



# Beacon Community Program

Awardee of The Office of the National Coordinator for  
Health Information Technology

*The Beacon Community Program goals include building and strengthening a health information technology infrastructure; improving health outcomes, care quality, and cost efficiencies; and spearheading innovations to achieve better health and health care.*

## Crescent City Beacon Community

### Overview of the Crescent City Beacon Community

Before Hurricane Katrina hit the city, residents of New Orleans (also called the Crescent City) had some of the highest rates of chronic diseases, such as asthma and diabetes. The hurricane only exacerbated the situation. One in 10 people in the Greater New Orleans area reported a decline in their physical health a year after the storm. African Americans, uninsured residents, and those living in poverty were more likely to report a decline. Difficulties with transportation, relocation of health care providers, and changes in social networks made getting needed health care more difficult for everyone, but especially the poor, the uninsured, and the 4 in 10 residents who report having a chronic disease. Many physicians and other health care providers left the area after the hurricane, meaning that 3 in 10 residents had to change providers and 13 percent had no provider at all.

Since the storm, the New Orleans community has come together to rebuild the health care infrastructure of the region. Hospitals and community clinics have made investments to deploy electronic health records, and improve the primary care system. These efforts have resulted in the New Orleans region having the one of the highest concentration of patient-centered medical homes in the country, and a significant rate of adoption of electronic health records across inpatient and outpatient settings.

The Crescent City Beacon Community (CCBC) will build on its health information technology (health IT) investments, improving the health system and the health care of residents in the Louisiana parishes of Orleans and Jefferson—which can be described as the City of New Orleans and the area that wraps around it to the south and west. While the two parishes are very different, their health care resources are intertwined by history and geography. People in both parishes have high rates of hypertension (1 in 3), diabetes (1 in 10), and current smoking status (1 in 5). Cardiovascular disease, diabetes, and smoking status are associated with greater use of the health care system and higher costs of care. Better management of cardiovascular disease and diabetes and more effective smoking cessation programs can help increase quality of life for these patients, while easing the burden on the health care system.

### Goal of the Program

The goal of the CCBC is to improve control of cardiovascular disease, diabetes, asthma, and smoking cessation and to reduce racial health disparities associated with these conditions. Specific CCBC goals are to:

- Increase the number of chronically ill patients with blood pressure, sugar, and lipid control

- Reduce hospitalization and emergency department use rates for poor management of diabetes, cardiovascular disease, and asthma
- Ultimately, reduce the growth in health care costs across the Beacon Community

### **Using Health Information Technology to Make a Difference**

The CCBC is supporting institutions equipped with electronic health records to pursue meaningful use of the technology, while also identifying potential linkages across institutions for a regional health information exchange in coordination with the state's health information exchange activities. Additionally, the CCBC is engaging consumer, public health, social work, and media partners to test innovative mobile health technologies. In 2011, CCBC has launched interventions with 3 community clinic partners, with a view to eventually expand to 21 locations; additionally, several hospital partners will be piloting the emergency department notification process, based on process and technology readiness.

Specific clinical interventions supportive of CCBC goals include:

- Increased care coordination and information sharing across institutions for more complete and effective care, beginning with targeted use of care managers for high-risk chronically ill in select settings including clinics
- Improved quality and content of patient registries to track outcomes and determine the efficacy of interventions
- Optimization of computerized clinical decision support tools in the community clinic and hospital setting, particularly around care for patients with diabetes
- Improved access to specialty care through use of an electronic referral triage tool completed by primary care physicians and reviewed by the receiving specialist
- Improved follow-up care by using electronic alert systems to notify providers when a patient is admitted to the emergency department or hospital
- Increased capability to conduct analytics on multi-payor claims data to understand population health trends and drive quality improvement
- Advanced ability to understand population risk for diabetes and engage consumers through a diabetes-focused mobile health technology campaign

### **A Team Approach**

Local partners in the CCBC effort include statewide hospital providers such as the Ochsner Health System, Tulane Medical Center, and Interim Louisiana State University Public Hospital; Community Health Centers; metro New Orleans school-based health centers; and the Louisiana Public Health Institute. The Children's Hospital and Touro Infirmary will be critical partners to improve the health of mothers and children in the region. The CCBC is also collaborating with the state's Health Information Exchange and Regional Extension Center initiatives, which are led by the Louisiana Healthcare Quality Forum. BlueCross BlueShield of Louisiana provides an important link to regional quality incentive programs; local and state public officials are participating in an advisory capacity to ensure broader alignment of regional and state health care agendas. The collaborative effort will also include the addition of new partners as the project progresses.

### **Improvements for Patients and the Community**

When providers share information easily, patients get more complete, convenient, and effective care. The CCBC expects that the introduction of health information technology will help:

- Increase access to preventive care, specialty referrals, and targeted care management for cardiovascular disease and diabetes, which will reduce emergency room visits, hospitalizations, and re-admissions

- Give providers easy access to clinical guidelines and best practices for the care and monitoring of diabetes and other chronic conditions through computerized clinical decision-support tools
- Reduce the number of duplicate tests
- Improve transitions from one care setting to another (from hospital to home, home to skilled nursing facility, etc.)
- Enable more accurate and effective tracking of patient care and outcomes in order to improve health care quality and safety

The CCBC will provide the unifying vision for Greater New Orleans as partners come together to create a more seamless and integrated health care delivery system. The CCBC will demonstrate to the rest of the country the possibilities of health IT-enabled care delivery in urban settings, such as school and community clinics, and the potential for improved transitions across different care settings. These interventions, combined with the strong partnerships at the local and state level, will ensure that improvements to the Greater New Orleans health care system will continue a sustainable path forward.

