

Brookings Conference on Addressing Health Disparities

Measurement Matters: Public Reporting to Shine a Light on Regional Disparities

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



Summary

- Better Health *Greater* Cleveland is a regional primary care practice-centered public reporting initiative to improve quality and eliminate disparities among persons with chronic medical conditions.
 - EMR-catalyzed reports shine a light on disparities by stratifying achievement and change.
 - Reports are trusted; and they motivate improvement
 - In diabetes, over 3 years most have improved, though those with fewer resources fare more poorly/improve less.
 - There are several barriers, including non-clinical barriers, to improvement.
 - Attacks on disparities must actively engage multiple stakeholders
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Better Health *Greater* Cleveland:

Mission and Methods

- **Mission: To improve the care and outcomes of the community's residents with chronic conditions**
 - and eliminate disparities in health
- **Methods:**
 - **Measure and Publicly Report Achievement**, practice site level and aggregated across the region's practices:
 - Nationally Endorsed, Locally Vetted quality standards
 - 31/45 practices use EMRs, representing ~90% of patients
 - **Regional results Stratified** by Insurance (including the uninsured), Race, Household Income, and Education
 - Semi-annual reports: cross-sections and cohorts (patient codes)
 - Implement Region-wide QI Learning Collaborative
 - Initiate Patient Engagement Strategies

Aligning Forces for Quality Communities

Supported by the Robert Wood Johnson Foundation

Humboldt County, Calif.

Willamette Valley, Ore.

Puget Sound, Wash.

Cincinnati, Ohio

West Michigan

Detroit, Mich.

Cleveland, Ohio

Wisconsin

Western New York

Minnesota

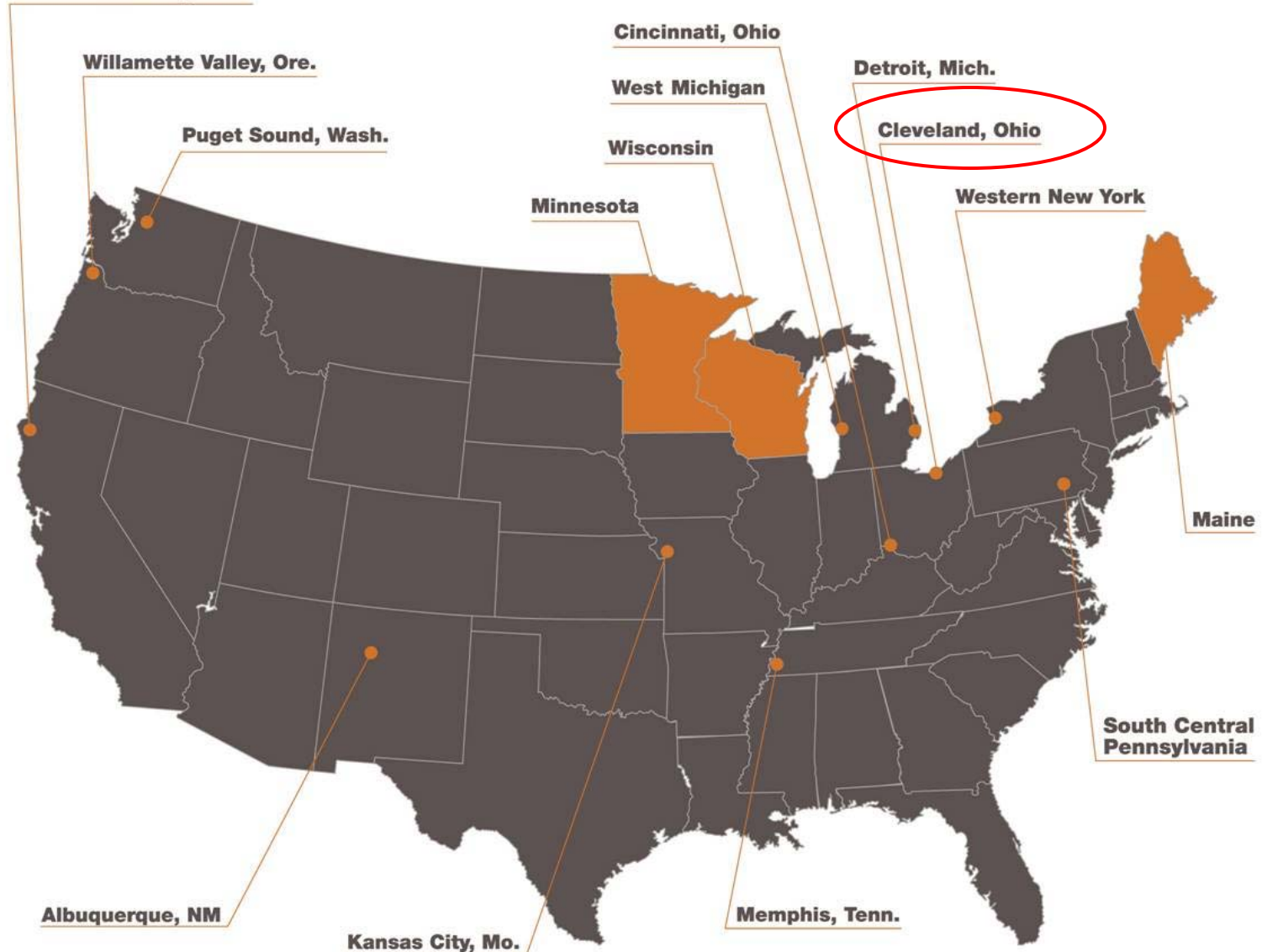
Maine

Albuquerque, NM

Kansas City, Mo.

Memphis, Tenn.

**South Central
Pennsylvania**



Public Reports that Highlight Region-wide Achievement, Stratified

Achievement by SES Factors:

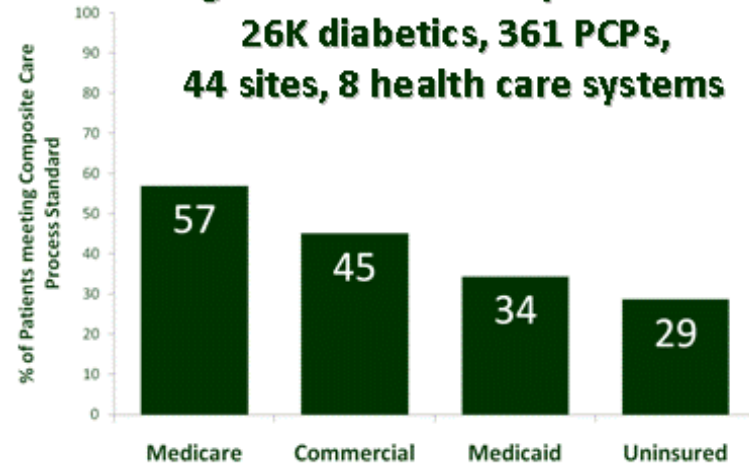
Medicaid and Uninsured fare more poorly; as do minorities, the poor, and those with least education

Achievement by measurement source:

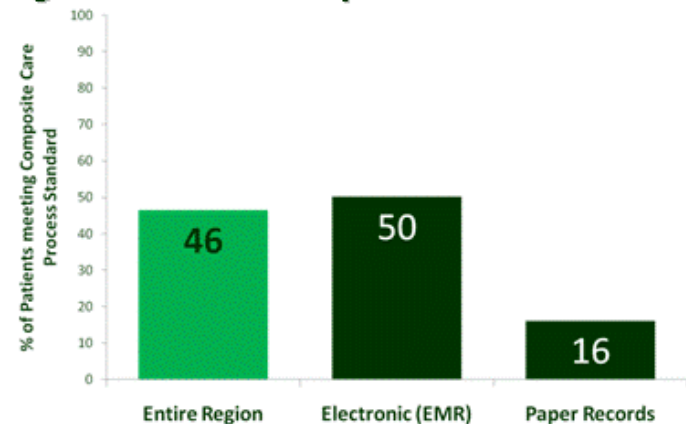
Paper-based practices fare more poorly

Region-wide results by Insurance:

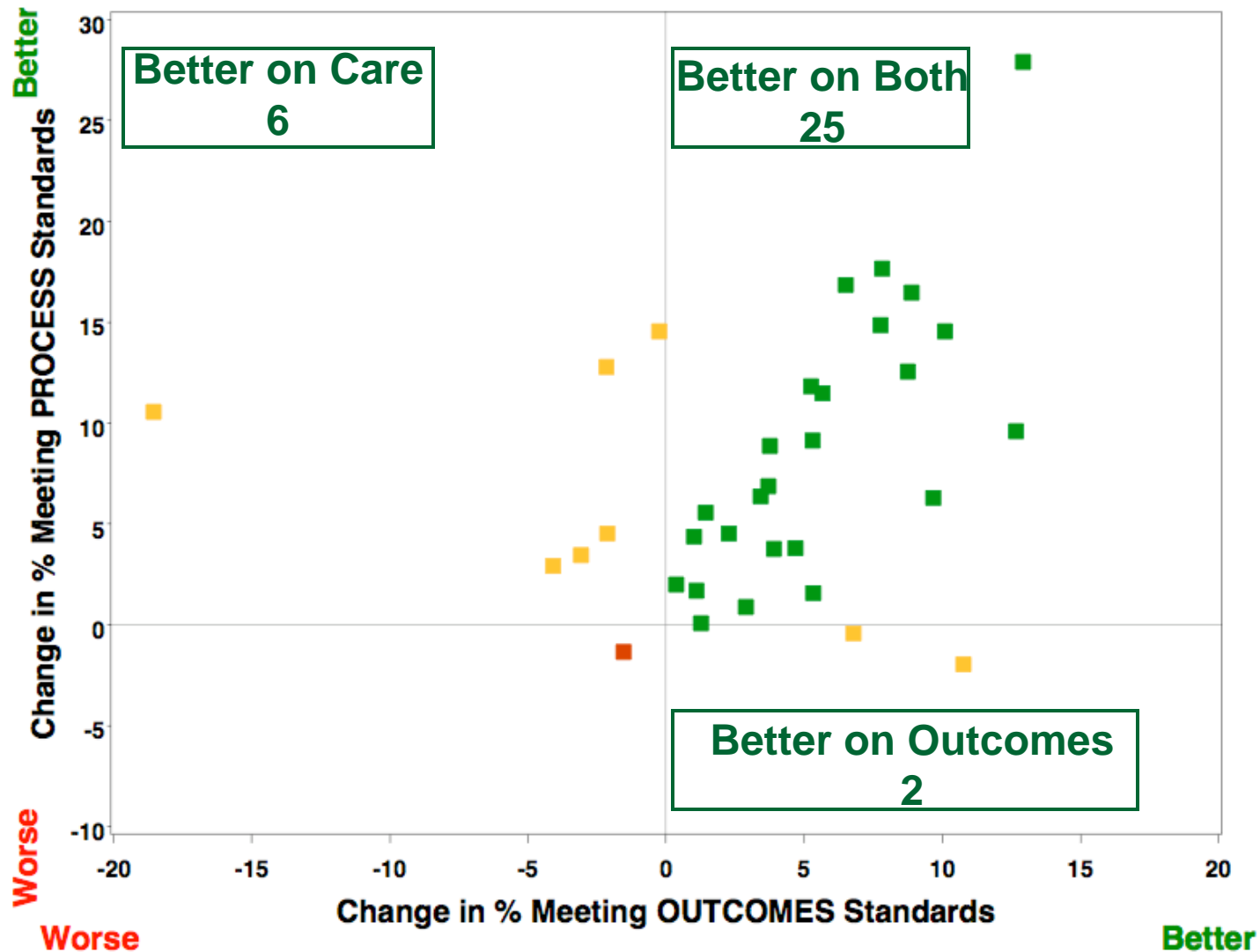
26K diabetics, 361 PCPs,
44 sites, 8 health care systems



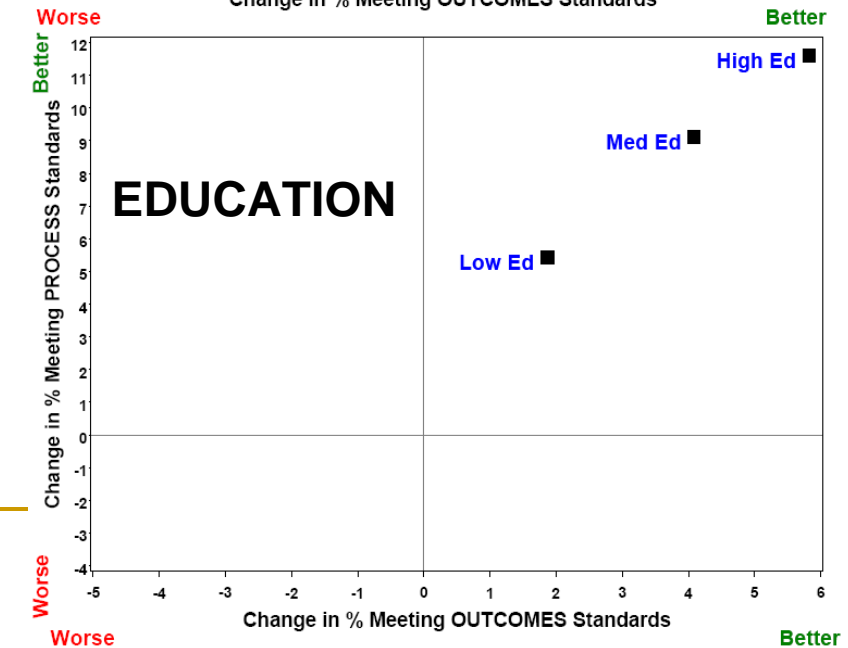
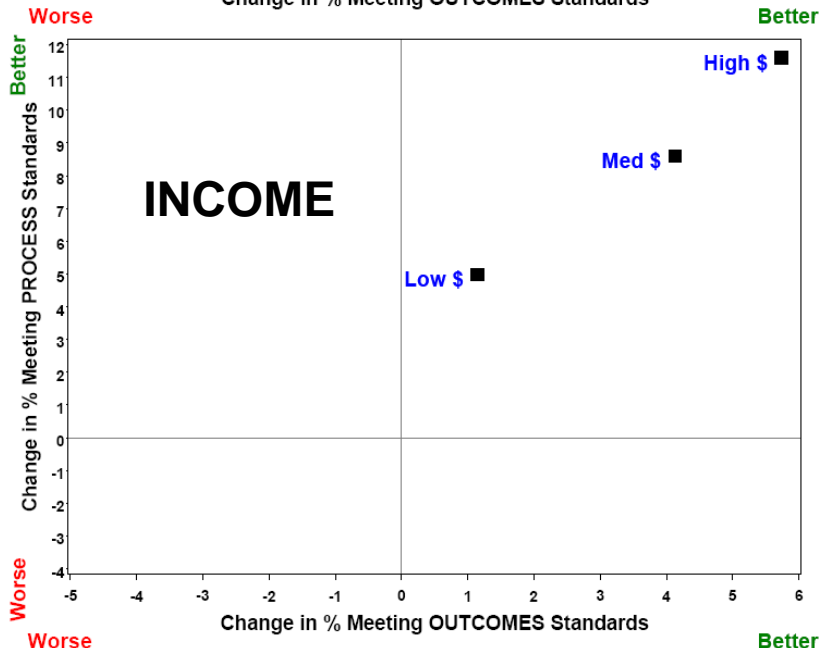
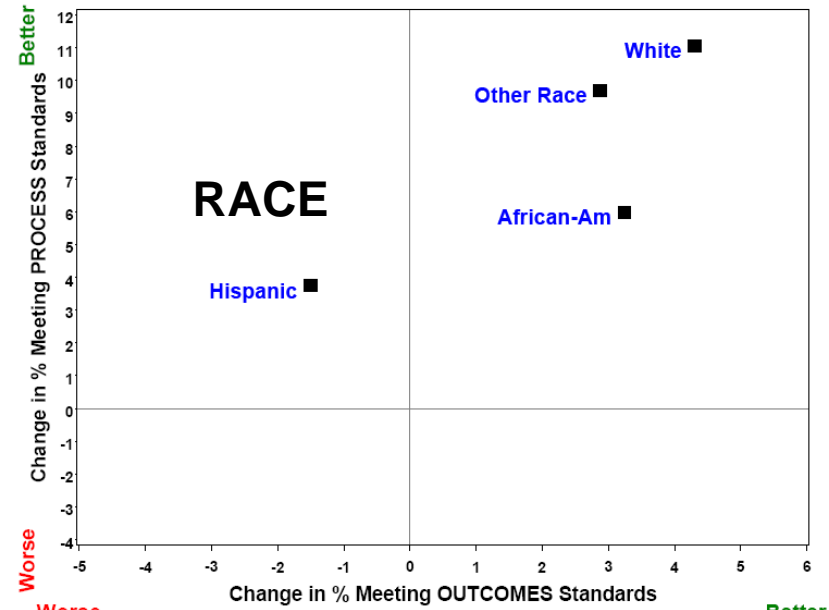
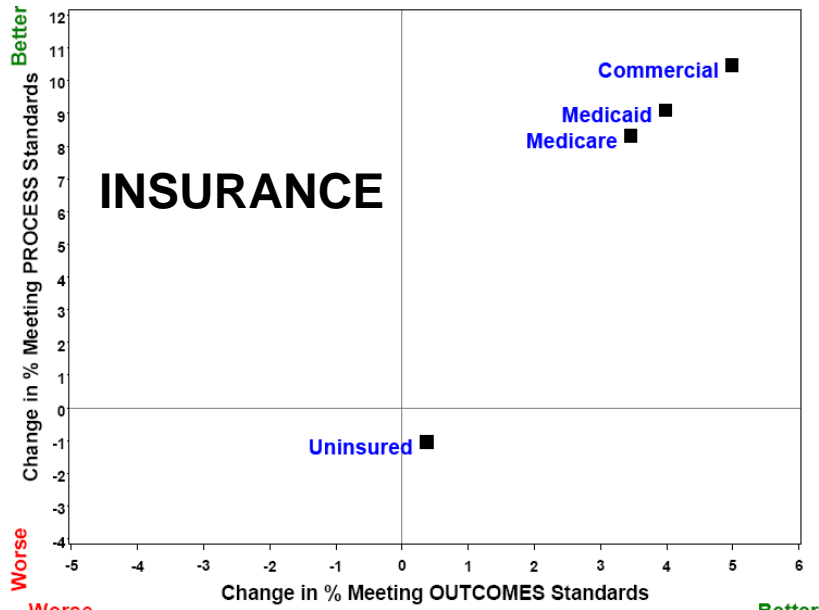
Region-wide results by Measurement Source



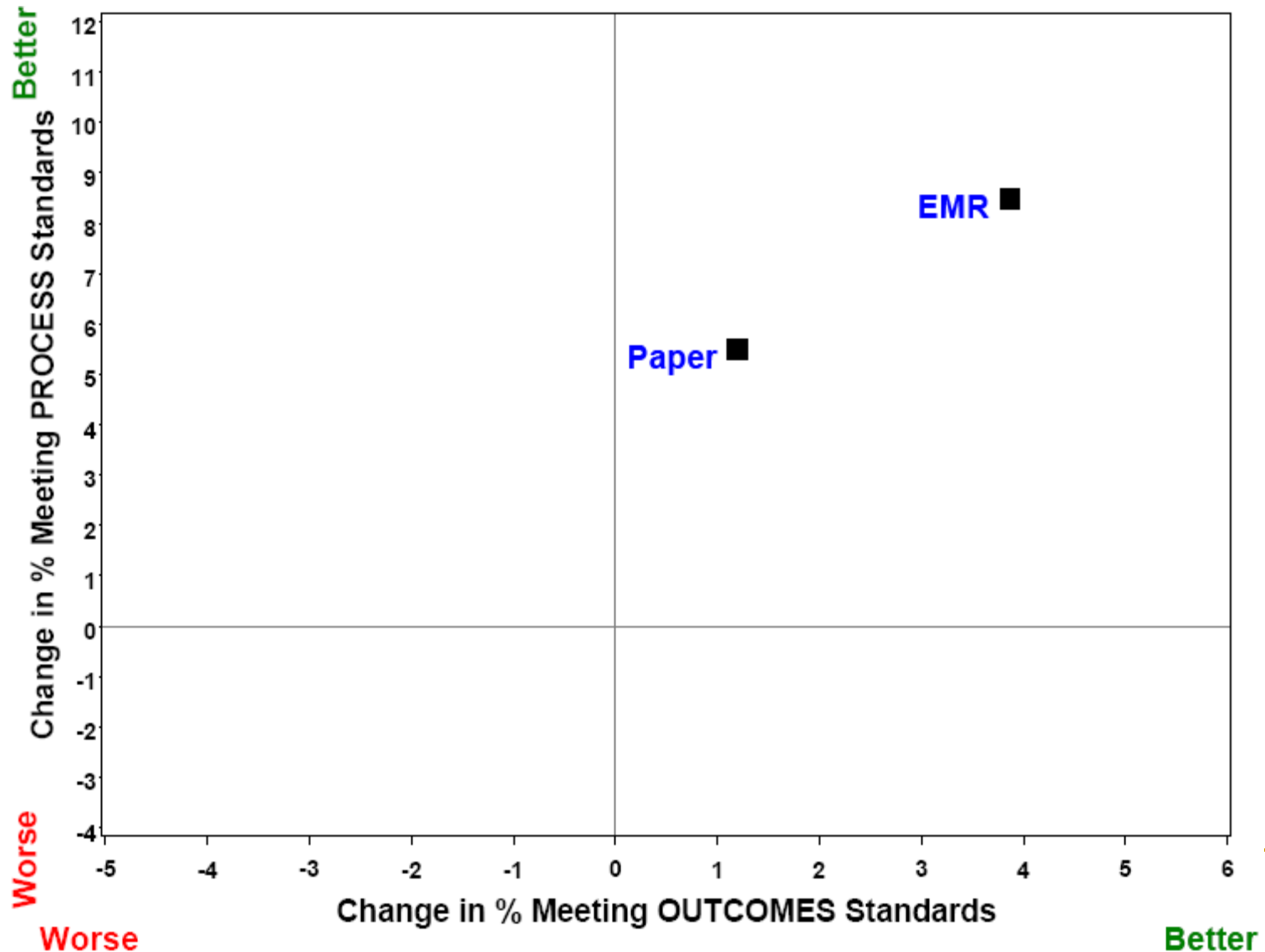
33 of 34 Practice Sites Improved in Care, Outcomes, or Both. 2007-2009



But patients with fewer resources improved less



And practices with fewer resources also improved less



Challenges to Eliminating Disparities Through Public Reporting

■ Gaps in data

- We don't measure those who don't receive care
- We don't publicly report Everyone we *do* see: we mimic NCQA
- We represent only ~40-50% of all practice sites
- We aren't [yet] measuring important outcomes; eg complications
- We don't measure cross-system care well – HIE is in its infancy

■ Most *systems* are not truly accountable

- It doesn't really matter if we don't measure complications or cross-system care well

■ The *community* is not truly accountable

- ROI resistance; “Someone else's problem”

■ Financing/payment systems are not aligned with improving patient-centered outcomes

An Accountable Community

- Some Short-term Steps (2-4 years):
 - Provider-centered Data & Interventions
 - For those without access, PCMH for the uninsured
 - HEALTH REFORM: ID the uninsurable for “high risk pool” support
 - To increase provider participation, leverage MU INCENTIVES/benefits
 - Target interventions to those most vulnerable (eg, minorities, uninsured)
 - To capture care across systems, begin true HIE
 - System Non-accountability
 - Multi-payer PCMH for M’caid-M’care-Commercial
 - Payment Reform
 - Community Non-accountability
 - Better engage policymakers, public health, land use, employers, health plans
 - Non-alignment of payment with desired patient-centered outcomes
 - Work with govt and employer-purchasers