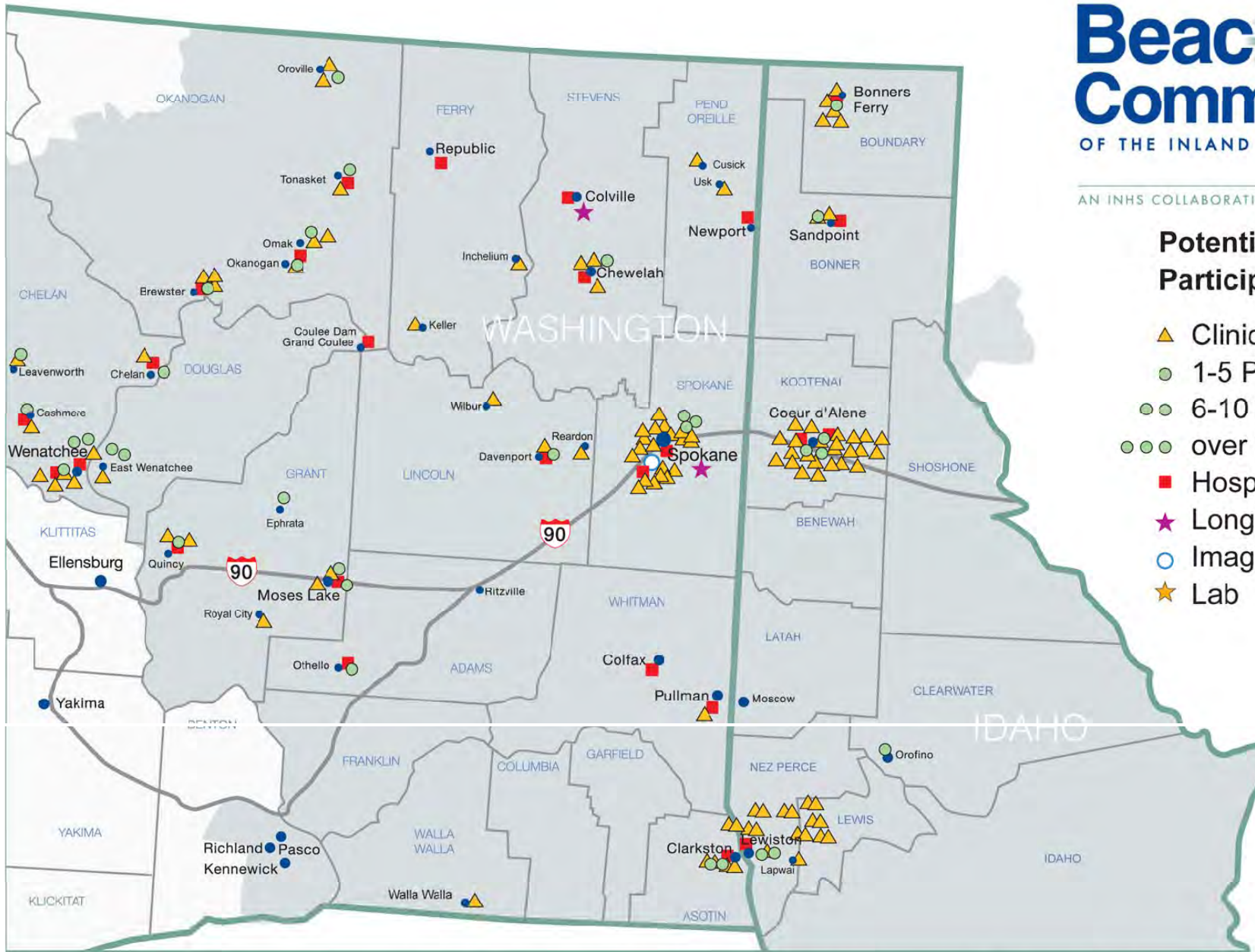
# Beacon Community™

OF THE INLAND NORTHWEST

AN INHS COLLABORATION

## Potential Participants

- ▲ Clinic
- 1-5 Pharmacies
- 6-10 Pharmacies
- over 10 Pharmacies
- Hospital
- ★ Long term care
- Imaging
- ★ Lab



Shaded area represents Spokane Referral Region as defined by Dartmouth Atlas

# BCIN Project Goals

- Help assure consistent care for a population that receives care throughout this region
- Fill information gaps so that physicians have a more complete record for clinical decision-making
- Objectives
  - Reduce use and costs of emergent and inpatient care for diabetes-related complications
  - Leverage HIE to increase adherence to diabetes preventive health services
  - Promote population health by improving access to diabetes health information by public health



# How?

- Identify key diabetes management practices
- Connect all participating providers to secure HIE for sharing patient information
- Provide access to centralized care coordination services and tools to physicians without that capacity
- Implement tools to help participating physicians track their patient population outcomes, regardless of where care was received
- Provide training and support in using the tools and best practices



# Roles of Participants

- All Participants
  - Providing information to and obtaining information from HIE pertinent to the patient's care in that participant's delivery setting
- Primary Care Providers
  - Providing disease management and care coordination
  - Reviewing quality reports and taking action as needed
- Specialists and Hospitals
  - Supporting care coordination and care transitions
  - Referring individuals without primary care for follow-up

# BCIN Care Coordination Framework

- Every patient with diabetes should have access to comprehensive care coordination and education services
- Based on most recent clinical guidelines and ‘best practices’ (e.g., ADA)
- *Clinical Decision Support* framework to compare to existing disease management tools or available centrally through a *Chronic Disease Management (CDM) Application Portal*
- Care Coordination Readiness Assessment to determine where each practice stands
- Training and coaching to implement tools and framework

# BCIN Quality Measurement

- Aggregated Feedback Reports to Providers
  - BCIN outcomes data reported quarterly
  - Population-based
  - Provider-Specific (compared with performance goal)
  - Clinic-Specific (compared with other clinic providers and performance goal)
  - Preventative Care Metrics
  - Hospital/ED Utilization Rates
  - Identified provider information shared with each provider; de-identified for comparison with others

# Technology Infrastructure

- Foundational System
  - Includes HIE with master patient index, clinical data repository, clinician portal and notification tools, diabetes disease management pathway
- Patient enrollment is opt-out at the primary care provider level
- Participating organizations control the data feed
  - Each organization can decide how much to send
  - Some process is needed for identifying patients who are participating – can be done within the originating information system, in an intermediary system or within the BCIN infrastructure



# BCIN Project Status

- Technical infrastructure configured and implemented
- Initial training sessions and Care Coordination Readiness Assessments completed
- First wave of connections underway in Spokane
- Participants in second wave being identified in Clarkston/Lewiston and Moses Lake/Othello
- Pursuing pilot programs with public and private payers to add financial incentives for participation

# BCIN Value Proposition

- Participation in regional collaboration to improve diabetes health outcomes
- Progress toward achieving meaningful use of health information technology
- Positioning for modified payment models
  - Access to data on a provider's entire patient population, regardless of where the care was received
  - Consistent quality measurement
  - Access to federal data sources to better support outcomes analyses
  - Cost effective shared infrastructure for quality measurement and reporting



# Fundamental Principle of Value-Based Purchasing:

What gets measured gets paid.



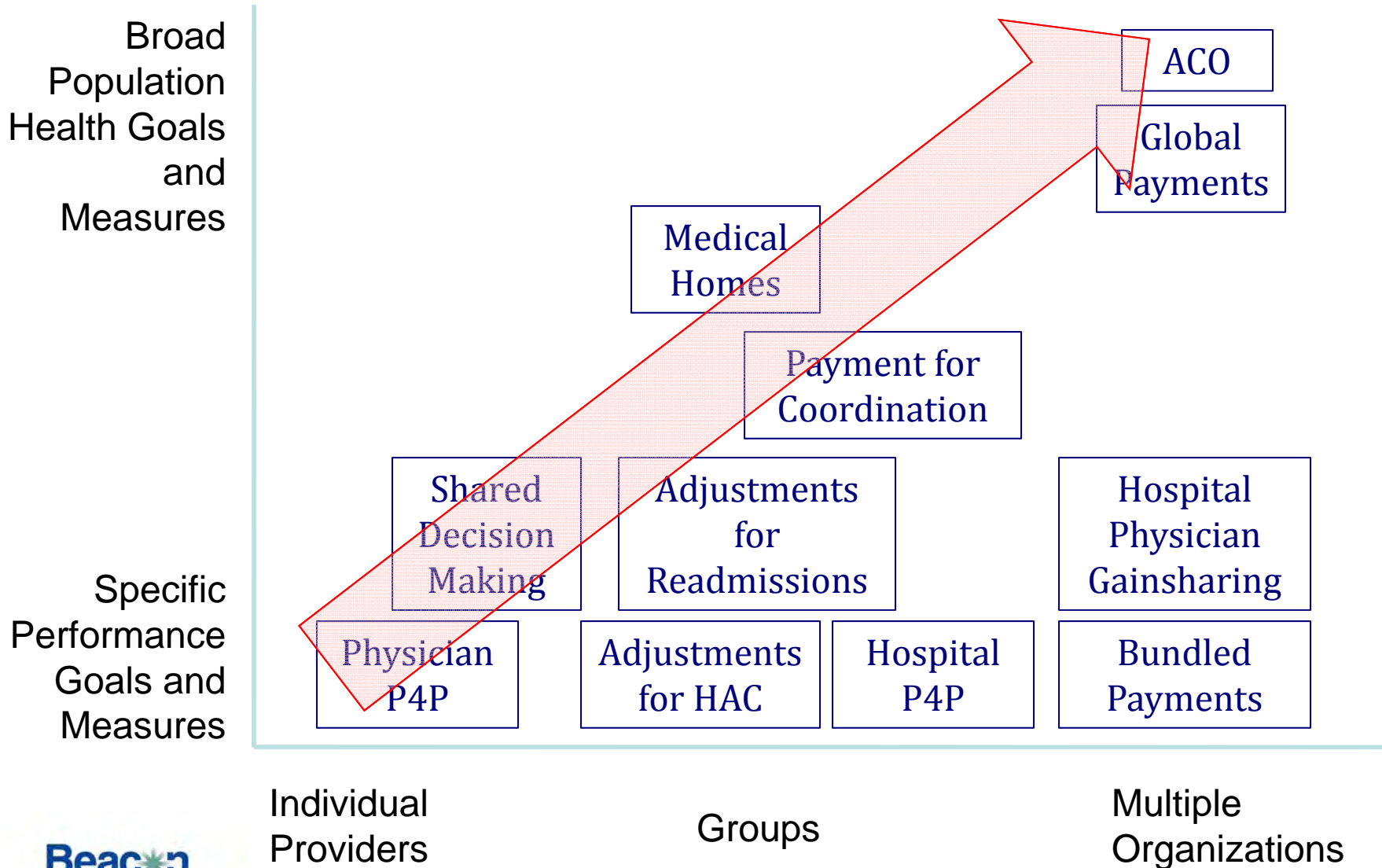
# Value-Based Purchasing

- Multiple models being tested by public and private sector payers
  - Global Payments
  - Accountable Care Organizations
  - Bundled Payments
  - Medical Homes
  - Gainsharing
  - Adjustments for Readmissions or Hospital Acquired Conditions
  - Pay for Performance

# Common Elements

- Use of performance measures and other patient population information to
  - Calculate payment
  - Assess quality and efficiency of care
  - Identify any negative consequences
- Population-based health care
  - Tracking needs and assuring delivery of care proactively across an entire patient population
  - Includes care delivered outside of individual facilities

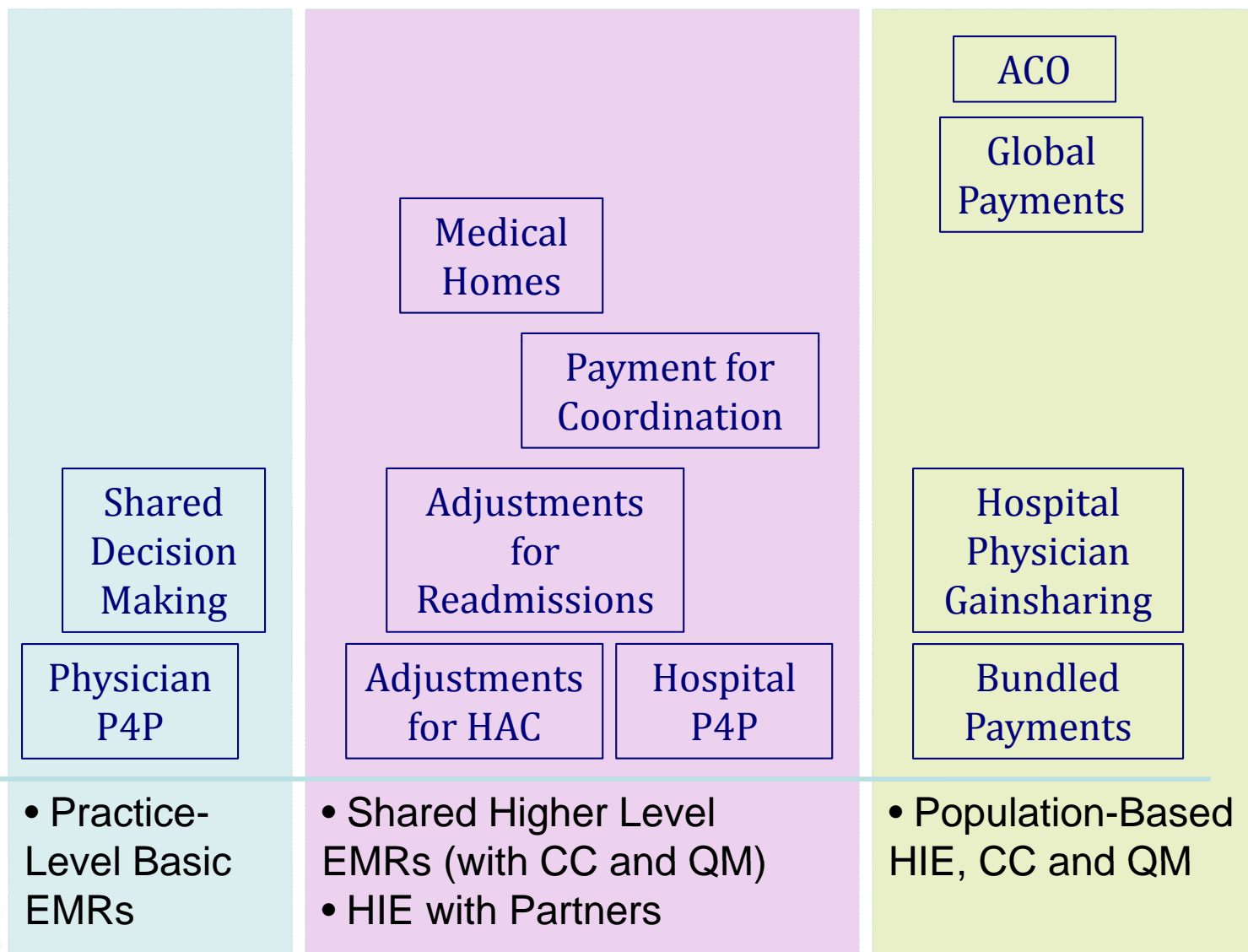
# Comparing Payment Models



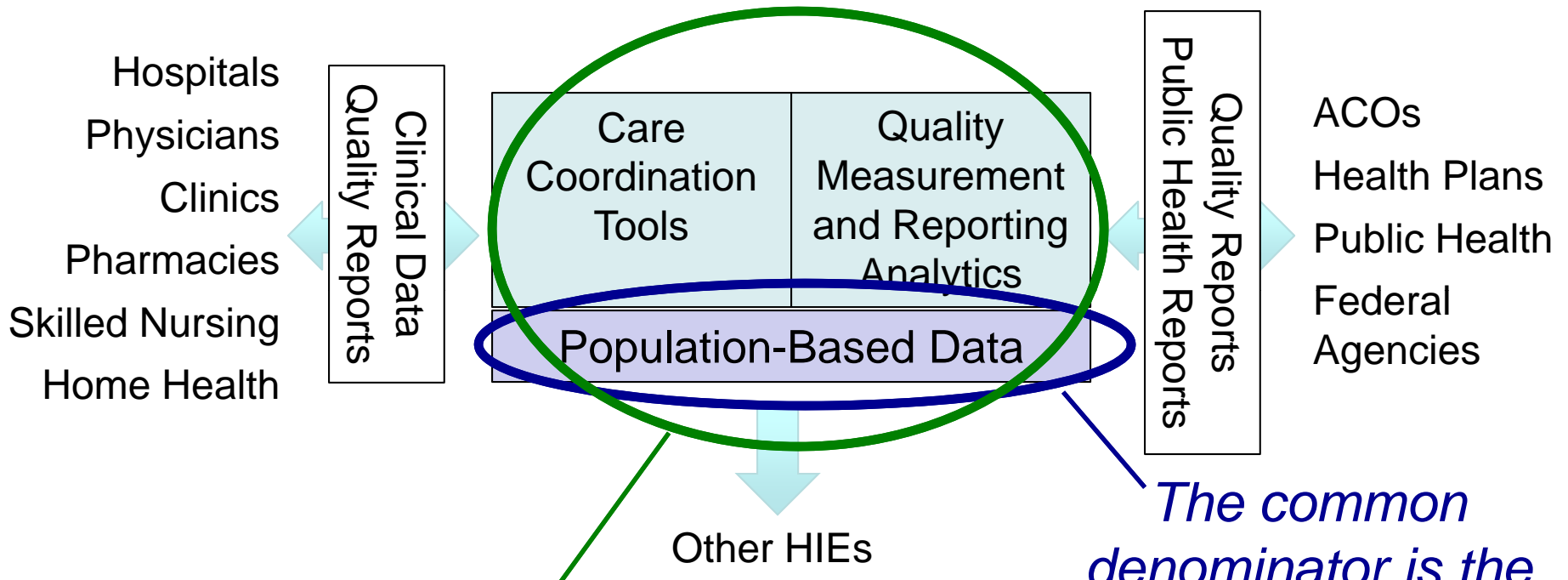
# Comparing Technology Needs

Broad  
Population  
Health Goals  
and  
Measures

Specific  
Performance  
Goals and  
Measures



# Role of Community Organizations



*Basing quality measurement and care coordination on the entire population avoids “silo-ization” of data, assures true comparability in measures, and protects patients who change jobs, insurers, or providers.*

*The common denominator is the community's population.*



# Thank You

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