

Preconference III: You Won't Improve What You Don't Measure

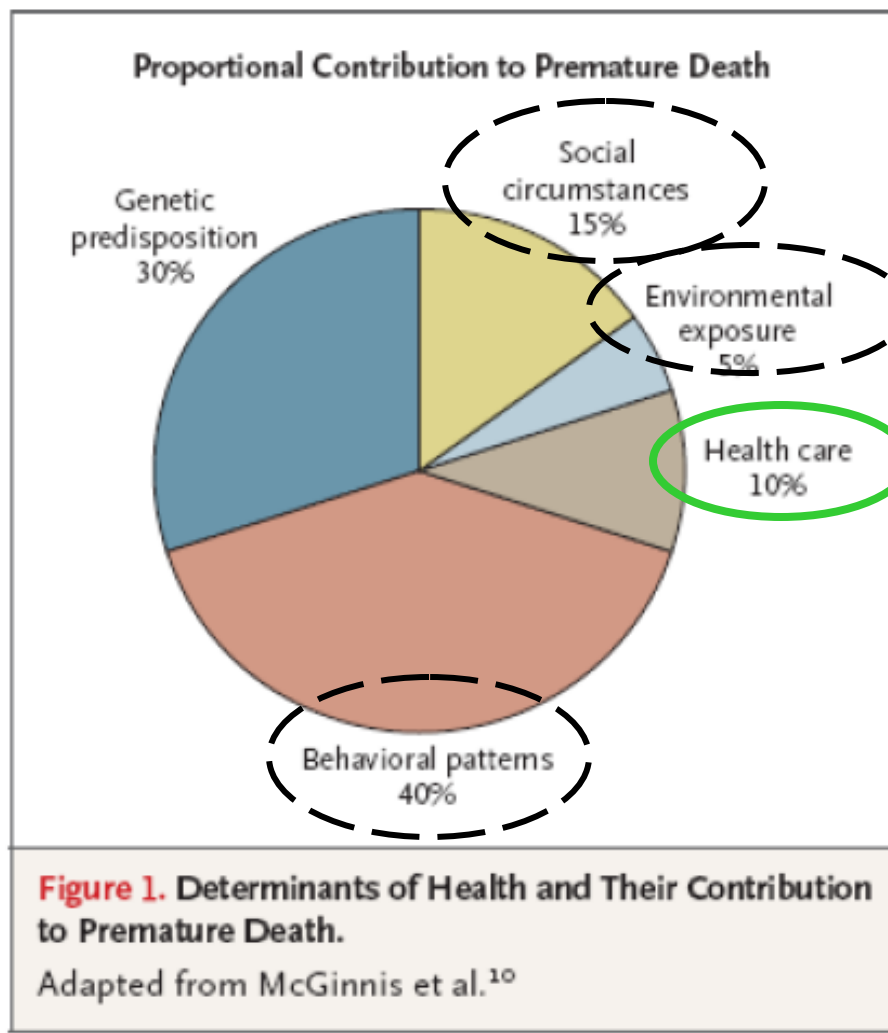
Measuring and Addressing Disparities in a P4P World

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What are disparities all about, anyway? How much can health care delivery help?



Schroeder SA.
Shattuck Lecture.
N Engl J Med.
2007; 357: 1221-28.

Overview of *Better Health*

- ***Our Vision:* To Make Greater Cleveland a Healthier Place to Live and a Better Place to Do Business**
- ***What we Do:* measure, publicly report and improve care/outcomes for the region's residents with chronic conditions**
 - EMR/HIT-catalyzed, primary care-focused
 - **Results stratified by SES traits: all insurance types, race/ethnicity, education and income**
 - 569 PCPs, 46 practices, 7 systems, including all 3 FQHCs
 - ~70% of county's residents with chronic conditions
 - Most recent public report: 115K patients with hypertension (107K), diabetes (27K), +/- heart failure (5K)

Better Health's Public Reporting Includes **Safety Net Practices**

- **SNPs:** high volume Medicaid and/or Uninsured

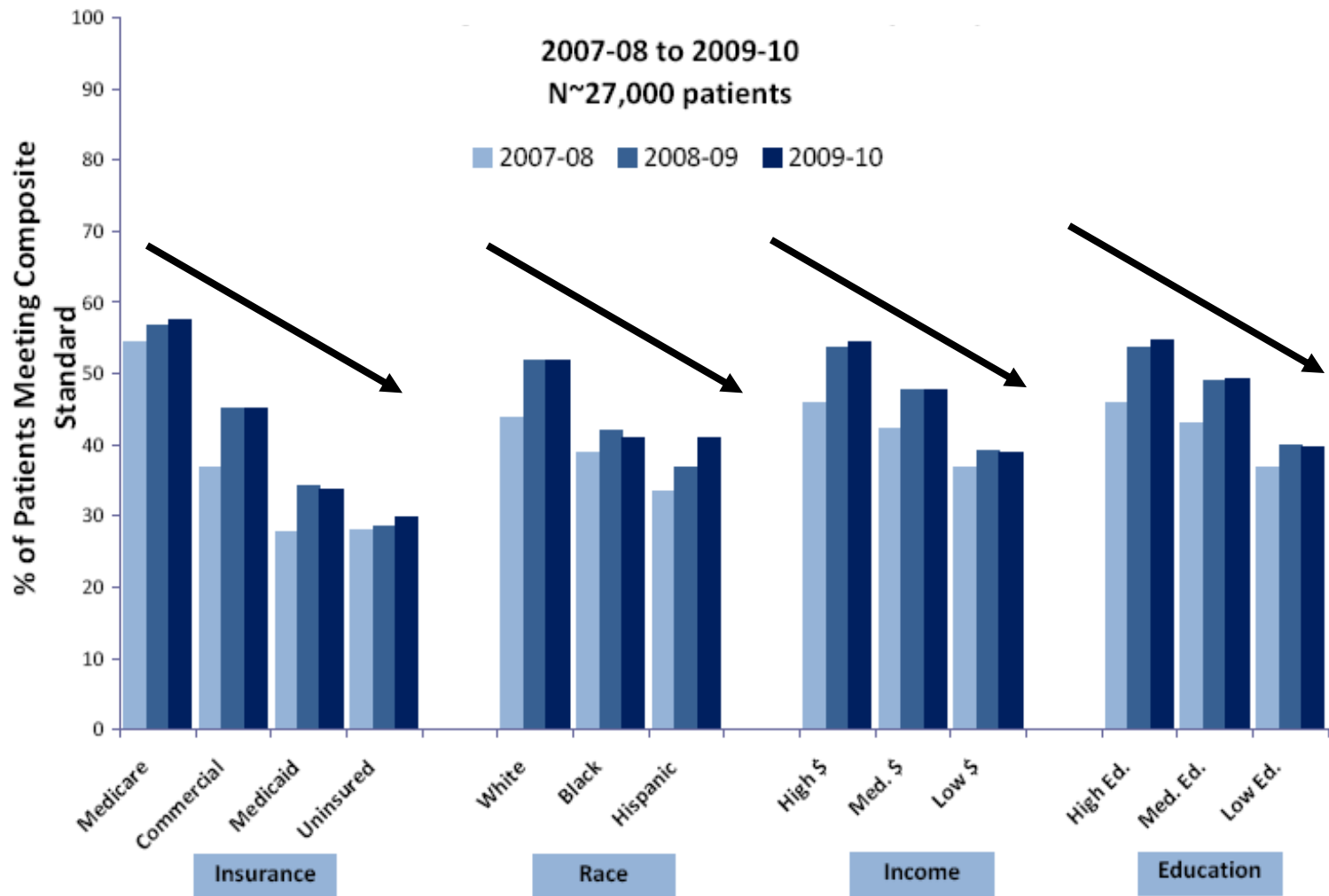


See “Find a Practice” at: www.betterhealthcleveland.org

Population Health/Disparities-Related Metrics: What we Measure and How

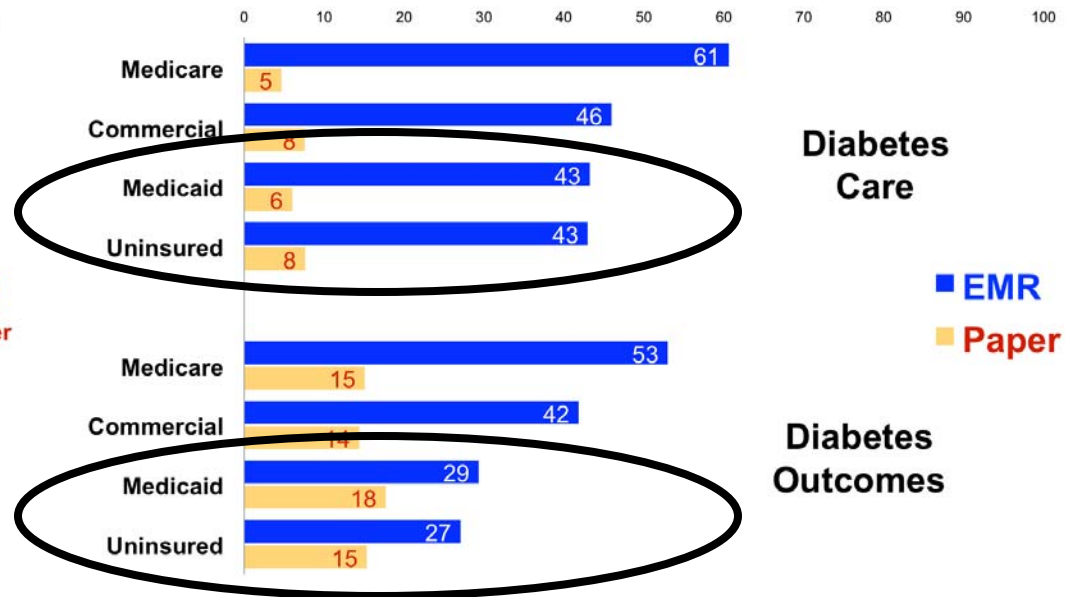
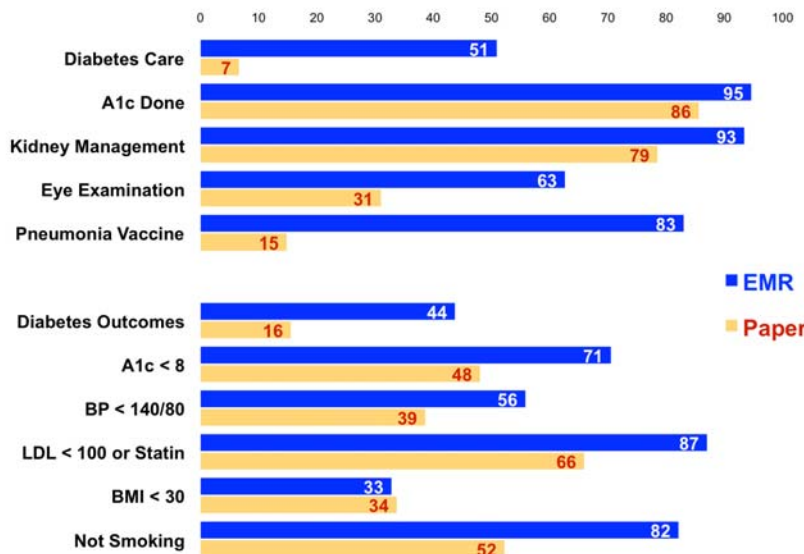
- Insurance EMR/Primary Recorded
- Race/ethnicity EMR/Self-report
- Language Preference EMR/Self-report
- Household Income EMR/Address/Census
- Education Attainment EMR/Address/Census
- Age, sex EMR
- BMI EMR
- Smoking Status EMR
- Measurement Source System: EMR vs. Paper

Disparities: Vulnerable Patients Do Worse

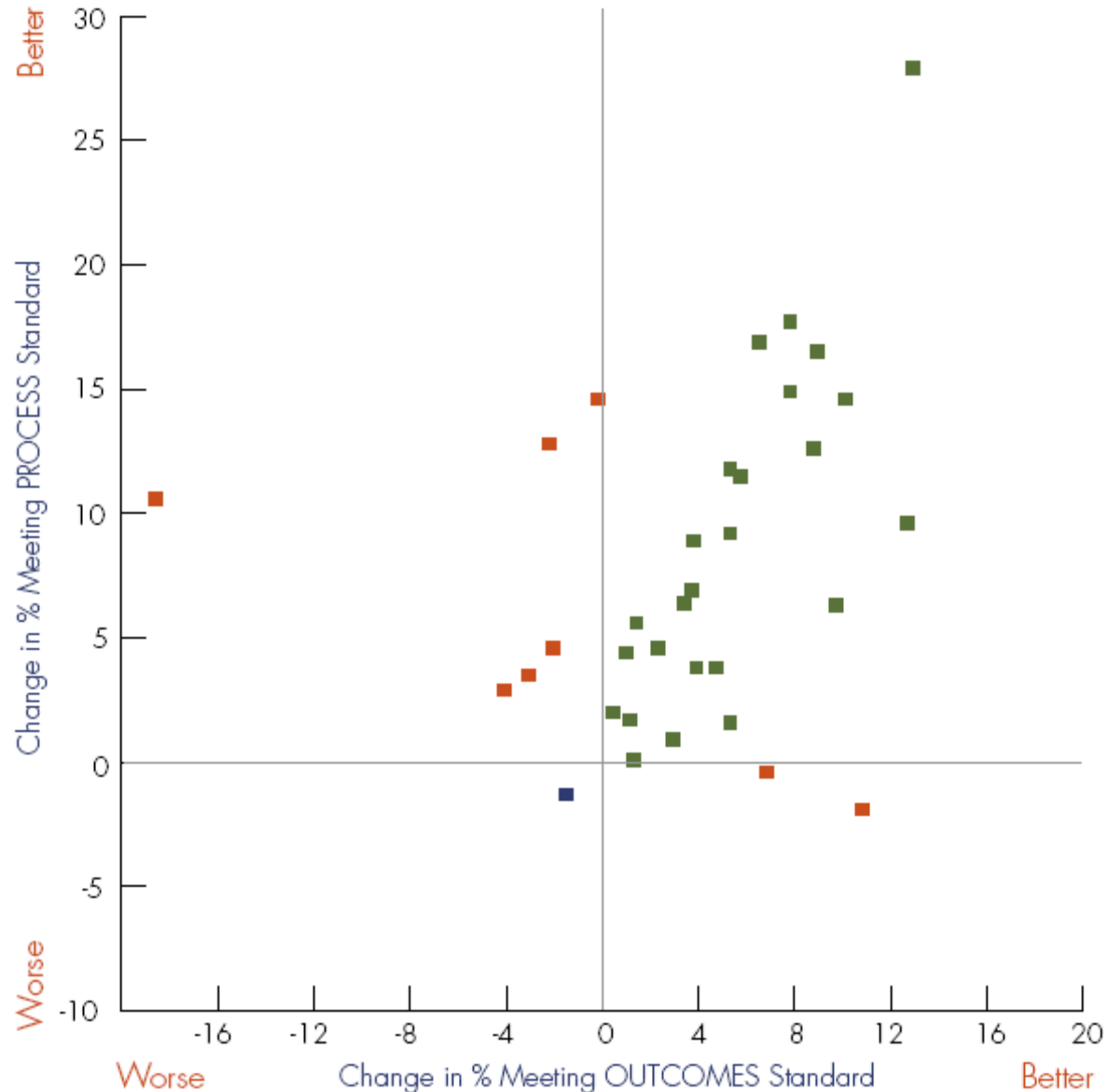


Disparities: Paper Practices Do Worse

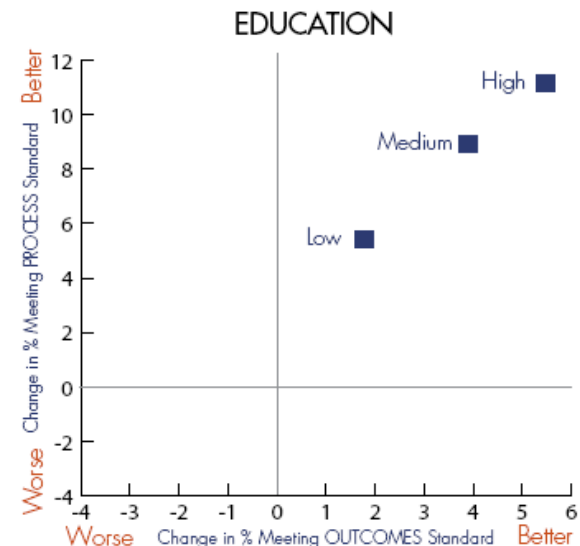
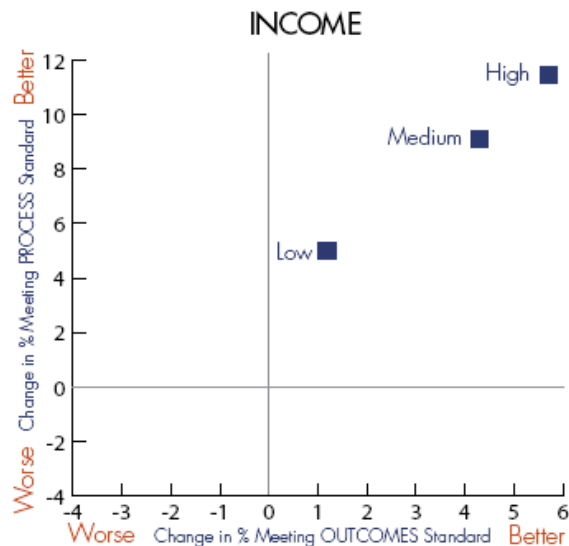
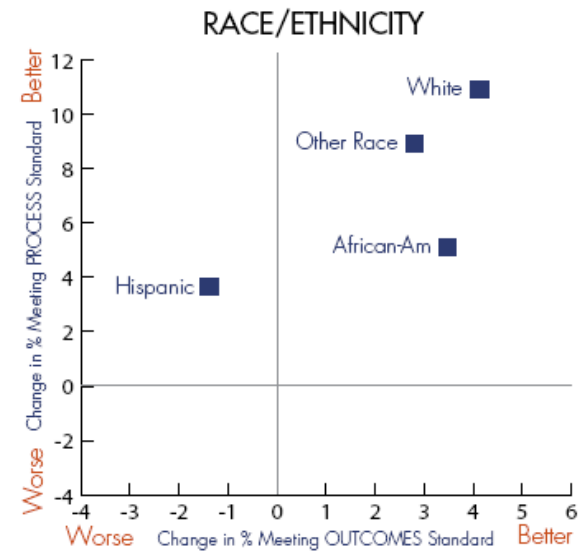
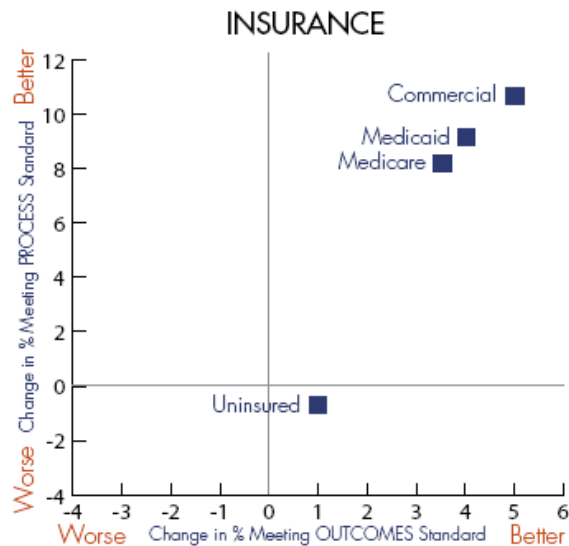
- Diabetes: 27,258 patients, 46 sites -2009-10
- Benefit larger for *Care* than *Outcomes*
- Benefits similar across insurance



In a regional collaborative, virtually all practices *Improve*



But some patients improve predictably *less* than others



**Some *Better Health* Partners:
Trying to be Accountable**

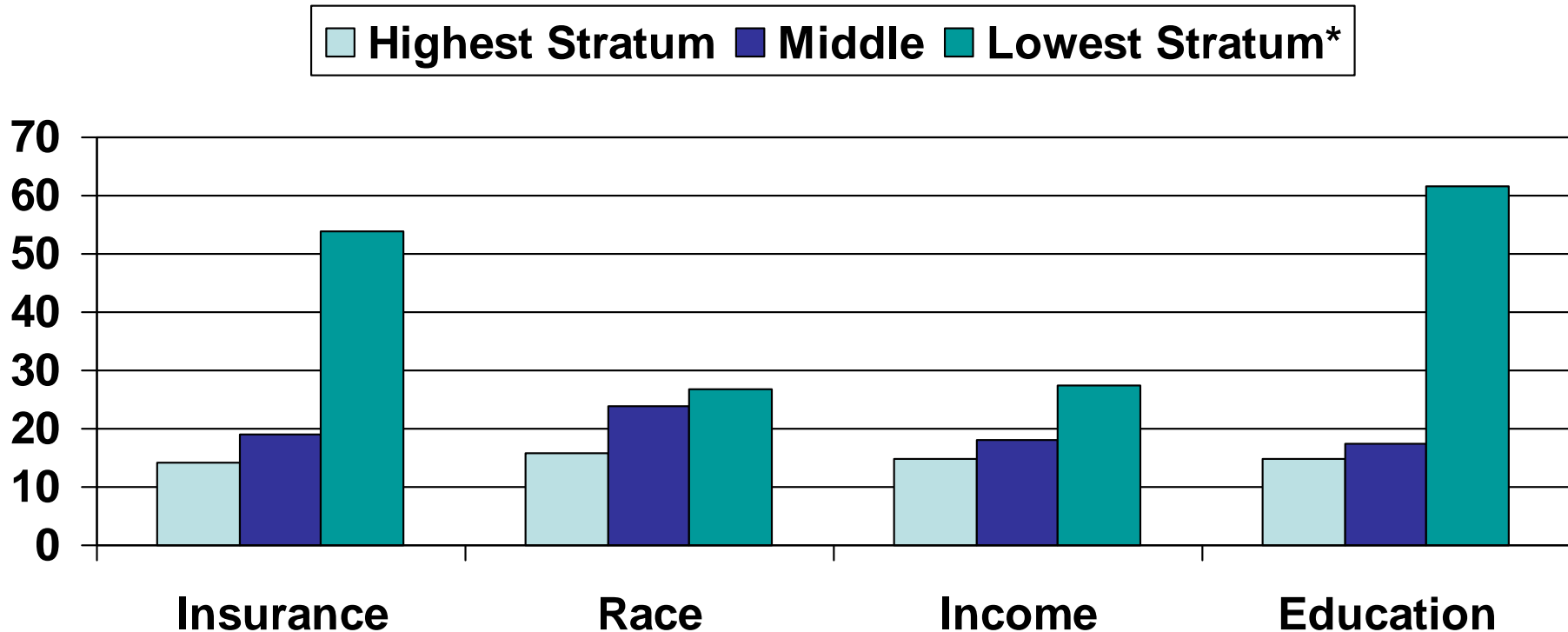
Disparities, Regional Health Improvement, and P4P

Current P4P: What do our Policies Incent?

1. Insurance Based
 - Having Insurance
2. Patients of specific insurers
 - Practice cherry picking and insurance free-riding
3. Selection for review:
 - All patients
 - Random sample
 - Consecutive sample
 - Avoiding risky patients
4. Paying by % over std
 - Avoiding risky patients

A ‘high value’ predictor of poor outcomes: Why Wouldn't Practices Avoid Risky Patients?

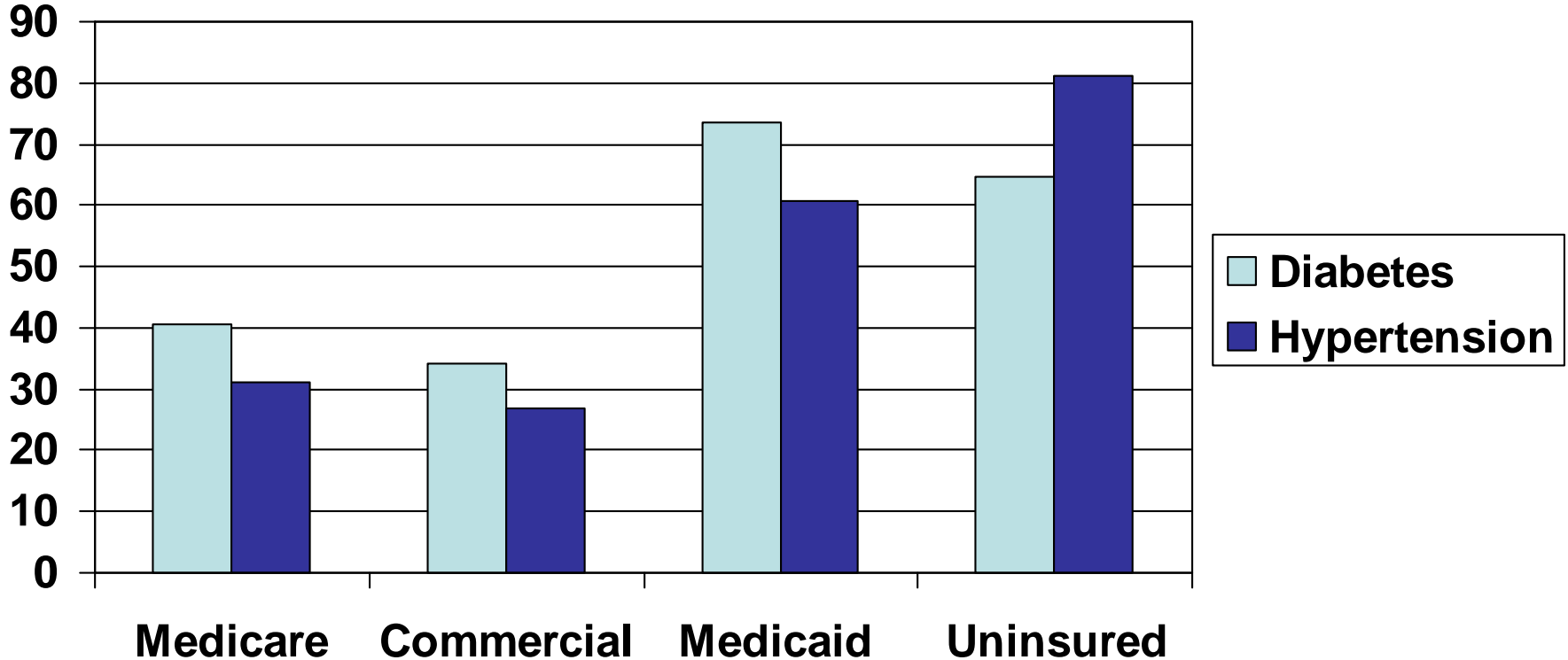
Poor Glycemic Control in Cleveland by SES (n=27,207, 2009-10)



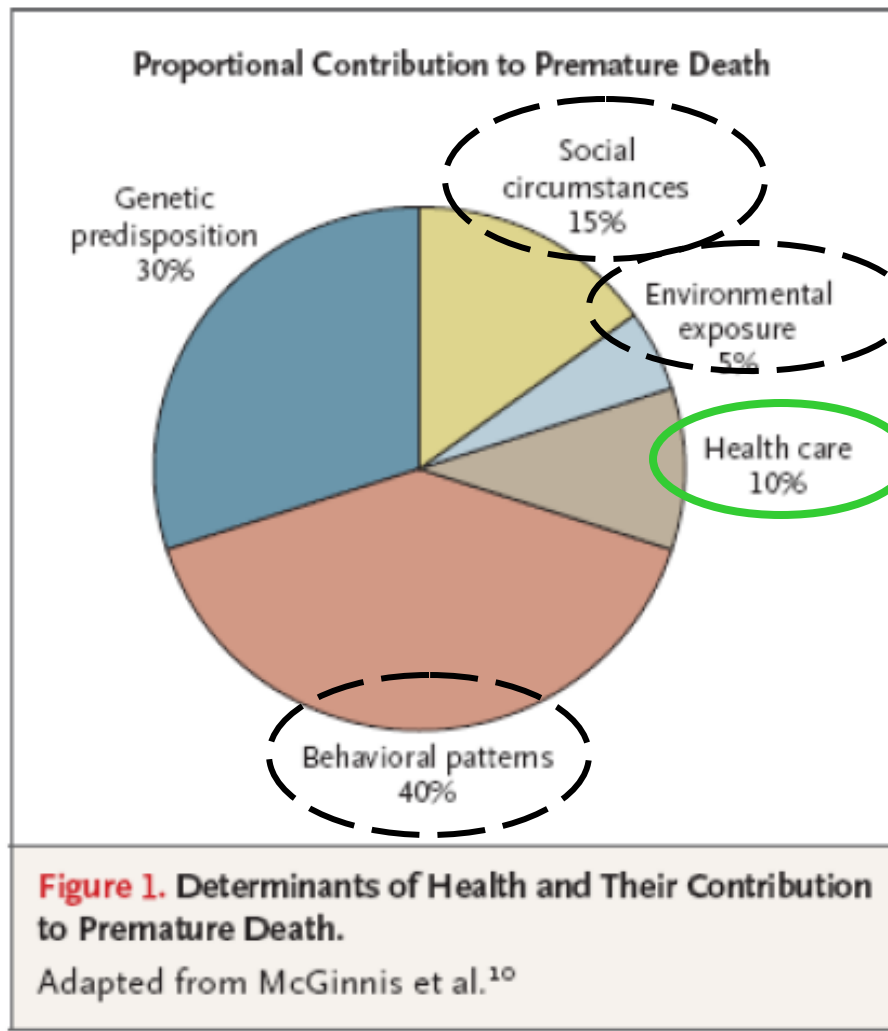
* Lowest Insurance = Medicaid + Uninsured

Medicaid and Uninsured (mis)use More: Why Wouldn't Practices Avoid Risky Patients?

ED Visits/past year (% with at least 1)



What would an Accountable Health Care Community Look Like? Who should Incent? Who should be Incented? For What People, Practices, and Performance?



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