Colorado Beacon Consortium

Our Story at One Year

Medical Home Summit West
September 21, 2011

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Practice Transformation

Teams Are Reaching Goals Every Time

Colorado Beacon Consortium

Today's Discussion

- Overview of Beacon Communities
  - Brief overview of the ONC Beacon Community Program
  - Overview of the Colorado Beacon Consortium
    - Partners, Goals and Program
    - Practice Transformation
    - HIT/HIE

National Priorities & Beacon Goals

- ARRA funding–HITECH Act

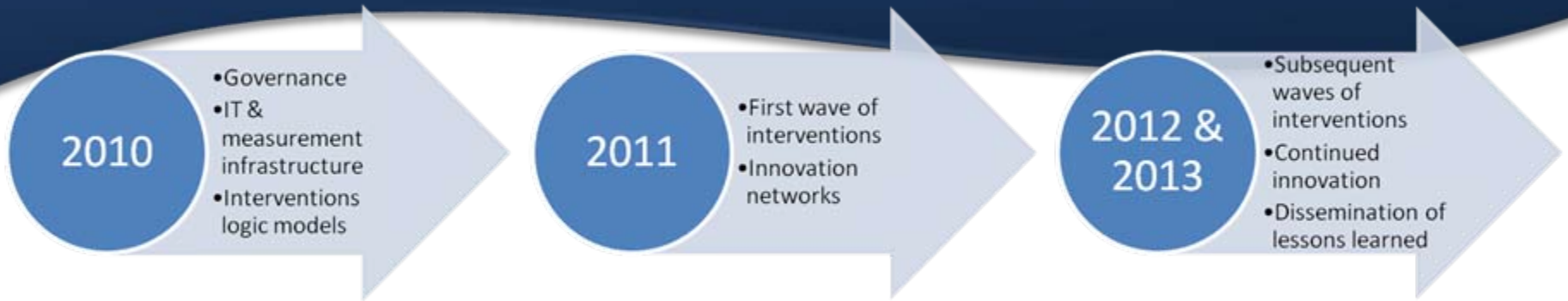
- Office of the National Coordinator for HIT (ONC)
  - State HIE
  - Regional Extension Centers (REC)
  - Beacon Communities
  - SHARP
  - Work Force Development–Health Care IT
- Goal: Share best practices that help communities achieve cost savings and health improvement
  - 17 demonstration communities that will:

–Build and strengthen their HIT infrastructure and exchange capabilities and showcase the Meaningful Use of EHRs

–Provide valuable lessons to guide other communities to achieve measurable improvement in the quality and efficiency of health services or public health outcomes

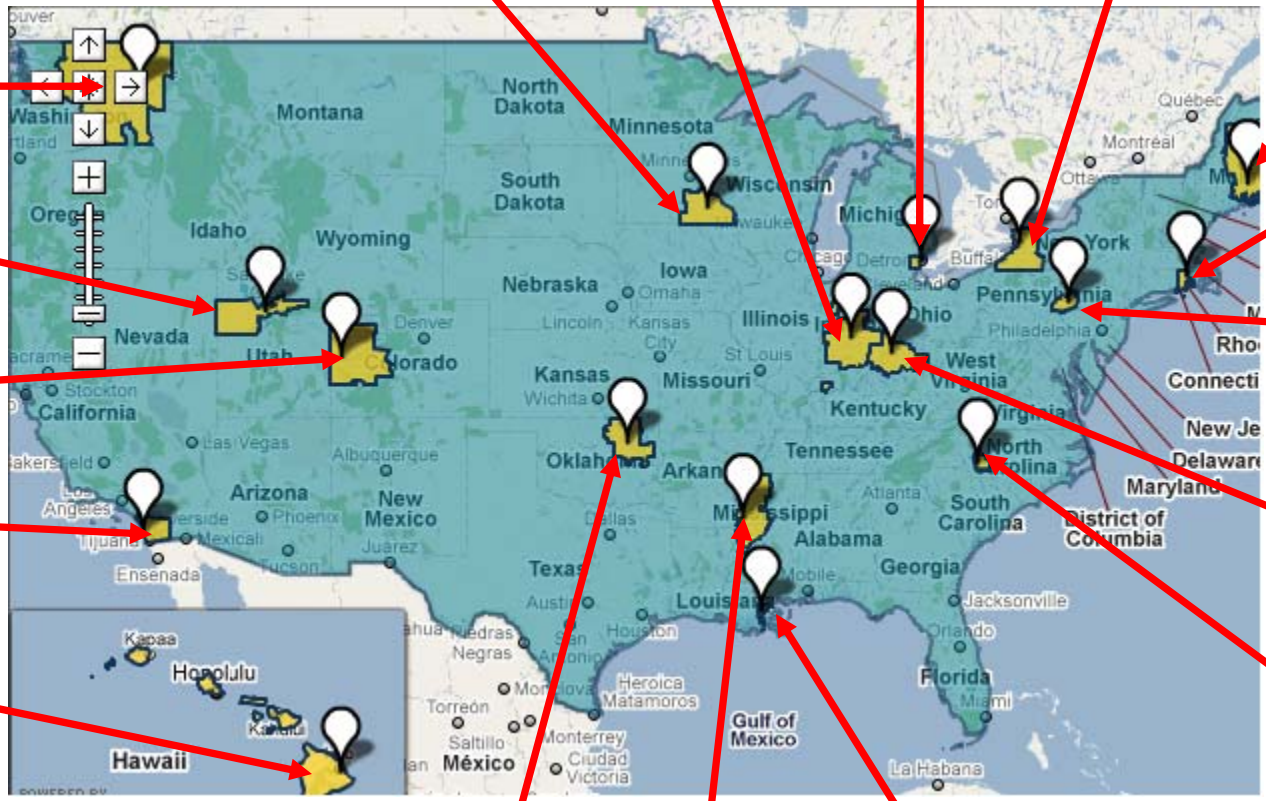
–Provide lessons & best practices for other communities

Beacon Communities Overview



- Beacon interventions are designed with a focus on achieving health and health care improvement. In 2011, for example,
  - 12 Beacon Communities' work includes improving care transitions (e.g., process improvements and information flow at hospital discharge).
  - 13 Beacon Communities are utilizing IT tools and process improvements (e.g., CDS) to improve performance of physician practices.
  - 3-4 Beacon Communities will implement mobile technology-enabled local campaigns to improve diabetes awareness and management
- All Beacons are generating cost/quality/health data on their performance quarterly and utilizing them for improvement efforts

Beacon Communities



Who is the Colorado Beacon Consortium?

The CBC is a collaboration of health providers and community agencies in Western Colorado. The project is led by the following Community members:

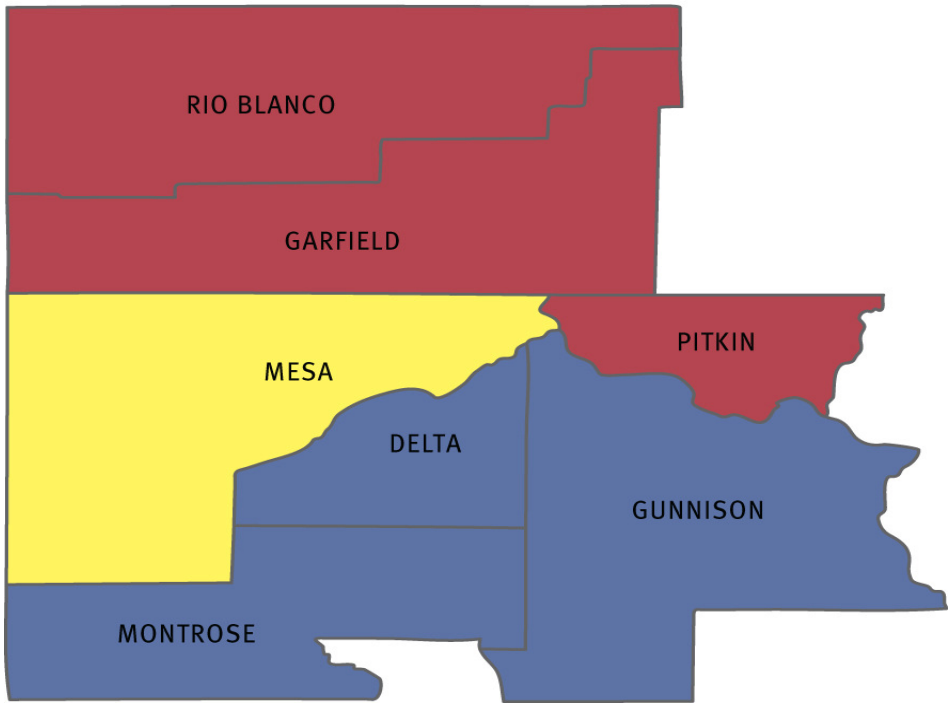
Sponsor	Representative
Quality Health Network:	Dick Thompson
Mesa County Physicians' Independent Practice Association:	Greg Reicks, DO
St. Mary's Hospital:	John Beeson, MD, MBA
Rocky Mountain Health Plans:	Steve ErkenBrack
Community Representative At Large:	Steve Reynolds

Colorado Beacon Communities

Region A — Delta, Gunnison, and Montrose

Region B — Mesa

Region C — Garfield, Pitkin, and Rio Blanco



CBC Goals

- The CBC will significantly Increase EHR Adoption and HIE participation (60% among all PCPs, minimum).
- The CBC will complete process transformations for 75 primary care practices within the CBC region.
  - Close the gap from clinic baseline to project goals by 50%
- The CBC will demonstrate specific quality and population improvements for all patients.

Our Offerings

Technology Enhancements

- HIE Connectivity
- EMR Interface
- Provider Portal (simplified sign on)
- Advanced Analytics (Archimedes)
- Community Technology Roadmap-PopHealth Registry, Data Layer and Patient Portal

Practice Transformation

- Clinical Process Efficiency Consultation
- Performance Improvement Skills
- Practice Transformation
- Advanced use of current technology
- Collaboration with REC Partner for Meaningful Use
- Financial incentives to reduce barriers to participation

CBC
Colorado Beacon Consortium

Practice Transformation Program Guiding Principles

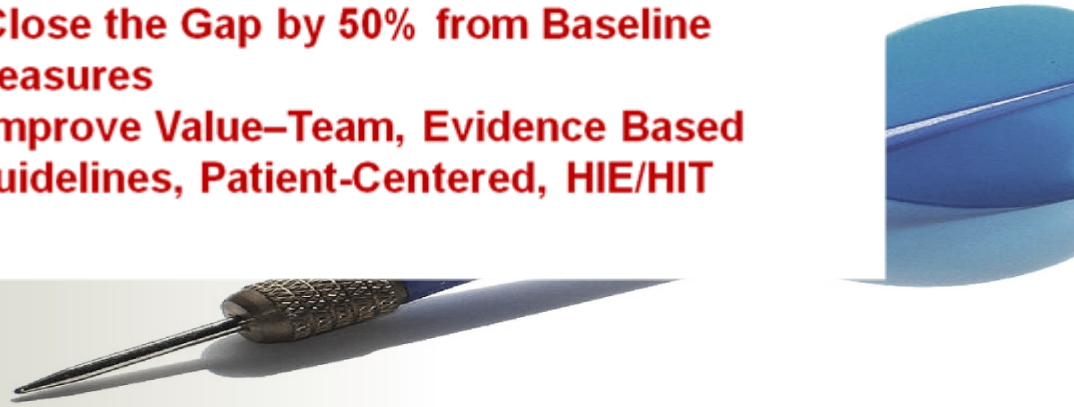
- IHI Triple Aim
- IOM Six Aims

Program Methodology

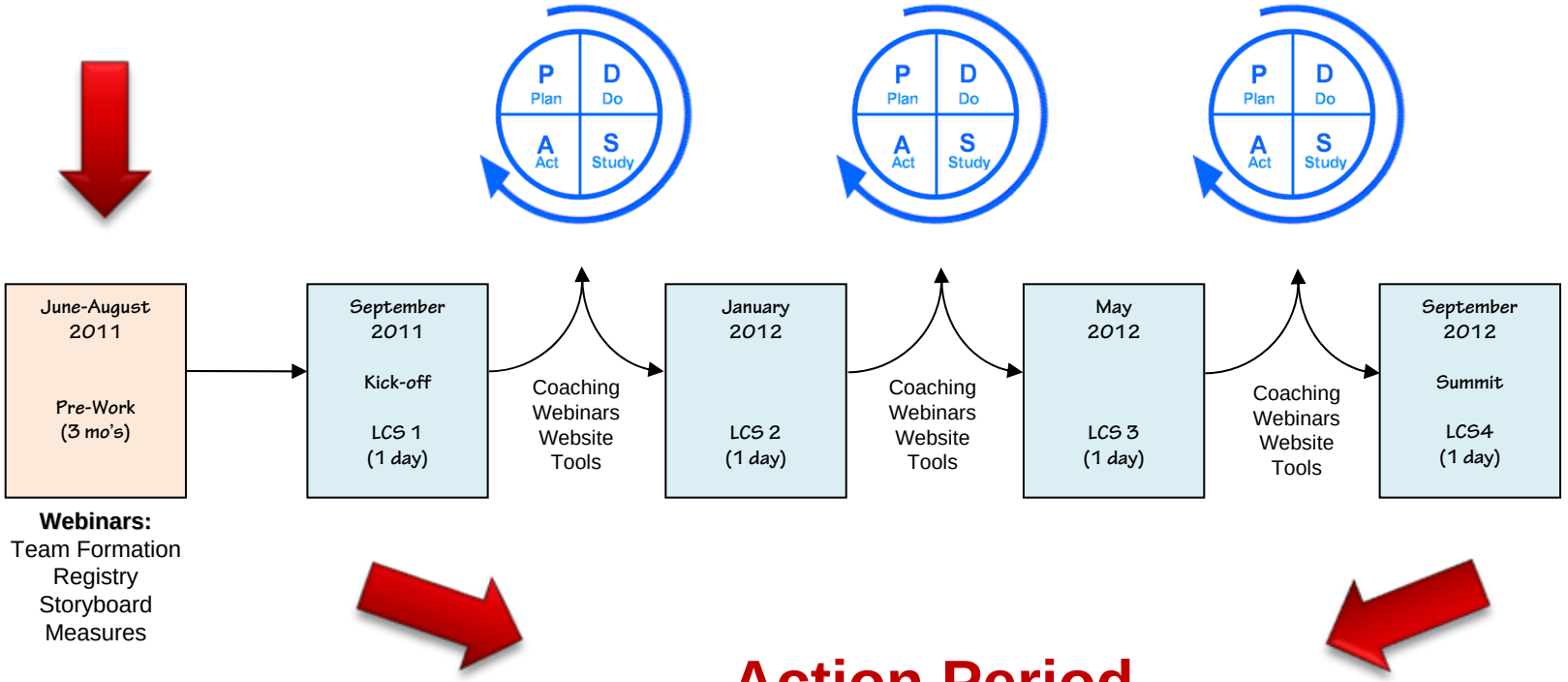
- Care Model
- Model for Improvement
- Performance Improvement
- QIAs and Learning Collaboratives

Timeframe and Goals

- Three Month Pre-work &One Year with Advisors and Learning Collaboratives
- Close the Gap by 50% from Baseline Measures
- Improve Value–Team, Evidence Based Guidelines, Patient-Centered, HIE/HIT



Pre-Work, Learning Collaboratives, and Action Periods



Clinical Measure Set

Pediatric

Phase I

- Asthma – Appropriate Medications for Persistent Asthma
- Immunizations – Up to date by age 2

Phase II

- Child Weight Assessment & Counseling

Adult

Phase I

- Diabetes (BP & HbA1c)
- IVD (Lipid screen and control)
- Depression Screening (Diabetes & IVD)

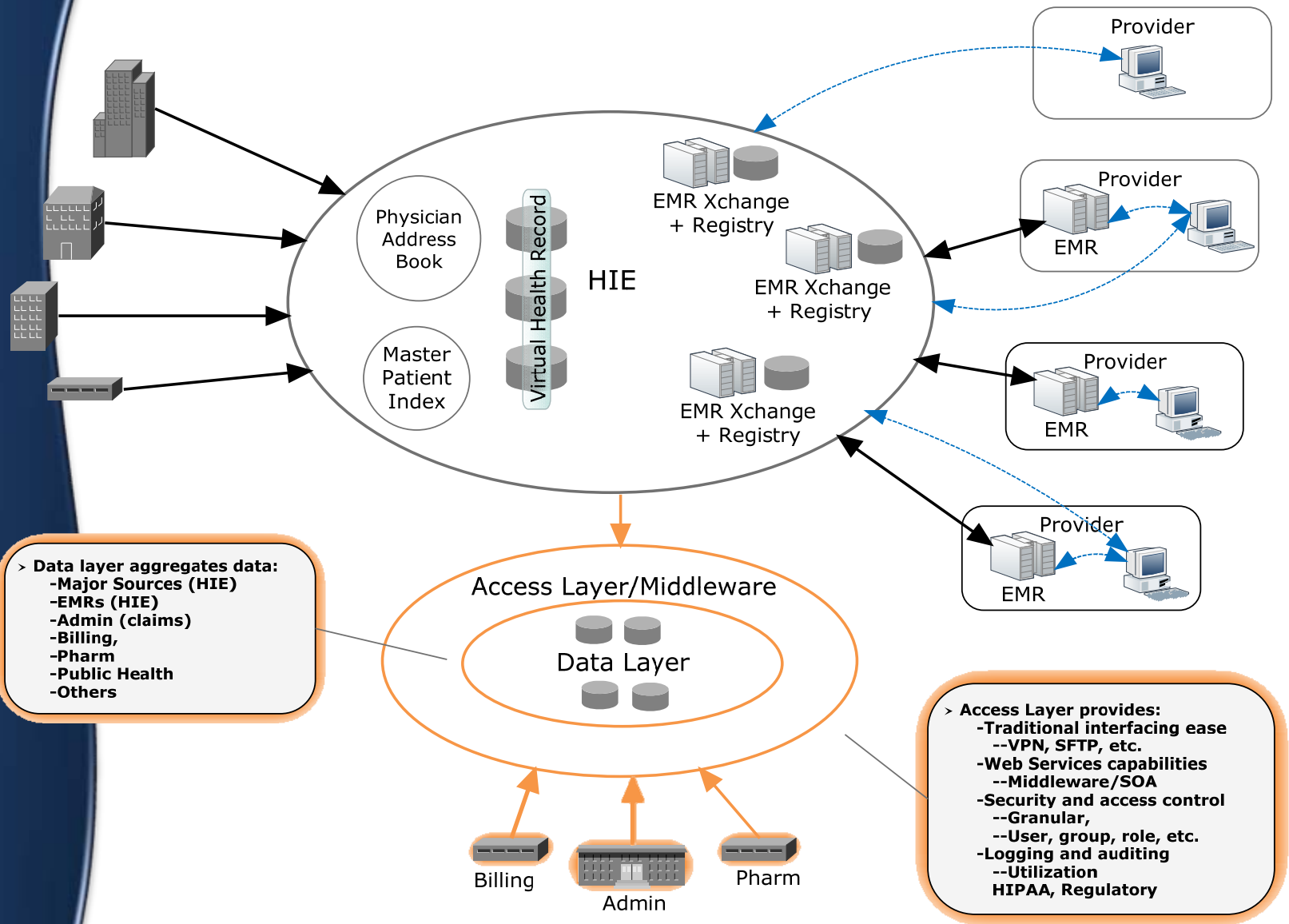
Phase II

- Adult Weight Assessment & Counseling
- Breast Cancer Screening
- Tobacco Ask & Counseling

Diagnosis specific ER and Avoidable Admission measures at the Program Level

QHN + Beacon Objectives

Data Layer and Access Layer

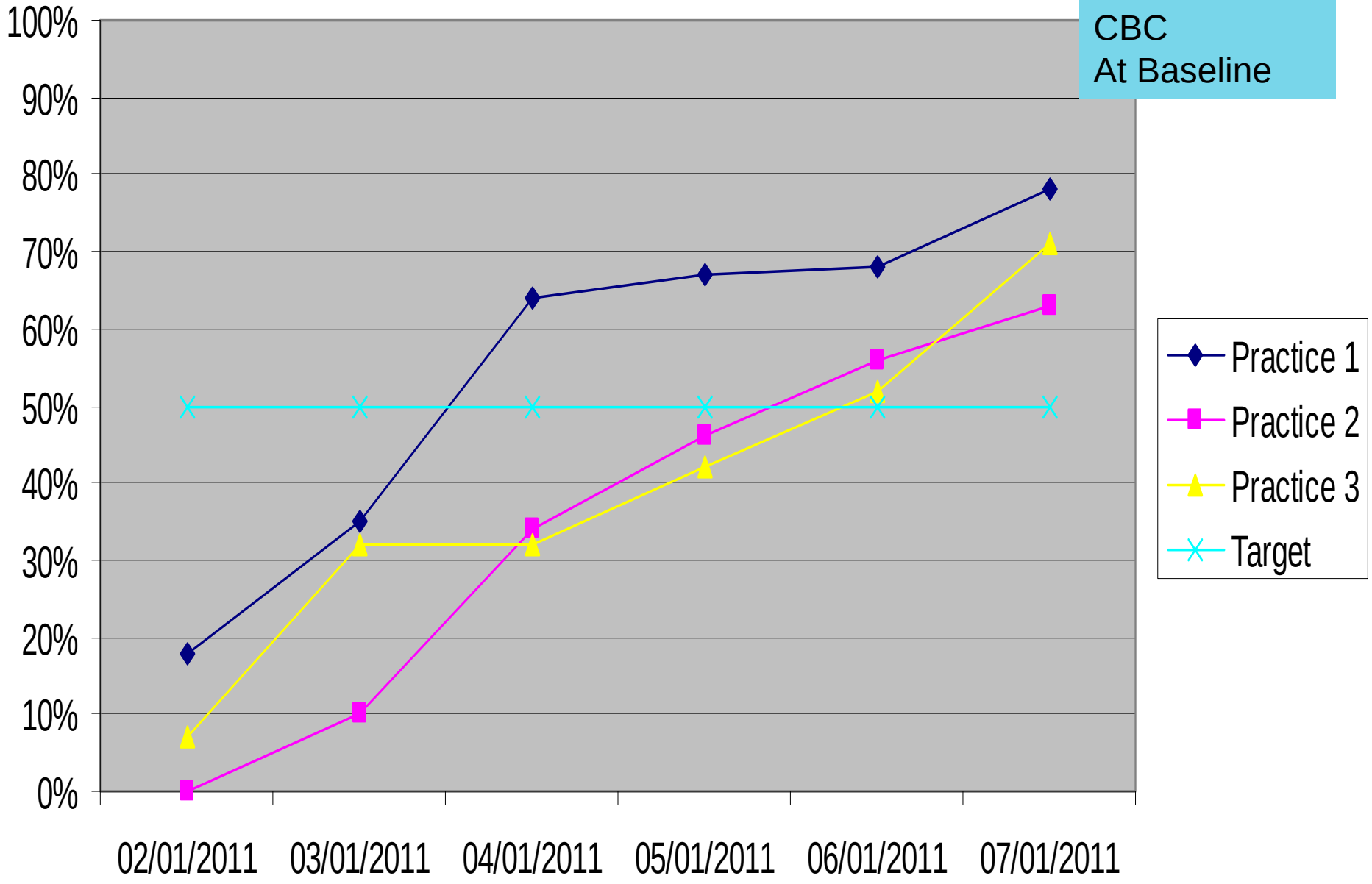


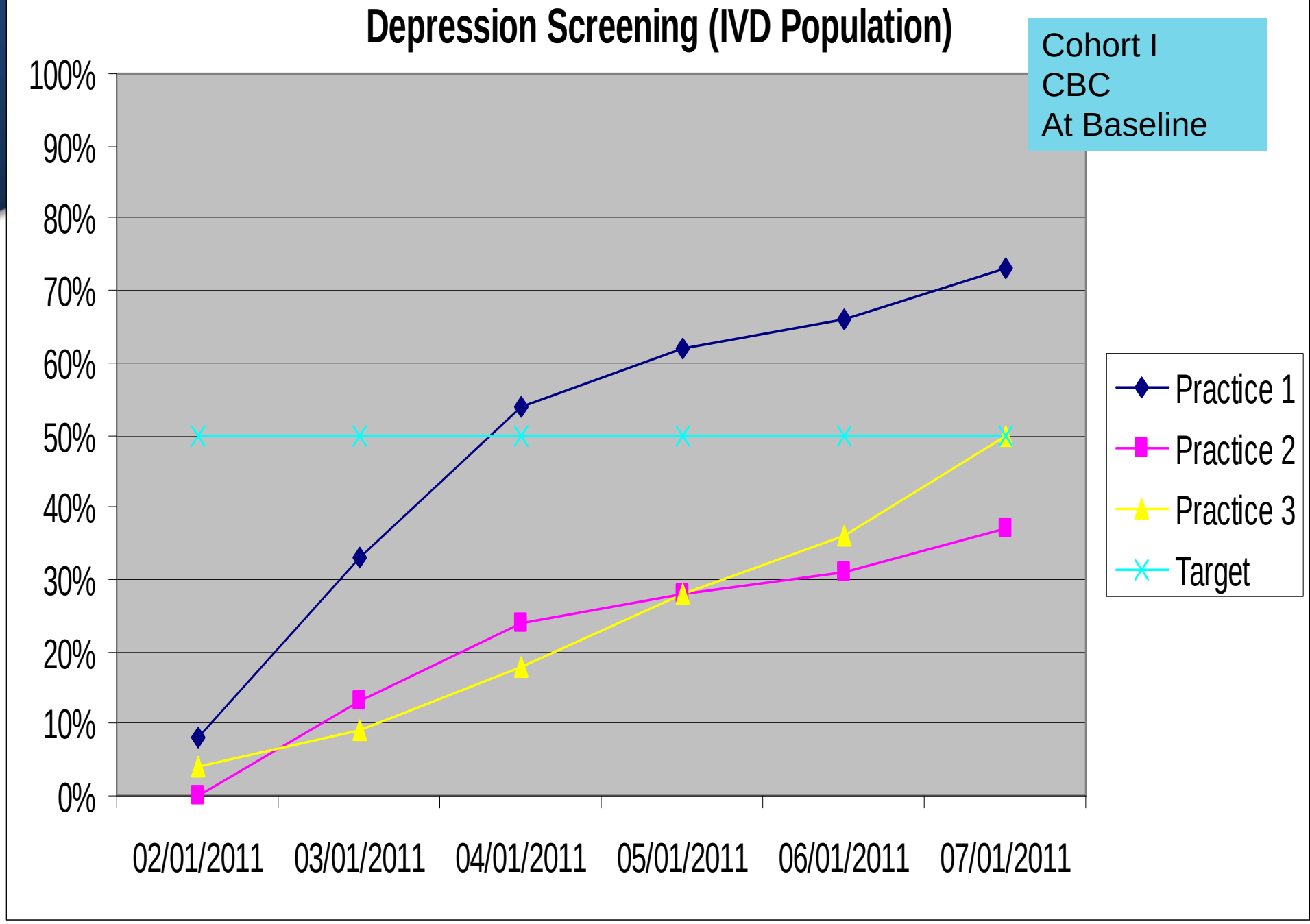
What have we accomplished?

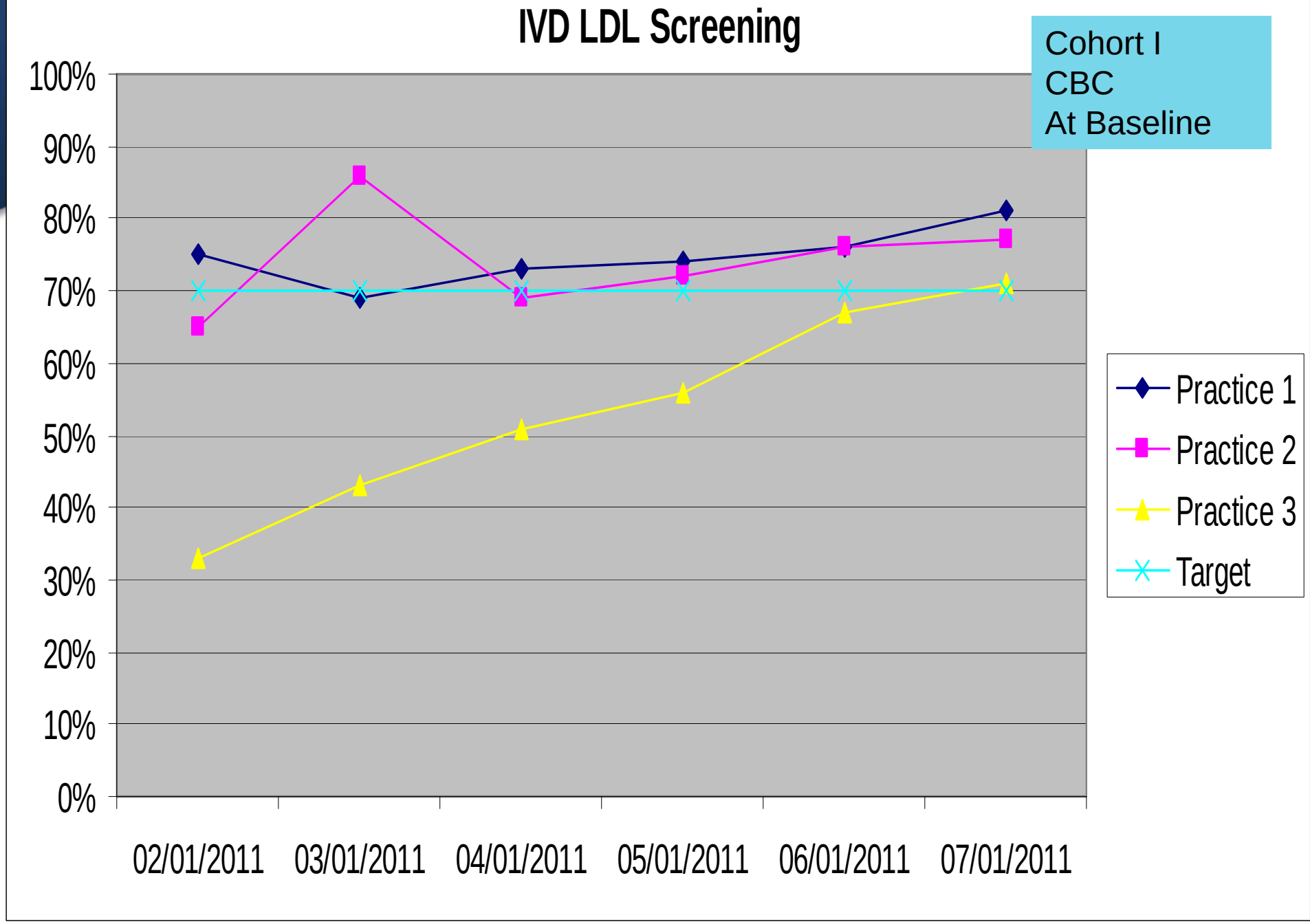
- Started 3 Cohorts-38 Practices Total
- Monthly Clinical reporting from 25 practices
- MU Upgrades-6 practices, In Process 30
- Achievement of Baseline Measures-5 practices
- Supported 2 Regional FQHCs in HRSA Funding
- Intangibles…..
  - Practices are creating community with each other
  - Learning QI tools and processes
  - Learning more about their technology and measurement
  - The work is tough but the feedback is “We will never go back!”

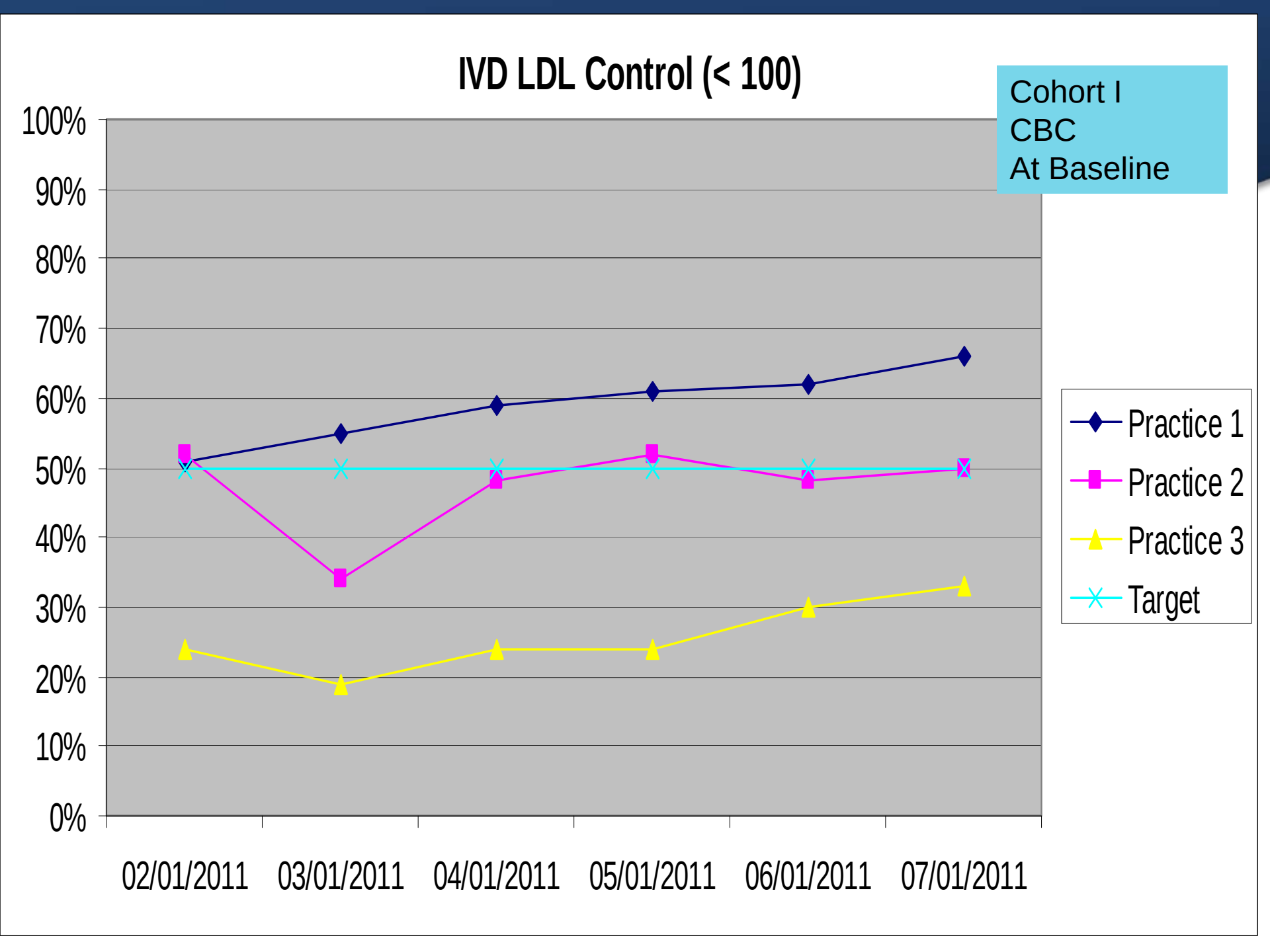
Depression Screening (Diabetes Population)

Cohort I
CBC
At Baseline



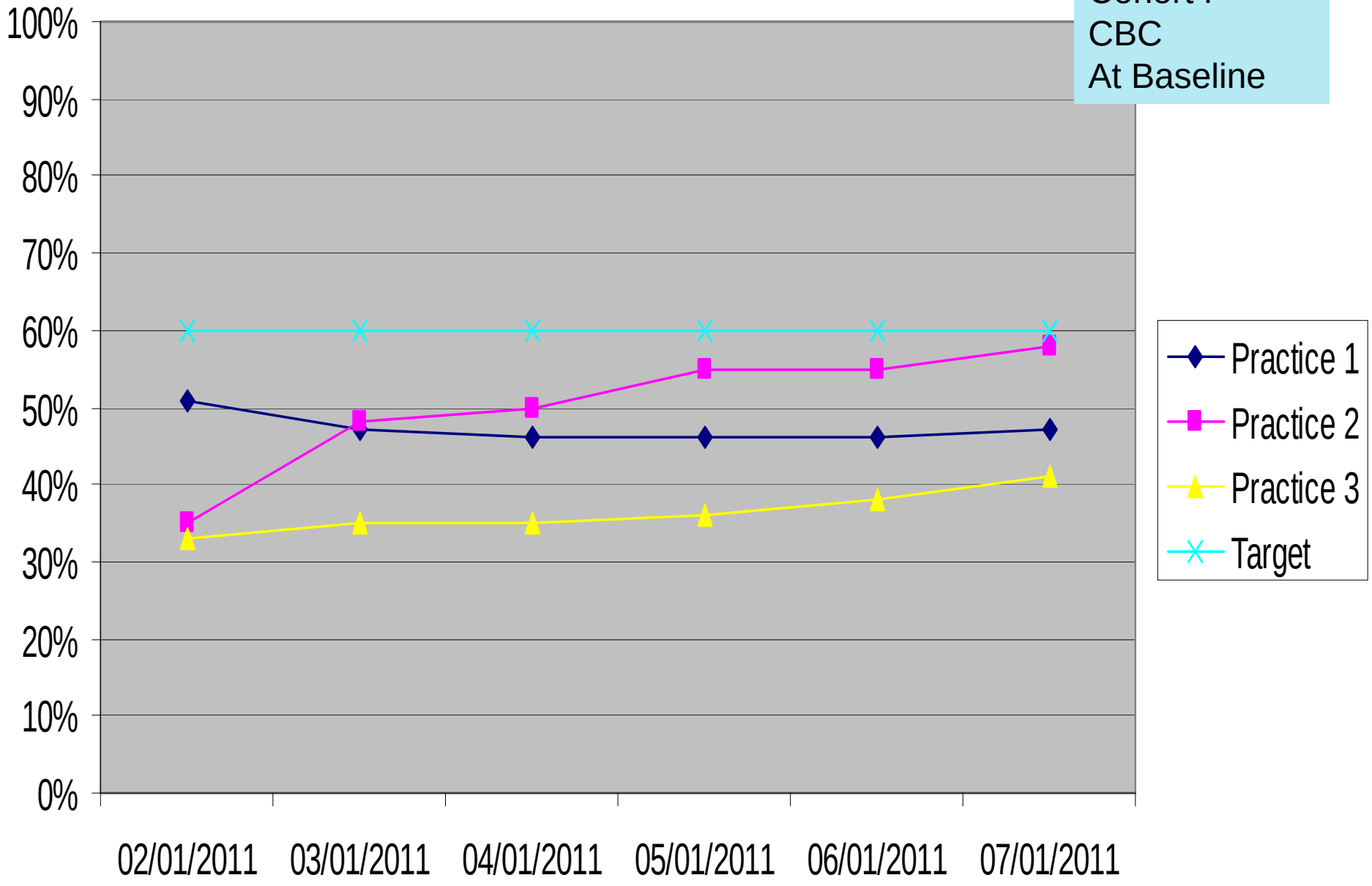

Depression Screening (IVD Population)
Cohort I
CBC
At Baseline
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
02/01/2011
03/01/2011
04/01/2011
05/01/2011
06/01/2011
07/01/2011
Practice 1
Practice 2
Practice 3
Target


IVD LDL Screening
Cohort I
CBC
At Baseline
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
02/01/2011
03/01/2011
04/01/2011
05/01/2011
06/01/2011
07/01/2011
Practice 1
Practice 2
Practice 3
Target


IVD LDL Control (< 100)
Cohort I
CBC
At Baseline
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
02/01/2011
03/01/2011
04/01/2011
05/01/2011
06/01/2011
07/01/2011
Practice 1
Practice 2
Practice 3
Target

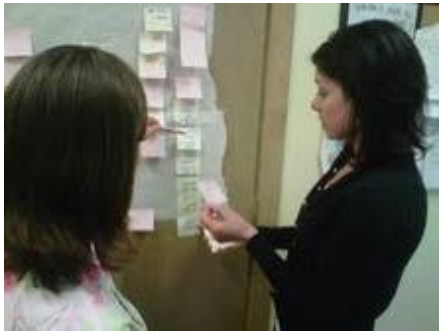
Breast Cancer Screening

Cohort I
CBC
At Baseline



What's Next?

- Alignment of HIE and Transformation--Archimedes Pilot and Implementation
- Motivational Interviewing Intensive with Colorado West & Collaborate with Mesa County Care Transitions program
- Implement Transitional Phase/Practice Portal for Forums on the CBC Website/Phase II Curriculum
- Community PopHealth Tool Procurement & Implementation
- Data Layer RFP
- NCQA CAHPS PCMH Survey Pilot
  - (Work in progress)
- Define Patient Portal Specs



Lessons Learned

- Meet practices where they are at!
- You see one EHR, you have seen one EHR (even if it is the same EHR)
- Got Data?
  - Clinical Measures Reporting is a new skill set
  - Implemented a MU Certified EHR? Reporting can still be a challenge
  - Where's the patient?-Patient Activation/Experience/Engagement
- Practices need support in optimizing their HIT/HIE capabilities
- Repeat after me….Standardization is important!
  - Process
  - Practice
  - System
  - Community/Region
- Transformation is a Journey….not a destination!
- Be a Learning Community!

Resources/References

AHRQ Technology Resources
http://healthit.ahrq.gov/portal/server.pt/community/health_it_tools_and_resources/919

Colorado Beacon Consortium
http://www.coloradobeaconconsortium.org/

The Commonwealth Fund
http://www.commonwealthfund.org/

HRSA Transformation Resources
http://healthcarecommunities.org/

Improving Chronic Illness Care-Care Model
http://www.improvingchroniccare.org/

Resources/References

Institute for Healthcare Improvement-Model for Improvement/Triple Aim
http://www.ihi.org/ihi

Institute of Medicine-Crossing the Quality Chasm Six Aims
http://iom.edu/

Office of the National Coordinator for HIT (ONC)
http://healthit.hhs.gov/portal/server.pt/community/healthit_hhs_gov__home/1204

Patient Centered Primary Care Collaborative
www.pcpcc.net

Safety Net Medical Home Initiative
http://www.qhmedicalhome.org/safety-net/publications.cfm

Thank You

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