



# 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.*

## **Beacon Community of the Inland Northwest**

### **Overview of Beacon Community of the Inland Northwest**

Better diabetes care coordination and management are at the heart of the Beacon Community of the Inland Northwest (BCIN). Patients with diabetes need preventive health services in order to stay healthy and reduce instances of complications related to the disease. For example, 3 in 10 diabetic patients do not receive the recommended number of blood sugar tests within a year, and more than 1 in 4 adults with diabetes do not receive an eye exam; both of which are part of the standard of care that can contribute to positive health outcomes. The BCIN is facing this problem head on. It represents 14 counties in eastern Washington, north central Washington, and northern Idaho, with large rural and traditionally medically underserved populations.

BCIN is building on and strengthening an existing quality improvement and technology infrastructure to spread care coordination services to a large population. It is expanding a successful Centers of Occupational Health & Education (COHE) initiative that deploys care coordinators to improve provider-patient communication and improve patient self-management and adapting this model to address diabetes care in the region. It is also strengthening and expanding the Inland Northwest Health Services (INHS) health information network, which connects 38 hospitals and health care facilities in eastern Washington and western Idaho, allowing thousands of providers to securely access patient information using wired and wireless technologies. It includes more than 3.5 million electronic health records (EHRs).

### **Goal of the Program**

The BCIN aims to increase care coordination for patients with diabetes in rural areas and expand the existing health information exchange network to provide a higher level of connectivity throughout the region. Specifically, the BCIN is working to achieve three objectives:

- Reduce emergency and inpatient care for diabetes and its complications
- Increase receipt of diabetes preventive health services
- Improve access to diabetes preventive health services information by public health agencies

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

One aspect of successful preventive care coordination is the exchange and meaningful use of electronic health information between providers responsible for different aspects of care. The BCIN is enhancing the data that are collected and the way data are shared to ensure BCIN patients with diabetes get the services they need. For example:

- Many complications from diabetes can be prevented when appropriate primary care is received in a routine and timely manner. When patients don't have complications, they don't need to visit the emergency room (ER) or go to a hospital. The BCIN is collecting data from the EHRs maintained by participating hospitals to track care received by Beacon patients in

ERs and hospitals. It hopes to see less use of these expensive services because of coordinated care and preventive services for patients with diabetes. As a result, patients are healthier.

- The BCIN is connecting more providers—and more kinds of providers—to the existing INHS health information exchange, gathering data on diabetes care, and helping providers give preventive health care services to their patients with diabetes.
- How well providers deliver these services is fed back to them in the form of quality dashboards and provider scorecards. It is anticipated that doctors will use this information to fill gaps in care; improved quality of care will lead to improved health for patients.
- Better data—and better access to data—help public health agencies develop better interventions to promote population health. The INHS health information network is connected to public health reporting systems so that BCIN-related aggregate data can be sent to and used by public health agencies.

The BCIN is also deploying disease management and electronic clinical decision support tools to help health care providers improve follow-up and management of patients with chronic disease with an initial focus on diabetes. Other information technology tools include quality dashboards—graphic arrays of information that highlight providers' performance in specific areas of quality—and provider report cards. Lessons learned from BCIN's experience in implementing community-based and provider-level performance monitoring and reporting will help other communities seeking to establish similar initiatives.

### **A Team Approach**

In addition to INHS, other BCIN partners include Community Choice, the Washington State Department of Health, the Washington Academy of Family Physicians, the Critical Access Hospital Network, SAIC, and the North Central Washington Health Collaborative. Twenty-five hospitals, 18 health centers, and more than 3,200 doctors, as well as pharmacies and long-term care agencies across vast geographic regions, have indicated interest in collaborating on the BCIN. The BCIN also works with the Washington & Idaho Regional Extension Center to help doctors select, install, and use EHRs.

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

The BCIN intends to improve the health of patients with diabetes and reduce regional health care costs due to diabetes-related complications through a variety of health information technology solutions, such as EHR upgrades and interfaces, to enable data sharing between providers.

The BCIN expects that these health information technology solutions will help improve the health of patients with diabetes by:

- Enacting more routine and timely care for diabetes patients to help prevent complications
- Reducing regional health care costs due to diabetes-related complications
- Improving coordination of care between health care providers and their patients with diabetes.

