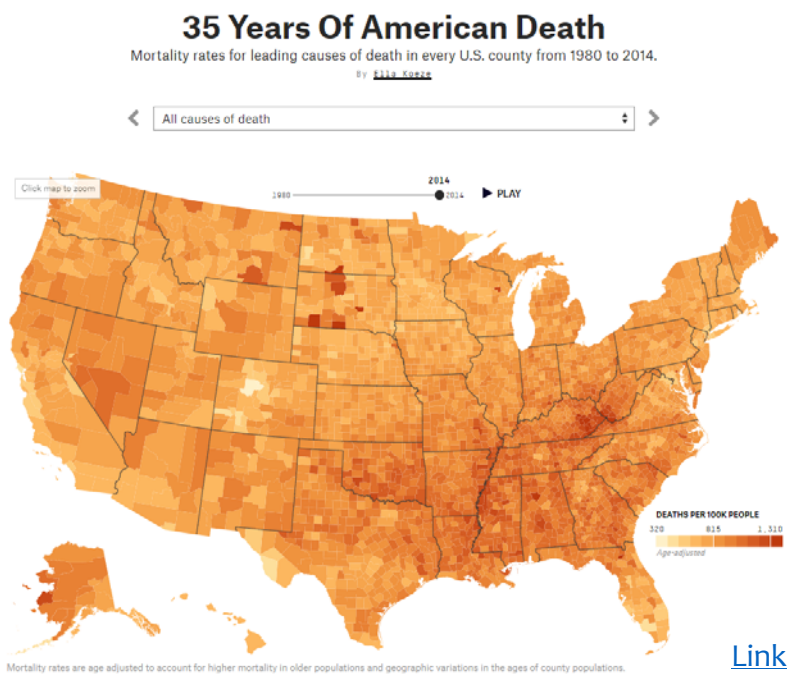
FiveThirtyEight

APR. 2, 2018 AT 4:17 PM

More Americans Are Dying From Suicide, Drug Use And Diarrhea

By Ella Koeze and Anna Maria Barry-Jester

Link



Link

children's health initiative
a program of Better Health Partnership

Better Health Partnership

Building Population Health at Better Health Partnership

Making an impact on the Health of Northeast Ohio

Thomas E. Love, Ph.D.
Chief Data Scientist, Better Health Partnership
Professor of Medicine,
Population & Quantitative Health Sciences, CWRU
Thomas.Love@case.edu

Community Health Research & Practice seminar talk: 2018-10-30

https://github.com/THOMASELOVE/mph-2018-10-30

Today's Topics

1. Better Health Partnership's Vision, Mission, and some insight into how it's working in its 12th year
2. Insights from data on adults with chronic illness
3. Findings from our Children's Health Initiative

https://github.com/THOMASELOVE/mph-2018-10-30

Vision and Mission

To Help Northeast Ohio Become a Healthier Place to Live and a Better Place to do Business

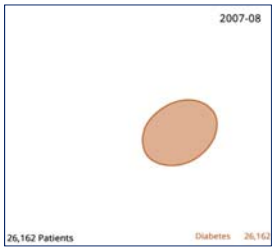
By creating a safe space for health care competitors to collaborate

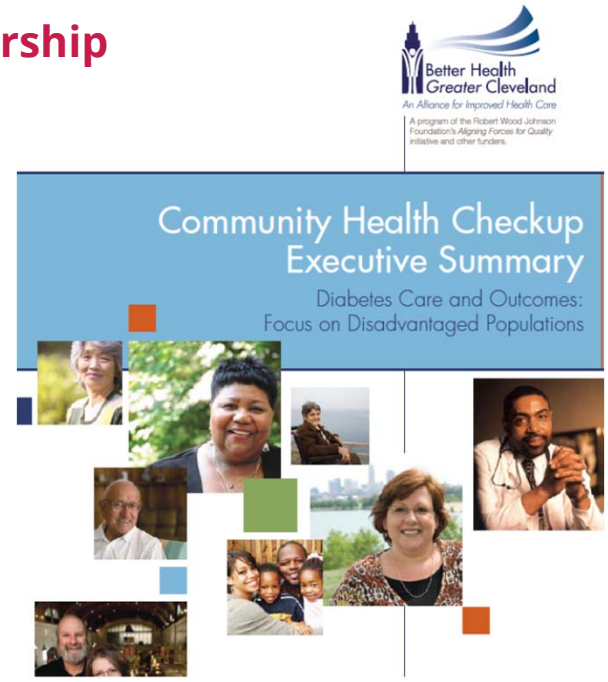
https://github.com/THOMASELOVE/mph-2018-10-30

Better Health Partnership in 2007

26,162 adults with diabetes

43 practices &
417 providers





https://github.com/THOMASELOVE/mph-2018-10-30

EVOLUTION OF BETTER HEALTH PARTNERSHIP

RWJ: ALIGNING FORCES FOR QUALITY (AF4Q)

Better Health Greater Cleveland — **Better Health Partnership**

Transforming Health Care Together

2007 - 2010	2011 - 2015
Practice-based transformation Individual Patient Care	Value-based health care transformation Attributed Patient Population Management
Shared goals: Quality improvement EMR	Shared goals: Improve health value PCMH and P4P
Targeted population: Adults with chronic disease	Targeted population: Adults with chronic disease

RWJ: ALIGNING TO BUILD A CULTURE OF HEALTH

Better Health Partnership

Collaborating for a Healthy Community

2016 - 2018	Current +
Health Care and Community transformation Attributed Patient and Regional Population Health	
Shared goals: Improve health value & equity ACO, TCOC	Shared goals: Improve community health, wealth, education and equity ACH, SDOH
Targeted population: Adults and children with chronic disease	Targeted population: Adults and children with chronic disease, infants, "twinkle to wrinkle"

https://github.com/THOMASELOVE/mph-2018-10-30

Table 1:

Characteristics of Patients in 2017 Report

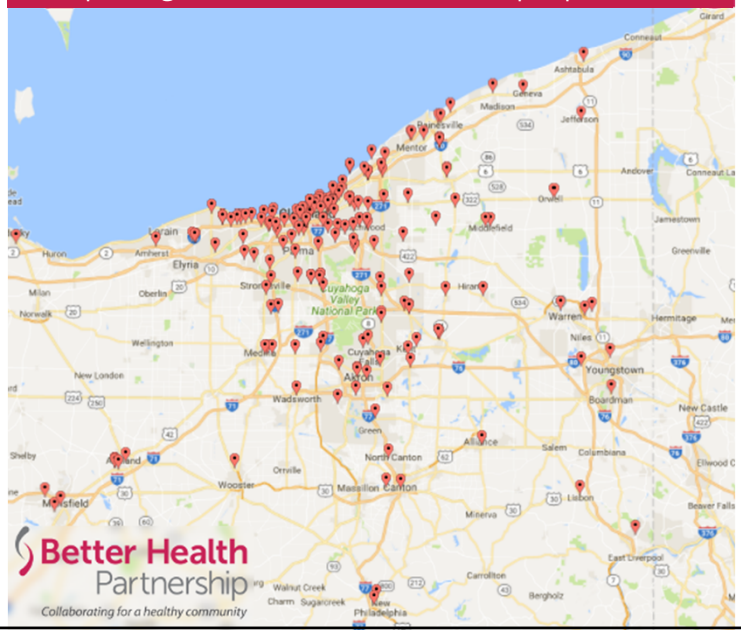
Better Health's 21st report (describing 2017) includes 289,704 patients seen by 878 providers, in 82 practices, within 10 health systems.

REPORTING PERIOD: 2017 View Reporting by Different Timeframe:

	Diabetes Patients		High Blood Pressure Patients		Heart Failure Patients		Colorectal Cancer Screening Patients	
Health Systems	9		10		3		10	
# of Patients	56,837		200,629		9,474		217,350	
# of Primary Care Practices	73		80		35		82	
# of Primary Care Providers	778		852		478		858	
	Better Health Population	Range of Values Across Sites	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	48.2	15 - 78	53.6	17 - 84	68.0	49 - 91	42.7	18 - 73
Commercial (and Veterans)	37.1	0 - 57	35.7	1 - 55	20.0	3 - 32	46.1	1 - 68
Medicaid	12.2	0 - 68	8.5	0 - 61	10.3	0 - 41	8.7	0 - 62
Uninsured	2.5	0 - 30	2.2	0 - 35	1.6	0 - 7	2.5	0 - 35
Race/Ethnicity (%)								
White	63.1	2 - 99	69.0	2 - 99	62.0	3 - 100	72.5	1 - 99
African-American	29.3	0 - 97	26.2	0 - 98	33.1	0 - 97	22.3	0 - 98
Hispanic	4.6	0 - 69	2.6	0 - 59	3.3	0 - 56	2.7	0 - 59
Other	3.0	0 - 10	2.2	0 - 9	1.6	0 - 5	2.5	0 - 12
Preferred Language (%)								
English	95.9	44 - 100	97.3	51 - 100	96.5	52 - 100	97.1	50 - 100
Spanish	2.3	0 - 56	1.3	0 - 48	1.8	0 - 46	1.3	0 - 49
Other Language	1.8	0 - 17	1.5	0 - 19	1.7	0 - 6	1.7	0 - 19
Demographics								
Average Age	60.7	51 - 67	64.7	52 - 73	69.4	58 - 80	62.3	57 - 67
% Female	38.2	2 - 69	40.8	2 - 72	49.9	26 - 67	45.9	3 - 74
% in City of Cleveland	32.3	0 - 95	28.9	0 - 95	42.3	3 - 87	26.2	0 - 93

https://github.com/THOMASELOVE/mph-2018-10-30 has the link

189 Primary Care and Pediatric Practices
reporting to Better Health Partnership (April 2018)



Better Health Partnership

Our new reports describe over **530,000** unique residents of Northeast Ohio.

children's health initiative

What Does BHP measure in adults, and how often?

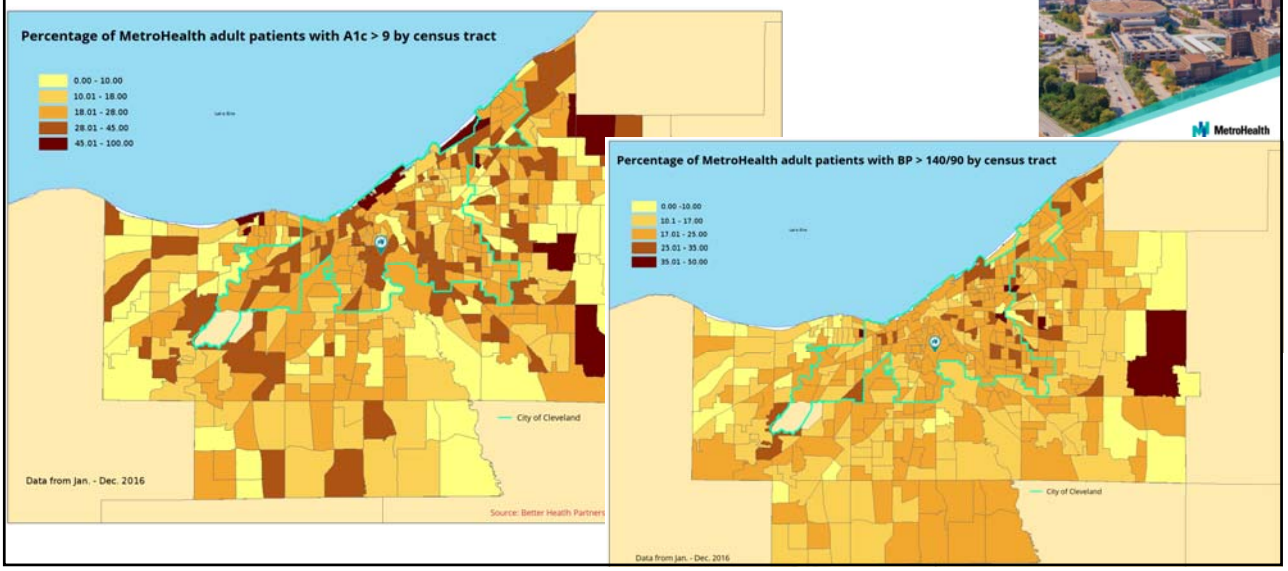
- Health Systems submit data that they have gathered from their electronic health records
- Data submission via a portal, every 6 months
- Overlapping 12-month periods
- Summer 2018 report describes data from 2017.

Data Elements…

- **44** Core measures
- Practice identifiers, Provider codes
- **6** specialized DM measures
- **16** specialized HBP measures
- **12** specialized HF measures
- Ages 50-75 CRC screening
- Geo-coded (address-based) education, income estimates

https://github.com/THOMASELOVE/mph-2018-10-30

MetroHealth Adults: Diabetes and Hypertension (from CHNA)



Data Elements Excerpt

Better Health Partnership

Data Elements for Report 21
Reporting Period: January 1, 2017 - December 31, 2017
Revised: 1/30/2018

CORE DATA ELEMENTS TO BE GATHERED ON ALL REPORTED PATIENTS (i.e. All Patients with QUALDM or QUALHTN or QUALHF = 1) TWELVE MONTH REPORTING PERIOD for Report 21 : start date: January 1, 2017 through end date: December 31, 2017				
#	Variable	Name	Description / Codes	Comments / Business Rules
C-05	Does patient qualify for entry into *Better Health* reporting as a patient with **diabetes** in this reporting period?	QUALDM	See three qualifications at right. 0 = No, patient does not qualify for reporting as a diabetes patient. 1 = Yes, patient qualifies for reporting as a diabetes patient.	To qualify, patient must meet three criteria, specifically: [1] have a diabetes diagnosis (see Appendix 1 sheet for ICD10 codes) **on the problem list** and [2] be within the ages of 18 and 75, inclusive, on the start date of the reporting period, and [3] have at least 2 primary care office visits on different days during the twelve-month reporting period.
C-06	Does patient have a diabetes diagnosis?	DMDIAG	See three qualifications at right. 0 = No 1 = Yes, patient has a diabetes diagnosis (and at least one primary care visit in reporting period and is age 18+.)	To qualify, patient must: [1] have a diabetes diagnosis on the problem list - see Appendix 1 sheet for ICD10 codes. [2] be age 18 or older at the start of the reporting period. [3] have one or more primary care visits in reporting period. [Note: This includes all patients with QUALDM = 1, plus additional patients with diabetes, but who are older than 75 or who had only 1 primary care visit in the reporting period.]

Public Reporting Standards Excerpt

PUBLIC REPORTING STANDARDS FOR DIABETES

To qualify, patient must meet three criteria as outlined in data element C-05 (QUALDM), specifically:
[1] have a diabetes diagnosis (see Appendix 1 sheet in data elements document for list of ICD9/10 codes) and
[2] be within the ages of 18 and 75, inclusive, on the start date of the reporting period, and
[3] have at least 2 primary care office visits on different days during the reporting period.

Diabetes Care Standards

Name	Data Elements	Numerator	Denominator	Description
A1c Done	C-05 (QUALDM) DM-01 (A1C)	A1C not missing	QUALDM	% of qualifying diabetes patients with at least one hemoglobin A1c value (within the range of 3.9% to 20.0%, inclusive) obtained during the reporting period.
Kidney Management	C-05 (QUALDM) DM-03 (MALB) C-35 (ACEARB)	MALB not missing OR ACEARB = 1	QUALDM	% of qualifying diabetes patients with urine microalbumin or microalbumin/creatinine ratio screening or ACE/ARB prescription in reporting
Eye Examination	C-05 (QUALDM) DM-04 (EYEEX)	EYEEX = 1	QUALDM	% of qualifying diabetes patients with documented eye exam (via result report or patient self-report [health maintenance override]) in reporting
Pneumonia Vaccination	C-05 (QUALDM) DM-05 (PNEUM23) DM-06 (PNEUM13)	PNEUM23 = 1 or PNEUM13 = 1	QUALDM	% of qualifying diabetes patients with documented pneumococcal vaccination at any time between January 1, 1990 and the last date of the reporting period.

https://github.com/THOMASELOVE/mph-2018-10-30

Achievement of **HEDIS / NCQA** Measures
Better Health Partnership: 2017

Better Health Partnership

High BP	All	Medicare	Commercial	Medicaid	Uninsured
Blood Pressure Control	78	80	76	72	69

Diabetes Measures	All	Medicare	Commercial	Medicaid	Uninsured
BP below 140/90	76	75	77	78	76
Hemoglobin A1c testing	94	94	92	95	95
A1c control (< 8%)	68	72	66	58	57
A1c control (< 9%)	87	90	86	77	75
Eye Examination	68	73	65	55	54
Kidney Management	88	89	87	89	90

Cancer Screening	All	Medicare	Commercial	Medicaid	Uninsured
Colorectal Cancer Screening	73	79	71	58	55

Better Health Partnership

Better Health Partnership: 2017
vs. **National HMO/PPO data**, 2016

High BP	All	Medicare	Commercial	Medicaid	Uninsured
Blood Pressure Control	78	80	76	72	69

Diabetes Measures	All	Medicare	Commercial	Medicaid	Uninsured
BP below 140/90	76	75	77	78	76
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A1c control (< 9%)	87	90	86	77	75
Eye Examination	68	73	65	55	*54*
Kidney Management	88	*89*	*87*	*89*	*90*

Cancer Screening	All	Medicare	Commercial	Medicaid	Uninsured
Colorectal Cancer Screening	73	79	71	58	55

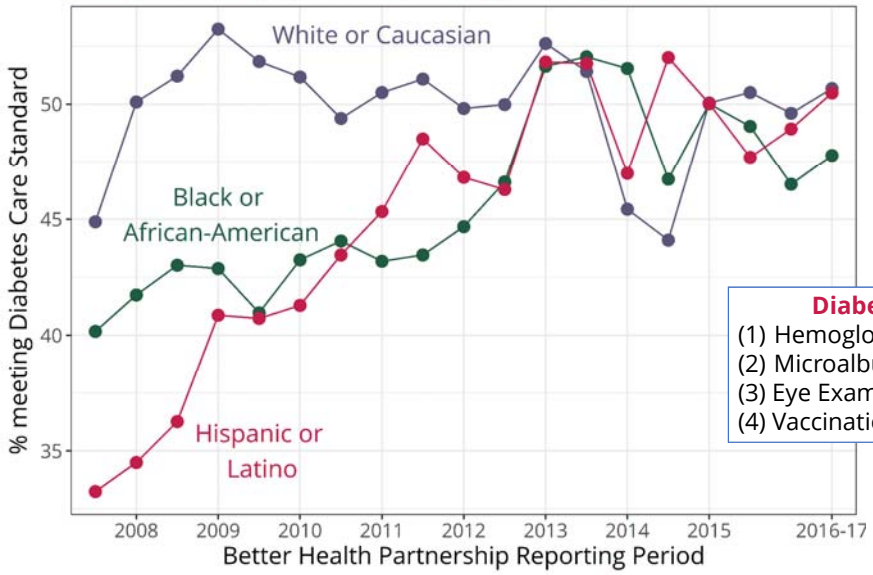
Better Health practices = **BETTER THAN** the national average

Better Health practices = **WORSE THAN** the national average

Care and outcomes of Better Health's **uninsured** patients are compared to **Medicaid** HMO patients nationwide.

HEDIS only reports colorectal cancer screening for Medicare and Commercial patients.

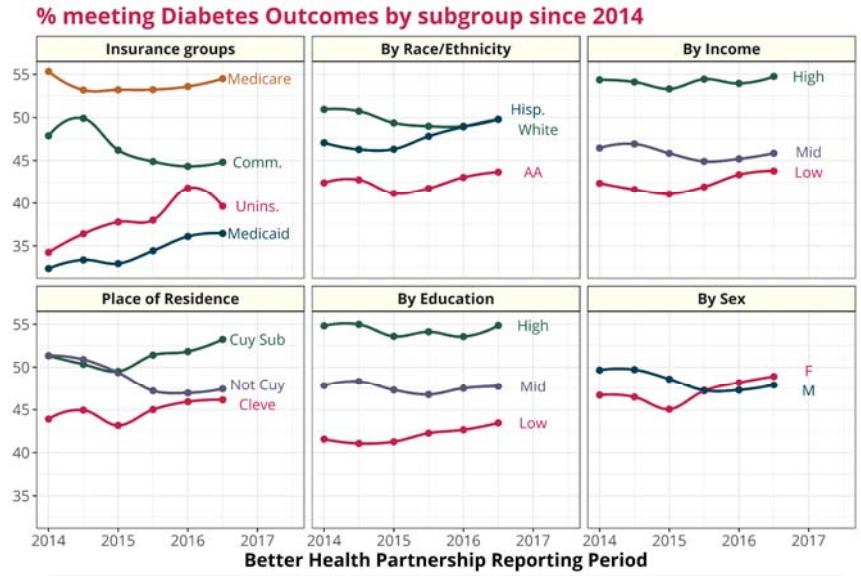
Better Health Partnership



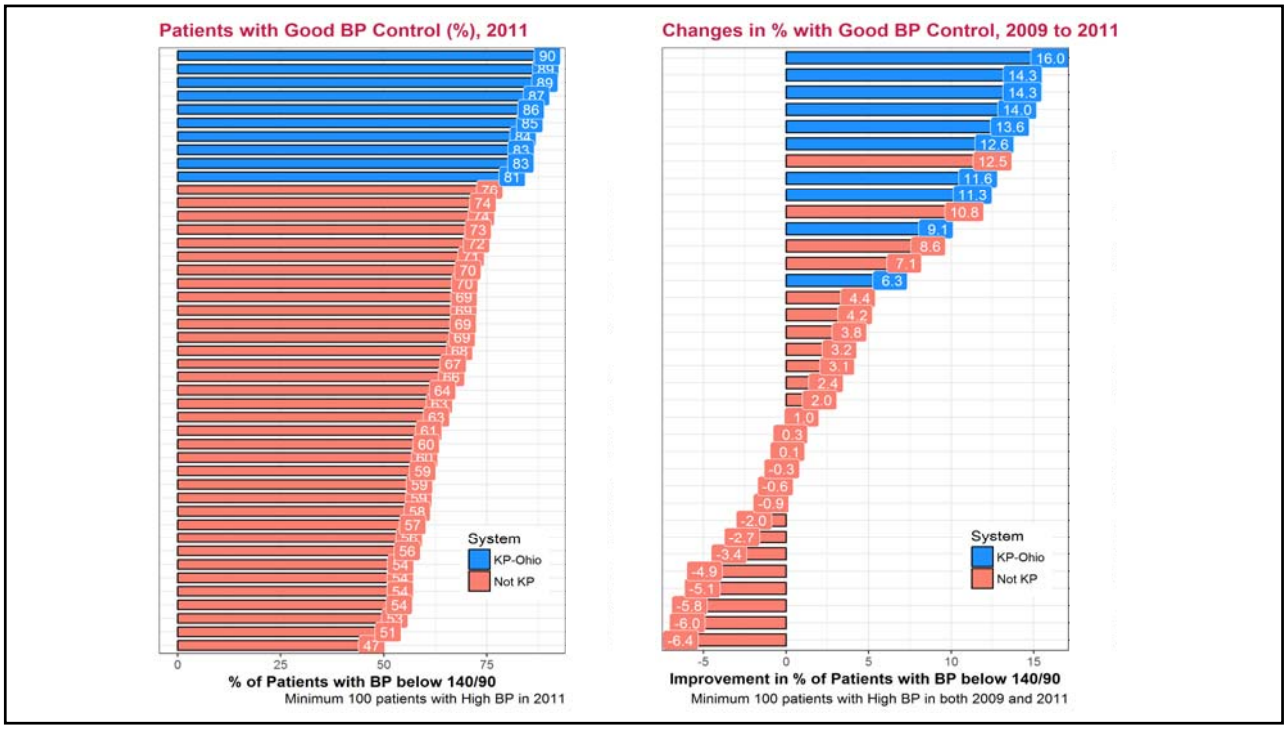
Diabetes Care standard
(1) Hemoglobin A1c checked
(2) Microalbumin screen or ACE/ARB
(3) Eye Examination
(4) Vaccination against Pneumonia

https://github.com/THOMASELOVE/mph-2018-10-30

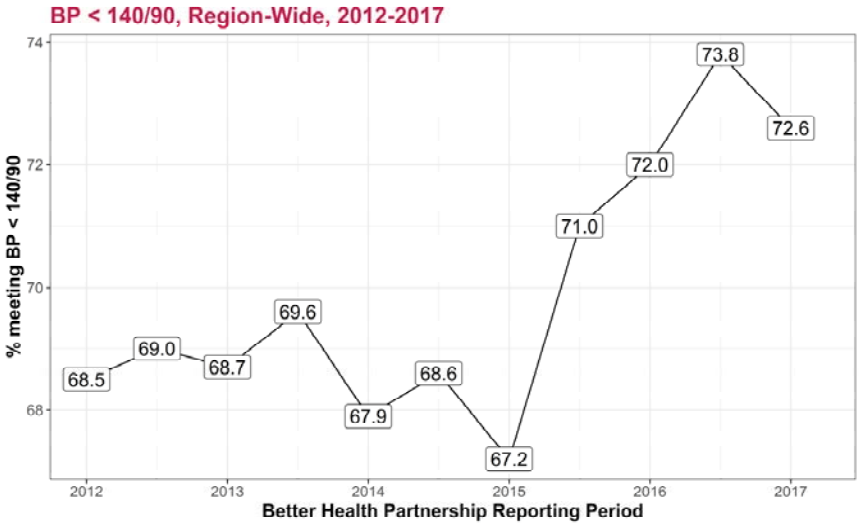
Better Health Partnership

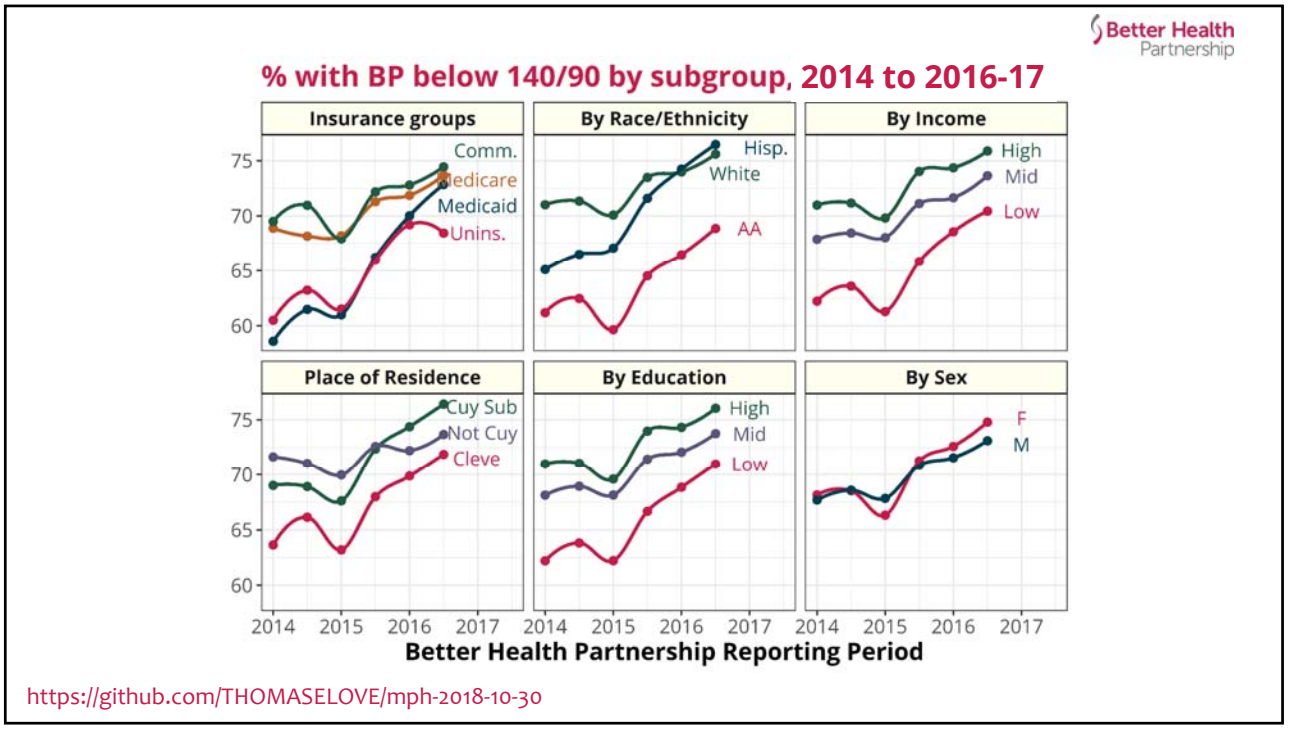


Diabetes Outcomes standard: Meet at least four of:
(1) Hemoglobin A1c < 8 (2) Blood Pressure < 140/90
(3) LDL < 100 or Statin (4) BMI < 30 (5) Not using tobacco



Blood Pressure Control (BP < 140/90) in adult patients with hypertension: **REGION**





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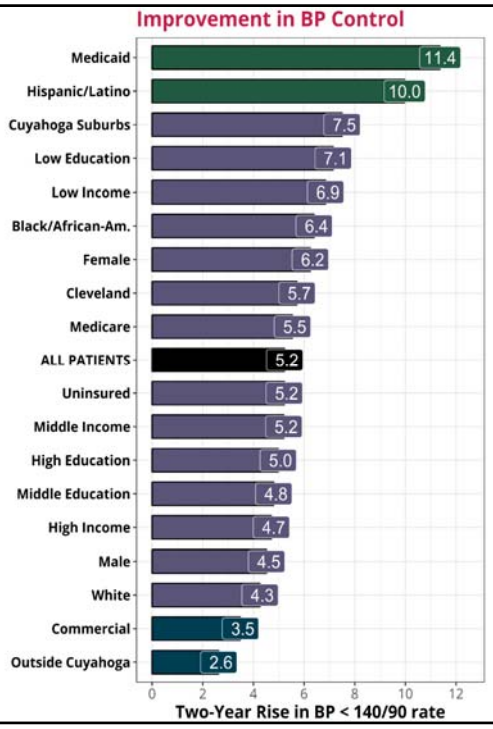


Better Health Partnership

Improvement in BP < 140/90 rate

from 2014-15 to 2016-17

https://github.com/THOMASELOVE/mph-2018-10-30

Better Health Partnership's Children's Health Community Report - Spring 2018

April 2018 | Better Health Data Center

Better Health Partnership's second public report on children's health includes care and outcome measures on obesity and blood pressure for 255,785 children who received care from 6 member health systems between October 2016 and September 2017.

Obesity is the most common chronic disease in children, frequently goes undiagnosed, and reliably results in chronic disease in adulthood. In addition, high blood pressure often accompanies children who are overweight or obese. Data we report help identify gaps that become opportunities to improve and exceptional achievements that become best practices to disseminate.

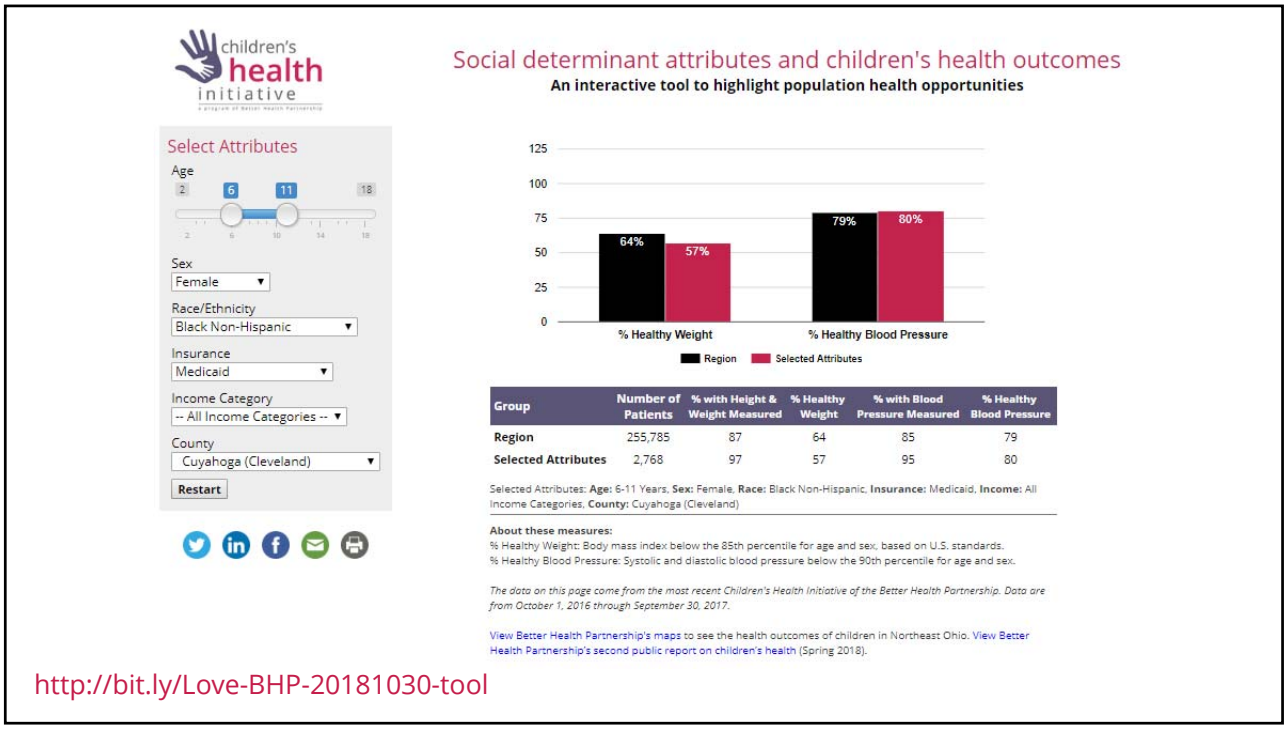
We thank all participating health systems and members of our Clinical Advisory Committee's subcommittees on childhood obesity and asthma, for which we offer a sneak preview below. We are grateful to all who shared their data, expertise and time in service of a healthier community.

Health System	Reported Children
Akron Children's Hospital	104,599
Care Alliance Health Center	1,106
The MetroHealth System	37,429
Neighborhood Family Practice	3,949
Sanders Pediatrics	6,386
University Hospitals Rainbow Babies & Children's Hospital	102,316

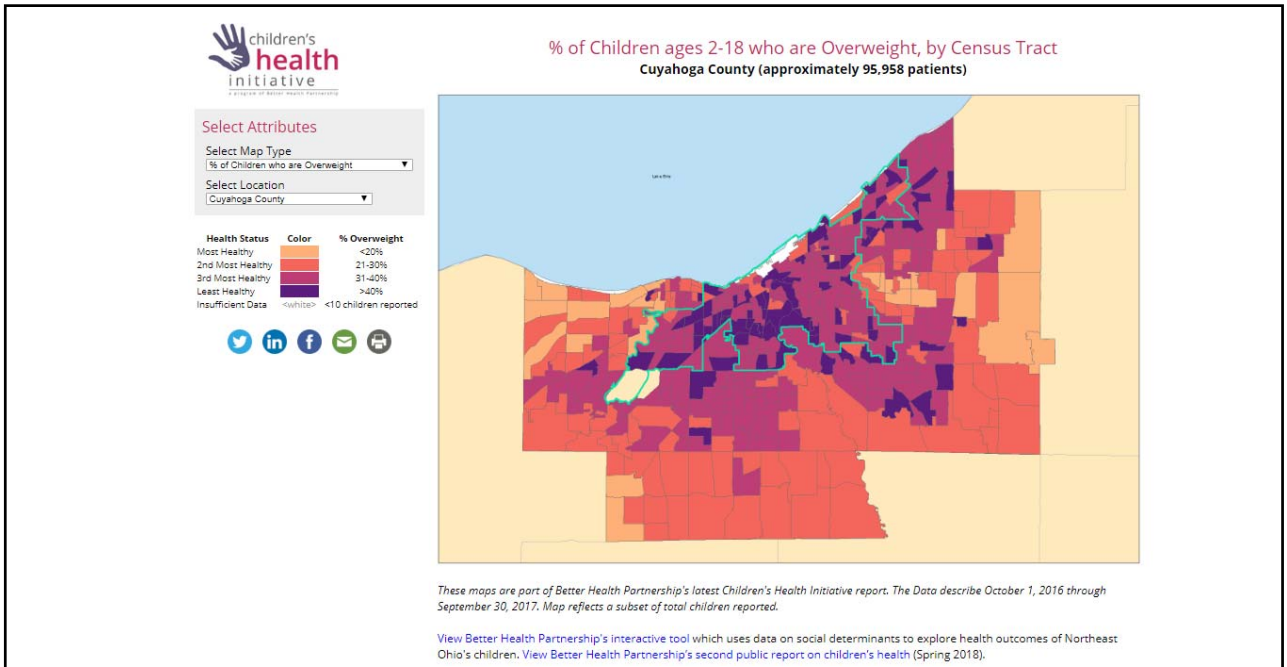
This report includes children from all over Ohio, with 23 counties reporting on at least 100 children. Most children in the report live in one of eight Northeast Ohio counties.

County	Reported Children
Cuyahoga	96,008
Summit	40,948

https://github.com/THOMASELOVE/mph-2018-10-30



http://bit.ly/Love-BHP-20181030-tool

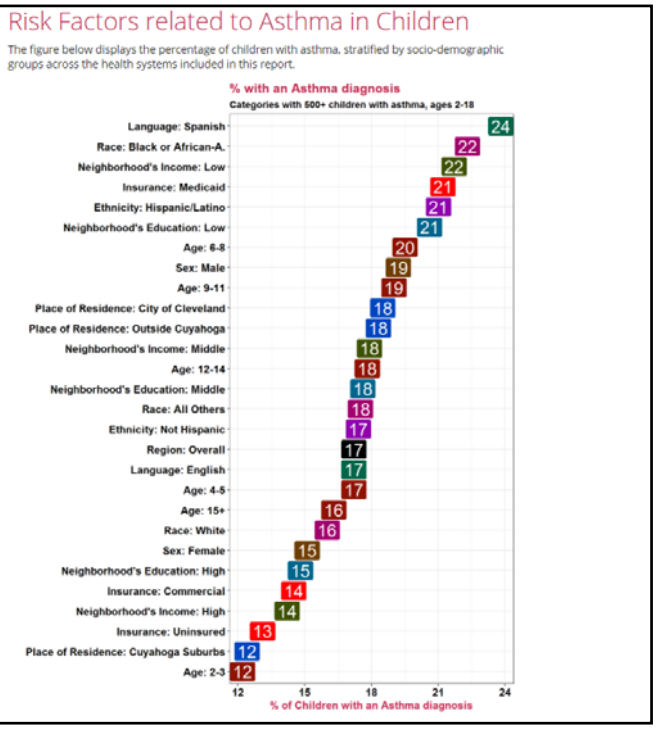


http://bit.ly/Love-BHP-20181030-map

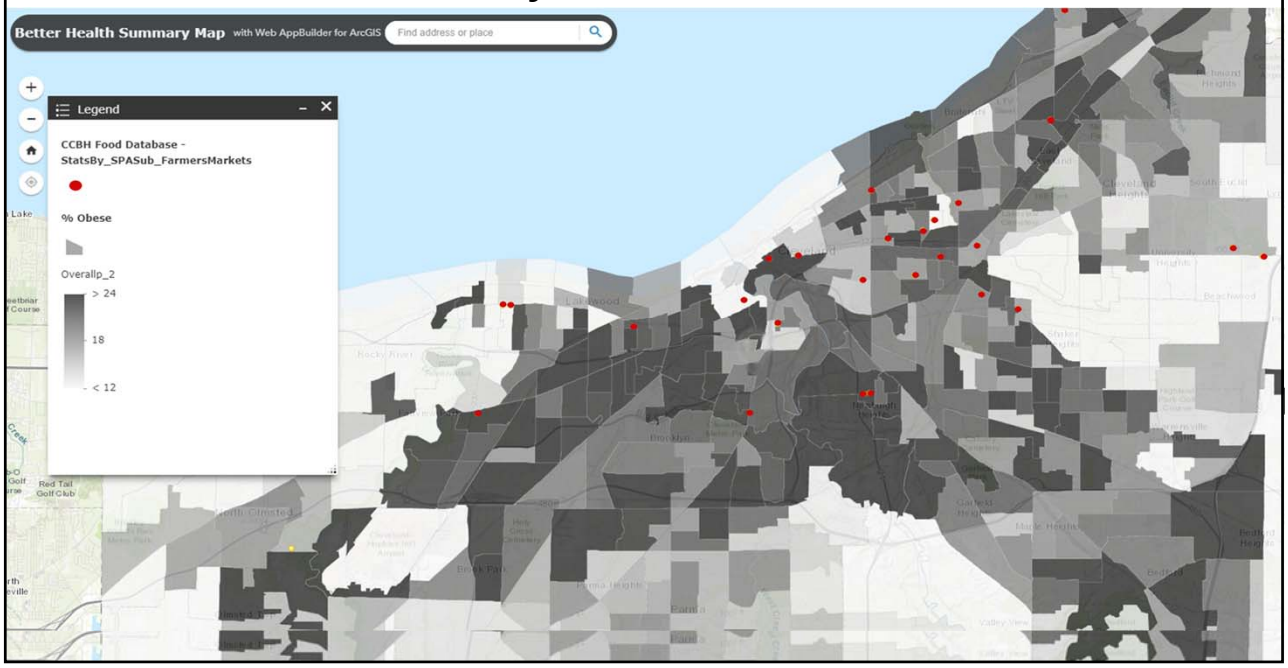
Detailed regional reports are available
for overweight and obesity
for elevated blood pressure
for asthma diagnosis

children's health initiative
a program of Better Health Partnership

https://github.com/THOMASELOVE/mph-2018-10-30



Childhood obesity rates and farmers' markets



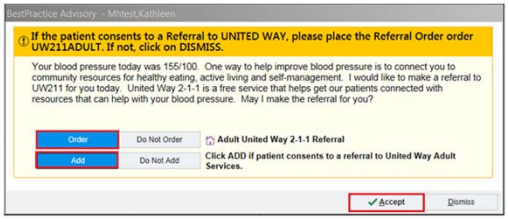
first year cleveland

Infant Mortality – prevent extreme prematurity

- Action team led by Dr. Brian Mercer (MH) - "Prevent the preventable"
- Participation from MetroHealth, University Hospitals, and Cleveland Clinic, and many other organizations.
- Identification of best practices/interventions that lead to better health and social outcomes
- Reduce racial disparities

BHP and United Way 2-1-1
Clinic to Community Linkages for Children and Adults

- Bi-directional electronic referral and feedback system to address social determinants by connecting patients with community resources
- Adults with HTN and elevated blood pressure and children with asthma and/or overweight/obesity
- J Glen Smith Health Center (launched) and Broadway Health Center (Q4)



Our Next Public Reports

Block-by-Block Better Health
Building Healthy Communities in Northeast Ohio

Friday, November 9, 2018| 8:00 am - 3:45 pm

Summit County Public Health
1867 West Market Street, Building A | Akron, OH 44313

Save the Date

March 1, 2019

City Club of Cleveland

info@betterhealthpartnership.org

Thank you!

Better Health Partnership

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