Beacon Communities

• Funded by U.S. Department of Health and Human Services
  – Administered by the Office of the National Coordinator for Health Information Technology

“The Beacon Program will support these communities... to improve care coordination, increase the quality of care, and slow the growth of health care spending... Beacon Communities will focus on specific and measurable improvement goals in the three vital areas for health systems improvement: quality, cost-efficiency, and population health.”

17 Beacon Communities
Common Beacon Goal

- Clinical Transformation enabled by health information technology (HIT) infrastructure and exchange capabilities
  - Improved care coordination
  - Increased quality of care
  - Slow the growth of healthcare spending
Southeast Michigan Beacon Community (SEMBC)

- Vulnerable Population
  - Detroit, Highland Park, Hamtramck, Dearborn, Dearborn Heights
  - Population Flight
  - Physician Flight
  - Considerations
    - Unemployed
    - Uninsured
    - Limited access to healthcare
SEMBC Stakeholders

Physicians  Health Systems  Payers  Employers  Educational Institutions

Non-Profits  Quality Organizations  Community & Faith-Based  HIT
Key Participants

- American Diabetes Association
- Blue Care Network
- Blue Cross Blue Shield of Michigan
- Center for Population Health
- Centers for Disease Control & Prevention (CDC)
- Centers for Medicare & Medicaid Services (CMS) Region V Office
- Community Health and Social Services Center
- Detroit Department of Health and Wellness Promotion
- Detroit Regional Chamber
- General Motors
- Greater Detroit Area Health Council (GDAHC)
- Health Alliance Plan (HAP)
- Juvenile Diabetes Research Foundation
- JVHL
- Michigan Department of Community Health
- Michigan Peer Review Organization
- Michigan State University
- Molina Health Care of Michigan
- National Kidney Foundation of Michigan
- Oakland Southfield Physicians
- Office of the National Coordinator for Healthcare Information Technology (ONC) Project Office
- Southeastern Michigan Health Association (SEMHA)
- St. Clair County Health Department
- The Ford Motor Company
- Thompson Reuters
- United Health Care – Great Lakes Health Plan
- University of Michigan
- Voices of Detroit Initiative (VODI)
- Voxiva
- Wayne County Medical Society
- Wayne State School of Medicine
Beacon in Southeast Michigan

• Focus on Diabetes
  – Provider interventions
  – HIT-enabled clinical and operational interventions
  – Patient and community outreach interventions
Clinical Transformation: Target Goals and Measures

1. A 5% increase in the proportion of diabetic patients who receive standard recommended testing and examinations

2. A 5% reduction in the proportion of non-urgent Emergency Department utilization among diabetic patients.

3. A 5% reduction in the proportion of diabetic patients having disparity ratios for quality of care and population health measure disparities related to gender, insurer, or race.
Interventions

Physician data reporting and performance feedback
- Establish a network of physicians who are committed to process change and data exchange.

Care Coordination – Ambulatory
- Utilization of patient navigators to help patients adhere to treatment plans.

Clinical Decision Support
- Targeted alerts, reminders, and decision support information.

Care Coordination – Hospital Emergency Departments
- Partnerships with ED that helps identify, treat, and coordinate care of diabetic patients.

Patient Engagement
- Partnerships with community and faith-based organizations that extend the reach of SEMBC.

Telehealth
- Use mobile and other messaging options to identify diabetes within the SEMBC.
text HEALTH to 300400
Text HEALTH Background

• Use technology to reach vulnerable populations
• “Reverse” the upward trend for digital technology
• Increased awareness of diabetes, the risks of diabetes, and how to manage diabetes
• Get people into a healthcare setting sooner rather than later
• Public-facing intervention vs. provider intervention
What is Text HEALTH?

• Leverage mobile technology to enable individuals to use their cell phone to assess their risk of type 2 diabetes.
• Based on assessment, receive a series of custom-tailored text messages that educate, motivate, promote community resources, and track exercise and weight loss.
• Curriculum is approximately 14 weeks
  – Five (5) messages per week.

Text HEALTH to 300400
Partners
Voxiva: text4baby

• Largest mHealth service in the US
  – 180,000+ Moms
  – 13,000,000+ messages sent
  – 500 partners in 50 states
Voxiva: text2quit

• Mobile technology combined with evidence-based best practices to help smokers successfully quit

• Incorporates Surgeon General’s smoking cessation guidelines and key lessons from peer-reviewed studies demonstrating effectiveness in helping smokers quit via mobile phone

• Studies have shown that text-based interventions are 2 times more likely to help smokers quit
  – 10.7% of those receiving text messages quit smoking vs. 4.9% who quit and did not receive text messages
User sends HEALTH to 300400

SYSTEM COLLECTS
- HEIGHT
- WEIGHT (BMI)
- AGE
- GENDER
- FAMILY HISTORY
- DIABETES DIAGNOSIS
- CHOLESTEROL
- HYPERTENSION
- SMOKING STATUS

SYSTEM CATEGORIZES
- DIABETIC
- PRE-DIABETIC
- HIGH/ MEDIUM RISK
- LOW RISK
- UNDERWEIGHT
- NORMAL WEIGHT
- OVERWEIGHT
- OBESE

Enrollment

Development of Profile

Goal Setting/Tracking (Weight & Exercise)

Education/Motivation (According to Risk)

Local Connections (Care & Activities)
Two Messaging Streams

1. Consumer/General Public
   - Partners/Community Outreach
   - Traditional media and marketing
   - Retail partner

2. Physician Referred
   - Doc suggests patient participation in Text HEALTH
   - Target pre-diabetics
   - Additional tool for docs to augment their care
Messageing

- 14-Week Curriculum,
  - Approximately five (5) messages per week
- Types of Messages
  - Risk Assessment
  - Local Resources and Services
  - Goal Setting and Tracking
  - Education

text HEALTH to 300400
Messaging Content

- Based on recommendations and guidelines of
  - US Preventive Services Task Force
  - National Diabetes Education Program’s Small Steps, Big Rewards program – a partnership of
    - The National Institutes of Health
    - The Centers for Disease Control and Prevention
    - The American Diabetes Association
Timing

• Soft Launch
  – Late November
• Public Launch
  – January 1, 2012
  – Active through CY 2012+
How to Get Your Organization Involved

- Advertising
- Website
- Customer/employee communications
- Direct mail
- Social marketing

- On-site posters/fliers
- Email
- Events
- Satellite/retail offices
- Business partners
- Other
Why Get Involved with Text HEALTH?

1. This is an ALL-NEW SERVICE AND IS NOT BEING USED ANYWHERE ELSE IN THE WORLD. What better way to differentiate your organization?
Why Get Involved with Text HEALTH?

There is no cost to your organization, employees, customers, etc. to use and promote this service*. **Make it yours, and run with it.**

*standard text messaging rates apply.
Why Get Involved with Text HEALTH?

Use Text HEALTH and its engaging call-to-action to supplement current wellness messages and campaigns.
Why Get Involved with Text HEALTH?

Enhance your image as a progressive organization – to employees, customers, and the entire Southeast Michigan community.
Why Get Involved with Text HEALTH?

Increased awareness, knowledge, and sensitivity among participants on diabetes PLUS real-world, interactive advice and engagement on how to establish a healthy lifestyle.
End