KEY PRIORITY
IMPROVE CHRONIC DISEASE MANAGEMENT

What is the problem?

In today's society, diseases like diabetes, high blood pressure, heart disease, asthma, and mental health illnesses touch everyone. These illnesses are known as chronic conditions or chronic diseases. You or one of your family or friends might be experiencing one of these conditions. One in four Americans has heart disease, which is the number-one leading cause of death in Cuyahoga County, the state of Ohio, and in the nation. Similarly, one in three Americans has high blood pressure, which leads to heart disease and stroke. The burden and costs of these diseases are high. Many studies report that, at the current pace, half the country will be diabetic or pre-diabetic by 2020. Over three trillion dollars now are spent every year on health care and 75% of this total goes toward treating chronic diseases.

Chronic diseases, or illnesses, either keep coming back or never go away and often send you to the doctor or hospital, can prevent you from enjoying your life, and can even cut your life short. For example, Ohioans die from stroke at nearly two times the rate of the average American. In Cuyahoga County, African Americans die from stroke at about one-and-a-half times higher rate than whites. Contributing to this is the fact that African Americans have more high blood pressure (41% vs. 27%), have worse blood pressure control (48% vs. 56%), and have a one-and-a-half to four times increased chance of having high blood pressure complications compared to their white counterparts. Those with fewer resources, like access to healthy food, good health care, and family support systems, have more complications and more deaths. **Figure 6**, based on 2014 data collected by Better Health Partnership, formerly known as Better Health Greater Cleveland, shows that those with fewer resources have poorer blood pressure control.

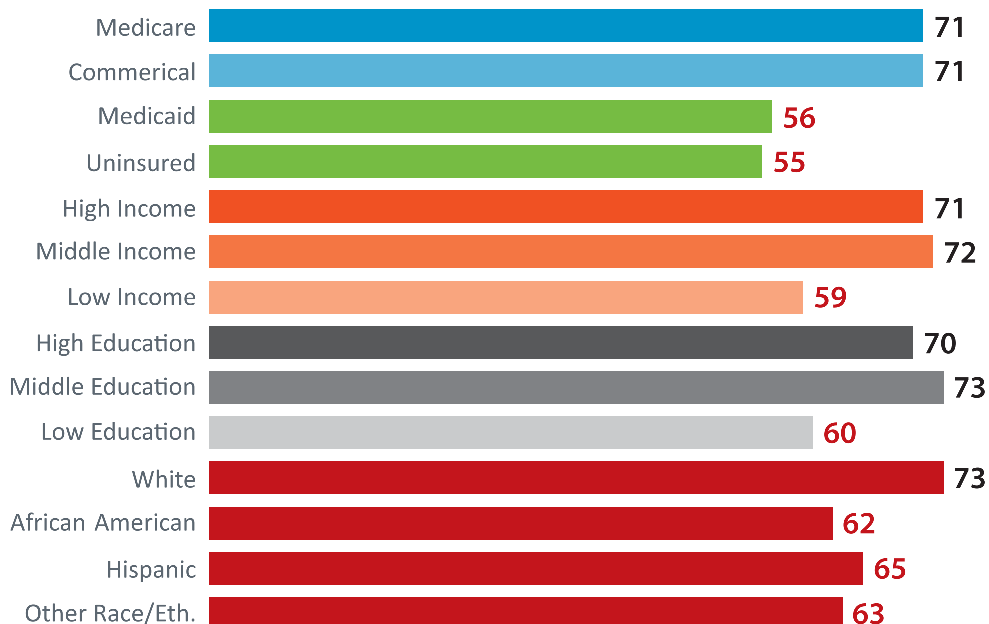

Figure 6: Percent of 141,534 patients with high blood pressure in Cleveland with good blood pressure control: by race, insurance type, household education, and income. Source: Better Health Partnership, formerly known as Better Health Greater Cleveland, 2014

Environmental factors like stress, financial problems, and unemployment prevent vulnerable populations from having better control of their blood pressure. Certain behaviors, like smoking, not exercising, and eating unhealthy food, contribute to getting and controlling high blood pressure and other chronic diseases *(see Figure 7)*. It is harder to practice healthy behaviors when you live in a vulnerable community where you can't get healthy food, where you don't have safe places to play or exercise, and where companies spend a lot of money marketing fast food and tobacco products.

Individuals of color and poorer individuals live in the City of Cleveland; thus they get chronic diseases more often and are more likely to have problems with controlling their chronic diseases. All of this leads to groups of individuals, in vulnerable communities, living sicker and dying earlier.

[Figure 7] Percent of Adults with Factors that Contribute to Getting and Managing Chronic Diseases by Location

LOCATION	SMOKING	PHYSICAL INACTIVITY	OBESITY	BELOW FEDERAL POVERTY LEVEL	UNINSURED
Cleveland	31.3	58.1	35.0	34.0	18.5
Cuyahoga County	20.5	51.2	26.2	17.9	12.5
Ohio	22.5	56.4	29.2	11.8	12.3
Nation	17.3	49.0	27.5	11.3	15.5

Source: Health Improvement Partnership- Cuyahoga, Community Health Status Assessment for Cuyahoga County, Ohio, 2013

What are the solutions?

While we can't totally expect to stop high blood pressure and chronic diseases, we can work together as a community to manage, or lessen, the burden that chronic diseases have on individuals, families, and Cuyahoga County, as a whole. The solutions fall into two different categories: chronic disease clinical management and chronic disease self-management.

Clinical management refers to making sure that all people have the same access to the health care system and skilled members of a health care team to manage their high blood pressure and/or chronic diseases. This is especially true for low-income populations of color, because studies clearly show that lowering blood pressure strongly reduces complications, like stroke and heart attack, by 20% to 50% among these groups. For clinical management to be effective, health care providers must understand and respect their patients and ensure that the care they receive is safe and easy to access.

KEY TERMS

CHRONIC DISEASE: conditions that keep coming back, or persistent conditions, that are the nation's leading causes of death and disability (i.e., high blood pressure, diabetes, asthma, heart problems, and mental illness). Most of the time, these conditions could have been prevented. They can lead to lifelong disability. They negatively impact an individual's quality of life, and they lead to high health care costs.

CHRONIC DISEASE CLINICAL MANAGEMENT: medical treatment of chronic disease that creates a partnership between the patient and the clinician to improve the patient's health.

CHRONIC DISEASE SELF-MANAGEMENT: nonmedical treatment of chronic disease that gives patients the tools they need to improve their health. These interventions can reduce symptoms, build patient confidence to manage their condition, and improve their quality of life.

AN EXAMPLE

Controlling High Blood Pressue

One in three Americans has high blood pressure, which leads to heart disease and stroke, the leading cause of death in the United States–and over half don't have it under good control.

Better Health Partnership, a regional health improvement collaborative, has long documented disparities in high blood pressure control in the health quality data it reports, with rates of good control among African Americans lagging. In 2012, its routine data analyses found that one health care system had achieved a dramatic rise in its rate of control of patients' blood pressure. At HealthSpan, then Kaiser Permanente Ohio, up to 90 percent of patients with high blood pressure had it under control–including African Americans.

HealthSpan's success was no accident. It had adopted a deliberate strategy that drove its results: new protocols to ensure accurate blood pressure readings, simplified medication instructions, stepped-up blood pressure checks and cultural sensitivity training for physicians and staff to help build trusting relationships with patients. Now, Better Health is helping primary care safety-net practices adopt the methodology across Northeast Ohio.

Thanks to Better Health and its collaborators, which include HIP-Cuyahoga members, data that regional health care systems provide for performance measurement and public reporting are uncovering best practices like HealthSpan's–and spreading them across the community to improve health.

Why are publicly reported health care quality data such an important part of improving community health?

"It motivates providers, who want to do their best for their patients and for their community," says Diane Solov, director of Communications and Foundation Relations. "If you know what the gaps are, you can develop a plan to improve. You can't manage what you don't measure."

The public reports are just one of the ways that Better Health pursues its vision to make northeast Ohio a better place to live and to do business. "By providing a safe place for competitors to collaborate, we're working together with employers, health care providers, and community efforts like HIP-Cuyahoga to transform health and health care across the region," Solov says.

The Chronic Disease Management subcommittee members will use the following clinical management methods (based on Kaiser Model Best Practices) to improve the quality of life for those who have high blood pressure:

- train clinicians and staff to communicate well with their patients from different backgrounds;
- train clinicians and staff on how to build trusting relationships with their patients;
- make sure that clinicians measure blood pressure correctly;
- encourage the use of low-cost medication that is only taken once a day;
- communicate regularly with patients who have high blood pressure; and
- have a nurse or medical assistant visit patients until their blood pressure is controlled.

Chronic disease self-management refers to the actions that an individual takes to control his or her chronic illnesses or the risk factors or behaviors that can make the condition worse. For example, unhealthy food choices, smoking, and not exercising can lead to the development of a chronic disease. There is growing evidence showing a strong relationship between patient self-management and improved health outcomes. The Chronic Disease Management subcommittee will use the following self-management methods:

- train community members with Stanford University's Chronic Disease Self-Management and Diabetes Self-Management programs;
- have community residents assist with developing an easy-to-understand message to motivate and encourage residents in vulnerable populations to take care of their chronic diseases or to practice healthy behaviors that will reduce the chances of developing chronic diseases; and
- help to link patients with services in both health care and community settings that promote healthy eating, physical activity, and other chronic disease self-management programs.

The ultimate goal of both clinical and self-management care is to ensure that all in Cuyahoga County have the opportunity to achieve their best possible health.

Why does it matter?

It matters because our entire community is impacted by the multiple costs of chronic diseases. People are dying before their time and suffering needlessly. Families are burdened, and everyone, including businesses, pays a price, both in time and in money. It doesn't have to be this way. Vulnerable citizens in our community lack health care tailored to their specific needs; lack affordable access to healthy food; and lack safe and affordable places to play and exercise. Since the choices we make are based on the choices we have, many environmental factors also make it difficult for people living in low-income and communities of color to live healthy lives.

KEY TERMS

ENVIRONMENTAL FACTORS: conditions that impact the health of people and communities. The amount of money, power, and resources that people have in their daily lives shapes these conditions. Examples include access to healthy food, as well as safe places to play and exercise; levels of stress; financial instability; insufficient or lack of employment; lack of quality education; unstable housing; and substandard health care.

VULNERABLE COMMUNITIES: neighborhoods or places at risk for experiencing societal injustices based on such factors as race/ethnicity; income level; gender; age; sexual orientation; and physical or learning disability.

Summary of Goals and Intended Outcomes

SHORT-TERM (1-2 YEARS)

» We will determine and communicate community resources available to individuals with high blood pressure and related conditions.
» We will use surveys and conduct community focus groups to develop a message campaign that encourages individuals to engage in healthy behaviors and to manage their chronic diseases.
» We will conduct a review of high blood pressure interventions being used in health care settings for vulnerable communities.
» A quality high blood pressure clinical care program will be implemented in target communities.
» Community residents will be trained in chronic disease and diabetes self-management programs.

MID-TERM (3-5 YEARS)

» We will develop a relevant, appropriate, simple, and understandable chronic disease self-management campaign message for vulnerable populations.
» The number of individuals from vulnerable communities participating in quality high blood pressure clinical care programs will be increased.
» The number of individuals from vulnerable communities participating in chronic disease self-management and diabetes self-management programs will be increased.

LONG-TERM (5+ YEARS)

» High quality high blood pressure clinical care programs will be practiced across the county.
» Communities will have the resources to sustain, or continue, the chronic disease and diabetes self-management programs.
» We will create and maintain a database of community resources to aid in chronic disease self-management and to aid providers in clinical settings with referrals to these resources for their patients.
» We will use ZIP codes to track impact of high blood pressure clinical care programs and chronic disease and diabetes self-management programs.
» Results will be shared widely through various communication channels, including an education summit.

Subcommittee Structure

The anchor organization and individual responsible for this subcommittee is:

Better Health Partnership (BHP)
Rita Horwitz, Director of Business Development and Operations

BHP, a nonprofit regional health improvement organization, is strategically leading the continuous growth, financial stability, and achievement of the organization's vision, mission and goals for improving the health of the population in Northeast Ohio.

For more information on this subcommittee or to get involved, please contact:
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