Beacon Community Program

Southeast Minnesota Beacon Community Perspectives

Minnesota Rural Health Conference
June 25, 2012
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Director, Project Management Office
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No financial disclosures
No conflicts to declare
The Beacon Community Program: Where HITECH Comes to Life

Regional extension centers

Workforce training

Medicare and Medicaid incentives and penalties

State grants for health information exchange

Standards and certification framework

Privacy and security framework

Adoption of EHRs

Meaningful use of EHRs

Exchange of health information

Research to enhance HIT

BEACON

Improved individual and population health outcomes
Increased transparency and efficiency
Improved ability to study and improve care delivery

Taken from: Blumenthal, D. “Launching HITECH,” posted by the NEJM on 12-30-2009.
17 grantees each funded ~$12-15M over 3 yrs to:

**Build and strengthen** health IT infrastructure and exchange capabilities - positioning each community to pursue a new level of sustainable health care quality and efficiency over the coming years.

**Improve** cost, quality, and population health - *translating investments in health IT in the short run to measureable improvements in the 3-part aim.*

**Test innovative approaches** to performance measurement, technology integration, and care delivery - *accelerating evidence generation for new approaches.*
Create a sustainable path for near-term success and on-going improvement

Near Term Success: The Beacon Communities Are Using One Voice to...

- Highlight critical issues to state policy makers and align major initiatives (Policy Roundtable with State Leaders in September 2011)

- Prioritize needs of safety net providers (HRSA joint funding opportunity, releasing $100K to each FQHC in a Beacon catchment area, September 2011)

- Pilot community-level dashboards to drive improvement using Medicare data (CMS, Brandeis, Buccaneer)

- Establish a workgroup (6 vendors, 17 Beacon Communities) to develop a standard CCD that can be automatically exported to an HIE upon a pre-defined trigger by mid-Q2 2012
Create a sustainable path for near-term success and on-going improvement

On-going Improvement: Identify how high-value infrastructure and innovation can be sustained

- Payment pilots – local and national (IN, ME, MI, OH, NY, OK, CO)
- System and infrastructure for community-wide measurement and population analytics
- Governance structure to support execution of the community health agenda
- Purchaser engagement: payers and employers
- National and local spread and dissemination: learning collaboratives, trade associations, etc.
Consists of Eleven Counties in SE MN

Dodge, Fillmore, Freeborn, Goodhue, Houston, Mower, Olmsted, Rice, Steele, Wabasha, Winona

Asthma
Consists of 47 school districts in the eleven counties in SE MN.

Diabetes
Consists of Home health facilities and nursing homes for example

Communities of Practice
(Example from SE MN Beacon)
Ensuring the values and preferences of informed patients are brought into our program through meaningful conversation.
Community Engagement / Qualitative Study / Focus Groups

Identify perceived needs and potential barriers related to each Beacon project initiative
(i.e. the wide spread use of asthma action plans for school children.)

Groups of interest:
- Parents of school aged children
- Public health, School nurses & population care managers
- Physicians / nurses who provide health care
- Community leaders

Settings
- Convened where the groups of interest are located
- Professional moderators
- Relaxed atmosphere with a constructive dialogue

Focused discussions: Participants have privileged seats at the table
Hopes and Concerns Exercise

I am most hopeful...

- Electronic Medical Record
- Efficient Communication
- Life-saving...
- Info is correct and up to date...
- Useful database
- Decrease hazards/reduces health risk
- Each medical provider has access to relevant info on the patient
- Cost savings

I am most concerned...

- System Failure
- What if computer crashes?
- Legal issues
- Privacy issues
- Confidentiality
- Info use by those who need it, not those who shouldn't
- Does not interfere with daily life
- Information shared with the wrong people
Hopes

- **Overall tone:** Hopes outweigh concerns
  - “I hope this program succeeds” “life saving”

- **Communication**
  - “patients not getting medicine that is bad for them because of allergies”

- **Coordination of care**
  - “fast action if an emergency arises such as an asthma attack in school”

- **EHR access from diverse locations**
  - “information available in case of emergency”
  - “cut down on my paperwork”
  - “looking at medical record at home”
Concerns

• Privacy
  – Large scale
    • “large breaches of personal health information” “ID theft”
  – Small scale
    • “…staff members snooping around”
    • “not having your whole life open so everyone knows”
    • Criteria needed: “Who needs to know?”

• Discrimination/Misuse
  – “personal or family history being used to disqualify someone”
  – “information used for non-medical purposes…marketing”
Healthcare Transformation

Enable Knowledge discovery in world of data

Patient & Community ‘Voice’

New models

ONC Pillars: | Build & Strengthen | Improve | Test Innovation
Peer-to-Peer HIE

- 100 % EHR Adoption Rate
- Six EMR systems used across SE MN Beacon including PH- Doc used by Public Health
- NwHIN Connectivity
- CCD’s parsed into discrete data and persisted
Demonstration at Interoperability Showcase
HIMSS, ONC/FHA Innovation Area

MEDICAL RECORDS

Area health providers tout program at conference

By Jeff Hansel
jhansel@postbulletin.com • (507) 285-7615

Southeast Minnesota health systems and county public health units have been on display in Las Vegas this week.

But not in a dance line or at a casino. Rather at the Healthcare Information and Management Systems Society Conference and Exhibition, which concludes today, describing the Southeast Minnesota Beacon Community, a federally funded effort to make a person's medical records easily and securely accessible to all health providers in the region who provide care to that individual.

Dan Jensen, associate director of Olmsted County Public Health, said that health providers in southeastern Minnesota, including 11 county public health units, are developing ways for a health provider in rural Wabasha, urban Rochester or suburban Winona to access a person's medical record when needed.

A public-health nurse who makes a home visit, for example, can trigger consideration of an alternative drug. Or perhaps she can't afford the pills. That might trigger intervention by a social worker who can help find affordable options or assistance programs. "That helps us to understand what's happening in that client's life," Jensen said.

All in one

It doesn't matter whether you're treated at Winona Health, Mayo Clinic or by a public health nurse in Dodge County. Treatment plans from all three will get included in the medical record.

The diverse health providers of southeastern Minnesota are using "program health documentation," or PHDoc for short. PHDoc is software made by ACS, a Xerox company. The system allows local public health agencies to document work in a variety of settings.

Public health units locally have been using PHDoc for years. But as federal eyes focused on ways to integrate each person's health-care experience, Mayo Clinic got interested in what public health units were doing. Eventually, the Beacon grant application included millions of dollars to further develop the effort.

When a health provider has "ample information regarding a person's medical history, treatments are more effective and efficient," says an announcement about this week's conference. "Unfortunately, few people have complete medical records — due, in large part, to a lack of any universal repository tools for keeping those records."

Beacon health groups in southeastern Minnesota are trying to solve that using PHDoc. They plan to share what they learn with other health groups nationally.

Plan of action

Progress has been made already. "We're in the early stages of being able to exchange data," Jensen said late last year. The current focus is Type 2 diabetes and asthma care.

"We have asthma 'action plans' in place for children in school," Jensen said. The action plan clarifies how school nurses should respond if a student has an asthma exacerbation.

Beacon groups are working on the possibility of adding diabetes and seizure action plans.

Olmsted Medical Center research has shown that children with asthma often get a higher-dose prescription when they have a crisis. But that higher dose often doesn't get returned to normal, leading to dose escalation.

The action plan might include preemptively bumping up the dose when a child has previously experienced problems and decreasing it later if symptoms remain in check.

Beacon funds last through March 2013. The goal is to have it self-sustaining by then.

Planners say their measure of success will be the ability to check a person's medical history from an assisted-living facility, school, medical clinic, jail or home. Jensen said improved diabetes and asthma outcomes also will show that Beacon is working.

Health reporter Jeff Hansel writes the Monday Pulse on Health column. Follow him on Twitter @JeffHansel.


Mayo Clinic, Partners Seek Medical Records Solution

Tuesday, February 21, 2012

ROCHESTER, Minn. — Medical records are an invaluable tool in treating patients. When a caregiver has simple information regarding a person's medical history, treatments are more effective and efficient. Unfortunately, few people have complete medical records — due, in large part, to a lack of any universal repository tools for keeping those records. Mayo Clinic, along with its partners in a program called the Southeast Minnesota Beacon Community, is working on solutions to this problem. They are showcasing their work through demonstrations at the 12th annual Healthcare Information and Management Systems Society Conference & Exhibition (HIMSS), from Feb. 20 to 24 in Las Vegas.

In May 2010, southeastern Minnesota was one of 17 areas nationwide selected for funding by a U.S. Department of Health and Human Services initiative called the Beacon Community Program. The initiative sought to fund health care entities looking for ways to use technology to improve the efficiency and delivery of health care while cutting costs. The Southeast Minnesota Beacon Community was created through collaboration among Mayo Health System, Olmsted Medical Center, Gundersen Hospital Owatonna, and 11 county public health units.

Now, less than two years after it has been asked to share its work at this technology and processes developed, information can be transferred between care providers in real-time. Two scenarios are being shown in the HIMSS exhibition hall.

Clinical Data Repository
‘aka Community Data Repository’

- Hosted at Regenstrief Institute
- Site Clinical Repository
- Research Data Repository
- Population Management
- Quality Measures Reporting
- Research
- Population Management
- Error handling
- Point of Care (Future Use)
Clinical Data Repository
‘aka Community Data Repository’

**CDR: Current Approved Use**
- Quality Measure Reporting
- Population Management
- Research
- Simple queries: 54,069 patients in <15 seconds
- Complex queries: (A or B) and (C) HF or CAD and BP < 130: 21,927 patients in 10 seconds

**CDR Database**
- Database locates additional records and delivers to hospital EHR
- EMT queries database
- Database delivers record abstract with key information

1. Patient and Primary Care Provider
   - PCP sees patient at local clinic
   - PCP documents:
     - Problem list (current diagnoses)
     - Med list
     - Med allergies
     - Vitals
     - Labs
     - Demographics
     - Etc.

2. Patient is injured and is unconscious. EMT uses CareWeb to query database for patient info from ambulance.

3. Provider sees additional information on hospital EHR
   - In hospital, provider can use CareWeb to query further viewing more record details and additional records from specialists.
   - Patient arrives at hospital in stable condition, since CDR provided essential information for proper care during transit.

4. Patient receives informed care and recovers quickly

**CDR: Future Use Cases**
- Transitions of Care
- CareWeb
- EHR
- Other EMR

Data from other providers also accessible to database.
## Clinical & Population Metrics

### ASTHMA

<table>
<thead>
<tr>
<th>Objective (originates from 60 day Report)</th>
<th>Goal</th>
<th>2009 - Baseline</th>
<th>2010</th>
<th>2011</th>
</tr>
</thead>
<tbody>
<tr>
<td>Improve % of asthma patients who are assessed annually for triggers and have a documented asthma action plan</td>
<td>Increase by 10%</td>
<td>5-40 years</td>
<td>Denom Num %</td>
<td>Denom Num %</td>
</tr>
<tr>
<td></td>
<td></td>
<td>3015 52</td>
<td>17%</td>
<td>2725 60</td>
</tr>
<tr>
<td>Improve % of AAP's on file in the schools</td>
<td>75% of ped w/asthma</td>
<td>Pediatric [School Age ~5-12yrs]</td>
<td>1535 40</td>
<td>26%</td>
</tr>
<tr>
<td>Reduce emergency room utilization per asthmatic patient</td>
<td>Reduce by 10%</td>
<td>5-40 years</td>
<td>3015 153</td>
<td>51%</td>
</tr>
<tr>
<td>Reduce hospitalizations per asthmatic patient</td>
<td>Reduce by 5%</td>
<td>18-40 years</td>
<td>6323 67</td>
<td>0.11%</td>
</tr>
<tr>
<td>Improve % of asthma patients who get annual influenza vaccine</td>
<td>Increase by 10%</td>
<td>5-40 years</td>
<td>3015 1294</td>
<td>43%</td>
</tr>
<tr>
<td>Improve % of asthma patients who get a pneumonia vaccine</td>
<td>Increase by 10%</td>
<td>5-40 years</td>
<td>3015 969</td>
<td>32%</td>
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</tbody>
</table>

### DIABETES

<table>
<thead>
<tr>
<th>Objective (originates from 60 day Report)</th>
<th>Goal</th>
<th>2009 - Baseline</th>
<th>2010</th>
<th>2011</th>
</tr>
</thead>
<tbody>
<tr>
<td>Improve % of Medicare Diabetic patients with HbA1c Testing</td>
<td>Increase by 5%</td>
<td>21-75 years</td>
<td>Denom Num %</td>
<td>Denom Num %</td>
</tr>
<tr>
<td></td>
<td></td>
<td>17952 16493</td>
<td>92%</td>
<td>18908 16622</td>
</tr>
<tr>
<td>Improve % of Diabetic patients with HbA1c less than 8</td>
<td>Increase by 10%</td>
<td>21-75 years</td>
<td>3290 2087</td>
<td>63%</td>
</tr>
<tr>
<td>Improve Median Avg of Diabetics with HbA1c less than 8</td>
<td>Increase by 5%</td>
<td>21-75 years</td>
<td>Aggregate avg</td>
<td>50%</td>
</tr>
<tr>
<td>Reduce % of Diabetic patients with HbA1c greater than 9</td>
<td>Decrease by 3%</td>
<td>21-75 years</td>
<td>3715 352</td>
<td>9%</td>
</tr>
<tr>
<td>Improve % of Medicare Diabetic patients with LDL-C Screen</td>
<td>Increase by 5%</td>
<td>21-75 years</td>
<td>17952 15026</td>
<td>84%</td>
</tr>
<tr>
<td>Improve % of Diabetic patients with LDL &lt; 100</td>
<td>Increase by 10%</td>
<td>21-75 years</td>
<td>3290 1912</td>
<td>58%</td>
</tr>
<tr>
<td>Improve Median Avg of Diabetics with LDL &lt; 100</td>
<td>Increase by 5%</td>
<td>21-75 years</td>
<td>Aggregate avg</td>
<td>57%</td>
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<tr>
<td>Improve % of Diabetic patients with BP &lt; 130/80</td>
<td>Increase by 10%</td>
<td>21-75 years</td>
<td>3290 1782</td>
<td>54%</td>
</tr>
<tr>
<td>Improve Median Avg of Diabetic patients with BP &lt; 130/80</td>
<td>Increase by 5%</td>
<td>21-75 years</td>
<td>Aggregate avg</td>
<td>56%</td>
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<tr>
<td>Improve dilated eye exams for Medicare diabetic patients</td>
<td>Increase by 5%</td>
<td>21-75 years</td>
<td>17952 17494</td>
<td>97%</td>
</tr>
<tr>
<td>Reduce emergency room utilization per diabetic patient</td>
<td>Reduce by 10%</td>
<td>21-75 years</td>
<td>Sample avg</td>
<td>33%</td>
</tr>
<tr>
<td>Reduce Diabetes Long-term Complication admission rate</td>
<td>Reduce by .5%</td>
<td>21-75 years</td>
<td>9071 116</td>
<td>1.28%</td>
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<tr>
<td>Improve % of Tobacco Free Diabetic patients</td>
<td>Increase by 10%</td>
<td>21-75 years</td>
<td>3290 2293</td>
<td>70%</td>
</tr>
<tr>
<td>Improve % of asthma patients who get annual influenza vaccine</td>
<td>Increase by 10%</td>
<td>21-75 years</td>
<td>Sample avg</td>
<td>56%</td>
</tr>
<tr>
<td>Improve % of asthma patients who get a pneumonia vaccine</td>
<td>Increase by 10%</td>
<td>21-75 years</td>
<td>Sample avg</td>
<td>75%</td>
</tr>
</tbody>
</table>

### Pop Health

<table>
<thead>
<tr>
<th>Goal</th>
<th>Target Pop*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Goal</td>
<td>Target Pop*</td>
</tr>
</tbody>
</table>

### Cost

<table>
<thead>
<tr>
<th>Goal</th>
<th>Target Pop*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Goal</td>
<td>Target Pop*</td>
</tr>
</tbody>
</table>
Transitions of Care - LPH

All Case managers collaborate on discharge planning to reduce readmissions and improve health outcomes. Achieved through community based delivery model.

Patient correlation occurs via live ADT registration feed.

Synergistic Plan of Care at Discharge

Live, consented CDA/ HL-7 message to Provider(s) with patient and case manager demographics.

Patient Admitted

No Match

Patient match triggers alerts

Push Alert to LPH Case manager

Push Alert to Mental Health case manager

Hospital Staff Alerted

Mental Health Center

Olmsted

Winona

Transitions of Care - LPH

Public Health

Public Health

Mental Health Center
Transitions of Care - Schools

Includes processes of care coordination with providers, public health, parents and schools
Why is This Important to Schools?:

The health of our students will strongly influence whether they attend school and are successful learners.

Our Beacon project addresses the issue of asthma management (as well as other chronic conditions) of children in the school settings. School nurses play a major role in screening, education, and care coordination.
Legal Considerations

• Business Associate Agreements between
  – Between or among Beacon participants
  – Beacon consortium and data repository

• Privacy Compliance:
  – Health Insurance Portability and Accountability Act (HIPAA)
  – Family Educational Rights and Privacy Act (FERPA)
  – Public Health Agency State Data Practices Act (DPA)

• Consent & Authorization Compliance:
  – Minnesota Standard Consent Form to Release Health Information
  – Minnesota Research Authorization statute
  – Federal protection of human subject research regulations

• Regional Exemption Obtained for State Certificate of Authority:
  – Health Information Exchange, Health Data Intermediary, Record locator service
Building on Success: Key Insights

**Kids spend significant hours at school**
(in care of staff, without parents present)

**Health is critical to school success**
(from absenteeism to academic performance)

**Parents want their kids to be successful. At the same time they are challenged with varied pressures.**
(we must be understanding, positive and supportive of their child’s health issues).
Schools are a central location
(providing care for families where they are – places school as central location for many families & communities in rural settings)

Health communication exchange scalable
(The workflow & IT infrastructure was built to scale to other chronic conditions: diabetes, ADHD, etc.)
Many **school-aged children** are never **vaccinated** for the influenza virus **due to the inconvenience** it can cause. Parents/guardians must take time off of work in order to pull their child from school for an appointment.

SE MN Beacon aimed to increase the influenza vaccination rate for juvenile patients through school-based delivery pilot process & expanding best practices to the region.
"We are really seeing the key stakeholders in the community come together and unite around this goal of improving health."

- Aaron McKethan, Beacon's National Program Director
Health Awareness in School Campaign

Focused on the importance of managing chronic health conditions, getting health plans updated, sharing with schools as well as promoting healthy behaviors in school.

Get Health Ready! ©

Make your plan. Update it yearly.
please touch the picture that corresponds to your single biggest concern right now...

personal relationships
- Family
- Friends

monitoring health
- Testing blood sugars
- Checking feet

emotional health
- Sad
- Anxious
- Other emotional concerns

money
- Cost of medicine or supplies
- Paying for care

health behaviors
- Diet
- Exercise
- Sleep

Please check the number that describes your feelings over the past month from as bad as it can be to as good as it can be.

Your overall quality of life:
- as bad as it can be
- as good as it can be

Your overall physical well being:
- as bad as it can be
- as good as it can be

Your overall emotional well being:
- as bad as it can be
- as good as it can be

Your social interaction with other people (family, friends, or others):
- as bad as it can be
- as good as it can be

something else
- back
- next
Synergistic Community Care

Patient comes in for PCP appointment

Desk staff administer PROQOL

PCP reviews PROQOL uses Med Decision Aid for new med choices

Patient admitted to a Mayo Clinic Hospital

Physician connects via peer-to-peer network & reviews CCD

PH case manager follows up in home care setting
- Pulls CCD’s
- Reconciles Medication
- Administers

Patient discharged from Hospital

PH case manager follows up in home care setting
- Pulls CCD’s
- Reconciles Medication
- Administers

Results can be viewed by PCP at next visit
Reports, Treatment Pathways & Trends

Assessment Date: August 11, 2011
Patient: Marshall Mathers III

Single Biggest Concern Domain Today
Specific Concerns Identified Today
- Problems paying your medical bills
- Cut pills in half or skipped doses of medicine
- Skipped dental, vision or mental health care costs because of cost

Suggested Actions: Money

Problems paying your medical bills:
- Direct patient to your clinic's patient account services for information on payment options.
- Connect patient with financial aid services.
http://www.medicare.gov/Enroll/FindAFC/FindAFC.html

Cut pills in half or skipped doses of medicine:
- Consider printing and reviewing with the patient the Financial Help for Diabetes Care information from the NIDDK website.

Skipped dental, vision or mental health care costs because of cost:
- Direct patient to resources for free or discounted dental care.
http://www.health.state.mn.us/clearinghouse/resources.html

Actions Taken (please include name of person taking action):
Welcome to Beacon

Beacon is a community-based program to spotlight a variety of efforts to improving health and health care delivery in the United States. Through the Department of Health and Human Services, the Office for Health Information Technology, the Beacon Communities is a group of medical practice and research coalitions focusing on specific communities and utilizing and developing efficient systems based on their areas and utilizing and developing efficient systems based on this expertise.

Overall, each Beacon program seeks to:

- Improve quality, safety, efficiency, and reduce health disparities
- Engage patients and their families in their health care
- Improve health care coordination
- Improve public health and the health of the community’s population
- Ensure privacy and security protections for personal health information

http://semnbeacon.org
## Shared Decision Making

### Weight Change

<table>
<thead>
<tr>
<th>Drug</th>
<th>Effect</th>
</tr>
</thead>
<tbody>
<tr>
<td>Metformin</td>
<td>None</td>
</tr>
<tr>
<td>Insulin</td>
<td>4 to 6 lb. gain</td>
</tr>
<tr>
<td>Gliptozones</td>
<td>More than 2 to 6 lb. gain</td>
</tr>
<tr>
<td>Exenatide</td>
<td>3 to 6 lb. loss</td>
</tr>
<tr>
<td>Sulfonylureas</td>
<td>2 to 3 lb. gain</td>
</tr>
<tr>
<td>Glitins</td>
<td>None</td>
</tr>
</tbody>
</table>

### Blood Sugar

#### (A1c Reduction)

### Cost

<table>
<thead>
<tr>
<th>Drug</th>
<th>Price</th>
</tr>
</thead>
<tbody>
<tr>
<td>Metformin</td>
<td>$80.00 per 3 months</td>
</tr>
<tr>
<td>Insulin</td>
<td>$600.00 per 3 months</td>
</tr>
<tr>
<td>Gliptozones</td>
<td>$80.00 per 3 months</td>
</tr>
<tr>
<td>Exenatide</td>
<td>$80.00 per 3 months</td>
</tr>
<tr>
<td>Sulfonylureas</td>
<td>$50.00 per 3 months</td>
</tr>
<tr>
<td>Glitins</td>
<td>$60.00 per 3 months</td>
</tr>
</tbody>
</table>

### Side Effects

- **Metformin**: In the first few weeks after starting Metformin, patients may have some nausea, belching, or diarrhea.
- **Insulin**: There are no other side effects associated with insulin.
- **Gliptozones**: Over time, 10 to 100 people may have fluid retention (edema) while taking Gliptozones. For some, it may be so little as ankle swelling; for others, fluid may build up in the lungs making it difficult to breathe. This may resolve after you stop taking the drug.
- **Exenatide**: After starting Exenatide, some patients may have nausea or diarrhea. In some cases, the nausea may be severe enough that a patient has to stop taking the drug.
- **Sulfonylureas**: Some patients get nausea, rash and/or diarrhea when they first start taking Sulfonylureas. This type of reaction may force them to stop taking the drug.
- **Glitins**: A few patients may get nose and sinus congestion and headaches.

Transitions of Care – Rural Telemed

- Healthcare Provider
- Coordinator or Receptionist
- Virtual Appointment Room
- Patient/Nurse
- Caretaker/Patient Guests
- Help Desk Agent
- Telephone Bridge Participants

Participants:
- Patient/Guests
- Healthcare Provider
- Caretaker/Patient
- Coordinator or Receptionist
- Healthcare Provider
- Help Desk Agent
- Virtual Appointment Room
- Patient/Nurse
- Caretaker/Patient Guests
- Telephone Bridge Participants
Welcome to Beacon

Beacon is a community-based program to spotlight a variety of “best practice” approaches to improving health and health care delivery in the United States. Funded by the U.S. Department of Health and Human Services, through the Office of the National Coordinator for Health Information Technology, the Beacon Communities [see the Beacon videos] are a series of medical practice and research coalitions focusing on specific health conditions in their areas and utilizing and developing efficient systems based on their foundational expertise.

Overall, each Beacon program seeks to:

- Improve quality, safety, efficiency, and reduce health disparities
- Engage patients and their families in their health care
- Improve health care coordination
- Improve public health and the health of the community’s population
- Ensure privacy and security protections for personal health information