Aligning Incentives for the Health Care We Want

Executive Summary, 7TH Report

THE POWER OF PARTNERSHIP

SUMMER 2011

Better Health Greater Cleveland

An Alliance for Improved Health Care

A program of the Robert Wood Johnson Foundation's *Aligning Forces for Quality* initiative and other funders

Randall D. Cebul, MD, Director

OUR VISION

Better Health's vision is to make Greater Cleveland a healthier place to live and a better place to do business.

OUR MISSION

Better Health *Greater* Cleveland is a multi-stakeholder partnership that improves the health and value of health care provided to people with chronic medical conditions in Northeast Ohio.

We are committed to:

- improving care and outcomes of all people with chronic conditions;
- eliminating disparities in health observed among disadvantaged populations by insurance, race and income; and
- transparency across collaborating organizations, and, through public reporting of patient care data, with our community.

TO THE COMMUNITY

At a recent meeting of the Robert Wood Johnson Foundation's *Aligning Forces for Quality* communities, several of *Better Health's* staff and I had the opportunity to hear a keynote presentation by Chip Heath, professor at Stanford's School of Business and co-author of *Switch*. Heath's talk got us all thinking about specific approaches to making radical change in challenging times and environments. While I often use the keynote time to return to my hotel room and catch up on my day job, I was glad I stayed to hear Heath's presentation.

For me, two of Heath's approaches stood out. The first is setting out to find the "bright spots" in what seems like an intractably dark situation, learning from these exceptionally positive performers, and disseminating the learnings. A heroic story that led to this approach became the basis for the change theory of "positive deviance," which uses data to find the bright spots. This is what *Better Health* has begun to do by using our data to find and disseminate what we call Replicable Best Practices – of individual providers, group practices, and systems of care. Our clinical partners' pride in their achievement or their improvement against great odds motivates them to share their approaches to accelerate improvement in our region's health care and outcomes.

The second approach Heath described is the key strategy he calls "shortening the path" to where we want to be. In other words, make it easier to do the right thing to get to the right place. For *Better Health*, and, we believe, the region more generally, the destination is clear when it comes to what virtually all health care stakeholders want, especially for those of us with chronic medical conditions. We want more value and better outcomes for our health care dollars to make Cleveland a healthier place to live and a better place to do business.

Shortening the path to this ideal state is more challenging. However, we believe we have identified the tools needed to get there: re-aligned financial incentives, electronic health records, and staff embedded in primary care practices dedicated to helping patients do better in our world, and, more importantly, in theirs – their homes, neighborhoods and communities.

Heath reminded us that there is a path to change, no matter how challenging. But it's one that we must chart together. Greater Cleveland has the capabilities to lead the way to the right place. With support from all stakeholders, *Better Health* can help to shorten the path.

Randall D. Cebul, M.D., Director
Better Health *Greater* Cleveland

INTRODUCTION

Better Health *Greater* Cleveland was established in 2007 with a vision to help make Greater Cleveland a healthier place to live and a better place to do business. From its inception, our focus has been on improving the quality of health care delivered to patients with chronic medical conditions in primary care settings. We are pleased that our growing number of clinical partners serve more than 70 percent of the chronically ill in Cuyahoga County. This enables us to envision a time when we will be able to actually document change at a *population* level – that is, to document an important part of *Better Health's* role in making Greater Cleveland a healthier place to live.

As our program has matured, we have added metrics and improvement activities pertaining to events in our patients' lives that bear heavily on the *costs* of health care in addition to reflecting changes in their health. Specifically, *Better Health's* clinical partners have committed to measuring and reporting the frequency of hospitalizations, re-hospitalizations, and Emergency Department visits of our patients with diabetes, high blood pressure, and heart failure. Because these medical conditions are widely considered to be "ambulatory care sensitive," proper clinical and self-care should reduce the occurrence of hospitalizations and Emergency Department visits.

Collectively, hospital admissions in Cuyahoga County for these conditions alone were associated with more than $3 billion in charges in 2008, not counting physician charges or follow-up outpatient care, according to data from the Ohio Hospital Association. Included in these admissions during 2009-10 were expenses for 509 leg amputations of Cuyahoga County residents with diabetes. Hospital charges totaled almost $26 million for these amputations, most of which would have been unnecessary with better care. Additionally, we know that nearly one in four patients admitted for heart failure are re-hospitalized within 30 days, as documented by the Center for Medicare and Medicaid Services (CMS) and reported on the *Better Health* web site, www.betterhealthcleveland.org. These data describe not only the tremendous burden of chronic illness in the region, but the failure of our health system to properly coordinate care and prevent adverse health outcomes and avoidable use of expensive resources.

While public health advocates have long decried the suboptimal health status of Americans compared to all other nations with advanced economies, health care purchasers only recently have become vocal about the costs of care. The misalignment of incentives for health care increasingly is identified as the major cause of these poor results. Instead of simply paying for the volume of services delivered, the purchasers of health care – meaning employers, their employees, and taxpayers – have begun to call for the creation of incentives that will deliver the health care and health outcomes we want.

This Executive Summary of *Better Health's* seventh Community Health Checkup highlights opportunities to change the trajectory in Greater

Rebecca Collins-Kunes, photographer

Prosthetic feet at Leimkuehler Inc. provide a vivid reminder of the impact of poorly managed diabetes.

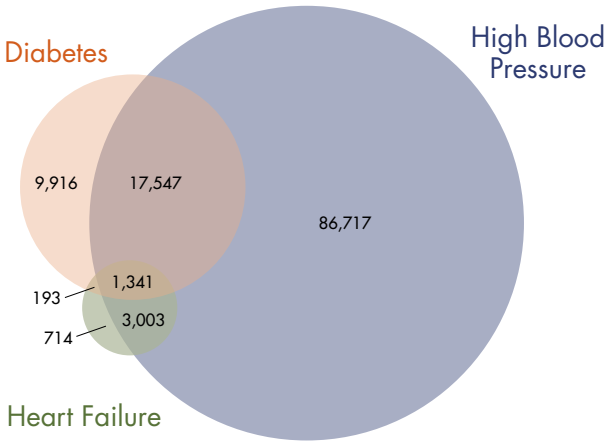

Figure 1. In this report, we describe the health and health care of 119,431 Northeast Ohio residents living with chronic disease (up from just over 115,000 in our last report, six months ago). More than 108,000 have high blood pressure, nearly 29,000 have diabetes, and more than 5,000 have heart failure. More than 1,300 of these patients are living with all three of these conditions.

James E. Misak, MD
The MetroHealth System

Timothy Kowalski, MD
Progressive Insurance

Bringing more value to health care requires effort by all those who provide, pay for and use services.

Harold Miller, used with permission

[1]Kaiser Family Foundation. Employer Health Insurance Costs and Worker Compensation. February 2011 www.kff.org/insurance/snapshot/Employer-Health-Insurance-Costs-and-Worker-Compensation.cfm

Cleveland. As with prior Checkups, we highlight the achievement and improvement of our partners in the care and outcomes of their patients. Collectively, our partners report on almost 120,000 patients, many of whom have more than one of our three target conditions (Figure 1). The period reported is calendar 2010, and our results have been known to *Better Health's* partners for over two months, reflecting the success of the region in harnessing the power of electronic health records (EHRs) to efficiently measure care and outcomes in a timely way. We also describe, in more detail than previous Checkups, the Patient Centered Medical Home (PCMH), a primary care-based model that serves as the foundation for the transformation of health care delivery and the reform of incentives – away from payment for volume, and in the direction of payment for value, the health care we want.

PATIENT CENTERED MEDICAL HOME – EXPANDING A MODEL THAT WORKS

Necessity spurred MetroHealth's Center for Community Health to make over its primary care delivery system. The recession required new strategies to serve a growing number of uninsured patients with the limited resources of a public health system. In 2009, MetroHealth launched *Partners in Care*, a program for uninsured patients that would encourage *more* medical appointments and devote more resources to coordinating all the health care of each participating patient.

The program is based on a model widely known as the Patient Centered Medical Home (PCMH), which increasingly is viewed as a central component of the solution to ever-rising health care costs. The theory is that with access to more proactive, preventive and organized care, patients would use fewer higher-cost services, such as care in the Emergency Department, and do better clinically, too. "If we could deliver better care at lower costs, it would be a win-win for everyone," said James E. Misak, MD, Associate Director of Family Medicine at the MetroHealth Center for Community Health.

MetroHealth already was paying the bills of patients who couldn't, so it invested in changes needed to transform five primary care practices to the PCMH model and has plans underway for all of its Center for Community Health sites. Operations were retooled to accommodate same-day appointments, team-based care, re-designed care processes, and care coordination, and each of the 10,267 patients in the program was assigned to a medical team. The new position of Care Coordinator, a registered nurse, became a beacon of each team, building personal relationships with patients and interacting with them regularly, both inside and outside the medical office. After a full year of operation in 2010, a preliminary evaluation of the program suggests the plan has shown a return on the investment.

Patients in the program had more office visits, but they had 35% fewer hospitalizations and 6.7% fewer visits to the Emergency Department than demographically similar patients in the same practices. At the end of its first year, *Partners in Care* members' medical costs were already lower than those of non-members. Their health outcomes are better, too, for common conditions such as diabetes and high blood pressure, with more improvement in key clinical measures the longer they have been in the program. "Cost, utilization

and outcomes metrics are headed in the right direction," said Misak, who noted that neither the care coordinator nor their patient interactions – believed to be the major driver of improvements — would be reimbursed if these patients had private or government health insurance.

With the sluggish economy and a cumulative 138% increase in health insurance premiums between 1999 and 2010[1], a growing number of health plans and employers see the same urgency for change in health care delivery. "I believe the corporate community is increasingly aware of the need to move away from an exclusively treatment-of-disease model and towards incenting improved health outcomes, said Timothy Kowalski, MD, Chief Medical Officer at Progressive Insurance, which has seen the positive impact on costs and health through the use of PCMH-accredited on-site primary care clinics at its offices. "There's a willingness for payers to assist providers in achieving those outcomes."

Kowalski said he believes the PCMH model can deliver better outcomes at a lower cost for employees and other consumers with private health insurance. "The corporate community is interested in finding a way to support that," he said.

A number of programs have been created to provide additional payments to primary care practices so they can restructure their services to be consistent with the principles of the Patient-Centered Medical Home (PCMH).

There's no one-size-fits-all strategy for payment reform, but Harold Miller, Executive Director of the Center for Healthcare Quality and Payment Reform, believes that all payers in a community need to implement the *same* payment reforms. It is in both payers' and providers' interests for all payers to adopt new payment arrangements to enable clinicians to change their care processes for all of their patients without being financially penalized for any of them, Miller said. A multi-payer approach also avoids "free riding" on the payment changes of an individual payer which makes payment changes by other payers which do not.

Readmission to a hospital soon after their discharge is a good example of potential savings for health plans, employers — and patients. About one of every four adults hospitalized with heart failure in northeast Ohio returns to the hospital within 30 days, a rate that exceeds the national average. It's well known that many readmissions among patients with chronic diseases such as diabetes and heart failure can be prevented. Miller notes that the prevention comes from improvements in primary care, and not just from changes in hospital care.

"Study after study has shown that very simple, low-cost interventions by primary care practices, such as in-person education of patients about how to manage their conditions and use medications properly, can dramatically reduce hospitalizations and readmissions among people with chronic disease," said Miller, who also serves as President of the Network for Regional Healthcare Improvement, of which *Better Health* is a member organization. "Unfortunately, under current payment systems, Medicare and commercial health insurers won't pay for many of the services that would keep patients out of the hospital, even though they will pay every time the patient goes into the hospital."

A payment reform program can address this scenario with health plan payments to primary care practices for the kinds of patient education and self-management

BETTER HEALTH'S TARGET GOALS FOR DIABETES, HEART FAILURE AND HYPERTENSION

Hospitals: Target Goals for Diabetes, Heart Failure and Hypertension, by 2013

- Emergency Department visits
  – Reduce 20%.
- Hospitalizations and 30-day re-hospitalizations
  – Heart Failure: Reduce 20%
  – Diabetes: Reduce 10%
  – Hypertension: Reduce 10%

Ambulatory Care: Target Goals for Achievement on Better Health's Composite Standards by 2013:

- Heart Failure
  – Evaluation: 8% improvement
  – Treatment: Maintain 96% or better
- Diabetes
  – Care: 21% improvement
  – Outcomes: 15% improvement
- Hypertension
  – Care: 5% improvement
  – Control: 13% improvement

Kevin Lauterjung
Medical Mutual of Ohio

Better Health *Greater* Cleveland's Practice Coach Program supports primary care practices in their efforts to enhance their value for insurers, employers, and most importantly, patients.

BETTER HEALTH COACHING STAFF

Caroline Carter, MS, LSW
- Leadership Coaching
- Culture Change
- PCMH Implementation
- Quality Improvement

Bonnie Hollopeter, LPN, CPHQ, CPEHR
- EHR Implementation & Optimization
- Workflow Redesign
- Quality Improvement

Linda Stokes, MSPH
- NCQA Recognition for PCMH
- Health IT
- Population Management

Aleece Caron, PhD
- Quality Improvement
- Part IV Maintenance of Certification

support that have been shown to reduce hospitalizations for patients with chronic disease, Miller said. In return, participating practices would agree to tackle goals to reduce their patients' readmissions enough to at least offset the cost of the extra payments they receive and would forego payment if they were short of the mark. Payers could leverage their investment by re-designing benefit plans to incentivize members to have preventive visits and adhere to medication regimens.

A number of health plans operating in Northeast Ohio have committed to funding efforts led by *Better Health* to support the PCMH model, focusing on payment alignment for physicians to incentivize the right care at the right time and to support care coordination, a function that practices can't otherwise afford. "It's a logical, obvious developmental concept that's right in front of us to achieve lower cost with higher quality," said Kevin Lauterjung, an executive vice president of Medical Mutual of Ohio.

Lauterjung said that change in health care finance and delivery is both a civic responsibility and a business imperative for Medical Mutual. "We've been working under a fee-for-service model for many years, and most people recognize its many flaws and how the incentives are not aligned for the patient, the provider or the payer," he said. "Payment reform is about converting from a fee-for-service environment that pays for volume of services delivered to one that pays for value."

TARGETING EFFECTIVE AND EFFICIENT CARE

New initiatives of the federal government are underway that align with *Better Health's* vision to help make Greater Cleveland both a healthier place to live *and* a better place to do business. With a new two-year round of support from the Robert Wood Johnson Foundation's *Aligning Forces for Quality* program underway, *Better Health* is pursuing specific goals to improve the care and outcomes of our partners' patients with diabetes, heart failure and high blood pressure, including reductions in avoidable emergency department visits and hospitalizations. Our strategies include:

- Accelerating change in health care delivery to become more patient-centered
- Increasing use of health information technology to support evidence-based care, minimize redundancy of tests and reduce costs
- Convening purchasers, payers and providers to come together to enable transformation to the PCMH model by aligning incentives, payments and outcomes for higher quality at lower cost.

A new federal program that will recognize "Accountable Care Organizations" will incentivize formation of broad networks of health care providers to become accountable for coordinating care and producing better outcomes, further re-shaping the health care landscape. At the center of these networks are primary care practices, which increasingly are adopting electronic health records (EHRs) and the PCMH model. More than a dozen *Better Health's* partner practices have achieved recognition from the National Committee for Quality Assurance for their practices' PCMH capabilities, and many others have recognition applications underway.

BETTER HEALTH NEWS

- We are pleased to welcome North Coast Health Ministry and to congratulate it on its debut in our Community Health Checkup. North Coast, a faith-based free clinic, provides healthcare services to low-income individuals in western Cuyahoga and eastern Lorain counties.

- We have expanded our Practice Coaching capabilities and staff, who have expertise in improving quality, improving practice operations, effective use of EHRs, and successfully applying for NCQA recognition for PCMH (page 4).

- Our Learning Collaborative Summit on March 11 featured two prominent speakers. Ronald A. Paulus, MD, MBA, past Exec. V.P. and Chief Innovation Officer at Geisinger Health System, shared successful Geisinger care delivery changes and perspectives on the Accountable Care Organization model. Edward H. Wagner, MD, MPH, MACP, who led development of the Chronic Care Model, offered observations and answered questions about the PCMH model and its challenges to practices. Our next Learning Collaborative Summit, which brings together providers for a day of sharing best practices and learning, is September 23, 2011. The Summit is entitled *"Our Patients, Our Partners: Strategies for Improved Patient Care."*

- Better integration of patients' behavioral and physical health needs is becoming increasingly important for more effective care and outcomes. *Better Health's* clinical partners soon will begin screening adults with diabetes, heart failure or hypertension at least yearly for depression using a standard instrument, the Patient Health Questionnaire. Patients who test positive for depression should receive appropriate diagnosis, treatment and follow-up. A toolkit is under development to support practices in introducing new protocols to support depression screening, treatment and referrals as well as to assist practices in their implementation of the PCMH model.

- We know that patients and the payers who finance their health care place a high value on the patient "experience" in their medical office – whether they get the appointments they need, have good interactions with providers and staff and other interpersonal factors that studies show affect outcomes. Increasingly, practice recognition programs and compensation structures are using scores on Patient Experience surveys, which are moving to standardization to allow consumers, payers and plans to readily compare achievement. *Better Health* is coordinating efforts of our partner practices to move to common community-wide measurement of patient experience.

- One of the most frustrating and difficult challenges in health care is the fragmentation of care and lack of coordination that too frequently follows a hospitalization, contributing to poor outcomes, high costs and hardships for patients and their families. *Better Health* and the regional hospital association, the Center for Health Affairs, are expanding a joint effort to address these coordination gaps that includes our regional hospital systems as well as other key players in post-hospital care – from medical offices to home health care and social service agencies. Look for more information on how to get involved.

BETTER HEALTH PARTNERS

Founding Partners
The MetroHealth System, Robert Wood Johnson Foundation grantee
The Center for Community Solutions
Health Action Council Ohio

Primary Care Partners
Care Alliance Health Center
Case Western Reserve University Practice-Based Research Network
Cleveland Clinic, Main Campus and Family Health Centers
Huron Hospital, Community Health Clinic
Kaiser Permanente – Ohio
MetroHealth, Main Campus and Center for Community Health
Neighborhood Family Practice
North Coast Health Ministry
Northeast Ohio Neighborhood Health Services (NEON)
St. Vincent Charity Medical Center
University Hospitals Family Medicine

Hospital Partners
Cleveland Clinic Health System Hospitals
- Cleveland Clinic Main Campus
- Euclid
- Fairview
- Hillcrest
- Huron
- Lakewood
- Lutheran
- Marymount
- South Pointe

MetroHealth Medical Center

Employers and Health Plan Partners
CareSource
Health Action Council Ohio
Ohio Medicaid
Kaiser Health Plan
Medical Mutual of Ohio
UnitedHealthcare

Organizations and Agencies
Academy of Medicine of Cleveland & Northern Ohio
Center for Health Affairs
Cleveland Department of Public Health
Cuyahoga County Board of Health
CWRU Regional Extension Center
CWRU Clinical Translational Science Collaborative
Diabetes Association of Greater Cleveland
NetWellness.org
Ohio Department of Health
OneCommunity
SMART Center, Case Western Reserve University Bolton School of Nursing

Other Valued Supporters
Robert Wood Johnson Foundation
Mt. Sinai Health Care Foundation
The MetroHealth System
Medical Mutual of Ohio
The Cleveland Foundation
Saint Luke's Foundation
The Bruening Foundation
The Ohio Health Care Coverage & Quality Council
Wellpoint Foundation
Health Action Council Ohio
The Center for Community Solutions
OneCommunity

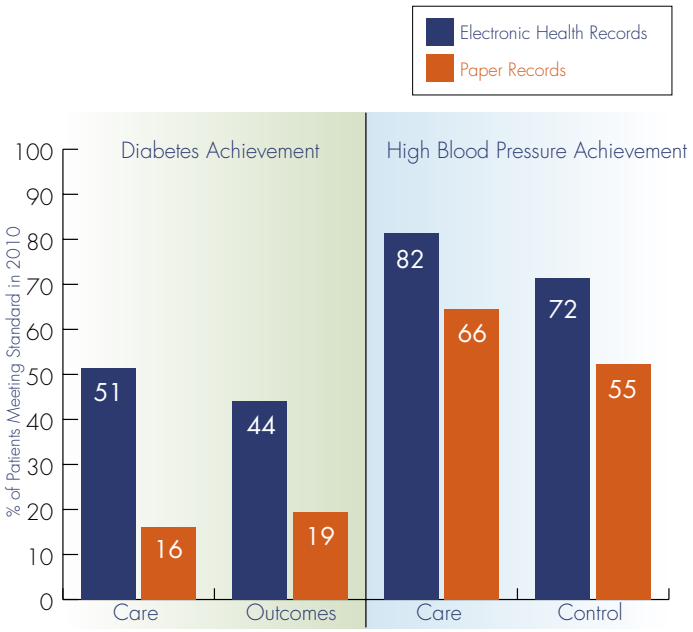

Figure 2. Comparison of Electronic Health Record systems to Paper Record Systems on Achievement in 2010 of Diabetes and High Blood Pressure Standards.

THE VALUE OF ELECTRONIC HEALTH RECORDS AS COMPARED TO PAPER RECORDS

A consistent theme of our work at *Better Health* has been to emphasize the impact of electronic health records on the ability of practices to improve the care for their patients through electronic decision support and more effective documentation. Our 2010 data (Figure 2) continue to show lower achievement among our paper-based practices, in both diabetes and high blood pressure. As seen in Table 1, our current partners with paper-based systems provide care for patients who are relatively disadvantaged, in terms of insurance coverage, and who reside in neighborhoods with lower household incomes and educational attainment.

ACCELERATING IMPROVEMENT, REDUCING DISPARITIES

Our 2010 data bring many reasons for optimism. As we reported in our last Checkup, several of our partner organizations (including all three Federally Qualified Health Centers [FQHCs] – Care Alliance, NEON and Neighborhood Family Practice) are in the midst of a transition from paper to EHR and to team-based care that includes care management. While there have been some growing pains, some initial results are very promising.

Diabetes is the most common cause of adult blindness in the United States, and early detection of retinal problems among diabetic patients can lead to treatment reducing the risk of blindness by almost half. Yet, many diabetes patients don't have an annual eye examination. Figure 3 shows that 2010 results among these FQHCs have improved enormously on this key measure despite the demands of transition to EHRs. Each of the FQHCs is substantially improved in 2010 from our last report six months ago.

Figure 3: Eye Examination Rates among diabetes patients in Federally Qualified Health Centers transitioning to Electronic Record Systems, compared to all other Care Organizations, 2007-2010.

TABLE 1. CHARACTERISTICS OF PATIENTS INCLUDED IN THIS REPORT

	Diabetes		**High Blood Pressure**		**Heart Failure**	
# of Patients	**28,997**		**108,608**		**5,251**	
# of Primary Care Practices	**48 (8 health systems)**		**48 (8 health systems)**		**33 (3 health systems)**	
	Better *Health* Population	Range of Values Across Sites	Better *Health* Population	Range of Values Across Sites	Better *Health* Population	Range of Values Across Sites
Insurance (%)						
Medicare	35.0	0 – 48	43.2	0 – 61	72.5	18 – 85
Commercial	43.3	0 – 74	41.4	0 – 78	19.2	2 – 40
Medicaid	8.9	0 – 39	6.3	0 – 37	5.2	0 – 34
Uninsured	12.8	0 – 100	9.1	0 – 100	3.1	0 – 21
Medicaid + Uninsured	21.7	0 – 100	15.4	0 – 100	8.3	0 – 49
Race/Ethnicity (%)						
White	52.6	2 – 96	60.8	2 – 98	64.6	3 – 97
African-American	39.6	1 – 97	34.5	0 – 97	32.0	0 – 97
Hispanic	4.6	0 – 64	2.2	0 – 54	1.9	0 – 46
Other	3.2	1 – 64	2.5	0 – 52	1.5	0 – 27
Non-White	47.4	4 – 98	39.2	2 – 98	35.4	3 – 97
Preferred Language (%)						
English	95.9	35 – 100	97.1	42 – 100	96.2	53 – 100
Spanish	2.2	0 – 57	1.1	0 – 51	1.2	0 – 48
Other Languages	1.9	0 – 63	1.8	0 – 57	2.6	0 – 30
Average Age	57.7	50 – 62	62.0	50 – 69	70.7	57 – 76
% Female	53.7	35 – 75	57.4	32 – 79	50.2	27 – 70
Median Household Income ($)	41,200	25,500 – 68,000	44,300	25,300 – 71,200	43,100	25,000 – 69,000
High School Graduation Rate (%)	79.6	64 – 90	81.7	66 – 92	80.9	65 – 91
Average Body Mass Index	34.1	29 – 36	31.7	28 – 35	Not reported.	
% Not Smoking	79.7	42 – 92	82.0	31 – 92		
COMPARISON OF ELECTRONIC to PAPER MEDICAL RECORD SYSTEMS						
	EHR Practices	Paper Systems	EHR Practices	Paper Systems	EHR Practices	Paper Systems
# of Practices	34	14	34	14	33	Not reported.
# of Patients	25,548	3,449	98,673	9,935	5,251	
Insurance (%)						
Medicare	37.0	20.1	45.5	20.8	72.5	
Commercial	47.8	10.4	44.4	11.5	19.2	
Medicaid	6.6	25.1	4.2	26.6	5.2	
Uninsured	8.6	44.2	6.0	40.8	3.1	
Medicaid + Uninsured	15.2	69.4	10.2	67.5	8.3	
Race/Ethnicity (%)						
White	57.1	20.3	65.5	15.2	64.6	
African-American	35.6	68.6	30.0	78.6	32.0	
Hispanic	3.9	9.4	2.0	4.2	1.9	
Other	3.4	1.7	2.5	2.0	1.5	
Non-White	42.9	79.7	34.5	84.8	35.4	
Preferred Language (%)						
English	95.9	96.0	97.0	97.6	96.2	
Spanish	2.1	2.7	1.1	1.7	1.2	
Other Languages	2.0	1.2	1.9	0.7	2.6	
Average Age	58.4	52.5	62.9	53.6	70.7	
% Female	53.3	56.7	57.0	60.7	50.2	
Median Household Income ($)	42,900	29,300	45,900	29,600	43,100	
High School Graduation Rate (%)	80.6	72.3	82.7	72.8	80.9	
Average Body Mass Index	34.0	35.1	31.5	33.4	Not reported.	
% Not Smoking	82.3	61.1	84.8	53.0		

DIABETES

COMPARING REGIONAL ACHIEVEMENT AGAINST NATIONAL HEALTH PLANS ON NCQA STANDARDS

Table 2 compares our achievement on the 10 comprehensive diabetes care standards established by the National Council for Quality Assurance (NCQA) with national benchmarks. *Better Health's* practices achieved better results than the national average among HMO health plans on all 10 standards among our Medicare, Commercial and Medicaid patients. While there are no national benchmarks for the uninsured, our uninsured patients also had better results than the Medicaid HMO health plan average nationwide on each of these standards.

TABLE 2 - REGIONAL ACHIEVEMENT (2010) COMPARED TO HEALTH PLANS NATIONWIDE (2009)

NCQA/HEDIS MEASURES FOR COMPREHENSIVE DIABETES CARE

Measure	Group	Medicare	Commercial	Medicaid	Uninsured	Overall
Blood Pressure Control (< 130/80)	Region	41.7	42.0	35.8	33.4	**40.3**
	National Mean	33.3	33.9	32.2	-	-
Blood Pressure Control (< 140/90)	Region	71.2	77.2*	61.8	63.2	**72.0**
	National Mean	60.5	65.1	59.8	-	-
Eye Examination	Region	69.2	60.1	54.4	57.8	**62.5**
	National Mean	63.5	56.5	52.7	-	-
Hemoglobin A1c testing performed	Region	95.2	93.8*	92.5*	93.6	**94.1**
	National Mean	89.6	89.2	80.6	-	-
A1c Control (< 7)	Region	52.7	46.4	41.2	34.2	**46.5**
	National Mean	not reported†	42.1	33.9	-	-
A1c Control (< 8)	Region	76.7	70.2	59.3*	53.1	**69.2**
	National Mean	63.7	61.6	45.7	-	-
A1c Control (> 9) [lower values are better]	Region	13.6	19.0	29.4	32.4	**19.8**
	National Mean	28.0	28.2	44.9	-	-
LDL Cholesterol Screening	Region	90.6	90.5	80.6	84.3	**88.9**
	National Mean	87.3	85.0	74.2	-	-
LDL Control (< 100)	Region	63.6	55.4	39.2	41.6	**55.1**
	National Mean	50.0	47.0	33.5	-	-
Monitoring Nephropathy	Region	93.1	91.3*	90.0*	89.0	**91.5**
	National Mean	88.6	82.9	76.9	-	-
Regional Diabetes Patients, %		10,115	12,520	2,557	3,700	**28,997**
		(35)	(43)	(9)	(13)	

Table 2. Regional Achievement (2010) Compared to Health Plans Nationwide (2009). National Data from The State of Health Care Quality 2010, www.ncqa.org

**Better Health's* regional performance on this measure exceeds the 90th percentile of health plans, nationally.

†Although NCQA does not report A1c < 7 rates for Medicare patients in 2009, *Better Health's* performance is above that of the national mean in Medicare HMOs for 2008.

CONTINUING IMPROVEMENT IN DIABETES CARE AND OUTCOMES

As for *Better Health's* nationally endorsed, locally vetted standards, we continue to be encouraged by trends in our diabetes data (Figure 4.) Since our initial report in 2007, we have substantially improved both diabetes **care** (which describes achievement of four standards for good routine care) and **outcomes** (good control over at least four of blood sugar, blood pressure, cholesterol, weight and smoking) across the region. As seen in Figure 5, all but three of the 36 partner practices reporting diabetes results since 2008 have improved in our measures of diabetes care and/or outcomes.

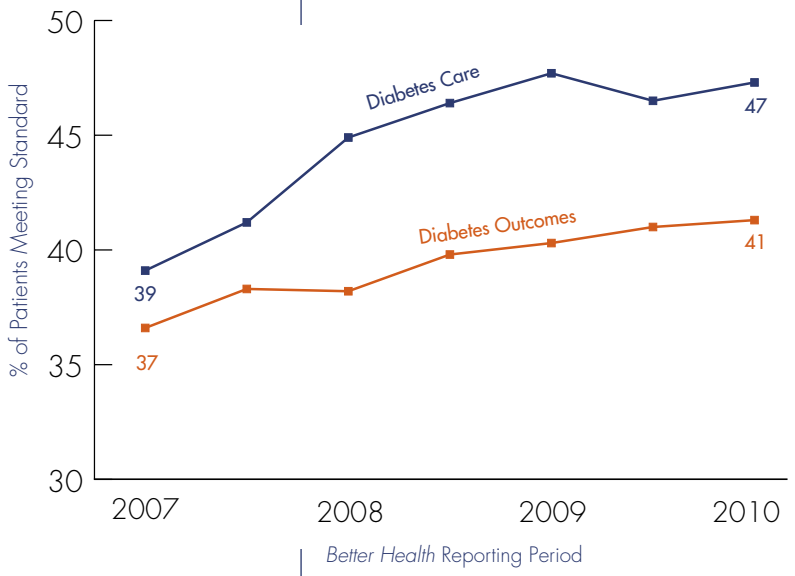

Figure 4. Regional Achievement on Diabetes Care and Outcomes, 2007-2010.

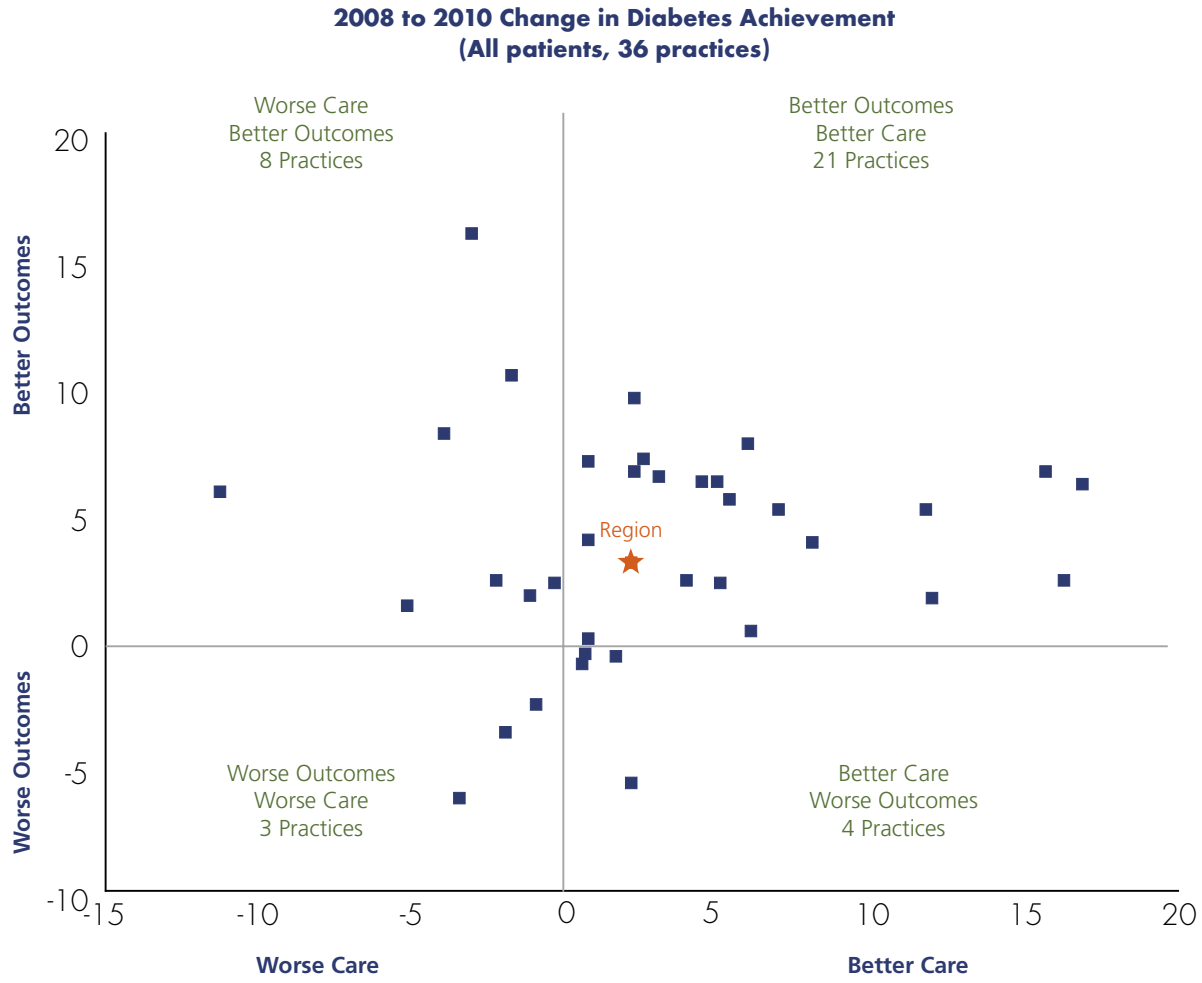

Figure 5. Change in Percentage of Patients Achieving Composite Standards for Diabetes Care and Outcomes from 2008 to 2010.

HIGH BLOOD PRESSURE

COMPARING OUR RESULTS TO NATIONAL BENCHMARKS

Table 3 compares our practices' achievement on control of high blood pressure with the national average among HMO health plans reported by NCQA, as we showed for diabetes measures in Table 2. Our region achieved better results than the 90th percentile nationally for Commercial and Medicare patients, while our Medicaid and uninsured results are comparable to the national Medicaid average.

TABLE 3 - REGIONAL ACHIEVEMENT (2010) COMPARED TO HEALTH PLANS NATIONWIDE (2009)

NCQA/HEDIS MEASURE FOR CONTROLLING HIGH BLOOD PRESSURE

Measure	Group	Medicare	Commercial	Medicaid	Uninsured	Overall
Blood Pressure Control (< 140/90)	Region	73.0*	74.0*	55.1	56.5	70.8
	National Mean	59.8	64.1	55.3	-	-
Regional High Blood Pressure Patients, #		46,832	44,834	6,798	9,901	108,608
		(43)	(41)	(6)	(9)	

**Better Health's* regional performance on this measure exceeds the 90th percentile of health plans nationally.

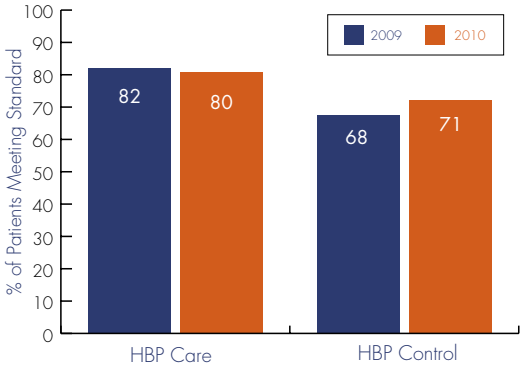

Figure 6. Regional Achievement on High Blood Pressure Care and Control (Blood Pressure at Goal), 2009 and 2010.

CONTINUED IMPROVEMENT IN BLOOD PRESSURE CONTROL

Region-wide, our main **control** measure (meeting the goal of having a blood pressure below 140/90) improved from 68% to 71% of high blood pressure patients across the region over the past year. However, our achievement of three key **care** standards for high blood pressure patients (appropriate checks of blood pressure, kidney function and cholesterol) dipped slightly from 2009 to 2010 (Figure 6).

INSURANCE REMAINS A KEY FACTOR

Across our six previous Community Health Checkups, we documented substantial differences in achievement across health insurance types for our diabetes measures, which persisted across our EHR and paper-based record systems. Our 2010 high blood pressure results (Figure 7) show that patients cared for by EHR systems had better results in both Care and Control across insurance types.

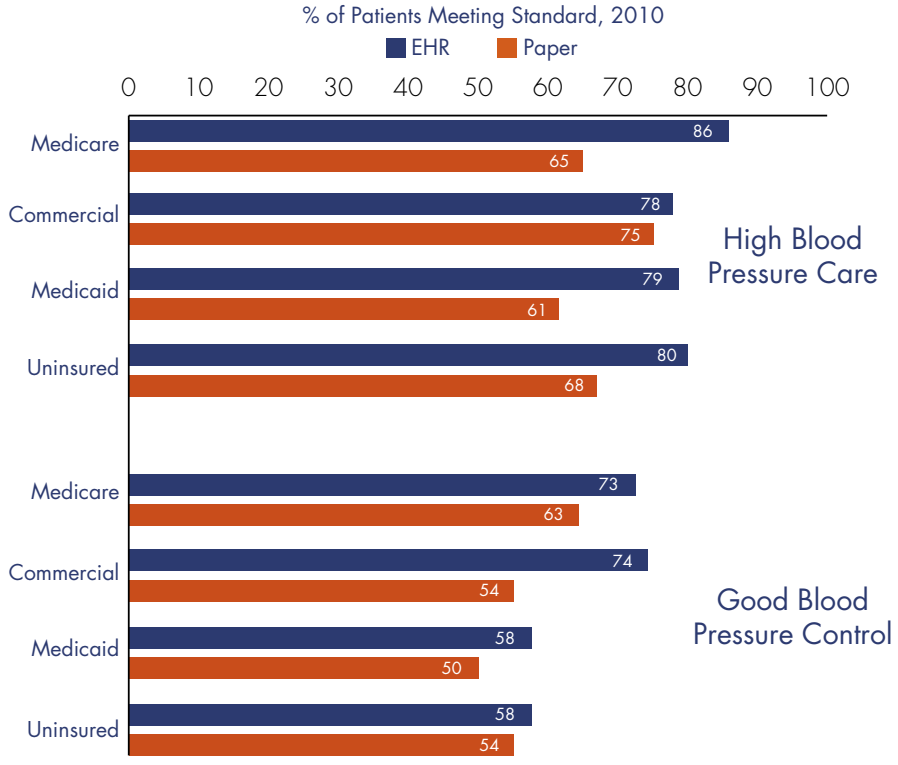

Figure 7. Achievement on High Blood Pressure Care and Control across EHR and Paper Record Systems, by Insurance Type, 2010.

HEART FAILURE

EXCELLENT TREATMENT RATES ACROSS THE REGION

Better Health has reported on primary care provider achievement in the **evaluation** and **treatment** of patients with heart failure since 2008. We report on 5,251 patients receiving care at 33 practices within Cleveland Clinic, Kaiser Permanente and MetroHealth (our three systems that treat large numbers of heart failure patients.) Our **treatment** standard describes the percentage of patients with moderate or severe heart failure who received appropriate evidence-based treatment, specifically, an ACE/ARB or Beta-Blocker medication (or both). Nearly all (96%) of our patients met this standard in 2010. Of the 31 practices reporting at least 25 heart failure patients in 2010, 23 met this important standard on at least 95% of patients (Figure 8).

Our **evaluation** standard requires a provider to complete appropriate heart function ("echo") assessment, and annual blood testing (basic metabolic panel) along with regular checks of the patient's weight and blood pressure. Our providers met all four of these standards for 73% of our their patients in 2010.

Although most of *Better Health's* heart failure patients are eligible for Medicare, we note that high achievement persists across all insurance subgroups, including the uninsured, which actually had the highest achievement across our practices in 2010. Figure 9 shows no substantial disparities in evaluation or treatment rates across insurance, race, income or educational attainment.

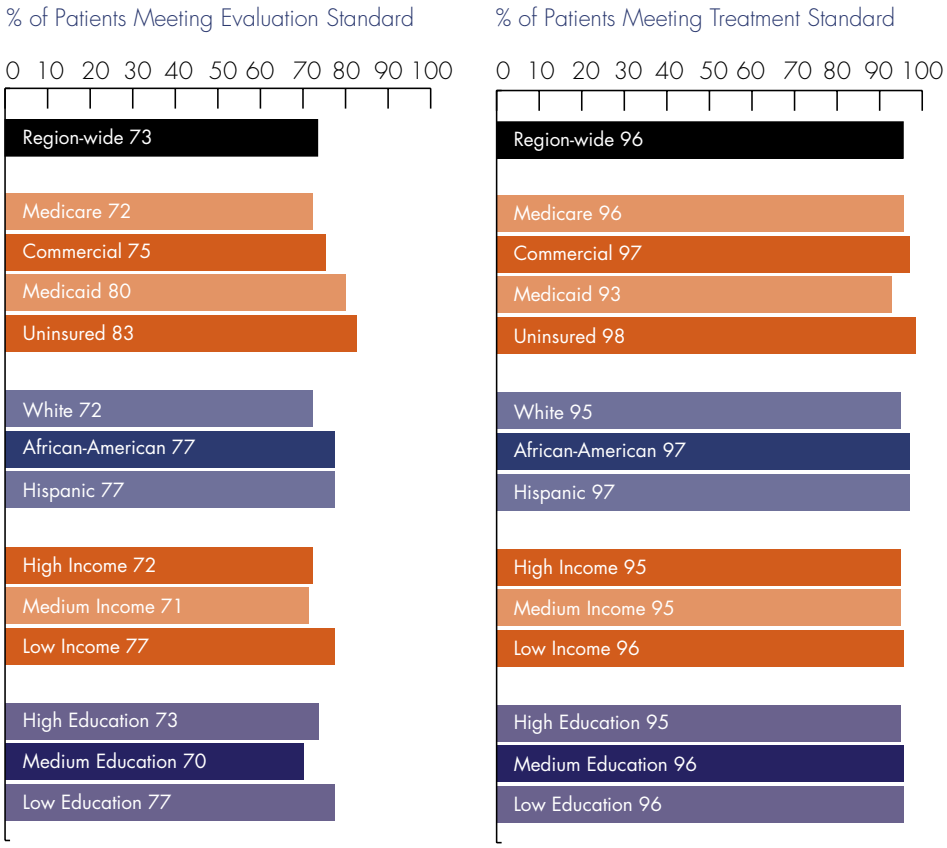

Figure 9. 2010 Heart Failure Achievement Region-wide and in Patient Subgroups

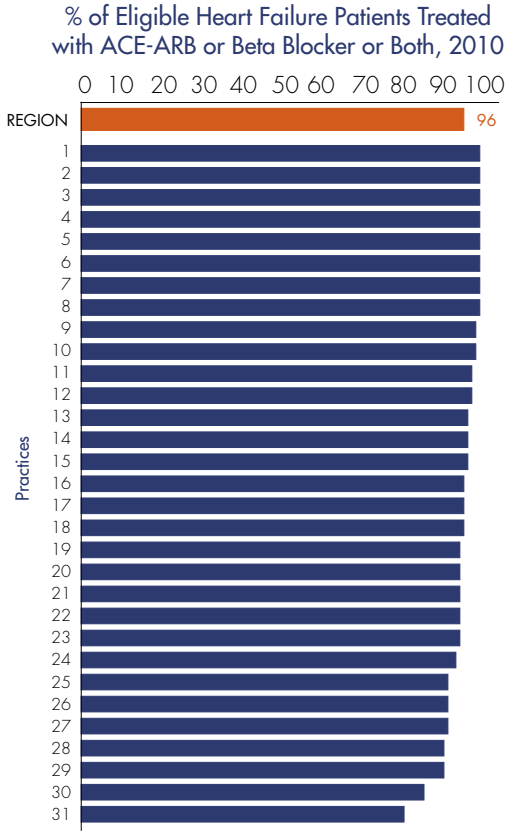

Figure 8. Use of ACE/ARB and/or Beta-Blocker medications in patients with Serious or Moderate Heart Failure in 2010. Twenty-three of 31 *Better Health* practices treated at least 95% of patients with one or both of these medications.

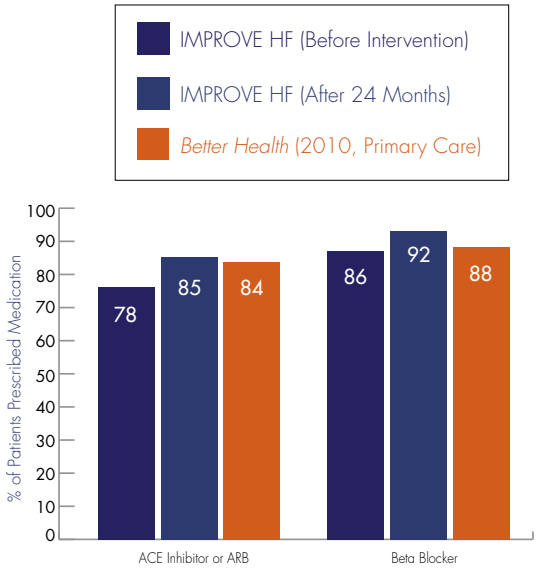

Figure 10. Comparison of evidence-based treatment decisions among cardiologists in a nationwide quality improvement program (IMPROVE HF) at the start of their program, and after 24 months, and primary care partners in 33 *Better Health* practices.

COMPARING TREATMENT RATES TO A CARDIOLOGY QUALITY IMPROVEMENT INITIATIVE

Better Health's treatment results are comparable with the results of a national consortium of 167 outpatient cardiology practices in a heart failure quality improvement initiative[2] called IMPROVE HF. IMPROVE HF showed a significant improvement over 24 months of intervention in the use of these important medications. *Better Health's* results in primary care are quite similar, as shown in Figure 10.

BUILDING ON PROGRESS, SEIZING OPPORTUNITIES

CONCLUDING COMMENTS

The data we present in our seventh Community Health Checkup shows steady progress in our partners' treatment of their patients' chronic conditions that are challenging to live with and manage, and costly for everyone. We are pleased to report these trends for the nearly 120,000 patients included this report. We believe these results are similar for thousands of our other patients who receive better care because of their clinicians' improved processes and heightened awareness. Change is happening.

Our collective strengths in measurement, transparency, health information technology and primary care present great opportunities to accelerate improvement and bring better value for all of us who purchase health care. We are excited that as this report goes to print, government purchasers, health plans and employers vested in a healthy local workforce and economy are rolling up their sleeves to hasten the pace of change.

In the last four years, *Better Health* has built the data management and quality improvement infrastructure to support health care stakeholders who are ready to pay for value rather than volume. We are anxious to support employers and insurers in efforts to provide incentives for consumers to seek preventive care, adopt healthy lifestyles and adhere to evidence-based treatment regimens. We also are optimistic that new multi-payer partnerships will be formed to build 'medical homes' for all patients in a practice that align incentives to improve outcomes and value. Together, we believe that we can help Greater Cleveland become a healthier place to live and a better place to do business.

[2] Fonarow GC et al. (2010) Improving Evidence-Based Care for Heart Failure in Outpatient Cardiology Practices: Primary Results of the Registry to Improve the Use of Evidence-Based Heart Failure Therapies in the Outpatient Setting (IMPROVE HF). *Circulation* 122: 585-596.

SPOTLIGHTING OUTSTANDING ACHIEVEMENT

These 35 practices had quality scores in the top 10% of one of our composite measures in diabetes, high blood pressure or heart failure in 2010, or improved the most in their care of diabetes, heart failure or hypertension patients through 2010. All have earned gold stars. Congratulations to you and your patients!

TABLE 4. OUTSTANDING ACHIEVEMENT AND IMPROVEMENT (2010)

	OVERALL	MEDICARE	COMMERCIAL	MEDICAID	UNINSURED
CARE ALLIANCE					
Care Alliance (All Practices)	HBP HBP↑			DM↑ HBP	
THE CLEVELAND CLINIC					
Beachwood Family Health Center		HBP			
Brunswick Family Health Center	HF HF↑	HF			HBP↑
Chagrin Falls Family Health Center	DM HF	DM HF			
Cleveland Clinic - Main Campus	DM HF	HF	HF	DM DM↑ HBP HBP↑	DM
Huron Hospital	DM↑	HBP↑			DM↑
Independence Family Health Center	DM HF	HF HF↑	DM		
Lakewood Family Health Center	HF HF↑ HBP↑	HF HF↑ HBP↑			
Solon Family Health Center	DM	DM HF HBP	DM		HBP HBP↑
Strongsville Family Health Center	DM HF	DM HF	DM		HBP↑
Westlake Family Health Center		HBP↑	HF HF↑		HBP
Willoughby Hills Family Health Center	HF HBP	HF HBP			DM HBP
KAISER PERMANENTE - OHIO					
Avon Medical Facility	DM↑ HF HF↑		HBP		
Bedford Medical Center	DM HBP	DM HBP	DM HF↑ HBP		
Chapel Hill Medical Center	DM DM↑ HBP	DM DM↑ HBP	DM↑ HBP		
Cleveland Heights Medical Center	HBP↑	DM DM↑ HF↑ HBP↑			
Fairlawn Medical Center	DM HBP	HBP HBP↑	DM HBP		
Parma Medical Center	HBP↑	HBP↑			
Rocky River Medical Center			HBP↑		
Strongsville Medical Center		DM HF↑			
Willoughby Medical Center	DM HBP HBP↑	HBP HBP↑	HBP↑		
THE METROHEALTH SYSTEM					
Asia Town Health Center	DM↑		HBP	HBP↑	HBP
Beachwood Health Center	HBP				
Broadway Health Center	DM↑ HF↑ HBP↑			DM↑ HBP↑	DM↑ HBP↑
Brooklyn Health Center	HBP	DM↑ HBP	HBP		
Buckeye Health Center			DM		
J. Glen Smith Health Center	HBP↑	HBP↑			
Lee-Harvard Health Center	HF↑ HBP↑		HBP HBP↑		HBP↑
MHMC - Faculty/Residents Practice	HF	HF		DM HF HF↑	DM HBP↑
MHMC - Family Practice			HBP↑		DM
Strongsville Health Center	DM↑	DM↑	DM↑		
Thomas F. McCafferty Health Center	DM↑	DM↑	DM↑ HBP↑		DM↑ HBP
West Park Health Center				HBP	
NEON: NORTHEAST OHIO NEIGHBORHOOD HEALTH SERVICES, INC.					
NEON (All Practices)	DM↑		DM↑ HBP	DM↑	
NEIGHBORHOOD FAMILY PRACTICE					
Neighborhood Family Practice (All Practices)		DM↑		HBP HBP↑	

OUTSTANDING ACHIEVEMENT IN
DM - Diabetes Care or Outcomes
HF - Heart Failure Evaluation or Treatment
HBP - High Blood Pressure Care or Control
DM↑ - Most Improved from 2008 to 2010 in Diabetes Care or Outcomes
HF↑ - Most Improved from 2009 to 2010 in Heart Failure Evaluation or Treatment
HBP↑ – Most Improved from 2009 to 2010 in High Blood Pressure Care or Control

Better Health *Greater* Cleveland

An Alliance for Improved Health Care

A program of the Robert Wood Johnson Foundation's *Aligning Forces for Quality* initiative and other funders

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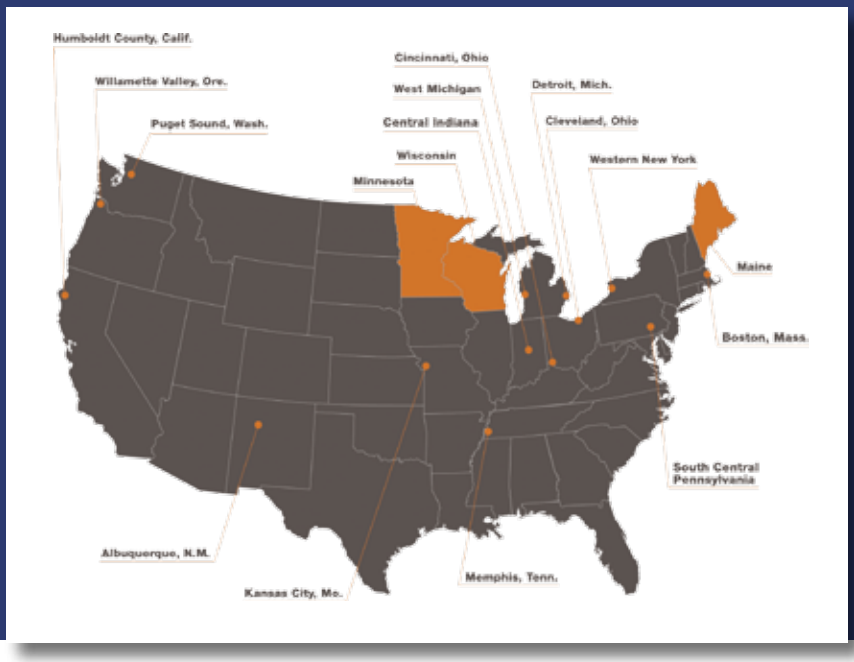
Better Health is one of 17 Regional Health Improvement Collaboratives in the Robert Wood Johnson Foundation's prestigious *Aligning Forces for Quality* initiative.



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