



# 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.*

## **Southeastern Michigan Beacon Community (SEMBC)**

### **Overview of the Southeastern Michigan Beacon Community**

A significant portion of the population that resides in the Southeast Michigan Beacon Community (SEMBC) is considered vulnerable: They have a high likelihood of being uninsured; experience limited access to health care; and are likely to be low income or poverty stricken. Unfortunately, diabetes disproportionately affects vulnerable populations. For example, those making less than \$20,000 a year are three times more likely to suffer from the preventable complications and effects of diabetes than those with incomes greater than \$75,000 per year.

Despite these socio-economic factors, SEMBC is making genuine progress in its efforts to improve the health care delivery system and elevate the health, livelihood, and productivity of the patients and overall community served by SEMBC. The key is informed and engaged physicians and patients; clinical transformation; and innovative, sustainable process interventions that are enabled by health information technology (health IT) and health information exchange (HIE).

### **Goal of the Program**

The goal of the SEMBC is to use health IT and HIE along with other clinical interventions to enable patient-centered care and test clinical and operational interventions that are *specifically designed* to deliver significant, measured results – better quality of care, lower health care costs, and ultimately, improved overall health of the population in Southeast Michigan. Beacon interventions in Southeast Michigan focus on diabetes identification, care, and management. The intent is for SEMBC's experiences to be transferable and scalable to additional populations and disease states.

The primary goals include:

- Increased standard testing and examinations among patients diagnosed with diabetes
- Reduced non-urgent emergency department (ED) utilization among patients diagnosed with diabetes
- Reduced disparity of treatment related to gender, insurer, or race among patients diagnosed with diabetes

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

The SEMBC is facing two enormous challenges.

1. **Enabling the exchange of pertinent clinical data among doctors, hospitals, patients, and extended care resources**, who to this point, have essentially worked in “silos” with limited exchange – and virtually no access to common data/information.

SEMBC is addressing this challenge by working across multiple stakeholders and establishing exchange functionality, population management, and point of care tools.

2. **The widespread impact and prevalence of diabetes across the population.** In Michigan alone, diabetes affects approximately 10 percent of the population—1,000,000 people:
  - 701,000 have been diagnosed with diabetes
  - 364,400 have diabetes, but are currently undiagnosed.

The estimated cost to Michigan is more than \$8 billion.

To address these challenges, SEMBC has deployed numerous clinical and operational resources and interventions that promote more informed physicians and patients, improved self-management and compliance among participating patients, and the identification of diabetics/pre-diabetics that are not yet in the health care continuum.

Specific examples of the clinical and process/operational interventions currently being deployed in SEMBC include:

1. **Physician data reporting and performance feedback:** Establishing a network of participating physicians, and establishing/enabling process change and data exchange.
2. **Care Coordination – Ambulatory:** Utilization of Patient Navigators to help patients adhere to their treatment plans.
3. **Clinical Decision Support:** The targeted use of alerts, reminders, and decision support information that improves patient care and helps eliminate potential errors in care.
4. **Care Coordination – Hospital Emergency Department:** Establishing processes with EDs that achieve increased consistency in the identification of diabetic patients, and assist in post-ED visit care coordination.
5. **Patient Engagement:** Developing partnerships with community and faith-based organizations to extend the reach and approachability of SEMBC.
6. **Telehealth:** Using mobile and text messaging tools to identify diabetic/pre-diabetic individuals, and deliver ongoing targeted messaging to educate them and offer a new point of entry into the health care continuum.

### **A Team Approach**

The Southeastern Michigan Health Association is the lead agency for SEMBC. Because SEMBC is a high profile initiative that will have long-lasting impact on the future of health care – both locally and nationally – it has attracted the interest, support, and active participation of the “Best-of-the-Best” across the health care continuum in Southeast Michigan. It is a unique, “game-changing” opportunity for all involved: Physicians, extended health care providers, hospitals, health systems, educational institutions, payers, employers, public health agencies, community-based organizations, pharmacies and laboratories and other relevant stakeholders.

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

By promoting and demonstrating the effective use of health IT and HIE, SEMBC is improving care quality, cost effectiveness, and population health of the community by:

- Transforming physician practices and helping them deliver optimal care for diabetic patients
- Helping diabetic patients play a more active, engaged role in the care and management of their condition

- Identifying diabetic/pre-diabetic patients and directing them to appropriate care and resources using clinical and non-clinical methodologies
- Coordinating the use of resources to deliver better, more efficient care

SEMBC is serving as a catalyst to not only meet the short-term objectives for the targeted population of diabetic patients and providers, but also serving as a more comprehensive, scalable model that for the use and deployment of health IT and HIE to engage a broader spectrum of health care challenges in the future.

