Better Health Partnership

Transforming Health Care, Together

19TH REPORT TO THE COMMUNITY

SUMMER 2017

www.betterhealthpartnership.org

June 2017

To the Community:

In Better Health Partnership's first decade, we trained our efforts on improving care and outcomes for adults with costly and debilitating chronic conditions. We developed strategies based on a trusted foundation of data, transparency, and public celebration of exceptional improvement and achievement. We launched Learning Collaboratives, creating a safe space for health care competitors to collaborate on two days each year.

From the start, our north star has been The Triple Aim – better care, better health and lower costs. Transforming care delivery using electronic health records and patient-centered practice redesign have been key strategies. In another, we use EHR data shared by diverse health care systems to discover and disseminate best practices for replication by others. Reports like this one have provided benchmarks on regional progress and highlighted new opportunities for improvement.

Thanks to the efforts of our partners, we have made a measurable difference across socioeconomic strata in Northeast Ohio. We have erased disparities in diabetes care and dramatically increased rates of blood pressure control among our most vulnerable patients. Thanks to better care, our patients' better health has averted almost 6,000 hospitalizations.

Still, as we continue to document successes in each component of the Tripe Aim, much work lies ahead for our region. We know that conventional medical care accounts for just 10- to 20 percent of the factors affecting good health. We also recognize that non-medical factors related to poverty and environmental forces present tremendous challenges for good health.

Over the last two years, we have broadened our scope, geographically, in clinical care, and in partnerships, to help our patients address non-medical factors that affect their health. In this report, we include colorectal cancer screening for the first time. More importantly, for our children and grandchildren, we have begun to address the problems of childhood obesity, in order to avoid chronic diseases that inevitably follow, and childhood asthma, the most common cause of avoidable hospitalizations and health-related school absenteeism. We understand the answers to these challenges reside as much in the community as they do in our clinics.

Better Health remains committed to our vision for a healthier Northeast Ohio. We are grateful for the many contributions of our members and other partners in our region who lend their time and talents to the collaborative efforts of Better Health Partnership. Thank you, all!

Randall D. Cebul, MD, President and CEO
Better Health Partnership

Vision and Mission

Better Health Partnership enters its second decade dedicated to the vision of making Northeast Ohio a healthier place to live and a better place to do business. As a neutral convener, our mission is to provide a safe place for health care competitors to collaborate on common health-related challenges and to accelerate region-wide transformation in health care delivery and payment. By harnessing the power of electronic health records, we publicly report data and drive continuous improvement, best practice sharing and innovation.

Better Health Partnership's twice yearly Learning Collaborative Summits: Sharing Best Practice

A decade of making a difference

Better Health's collective impact is documented in region-wide improvements in health care, outcomes, and costs of care that benefit those who receive, provide and pay for care. We proudly document improvements in health care delivery, population health, reduced disparities and lower costs, affecting thousands of lives.

More than 1,000 primary care providers across diverse health systems are members of Better Health, sharing data that we analyze to discover and spread best practices in the care of more than 400,000 adults and children in the region. A 16-fold increase (since 2007) in the number of patients on which we report reflects our attention to important and prevalent cardiovascular conditions (diabetes, hypertension, and heart failure), and, with this report, screening for colorectal cancer as well as initiatives that address children's obesity and asthma. Trusted measurement and evaluation validate effective strategies and inform health policy decisions, such as Medicaid expansion in Ohio.

Better control of high blood pressure

Since Better Health's first report on blood pressure (BP) in 2009, 74,901 more people with high BP have it under control, for a total of 141,870 in 2016. Disadvantaged patients have improved the most, especially in the last two years, as seen in Figure 1. The protocol that is improving BP control rates was first identified by Kaiser Permanente in 2010 and adapted by Better Health to meet the needs of disadvantaged patients in our region. Shari Bolen, MD, MPH, Better Health's Director of Cardiovascular Disease Programs, leads Better Health's Practice Consultants to help primary care practices implement the protocol.

"As a collaborative, we learn from each other," says Dr. Bolen. "We are delighted with the rapid climb in control rates, which lowers the risks of heart disease and stroke, and we expect the gains to continue."

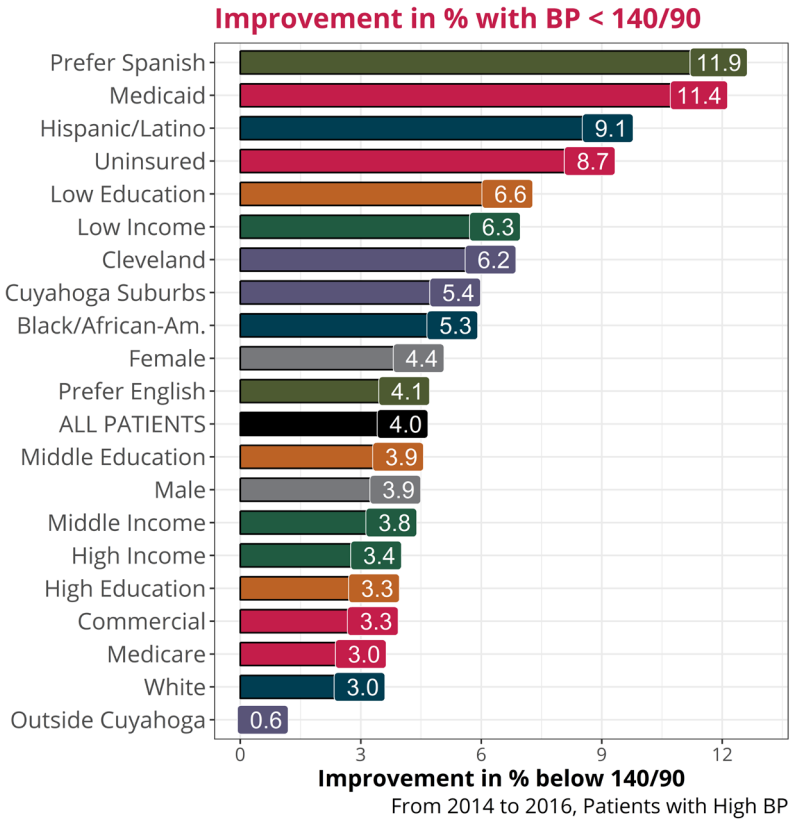


Figure 1. In the past two years, rates of blood pressure control have climbed quickly among disadvantaged groups.

Better diabetes care and elimination of disparities

Diabetes is a challenging and increasingly prevalent condition that disproportionately affects African-American and Hispanic patients. As shown in Figure 2, Better Health has made strong progress since 2007, as the number of people with diabetes who receive recommended care and meet our outcome standards have more than doubled. Moreover, the gap in good diabetes

care across race and ethnicity has closed, as displayed in Figure 3, reflecting dramatic improvement in testing and treatment for diabetes' complications, especially among minorities in Northeast Ohio.

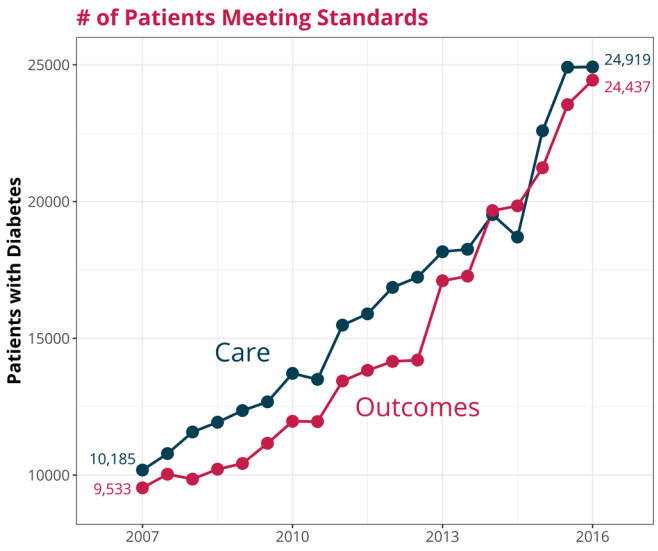


Figure 2. More than twice as many patients with diabetes meet recommended care and outcome standards now as compared to 10 years ago.

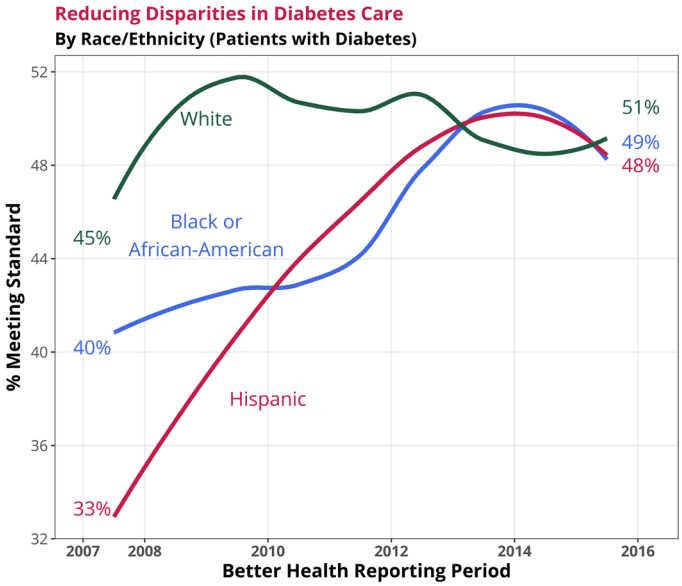


Figure 3. Diabetes care shows reduced disparities by race/ethnicity.

Lower costs and policy impact

Diabetes, hypertension, and heart failure are chronic conditions that, with the right care, can be well managed and reduce the need for costly hospital stays. Better Health studies have quantified the value of improved care and avoided hospital use since our efforts began:

- More than $40 million in savings in Cuyahoga County over seven years by averting nearly 6,000 hospitalizations related to diabetes and cardiovascular disease.
- Among the avoidable causes of these hospitalizations, improved vaccination rates for pneumonia saved an estimated $7 million over a five-year period, displayed in Table 1.

Table 1.
Improvement in Pneumonia Vaccination Rates Patients With Diabetes

2008-2009	
No. of Patients	% Meeting Goal
20,501	76.2
2014-2015	
No. of Patients	% Meeting Goal
30,712	84.3
# of Patients Vaccinated	
2008 - 2009	2014 - 2015
15,622	25,890

$7 Million Saved in Cuyahoga Country

Better Health's analyses on the relationship between better care and lower costs also contributed to major health policy changes, such as meaningful use of electronic health records for improved care and expansion of Medicaid in Ohio. In 2013, prior to Medicaid expansion, The MetroHealth System along with Care Alliance and Neighborhood Family Practice, broke new ground when it launched the MetroHealth Care Plus program, enrolling previously uninsured Cuyahoga County residents in a Medicaid-like insurance plan.

Across all 28,295 enrollees, total costs of care in 2013 were 28.7 percent below the budget cap, providing cause for optimism that a prepared safety net can meet the challenges of Medicaid expansion. At a Cleveland City Club speech in 2017, Barbara Sears, Director of Ohio Medicaid, credited the study for giving Ohio "the comfort level to do this on a statewide basis and make Medicaid expansion work."

Screening for colorectal cancer

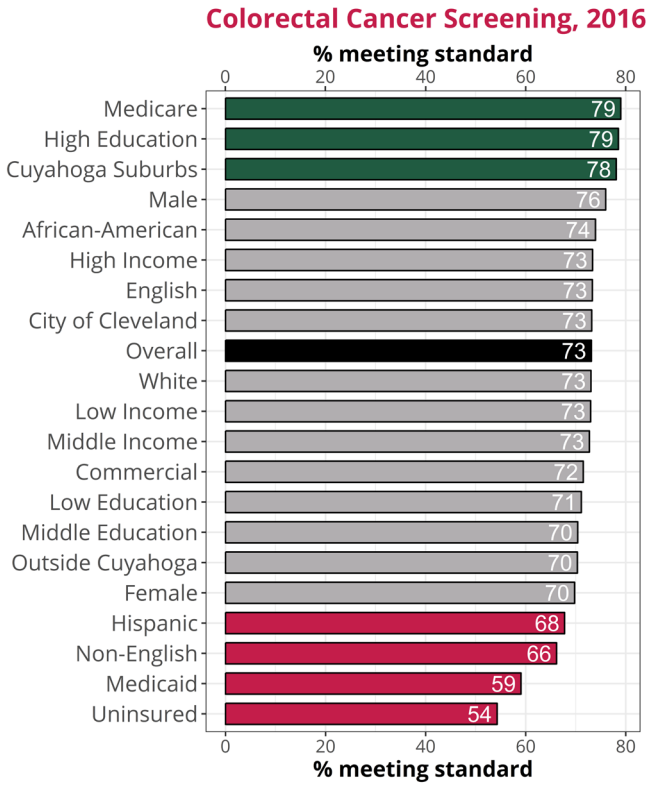


Figure 4. Screening rates for colorectal cancer across patient subgroups, 2016.

For the first time, we report data on rates of colorectal cancer (CRC) screening. CRC is the third most common cause of cancer deaths in the U.S. Mortality has steadily declined over the past three decades, attributed in large part to increased screening rates. Among 197,339 Northeast Ohio adults ages 50-75 in 2016, 74% received one of several screening tests, a rate significantly higher than the statewide rate of 63% but below the American Cancer Society's goal of 75%. Figure 4 displays differences in screening rates across several social determinants that provide opportunities for further improvement. Patients with Medicare and those who live in high-education neighborhoods or in Cuyahoga County suburbs were more likely to have recommended screening. Included among those with lower rates are uninsured patients, those covered by Medicaid, patients of Hispanic ethnicity, and those who prefer a language other than English.

Beyond Better Health: Partnering for community transformation

While the past 10 years have yielded great improvements in care, it is well understood that health systems alone cannot improve health. We have begun to build on the work that has advanced equitable health care by furthering multi-sector collaboration, leveraging education, technology, business, economic development, public health and social services to help transform our communities. A holistic approach is especially vital for children to foster their ability to thrive and become a productive future workforce. Through our Children's Health Initiative, we begin the journey to connect clinical providers with community resources to address childhood obesity and asthma.

We are excited about the potential to improve population health using "hot spotting" maps to identify high-density areas to target for clinical and community interventions. Figure 5 show electronic health record data to plot locations of overweight and obese children. Similar maps of children with hospitalizations or visits to the emergency department for asthma linked to housing quality information can help prioritize remediation efforts to reduce mold and other asthma triggers.

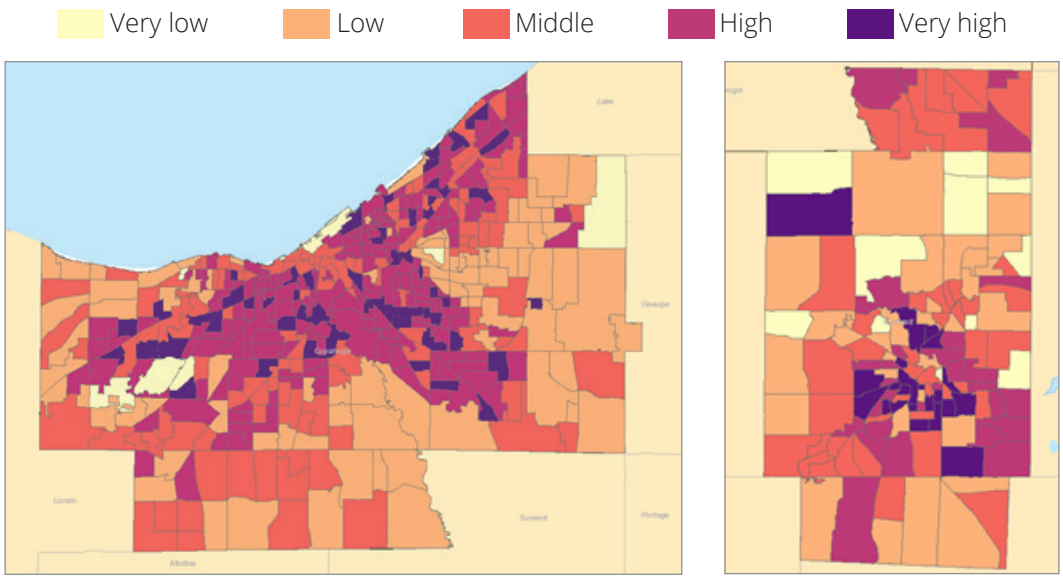
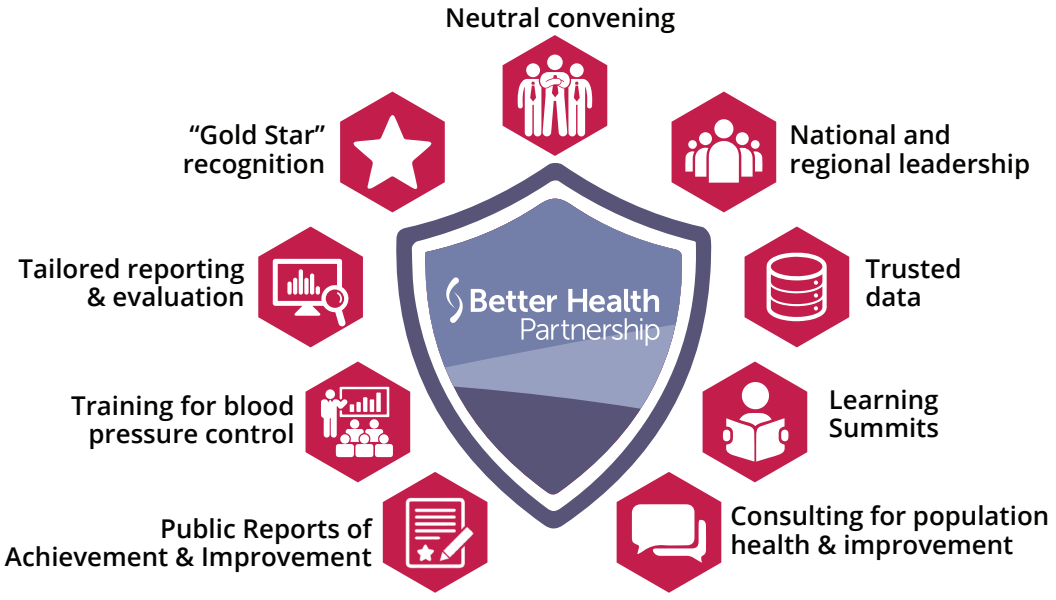


Figure 5. Hot-spotting maps show the childhood obesity or overweight rates seen across five health systems participating in Better Health's Children's Health Initiative pilot (left: Cuyahoga County, Summit County, right)

Better Health is partnering with United Way of Greater Cleveland's 2-1-1 Help Center to enable clinics to link patients with trusted community resources to address non-medical problems. The goal is to connect patients with effective community interventions to improve health, reduce costly utilization, and help identify gaps in community services. Success of an initial pilot program in children's obesity and asthma will set the stage to sustain and scale the model.

Better Health's roles in achieving the Triple Aim

As a regional health improvement collaborative, we add value to our partners and community through programmatic approaches proven to improve care, health outcomes and reduce costs:



Visit **www.betterhealthpartnership.org** or contact us at **info@betterhealthpartnership.org** to learn more.

BOARD OF DIRECTORS

Chair
Kevin S. Lauterjung
Principal,
Community Energy Advisors, LLC

Vice-Chair
David Bronson, MD
Emeritus Staff, Cleveland Clinic,
Chair, Board of Commissioners
of the Joint Commission

Secretary / Treasurer
Patty Starr
Executive Director
Health Action Council Ohio

Chair, Finance Committee
Anita Cook
Executive Director
West Side Catholic Center

Chair, Governance Committee
Jean Polster, RN, MS
President and CEO
Neighborhood Family Practice

President and CEO
Randall D. Cebul, MD
Director, CWRU Center for Health Care
Research & Policy at MetroHealth,
Professor of Medicine,
Epidemiology and Biostatics

Steve Eisenberg, Esq.
General Counsel
US Acute Care Solutions

Vanessa J. Evans
Partner, Bright Side, Inc.

James F. Gutierrez, MD
Chair, Department of Community
Internal Medicine in the
Medicine Institute
Cleveland Clinic

JB Silvers, PhD
Professor of Healthcare Finance,
CWRU

Jim Weisman
CEO-in-Residence, BioEnterprise

Ted Wymyslo, MD
Chief Medical Officer
Ohio Association of
Community Health Centers

OUR PARTNERS

FOUNDING MEMBERS

Health Action Council

The Center for Community Solutions

The MetroHealth System

PRIMARY CARE MEMBERS

Akron Children's Primary Care

Alyson's Place JFSA Medical Clinic

Asian Services in Action, Inc

Care Alliance Health Center

Circle Health Services

Cleveland Clinic
- Main Campus
- Family Health Centers
- Fairview Family Practice
- Stephanie Tubbs Jones Health Center

East Side Family Medicine

Lake County Free Clinic

Lake Health System

Mercy Health Physicians

MetroHealth
- Health Centers
- Main Campus
- Senior Health and Wellness Center

Middlefield Clinic

Neighborhood Family Practice

North Coast Health

Northeast Ohio Neighborhood Health Services (NEON)

Northeast Ohio VA Healthcare System

Senders Pediatrics

St. Vincent Charity Medical Center Primary Care Practices

UHCMC Douglas Moore Health Center

UHCMC Medical Access Clinic

University Hospitals
Rainbow Babies & Children's Hospital

FOUNDATION PARTNERS

ABIM Foundation

Akron Community Foundation

The Cleveland Foundation

Mt. Sinai Health Care Foundation

Robert Wood Johnson Foundation

Saint Luke's Foundation of Cleveland

Sisters of Charity Foundation of Cleveland

United Way of Greater Cleveland

HOSPITAL PARTNERS

Akron Children's Hospital

Cleveland Clinic
- Main Campus
- Avon Hospital
- Euclid Hospital
- Fairview Hospital
- Hillcrest Hospital
- Lutheran Hospital
- Marymount Hospital
- South Pointe Hospital

Lake Health System

MetroHealth Medical Center

Northeast Ohio VA Healthcare System

St. Vincent Charity Medical Center

University Hospitals
Rainbow Babies & Children's Hospital

EMPLOYERS AND HEALTH PLAN PARTNERS

Health Action Council

Johnson & Johnson Health Care Systems, Inc.

Lake County School Consortium

Lubrizol

Medical Mutual of Ohio

Progressive Insurance Corp.

ORGANIZATIONAL PARTNERS

Academy of Medicine of Cleveland & Northern Ohio

American Diabetes Association

American Heart Association

Case Western Reserve University

CWRU Practice-Based Research Network

CWRU Clinical Translational Science Collaborative

Cleveland Department of Public Health

Cuyahoga Community College

Cuyahoga County Board of Health

Health Improvement Partnership Cuyahoga

Health Policy Institute of Ohio

Healthy Cleveland

Hospice of the Western Reserve

Northeast Ohio Medical University (NEOMED)

NHRI: The Network for Regional Healthcare Improvement

Ohio Department of Health

Ohio Department of Medicaid

OneCommunity

Ohio Patient-Centered Primary Care Collaborative

University Settlement

West Side Catholic Center