



# 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.*

## **Greater THAN Beacon Community**

### **Overview of the Greater THAN Beacon Community**

Tulsa and the entire state of Oklahoma face more than their fair share of challenges in improving the health of their residents. The state ranks near the bottom of national rankings on a wide range of health indicators. More than 65 percent of adults in the state are obese or overweight, with fewer physicians per capita than most states. As a result, residents have trouble accessing and navigating the health care system, especially when they need specialty care.

But despite challenging statistics, Tulsa has long been at the forefront of utilizing health information technology (health IT) to drive improvements in coordination of care across provider settings and competitive boundaries. In 1999, the community developed a Community-wide Care Coordination System (CCC) to respond to inefficiencies and fragmentation in the local health care system. Since then, it has become an essential tool for coordinating care transitions between primary and specialty care, reducing health disparities, and improving access and health outcomes. Formed by more than 40 health care stakeholders following an intense and comprehensive community-wide planning effort, the Greater Tulsa Health Access Network (Greater THAN) Beacon Community is charged with further improving the overall regional health system.

### **Goal of the Program**

The Greater THAN Beacon Community is working to link more than 1,400 providers and 240,000 patients in a community-wide health information system that helps them better monitor and improve care. Specifically, the program seeks to:

- Improve care coordination during transitions between health care settings, such as from primary care to specialist care, from emergency room to primary care, and from hospital or skilled nursing facility to follow-up care
- Improve efficiency and appropriateness of referrals for testing, specialty treatment, hospital admissions, and emergency care
- Improve screening rates for breast and colon cancer
- Enable increased adherence to recommended immunization schedules for adults and children

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

Increased access to targeted applications of health care information technology is the backbone of the Greater THAN Beacon Community plan. The four prongs of the Beacon's technology solution include:

- **Building on already existing health information exchange successes in care coordination:** The CCC system was designed to help patients move more smoothly from primary to specialty care and also to help prevent unnecessary use of specialty services. Where such a system is not in use, patients often show up for specialist visits without the necessary records or background information for the visit. This leads to duplication of services, unnecessary visits, and/or rescheduled appointments. Using the proposed system, primary care providers can easily send needed information about patients directly to specialists before appointments are even scheduled. In preliminary results from a randomized control trial of the CCC system, the online communication system allowed specialists to determine before the patient visit that specialist care was not necessary in 32 percent of cases. This freed up appointments for specialists to see more urgent cases within days of the referral. The Beacon Community program is expanding the reach of the CCC system and integrating with other technologies to include more than 200 providers and approximately 24,000 patients by the end of 2011.
- **Expanding the depth and reach of health information exchange:** Area providers have chosen a common platform for health information exchange allowing more comprehensive, efficient, and secure information sharing among providers. The system's development plan includes an interface for patients to increase communication between patients and their providers.
- **Adding tools to make information more useful:** Data does little good for patients or providers if it is not presented in an understandable and useful way. In addition to working with providers on how to integrate new systems into their work flows and clinical processes, the Greater THAN Beacon Community is implementing a decision-support tool that calculates a patient-specific risk profile for certain health conditions, recommends certain interventions, and allows providers and patients to explore "what-if's" for different health-improvement strategies, such as quitting smoking, losing weight, or taking medications.
- **Analyzing data to measure health care quality and efficiency:** In order to ensure that the Beacon is reaching its goals, the system has the capability to process and analyze the data and produce useful reports to track:
  - Utilization of the technology within the community
  - Successful coordination of care
  - Use of clinical tools, such as risk profiles and decision support
  - Impact of technology on community health outcomes

### **A Team Approach**

Greater THAN's 48 partners include hospitals, first responders (e.g., ambulance, police, and fire departments), university medical systems, tribal health systems, safety-net or essential care clinics (including federally qualified health centers), physician practices, laboratories, public health organizations, pharmacies, and specialists.

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

By increasing communication, coordination, and cooperation among area providers, the Greater THAN Beacon Community strives to improve the health of residents in the 11-county area while reducing health care costs by millions per year. Some of the specific ways the program will achieve these objectives include the following:

- Proactive coordination of diabetes care greatly improves the quality of life for patients and reduces health care costs. Successful coordination requires engagement between multiple providers, specialists, and patients. The CCC system is tracking referrals and communicating lab results more easily, allowing providers and patients to stay involved in the process.
- Early detection of breast cancer and colon cancer improves the chances of successful treatment. Advanced clinical tools will allow providers to more easily recognize when

patients are due for screenings, such as mammograms for breast cancer and colonoscopy for colon cancer. Primary care providers and diagnostic centers will work together to ensure that patients know that they are due for these tests and help arrange for easy referrals and communication of results.

- Patients (adults and children) who are due for immunizations will be notified through their providers or through the patient portal.

New clinical tools are giving patients the opportunity to see their own risk profiles in order to discuss with providers ways to improve their health through lifestyle or medical interventions. In this way, Oklahomans are beginning to work together to reduce the high rate of death from preventable causes, such as smoking and obesity.

