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

Better Health *Greater* Cleveland
The Power of Partnership

EXECUTIVE SUMMARY, 8TH REPORT

WINTER 2012

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

Our twice yearly report offers an opportunity to reflect on *Better Health's* accomplishments over the past six months. "The Power of Partnership" is an apt theme for this eighth Community Health Checkup and the increasing value to our region that it represents.

Our value has been created mostly by *Better Health's* intrepid clinical partners, who accept public accountability for their achievement across widely disparate populations and resources for their care. By sharing best practices, we have helped those with the least resources as well as those with the most. Most visibly during the past six months, we have been assisting paper records-based health care organizations in their transition to becoming meaningful users of electronic health records.

As we establish more audacious goals and welcome new clinical partners, we also have strengthened our relationships with employers and health insurers in the region. We worked together in efforts to establish northeast Ohio as a favored site to be selected for the federal CMS Innovation Center's Comprehensive Primary Care Initiative grant opportunity. While a statistical long-shot for funding, the endeavor was recognized in a *Plain Dealer* editorial and an employer-led opinion article in *Crain's Cleveland Business*. Both highlighted the theme that we have to be "all-in-to-win," and regardless of the outcome, we have been delighted by the shared vision they represent and the groundwork they have laid.

This past fall, *Better Health* convened three region-wide summits and multiple stakeholders to consider these themes, including two that brought national leaders to northeast Ohio to assist our primary care and hospital partners improve their patients' transitions of care.

Our September article in the *New England Journal of Medicine* about the power of EHRs to improve quality of care garnered national attention from prominent media. It also prompted a November visit from Dr. Farzad Mostashari, the National Coordinator for Health Information Technology, and Kathleen Sebelius, U.S. Secretary of Health and Human Services. We were pleased that the director of the Agency for Healthcare Research and Quality, Dr. Carolyn Clancy, fittingly credited our findings as a reflection on both the power of EHRs and the value of health improvement collaboratives like ours as a testing ground for innovation in health care delivery and payment reform.

During the past six months, I frequently have heard the expression that keeping up with recent federal funding opportunities for health care delivery and payment change is akin to "drinking from a fire hose." I believe that we are well-prepared for these opportunities, and I am grateful to our partners for stepping up to the challenges they present.

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

INTRODUCTION

Better Health *Greater* Cleveland marks its fifth anniversary with the publication of this Community Health Checkup report, our eighth, and wraps up an eventful year. We've made great strides in engaging new partners, pursuing new opportunities that demonstrate the value of our alliance, and won national acclaim for a report in the *New England Journal of Medicine* that documented better outcomes and faster improvement for our patients with diabetes who are seen in medical practices that use electronic health records.

The theme of this Checkup is the "Power of Partnership," which we chose for three reasons: First, our growing collaborative continues to gain strength in numbers and scope. Second, because federal and national initiatives increasingly recognize the interdependence of health care stakeholders and have begun to *require* collaboration on programs that target improved health and lower cost. And, perhaps most importantly, because much of the power to create a health care delivery system that keeps people healthy and effectively treats them when they get sick resides with those who pay for it. The time is right for those who pay the health care bills to tap the value of the partnerships that *Better Health* has built.

Tim Kowalski, M.D., Chief Medical Officer at Progressive Insurance and president of Health Action Council's Quality Forum, put it this way in a January 9 Crain's Cleveland Business column: Despite a decades-long history of employer attempts to curb costs, "we have continued to pay for volume rather than value — something we typically avoid in other facets of our businesses. Rarely have we joined forces to use our purchasing weight to impact a single health care market."
(http://tinyurl.com/Crains-Kowalski)

We begin our alliance's sixth year at a time of great transition for all stakeholders in the health of our region. As we pause to recognize our successes and new challenges, we are confident that our collaborative has the foundation, the ability and the will to take even greater leaps toward our collective vision for making the region a healthier place to live and a better place to do business.

"THE CLEVELAND EXPERIMENT" WITH ELECTRONIC HEALTH RECORDS

Recent federal and private initiatives make clear that the path to true value for health care – an outcome that speaks to both higher quality *and* lower cost – requires coordinated pursuit of the interdependent goals of care, health and cost. Donald M. Berwick, M.D., the recently departed administrator of the Centers for Medicare and Medicaid Services (CMS), calls this the "Triple Aim."

It's no accident that health information technology is widely viewed as a foundational tool to achieve the Triple Aim. Electronic health record (EHR) systems provide the means to identify groups of patients with similar conditions and characteristics, such as patients with diabetes whose blood sugar needs to be controlled better. They allow health professionals to tailor care for an individual based both on what's important to the patient and the best available medical evidence. For example, the EHR can remind a provider to prescribe appropriate, low-cost medications to

"Businesses that produce paint or provide legal services never planned to be at the nexus of efforts to fix a health care system in need of a makeover. But as employers, that's where we find ourselves. As the biggest purchasers of private health insurance, we've got a big stake in making health care work like we all want it to."

— Tim Kowalski, MD
Chief Medial Officer, Progressive Insurance
President, Health Action Council Quality Forum
in *Crain's Cleveland Business*

Better Health in June kicked off its initiative to redesign health care delivery and payment, bringing together employers, health insurers and providers at the City Club of Cleveland.

James Misak, MD, shows Farzad Mostashari, MD, the patient care plan MetroHealth uses in its Patient Centered Medical Home for uninsured patients. The National Coordinator for Health IT accompanied U.S. Secretary Kathleen Sebelius to Cleveland in November.

delay complications of kidney disease for a patient with diabetes. And they make possible the coordination of care that a patient receives across health care systems, such as the results of tests done elsewhere that can inform decision-making and help to avoid expensive redundancy.

We continue to harness the power of clinical data from our partners' EHR systems to highlight continuing improvement of our clinical partners and their patients with diabetes, heart failure and high blood pressure, as we share later in this Checkup report. And we are pleased that both our data and our collaboration have contributed to the knowledge base about the effect of EHRs on patient outcomes.

In an article published in the *New England Journal of Medicine* this past September, *Better Health* data demonstrated that adults with diabetes in practice sites using EHRs were significantly more likely to have health care and outcomes meeting accepted standards than those whose providers rely on traditional paper records. Moreover, improvements in care and outcomes over a three-year period also were greater among patients in EHR practices. The findings held for patients regardless of what kind of health insurance they had or whether they had insurance at all as seen below in Figure 1.

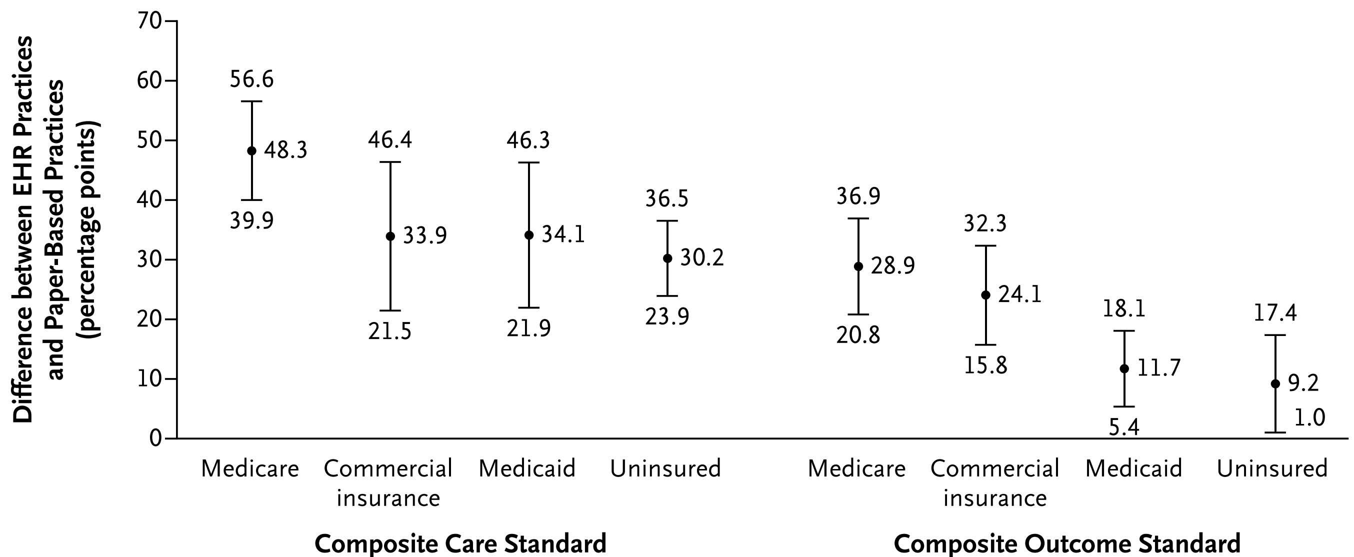


Figure 1. The difference between achievement of diabetic patients in EHR practices and those in paper-based practices, with 95% confidence intervals. Patients of all payer types benefit.

Source: Cebul RD Love TE Jain AK Hebert C Electronic Health Records and Quality of Diabetes Care *New England J of Medicine* 365: 825-833, September 1 2011.

The paper also noted that the differences in quality were found in the special context of a regional quality improvement collaborative – *Better Health* – where clinical partners choose to collaborate, to measure and publicly report their performance and to share strategies and best practices. *Better Health*'s contribution to the published results were reflected by comments of Carolyn M. Clancy, M.D., director of the federal Agency for Healthcare Research & Quality, who said: "The results of this study support both the value of electronic health records and community-based partnerships to improve quality of care."

Better Health's NEJM study was widely covered by national media, including the popular Health Care Blog, which called the findings the result of the "Cleveland Experiment," and noted that it could become "a seminal piece" in supporting federal efforts to drive change in health care. Kathleen Sebelius, U.S. Secretary for Health and Human Services, referred to it as a "landmark" study in a late November visit to Cleveland. Dr. Farzad Mostashari, the National Coordinator for Health Information Technology, who accompanied the Secretary on the trip, dedicated the morning of his visit at MetroHealth's Broadway clinic, learning how its providers use EHRs in a Patient Centered Medical Home program for its uninsured patients.

"It's (health information technology) becoming the most common and sound decision that physicians can make for the good of their practice, their patients and their bottom line."

— HHS Secretary Kathleen Sebelius, on a panel with Dr. Cebul, during a November visit to Cleveland.

Growing capabilities of EHR systems are beginning to facilitate exchange of health information across different health care organizations in "real time;" other capabilities are enabling patients to track their results and communicate with their providers through electronic "personal health records" that are linked to their physicians' EHRs. As these EHR capabilities expand and best practices in their use are shared, *Better Health* expects to be able to demonstrate improved patient experiences and reductions in the wasteful duplication of services. These additional values to the use of EHRs – for both patients and payers for health care – will serve as the next chapter in The Cleveland Experiment.

TRANSITIONING TO ELECTRONIC HEALTH RECORDS – WHAT WE'RE LEARNING

When *Better Health* began in 2007 to measure our clinical partners' achievement on national standards of care, several of our partners, including the three Federally Qualified Health Centers in Cuyahoga County, were still using traditional paper records. Over the last two years, they have adopted EHRs – an endeavor that's challenging for everyone in a medical practice. Practices face issues of manually transferring their patients' medical history from their paper records into the EHR and putting information in the right place so that it can be accessed for each patient. They must train everyone how to use the EHR and adapt workflows to accommodate the technology. For a time, productivity predictably slows, and documentation of past medical care may be inaccessible electronically either because it continues to reside in the old charts or cannot easily be retrieved in the new system. In one practice that made the transition, as seen in Figure 2, modest gains were documented in diabetes care between 2007 and 2009, when EHR replaced paper records, and then took a dramatic dip. The practice's achievement reached new heights in the current period, however, as its patients' EHRs became more complete and better represented current care. Lessons that we're learning about the transition process to EHR, and how to best minimize losses in productivity, are being shared through the *Better Health* partnership.

"Quality improvement in health care results from a constant conversation between 'What Is' and 'What Could Be Better,' said Walter Clark, M.D., Medical Director of Northeast Ohio Neighborhood Health Services (NEON). "With increasing access to EHR data and decision-support tools, our clinical teams have been able to participate more fully in that conversation."

Lows, then Highs, in Transition to EHR

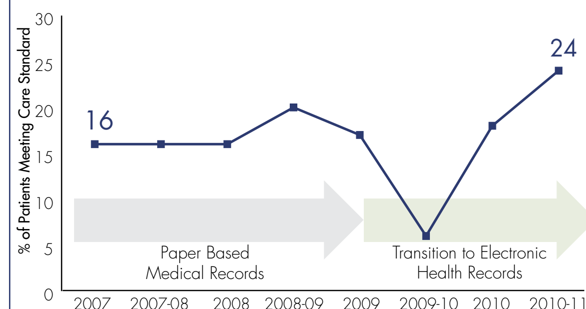
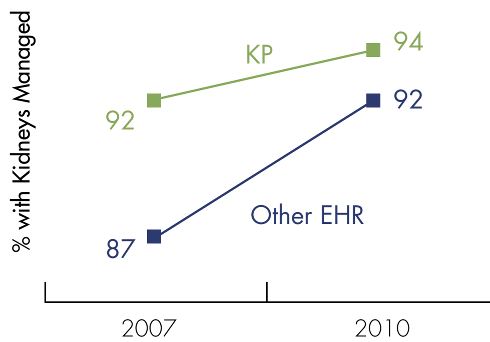
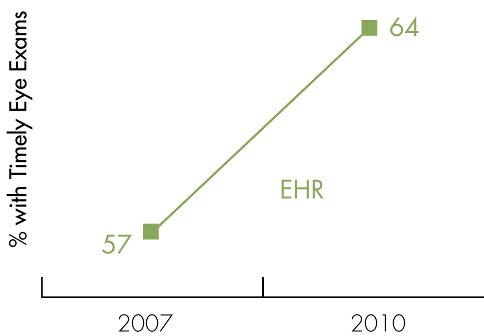


Figure 2. Achievement of Diabetes Care Composite Standard, 2007-present, for a practice that is now in the late stages of their transition from a paper to an electronic health record system.

Finding Bright Spots, Sharing Best Practices and Spreading Improvement





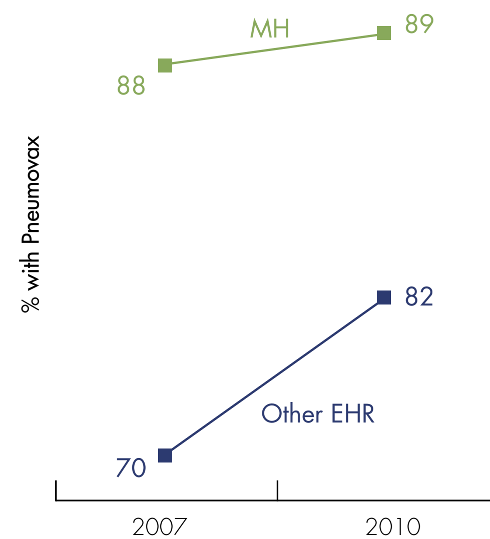


Figure 3. Improvement on Diabetes Care Standards associated with Replicable Best Practices.

SHARING BEST PRACTICES TO ACCELERATE IMPROVEMENT

A common vision and our sharing of experiences across sometimes competing health care organizations are key to the power of partnership. *Better Health* regularly uses data to identify and share "bright spots" – potentially **Replicable Best Practices** (RBPs) – with our partners, frequently highlighting those enabled by EHRs. Over our first few reports, we found and disseminated potential RBPs for three diabetes care standards. Achievement and improvement of these standards have been tracked over time in Figure 3. Continuing progress requires cross-system data-sharing and continued commitment by our partners to improve on our common standards.

Kaiser Permanente had the top eight practices in an early report for our kidney management (urine microalbumin or ACE/ARB prescription) standard. This remarkable achievement was traced to Kaiser's adoption of a provider-based mnemonic and EHR-catalyzed outreach to patients in need of treatment or testing. After sharing its RBP, Kaiser's results remained high, while the other two large EHR-based systems improved from 87% to 92% (Figure 3, top). For eye examinations, a potential RBP was identified among practices that actively used their EHR's "Health Maintenance" field. Regional achievement has subsequently improved from 57% to 64% (Figure 3, middle). Finally, several past Checkups highlighted the MetroHealth System's approach to improving its rates of pneumococcal vaccinations, including the establishment of standing orders and a special EHR-fueled protocol for practices to efficiently identify patients and administer vaccines. After dissemination of this approach, Metro's achievement remains high at 89%, while the other systems have improved from 70% to 82% (Figure 3, bottom).

PATIENT CENTERED MEDICAL HOME – THE FACE OF DELIVERY SYSTEM AND PAYMENT REFORM

The pace of change in health care delivery is quickening, and patient-focused primary care is at the center. As a result of increased focus on patient-centered *value* and game-changing initiatives of CMS and its Innovation Center that support the Patient Centered Medical Home (PCMH) model, health care purchasers, payers and providers are moving rapidly to redesign care and payment systems to achieve better outcomes and lower costs.

In Ohio, 74 practices have received Level 3 PCMH recognition by the National Committee for Quality Assurance (NCQA), and 15 of them, or 20%, are in Northeast Ohio. But 42% of Ohio physicians who work in PCMH-recognized reside in Greater Cleveland, where collaborative efforts to build a multi-payer PCMH program are logging strong progress.

A unique grant opportunity from the CMS Innovation Center, called the Comprehensive Primary Care initiative, was announced in late September that would bring together both public and private payers to transform care delivery in the PCMH model and reward both quality improvement and cost savings. Health insurers were eligible to apply, and five to seven regions in the nation that demonstrate high EHR adoption, commitment to PCMH, and, most importantly, active involvement of a high proportion of non-public payers, will be supported. *Better Health* played a convening role in coordinating health plans, encouraging them to apply and to select Northeast Ohio as a region in which they would

invest. We provided information to help plans strengthen their applications, and received a boost from an editorial in *The Plain Dealer* championing participation in the opportunity for Northeast Ohio (http://tinyurl.com/PlainDealerEditorial). Employers also were encouraged by Health Action Council Ohio to reach out to their insurers in an Op-Ed piece in Crain's Cleveland Business (http://tinyurl.com/Crains-Kowalski). While competition is fierce for the handful of regions that will be selected nationally, we are pleased that Northeast Ohio is a contender. Regardless of the outcome, our efforts have strengthened partnerships that can take us closer to building multi-payer support for PCMH, an initiative that we formally launched in June 2011.

At a June 30 meeting at Cleveland's City Club, Harold D. Miller, a national expert in health care payment change, introduced key features and applications of emerging payment mechanisms that could drive improvements in health care delivery and provide better value to those who pay for and receive care. On October 11, Miller returned to facilitate an all-day meeting designed to build consensus on principles that might be applied in Northeast Ohio. At multi-stakeholder sessions, participants rolled up their sleeves to begin the hard work of payment design in support of PCMH. At the end of the day, workgroups were formed to continue the work, including one that collaborated on the CMS innovations grant. Others will focus on value-based health care benefits design and on the difficult transitions for hospitals as care shifts increasingly to the outpatient setting and incentives become better aligned to foster health and prevent or more effectively manage chronic disease.

STEPS TO MEASURE AND IMPROVE THE PATIENT EXPERIENCE OF THEIR CARE

Another recent *Better Health* initiative takes aim at measuring and improving patients' experience, a guiding principle in the PCMH model. *Better Health* is leading a regional effort for partner practices to adopt a common, nationally endorsed survey to measure and improve the patient experience. In September, Dale Shaller, a national expert in the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey for patients' experience in ambulatory care, led a meeting to describe the survey and the value to the community for all our clinical partners to use the same metrics. Items within the CAHPS survey instruments can be used to create measures of patients' perceptions of access to care, including obtaining timely appointments, how well doctors communicate, and the courtesy and helpfulness of office staff.

Aleece Caron, Ph.D., a member of *Better Health's* practice coaching staff, is leading this community-wide effort, assisting practices in their development of survey protocols, coordinating with survey vendors, and consulting with Shaller. Particular interest lies in the PCMH version of the CAHPS survey, use of which by PCMH practices that have earned NCQA recognition will win an added "distinction in patient experience reporting." Provider partners have jumped in to implement CAHPS surveys. All clinical partners have agreed to field the PCMH version of the survey at the same time each year.

"We've been doing lots of stuff on things that will have long-term returns, but we've got to start figuring out some ways to start saving money now, which is what employers and health plans are looking for. And you have to have more value-driven health delivery systems built on a foundation of strong physicians and particularly strong primary care practices."

— Harold D. Miller, president and CEO of the Network for Regional Healthcare Improvement and Executive Director of the Center for Healthcare Quality & Payment Reform.

Eric A. Coleman, MD, MPH, Director of the Care Transitions Program at University of Colorado at Denver, visited Cleveland Nov. 2.

Room for Improvement: Too Many Patients Hospitalized with Heart Failure Return to Hospital Within 30 days.

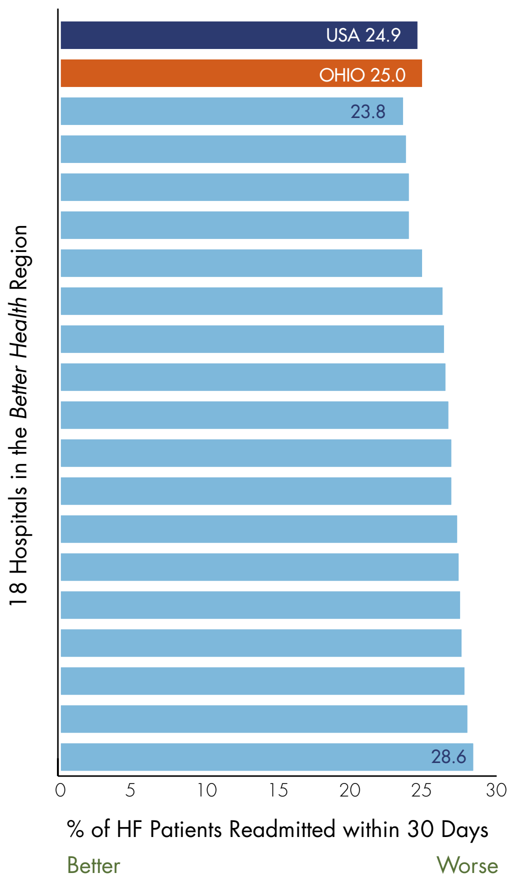


Figure 4. 30-Day Heart Failure Re-hospitalization Rates, as reported on October 11 by *Hospital Compare*. See betterhealthcleveland.org.

IMPROVING VALUE THROUGH PARTNERSHIPS WITH HOSPITALS AND OTHER COMMUNITY-BASED PROVIDERS

As we described in our discussion of "The Cleveland Experiment," we believe that exchanging health information across health care systems in "real time" not only will help physicians better coordinate their patients' care, but also will immediately reduce wasteful duplication of laboratory tests, X-rays and other expensive resources. Even greater opportunities for long-term cost savings – for patients and their payers – will come with better care and care coordination that results in fewer hospitalizations and re-hospitalizations. Diabetes, high blood pressure, and heart failure – the conditions targeted by our clinical partners for improvement – are considered *"ambulatory care sensitive conditions,"* because with better coordination and care, costly hospital use should decline.

Reducing avoidable hospitalizations and re-hospitalizations are goals that are both hard to achieve and complicated to measure, for several reasons, including misaligned incentives and the fragmented and complex nature of the health care system. While our primary care partners take accountability for better outcomes for their patients, we also recognize and have begun to draw other important players into our alliance – including health insurers, hospitals, skilled nursing facilities, hospice agencies, and other providers of care in the home.

To date, measurement of these metrics relies heavily on public sector (Medicare and Medicaid) insurance claims, and they show us that our region has a long way to go. Among Ohio's 88 counties, Cuyahoga ranks worst for avoidable hospitalizations and related costs for long-term complications in diabetes patients insured by Ohio Medicaid. At the hospital level, the federal government maintains current risk-adjusted re-hospitalization rates for heart failure, which are posted on *Better Health's* website. These data (Figure 4) show that our hospitals' rates are both quite variable and often worse than the national average – over one in four of our region's patients hospitalized for heart failure are re-hospitalized within 30 days. We know that hospitals alone, even with committed primary care providers, cannot eliminate these potentially avoidable events.

To address these complicated problems, *Better Health*, along with our partners at the Center for Health Affairs, engaged 10 of the region's hospitals in a nationwide collaborative sponsored by the Robert Wood Johnson Foundation to reduce re-hospitalizations. Last fall, we convened two conferences featuring national leaders in the development of evidence-based interventions to improved care transitions. Each conference included more than 200 participants representing health plans, hospitals and "hospitalists," primary care, skilled nursing facilities, and home health and hospice agencies. Nearly 100 attendees volunteered to participate in workgroups around transitions issues, overseen by a multi-stakeholder Steering Committee that began its work in January. While we recognize that the path ahead represents a team-based marathon, we believe that *Better Health* has assembled most, if not all, of the necessary teammates.

USING GEO-CODING TO LEARN ABOUT OUR PATIENTS' ENVIRONMENT

Better Health has regularly presented results on patient groups defined by the educational and income characteristics of the neighborhoods in which they live. These groups are developed through a two-step process that assigns census-related attributes to our patients. First, patient addresses are geo-coded to link that address to a particular neighborhood (either zip code, census tract or census block.) Then, using data from the 2005-2009 American Community Survey, we apply the neighborhood median family income and high school graduation rate to each patient with an address in that neighborhood, plus or minus a small amount of random noise, to maintain confidentiality of the patient's address. Figure 5 shows that the estimated median income for diabetes patients in one of our partner practices is $28,000, while the median in another practice is $79,000. The regional average for diabetes patients across all of our partner practices is just over $48,000.

Patients of *Better Health* Practices Span Economic Spectrum

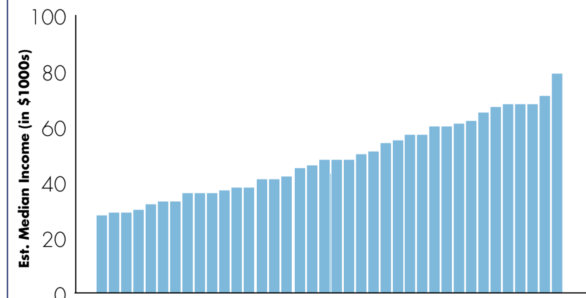


Figure 5. Estimated median income across diabetes patients, in thousands of dollars, via the American Community Survey. Each bar represents patients in one of our partner practices.

Across the region, we place patients in one of three categories according to income and to education level based on these geo-coded results. These groupings allow us to make interesting connections between achievement on our clinical measurement standards and the environment in which our patients live, work and receive their care. Figure 6 shows a strong relationship between socio-economic status (in terms of either neighborhood income or education) and smoking in our diabetes patients. Specifically, patients living in neighborhoods with lower income and education levels are more likely to smoke than those in higher income or education neighborhoods.

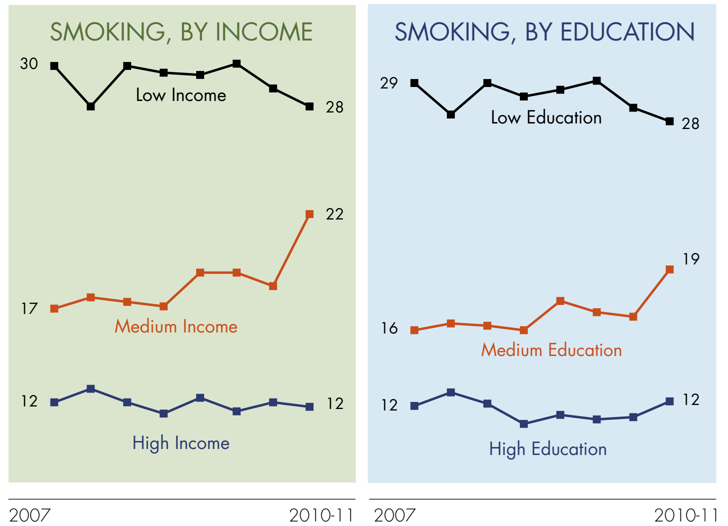


Figure 6. Percentage of Diabetes Patients Who Smoke, 2007-present, across income and education categories.

Figure 7, pertaining to obesity, shows an interesting pattern over time. Nearly two-thirds of diabetes patients across the region are obese (have a body mass index of 30 or higher.) However, these obesity rates (while still very high) have dropped a bit in recent reports, particularly among patients living in higher income and higher education neighborhoods. Note that the cut-offs we have established to specify low, middle and high education and income groups are designed to divide the population of our region into groups of roughly equal size (over 9,000 patients each).

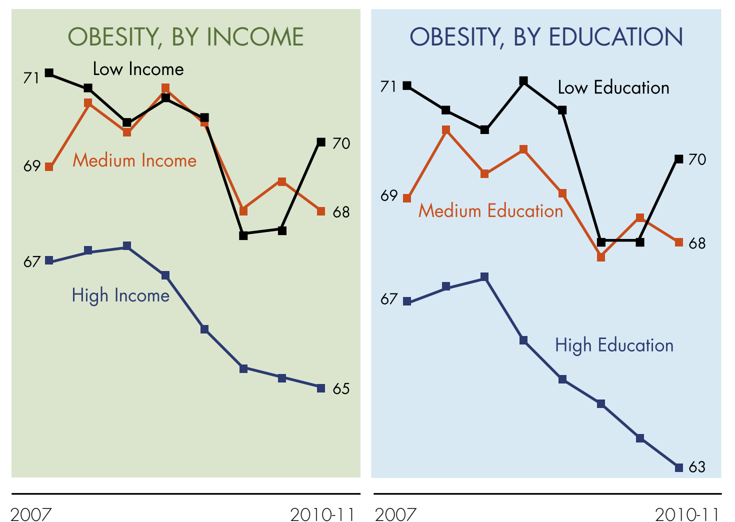


Figure 7. Percentage of Diabetes Patients Who Are Obese (BMI ≥ 30), 2007-present, across income and education categories.

Chronic Disease Among Patients in This Report

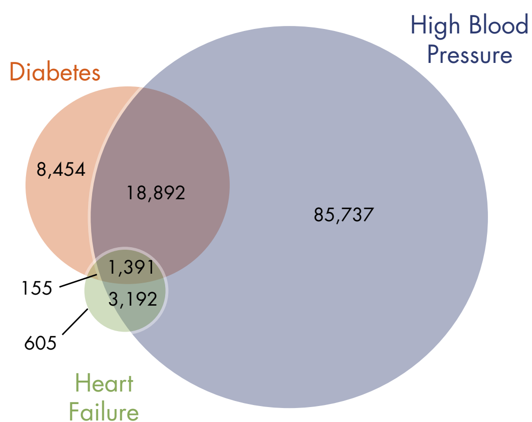


Figure 8. In this report, we describe the health and health care of 118,426 Northeast Ohio residents living with chronic disease every day (up from just over 115,000 one year ago.) More than 109,000 have high blood pressure, nearly 29,000 have diabetes, and more than 5,000 have heart failure, while nearly 1,400 patients are living with all three conditions.

OUR PARTNER PRACTICES, PROVIDERS AND PATIENTS

This eighth *Better Health* Community Health Checkup represents a diverse mix of 48 primary care practices within eight health care systems, including more than 450 different providers (Table 1). As in previous reports, these include the practices of three large health systems with electronic health records (Cleveland Clinic, Kaiser Permanente – Ohio, and the MetroHealth System), as well as five systems in various stages of transition from paper to electronic health records (Care Alliance, NEON, Neighborhood Family Practice, University Hospitals Family Medicine, and North Coast Health Ministry). All systems report on our measures for diabetes and high blood pressure, while our established EHR systems also report on their patients with heart failure. Detailed results by site for all three conditions appear at betterhealthcleveland.org.

The number of practices that measure and report on our common measures soon will grow. We are pleased to welcome Lake Health System as a new member.

Discussions are underway with other health systems, promising to add thousands more patients who receive care in practices that are dedicated to measuring, publicly reporting and improving outcomes.

While we appreciate the recognition of *Better Health's* value represented by membership growth, new members also provide new contributions to our shared learning and more opportunity to affect the health and health care costs of the region. Welcome Lake Health!

REPORT ON REGIONAL ACHIEVEMENT

HEART FAILURE

EVALUATION AND TREATMENT RATES ACROSS THE REGION

Better Health has reported the **evaluation** and **treatment** of patients with heart failure in our EHR partner systems (Cleveland Clinic, Kaiser Permanente and MetroHealth) since 2008, and Figure 9 displays our achievement through 2010-11. Our **treatment** standard requires an ACE/ARB or Beta-Blocker medication (or both) for patients with serious or moderate heart failure, and nearly all (96%) such patients met this standard in 2010-11. Our **evaluation** standard requires four standards for good assessment of all heart failure patients – appropriate heart function ("echo") and annual blood testing, as well as regular checks of weight and blood pressure. In 2010-11, 77% of our patients met these standards.

Heart Failure Standards Over Time

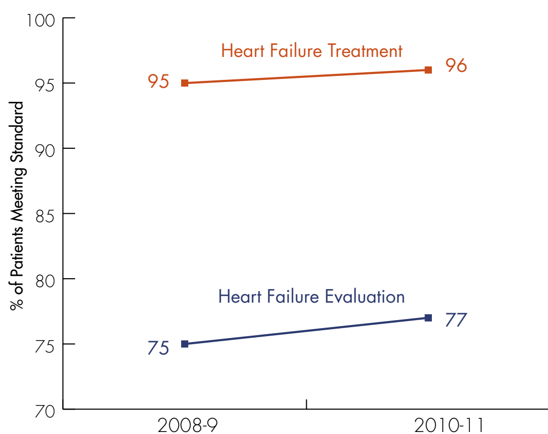


Figure 9. Achievement of Heart Failure Evaluation and Treatment Standards, 2008-09 – present, across *Better Health's* Partner Practices.

TABLE 1. CHARACTERISTICS OF PATIENTS INCLUDED IN THIS REPORT

	Diabetes Patients		**High Blood Pressure Patients**		**Heart Failure Patients**	
# of Patients	**28,892**		**109,212**		**5,343**	
# 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	35.5	0 - 47	43.7	0 - 60	72.9	41 - 85
Commercial	42.0	0 - 75	41.7	0 - 72	18.5	3 - 37
Medicaid	8.7	0 - 32	5.3	0 - 30	5.3	0 - 34
Uninsured	13.8	0 - 100	9.4	0 - 100	3.4	0 - 14
Medicaid + Uninsured	22.5	0 - 100	14.7	0 - 100	8.7	0 - 48
Race/Ethnicity (%)						
White	51.3	2 - 98	61.5	1 - 99	64.5	3 - 100
African-American	41.6	1 - 97	34.6	1 - 98	32.5	0 - 97
Hispanic	4.6	0 - 64	2.0	0 - 54	1.7	0 - 43
Other	2.5	0 - 64	2.0	0 - 52	1.3	0 - 31
Non-White	48.7	2 - 98	38.5	1 - 99	35.5	0 - 97
Preferred Language (%)						
English	95.0	38 - 100	96.9	47 - 100	96.1	57 - 100
Spanish	3.0	0 - 53	1.2	0 - 46	1.2	0 - 43
Other Languages	2.0	0 - 59	1.9	0 - 52	2.6	0 - 31
Average Age	57.7	51 - 62	62.6	51 - 69	71.2	57 - 77
% Female	54.2	36 - 73	58.1	35 - 76	50.3	35 - 74
Median Household Income ($1000s)	48.2	28 - 79	53.1	27 - 83	51.3	26 - 82
High School Graduation Rate (%)	83.8	71 - 92	86.0	72 - 94	84.9	70 - 94
% with Body-Mass Index < 30	32.8	23 - 64	47.4	25 - 65	50.2	22 - 68
% Not Smoking	80.2	50 - 92	83.9	50 - 92	88.8	65 - 98

COMPARISON OF ELECTRONIC HEALTH RECORD SYSTEMS to SYSTEMS TRANSITIONING FROM PAPER RECORDS

	EHR Practices	In Transition	EHR Practices	In Transition	EHR Practices	In Transition
# of Practices	34	14	34	14	33	Not reported.
# of Patients	25,036	3,856	99,924	9,288	5,343	
# of Primary Care Providers	445	79	420	80	362	
Insurance (%)						
Medicare	37.3	23.5	45.4	24.6	72.9	
Commercial	46.6	12.5	44.5	12.2	18.5	
Medicaid	6.9	20.6	4.0	19.0	5.3	
Uninsured	9.2	43.5	6.1	44.2	3.4	
Medicaid + Uninsured	16.1	64.1	10.1	63.2	8.7	
Race/Ethnicity (%)						
White	56.6	18.3	66.3	11.4	64.5	
African-American	36.4	73.6	29.7	85.2	32.5	
Hispanic	4.2	7.0	1.9	2.6	1.7	
Other	2.8	1.2	2.1	0.9	1.3	
Non-White	43.4	81.7	33.7	88.6	35.5	
Preferred Language (%)						
English	95.2	93.6	96.8	97.5	96.1	
Spanish	2.7	4.7	1.2	1.6	1.2	
Other Languages	2.1	1.6	2.0	0.8	2.6	
Average Age	58.4	53.1	63.2	55.8	71.2	
% Female	53.8	56.8	57.4	65.1	50.3	
Median Household Income ($1000s)	50.0	42.0	54.7	36.6	51.3	
High School Graduation Rate (%)	84.6	78.7	86.6	79.4	84.9	
% with Body-Mass Index < 30	33.5	28.6	48.3	37.5	50.2	
% Not Smoking	82.6	64.6	85.4	68.2	88.8	

DIABETES

CONTINUING IMPROVEMENT IN DIABETES CARE AND OUTCOMES

As noted, *Better Health* from the start has emphasized the value of EHRs in improving patient care. Figure 10 shows our improvement in both diabetes care (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) for partner health systems with established EHR and those that are in various stages of the transition to EHR. As seen in Table 1 (page 9), partner practices in transition to EHR provide care for patients who are relatively disadvantaged in terms of insurance coverage and reside in neighborhoods with lower household incomes and educational attainment.

DIFFERENCES IN ACHIEVEMENT BY INSURANCE PERSIST

Across our seven prior Community Health Checkups, we documented substantial differences in achievement across health insurance types, as well as groupings of patients by race/ethnicity, income and education. Figure 11 describes similar disparities in achieving diabetes care and outcomes standards across these groups. Substantial differences are seen across groups in almost every category, with better care and outcomes associated with Medicare (and to some extent Commercial) insurance, with White or Other (mostly Asian-American) race, and with higher neighborhood income and education levels. For the first time, we also show achievement grouped by preferred language.

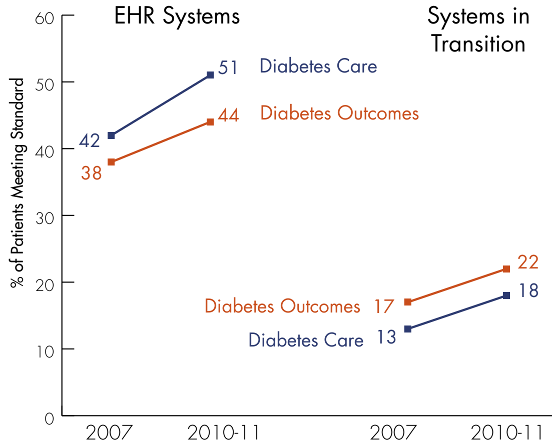


Figure 10. Achievement of Diabetes Care and Outcome Composite Standards, 2007–present, across *Better Health's* Partner Practices, by Medical Record Type.

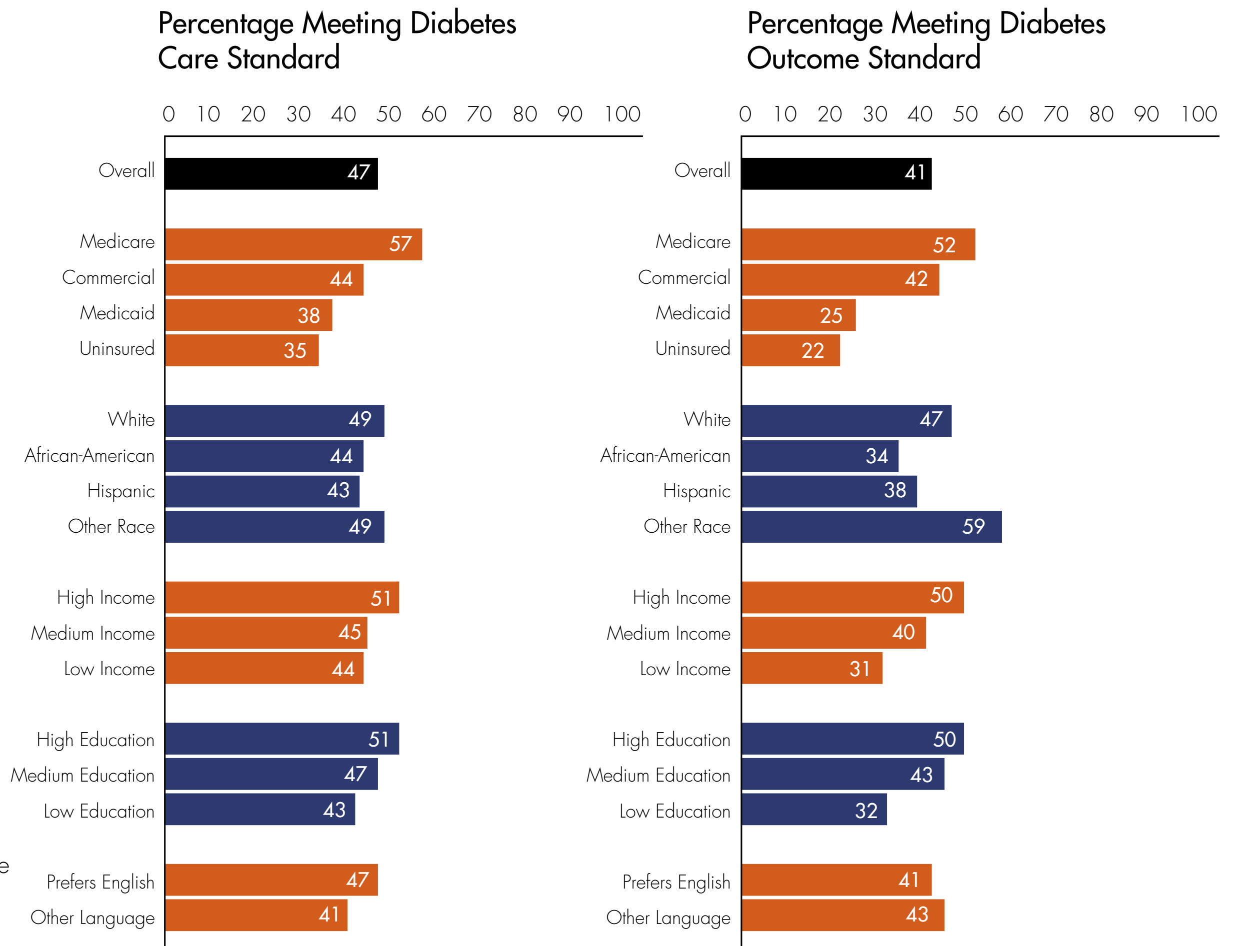


Figure 11. Achievement of Diabetes Care and Outcome Standards, by Patient Subgroups, 2010-11.

HIGH BLOOD PRESSURE

REGIONAL IMPROVEMENT IN BLOOD PRESSURE CONTROL

We began collecting data on patients with high blood pressure in 2009, focusing on care and control, that is, keeping blood pressure below 140/90. Achievement on meeting our three hypertension care standards (regular checks for blood pressure, serum creatinine and LDL cholesterol) have fallen off a bit across the region, particularly in practices transitioning to EHR. Achievement of blood pressure *control*, however, has improved across the region. As Figure 12 shows, this improvement is more pronounced in our seasoned EHR partners, compared to those systems making the transition.

Figure 13 describes relationships across patient subgroups by insurance, race/ethnicity, income, education and preferred language in achieving the standard for blood pressure control. In 2010-11, Medicare and Commercial patients had substantially better results than did Medicaid or Uninsured patients. Achievement of the control standard also is associated with income and education differences, as well as race/ethnicity, with African-American and Hispanic patients faring less well.

CONCLUDING REMARKS

Better Health's clinical partners move forward on their path of continuous improvement at a time of unprecedented opportunities to log progress toward achieving the "Triple Aim" of better health, better care and better cost. We are committed to helping our partners help our region get there.

Better Health provides numerous opportunities in various forums for our partners to learn, share and improve. Among these are our twice yearly, Learning Collaborative Summits, where we focus on peer-to-peer learning and sharing best practices. On March 23, we convene our 10th Summit, which features keynote Thomas H. Lee, M.D., Network President for Partners HealthCare System in Boston. Another is our seasoned team of Practice Coaches, who work on-site at primary care practices alongside staff. Our team has grown to meet practices' demands to learn to more effectively use EHRs; improve their patients' experience; build teams that center on patients' needs; improve quality metrics, reach Meaningful Use benchmarks and win NCQA recognition for PCMH. And more.

In our transitions of care work, we are pleased to convene and connect our partners within the medical community for better coordinated care, and to those outside the world of medicine, where people live. And we delighted to collaborate with nascent efforts, such as Healthy Cleveland and the Cuyahoga County Health Alliance, to promote health and wellness where people live and work.

Our new and established programs reflect our belief that primary care will play a starring role in health care improvement and that meaningful use of an EHR system is essential to serve the complex health needs of our patients and our community. But we also believe that the entire community – not just the "medical neighborhood" – must work in tandem to make Northeast Ohio a healthier place to live and a better place to do business.

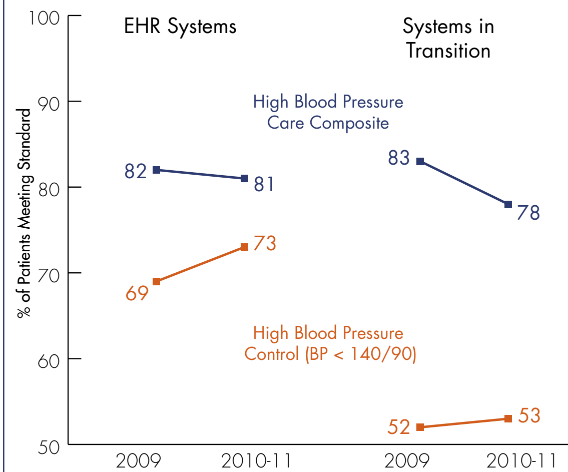


Figure 12. Achievement of High Blood Pressure Care and Control Standards, 2009 – present, across *Better Health's* Partner Practices, by Medical Record Type.

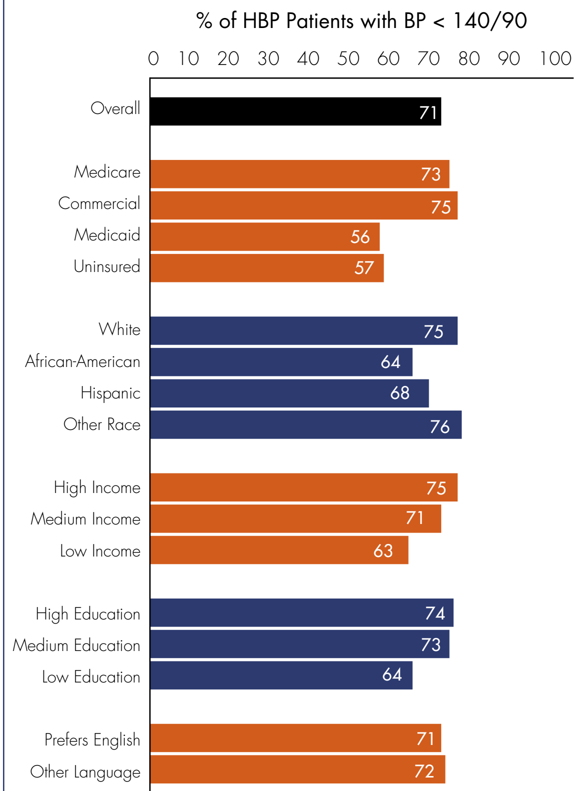


Figure 13. Achievement of Good Blood Pressure Control (BP < 140/90), by Patient Subgroups, 2010-11

ACHIEVEMENT AGAINST NATIONAL HEALTH PLANS ON NCQA STANDARDS

Table 2 (below) compares our practices' achievement on nine comprehensive diabetes care standards and one high blood pressure control standard established by the National Committee for Quality Assurance (NCQA) for HMO health plans. *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 on all but one standard (A1c < 7).

TABLE 2 - PARTNER PRACTICES' ACHIEVEMENT (2010-11) COMPARED TO HEALTH PLANS NATIONWIDE (2010)						
NCQA/HEDIS MEASURES FOR COMPREHENSIVE DIABETES CARE						
Measure	Group	Medicare	Commercial	Medicaid	Uninsured	Overall
Blood Pressure Control (< 140/90)	Region	72.5	78.7*	63.6	62.4	72.9
	National Mean	62.3	65.7	60.4	-	-
Eye Examination	Region	67.3	58.0	55.9	56.8	60.9
	National Mean	64.6	57.7	53.1	-	-
Hemoglobin A1c testing performed	Region	94.9	92.9	95.0*	93.0	93.8
	National Mean	90.4	89.9	82.0	-	-
A1c Control (< 7)	Region	47.9	42.8	35.2	33.3	42.6
	National Mean	Not reported.	42.5	34.7	-	-
A1c Control (< 8)	Region	73.3	67.0	55.0	52.2	66.2
	National Mean	65.6	62.3	46.9	-	-
A1c Control (> 9) [lower values are better]	Region	16.1	20.9	29.1*	32.9	21.6
	National Mean	27.3	25.9	44.0	-	-
LDL Cholesterol Screening	Region	89.0	88.8	80.1	82.1	87.2
	National Mean	87.8	85.6	74.7	-	-
LDL Control (< 100)	Region	63.7	55.3	41.2	38.7	54.7
	National Mean	52.1	47.7	34.6	-	-
Monitoring Nephropathy	Region	92.6	90.5*	89.0*	87.6	90.7
	National Mean	89.2	83.6	77.7	-	-
Regional Diabetes Patients, # (%)		10,246 (35)	12,146 (42)	2,522 (9)	3,976 (14)	28,892
NCQA/HEDIS MEASURE FOR CONTROLLING HIGH BLOOD PRESSURE						
Measure	Group	Medicare	Commercial	Medicaid	Uninsured	Overall
Blood Pressure Control (< 140/90)	Region	72.8	75.0*	56.0	56.9	71.4
	National Mean	61.9	63.4	55.6	-	-
Regional High Blood Pressure Patients, # (%)		47,679 (44)	45,553 (42)	5,760 (5)	10,220 (9)	109,212

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

Table 2. Regional Achievement (2010-11) Compared to Health Plans Nationwide (2010). National Data from The State of Health Care Quality 2011, ncqa.org

SPOTLIGHTING OUTSTANDING ACHIEVEMENT AND IMPROVEMENT

34 practices met our standards to earn gold stars in 2010-11. Each of these practices either had quality scores in the top 10% of one of our composite measures in diabetes, high blood pressure or heart failure, or were in the top 10% of practices in terms of their improvement in one of these measures.

Congratulations to our partners and their patients!

TABLE 3. OUTSTANDING ACHIEVEMENT AND IMPROVEMENT (2010-11)

	OVERALL	MEDICARE	COMMERCIAL	MEDICAID	UNINSURED
THE CLEVELAND CLINIC					
Beachwood Family Health Center		HBP			
Brunswick Family Health Center	HF	HF			HBP
Chagrin Falls Family Health Center			DM		
Cleveland Clinic - Main Campus	DM HF		DM HF		DM
Huron Hospital, Community Health Clinic	HBP↑	DM↑			HBP↑
Independence Family Health Center	DM		DM		
Solon Family Health Center		HBP HF	DM		HBP
Strongsville Family Health Center	HF	HF	DM		
Westlake Family Health Center			HF HF↑		
Willoughby Hills Family Health Center		HF	HF		DM HBP
KAISER PERMANENTE - OHIO					
Avon Medical Facility	DM↑ HBP HBP↑ HF HF↑	HBP	HBP		
Bedford Medical Center		DM HBP HF			
Chapel Hill Medical Center	HBP HF↑	HBP HF↑	HBP		
Cleveland Heights Medical Center	HBP↑ HF↑	DM HBP↑	HF HF↑		
Fairlawn Medical Center	DM HBP HBP↑ HF↑	DM DM↑ HBP HBP↑ HF↑	DM HBP HBP↑		
Parma Medical Center	DM DM↑ HBP↑	DM↑ HBP↑ HF	DM↑ HBP↑		
Rocky River Medical Center	HF				
Strongsville Medical Center	DM HBP HBP↑	DM HBP↑ HF	HBP		
Twinsburg Medical Center	DM↑				
Willoughby Medical Center	DM HF↑	DM HF HF↑			
THE METROHEALTH SYSTEM					
Asia Town Health Center	DM↑				
Broadway Health Center	DM↑	DM↑ HBP↑	DM↑ HBP↑	DM↑ HBP↑	DM↑
Brooklyn Health Center	HBP	HBP		HBP	DM DM↑ HBP
Buckeye Health Center	DM	DM	DM DM↑	DM	DM DM↑
Lee-Harvard Health Center			HBP	DM DM↑	HBP HBP↑
MHMC - Faculty/Residents Practice				DM HF	
MHMC - Family Practice			DM↑ HBP↑	DM↑ HBP↑	HBP↑
MHMC - Internal Medicine				HBP	HBP↑
Strongsville Health Center	DM↑	DM↑	DM↑		
Thomas F. McCafferty Health Center	DM↑ HBP HF	DM↑ HBP	DM↑ HBP	DM↑	
NEON: NORTHEAST OHIO NEIGHBORHOOD HEALTH SERVICES, INC.					
NEON (All Practices)		DM↑	HBP↑		
NEIGHBORHOOD FAMILY PRACTICE					
Neighborhood Family Practice (All Practices)		DM↑			
NORTH COAST HEALTH MINISTRY					
North Coast Health Ministry	HBP				HBP
UNIVERSITY HOSPITALS OF CLEVELAND					
University Hospitals Family Medicine	DM↑ HBP	HBP↑	DM↑ HBP HBP↑	HBP	

OUTSTANDING ACHIEVEMENT IN
DM – Diabetes Care or Outcomes
HBP – High Blood Pressure Care or Control
HF – Heart Failure Evaluation or Treatment

OUTSTANDING IMPROVEMENT IN
DM↑ Diabetes Care or Outcomes from 2008-09 to 2010-11
HBP↑ High Blood Pressure Care or Control from 2009-10 to 2010-11
HF↑ Heart Failure Evaluation or Treatment from 2008-09 to 2010-11

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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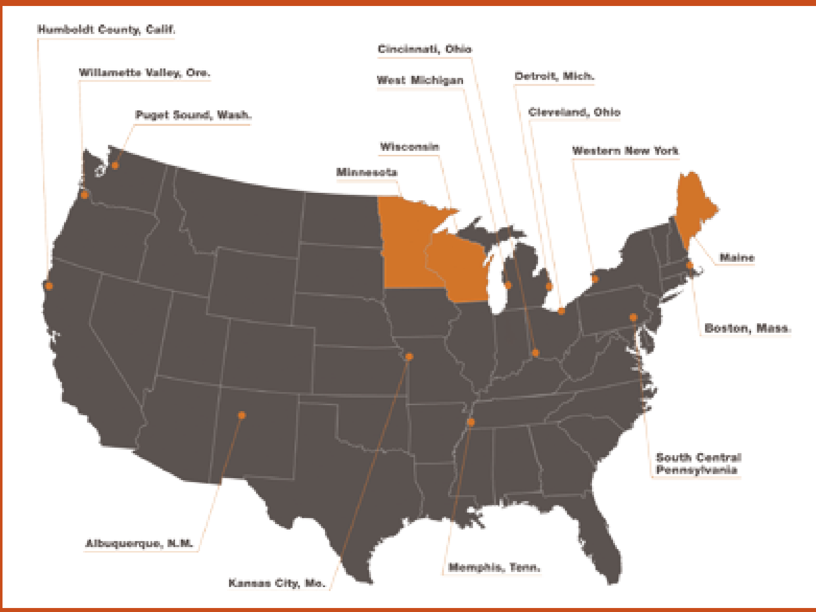
Better Health is one of 16 Regional Health improvement Collaboratives in the Robert Wood Johnson Foundation's prestigious *Aligning Forces for Quality* initiative.



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1.15.2012