Strategic Partnerships, Inc.
www.spartnerships.com

Details of the ARRA funding for health IT pilot communities are listed below. If you are interested in having SPI point you to specific opportunities, contact Reagan Weil at 512.531.3900.

Beacon Community Awardee	Funding Amount	Beacon Community Goals for Population Health in Service Area
Community Services Council of Tulsa, Tulsa, Okla.	$12,043,948	Leverage broad community partnerships with hospitals, providers, payers, and government agencies to expand a community-wide care coordination system, which will increase appropriate referrals for cancer screenings, decrease unnecessary specialist visits and (with telemedicine) increase access to care for patients with diabetes
Delta Health Alliance, Inc., Stoneville, Miss.	$14,666,156	Focus on achieving improvements for diabetic patients by electronically linking isolated systems and practices for care management, medication therapy management and patient education
Eastern Maine Healthcare Systems, Brewer Maine	$12,749,740	Expand community connectivity, including long-term care, primary care and specialist providers, to existing Health Information Exchange and promote the use of telemedicine and patient self-management in order to improve care for elderly patients and individuals needing long-term or home care
Geisinger Clinic, Danville, PA	$16,069,110	Enhance care for patients with pulmonary disease and congestive heart failure by creating a community-wide medical home, promoting Health Information Exchange and extending Geisinger's proven model for practice redesign to independent healthcare organizations throughout region
HealthInsight, Salt Lake City, Utah	$15,790,181	Improve Diabetes management performance measures by increasing availability, accuracy and transparency of quality reporting, leverage Intermountain Healthcare's strategies to reduce health systems costs throughout the region, and improve public health reporting
Indiana Health Information Exchange, INC., Indianapolis, Ind.	$16,008,431	Expand the country's largest Health Information Exchange to new community providers in order to improve cholesterol and blood sugar control for diabetic patients and reduce preventable re-admissions through telemonitoring of high risk chronic disease patients after hospital discharge
Inland Northwest Health Services, Spokane, Wash.	$15,702,479	Focus on increasing preventive services for diabetic patients in rural areas by extending Health Information Exchange and establishing anchor institutions in close proximity to remote clinics that will promulgate successes in health IT supported care coordination
Louisiana Public Health Institute, New Orleans, La.	$13,525,434	Reduce racial health disparities and improve control of diabetes and smoking cessation rates by linking technically isolated health systems, providers, and hospitals; and empower patients by increasing their access to Personal Health Records

Mayo Clinic Rochester, d/b/a Mayo Clinic College of Medicine, Rochester, Minn.	$12,284,770	Enhance patient management and, reduce costs associated with hospitalization and emergency services for patients with diabetes and childhood asthma and address reduce health disparities for underserved populations and rural communities
Rhode Island Quality Institute, Providence, R.I.	$15,914,787	Improve the management of patients with diabetes through several health IT initiatives to support Rhode Island's transition to the Patient Centered Medical Home model and adapt infrastructure proven to improve childhood immunizations in order to achieve improvements in adult immunization rates
Rocky Mountain Health Maintenance Organization, Grand Junction, Colo.	$11,878,279	Enable robust collection of clinical data from health systems, providers, and hospitals in order to inform practice redesign to improve blood pressure control in patients with diabetes and hypertension, increase smoking cessation counseling, and reduce unnecessary emergency department utilization and hospital re-admissions
Southern Piedmont Community Care Plan, Inc., Concord, N.C.	$15,907,622	Improve care coordination for patients with diabetes, heart disease, hypertension, and asthma by engaging patients and providers in bidirectional data sharing through a Health Record Bank, empowering patients and family members to participate in self-management through patient portals, and expanding access to care managers to facilitate post-discharge planning
The Regents of the University of California, San Diego, San Diego, Calif.	$15,275,115	Expand pre-hospital emergency field care and electronic information transmission to improve outcomes for cardiovascular and cerebrovascular disease, empower patients to engage in their own health management through web portal and cellular telephone technology, and improve continuity of care for veterans and military personnel through the Veterans Affairs/Department of Defense Virtual Lifetime Electronic Record initiative
University of Hawaii at Hilo, Hilo, Hawaii	$16,091,390	Implement a region-wide Health Information Exchange and Patient Health Record solution and utilize secure, internet-based care coordination and tele-monitoring tools to increase access to specialty care for patients with chronic diseases such as diabetes, hypertension, and obesity in this rural, health-professional shortage area
Western New York Clinical Information Exchange, Inc., Buffalo, N.Y.	$16,092,485	Utilize clinical decision support tools such as registries and point-of-care alerts and reminders and innovative telemedicine solutions to improve primary and specialty care for diabetic patients, decrease preventable emergency room visits, hospitalizations and re-admissions for patients with diabetes and congestive heart failure or pneumonia, and improve immunization rates among diabetic patients

Source: U.S. Dept. of Health and Human Services