Better Care, Better Health, Lower Cost

IT TAKES A COMMUNITY

EXECUTIVE SUMMARY, 10TH REPORT WINTER 2013

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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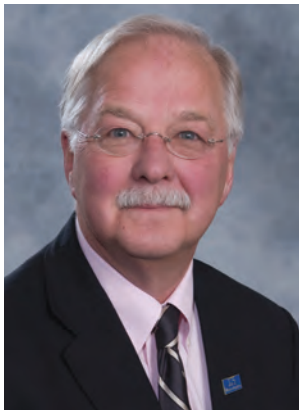


Randall D. Cebul, MD

TO THE COMMUNITY

This Executive Summary highlights results of *Better Health's* 10th Community Health Checkup since 2008. It also identifies ambitious directions *Better Health* is taking that reflect the greater breadth and depth of our leadership and partnerships in the region. Our directions align with national goals to achieve the "Triple Aim" of measurably Better Care, Better Health, and Lower *per capita* Costs of health care. They also recognize that all health care is local – and that achieving the Triple Aim requires alignment of all forces in our community that bear on care, health and health care costs.

At its core, *Better Health* focuses on improving care by measuring and improving patient-centered primary care for Greater Cleveland's residents who have chronic medical conditions. Our geographic footprint, as defined for our principal funder, the Robert Wood Johnson Foundation, has been Cuyahoga County. With our recent efforts, we have expanded the number of clinical members in Cuyahoga County, enabling us to better represent its health and health care outcomes. At the same time, we have welcomed primary care partners outside of the County who are relevant not only to the health of a larger population, but also to key employer stakeholders whose employees seek care outside Cuyahoga's borders. In addition, we are beginning to measure our patients' mental health challenges and their experience with our care, and we have committed to also report on preventive services. With our university and public health partners, we have embarked on action plans and development of a regionwide dashboard to monitor our progress.

Lowering hospitalization rates for "ambulatory care sensitive" conditions, including those we report, is a nationally recognized measure of access to better primary care. Perhaps most relevant to taxpayers and private employers, therefore, is strong progress we mark toward our longstanding goal to reduce avoidable hospitalizations of our patients. In this Checkup, we demonstrate remarkable cost savings of over $20 million between 2009 and 2011 by averting almost 3,000 admissions for patients with diabetes and other cardiovascular diseases in Cuyahoga County.

We believe these results reflect better care that has resulted in better health and lower costs to those who purchase care. While many challenges remain, we think that we're moving in the right direction. We are grateful to those who share and are helping to shape our mission.

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

INTRODUCTION

The publication of our 10th Community Health Checkup comes at a propitious time for our region to accomplish Donald Berwick's challenging "Triple Aim" of Improved Care, Improved Health, and Lower Costs in health care. The Affordable Care Act's multiple initiatives, if imperfect, are underway, and test new patient-centered approaches and ways to pay for care that align with better outcomes at affordable costs. The health of communities is being measured and compared across multiple dimensions to promote policies that advance healthier environments and lifestyles. Taxpayers and private employers recognize and are starting to address the unsustainable growth in health care costs. All key forces are aligning for better care, better health and lower costs.

Through *Better Health's* leadership and partnerships nationally and in Northeast Ohio, we are doing our part to achieve the Triple Aim. In this Checkup, we report improvements in chronic disease care and outcomes for five times more patients than in 2007. For the first time, 100% of our reported patients are from organizations using electronic health records (EHRs), reflecting recent conversions to EHRs and their meaningful use by four of our safety net partners.

Since our inception, Cuyahoga County has been the healthcare "market" targeted in *Better Health's* programs, including those addressing cost. For the first time, we report reductions in avoidable hospitalizations among Cuyahoga County's residents who have the cardiovascular conditions that we address. Compared to the next five largest Ohio counties, we reduced these "ambulatory care sensitive" hospitalizations by nearly 3,000 between 2009 and 2011 and document over $20 million in avoidable costs.

Much work remains to be done. We report continuing disparities in care by insurance and race, income, and educational attainment. To improve clinical outcomes among our minority patients with high blood pressure, we have identified "bright spots" reflecting promising approaches in one health care organization that will be disseminated across our other practices. We can do more to improve health at a population level. Here, we report new partnerships to address multiple dimensions of health and health behavior through legislative policy and by recognizing the role of governments as employers with investments in a healthy workforce. Finally, we can do more to improve costs. In future Checkups, we will include new primary care practices and hospitals in Cuyahoga County, which now include providers in Lake and Stark Counties that are important to our employer and health insurer partners. Here, we also describe pilot projects engaging employers and health plans in patient-centered practices designed to improve care at affordable costs.

We recently submitted our fourth and final major grant proposal to the Robert Wood Johnson Foundation under its ambitious Aligning Forces initiative that will help support *Better Health* through mid-2015. As we faced our own "fiscal cliff," *Better Health's* Board of Directors undertook a strategic planning process that began with a community-wide survey of stakeholders and interviews by an independent consultant. The results reinforce the unique value that *Better Health* provides the region and our focus on better care, better health, and lower costs. Our Board slightly expanded our Vision to broaden our 'target region' from Greater Cleveland to Northeast Ohio and highlighted *Better Health's* role in a revised Mission statement:

Where collaboration and competition come together with data and insights to improve health for everyone.

TABLE 1. BETTER HEALTH *GREATER* CLEVELAND AND THE TRIPLE AIM

Better Health's Goals	The Triple Aim		
	IMPROVE PATIENT CARE	IMPROVE POPULATION HEALTH	REDUCE PER CAPITA COST
Reduce hospitalizations and charges for patients with diabetes and heart failure, and re-hospitalizations for heart failure.	✓	✓	✓
Improve care and management of patients with diabetes, heart failure and hypertension.	✓	✓	✓
Improve blood pressure control in African-American patients with diabetes and hypertension.	✓	✓	✓
Measure and improve screening rates for breast, colorectal and cervical cancer, and assess smoking status, obesity and blood pressure across the region's adult population.	✓	✓	✓
Measure and improve screening rates for depression.	✓	✓	✓
Measure and improve patient experience scores.	✓	✓	✓
In "Super-Utilizer" pilot, measure and improve utilization, costs, patient experience, depression screening and care for patients with diabetes, heart failure and hypertension.	✓	✓	✓

Larger checks indicate direct impact; smaller checks point to indirect impact.

[1] Berwick DM, Nolan TW, Whittington J. The triple aim: care, health, and cost. *Health Aff.* 2008; 27: 759-769. Also see Cambridge, MA: Institute for Healthcare Improvement (Available at www.IHI.org)

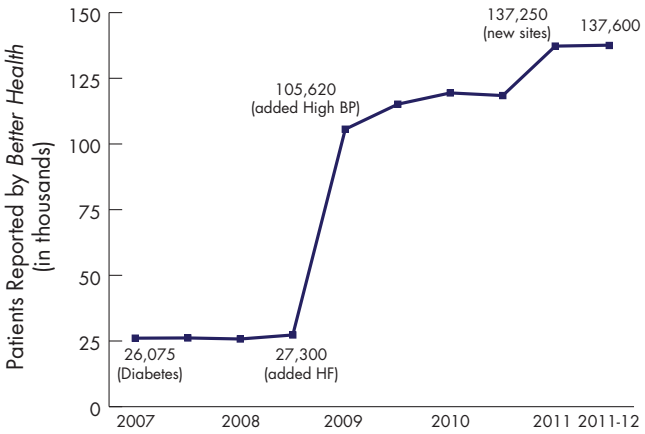


Figure 1. Patients reported by *Better Health* in its first 10 Community Health Checkups

This report describes the care and outcomes of 137,600 unique patients at 55 practice sites of eight health systems receiving care from 614 providers, which include general internal medicine, family practice and medicine / pediatrics physicians and advanced practice nurses with prescribing privileges. Since 2007, our primary care partners have reported on data describing patients with diabetes, and more recently heart failure and high blood pressure (Figure 1). We also share updates on our alliance's initiatives, activities and resources, which we believe are nudging health care quality and cost in the right direction. As the value of higher quality health care comes into focus, so, too, do the stakes for Northeast Ohio, its communities, employers and the family, friends and co-workers in our lives.

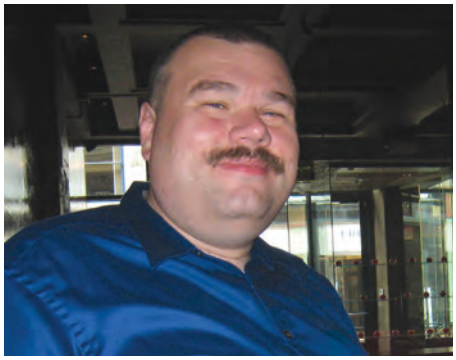
BETTER CARE, BETTER HEALTH, LOWER COST

Nearly 3,000 fewer hospitalizations

At the start of 2012, the 315 pounds that Dennis Duck carried on his 5-foot-10-inch frame classified him as morbidly obese. His cholesterol and blood pressure were elevated, and he was at risk for diabetes.

Duck, 45, knew all this. For years, his Neighborhood Family Practice physician had urged him to lose weight. But it wasn't until last January when Duck, an avid traveler, took his seat on a jet headed for Senegal, West Africa, that he found his inspiration to act. "I had a hard time fastening my seat belt," he said. On his return to Cleveland, Duck bought a treadmill, downloaded a calorie-management app, and proceeded to drop 108 pounds. His clinical numbers have fallen enough to stave off diagnoses of diabetes and high blood pressure that alter the health trajectory of so many lives in northeast Ohio.

ONE OF THE LUCKY ONES



Dennis Duck (before)

Dennis Duck (after)

Duck is one of the lucky ones. Nearly 140,000 patients of *Better Health's* primary care partners already have one or more of these conditions. The good news is their illness can be managed well with appropriate care and lifestyle changes. But when poorly managed, irreversible complications exact a large toll. Debilitating illness, high cost and declining productivity are felt in the community. Because these conditions can be prevented and treated in outpatient settings, hospitalizations represent a "canary in the coal mine" for the healthcare system. Hospital stays signal poorly managed disease that could have – and should have – been managed in a doctor's office.

In this report, we are pleased to present new data documenting that Northeast Ohio is moving in the right direction when it comes to treating common cardiovascular conditions, the mainstay of *Better Health's* improvement efforts. In this report and our prior Community Health Checkups, we have demonstrated improvement in quality standards and outcomes for adults with diabetes, heart failure and high blood pressure. Now, we tackle the question of whether *Better Health's* activities have helped avert costly and unnecessary hospitalizations for patients with these conditions – those that can be controlled with care received outside of the hospital.

Figure 2 shows estimates of hospitalizations (and related costs) for patients with diabetes, heart failure, high blood pressure or angina *that didn't happen* in Cuyahoga County in the three years from 2009 through 2011. Our analysis[2] estimates that Cuyahoga County residents had 2,854 fewer hospital stays in this period, saving $20.1 million. Moreover, the improvement grew from year to year. In 2009, the first year of major *Better Health* activities, we estimate that 650 hospitalizations (5.7% of cardiovascular hospitalizations in the County) would have been expected to happen but didn't, with steady climbs in savings the two following years.

The numbers suggest that improved primary care across *Better Health* practices has started to reap dividends. Across the region, practices are adopting patient-centered models of care, using electronic tools more effectively and routinely measuring their care so they can identify opportunities to continuously improve. The changes are helping people change the course of their health, and they're adding up to measurable impact on the community – in health, care and cost.

COMMUNITY ACTION

As a Regional Health Improvement Collaborative, *Better Health* provides a neutral and trusted organization with the capacity to inform, advance and facilitate integration of the variety of activities required to transform local health care. We do performance measurement, public reporting, coaching and training for improved clinical performance and patient experience and multi-stakeholder projects to support high-value patient-centered care. Increasingly, we're helping allied organizations to plan, share knowledge and connect with others.

Improving Cuyahoga County's Health Ranking in Ohio: We're 65th!

Better Health has joined with regional governments, universities and public health organizations to collectively address Cuyahoga County's health ranking — 65th of 88 Ohio counties (countyhealthrankings.org). The Health Improvement Partnership-Cuyahoga (HIP-C), an initiative led by the Cuyahoga County Board of Health, is establishing social and health priorities and creating strategies to improve health in the county. *Better Health* has contributed staff and expertise, helping to identify health issues in a countywide survey and as part of a leadership team tasked to prioritize strategies and develop action plans.

In April 2012, *Better Health* responded to a call to action from County Executive Edward FitzGerald and became an institutional partner in the Cuyahoga County Health Alliance. *Better Health's* principal role is to provide technical support for developing evidence-based health improvement programs and interventions at worksites and in the community.

[2] Changes in hospitalizations are described for adult residents of Cuyahoga County with cardiovascular conditions (diabetes, high blood pressure, angina and heart failure) comparing the observed results for 2009-2011 to trends from 1999 through 2008, preceding *Better Health's* public reporting. The full analyses estimate savings based on changes in Cuyahoga County compared with the next five largest Ohio counties (Franklin, Hamilton, Lucas, Montgomery, and Summit), accounting for 1999-2008 trend, population, age and sex. Data are from the Ohio Hospital Association, and estimates are based on hospitalization rates as identified by Prevention Quality Indicator codes, adjusted for age and sex. Hospital-specific costs are converted from reported charges using cost-to-charge ratios published by the Centers for Medicare and Medicaid Services (CMS).

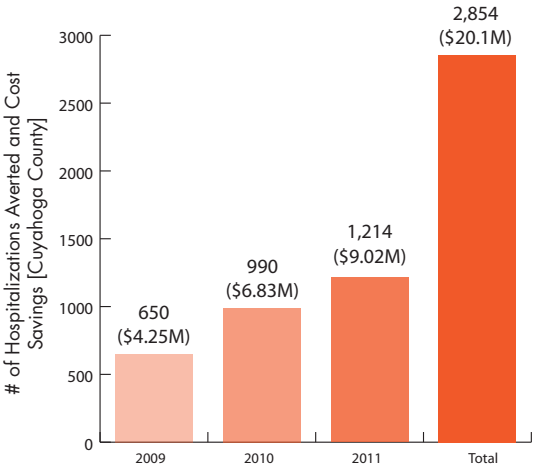


Figure 2. Estimated averted hospitalizations (and cost savings) for ambulatory care sensitive conditions in Cuyahoga County since *Better Health's* first public report, 2009-2011.

WHAT IS AN AMBULATORY CARE SENSITIVE CONDITION?

A condition for which hospital admission could be prevented by interventions in primary care.

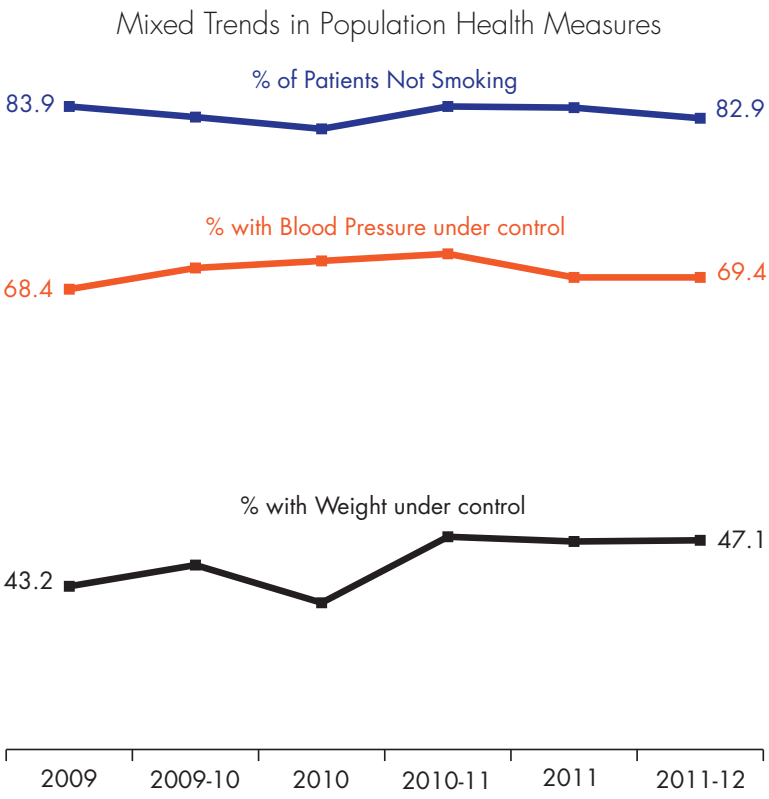


Figure 3. Changes in rates of not smoking, control of blood pressure (BP below 140/90) and control of weight (body-mass index below 30) among patients with high blood pressure reported by *Better Health*, 2009-present.

Where people live, work, and play affects their quality of life. The health of minority and poor communities suffer disproportionately, with corresponding disparities in life expectancy – up to 25% lifespan difference between residents in Cleveland and its suburbs in Cuyahoga County.

Chronic disease rates associated with obesity, sedentary lifestyle and tobacco use are climbing in Cuyahoga County and account for more than 60% of all deaths. *Better Health* data (Figure 3) show modest improvements in two of three important public health measures: more people with high blood pressure are in control of their *weight* and *blood pressure* compared to 2009, but fewer of them are tobacco-free. The Plain Dealer reported in January 2012 that Ohio received "F's" from the American Lung Association for not funding cessation support and tobacco prevention efforts. In Ohio, one of four adults smokes, compared with less than one in five nationally.

Better Health also is contributing to efforts led by Case Western Reserve University School of Medicine to develop a community health "dashboard" to align organizations, motivate action and gauge progress on key determinants of health. Collecting data and measuring results consistently ensures efforts remain aligned and that community participants can hold each other accountable for improved outcomes.

Better Health also hopes to play supporting roles in community efforts such as *Healthy Cleveland,* an initiative of the City of Cleveland. The region is increasingly aware of the role that health plays in workforce productivity, economic development, educational attainment, quality of life and neighborhood revitalization.

Improving Primary Care Across the Region and State

Better Health is playing a key leadership role in the Ohio Department of Health's effort to advance implementation of patient-centered primary care across the state through its Ohio Patient Centered Primary Care Collaborative (OPCPCC). *Better Health* Director Randall D. Cebul, MD, along with Rita Horwitz, Director of Business Development for *Better Health*, serves on the Steering Committee and chairs the OPCPCC Payment Reform Committee. Our expertise in primary care and regional health care delivery and payment change was featured in a statewide conference on November 30, 2012.

ARE YOU A MEMBER?

Learn more about the Ohio Patient Centered Primary Care Collaborative at http://www.odh.ohio.gov/landing/medicalhomes/opcpcc.aspx

In December 2012, *Better Health* accepted an invitation to assist Cuyahoga Community College in establishing a patient centered care-related curriculum for training various health workers in information technology – a core strength of *Better Health*. The community college, which has won stimulus support for HIT workforce development, was honored with a visit in November 2011 by U.S. Secretary of Health and Human Services Kathleen Sebelius for achievements in training, and we are pleased to participate in this new work in primary care.

NEW DEVELOPMENTS

Better Health marks the start of its seventh year with clear strategies that we are confident will allow us to continue to increase our impact. With the U.S. Supreme Court's decision in June 2012 upholding the Patient Protection and Affordable Care Act, we enter a time of great change and uncertainty for all health care stakeholders. From burgeoning accountable care organizations to insurance exchanges and potential Medicaid expansion in Ohio, trusted data on health care quality and cost has a central role to play in health care purchasing decisions – as well as to serve as guideposts for improvement.

Next Steps in Key Program Areas

Our ongoing and new initiatives align well with new regional, state and national policies, programs and objectives for better care, better health and lower costs. In October 2012, we submitted our proposal for the fourth and final phase of funding under the Robert Wood Johnson Foundation's Aligning Forces for Quality national program, with which *Better Health* was first established in 2007. The grant will support our current initiatives in quality measurement, value-based purchasing and primary care transformation, and our work to help advance common agendas of aligned organizations.

The new grant also will support a new approach to the persistent and challenging need to improve transitions of care across health care settings, particularly following hospitalizations. James Campbell, MD, MS, Director of the Geriatric Center at the MetroHealth Senior and Wellness Center, will lead efforts to develop improvement strategies driven by primary care practices that care for patients before and after their hospital stays.

We also will begin to directly address the disparities in care and outcomes that our data consistently identify. As shown in Figure 4, measures for good control of high blood pressure among our diabetes patients demonstrate improvement since 2007. However, good control is improving faster among Whites and Hispanics than for African Americans, resulting in a widening gap across patient groups.

Our updated vision and mission statements reflect our continuing commitment to providing a trusted vehicle for multi-stakeholder collaboration among otherwise competing organizations for the benefit of the community.

OUR VISION

To help make Northeast Ohio a healthier place to live and a better place to do business.

OUR MISSION

Where collaboration and competition come together with data and insights to improve health for everyone.

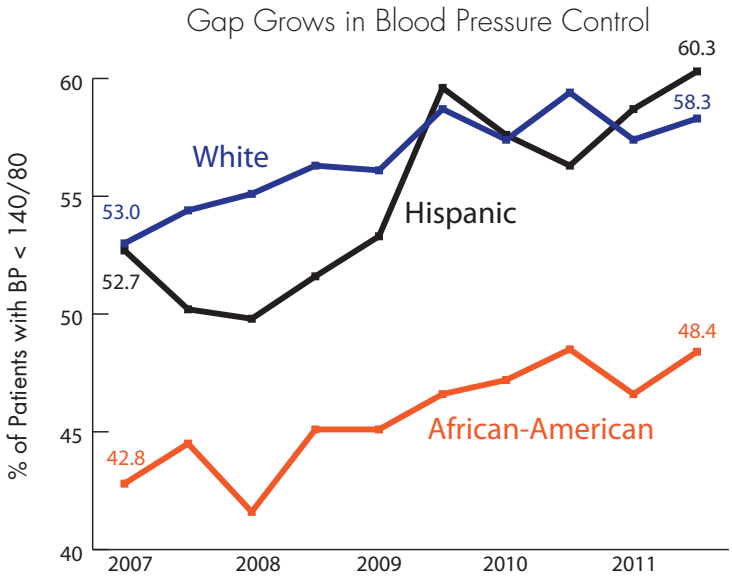


Figure 4. Blood Pressure Control (BP < 140/80) among Diabetes patients by race/ethnicity, 2007 to 2011-12

Christopher Herbert, MD, MS

An opportunity to address these gaps arose from a "Bright Spot" that we identified in 2012 in the course of our data analysis and reporting. Our Data Center found that Kaiser Permanente practices topped their peers in controlling high blood pressure for all patients – and for African Americans as a group. Kaiser shared its processes, and Christopher Hebert, MD, Associate Medical Director of Quality Improvement at Kaiser, stepped up to lead development of a structured improvement program that we soon will offer to partner practices to adopt or adapt. The specific protocols are aimed at closing the gap in blood pressure control – and continuing the gains across all groups. Achieving our 70% goal for region-wide control among African-American patients would improve the health of over 2,800 African Americans living with high blood pressure.

POWERING HIGH-PERFORMING PRIMARY CARE

Measurement remains the foundation for our work – and we're doing more all the time. In addition to the increased number of patients, new metrics are in the works that will provide important information on patients' experience with their care, whether they obtained recommended cancer screenings and whether they were assessed for depression, which affects more than one of three patients with chronic illness.

Our metrics allow health care providers and our alliance identify opportunities to improve and further catalyze and spread high-value health care. *Better Health* also provides member practices with interactive tools that allow individual providers to track the results of their own panel of patients and compare them to the results of colleagues at their practice site and throughout their health care system and the region – over time and across health conditions. Giving physicians timely feedback on their performance puts them in the driver's seat to navigate to higher quality care.

With several years' worth of data on diabetes, heart failure and high blood pressure, we can identify trends, progress and continued challenges, across the region and in sub-populations. Many of these are fully explored later in our regional data results, starting on page 9.

On Sept. 14, 2012, we convened our 11th Learning Collaborative Summit, when we welcomed newcomers and old-timers in a new venue, Tri-C Corporate College East. The theme of the day-long meeting was *Hiking Through the Healthcare System: Shortening the Path to Value, Quality and Cost*. Keynote speaker Ron Copeland, MD, FACS, played a starring role in highlighting the importance of improving health equity to achieve high-value care. In other sessions, Kaiser Permanente clinicians shared their Best Practice in improving blood pressure control; attendees participated in a team-building exercise and learned how practices have used teams and electronic health record tools to proactively manage their patients' chronic conditions.

Ron Copeland, MD, FACS

Save the date for Learning Collaborative Summit XII on March 8:
Bridging Care and Community: Patient Centered Medical Home and Community Partnerships to Achieve Population Health

Better Health's experienced practice coaches are an integral part of our alliance's improvement resources and have contributed to improvement initiatives across the region, at practices ranging from Care Alliance, a health center that primarily cares for homeless patients, to the Cleveland Clinic. In 2012, our coaches spent over 1,200 hours in primary care practices across nine health systems on engagements related to measuring and improving patients' experience, screening for and treating depression, optimizing EHR use, and improving teamwork, workflow and clinical quality. Some examples:

- Care Alliance recently received recognition and North Coast Health Ministry awaits notification from the National Committee for Quality Assurance (NCQA) on their applications for recognition as a Patient-Centered Medical Home that our coaching staff helped prepare. Congratulations, Care Alliance!
- Cleveland Clinic Willoughby Hills Family Health Center used coaches to improve teamwork for follow-up appointments and patient checkout.
- Coaches helped Neighborhood Family Practice implement huddles, improve teamwork and create processes to ensure more patients received the care they needed. Improvements helped it boost the percentage of its patients whose high blood pressure is well controlled, even as its patient volumes grew.
- Several MetroHealth Community Health Centers referred patients with chronic conditions to its The Healthy You-Take Charge Program, based on a program developed at Stanford to empower patients with chronic conditions. Working with Fairhill Partners, two *Better Health* practice coaches became master trainers and helped MetroHealth launch classes that helped patients like Albert Brooks II, at right, manage and impact their health.

WHAT IS A HUDDLE?

A quick meeting – less than 7 minutes — at the start of the day to help a health care team manage their day by preventing confusion and bottlenecks to improve patient care and teamwork.

Albert Brooks II

WITH A LITTLE HELP FROM HIS PRIMARY CARE PROVIDERS . . .

It was unrelenting pain in his right knee that finally sent Albert W. Brooks II to a doctor at MetroHealth's Broadway Health Center. It was the routine blood pressure check that triggered the journey that keeps him coming back.

Brooks learned that day in January 2012 that his blood pressure was dangerously high, and more bad news arrived when his blood tests came back a few days later. He also had diabetes, high cholesterol and was officially morbidly obese.

Brooks hadn't been to a doctor in years. He had been struggling with job loss and the stress and depression that often accompany it. Now he was frightened. "Out of the four conditions, I think diabetes is the one that scared me the most," said Brooks, 45, who lives in Cleveland Heights. "I knew the damage it could cause."

His fear turned to action when his MetroHealth physicians explained what he could do about it. A MetroHealth nutritionist got him started and referred him to a class called Healthy You – Take Charge to help him learn how to live with chronic illness.

Brooks took charge. In the class, Brooks found peer support, learned how to read food labels and soaked up strategies to help him make lifestyle changes and manage stress. Between diet, exercise and medications, he's lost 55 pounds, and got his diabetes, blood pressure and cholesterol under control. Getting to a healthy weight is a work in progress, but he has a clear goal to drop another 60 pounds by August.

These days, he's feeling better about himself than he has in years. "I look at it as a blessing, and it built my character up," Brooks said. "If my story would motivate somebody else, that would be awesome."

MAINTENANCE OF CERTIFICATION

Better Health was certified in August 2012 as a Maintenance of Certification (MOC) Portfolio Sponsor for the American Board of Internal Medicine (ABIM), which assures a physician's expertise in a particular subspecialty or medical practice. As a Portfolio Sponsor, *Better Health:*

- Streamlines physicians' participation in MOC activities by reducing administrative burden;
- Accepts accountability for managing physicians' QI activities and ensuring they meet ABIM standards for recertification approval; and
- Empowers physicians by building their skills to improve quality, a responsibility as central to excellence as staying up-to-date on clinical practices

Better Health recently submitted an application to be a MOC Portfolio Sponsor for the American Board of Medical Specialties, which would enable us to assist physicians in Family Medicine and other specialties.

Partnering with Payers and Purchasers to Support High-Value Care

Our efforts to engage employers directly in transforming primary care are bearing fruit. Two projects are underway that are building partnerships between primary care providers and the employers and health plans with a stake in the lower costs that come from improved health. Discussions have begun with large union trust managers and public employers that seek to improve the region's health and cut wasteful health care expenses. An important common goal is to align value-based purchasing and effective, coordinated and patient-centered care.

In early 2012, *Better Health* and Health Action Council Ohio (HAC) began discussions with private and public employers interested in exploring a partnership with Lake Health System. In August, the employers committed to a joint program with Lake to improve care and achieve cost savings by reducing avoidable use of hospitals and emergency departments. The program is scheduled to launch in January 2014.

Better Health launched a second program in June, following a grant from the Robert Wood Johnson Foundation to develop innovative care delivery models for "Super-Utilizing" patients. In the program that we've dubbed Red Carpet Care, Medical Mutual of Ohio and Buckeye Health Plan are partnering with MetroHealth to improve health and reduce costs for 150 enrollees who frequently use expensive hospital and ED care. The health plans support two nurse practitioners who direct and coordinate care of Red Carpet enrollees from their offices at each of two MetroHealth sites that host these "clinics within clinics." The health plans also share utilization data and have committed to share their cost savings from anticipated declines in hospital use with MetroHealth, which stands to lose revenue with less hospital use under the fee-for-service payment system. The project will help inform development of similar programs.

We also are partnering with HAC, a founding member of *Better Health*, on a new initiative to improve regional employers' understanding of the value of payment change to support high-performing primary care. Funded jointly by the Robert Wood Johnson Foundation and the National Business Coalition on Health, the project also will contribute to our current and future payment change initiatives.

OUR PARTNER PRACTICES, PROVIDERS AND PATIENTS

Our 10th *Better Health* Community Health Checkup describes a diverse group of 55 primary care practices within eight health systems, including a total of 614 primary care providers (Table 2.) Our new data describe results from July 2011 through June 2012 for the same eight health systems which participated in our last report. In all, 137,600 patients are described (Figure 5), and as compared to one year ago, we report now on nearly 20,000 additional patients. Detailed results for all three conditions by practice site may be found at betterhealthcleveland.org.

Our new reports include patients with diabetes and high blood pressure at practices of four large health systems with long-standing electronic health records (Cleveland Clinic, Kaiser Permanente, The MetroHealth System and the Louis Stokes Cleveland VA Medical Center) and four systems that recently made the transition from paper to electronic health records (Care Alliance, Neighborhood Family Practice, NEON and North Coast Health Ministry). Cleveland Clinic, Kaiser Permanente and The MetroHealth System also continue to report data on their patients living with chronic heart failure.

Several additional organizations, including Lake Health System and St. Vincent Charity Medical Center, are piloting their data collection and reporting procedures, aiming to publicly report in subsequent Community Health Checkups. These systems will soon be joined by our newest partner, Aultman Family Medicine Residency, in Canton.

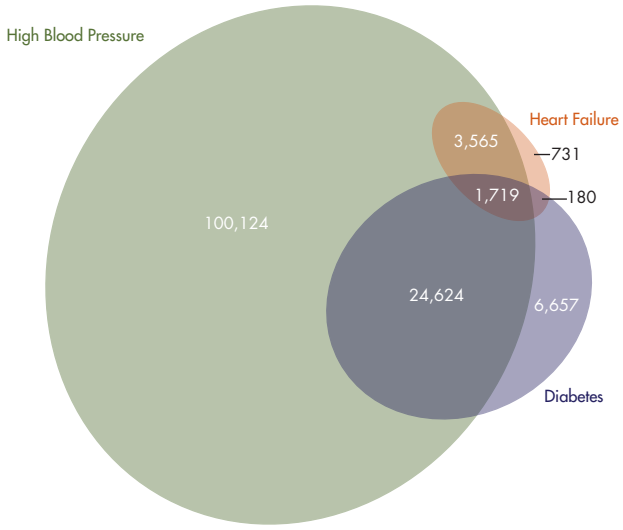


Figure 5. Patients represented in the current Checkup. This report describes the health of 137,600 adult residents of Northeast Ohio who are living with chronic disease, a substantial increase over the 118,426 patients we reported one year ago. More than 130,000 of these patients have high blood pressure, over 33,000 have diabetes, and over 6,000 have heart failure. Over 30,000 (22%) have at least two of these conditions, while more than 1,700 of our patients live with all three.

TABLE 2. CHARACTERISTICS OF PATIENTS INCLUDED IN THIS REPORT

	Diabetes Patients		**High Blood Pressure Patients**		**Heart Failure Patients**	
# of Patients	**33,180**		**130,032**		**6,195**	
# of Primary Care Practices	**55 (8 health systems)**		**55 (8 health systems)**		**41 (3 health systems)**	
# of Primary Care Providers	**525**		**588**		**371**	
	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	37.1	8 – 67	44.4	7 – 75	73.7	41 – 87
Commercial (and Veterans)	43.2	0 – 76	42.2	1 – 67	16.9	0 – 40
Medicaid	7.6	0 – 33	4.8	0 – 33	5.5	0 – 38
Uninsured	12.0	0 – 75	8.6	0 – 75	3.9	0 – 21
Race/Ethnicity (%)						
White	51.8	2 – 98	60.7	1 – 98	63.5	1 – 98
African-American	41.1	2 – 97	35.4	1 – 98	33.4	0 – 99
Hispanic	4.5	0 – 63	2.0	0 – 55	1.9	0 – 52
Other	2.6	0 – 63	1.9	0 – 56	1.2	0 – 5
Preferred Language (%)						
Preference Documented	97.9	67 – 100	97.4	68 – 100	97.5	86 – 100
English	95.0	37 – 100	96.7	45 – 100	95.8	49 – 100
Spanish	3.0	0 – 55	1.4	0 – 46	1.5	0 – 51
Other Languages	2.0	0 – 62	1.9	0 – 54	2.7	0 – 8
Average Age	58.1	49 – 66	62.1	51 – 73	70.5	58 – 77
% Female	50.1	5 – 71	54.4	6 – 74	52.0	32 – 68
Median Household Income ($1000s)	48.3	27 – 78	52.9	27 – 81	50.4	26 – 81
High School Graduation Rate (%)	83.9	71 – 93	85.9	72 – 93	84.7	71 – 93
% with Blood Pressure < 140/90	73.2	47 – 92	69.4	36 – 90	79.1	58 – 93
% with Body-Mass Index < 30	33.3	22 – 64	47.1	29 – 71	45.4	0 – 68
% Not Smoking	80.2	42 – 92	82.9	46 – 92	88.4	54 – 100

WELCOME!

To the nine staff physicians and 21 residents of Aultman Family Medicine Residency in Canton, our newest member

TRANSITION COMPLETE: FROM PAPER TO ELECTRONIC RECORDS

Since our founding in 2007, we have emphasized the impact of electronic health records (EHR) on the ability of practices to improve the care and outcomes of their patients through electronic decision support and more effective documentation. In our prior Checkups, which can be found on our website, and in various other publications, we have documented large differences between our EHR - and paper-based systems in terms of achievement and improvement of our standards in diabetes[3] and high blood pressure.

As a result, we are especially delighted to report that, for the first time, all eight systems reporting data to *Better Health* are now doing so with the help of fully implemented electronic health record systems (Figure 6). The work of completing the transition is still ongoing in several of our partner systems and is not always a smooth process. Soon, we will provide evidence that describes the long-term impact of making the switch. So far, the short-term results are promising, as several of our formerly paper-based systems show substantial improvements in documented care of their patients.

Three of our reporting systems (Care Alliance, Neighborhood Family Practice, and NEON) are Federally Qualified Health Centers. Over the past two years, all three have transitioned to electronic health records while also implementing team-based care. All three systems report increased numbers of patients with diabetes and substantially improved achievement. In fact, all three systems received *Better Health's* "Gold Stars" for improvement in diabetes care and outcomes in this report (see inside back cover).

It should be emphasized that these (formerly paper-based) systems still face intense pressures on their resources. Further, they continue to provide care for patients who are disadvantaged in terms of insurance coverage, and who reside in neighborhoods with lower household incomes and educational attainment. However, the ability to report on all patients in a consistent way is an important step toward the goal of improving the health of our patients. Congratulations to all of our partner practices!

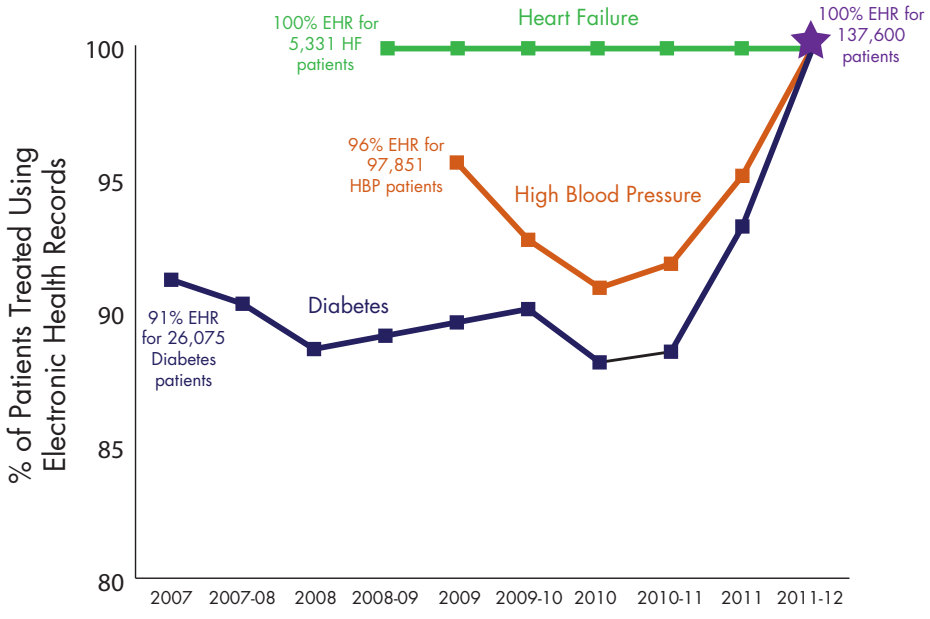


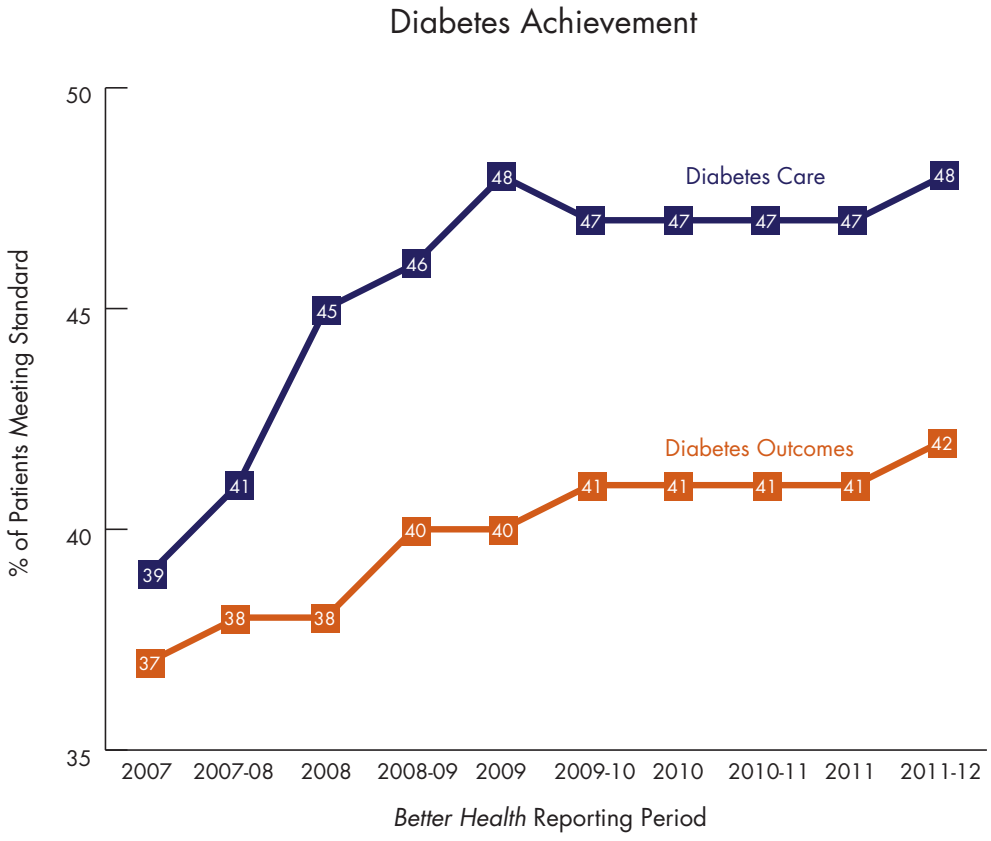
Figure 6. Percentage of patients reported to *Better Health* that use electronic health record systems (as opposed to paper-based systems) since the inception of data reports in 2007. Diabetes and High Blood Pressure data have been reported by all participating systems, while Heart Failure data have been reported only by three EHR-based systems. This 2011-12 report is our first to gather all data on all patients for all conditions using electronic health records.

[3] Cebul RD Love TE Jain AK Hebert CJ Electronic Health Records and Quality of Diabetes Care, *N Engl J Med* 2011; 365: 825-33.

REPORT ON REGIONAL ACHIEVEMENT

Continuing Improvement in Diabetes Care and Outcomes

Figure 7 shows our improvement since 2007 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) across all of our partner health systems. Although we observe substantial improvement in rates of care (39 to 48%) and outcomes (37 to 42%), we should emphasize that a much larger group of patients is represented in 2011-12 that includes 13 additional practice sites, many with somewhat limited resources and disproportionately disadvantaged patients in terms of insurance, neighborhood income and education. Much work remains, but we are delighted to report that as compared to five years ago, we now report 5,708 more patients with documented good routine diabetes care, and 4,392 more patients in good control of their intermediate outcomes.



SHARING BEST PRACTICES, IDEAS AND CHALLENGES AT *BETTER HEALTH'S* SEPTEMBER 2012 LEARNING COLLABORATIVE SUMMIT

Figure 7. Achievement of Diabetes Care and Outcomes Standards, 2007 to present, across *Better Health's* partner practices.

DIFFERENCES IN ACHIEVEMENT BY INSURANCE PERSIST

In our prior Community Health Checkups, we documented substantial differences in achievement across health insurance types, as well as by patients' race/ethnicity, income and education. Figure 8 describes similar disparities in achieving both our diabetes outcomes and care standards in our new data for 2011-12. Disparities associated with insurance coverage in our patients with diabetes are highlighted. Specifically, Medicare patients are associated with substantially better outcomes and higher care achievement than patients with Commercial insurance, while patients with Medicaid insurance and the Uninsured lag on both measures. We also observe less pronounced but substantial differences among patients living in neighborhoods with lower education and income levels, and among African-American patients. In addition, when we examine improvement over time across groups, all have improved since 2007, though Uninsured patients show much slower growth. Detailed information may be found in our Supplemental Data Report at betterhealthcleveland.org.

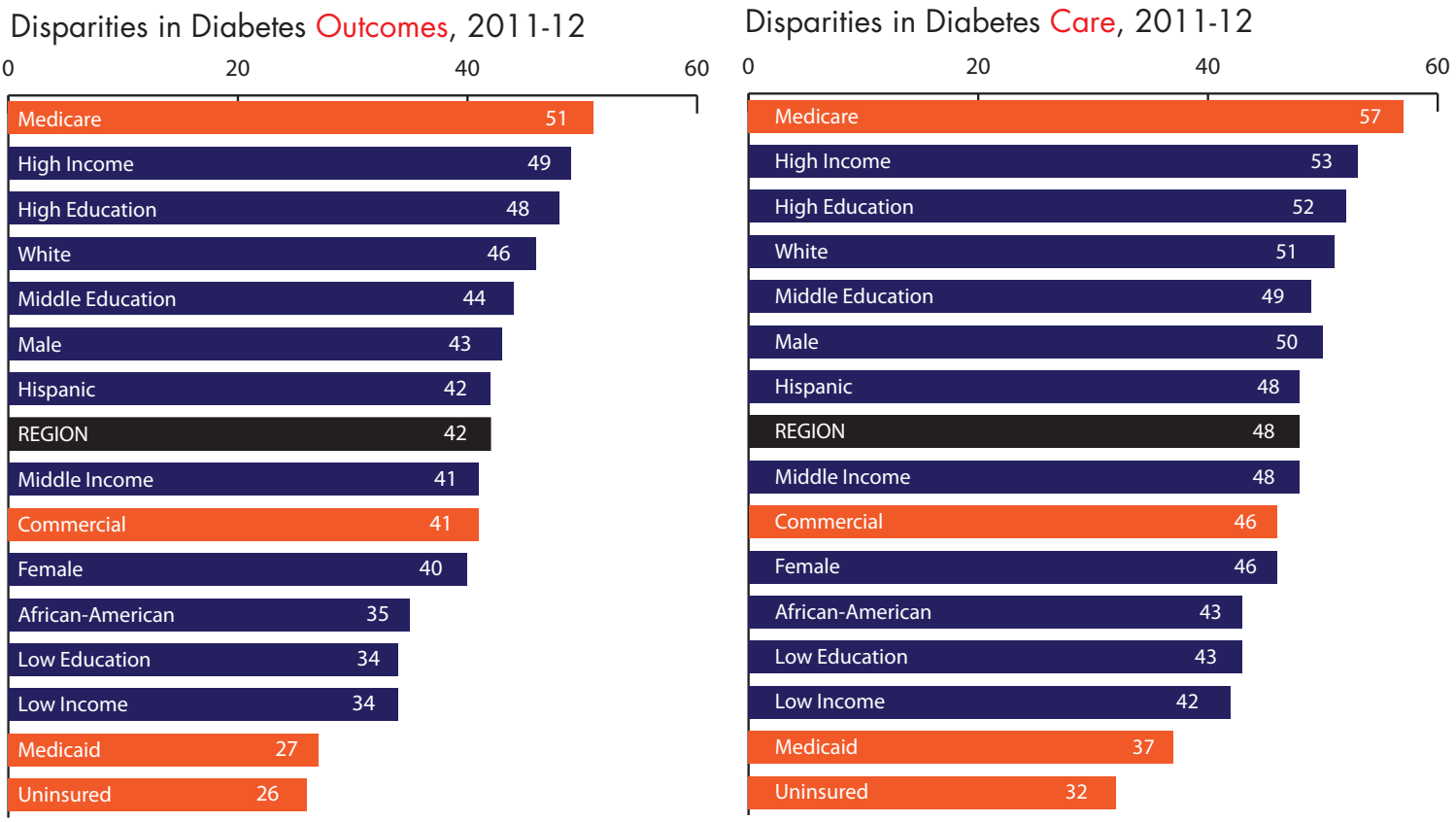


Figure 8. Regional achievement of our Diabetes Outcome and Diabetes Care standards in 2011-12, overall, and within groups defined by insurance, gender, race/ethnicity, income, and educational attainment.

IDENTIFYING "BRIGHT SPOTS" TO ACCELERATE IMPROVEMENT

The power of *Better Health's* partnerships is our common vision and willingness to share our experiences. One of our most important strategies for improvement is to identify and share "bright spots" – what we call potentially Replicable Best Practices – with our partners. We previously have reported on RBPs for several diabetes care standards, and, in our most recent report, for the control of blood pressure, particularly among African-American patients. With our new data, we have uncovered a new potential "bright spot" for cholesterol control in our diabetes patients.

As Figure 9 shows, the practices of System A have improved substantially on our cholesterol standard (LDL cholesterol below 100 or a prescription for a statin medication). In fact, nine of the 10 "most improved" practices on this measure come from System A, and all 11 System A practices exceed the region-wide improvement score.

In 2011-12, System A also demonstrated outstanding achievement on this measure, results for which can be seen in our Supplemental Data Report posted on betterhealthcleveland.org. System A represents the top 10 practices regionwide, with 93% – 97% achievement, compared to our regional average of 89%.

We hope that further investigation into the causes of this "bright spot" will help us to identify specific and replicable best practices for cholesterol control that can be shared and implemented across all of our partner health systems.

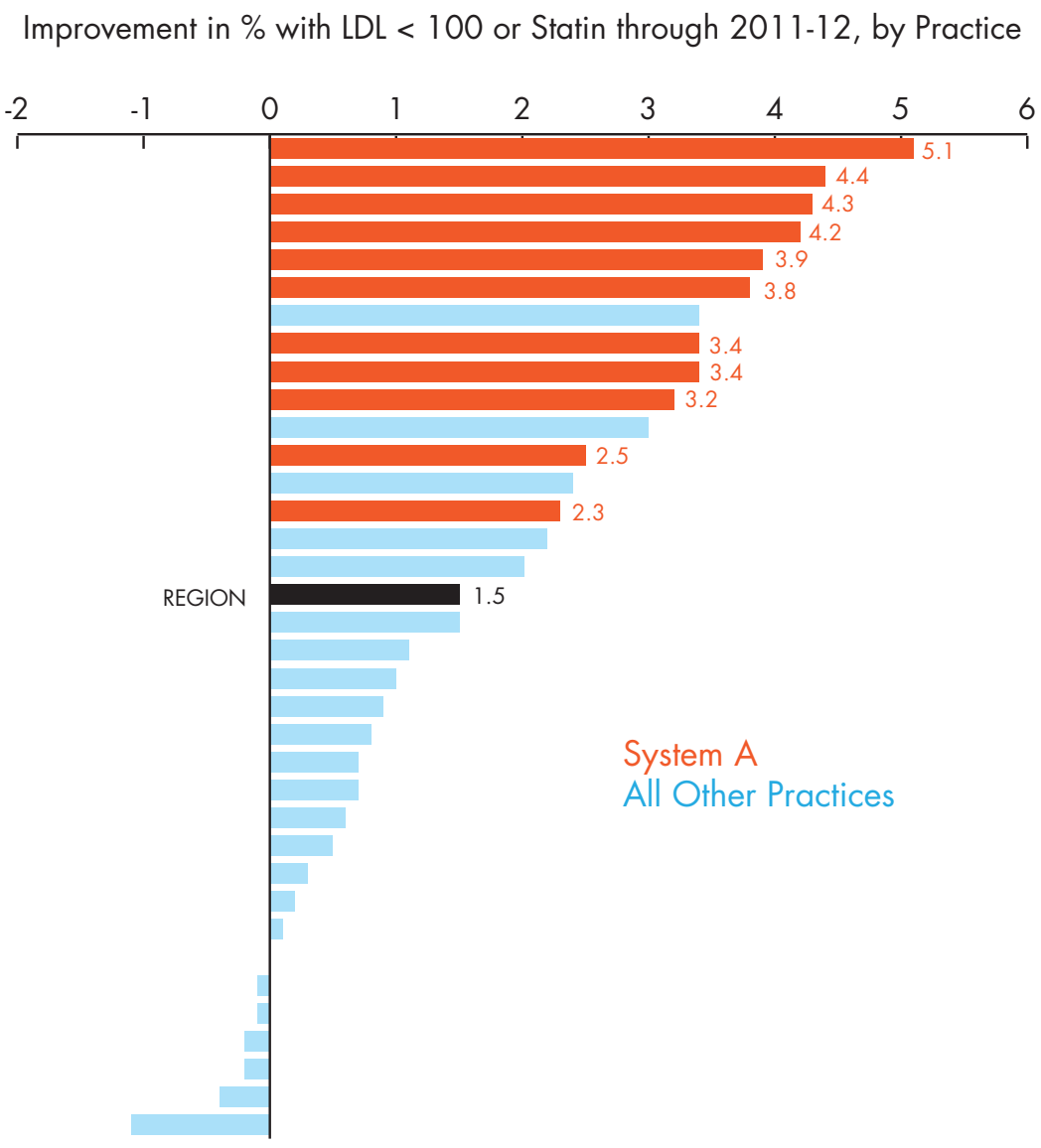


Figure 9. *Better Health* practices whose rates of meeting our standard for cholesterol control (LDL cholesterol < 100 or statin prescription) were most improved from 2007 through 2011-12. Nine of the 10 most improved practices are part of System A, as identified by the orange bars. In addition, the top 10 achieving practices (ranging from 93 – 97% on this measure in 2011-12) all come from System A.

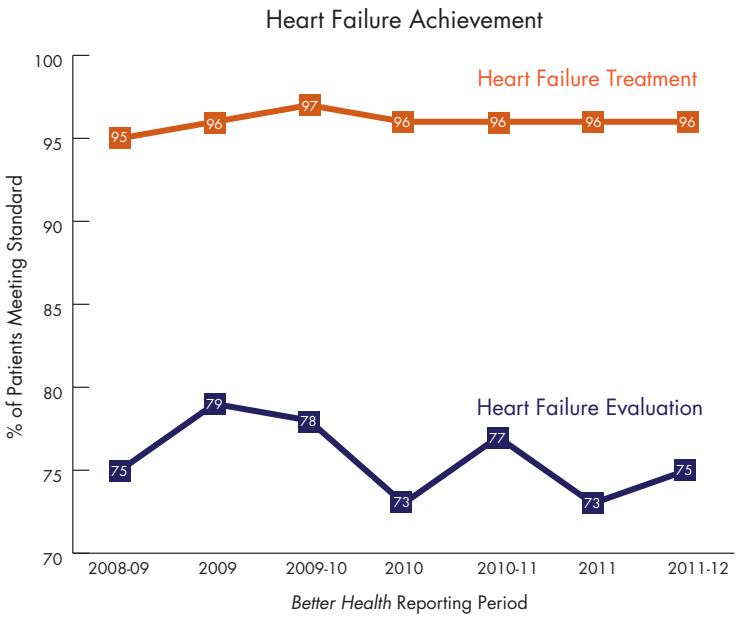


Figure 10. Achievement of Heart Failure Evaluation and Treatment Standards, 2008-09 to present, across *Better Health's* partner practices.

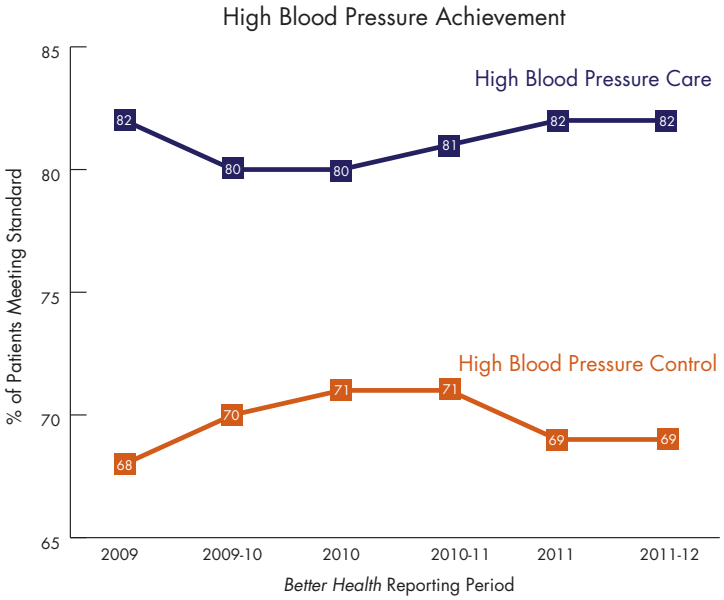


Figure 11. Achievement of High Blood Pressure Care and Control Standards, 2009 to present, across *Better Health's* partner practices.

HEART FAILURE

Regional Evaluation And Treatment Rates Remain High

Over its past seven Checkups, *Better Health* has reported the evaluation and treatment of patients with heart failure in three of our partner systems (Cleveland Clinic, Kaiser Permanente, and The MetroHealth System). Figure 10 describes our continuing high achievement on these measures through 2011-12, when we report on a record 6,195 patients with heart failure. The care of three-quarters (75%) of our heart failure patients meets our standard for evaluation, which requires appropriate heart function ("echo") and annual blood testing, as well as regular checks of weight and blood pressure. In describing proper treatment, *Better Health's* standard applies to the 2,103 patients (in 2011-12) with serious or moderate heart failure (just over 1/3 of all heart failure patients). Just over 96% of these 2,103 patients met this standard in 2011-12, which requires either an ACE/ARB or Beta-Blocker medication (or both).

HIGH BLOOD PRESSURE

Improving Rates Over a Larger Group of Patients

As seen in Figure 11, regional achievement of our key high blood pressure standards remains consistent with our previous reports, despite a 33% increase in patients with high blood pressure, from just under 98,000 in 2009 to more than 130,000 today. In 2009, a total of 66,969 (68%) patients had control of their blood pressure (below 140/90), while in 2011-12, 90,268 (69%) of our patients had good control – a difference of more than 23,000 patients. Achievement of our high blood pressure care standard, which requires appropriate and timely checks of blood pressure, kidney function and cholesterol, remains at 82% region-wide. This represents an increase of more than 27,000 patients who received this good routine care over the past three years.

Figure 12 displays 40 practices and health systems that have continuously reported high blood pressure data. Of these 38 have demonstrated improvements in their patients' care, outcomes, or both over the past three years. As shown, our overall regional improvement rate has been modest over time, but our 2011-12 report describes a pool of patients that is 33% larger and generally more disadvantaged than patients in our 2009 report.

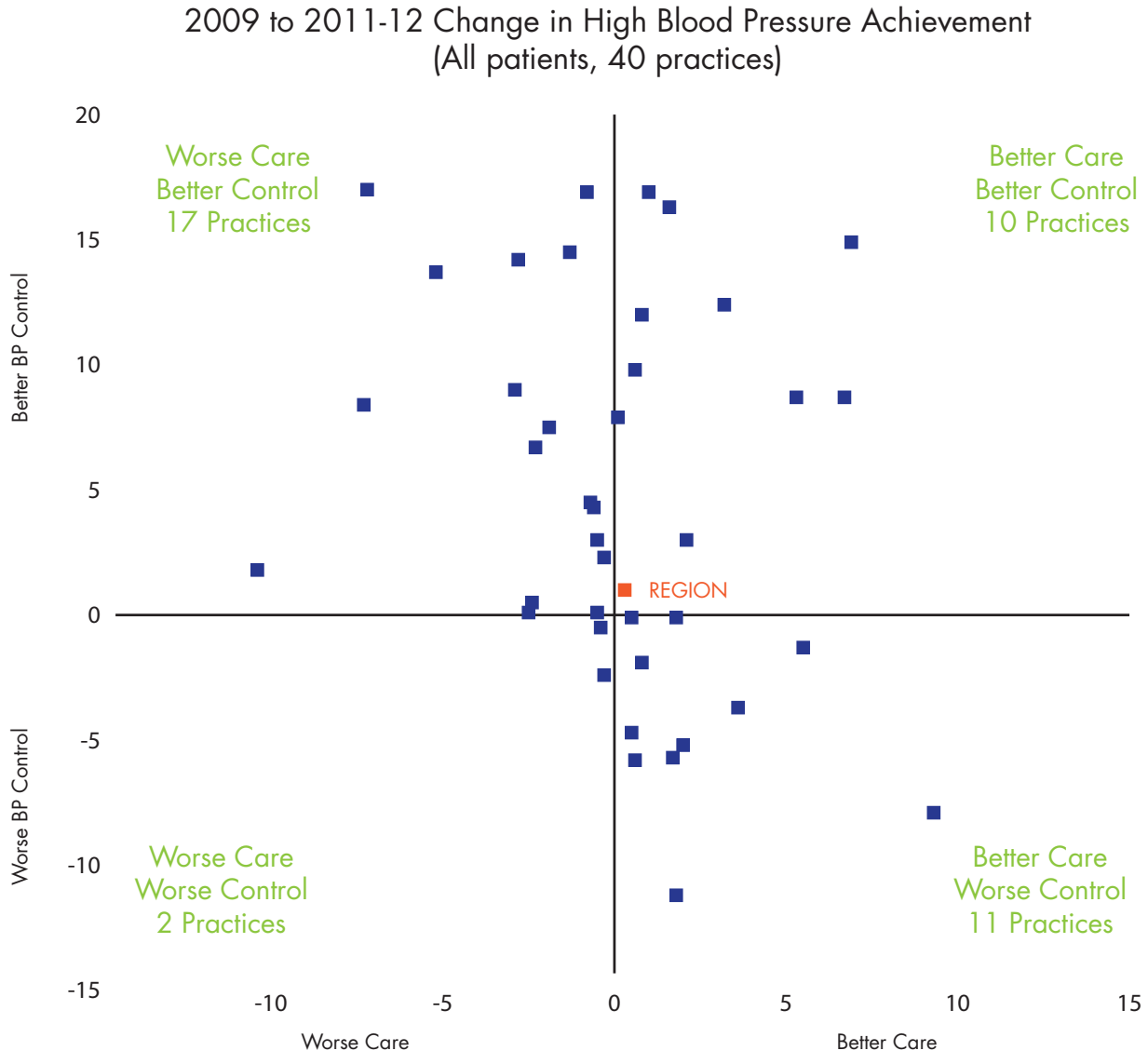


Figure 12. Change in percentage of patients achieving composite standards for High Blood Pressure Care and Control from 2009 to present.

STRONG PERFORMANCE VS. NATIONAL BENCHMARKS

Table 3 compares our partners' achievement with national benchmarks on the 10 comprehensive diabetes care standards and one standard for high blood pressure control established by the National Council for Quality Assurance. Once again, *Better Health's* practices achieved better results than the national HMO health plan average on all of these standards among our Medicare and Commercial patients, and on all but Diabetes Eye Examination among our Medicaid patients. Our uninsured patients, though lacking a national benchmark, had better results than the nationwide Medicaid average on 10 of these 11 standards.

TABLE 3. REGIONAL ACHIEVEMENT (2011-12) COMPARED TO HEALTH PLANS NATIONWIDE (2011)

NCQA/HEDIS MEASURES FOR COMPREHENSIVE DIABETES CARE

Measure	Group	Medicare	Commercial	Medicaid	Uninsured	Overall
Blood Pressure Control (< 140/80)	Region	59.2	53.7	50.7	45.9	54.5
	National Mean	48.2	44.2	39.4	N/A	N/A
Blood Pressure Control (< 140/90)	Region	72.2	77.1	67.9	65.3	73.2
	National Mean	63.1	65.8	60.9	N/A	N/A
Eye Examination	Region	67.0	60.0	47.3	49.3	60.3
	National Mean	66.0	56.9	53.3	N/A	N/A
Hemoglobin A1c testing performed	Region	95.1	95.0*	93.1*	93.8	94.7
	National Mean	91.0	90.0	82.5	N/A	N/A
A1c Control (< 7)	Region	53.7	47.7	41.4	37.2	48.2
	National Mean	N/A	42.2	35.4	N/A	N/A
A1c Control (< 8)	Region	75.4	69.5	58.1	55.2	69.1
	National Mean	65.2	61.2	48.1	N/A	N/A
A1c Control (> 9) [lower values are better]	Region	14.4	18.9	30.0	31.5	19.6
	National Mean	26.5	28.3	43.0	N/A	N/A
LDL Cholesterol Screening	Region	88.6	90.6	77.4	78.6	87.4
	National Mean	88.3	85.3	75.0	N/A	N/A
LDL Control (< 100)	Region	63.5	56.7	40.6	39.7	56.0
	National Mean	52.5	48.1	35.2	N/A	N/A
Monitoring Nephropathy	Region	92.7	91.6*	89.2*	89.7	91.6
	National Mean	89.9	83.8	77.8	N/A	N/A
Regional Diabetes Patients, # (%)		12,320 (37)	14,347 (43)	2,529 (8)	3,984 (12)	33,180

NCQA/HEDIS MEASURE FOR CONTROLLING HIGH BLOOD PRESSURE

Measure	Group	Medicare	Commercial	Medicaid	Uninsured	Overall
Blood Pressure Control (< 140/90)	Region	70.8	72.1	58.9	54.9	69.4
	National Mean	64.0	65.4	56.8	N/A	N/A
Regional High Blood Pressure Patients, # (%)		57,759 (44)	54,932 (42)	6,228 (5)	11,113 (9)	130,032

* *Better Health's* regional performance on this measure exceeds the 90th percentile of health plans, nationally.
N/A = Not Available.

National Data from The State of Health Care Quality 2012, www.ncqa.org.

SPOTLIGHTING OUTSTANDING ACHIEVEMENT AND IMPROVEMENT

In 2011-12, 39 partner practices and health systems met our standards to earn *Better Health* gold stars. Each of these practices had quality scores in the top 10% of one of our composite measures in diabetes, high blood pressure or heart failure, or was in the top 10% of our practices in terms of their improvement of these measures. Congratulations to our partners and their patients!

TABLE 4. OUTSTANDING ACHIEVEMENT AND IMPROVEMENT (2011-12)

	OVERALL	MEDICARE	COMMERCIAL	MEDICAID	UNINSURED
CARE ALLIANCE					
Care Alliance (All Practices)	DM↑				DM↑↑ HBP↑↑
THE CLEVELAND CLINIC					
Beachwood Family Health Center	HF	HBP HF HF↑↑			
Chagrin Falls Family Health Center	DM DM↑↑	DM DM↑↑			
Cleveland Clinic - Main Campus	DM	DM HF↑	DM HF		
Independence Family Health Center	DM	DM	DM		
Richard E. Jacobs Health Center					DM
Solon Family Health Center	DM	DM	DM		
Stephanie Tubbs Jones Health Center	HF	HF			
Strongsville Family Health Center	DM HF	HBP HF	DM		HBP
Willoughby Hills Family Health Center		HBP	DM		
KAISER PERMANENTE					
Avon Medical Offices	DM↑↑ HBP HBP↑↑	DM↑↑ HBP	DM↑↑ HBP		
Bedford Medical Offices		DM	HBP↑↑		
Chapel Hill Medical Offices	DM HBP	HBP	DM HBP		
Cleveland Heights Medical Center		DM	HF HF↑↑		
Concord Medical Offices	HBP				
Fairlawn Medical Offices	HBP HBP↑↑	HBP	HBP HBP↑↑		
Kent Medical Offices	HBP				
Medina Medical Offices	DM				
Parma Medical Center	DM↑ HBP↑ HF HF↑↑	HBP↑↑HF HF↑↑	HBP↑↑		
Rocky River Medical Offices	HBP↑↑	HBP↑↑			
Strongsville Medical Offices	DM HBP HBP↑↑	DM HBP HBP↑	HBP HBP↑		
Twinsburg Medical Offices	HBP↑	HBP↑	HBP↑		
Willoughby Medical Offices	DM	DM			
LOUIS STOKES CLEVELAND VA MEDICAL CENTER					
VA Medical Center at Wade Park*	DM HBP	DM HBP	DM HBP		
THE METROHEALTH SYSTEM					
Asia Town Health Center	DM HBP↑	HBP↑			
Broadway Health Center		HBP↑	DM↑ HBP↑		
Brooklyn Health Center	HF			HBP	DM HBP
Buckeye Health Center	HBP	HBP	HBP		DM
J. Glen Smith Health Center		DM↑			DM↑ HBP↑
Lee-Harvard Health Center	HBP HF↑				HBP HBP↑
MHMC - Faculty/Residents Practice	HF			DM HBP HBP↑ HF	
MHMC - Family Practice	HF↑		DM↑	HBP↑	DM DM↑ HBP↑
MHMC - Internal Medicine	DM↑ HBP	HF		DM DM↑ HBP	DM HBP HBP↑
Old Brooklyn Health Center	HBP		HBP	DM HBP	DM HBP
Strongsville Health Center	HF↑	DM↑	DM HBP		DM↑
Thomas F. McCafferty Health Center	HBP HF	DM↑ HBP			
West Park Health Center	DM↑			DM	
NEIGHBORHOOD FAMILY PRACTICE					
NFP (All Practices)	DM↑	DM↑	DM↑	DM↑	DM↑
NFP - Main Office				HBP	HBP
NEON: NORTHEAST OHIO NEIGHBORHOOD HEALTH SERVICES, INC.					
NEON (All 6 Practices)			DM↑↑		

*Patients with Veterans' insurance are included in the Commercial group if under age 65, otherwise in the Medicare group.

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

OUTSTANDING IMPROVEMENT (over past two years) IN
DM↑ Diabetes *Care* or *Outcomes*
HBP↑ High Blood Pressure *Care* or *Control*
HF↑ Heart Failure *Evaluation* or *Treatment*

Better Health *Greater* Cleveland
An Alliance for Improved Health Care

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The Center for Community Solutions
Health Action Council Ohio

PRIMARY CARE MEMBERS
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Care Alliance Health Center
Cleveland Clinic, Main Campus, Family Health Centers,
- Stephanie Tubbs Jones Health Center & Fairview Hospital

Kaiser Permanente Ohio
Lake Health System
Louis Stokes Cleveland VA, Wade Park Campus
MetroHealth, Main Campus, Center for Community Health
- & Senior Health and Wellness Center

Neighborhood Family Practice
North Coast Health Ministry
Northeast Ohio Neighborhood Health Services (NEON)
St. Vincent Charity Medical Center Primary Care Practices
University Hospitals Family Medicine

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

Lake Health System
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St. Vincent Charity Medical Center

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Buckeye Health Plan
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1.23.2013