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.

JANUARY 2009

Community Health Checkup Executive Summary

Diabetes Care and Outcomes: Focus on Disadvantaged Populations








Visit www.betterhealthcleveland.org to read the full report

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:

In February, 2007, the Robert Wood Johnson Foundation embarked on a bold initiative to create regional partnerships to improve the health of people with chronic conditions by aligning the often different interests of those who get care, give care and pay for care. Better Health *Greater* Cleveland is proud to be among an elite group of 14 communities supported by the Foundation's program, called *Aligning Forces for Quality*.

The backbone of Better Health *Greater* Cleveland is public reporting of achievement on nationally endorsed measures of Care and Outcomes for our patients with chronic conditions. Our public reporting is supported by a vital region-wide program in quality improvement and by parallel efforts to develop better partnerships between patients and their health care teams.

The Greater Cleveland initiative increasingly is recognized for reporting results across all patients, including those without insurance and in groupings by race, income and education. We are unique in obtaining our measures from the practices themselves, which is facilitated by the large penetration of electronic medical record systems in the region. Our electronic medical records enable us to have a full and accurate view of the care of *all* our patients, regardless of insurance status or other barriers to conventional measurement.

In this, our second Community Health Checkup, we report the achievement of 42 primary care group practices with their more than 25,000 adult patients with diabetes. Included among these are 33 practices that reported their results in the first Checkup, offering a first glimpse at *changes* in our region-wide achievement. Our results in many ways are encouraging, as they demonstrate unanticipated region-wide improvements in most of our standards for care and outcomes over a short time period.

At the same time, however, we report continued disparities in Outcome achievement among those with fewer resources in our community. Safety-net practices and those using paper-based medical records continue to do less well than more advantaged practices. Likewise, we observe poorer Outcomes among non-white and poorer patients, as well as those with lower educational attainment. Perhaps most challenging are poorer Outcomes among our uninsured patients, whose achievement was both lower than insured patients and showed no improvement over the two year-long measurement periods. As Greater Cleveland currently is projected to have unemployment rates reaching 10% in 2009, we certainly will be caring for more patients who lack adequate health insurance in the coming months.

These challenges come at a time of national transition, hope, and increased expectations for civic responsibility. We are called upon to find creative solutions by involving all stakeholders in better health. Eliminating disparities and improving the health of our community require active engagement of patients and their health care teams. Government, public health agencies, businesses and health plans must do their part, too. Everyone has a role to play to bring better health to Greater Cleveland.

We look forward to hearing from you. Visit our web site: www.betterhealthcleveland.org, or give us a call.

Randall D. Cebul, M.D., Director | Better Health *Greater* Cleveland | January, 2009

Introduction and Overview

In Better Health *Greater* Cleveland's second Community Health Checkup, we report the achievement of 42 primary care group practices in the care and outcomes of more than 25,000 adult patients with diabetes. Included are 33 practice sites in six health care organizations that reported in our first Community Health Checkup in June, 2008. The availability of these longitudinal data allows a first glimpse of *changes* in our achievement between calendar year 2007 and the current reporting period, which spans the 12 months between July 1, 2007 and June 30, 2008. As in our first report, we summarize our region-wide findings overall and in patient subgroups according to race, income, educational attainment and insurance status, including patients without health insurance. Also as before, practice site-level achievement is reported overall and by insurance status. Our nine nationally endorsed and locally vetted standards continue to be grouped into two composite standards, including a summary of five *clinical outcomes* and a summary of four *care processes*.

Our latest results highlight five main categories of findings:

1. We summarize our favorable achievement compared to national results from health plans;
2. We describe unanticipated improvements in achievement in our overall composite outcome and process-of-care standards;
3. We find continued disparities in outcomes among our practices and patients with fewer resources;
4. We describe opportunities for accelerating region-wide improvement by focusing on practice sites and systems with exceptional achievement and/or exceptional improvements over time.
5. Finally, we include national data on other important diabetes outcomes that represent substantial technical and performance challenges to Greater Cleveland.

Ongoing parallel efforts of the Better Health alliance include a commitment to add achievement measures for outpatients with heart failure, as well as hospital-centered programs. The inpatient initiatives center on improving care and patient satisfaction and reducing re-admission rates for patients with cardiovascular disease, including diabetes, stroke, heart failure and coronary heart disease.

Also noteworthy are new relationships with *Bridges to Excellence*, the premier performance-recognition program in the country, and our organizational membership with the *National Quality Forum*, the nationwide "clearinghouse" and leader in developing and disseminating standards for quality in health care.

Why Focus on Diabetes?

At least one in 13 people in Northeast Ohio has diabetes, and 3 out of 5 people with diabetes also have other serious health problems. Diabetes is the most preventable cause of kidney failure, blindness, leg amputations and vascular disease. The American Diabetes Association reports that one in five health care dollars is spent on people with diabetes.

Ellen has learned that doctors aren't the only experts. She has become an expert, too. Because she lives with diabetes every day. Ellen knows that talking with her doctor is an important step on the path to better health. "If you share a problem, you cut it in half," Ellen said.

The Robert Wood Johnson Foundation's *Aligning Forces for Quality* initiative supports the following 14 regions:

Cleveland, Ohio
Cincinnati, Ohio
Detroit, Michigan
Humboldt County, California
Kansas City, Missouri
Maine
Memphis, Tennessee
Minnesota
Seattle, Washington
South Central Pennsylvania
West Michigan
Western New York
Willamette Valley, Oregon
Wisconsin

For more information, go to www.rwjf.org/qualityequality/af4q/

Diversity: Our Partner Practices and Their Patients with Diabetes

Among the 14 market regions that participate in the Robert Wood Johnson Foundation's *Aligning Forces for Quality*, Better Health is unique in the diversity of health care organizations and practice sites that share their medical records-based clinical information. In particular, the active engagement of all Federally Qualified Health Centers (FQHCs) and other safety net practices alongside more affluent systems and patients enables us to provide a more representative summary of the region's achievement and to compare our performance across patients of different socio-economic and insurance strata. As compared to the first Checkup, this report adds information about mostly Asian-American patients in The MetroHealth System's Asia Plaza site and mostly African-American patients cared for at Huron Hospital in East Cleveland. Of the 42 practices submitting data for this report, 31 use electronic medical records (EMRs) and 11 provide information from their paper-based records. The high penetration and use of EMRs in Greater Cleveland also is unique across the *Aligning Forces* regions, enabling relevant practices to better capture all their patients' information – regardless of insurance status or other barriers to conventional measurement – and to offer sophisticated support for their providers and patients.

Table 1 provides a high-level view of our partner practices and their patients with diabetes. About one in five patients are either uninsured or covered by Medicaid, although the proportion of poor or uninsured patients across the 42 sites ranges from 0% to 93%. Traditionally defined minority patients

TABLE 1. CHARACTERISTICS OF PARTNER ORGANIZATIONS AND PRACTICE SITES

	BHGC Population	Range of Values Across Sites
Health Systems, Number	7	-
Practice Sites, Number	42	-
Use Electronic Medical Records	31	
Use Paper-based Medical Records	11	
Primary Care Physicians, Number	322	-
Qualifying Diabetic Patients, Number	25,634	66 – 1,988
Diabetic Patient Characteristics		
Insurance, %		
Medicare	35	4 - 50
Commercial	46	3 - 73
Medicaid	8	0 - 47
Uninsured	11	0 - 79
Medicaid + Uninsured	19	0 - 93
Race/Ethnicity, %		
White	39	2 - 91
African-American	28	2 - 97
Hispanic	4	0 - 61
Other	2	0 - 55
Non-White	61	9 – 98
High School Graduation Rate, %	79.7	65.6 – 90.0
Median Household Income, $	40,164	22,125 – 67,842

(mostly African-American and Hispanic) constitute 61% of our patients with diabetes, although non-white patients vary in prevalence across practices from 9% to 98%. Table 1 also highlights considerable variation across practice sites in their patients' educational attainment and household income. As highlighted below and described in more detail in the complete Community Health Checkup, these sources of variation are strong predictors of achievement of outcomes. Among patients who are either uninsured or covered by Medicaid, these patient characteristics predict the reduced likelihood of improved performance over the two reports.

Favorable Comparisons to Health Plans Nationwide

In our first Community Health Checkup, we noted that our partner practices performed well on national "HEDIS" standards reported for health plans by the National Committee on Quality Assurance (NCQA). Table 2 shows the favorable performance of our region as compared to these national benchmarks. Here, regional achievement describes the 42 practices from our seven reporting systems for the July 1, 2007 – June 30, 2008 reporting period, while national means describe calendar 2006 data reported to NCQA and HEDIS.

What is HEDIS?

The Healthcare Effectiveness Data and Information Set (HEDIS) is used by most American health plans to measure the performance of health care systems on a broad range of important health issues, including comprehensive diabetes care.

TABLE 2. REGION-WIDE ACHIEVEMENT COMPARED TO HEALTH PLANS NATIONWIDE. HEDIS COMPREHENSIVE DIABETES CARE MEASURES REPORTED BY THE NATIONAL COMMITTEE ON QUALITY ASSURANCE (NCQA)

Measure	Group	Medicare	Commercial	Medicaid	Uninsured	Overall
HbA1c testing performed	Region	95.2	92.6	91.9	92.5	93.5
	National Mean	87.2	87.5	78.0	-	-
Excellent HbA1c Control (<7)	Region	52.7	44.1	45.0	38.6	46.6
	National Mean	45.9	41.8	30.2	-	-
Poor HbA1c Control (>9) ✷	Region	13.7	21.6	28.3	29.8	20.3
	National Mean	27.3	29.6	48.7	-	-
Eye Exam performed	Region	70.0	60.3	55.3	58.4	63.1
	National Mean	62.3	54.7	51.4	-	-
Monitoring Nephropathy ✓	Region	91.9	90.1	84.9	87.4	90.0
	National Mean	85.4	79.7	74.6	-	-
LDL Screening	Region	88.0	87.9	75.7	77.0	85.8
	National Mean	84.8	83.4	71.1	-	-
Good LDL Cholesterol Control (<100)	Region	59.1	51.2	33.6	34.0	50.8
	National Mean	46.9	43.0	30.6	-	-
Excellent BP Control (<130/80)	Region	39.5	39.8	34.1	31.9	38.4
	National Mean	30.2	29.9	30.4	-	-
Good BP Control (<140/90)	Region	68.4	71.9	59.6	62.3	68.7
	National Mean	57.8	61.4	57.3	-	-
Regional Patients, Number (%)		9,031 (35%)	11,827 (46%)	2,066 (8%)	2,696 (11%)	25,634

✷ Lower values for the poor HbA1c Control standard are better.

✓ Monitoring Nephropathy describes Kidney Management (urine microalbumin screen or ACE-inhibitor or ARB prescription)

National Measures Locally Vetted

Northeast Ohio physicians reviewed national standards for diabetes care to develop our measures and standards. Our outcome measures show how doctors' practices and their patients did on key indicators of good diabetes control. Our care process measures show how they did at getting recommended tests, treatments and vaccinations.

Our achievement among uninsured patients – who are not reported by NCQA, preventing head-to-head comparisons – continues to exceed national Medicaid plan averages for all HEDIS standards, as well as Commercial plan averages for most standards. It is worth noting that while Better Health *Greater* Cleveland's standards vary somewhat from NCQA's, we have captured our practice-based measures in a way that permits us to describe our achievement on NCQA and others' standards as well.

Better Health's Standards for Diabetes Care and Outcomes

Table 3 summarizes five individual standards that we have assembled as a composite Outcome Standard and four individual standards that we have combined as a composite Process Standard. We continue to believe that Process standards are mostly responsive to *provider* or health care *system* actions, while achievement on Outcome standards also reflects *patient* resources, *patient* behaviors and the effectiveness of patient partnerships with their health care providers. The rationale for each individual standard was summarized in our first Community Health Checkup, and our methods also are provided in greater detail in the Appendix to this report available at www.betterhealthcleveland.org. Each practice site's Outcomes are reported individually and by the percentage of its patients who meet *at least four of the five* Outcome standards. Each practice site's Care Processes also are reported individually and by the percentage of patients who meet *all four* Process standards – a higher achievement criterion for processes than for outcomes.

TABLE 3. BETTER HEALTH'S INDIVIDUAL AND COMPOSITE STANDARDS

CLINICAL OUTCOMES 5 standards of good control:	CARE PROCESSES 4 standards for good routine care:
• Blood Sugar (HbA1c<8%) • Blood Pressure (<140/80) • Cholesterol (LDL Cholesterol <100) • Weight (Body Mass Index <30) • Documented non-smoker	• Blood sugar control test done • Screening or treating kidney problems • Annual eye exam • Pneumonia vaccine given
Composite Reported: Percentage of patients who met at least 4 standards	Composite Reported: Percentage of patients who met all 4 standards

Region-wide Achievement in Care Processes and Outcomes

Figure 1 summarizes region-wide achievement on our composite standards for care processes and outcomes from July 1, 2007 through June 30, 2008. Despite setting the achievement bar higher for processes than for outcomes as in the first Checkup, 50% of our patients met all four Process Standards, while only 40% met four or five of the five Outcome Standards. Details on region-wide achievement for individual standards are provided in the complete Checkup, which is available at www.betterhealthcleveland.org.

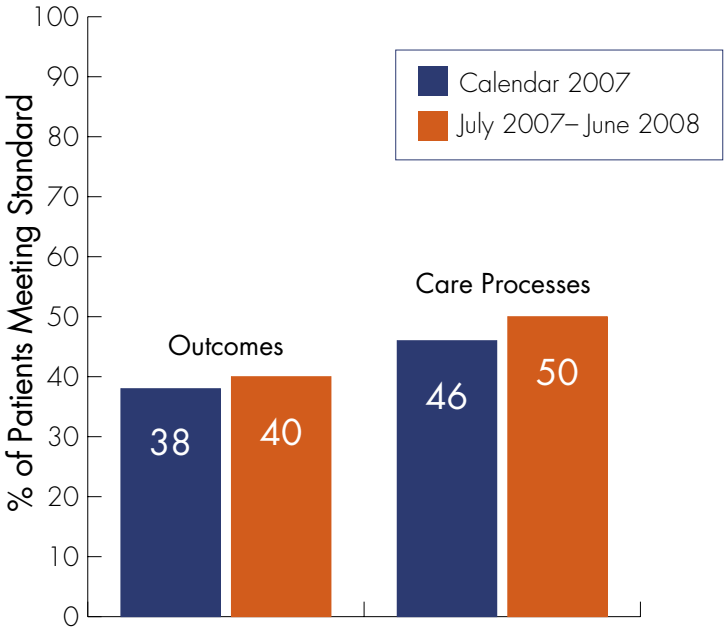


Figure 1. Achievement on composite standards for diabetes

Improvements on Most Standards and Patient Subgroups

Despite the short interval between Checkups, the current report describes unanticipated improvements in our overall composite Outcome and Process Standards, as displayed in Figure 1. As described in the complete Checkup, more patients met each of the four Process Standards, while among the Outcome Standards, achievement improved for all but the "weight control" and "non-smoking" standards. These highlight excellent targets for intensified efforts.

For the 30 practice sites with EMRs and measurements in both periods, results for most individual standards also improved, as did achievement across subgroups by race, income and educational attainment (Figures 2-4). Process-of-care achievement also improved across all patient subgroups, including uninsured patients and poor patients covered by Medicaid.

Betty is one savvy patient. She found a doctor and nurse she likes and trusts. Then she built a winning partnership with them, Dr. Martin Ryan and Marti Marshall.

Besides quick access to a patient's treatment history, electronic medical records (EMRs) offer physicians and patients a way to measure their progress – so they can improve. Several local health systems, including Kaiser Permanente, the MetroHealth System and the Cleveland Clinic, use the same EMR.

Changes in Achievement

Calendar 2007
July 2007–June 2008

OUTCOMES

CARE PROCESSES

RACE

Figure 2a.

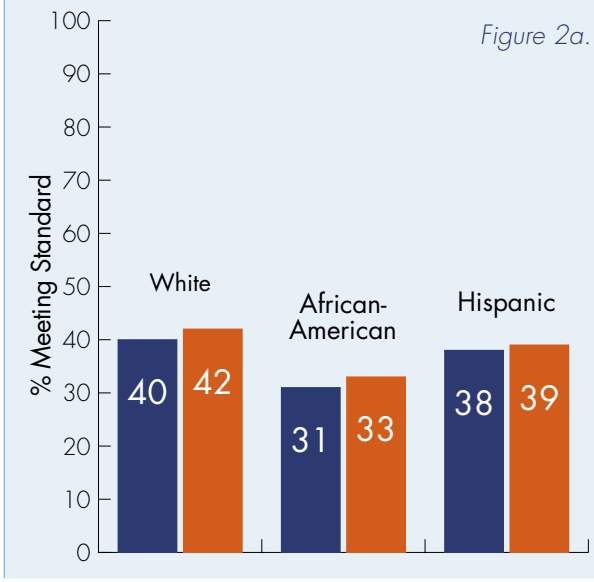
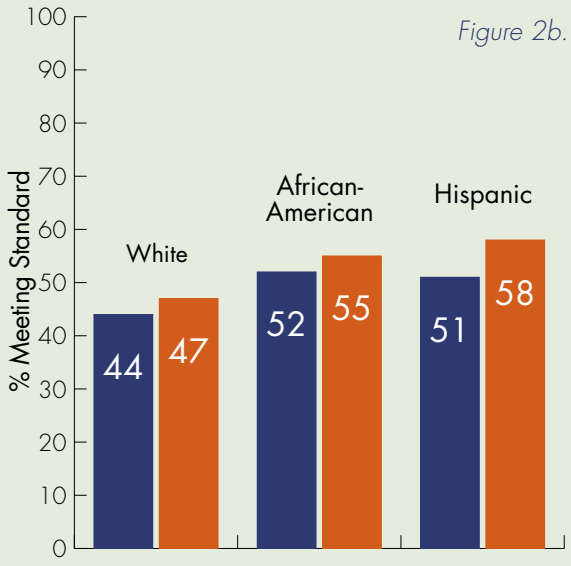


Figure 2b.



INCOME

Figure 3a.

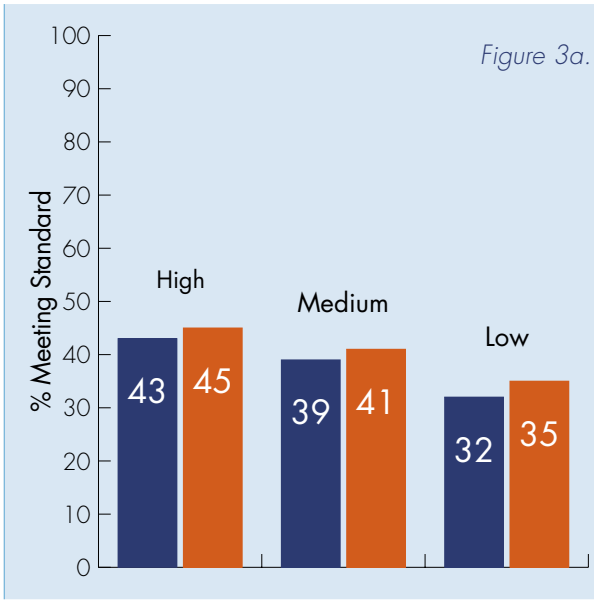
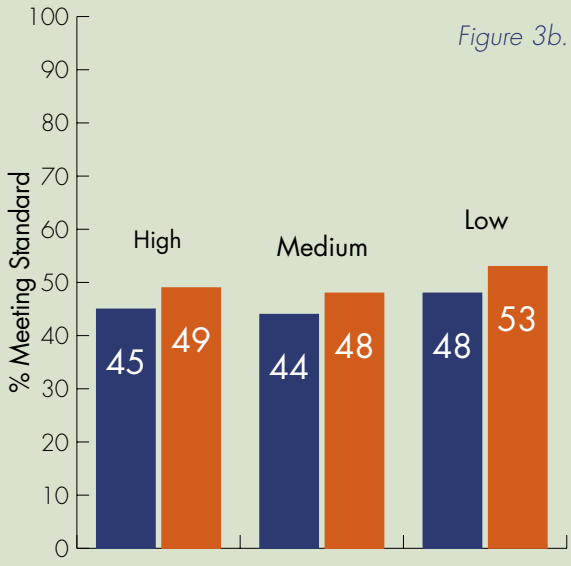


Figure 3b.



EDUCATION

Figure 4a.

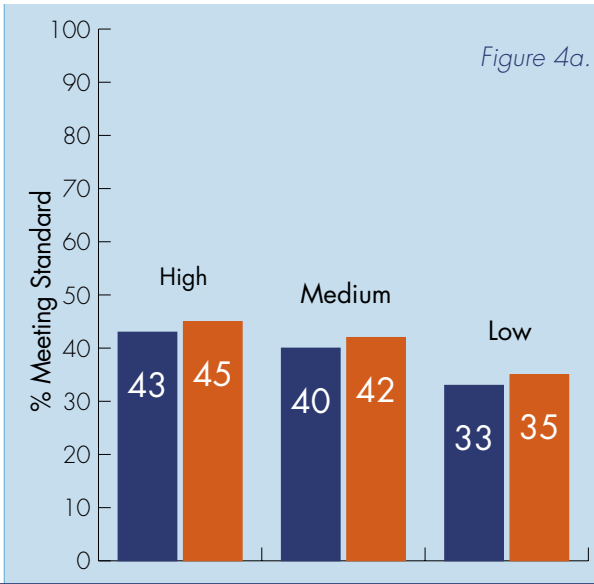
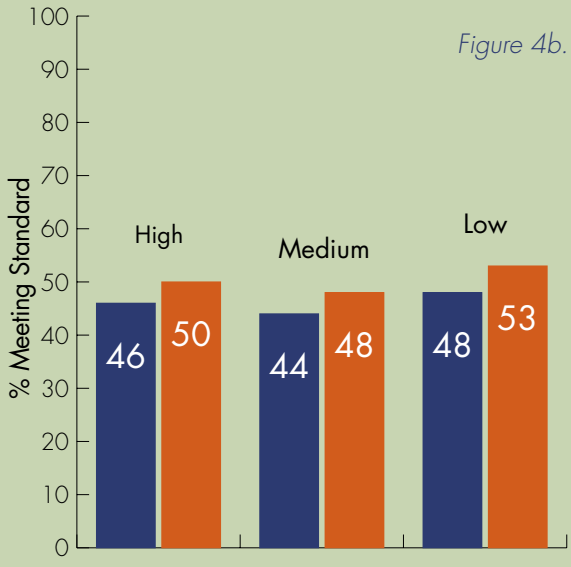
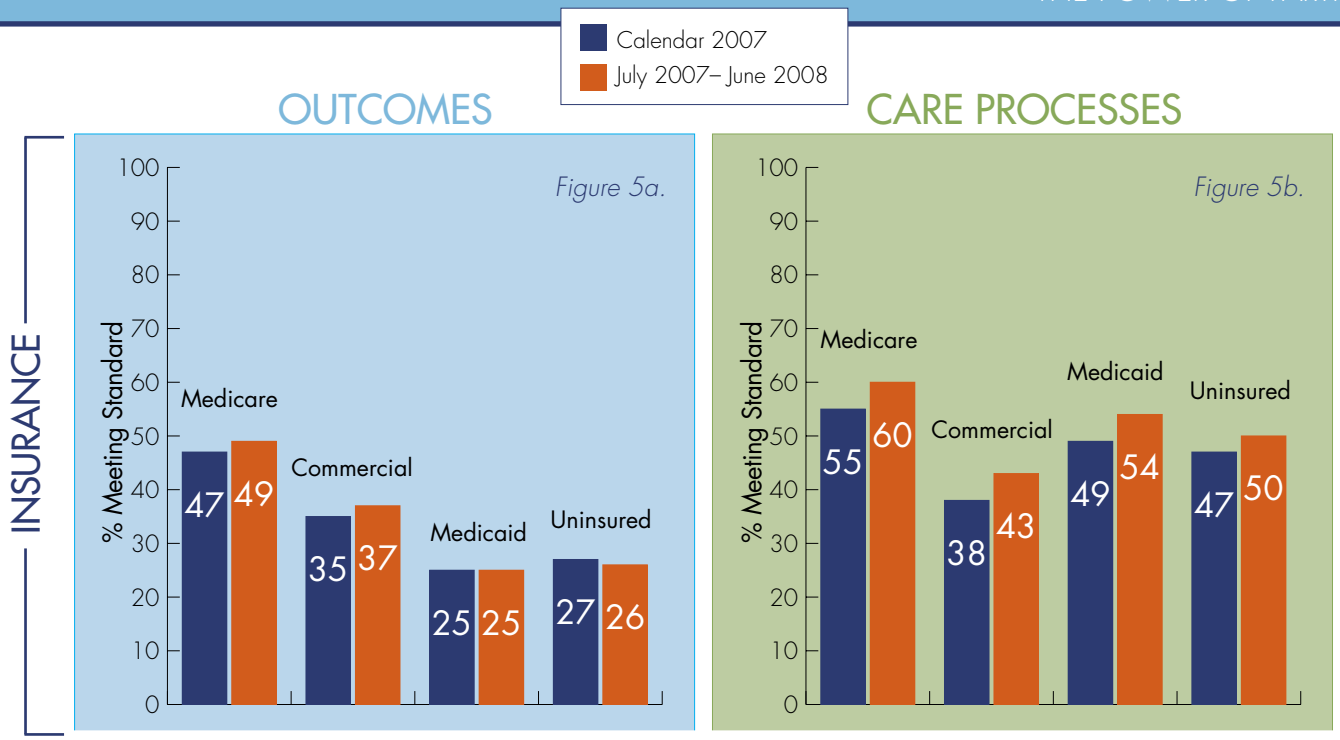


Figure 4b.





Persisting Disparities

In contrast to these overall improvements, practices and patients with fewer resources continue to have poorer performance than those with more resources (Figures 2-5). Practice sites with paper-based medical records document and facilitate clinical support of their patients less well than sites with EMRs. Traditionally defined minority patients (mostly African-American and Hispanic) have lower Outcome achievement, as do those with lower household incomes and educational attainment. Perhaps most strikingly, uninsured patients and those covered by Medicaid continue to have lower scores on our composite Outcome Standard and show virtually no improvement in outcomes in the current report (Figure 5).

Opportunities to Identify and Accelerate Region-wide Improvement

Better Health's philosophy is to provide transparency and promote continuous improvement in care and outcomes. We deliberately avoid comparisons among health care organizations or practice sites that invite broad judgments about quality, because our initiative currently is based on relatively narrowly defined clinical problems and measures. Nonetheless, the richness of our data permits us to identify practice sites or systems that are *Exceptional Achievers* or *Exceptional Improvers* over successive measurement periods. By committing both to transparency and continuous improvement, we can foster sharing of "best practices" with others, asking, in effect, "How did you do this?" To the extent that best practices are replicable, we intend to accelerate improvement throughout the region, resulting in Better Health and a *Greater* Cleveland.

Antonia and Justino, who both have diabetes, go together to their visits with Dr. Ann Reichsman, third from left. With guidance and a careful eye on their test measures, their diabetes is better controlled. Better health has meant more energy for their grandchildren.

System A solved the problem: it changed the way it identified patients who needed a vaccine and the process for administering it.

Figures 6 and 7 highlight two means by which our data can accelerate region-wide improvement. Figure 6 shows pneumococcal vaccination rates at 35 practices in the current report that vary from 0% to 92% across sites. Among the top 10 practices, nine are part of the same health care organization (labeled "A" in the figure). Clearly, system "A" has figured out something that the others have not. To the extent that the solution is shared and can be replicated, future Checkups should show substantial region-wide improvements in vaccination rates.

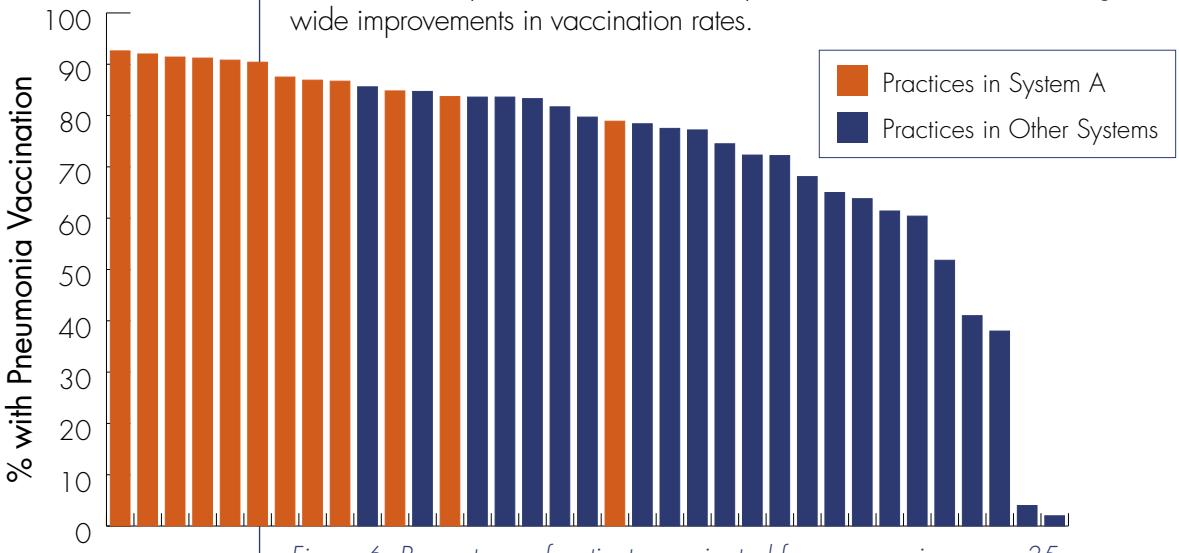


Figure 6. Percentage of patients vaccinated for pneumonia across 35 practice sites in the current reporting period (July 1, 2007 – June 30, 2008)

Three practices show exceptional improvement in both outcomes and processes standards.

Figure 7 describes site-level *changes* in the current measurement period as compared to the first Checkup report on achievement in the composite Process and Outcome Standards. Collectively, 33 practices provided data for both periods. Sites in the right upper (or "northeast") corner (21 of 33) improved in both composite Outcome and Process Standards, including 3 with *Exceptional Improvement* on both standards (highlighted).

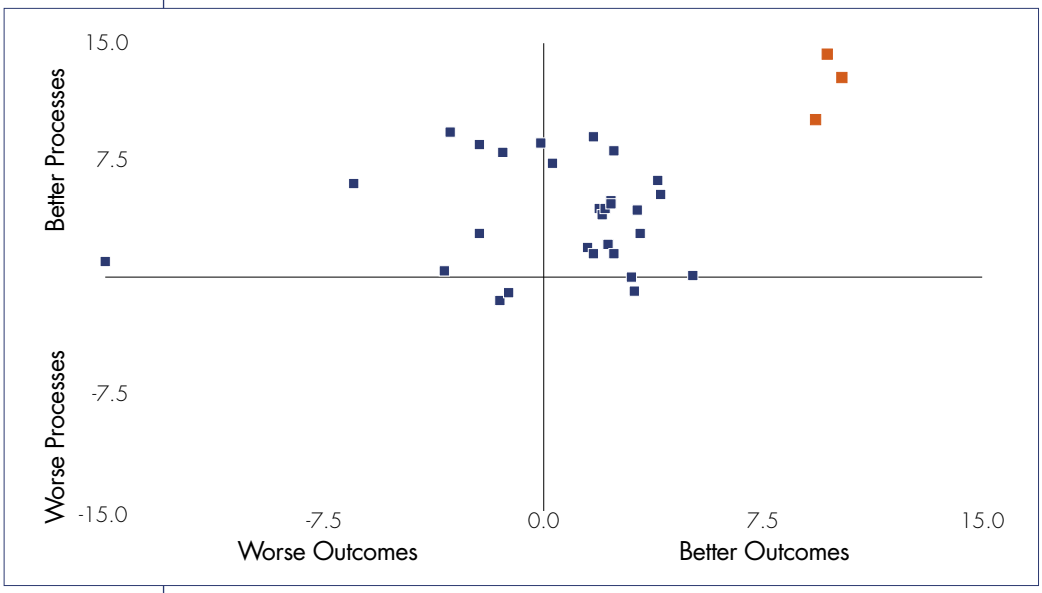


Figure 7. Percentage changes in achievement on composite standards for outcomes and care processes

Sites in the southwest corner (2 of 33) had slight declines in achievement for both composite standards; sites in the northwest corner (8 of 33) improved process scores but declined in outcome achievement; and, sites in the southeast corner (1 of 33) improved in outcomes but declined in achievement of their care processes. The graph suggests two types of opportunities for accelerating region-wide improvement. First, all practices – especially those with less desirable changes – can identify their greatest opportunities for improvement. Second, by identifying and engaging our *Exceptional Improvers* to share with other practices what they have done, all practice sites and their patients stand to benefit.

Challenges to Greater Cleveland: Other National Comparisons

Greater Cleveland's care is under the national quality-of-care microscope as one of 14 health care markets supported in Robert Wood Johnson Foundation's *Aligning Forces for Quality* initiative. In particular, data relevant to important diabetes outcomes have been assembled and published by faculty of the Dartmouth Atlas Project, a long-standing and highly visible initiative that examines variations in care and health outcomes among regions across the United States. Figures 8 and 9 summarize two analyses that pose challenges to Better Health and to Greater Cleveland more generally. Both examine outcomes among Medicare beneficiaries across the 14 Aligning Forces market areas.

Figure 8 displays rates of hospital admissions for "ambulatory-care sensitive" conditions, also considered "preventable" hospitalizations. Among such conditions, diabetes is one of the most prevalent. The message is clear: Greater Cleveland has much room to improve.

"In chronic conditions such as diabetes, it's a lifetime commitment. It's a commitment not only by patients, but by physicians as well, to work together to improve their health."

— Dr. E. Harry Walker
MetroHealth

Laura has a simple slogan when it comes to dealing with her diabetes: Knowledge is Power.

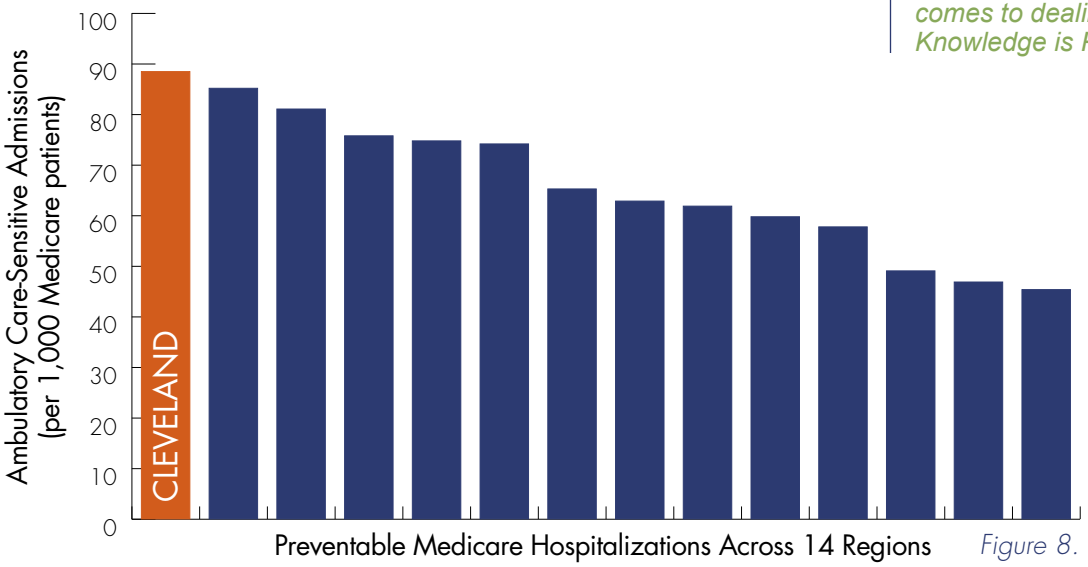
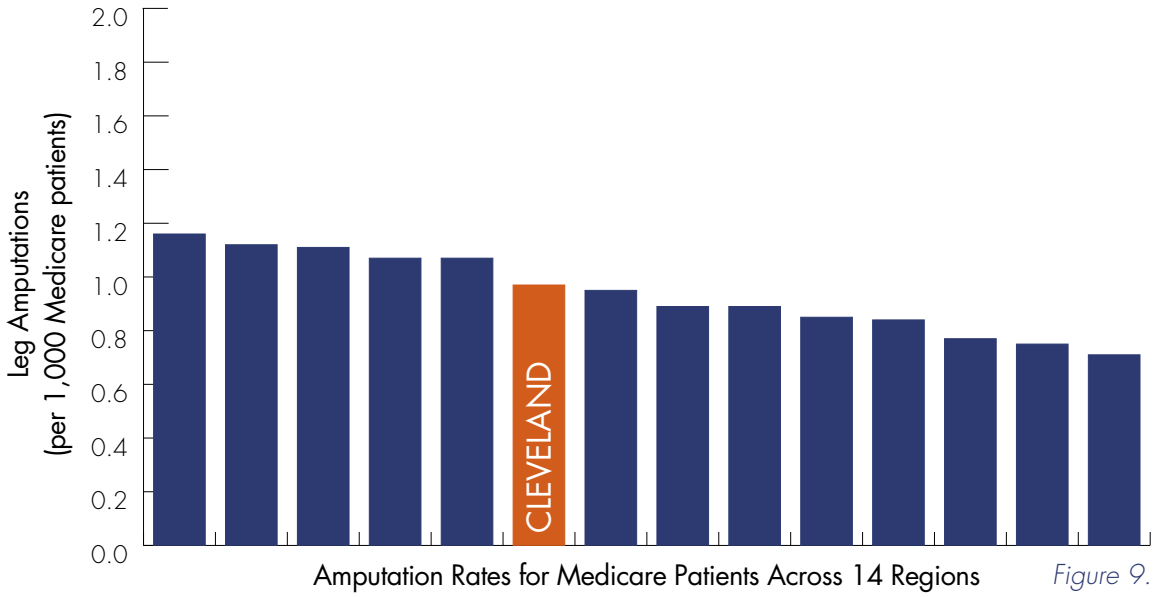


Figure 8.

Figure 9 displays rates of leg amputations among Medicare beneficiaries across the 14 communities. Poorly controlled diabetes is the most common cause of leg amputations among adults in the United States. Again, the message is clear: Far from being "best in class," Greater Cleveland can do better. In addition to improving lives by improving diabetes care, doing better would save money – in this case, for taxpayers who paid the bill through Medicare. While we have no evidence that these same results apply to our patients without insurance, or to those covered by Medicaid or Commercial insurers, we have no reason to believe otherwise. Indeed, the data provided in this Checkup suggest that patients with Medicare do better than those with other insurance.



Amputation Rates for Medicare Patients Across 14 Regions *Figure 9.*

Roberta knows how to take her medications and what each one is for. She knows her health goals and what she must do to avoid serious complications.

Other Ongoing Efforts

This Checkup highlights achievements of our health care partners in the care and outcomes of their patients with diabetes. Public reporting on diabetes begins to address a problem of enormous clinical, cost and public health concern. Better Health also has begun to tackle other clinical conditions and hospital-centered quality measures. Related initiatives focus on *measurement, region-wide quality improvement aimed at health professionals and engaging and enabling patients and the public to partner with us for better care.* While each of these initiatives stands to contribute to better health care, together they offer the framework necessary for momentous change.

As we proceed, our efforts in measurement and public reporting will include achievement measures for outpatients with heart failure. Hospital measures will focus on improving patients' satisfaction with what happens when they are discharged from the hospital, as we simultaneously work to bridge gaps in the transition that too often require patients to be re-admitted. One clear objective is to reduce re-admission rates for patients with cardiovascular disease. Ten hospitals in the region are participating in this effort, which largely is directed by nurse leaders and coordinated through Better Health's partnership with the Center for Health Affairs.

Region-wide initiatives focused on physicians' use of our achievement data to motivate improvements across our partner practices. The quality improvement initatives capitalize on strong quality improvement leadership at the Louis Stokes Cleveland VA hospital and at Case Western Reserve University.

Our efforts to engage patients and the public currently take several forms, including a web site, www.betterhealthcleveland.org, and a poster campaign for physicians' offices that features some of our patients who have taken control of their diabetes. Our partnership with Netwellness.org, an objective source for consumer health information, provides a proven path to trustworthy information.

Our founding partners — The MetroHealth System, Health Action Council Ohio and the Center for Community Solutions – continue to provide the support and insight that has strengthened our alliance. As it grows stronger, so, too, do our ties to national quality improvement organizations such as *Bridges to Excellence* and the *National Quality Forum*.

"The most exciting development in health care today is people with chronic diseases partnering with their provider, reviewing their numbers and working out a plan for successful management of their conditions. Everyone can benefit from having access to the data that drives change."

— Dr. Ann Reichsman
Neighborhood Family Practice

"One of the challenges of quality improvement is to make sure you're meeting standards with your patient, while at the same time addressing the things that the patient feels are important. Another challenge is to help your patients understand why these measures are important."

— Dr. James Gutierrez
Cleveland Clinic

Lily finds power in knowing that diabetes is a health problem she can do something about. She watches her diet and looks for new, healthy foods to eat.

Comments

The publication of our second Community Health Checkup falls on the second anniversary of Better Health *Greater* Cleveland, in the midst of a dramatic global economic crisis. It also is a time of hopeful national transitions. The improvements we have seen in our brief existence prompt us to consider how our alliance can have even greater impact on the health of our community and its economic well-being. If we measure and report diabetes outcomes such as blindness, amputation and kidney failure – which have tremendous costs for our patients, purchasers and community – could we find the paths needed to reduce them? Our current practice partners represent only about 40% of the primary care physicians in Cuyahoga County. If we expand our reach to include other groups, could we more effectively "move the metrics" for the region and also improve the care of individual patients? Each opportunity comes with its own challenges. Most of the practices that are not currently in the partnership – especially smaller practices that are not aligned with large health care systems – lack the resources to implement EMR systems. Measuring and improving true outcomes, such as amputation rates, requires finding a way for health providers to share information about the patients we have in common. These are difficult challenges to overcome. As a community, we have much to gain by trying.

Creative solutions are especially important to maintain and improve health outcomes for those in our community who are disadvantaged. Safety net practices in Better Health are developing strategies to motivate and facilitate better self-care by their patients. As job losses cause more people to be uninsured, other regional stakeholders, including government and other payers, also can help. Regional models, such as the "patient-centered medical homes" in San Francisco and other markets, are being tested to improve access and quality of care for their residents without health insurance while reducing costs. New federal and state-level initiatives are likely to support similar efforts. Federal initiatives in health reform will likely include significant new investments in health information technology and incentives for data-sharing that will improve the safety and quality of patient care. In Greater Cleveland, United Way funding is supporting OneCommunity, an international leader in broadband health networking services, to find EMR and connectivity solutions for our paper-based Federally Qualified Health Centers.

Better Health *Greater* Cleveland is committed to improving the care and outcomes of all people in our region with chronic conditions and to eliminating disparities in health among disadvantaged populations. Along with our partner organizations, we have opened a window to the information that patients, purchasers and health care providers need in order to make change. With focus, collaboration and creativity, we are confident that many solutions are within our grasp. To learn more about our progress and about how you can get involved, we invite you to visit us at www.betterhealthcleveland.org.

The full report of the second Community Health Checkup on Diabetes is posted at www.betterhealthcleveland.org. Also available is the first Checkup, which was published in June, 2008.

Visit our web site to learn more about Better Health *Greater* Cleveland and our partners. Watch videos of physicians and patients. Read patients' stories. Learn how others are playing their part for better health, and find resources. And get involved.

We all have a role to play in a healthier Greater Cleveland.

Visit www.betterhealthcleveland.org today.

Everyone has a role to play for better health.

Patients can demand better care, ask good questions and recognize that their active engagement is vital to their health.

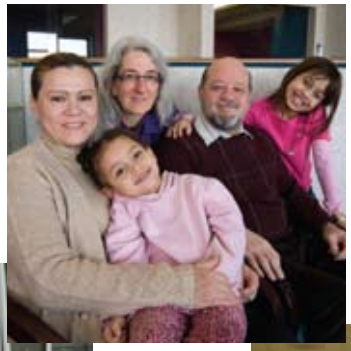
Public health officials and policy makers can advocate for patient-centered resources that otherwise limit what the patient and her doctor can achieve.

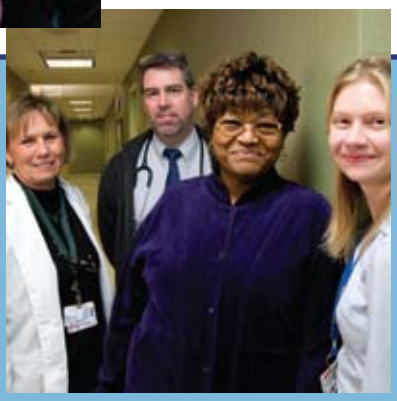
Physicians can partner with their patients, and their practices can identify and share "best practices," design systems that make the right decisions the easiest ones to make, and develop ways to help their patients help themselves.

Employers and health plans can align with patients and providers to prevent and effectively manage chronic conditions – as an investment in their bottom lines and in the health of the community.

Larry and Dawn know that getting the health care they deserve can be as easy as...asking.

THE POWER OF PARTNERSHIP





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FOUNDING PARTNERS

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An Alliance for Improved Health Care

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