



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.

Utah Beacon Community

Overview of the Utah Beacon Community

The Salt Lake City area has a long history of collaboration on quality management and care process redesign, state-level health care delivery, payment reform initiatives, as well as strong community coalitions and staff experienced in executing projects that improve health care. This cooperative spirit has been greatly enhanced through extensive adoption of health information technology (health IT), including electronic health records (EHR), participation in health information exchange, and nearly universal use of the Utah Health Information Network for administrative exchange.

Designated by the Centers for Medicare & Medicaid Services as a quality improvement organization and by the Agency for Healthcare Research and Quality as a Chartered Value Exchange, HealthInsight serves as the lead organization for the counties that make up the Salt Lake Metropolitan area: Salt Lake, Summit, and Tooele Counties. In this role, HealthInsight will serve as the primary agent in focusing the energy of local health care stakeholders and maintaining their willingness to work together for the good of the general community.

Despite its national reputation for high-quality, efficient health care systems, Utah has a number of important health care challenges, such as a limited number of primary care providers, low rates of some preventive health screenings and immunization coverage for children, and a high rate of avoidable hospital admissions. For example, only 40 percent of patients with diabetes receive recommended care each year. The Utah Beacon Community Program, called the IC³, “Improving Care Through Connectivity and Collaboration,” aims to leverage health information technology (health IT) to bring about improvements in health care quality and efficiency.

Goal of the Program

The IC³ aims to improve the care that patients receive, particularly those with diabetes and other life-threatening conditions; decrease unnecessary costs in the health care system; and improve public health. Specifically, it is working to achieve three primary objectives:

- Improve the health and health care for people with diabetes through management and coordination of care
- Reduce avoidable hospital stays and emergency department (ED) visits for people with diabetes
- Improve consistency between patient wishes and care provided during the last six months of life and reducing associated hospital utilization consistent with patient preferences

Using Health Information Technology to Make a Difference

Leveraging the region's culture of using data to drive improvement, the IC³ is working to achieve its objectives through the strategic use of health IT and exchange, care process redesign, payment reform, performance monitoring and feedback, and community collaboration. The health IT activities include:

- Connecting doctors and hospitals to Utah's Clinical Health Information Exchange (cHIE), a secure electronic network that provides doctors with a way to view and share patient information, including procedures performed and services accessed
- Conducting rigorous primary care practice assessments and workflow redesign to help approximately 350 area providers implement and meaningfully use EHRs
- Helping doctors make decisions at the time of a patient's visit through computerized decision support tools, such as the *Intermountain Healthcare Diabetes Patient Worksheet* (which lists a patient's medications, allergies, clinical and lab data, tests, and vital signs) and population-based reports (which identify patients overdue for visits or screenings)
- Creating a broad-based quality improvement reporting and feedback system
- Facilitating the communication of Physician Orders for Life-Sustaining Treatment (POLST) documentation to health care providers via an electronic form repository and training providers to access and use POLST information appropriately
- Transmitting communicable disease information electronically to improve the public health response related to 74 reportable conditions

A Team Approach

Building on the region's success in community collaboration around the most difficult issues facing the health care system, HealthInsight has convened key partners, such as Intermountain Healthcare, the University of Utah, the Utah Department of Health, the Utah Commission on Aging, and the Utah Health Information Network to participate in the Beacon project. HealthInsight also operates the Regional Extension Center for Utah and Nevada, also funded by the Office of the National Coordinator for Health Information Technology and tasked with leading the area's providers to quickly adopt and become meaningful users of EHRs.

Improvements for Patients and the Community

The IC³ is working to improve the quality and coordination of care for patients with diabetes and other life-threatening conditions, as well as improving the reporting of communicable diseases in Utah. Through an integrated approach of promoting and supporting health IT, onsite coaching, and periodic community-wide learning sessions, the IC³ has already taken steps that allow patients in Utah to:

- Properly manage their diabetes through new reliable health care processes, accurate and timely data, and good care coordination among providers
- Experience improved diabetes care in their doctors' offices, which should lead to reductions in avoidable hospital admissions and ED visits as well as a decrease in costs
- Receive the care they prefer during the last months of life
- Access more timely care in addressing their needs related to communicable diseases

While HealthInsight has placed an emphasis on care processes for patients with diabetes, failures in care processes for other chronic diseases are largely due to the same underlying problems. For this reason, it is expected that the strategies implemented as part of the Beacon Community program will improve care processes for other chronic diseases, especially for those with multiple chronic diseases.