Better Health Partnership

Adult Health Report

Virtual Annual Report to the Community-2020
2nd in a Series

August 12, 2020

Better Health Partnership
Collaborating for a healthy community

Welcome!

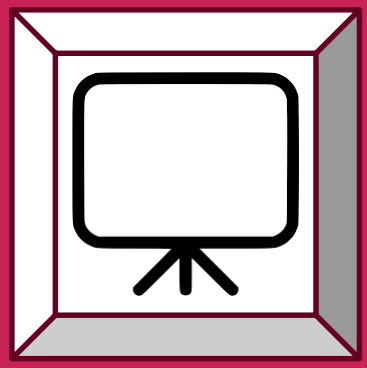
Donald Ford, MD
Chief Medical Officer
Better Health Partnership

Before we begin…

Everyone will be muted.

Submit your questions via the “Chat” window.

We will do Q & A at the end.



Presentations will be posted on our website.

Working together since 2007….

to collectively improve health and reduce health disparities

Better Health Partnership

Vision

Northeast Ohio is one of the healthiest places to live and best places to do business

Mission

We bring health care providers, social services, and other sectors together, to share best practices and accelerate data-informed improvements in equitable population and community health.

Better Health Partnership's Population Health Improvement Priorities

2020-2022 State Health Improvement Plan (SHIP) framewo

Equity Health equity is achieved when all people in a community have access to affordable, inclusive and quality infrastructure and services that, despite historical and contemporary injustices, allows them to reach their full health potential.

Priorities The SHIP identifies three priority factors and three priority health outcomes that affect the overall health and well-being of children, families and adults of all ages.

What shapes our health and well-being?

Many factors, including these
3 SHIP priority factors*:

Community conditions
- Housing affordability and quality
- Poverty
- K-12 student success
- Adverse childhood experiences

Health behaviors
- Tobacco/nicotine use
- Nutrition
- Physical activity

Access to care
- Health insurance coverage
- Local access to healthcare providers
- Unmet need for mental health care

How will we know if health is improving in Ohio?

The SHIP is designed to track and improve these
3 SHIP priority health outcomes:

Mental health and addiction
- Depression
- Suicide
- Youth drug use
- Drug overdose deaths

Chronic disease
- Heart disease
- Diabetes
- Childhood conditions (asthma, lead)

Maternal and infant health
- Preterm births
- Infant mortality
- Maternal morbidity

All Ohioans achieve their full health potential
- Improved health status
- Reduced premature death

Vision
Ohio is a model of health, well-being and economic vitality

Strategies The SHIP provides state and local partners with a menu of effective policies and programs to improve Ohio's performance on these priorities.

* These factors are sometimes referred to as the social determinants of health or the social drivers of health

Better Health Partnership's Population Health Improvement Priorities *"Twinkle to Wrinkle"*

Infant & Maternal Health (2018 - present)	Children's Health (2016 - present)	Adult Health (2007 - present)
Extreme Prematurity	Obesity, Asthma	Hypertension Diabetes Colorectal Cancer Screening
	Mental/Behavioral Lead Exposure	

Better Health Partnership

Pathways HUB integrates with all to address SDOH/ improve outcomes

Better Health PATHWAYS HUB Serving Cuyahoga County

Adult Population Health
State-Wide and County Initiatives

- **Diabetes Quality Improvement** – State-wide
- **Hypertension Quality Improvement** – State-wide
- **Cardi- OH** – State-wide
- **CDC REACH** (Racial and Ethnic Approaches to Community Health); Adults with hypertension and leverages Clinic to Community Linkages (CCL), to address health, social and economic needs

Better Health Partnership

Strategic, Equitable Community Health Improvement for 8 Akron Neighborhoods

In collaboration with Huntington Bank-Akron, Summit County Public Health, Summit County UW 2-1-1, Summit County Pathways HUB, and Health Systems: AxessPointe, Asia, Summa Health, Akron-Childrens

- **What is the alternative future state we want to create?**
- **How can we work together differently to achieve greater equity and impact for people in our Akron neighborhoods?**
- **How can we improve data-sharing and measure the impact of our strategic interventions in Akron neighborhoods?**

Better Health Partnership

FQHC COVID-19
Community Testing Collaborative (CTC)

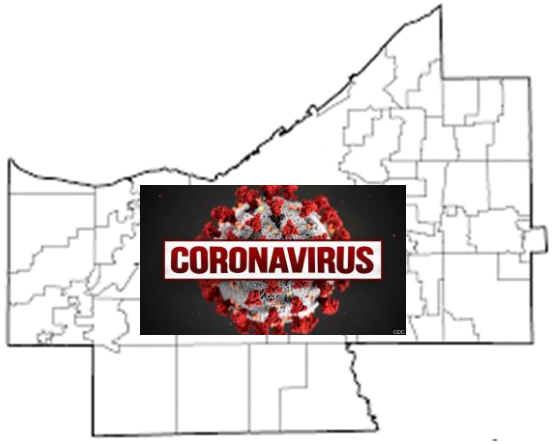
Goal: Reduce spread of COVID-19 – especially among low-income and minority populations living in Cuyahoga County

Objective: Establish timely, affordable, and widespread testing, easily accessible to minority and low-income populations

Future: equitable access to vaccination and treatment

Partners

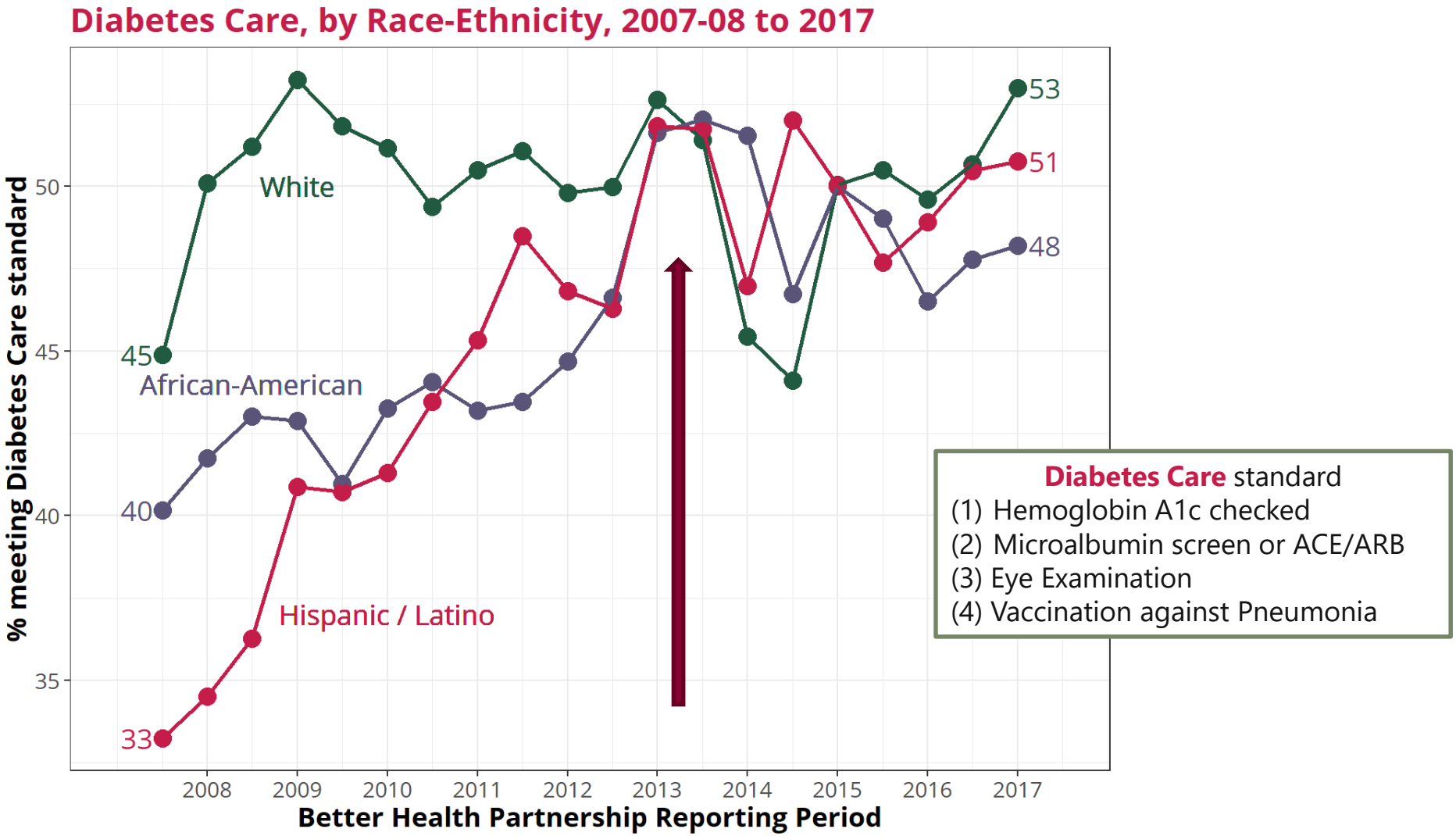
- Asian Services In Action
- Care Alliance Health Center
- Circle Health
- City of Cleveland
- Cleveland Clinic
- Cleveland Department of Public Health
- Cleveland Metropolitan School District
- Cleveland Metropolitan Housing Authority
- Cuyahoga County Board of Health
- Cuyahoga County
- Greater Cleveland Congregations
- The MetroHealth System
- Neighborhood Family Practice
- NEON
- Signature Health
- University Hospitals Health System



Our Collective Impact on:

Triple Aim: Better care, Better Health, Lower Costs

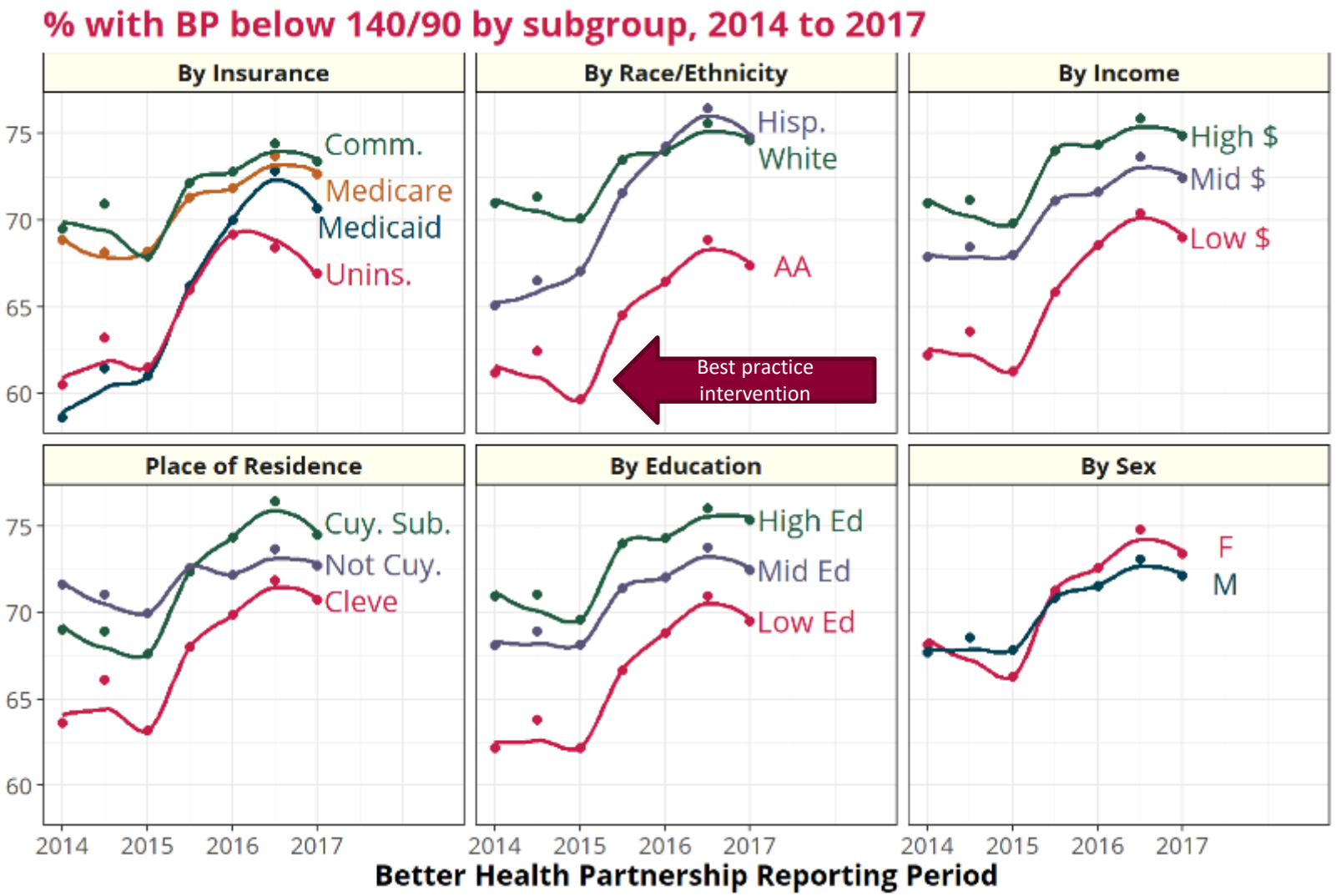
Better Care: Reduced Gaps in Adult Diabetes Care by Race/Ethnicity



Best practice sharing:
"Rising Tide Floats all Boats"

Better Health Partnership

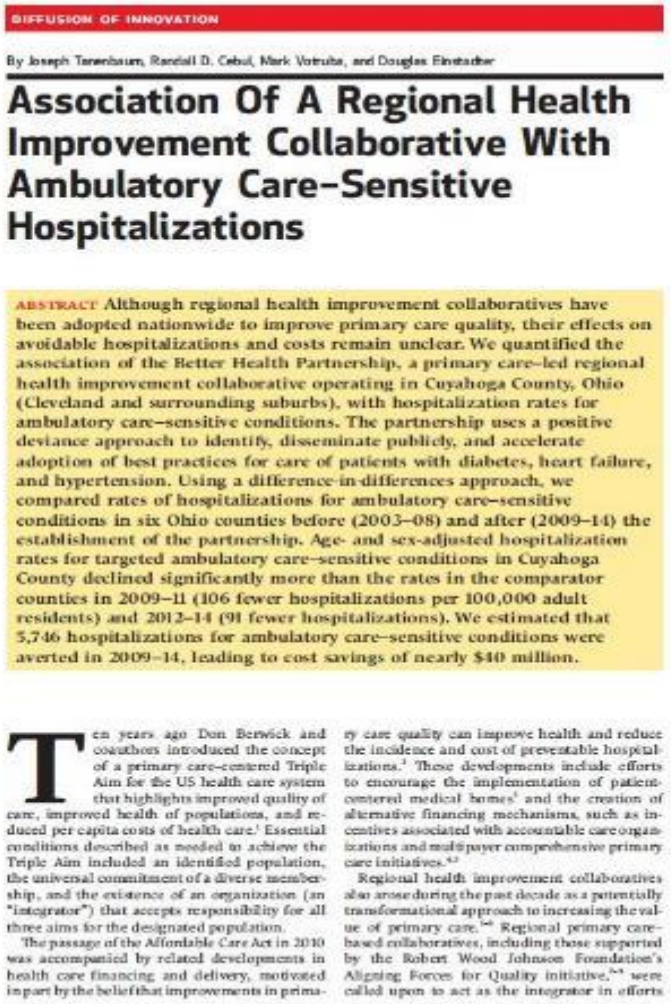
Better Health: Improved Adult BP Control in all Sub-Groups



Best practice sharing:
"Rising Tide Floats all Boats"

Better Health Partnership

Lower Costs: Adult Avoidable Hospitalizations



DIFFUSION OF INNOVATION

By Joseph Tarrenbaum, Randall D. Cebul, Mark Votruba, and Douglas Einstadter

Association Of A Regional Health Improvement Collaborative With Ambulatory Care–Sensitive Hospitalizations

ABSTRACT Although regional health improvement collaboratives have been adopted nationwide to improve primary care quality, their effects on avoidable hospitalizations and costs remain unclear. We quantified the association of the Better Health Partnership, a primary care–led regional health improvement collaborative operating in Cuyahoga County, Ohio (Cleveland and surrounding suburbs), with hospitalization rates for ambulatory care–sensitive conditions. The partnership uses a positive deviance approach to identify, disseminate publicly, and accelerate adoption of best practices for care of patients with diabetes, heart failure, and hypertension. Using a difference-in-differences approach, we compared rates of hospitalizations for ambulatory care–sensitive conditions in six Ohio counties before (2003–08) and after (2009–14) the establishment of the partnership. Age- and sex-adjusted hospitalization rates for targeted ambulatory care–sensitive conditions in Cuyahoga County declined significantly more than the rates in the comparator counties in 2009–11 (106 fewer hospitalizations per 100,000 adult residents) and 2012–14 (91 fewer hospitalizations). We estimated that 5,746 hospitalizations for ambulatory care–sensitive conditions were averted in 2009–14, leading to cost savings of nearly $40 million.

Ten years ago Don Berwick and coauthors introduced the concept of a primary care–centered Triple Aim for the US health care system that highlights improved quality of care, improved health of populations, and reduced per capita costs of health care.[1] Essential conditions described as needed to achieve the Triple Aim included an identified population, the universal commitment of a diverse membership, and the existence of an organization (an "integrator") that accepts responsibility for all three aims for the designated population.

The passage of the Affordable Care Act in 2010 was accompanied by related developments in health care financing and delivery, motivated in part by the belief that improvements in primary care quality can improve health and reduce the incidence and cost of preventable hospitalizations.[2] These developments include efforts to encourage the implementation of patient-centered medical homes[3] and the creation of alternative financing mechanisms, such as incentives associated with accountable care organizations and multipayer comprehensive primary care initiatives.[4,5]

Regional health improvement collaboratives also arose during the past decade as a potentially transformational approach to increasing the value of primary care.[6–8] Regional primary care–based collaboratives, including those supported by the Robert Wood Johnson Foundation's Aligning Forces for Quality initiative,[9,10] were called upon to act as the integrator in efforts

A study published in *Health Affairs* found BHP health care partners' collaboration **averted 5,746** hospitalizations between 2009-2014, with estimated **cost savings** of **$40 million.**

Better Health Partnership

Collaborating for a healthy community

Better Health Partnership
Adult Health Report
2019 Data

Chris Mundorf, MPH, PhD
Director, Data Analytics & Reporting
Better Health Partnership

The Better Health Partnership Collaborative

Over **193,000 Adults**

Reporting systems

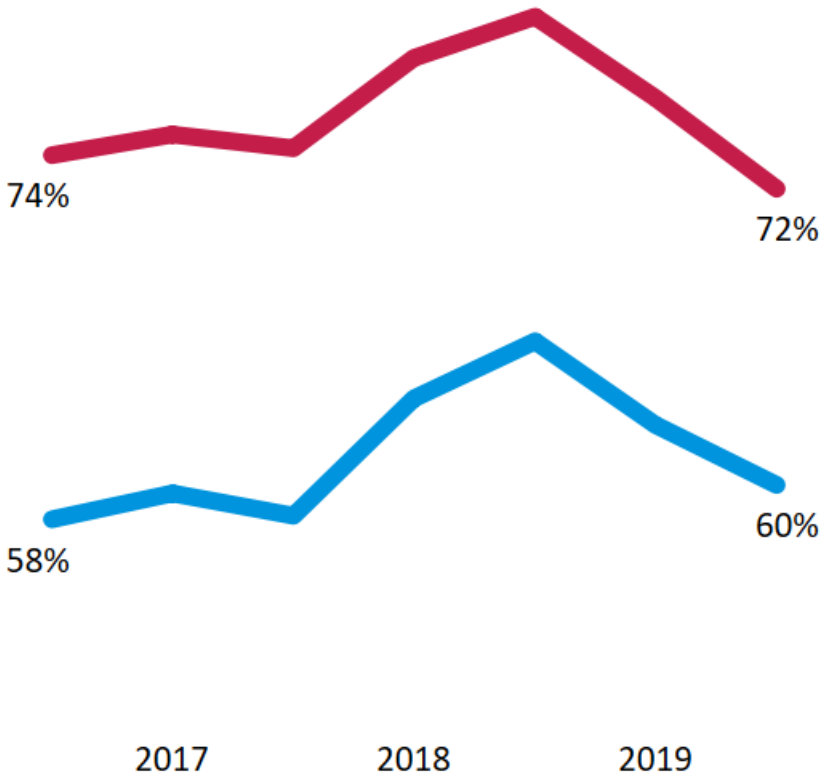
- *Asian Services in Action*
- *Care Alliance Health Center*
- *Circle Health Services*
- *Lake Health System*
- *The MetroHealth System*
- *Neighborhood Family Practice*
- *VA Northeast Ohio Healthcare System*

- *Summa Health (pilot phase; not included this report)*

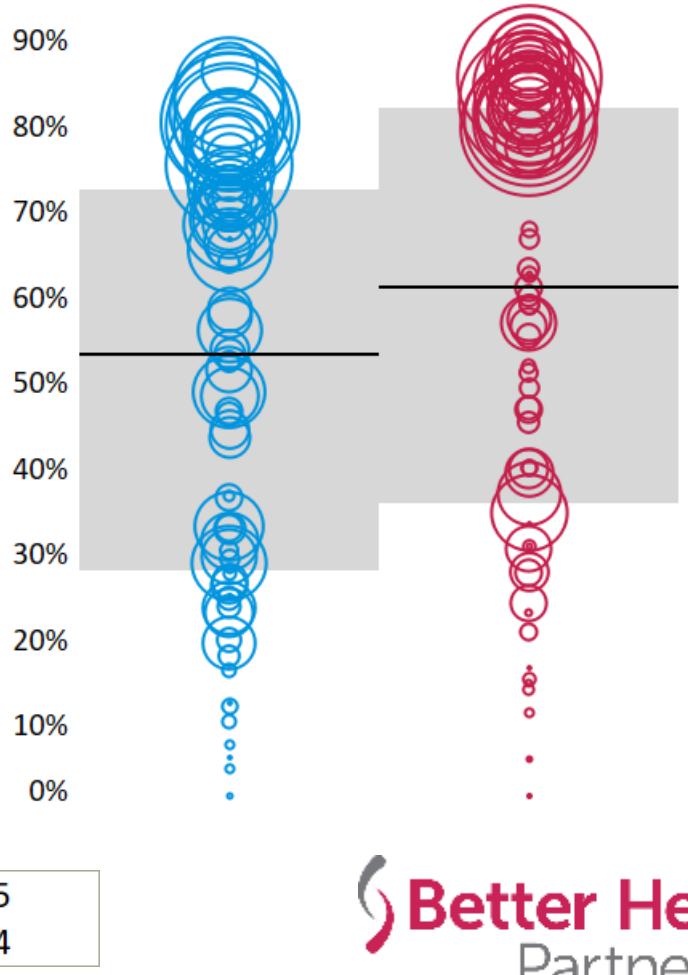
Better Health Partnership

% Adults – Colorectal Cancer Screening

% Adults With Screening By Age, 2016-2019



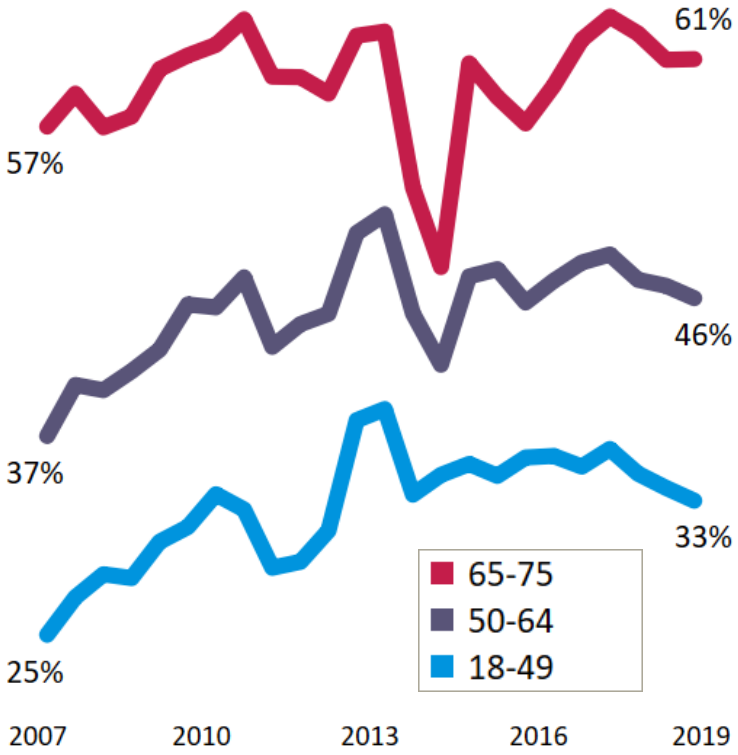
% Adults With Screening By Age and Practice, 2019



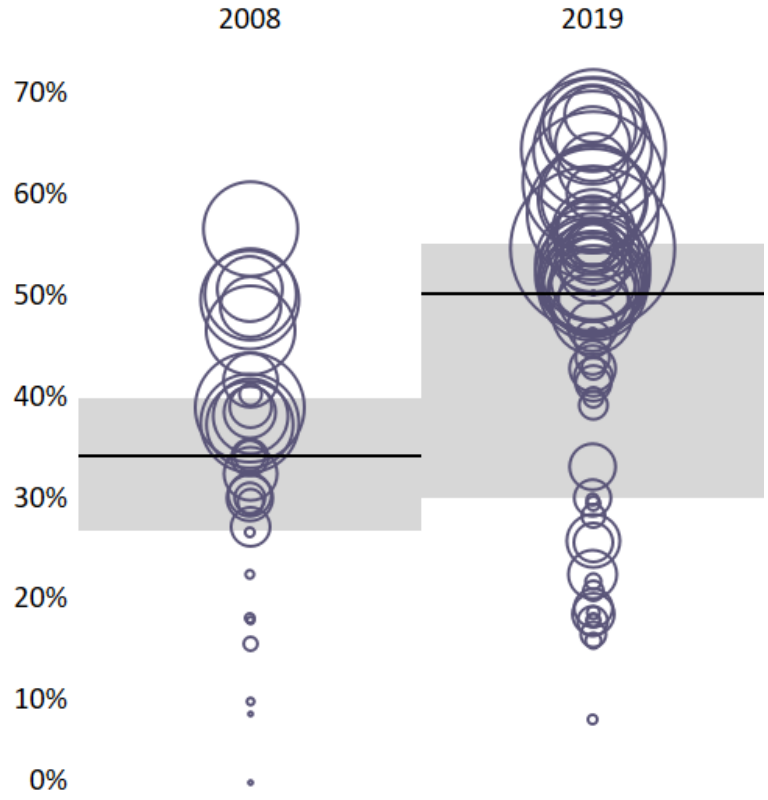
Better Health Partnership

% Adults – Meeting Diabetes Care Composite

% Adults With Care By Age, 2007-2019



% Adults With Care By Practice, 2008 vs 2019



Completion of All Four

1. A1C Measured
2. Eye Exam
3. Kidney Mgt.
4. Pneumo Vaccine

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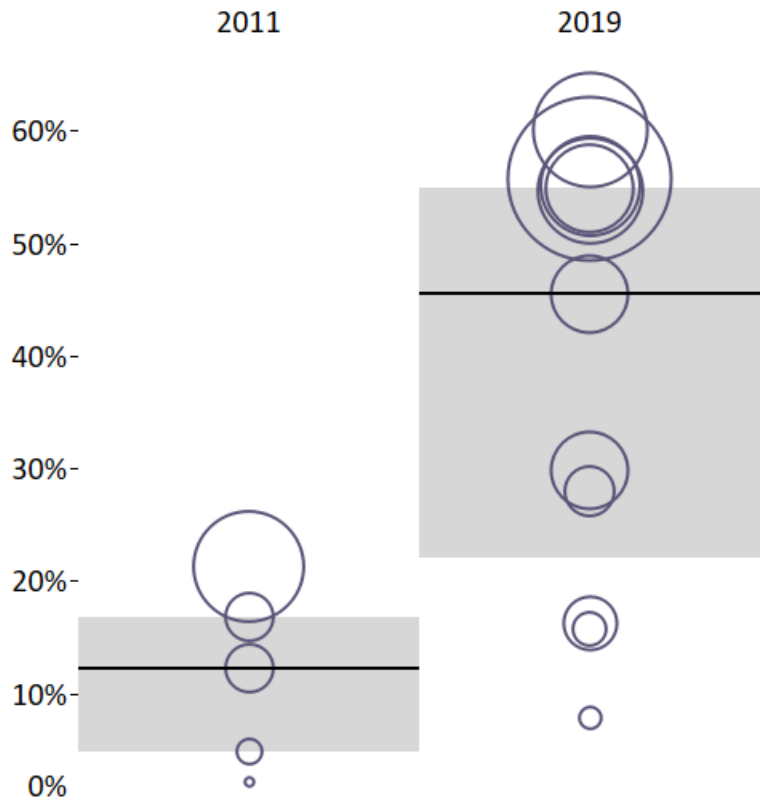
Improvements among FQHCs- Diabetes

Diabetes Care by Practice



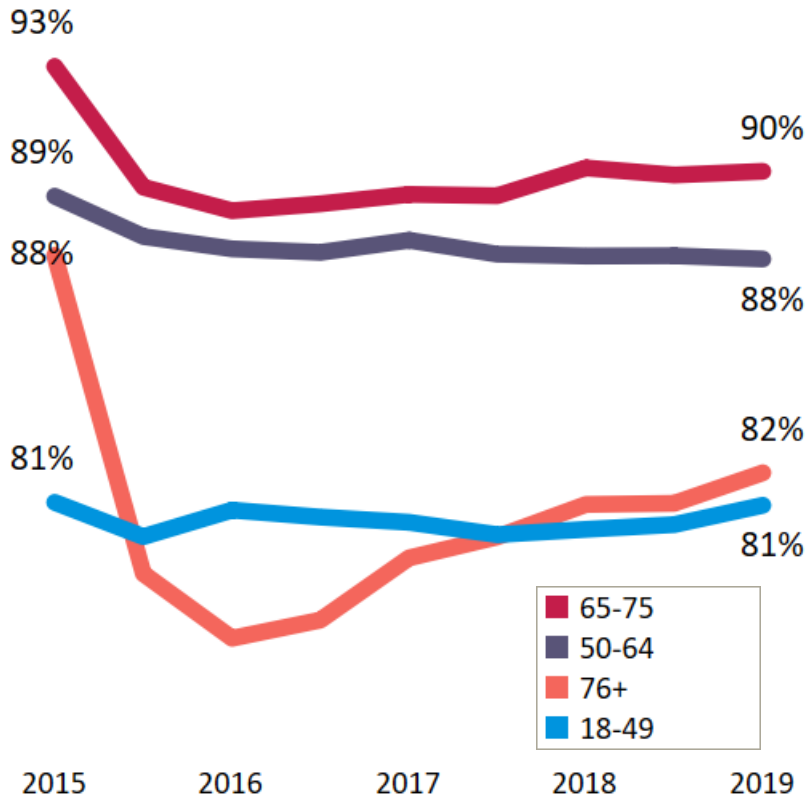
Diabetes Outcome by Practice

Federally Qualified Health Centers primarily serve the safety net population

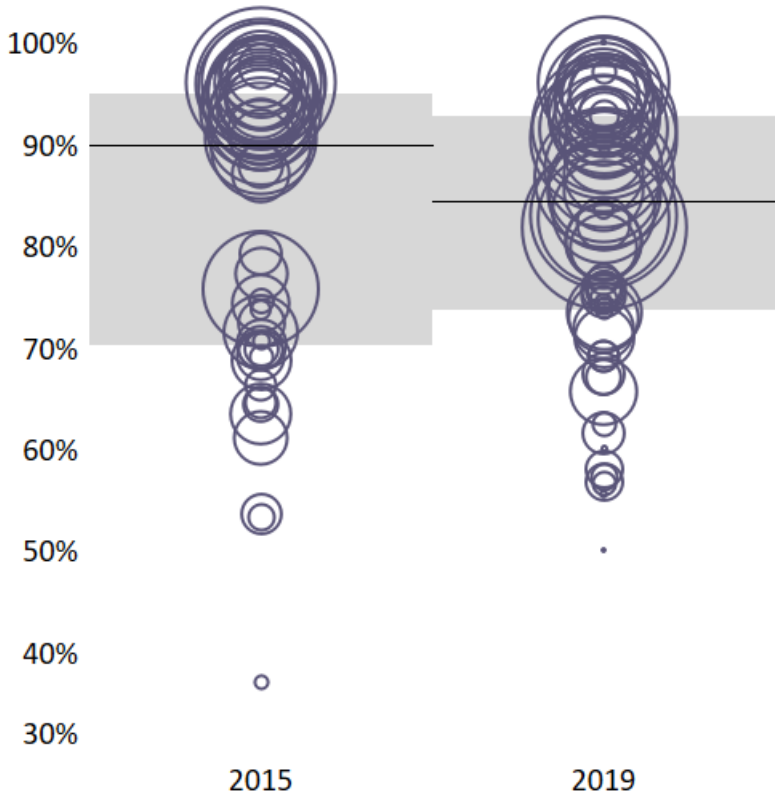
Better Health Partnership

% Adults – Meeting Hypertensive Care Composite

% Adults With Care By Age, 2015-2019



% Adults With Care By Practice, 2015 vs 2019



Measurement of All Three

1. BP 2. LDL 3. Serum Creatinine

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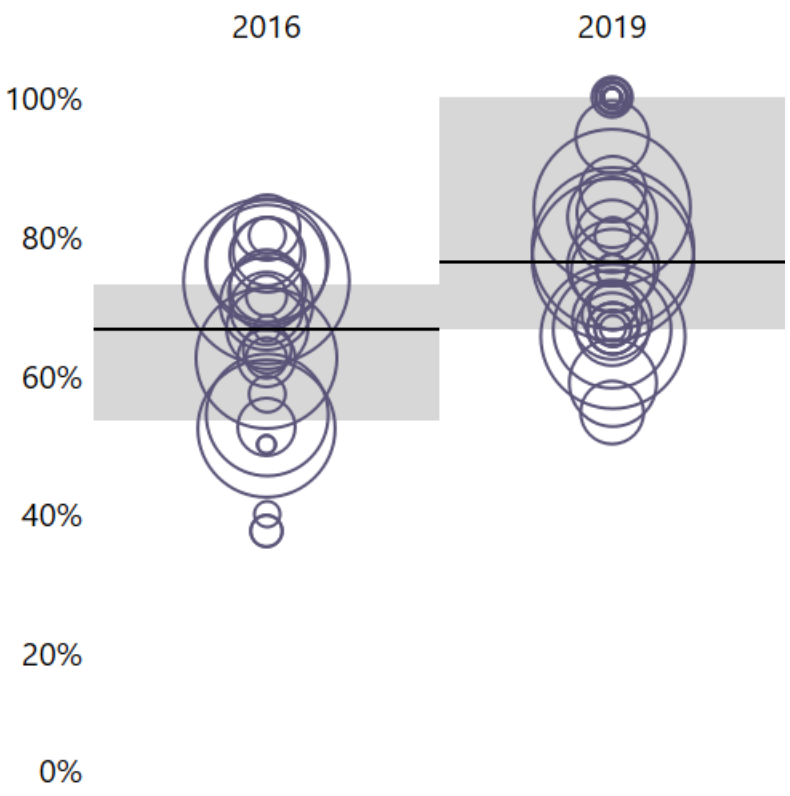
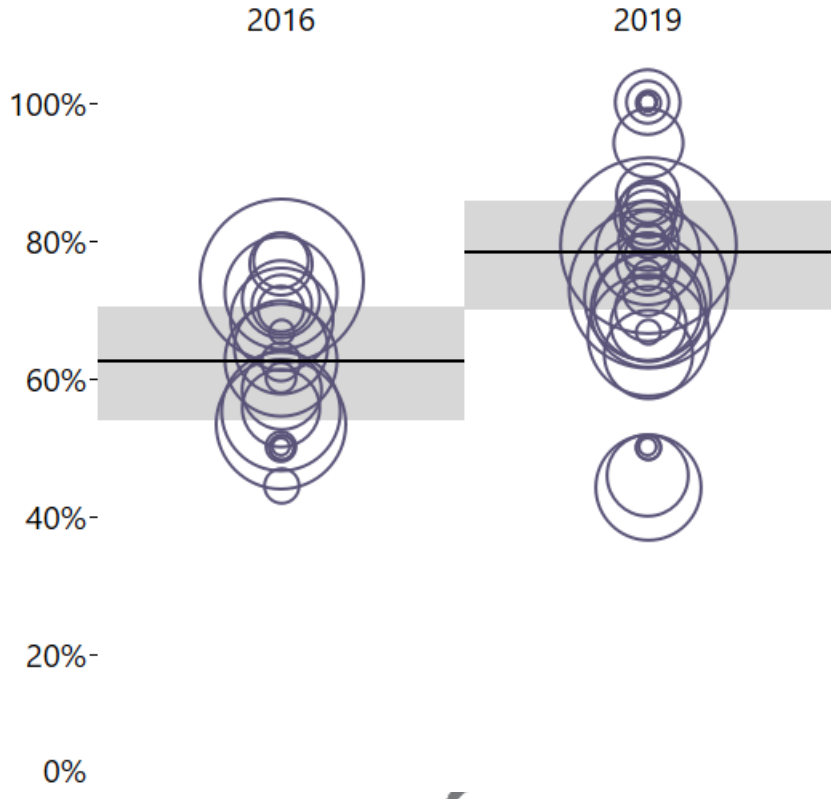
Improvement among FQHCs – Blood Pressure

Hypertensive Care for Latinx by Provider



Hypertensive Care for ESL by Provider



Federally Qualified Health Centers primarily serve the safety net population

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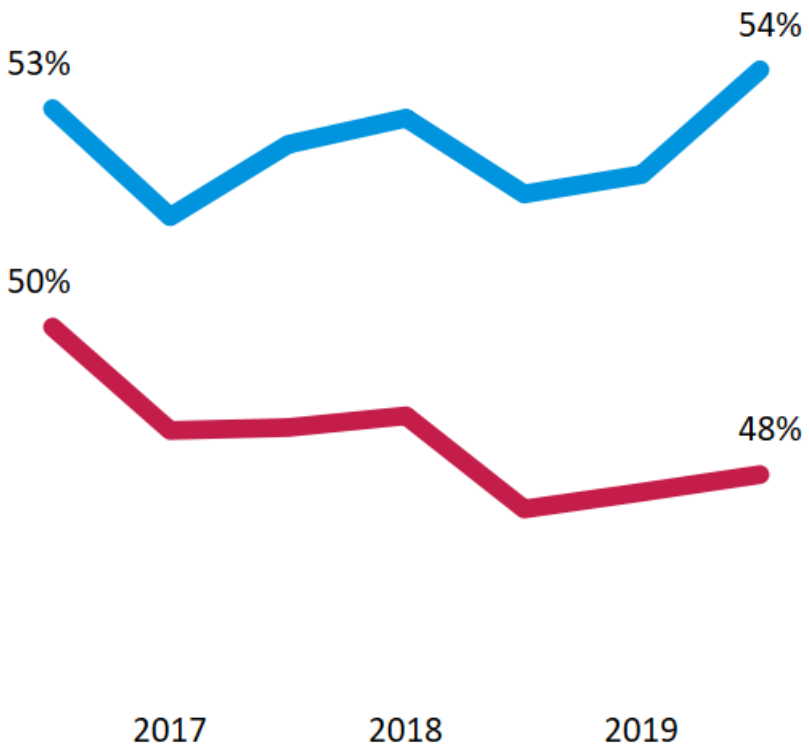
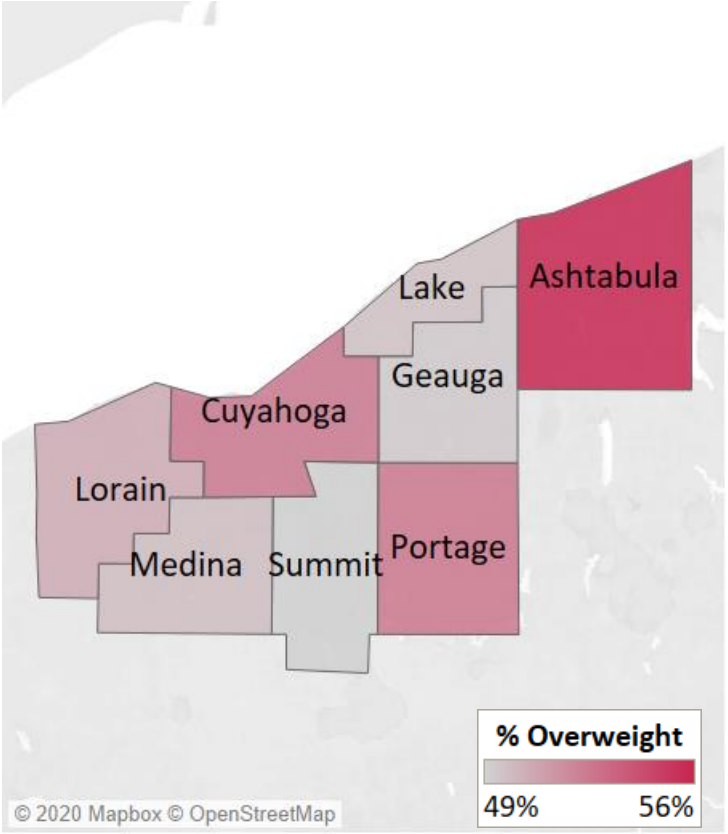
% Adults - High BMI

% Adults With High BMI By Age, 2016-2019



% Adults With High BMI (50-75) By County, 2019



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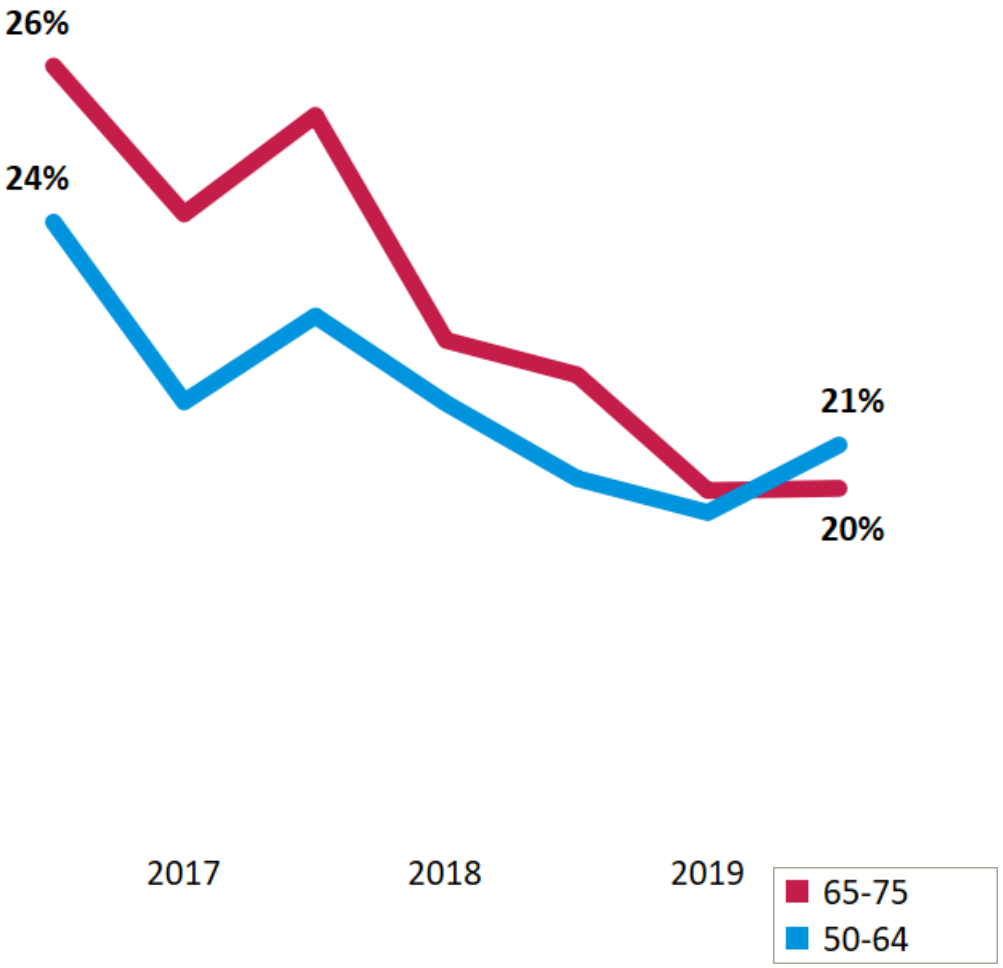
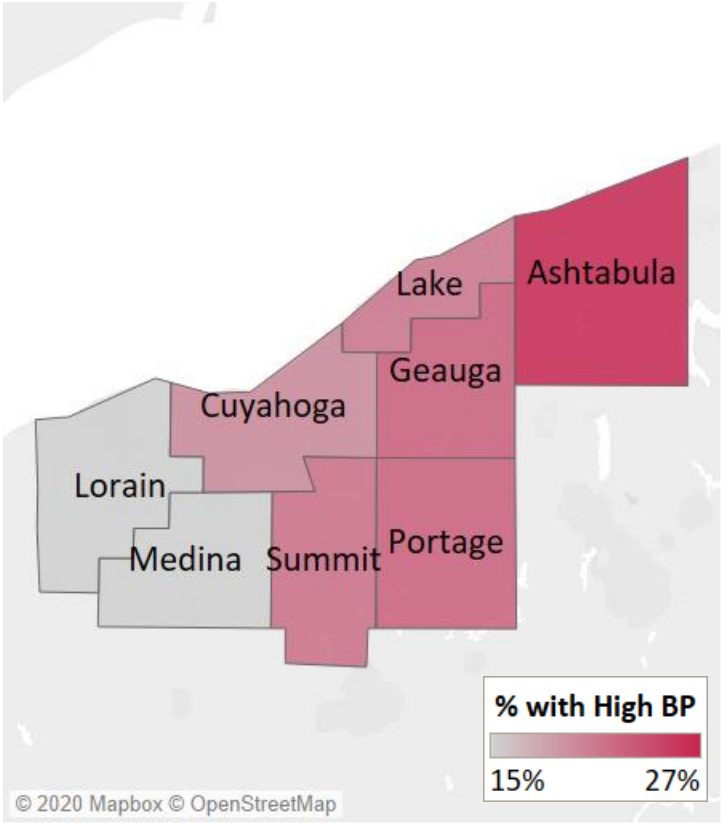
% Adults - High Blood Pressure

% Adults With High BP (50-75) By Age, 2016-2019



% Adults With High BP (50-75) By County, 2019



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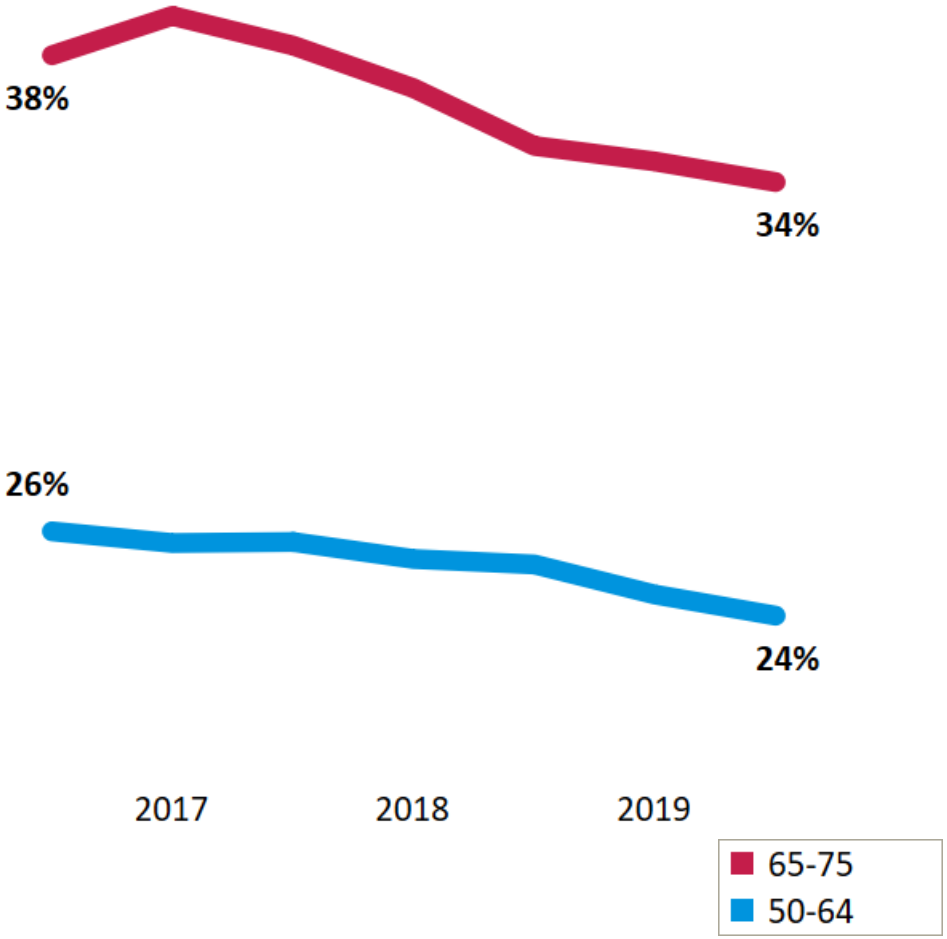
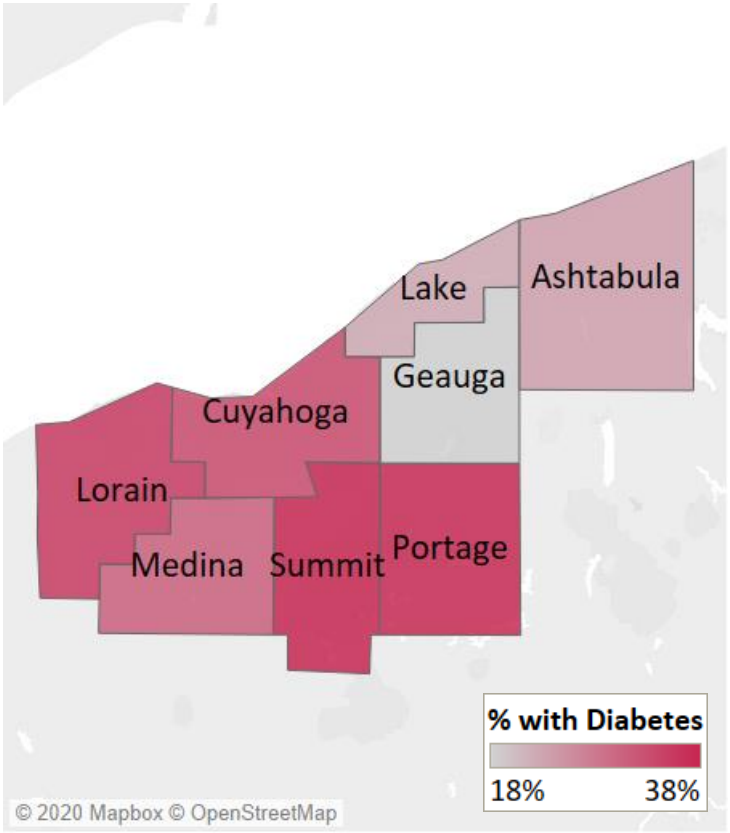
% Adults - Diabetes

% Adults With Diabetes By Age, 2016-2019



% Adults With Diabetes (50-75) By County, 2019



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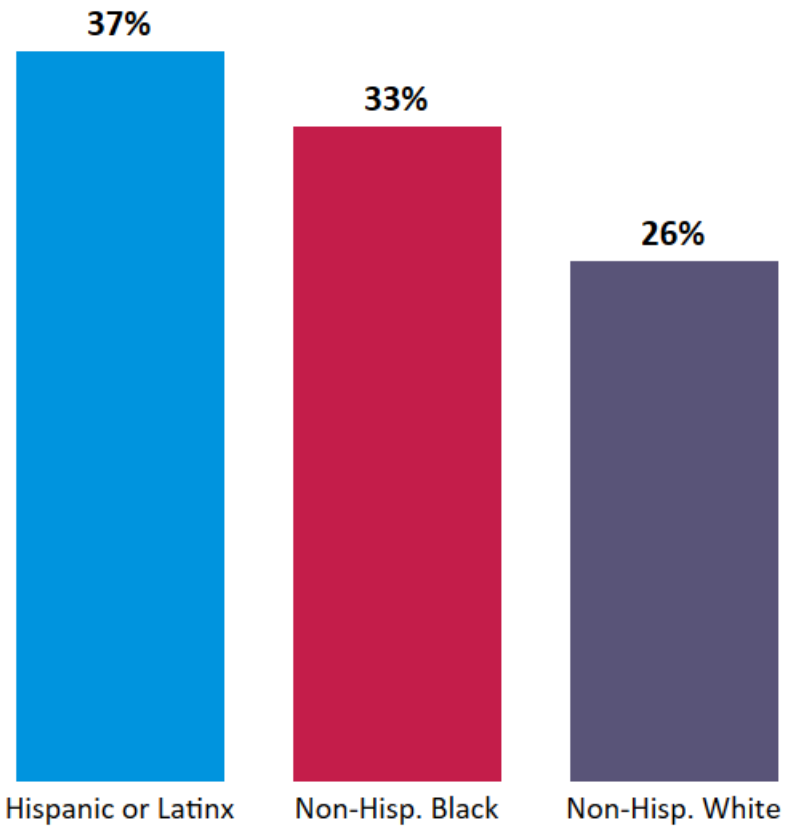
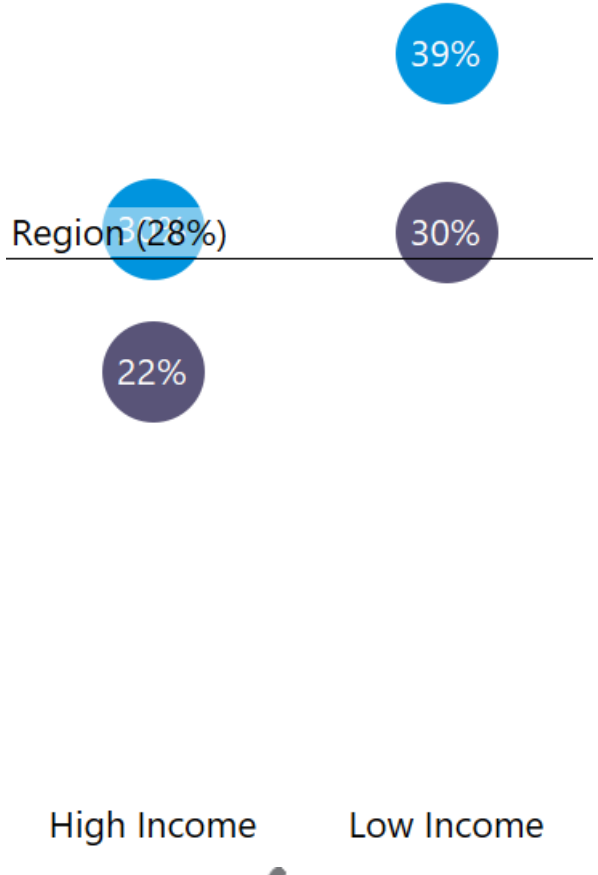
% Diabetic Patients by Race/Ethnicity/Income

% Diabetic (50-75) by Race/Ethnicity



% Diabetic by Neighborhood Income

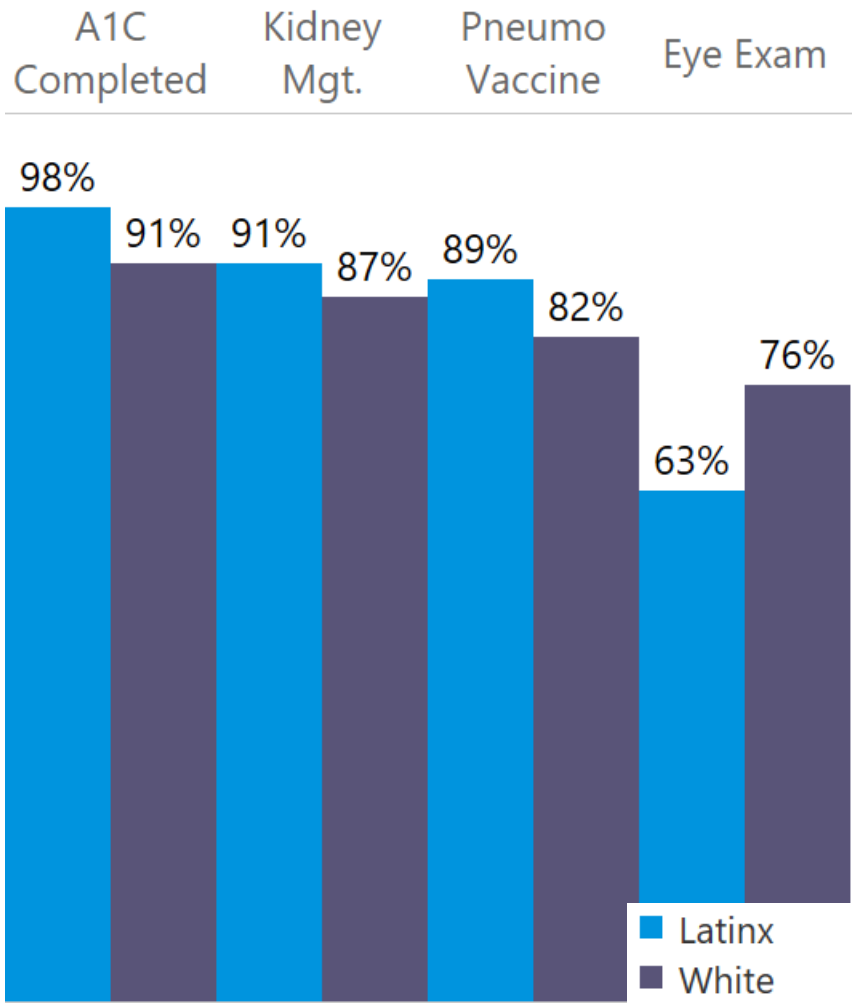


Latinx adults - over **40% more likely** to have diabetes than White adults

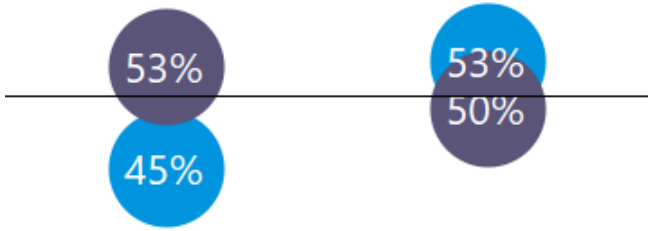
Better Health Partnership

Addressing Disparities in the Clinic – Diabetes Care

% Meeting Care Categories By Ethnicity



% Meeting Care Composite By Ethnicity and Neigh. Income

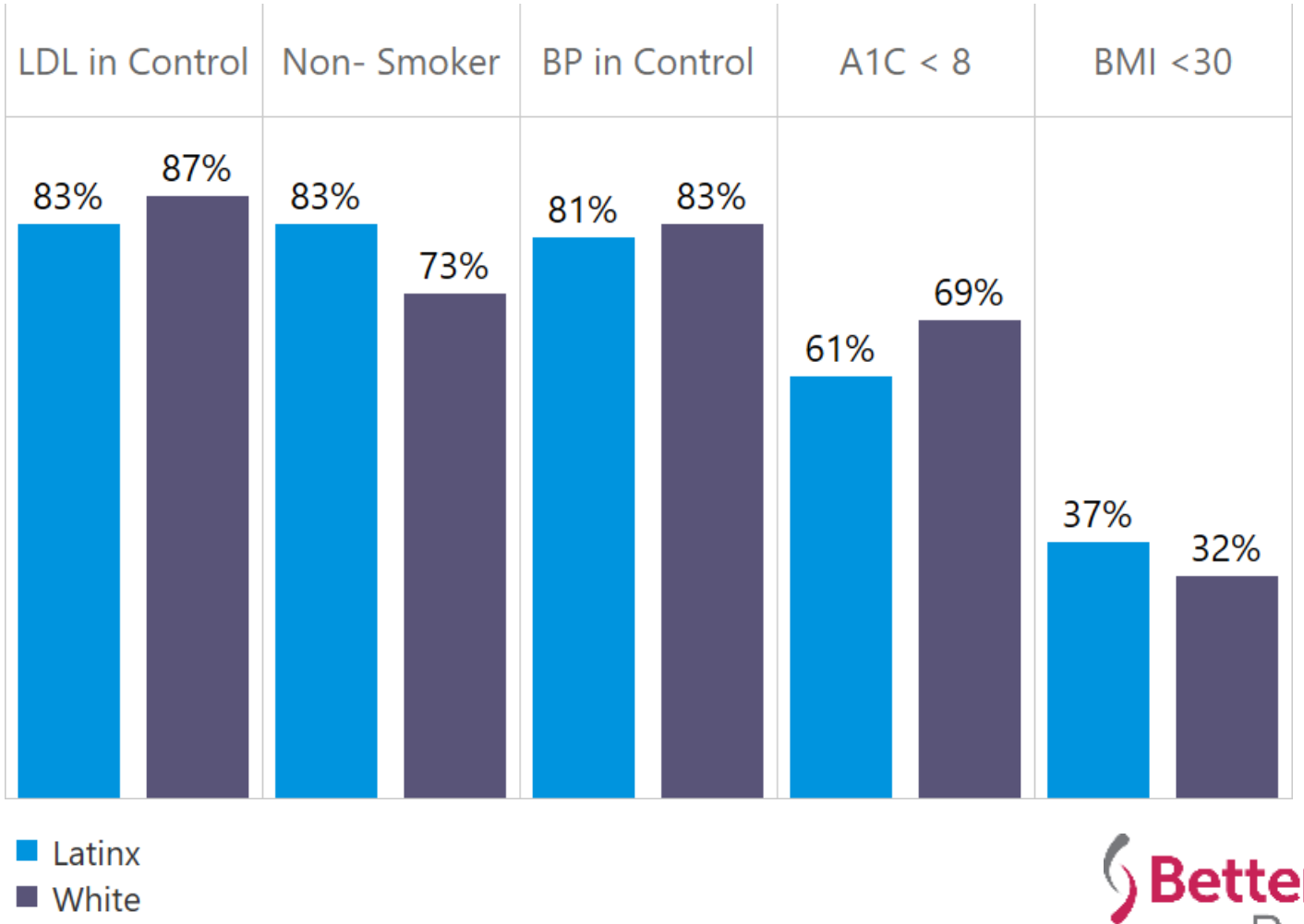


High Income Low Income

Better Health Partnership

Addressing Disparities in the Clinic – Diabetes Outcomes

% Meeting Outcome Categories By Ethnicity



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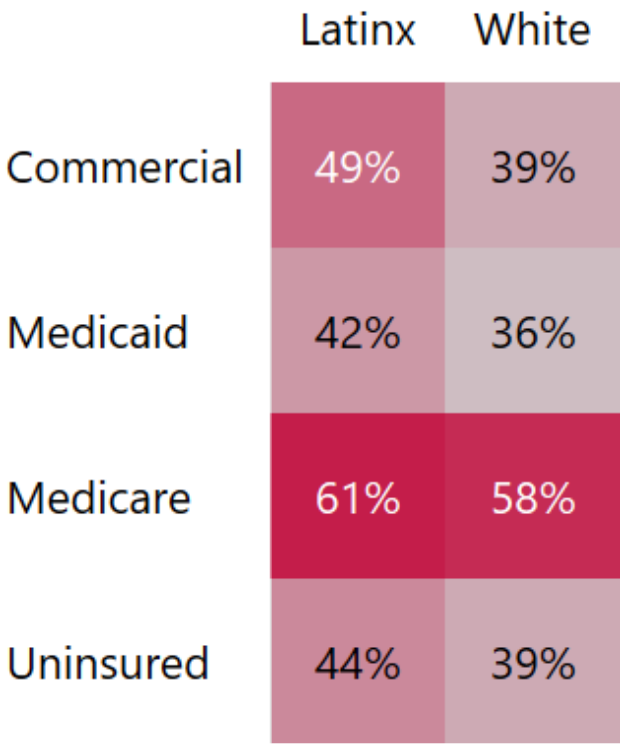
Impact on Latinx Population – Diabetes Outcomes

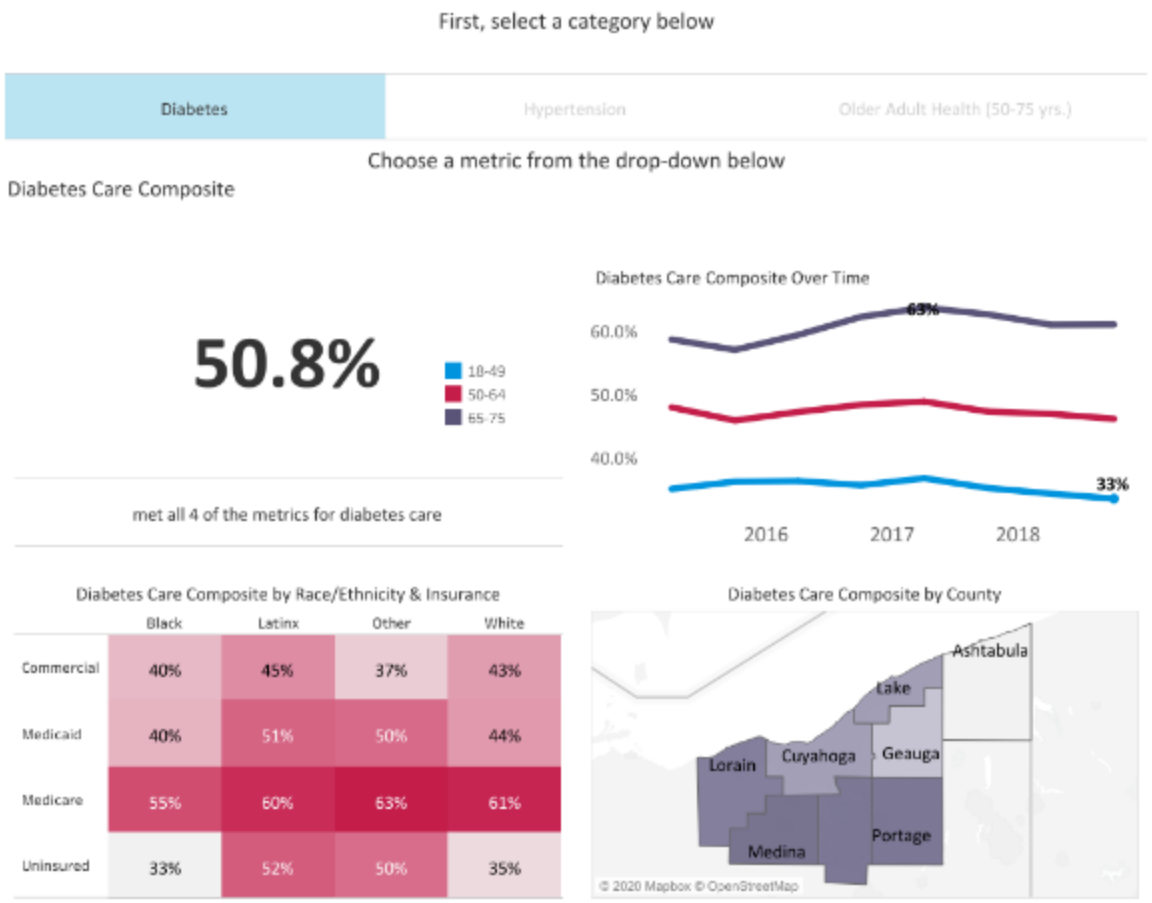
% Meeting Diabetes Outcome Composite By Ethnicity and Insurance



Assuming community disparities in diabetes persisted, Northeast Ohio health systems helped an additional **700 Latinx diabetics** achieve optimal health outcomes for diabetes in 2019

Better Health Partnership

Continue Self- Exploration Through BHP's Interactive Dashboards on Web Site



Our adult metrics

https://tinyurl.com/bhp-adult-health-dash

Our children's metrics

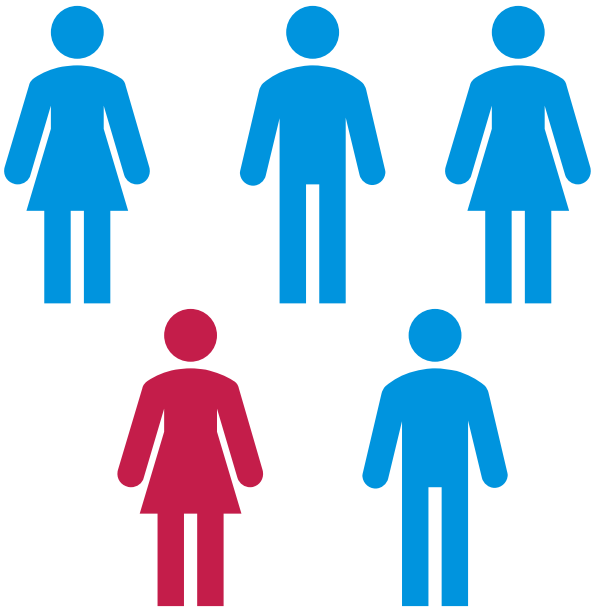
https://tinyurl.com/bhp-chi-report

Better Health Partnership

COVID- 19
Adult Risk Factors and Quality of Care

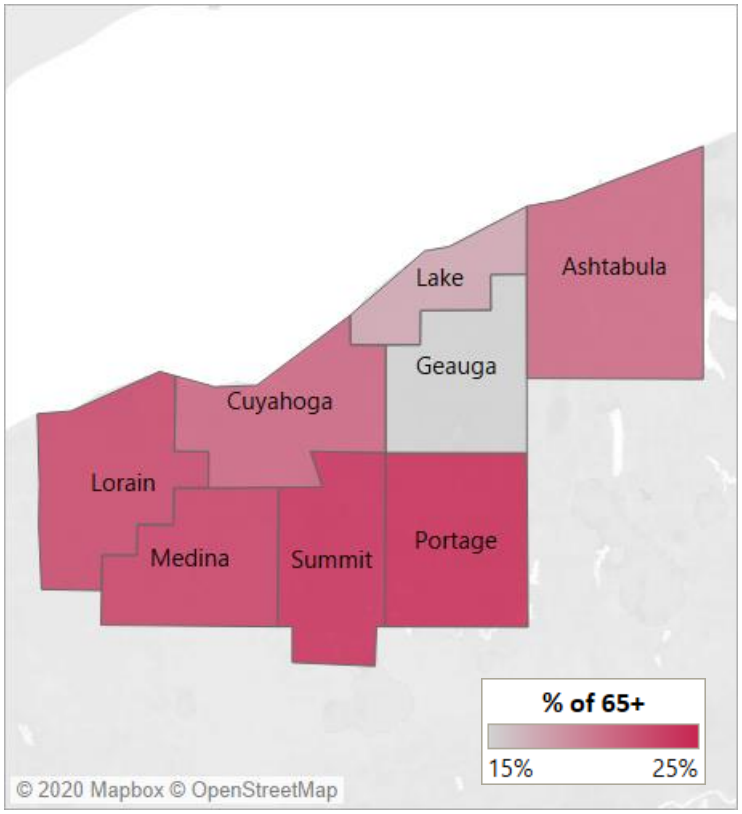
COVID-19

Estimated Risk Factors



20% of Adults over 65 yrs. Old
Had Diabetes and BMI >30

(1 in 5 adults)



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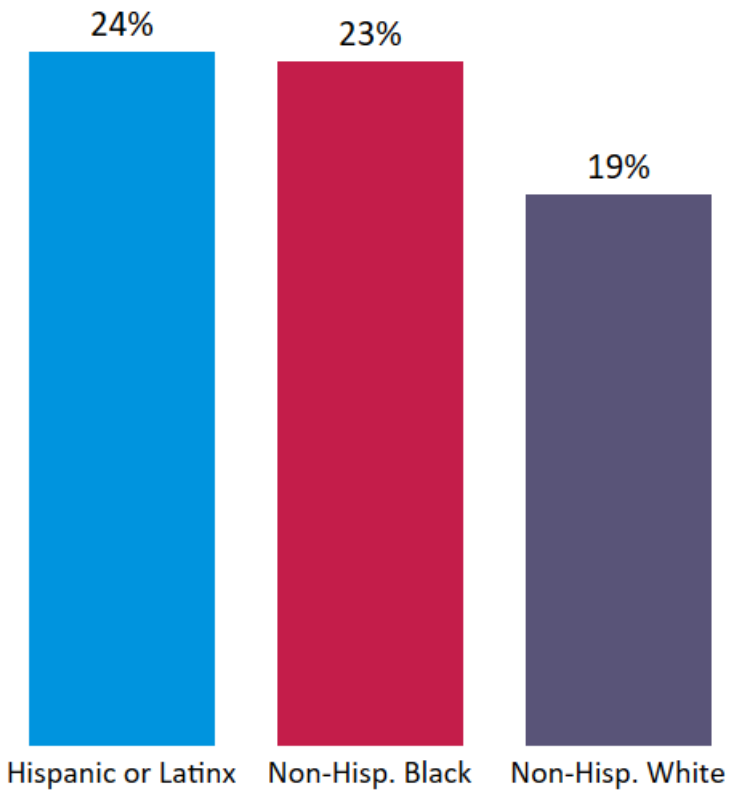
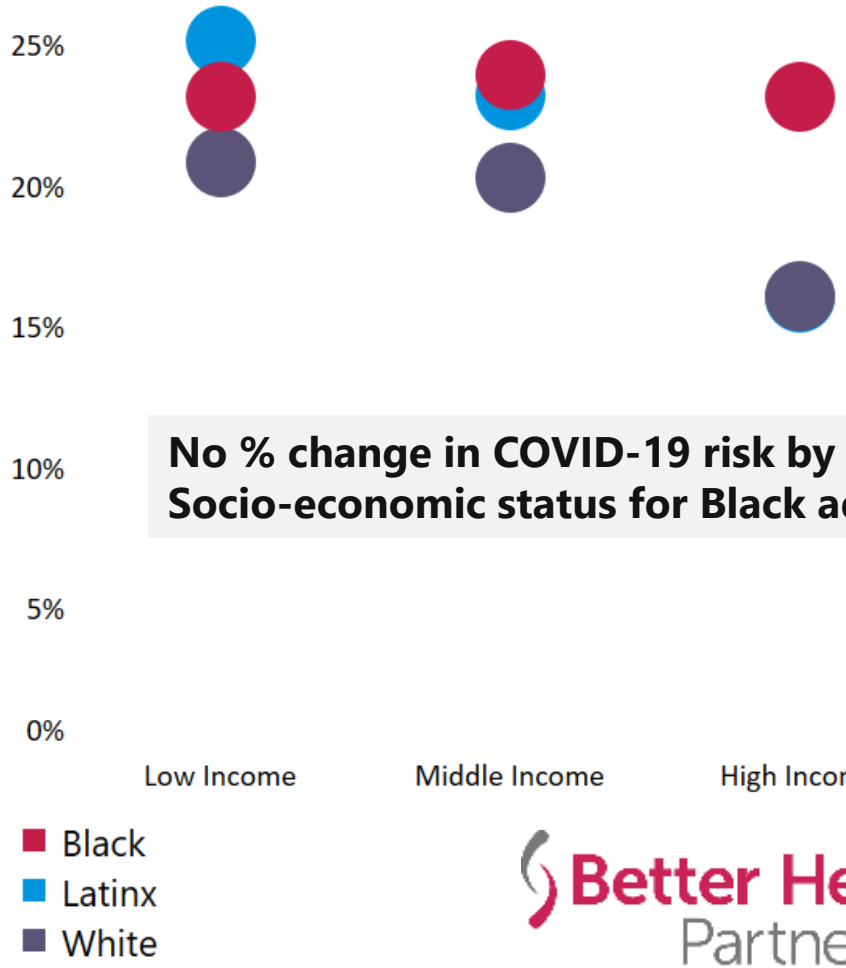
COVID Risk Factors by Race and Income; Cuyahoga County

% of 65+ with COVID Risk Factor By Race



% of 65+ with COVID Risk Factor By Race and Neighborhood Income



No % change in COVID-19 risk by Socio-economic status for Black adults

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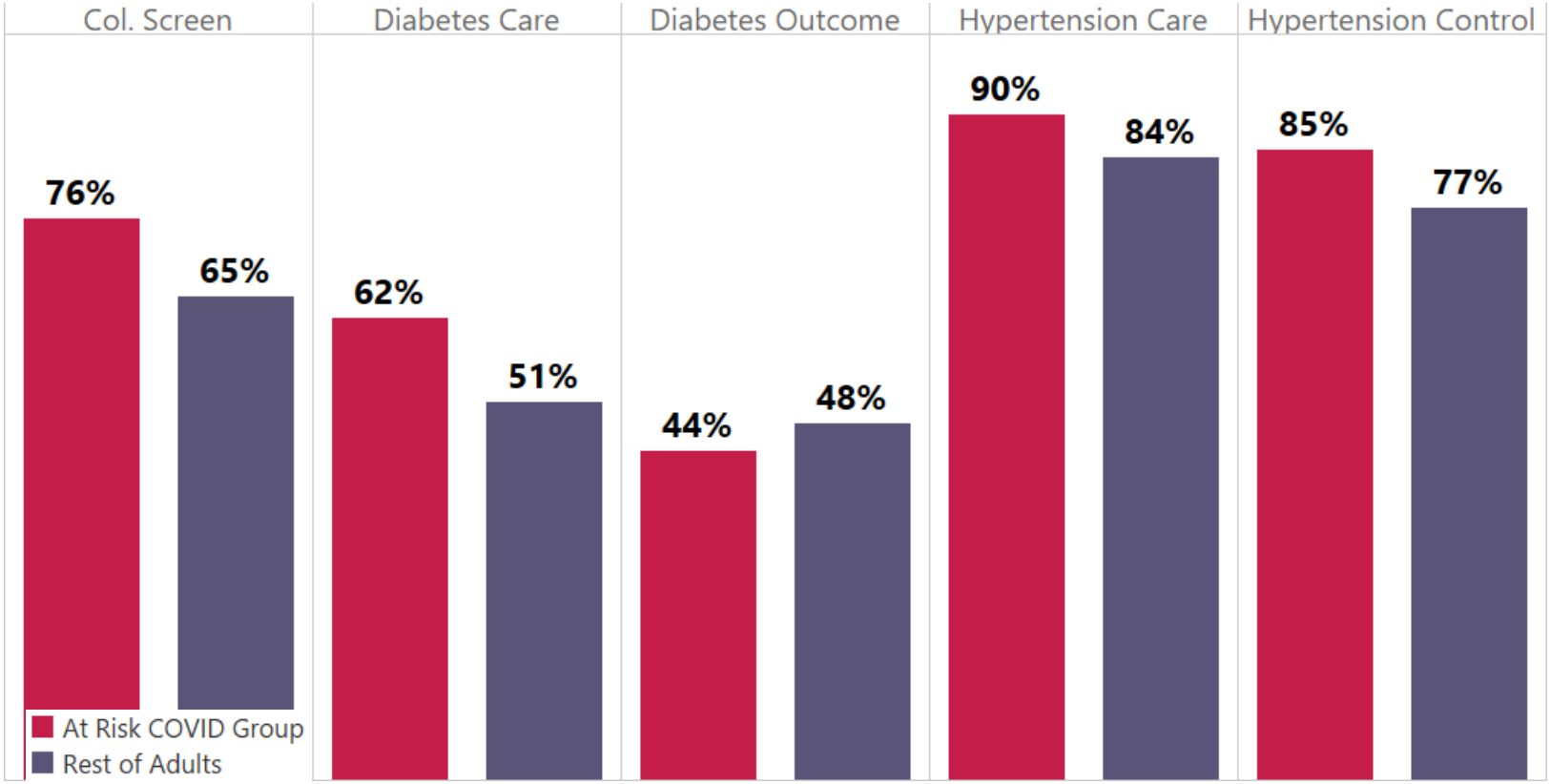
Quality of Care and Outcomes for At-Risk COVID Groups vs Others



Adults 65+, Diagnosed Diabetic, and Obese received overall higher quality care and achieved better outcomes with bp control

Polling Question

Integrating Data and Collaboration for Improved Outcomes

Ron Lloyd RN, MBA
Vice President of Performance Improvement
Neighborhood Family Practice

Neighborhood Family Practice
COMMUNITY HEALTH CENTERS

NFP Community Partnerships

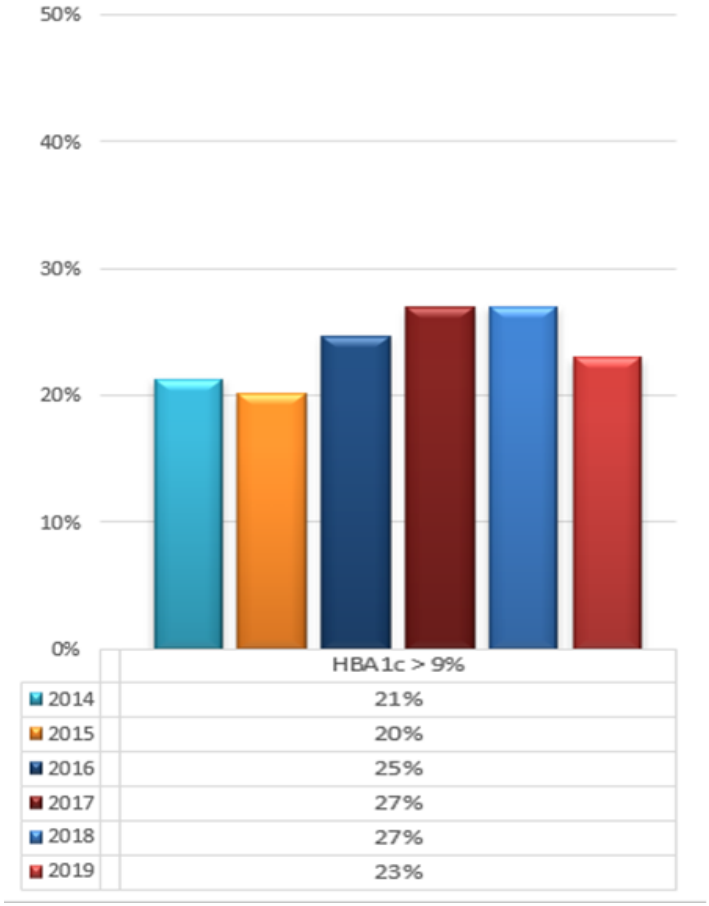
Case Western Reserve University Est. 1826

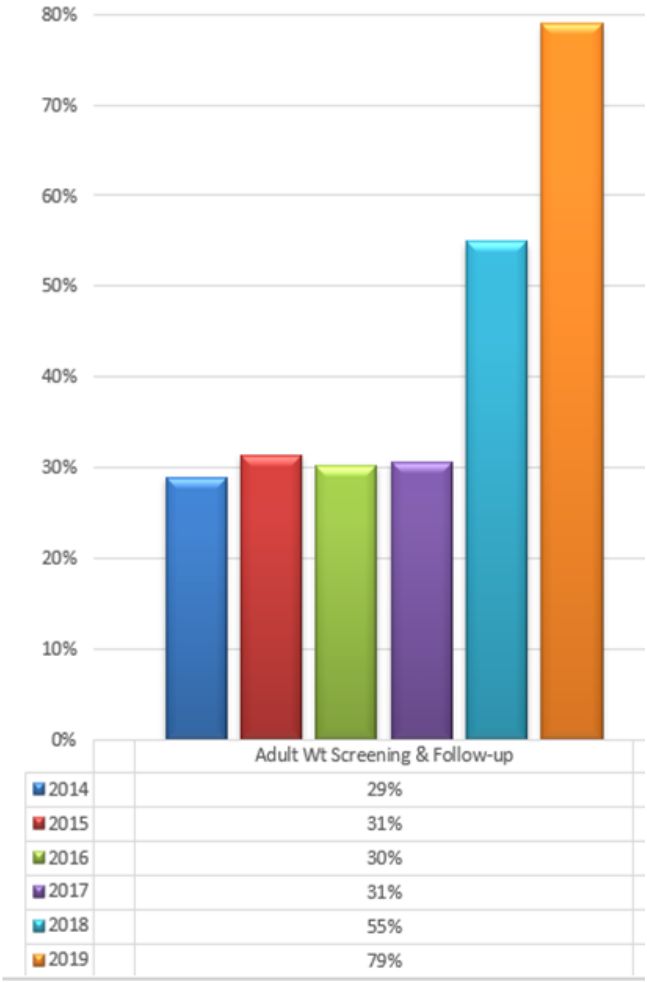
Greater Cleveland Food Bank

Better Health Partnership
Collaborating for a healthy community

Hunger Network of Greater Cleveland
Everyone has a place at our table

NFP Uniform Data Systems (UDS) Metrics





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NFP vs. Regional BHP Adult Data Report – Chronic Disease Metrics

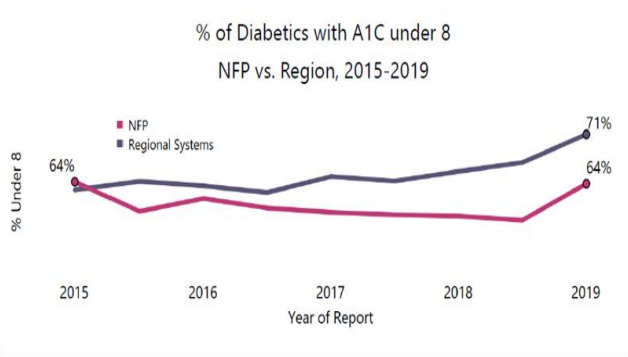
1,708

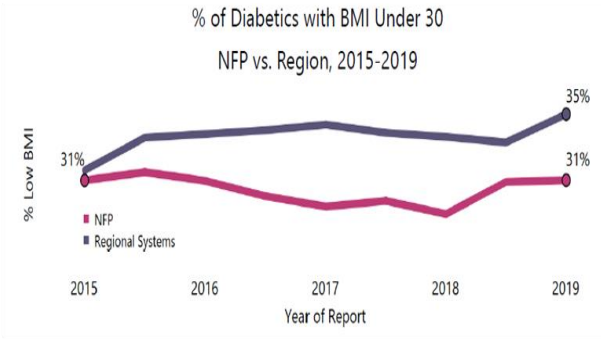
Adults (18+) are diagnosed diabetic at Neighborhood Family Practice

Number of Diabetic Patients (18+ yrs.) seen at NFP Practices, 2019

55%

of adults (50-75) have a BMI ≥30 in 2019

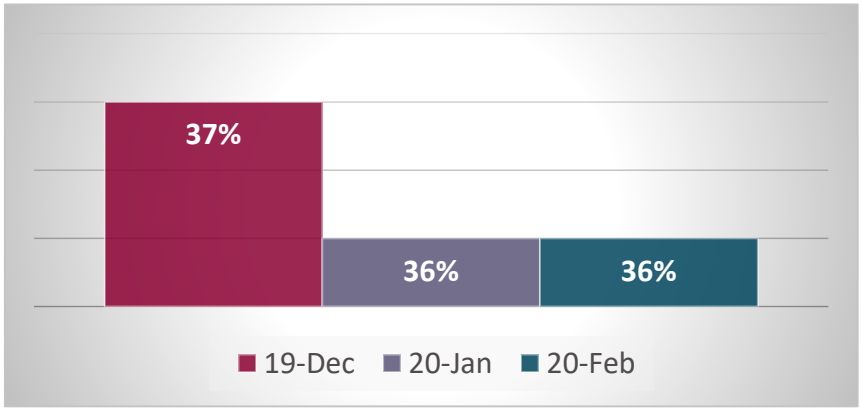




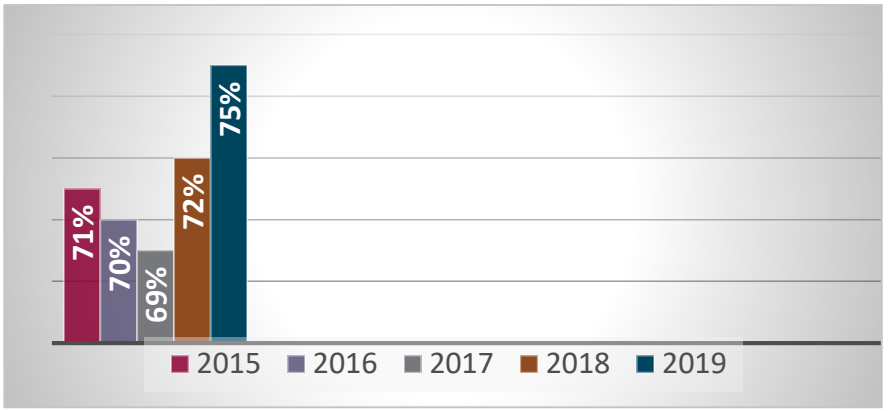
Better Health Partnership

NFP vs. Regional BHP Adult Data Report – Chronic Disease Metrics

Colorectal Cancer Screenings

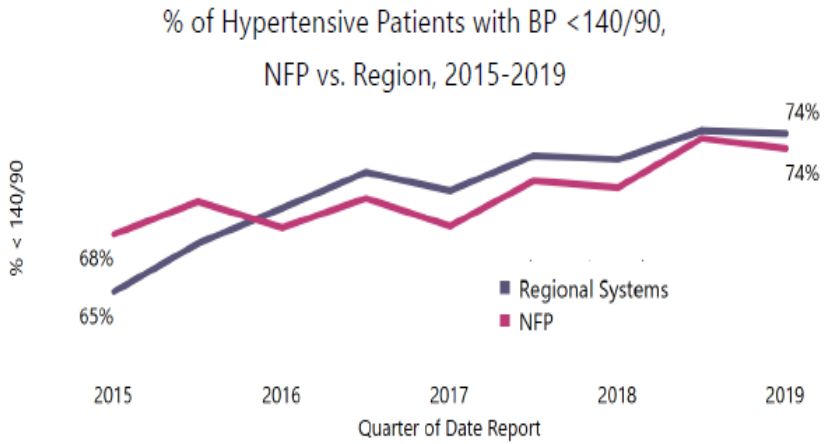


Hypertension Patients Controlled



53%

Of eligible adults (50-75) were up-to-date in their colorectal cancer screening in 2019



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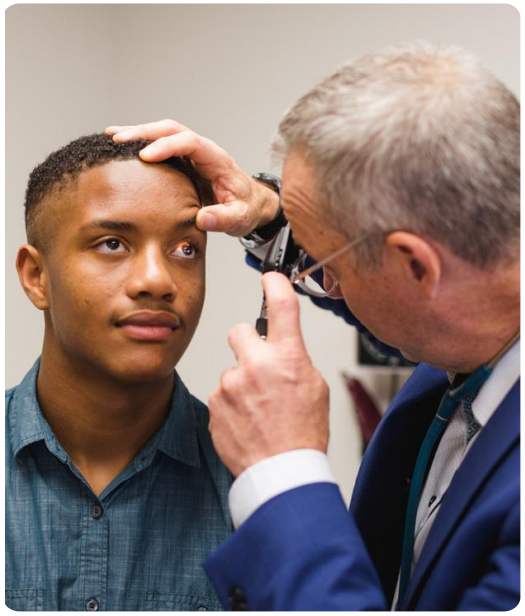
Redesigning Healthy Behaviors

- Community and Patient-centered programs
- Patient Chronic Disease Education
- Food Distribution Days

NFP Continues to Innovate and Promote Collaboration

- Drive-up Testing for Chronic Disease
  - HgbA1C and INR
- CASE Medical and Nursing Students
  - CRC pilot
  - Covid preventative education
- Managed Care Plans collaborations in:
  - Remote Patient Monitoring (RPM)
  - Social Determinants of Health (SDOH)



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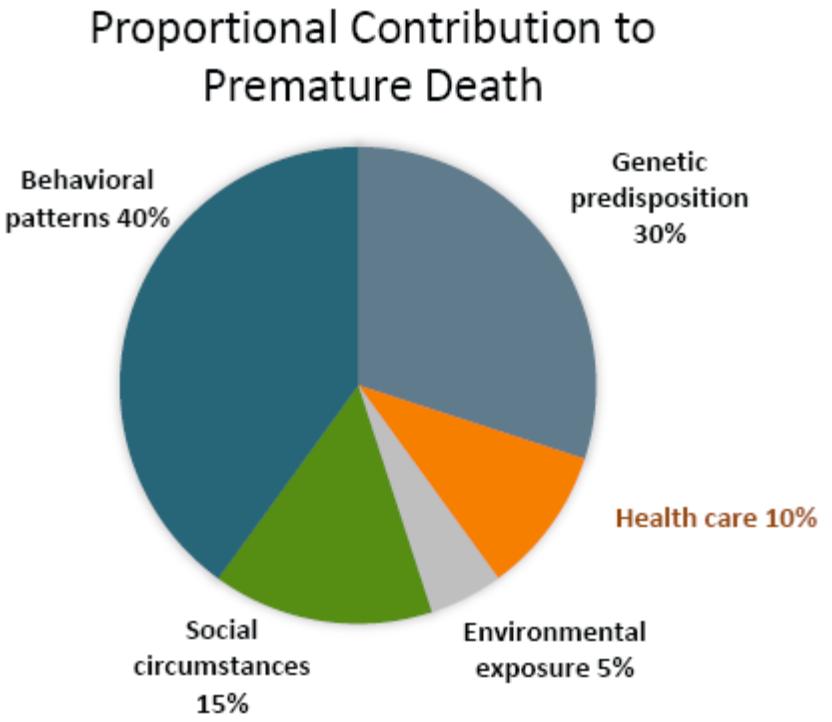
Summing UP.....

- Collaborative efforts are instrumental

- Identify and Promote Health Behaviors that are relatable

- Open to multiple tools and resources to develop sustainable deliverables



McGinnis et al. The case for more active policy attention to health promotion. *Health Affairs*. 2002;21(2):78-93.

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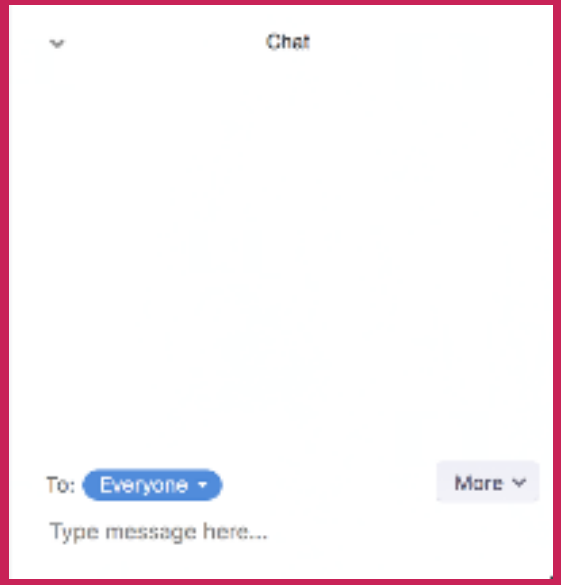
Questions?
Please submit through chat function



Register for Future Webinars

- **August 26 The Better Health Pathways HUB**
- September 3 Prioritized Findings from First Year Cleveland's Action Team #4 Extreme Premature Births
- September 23 Prioritized Findings from First Year Cleveland's Action Team #1 Patient Experiences; Racial Disparities

- Need more information? Please send your requests to Carol Kaschube ckaschube@metrohealth.org

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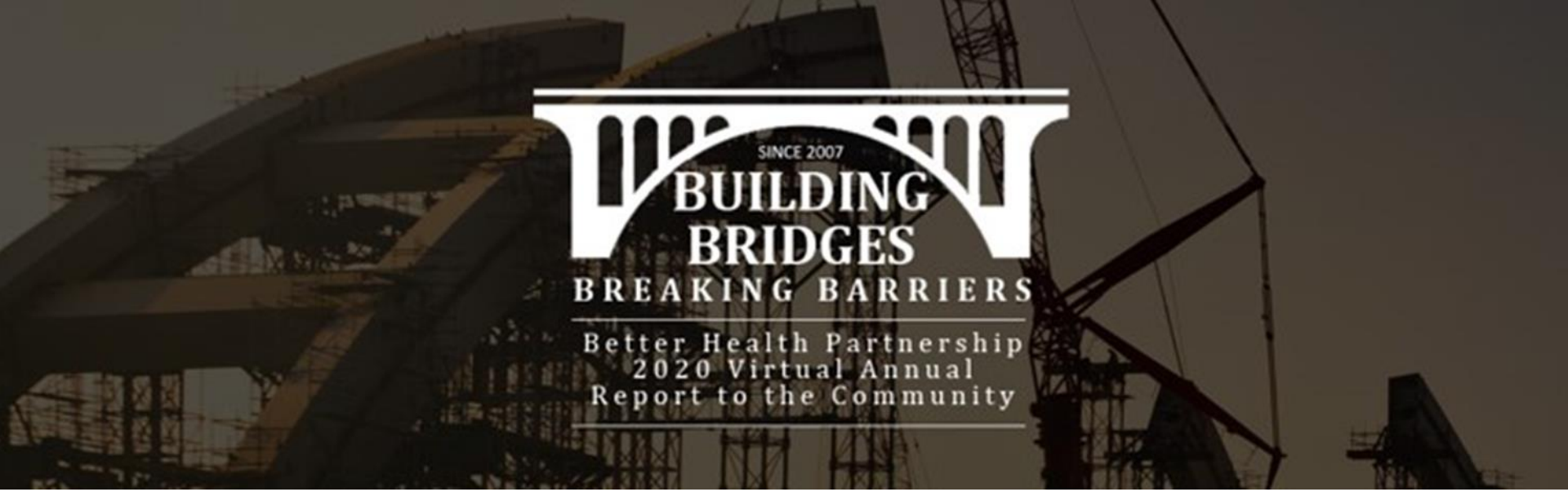

Thank You!

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Collaborating for a healthy community

www.betterhealthpartnership.org