



Department of Health & Human Services
Office of the National Coordinator for
Health Information Technology

Beacon Communities: Improving Health and Healthcare on a Foundation of Health IT

The Patient Centered Primary Care Collaborative

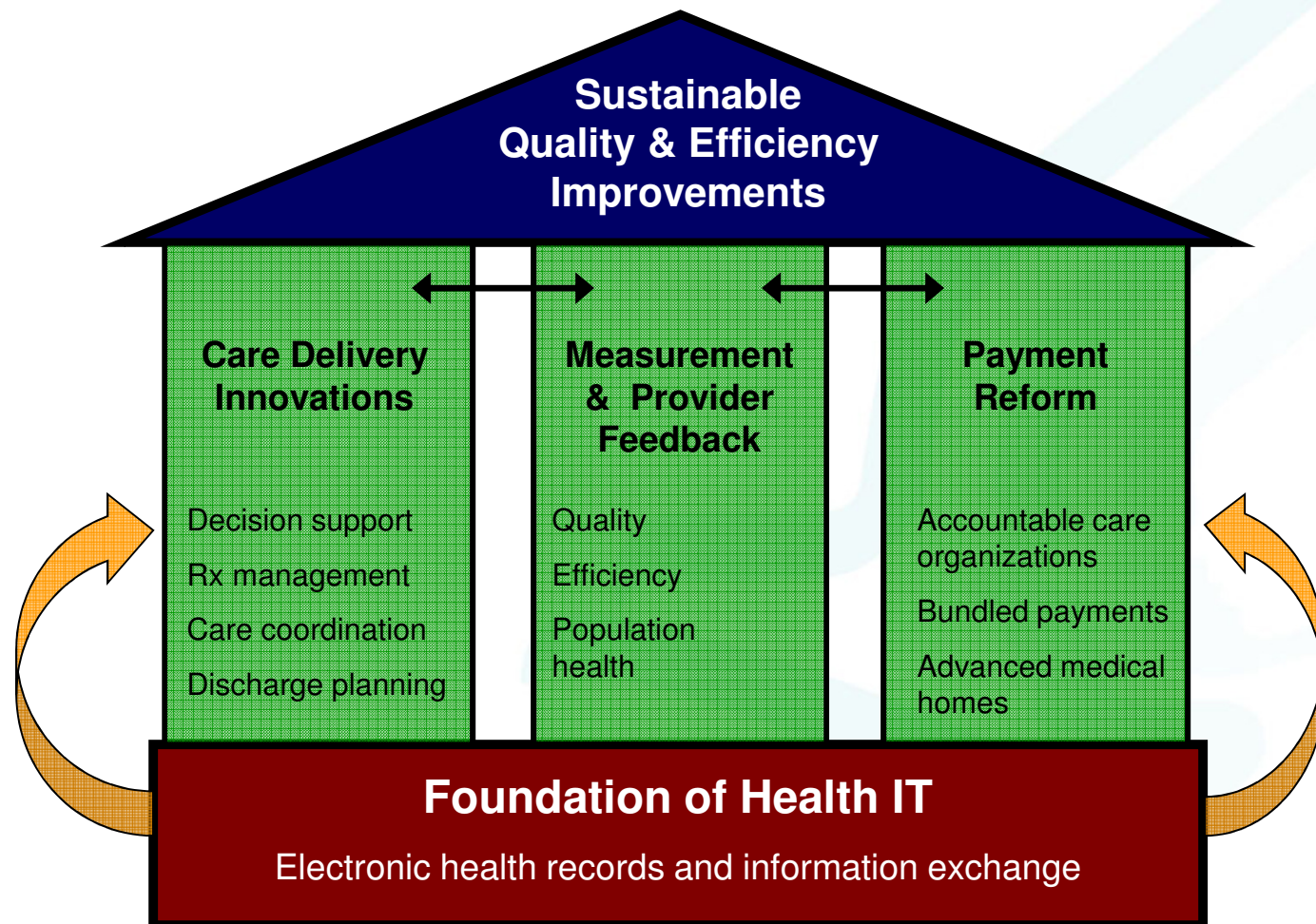
Craig Brammer

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The Beacon Community Program

- **AIM:** 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 healthcare quality, cost and population health

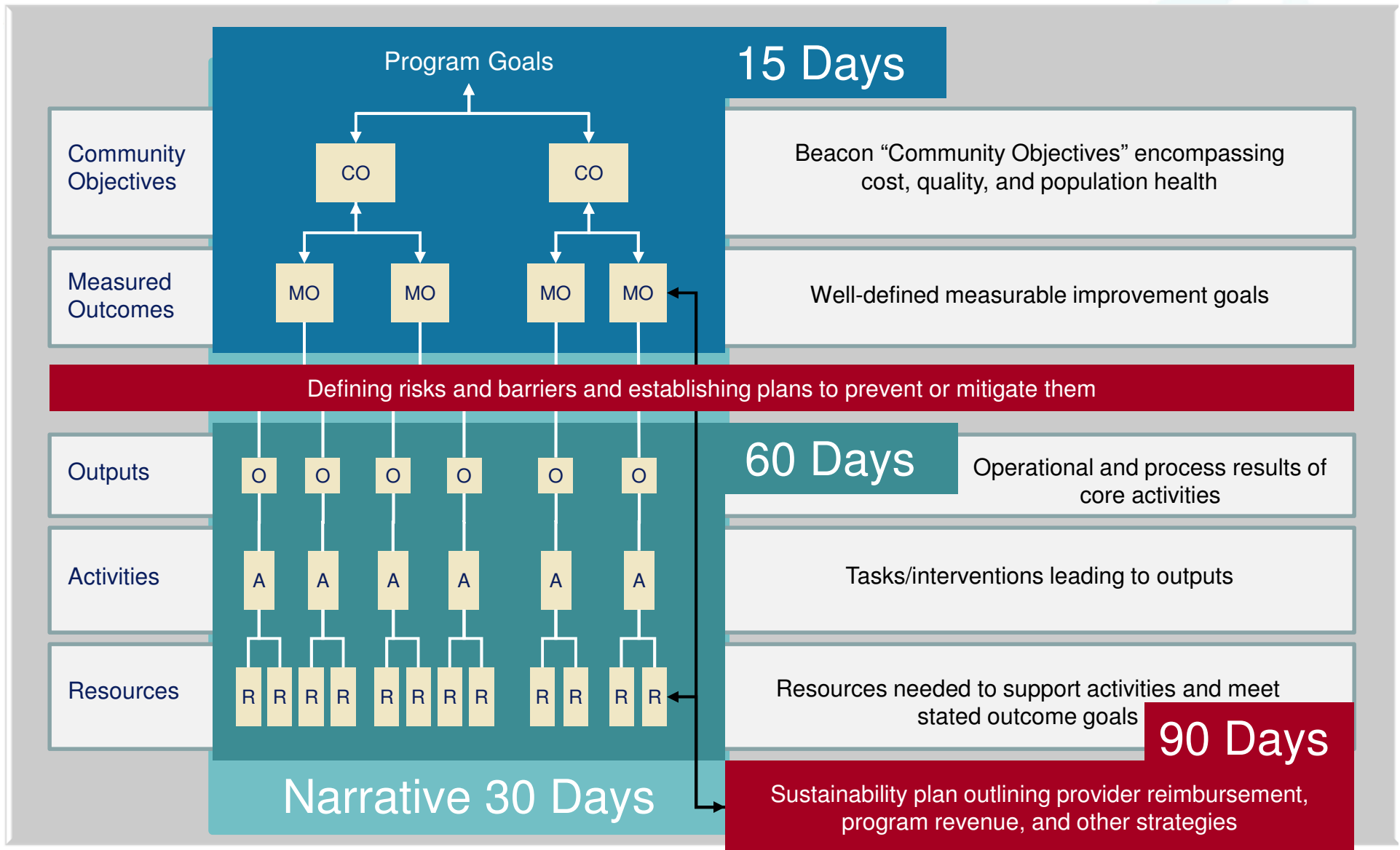
Beacon Community Conceptual Model



Beacon Communities

Lead Organization	Location
Community Services Council of Tulsa	Tulsa, Oklahoma
Delta Health Alliance	Stoneville, Mississippi
Eastern Maine Healthcare System	Brewer, Maine
Geisinger Clinic	Danville, Pennsylvania
HealthInsight	Salt Lake City, Utah
Indiana Health Information Exchange	Indianapolis, Indiana
Inland Northwest Health Services	Spokane, Washington
Louisiana Public Health Institute	New Orleans, Louisiana
Mayo Clinic College of Medicine	Rochester, Minnesota
The Regents of the University of California, San Diego	San Diego, California
Rhode Island Quality Institute	Providence, Rhode Island
Rocky Mountain Health Maintenance Organization	Grand Junction, Colorado
Southern Piedmont Community Care Plan, Inc.	Concord, North Carolina
University of Hawaii at Hilo	Hilo, Hawaii
Western New York Clinical Information Exchange	Buffalo, New York
HealthBridge	Cincinnati, Ohio
Southeastern Michigan Health Association	Detroit, Michigan

Beacon Community Workplan



Technical Assistance / Evaluation

- Technical Assistance: Booz Allen Hamilton, the Engelberg Center for Health Care Reform at Brookings, and the Institute for Healthcare Improvement
- CMS Data Analytics: TBD
- Program Evaluation: TBD

PCMH efforts in Beacon Communities

- More than half of Beacon Communities involve PCMH programs, with features that include:
 - HIE for more comprehensive view of patient/care
 - HIE for streamlined referral and care coordination
 - Optimized EHRs with clinical decision support
 - Data aggregation for performance measurement
 - PCMH as part of larger ACO strategy

Questions yet to be answered...

- What is the requisite information architecture for supporting multiple ACOs/PCMHs within a given community?
- What data are necessary—and what are the best analytic models—to accurately identify high-risk patients in real time?
- How do we ensure that the lessons learned from Beacon Communities are shared more broadly?
- And many more...

For More Information

Visit the ONC Web site: healthit.hhs.gov

