

Crescent City Beacon Community (New Orleans, LA)



Overview and Goals

The [Crescent City Beacon Community \(CCBC\)](#) is one of 17 Beacon Communities building and strengthening local health IT infrastructure and testing innovative approaches to make measurable improvements in health, care and cost.

[Meaningful Use](#) of electronic health records (EHR) is the foundation of the exciting work in each community. Funded by the Office of the National Coordinator for Health Information Technology, CCBC is using technology to lower the burden of chronic disease, primarily diabetes and cardiovascular disease, by:



- Improving the quality of care in patient-centered medical homes to impact population outcomes
- Better coordinating care to decrease preventable emergency department (ED) and inpatient visits and consequently reduce healthcare costs
- Using innovative tools to engage consumers in the healthcare process.

Partners

CCBC's major partners include: Ochsner Health System, Tulane Medical Center, Children's Hospital, Touro Infirmary, Interim LSU Public Hospital, BlueCross BlueShield of Louisiana (BCBSLA), the Primary Care Development Corporation, and the Txt4Health Community Advisory Group (which includes the Louisiana Department of Health & Hospitals, New Orleans Department of Health, , American Diabetes Association, Centers for Disease Control & Prevention, BCBSLA, Walmart, Novo Nordisk and the New Orleans Hornets).

Crescent City Beacon Community Background	
Total grant award	\$13,525,434 over 3 years
Lead grantee	Louisiana Public Health Institute (LPHI)
Geography (counties)	Orleans, Jefferson, Plaquemines and St. Bernard parishes
# of lives affected by Beacon interventions	137,183
# of providers involved in Beacon interventions	160
# of hospital partners	5
# of insurance partners	1
# of FQHCs and community health clinics	17

“The Crescent City Beacon Community focuses on blood pressure management among patients with diabetes and/or cardiovascular disease. Our chronic care management efforts have taken root, with clinics surpassing NCQA’s threshold of at least 25% of diabetes patients with blood pressure under control.”

- Anjum Khurshid, CCBC Project Director

For a patient story, [click here](#).

Strategies and Achievements

Building and Strengthening Health IT Infrastructure

Approach: CCBC is building the Greater New Orleans Health Information Exchange (GNOHIE), which will connect three hospitals and approximately 50 clinics (largely safety net providers) by the end of the Beacon program. GNOHIE is focusing initially on two objectives: ensuring patients receive timely, seamless care across clinical settings by notifying primary care providers when one of their patients is admitted or discharged from the hospital, and by facilitating referrals between primary care providers and specialists.

Progress:

- The GNOHIE Consent Form and GNOHIE Operational Policies regarding patient consent, breach notification, user access control, and data use and disclosure were approved by the CCBC governance body and went into effect on June 15, 2012.
- Notifications of patient admission and discharge are successfully flowing from a major hospital partner to GNOHIE.

- Historical data from the past two years on over 250,000 encounters for 70,000 patients has been uploaded to the data warehouse supporting GNOHIE, and data continues to be added from new partner sites.
- Interface development has been completed with the electronic medical records vendors for two primary care practices and one hospital.

Improving Health, Care and Costs

Approach: CCBC is working closely with a core group of 16 primary care practices to implement a suite of interventions around [chronic care management](#) and transitions of care. CCBC's chronic care management interventions use electronic medical records and established care management standards and protocols to deliver effective, evidence-based care for patients with diabetes and cardiovascular disease in the outpatient setting. Practices are employing a variety of strategies to improve care delivery, including: care management and care team strategies, population-based disease registries, risk

stratification, and computerized clinical decision support. Transitions of care projects are improving care coordination across the healthcare delivery system to ensure seamless transition of patients among primary care, specialty care, and hospital-based settings. This work aligns with the functionality being developed for GNOHIE around emergency department/inpatient notification and electronic specialty care referral.

Progress:

- All of CCBC's clinics have established clinical care teams and developed criteria to stratify their patient populations based upon risk of further complications, such as disease progression or hospitalization.
- Nine of 16 CCBC clinics have initiated chronic disease registries for patients with diabetes, and 11 of 16 are able to generate lists of their patients electronically.
- 11 of 16 CCBC clinics have implemented at least one clinical decision support rule related to diabetes care delivery.

Early Results: By the Numbers

Between when CCBC Beacon interventions began in April 2011 and the second quarter of 2012, diabetes HbA1c control (<8.0%) has increased.

- In wave 1 (3 sites) HbA1c control increased seven percentage points (from 50% to 57%). The number of patients represented ranged from 1,143 to 1,218.
- In wave 2 (11 sites) HbA1c control increased four percentage points (from 45% to 49%). Number of patients represented ranged from 2,606 to 3,944.

HbA1c control is the proportion of patients aged 18-75 with diabetes whose HbA1c was less than 8.0%.

- From July to September 2012, the ED/inpatient notification intervention will go live in 14 primary care practices and one hospital. The goal is for implementation to occur in an additional 37 primary care practices and one hospital from October 2012 to March 2013.

Testing Innovative Approaches

Approach: CCBC is deploying [txt4Health](#) (a text message-based service) to help individuals better understand their risk of diabetes and become more informed about lifestyle changes that can lead to a healthier life. The txt4Health service is available throughout the greater New Orleans region (as well as in the Southeast Michigan and Cincinnati Beacons). Participants text the word “HEALTH” to 300400, complete a diabetes risk assessment, and receive a customized series of text messages with educational information, exercise and weight loss tracking, and links to local health and lifestyle resources. The txt4Health Community Advisory Group includes, but not limited to: the Louisiana Department of Health & Hospitals, New Orleans Department of Health, American Diabetes Association, Centers for Disease Control & Prevention, BCBSLA, Walmart, Novo Nordisk and the New Orleans Hornets.

Progress:

- 84% of nearly 1,000 participants have reported height and weight to calculate their body-mass index using the service.
- 67% of participants set a personal weight goal over the 14-week txt4health program.

For more information on the Crescent City Beacon Community, visit:
www.crescentcitybeacon.org.

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