

Greater Cincinnati Beacon Collaboration (Cincinnati, OH)



Overview and Goals

The [Greater Cincinnati Beacon Collaboration](#) (GCBC) 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, and led by HealthBridge, one of the nation's largest providers of health information exchange (HIE) services, GCBC is focused on implementing advanced health information technology (IT), HIE, and proven clinical interventions for pediatric asthma and adult diabetes.



GCBC is working with multiple local payers to create incentives for the development of patient-centered medical homes and is involved in a national payment pilot through the Center for Medicare and Medicaid Innovation's Comprehensive Primary Care initiative. GCBC is focused on:

- Investing in a new advanced shared IT infrastructure that gives the community unprecedented data reporting, quality improvement, and analytics capabilities needed for meaningful use and payment reform
- Building on existing community data exchange to create an Emergency Department (ED)/Admission Alert System aimed at reducing preventable ED visits and readmissions
- Implementing a robust integrated disease registry with diabetes and asthma measurement capabilities, integrated data from electronic health records, and patient management systems

Partners

GCBC's major partners include: HealthBridge, the Greater Cincinnati Health Council, the Health Collaborative, Cincinnati Children's Hospital Medical Center, University of Cincinnati, Hamilton

County Public Health and General Electric. Other partners include The Kroger Company, Cincinnati State Technical and Community College, Council on Aging of Southwest Ohio, Ohio Valley Primary Care Associates/Tri State Child Health Services, Healthcare Access Now, The Health Foundation of Greater Cincinnati, and Employers Health.

Greater Cincinnati Beacon Collaboration Background	
Total Grant Award	\$13,775,630 million over three years
Lead Grantee	HealthBridge
Geography	16 counties across three states in the Greater Cincinnati metro area: Ohio, Kentucky, and Indiana.
# of lives affected by Beacon interventions	300,000
# of providers involved in Beacon interventions	725 physicians, 87 practices
# of hospital partners	18
# of insurance partners	3
# of FQHCs and community health clinics	7

“Having an EHR and all the capabilities it provides has revolutionized our practice workflow. We now quickly run reports to help our providers identify patients who are due for flu shots, mammograms or other screenings. This proactive activity will help patients and providers forge a partnership to improve each patient’s health care. It’s also been an asset to be involved with the Beacon Collaboration. Learning from other practices through collaborative training sessions and having access to hands-on coaching from Beacon has made an overwhelming process seem totally doable.”

- Leah Brunie, Family Nurse Practitioner, Summit Family

Strategies and Achievements

Building and Strengthening Health IT Infrastructure

Approach: GCBC is expanding the reach and functionality of HealthBridge, a provider of HIE services connecting over 50 hospitals and 800 physician practices in the region, with the goal of developing an advanced shared IT infrastructure for the community. This infrastructure will provide the greater Cincinnati region with the data reporting, quality improvement, and analytics capabilities that are needed for meaningful use and payment reform efforts. Key functionality being developed under Beacon includes an alert system that notifies providers when a patient has been admitted to the hospital or emergency room, and a disease registry that integrates data from electronic health records and patient management systems across the community. GCBC is also working to gather the information necessary to drive reductions in health disparities related to race, ethnicity, or language (REL). Standardizing patient self-reported REL

categories and investigating how that data is collected is imperative to garner high quality and useable data.

Progress:

- 87 sites are now live with the ED/Admission Alert System, and more than 26,000 alerts had been sent as of October 2012.
- Shared IT Infrastructure and integrated disease registry went live in the Summer of 2012.

Improving Health, Care and Costs

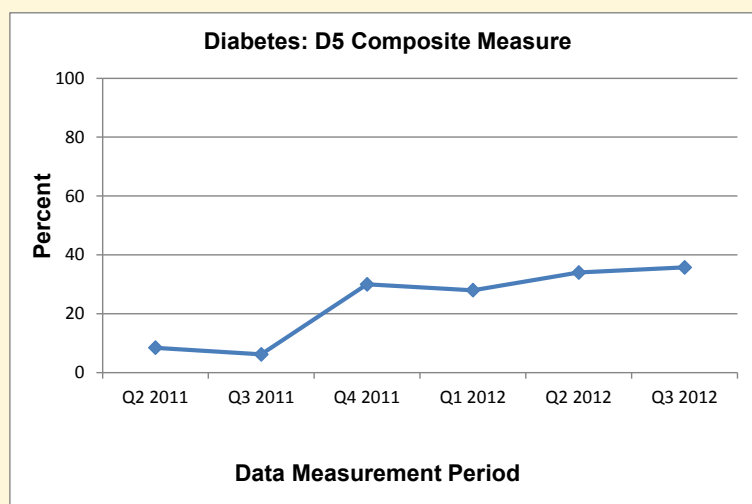
Approach: GCBC is providing intensive practice coaching to 44 practices to improve care for nearly 34,000 diabetic patients. Efforts are focused on helping these practices achieve certification as patient-centered medical homes, and improving performance on key outcome measures for their diabetic patients. The use of an electronic health record, which provides regular quality reporting and implementation of a patient registry, is one of the major technology tools to support improvement work at the practice level. Work is also underway with 18 hospitals focused on reducing readmissions through the adoption of best practices, such as utilizing risk assessment tools with incoming patients, providing real-time handover communications when patients are transferring from hospital to home, and following up with the patient or caregiver within 48-72 hours after discharge. Another initiative focuses on care coordination for high-risk Medicaid patients with asthma. A “root cause analysis” tool developed by GCBC guides practices through a deep dive analysis around the cause for an ED visit or hospital admission. A web-based clinical decision support tool then incorporates these results and suggests appropriate follow-up activities.

Progress:

- Supporting more coordinated, patient-centered care through patient-centered medical home (PCMH) transformation and diabetes improvement initiatives. 13 of 18 Beacon PCMH

Early Results: By the Numbers

GCBC’s clinical transformation work is increasing the proportion of patients aged 18-75 with diabetes who met clinical goals for all five components (HbA1c control, LDL-C control, BP control, aspirin use, and tobacco nonuse) of optimal diabetes care.



Number of patients included: 711 to 1,349

practices have received the highest level of National Committee for Quality Assurance PCMH recognition (Level 3). By the end of 2012, an additional five Beacon practices will submit applications for NCQA PCMH recognition.

- Enrolling high-risk Medicaid patients with asthma into an intensive care coordination program. The time between asthma-related ED/urgent care visits for high-risk Medicaid patients has improved by more than a hundred days.
- Addressing health disparities through improved data collection practices and training on race, ethnicity, and primary language. The percentage of acute care hospitals that are submitting complete data for patients' race, ethnicity, and primary language has increased to 94% from 56%.
- Reducing readmissions at 18 hospitals through endorsement of best practices standards and formation of a hospital discharge planners group to help support standards implementation.

Testing Innovative Approaches

Approach: GCBC is deploying [txt4Health](#) (a mobile health text-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 service is available throughout GCBC's 16-county region (as well as in the New Orleans and Detroit Beacon Communities). 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, as well as links to local health and lifestyle resources. GCBC has partnered with a variety of regional stakeholders to drive enrollment in the program. Several large employers are enrolling employees and promoting company-specific events behind txt4health, while regional healthcare systems are encouraging providers to incorporate txt4health into their protocols for diabetes care.

Progress:

- Greater Cincinnati has had nearly 4,000 participants in the txt4health initiative.
- More than 7,500 Direct secure emails have been sent between providers for various uses.

For more information on the Greater Cincinnati Beacon Collaborative, visit:
<http://www.healthbridge.org/beacon>.

Patricia G Bondurant, DNP, RN
Program Director
pbondurant@healthbridge.org

Trudi Matthews
Communications Lead
tmattthews@healthbridge.org