



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.

Western New York Beacon Community

Overview of the Western New York Beacon Community

The Western New York Beacon Community serves the City of Buffalo and eight surrounding counties. More than 1 in 10 people in this area of the state have been diagnosed with diabetes. Prevalence in the region is even higher among certain ethnic or racial groups: 14.3 percent of African Americans and 12.3 of Hispanics have diabetes, compared to 10.8 percent of whites. Significantly more African Americans and Hispanics die of diabetes-related complications than non-Hispanic whites.

Health care costs for individuals with diabetes are more than five times greater than those who do not have the disease. People with poorly managed diabetes are more likely to experience complications. They are also more likely to be hospitalized for flu and pneumonia, and they may also develop congestive heart failure, another condition associated with low quality of life and high health care service use.

For more than 10 years, Buffalo, NY and the greater western New York region have been leaders in regional efforts to sustainably develop health information exchange (HIE). Due to the collaborative leadership of local payers, employers, hospitals, and public officials, the western New York region is home to a sophisticated regional HIE, called HEALTHeLINK. It connects nearly half of health care providers and just under half (45 percent) of hospitals in the area. Increasing health information exchange capabilities will continue to be key to increasing quality, reducing costs, and improving public health. The Beacon program is serving as the impetus to expand existing health information technology (health IT) investments and using them to build new care delivery improvements that translate into improved quality, cost, and population health.

Goal of the Program

The Western New York Beacon Community (WNYBC) is expanding the western New York network, closing gaps in service, and improving health outcomes for patients with diabetes. Specifically the goals of the program include:

- Achieve 5 percent reduction in emergency department visits, hospitalizations, and readmissions
- Increase percentage of diabetic patients with blood sugar, cholesterol, and blood pressure control
- Reduce health disparities, especially in urban and rural underserved areas, using health IT, including clinical decision support
- Expand consumer access to health information

Using Health Information Technology to Make a Difference

The WNYBC is built on the conviction that the appropriate and meaningful use of health information technology will help increase the quality of care for patients with diabetes. Research on electronic health record (EHR) implementation has identified three critical success factors: use of disease registries, workflow integration, and real-time clinical decision support. In year one, Beacon activities are helping more than 275 providers realize the benefits of health IT by:

- Assisting health care providers with using electronic patient registries and clinical decision support tools
- Deploying clinical decision tools (EHR alerts and registries) coupled with technology-enabled community supports (home monitoring/telemedicine, patient portals/personal health records, and education) to improve outcomes for individuals with diabetes
- Implementing medication-adherence programs within EHRs, with medication management especially for high-risk patients
- Piloting shared care manager resources for small physician practices to help manage high-risk or chronically ill patients
- Piloting the use of advanced remote monitoring technology to help 100 high-risk diabetes patients actively manage their health without visiting a hospital or physician's office
- Providing training and technical support for physician office workflow redesign, use of clinical decision software, and other practice transformation relevant to EHR meaningful use

A Team Approach

HEALTHeLINK, the western New York clinical information exchange, is a collaborative effort among various organizations including: The Catholic Health System, Erie County Medical Center Corporation, HealthNow New York (BlueCross BlueShield of Western New York), Independent Health Association, Kaleida Health, Roswell Park Cancer Institute, Univera Healthcare, and the Health Care Efficiency and Affordability Law for New Yorkers Capital Grant Program from New York State. HEALTHeLINK stakeholders include a broad representation of health care professionals and organizations throughout the eight-county western New York region such as the Buffalo Academy of Medicine (BAM), Erie County Department of Health, the State University of New York at Buffalo, and the WNY R-AHEC (Rural Area Health Education Center). Through the Beacon Community initiative, HEALTHeLINK, along with the P² Collaborative of Western New York (NYeCregional extension agent), and 40 community partners will advance and leverage resources as well as areas of excellence.

Improvements for Patients and the Community

Increased access to health IT in western New York is leading to better care for all residents. When health care providers have access to EHRs and engage in HIE, there are increased opportunities for preventive care that help community members avoid illness and complications. Moreover, the widespread use of health IT and disease registries allows health care providers to:

- Easily identify high-risk patients whose lab results are outside recommended guidelines, and link them to care managers for more personalized, active follow-up
- Use clinical decision-support tools embedded in the EHR to determine if recommended protocols are being followed or need to be adjusted
- Link patients to specialists when needed
- Refer patients to recommended services, such as community or organization-specific diabetes programs
- Identify and follow up with patients who need immunizations or additional care using reminders built into the EHRs

By expanding current HIE capabilities and equipping more providers, particularly in smaller, rural practices, to be meaningful users of EHRs, the Western New York Beacon Community will be well poised to demonstrate the linkages between health IT and improvements in affordable, high-quality care. Additionally, as a home to a more mature HIE, HEALTHeLINK and its partners can inform sustainability strategies to newer information exchange efforts across the country.