Advancing Population Health Improvement

Michelle J. Lyn, MBA, MHA
Fred S. Johnson, MBA
Division of Community Health
Duke Health

Please note that the views expressed are those of the conference speakers and do not necessarily reflect the views of the American Hospital Association and Health Forum.
Learning Objectives

1) Learn the definitions and distinctions between population health management and Advancing Population Health Improvement or Community Health.

2) Use the Triple AIM Objectives to define population health management objectives and identify community health strategic aspirations and priorities.

3) Acquire a scalable framework to facilitate, design, develop and evaluate strategies that foster and align clinical and community integration.
Overview

*Let chaos storm!*

*Let cloud shapes swarm!*

*I wait for form.*

ROBERT FROST, "V. Pertinax"

Hospital and Health System Transformation

– Transitioning from successful volume enterprise to a successful value based organization

– Transitioning from Episodic Non Integrated Care to Community Integrated Care
**The Future State is Now**

Source: Health Care Advisory Board interviews and analysis.

- Acute medical, surgical interventions
- Outpatient procedural, primary care services
- Chronic disease management
- Care coordination
- Total cost management
- Population health management
- Patient Experience

Past (in some cases current environment)

Transition

Present State  TRIPLE AIM (in some cases current environment)
Population Health Management

Current State Strategies

• Value base programs, Risk, ACO’s, CIN,

• Care Management of Complex Populations Regardless of Payer

• Investment in EMRs, Analytics and Exchanges

• Quality – Care guideline Incentive programs

• Interdisciplinary Team Care, Engineered workflow, and each skill working at the top of their license
Population Health Management

Current State Payer Strategies

• Bundled payments
• ACO
• Capitation and risk contracts
• Shared Savings
• Quality Incentives
TRIPLE AIM
Piers
Cost Piers

• Downward Cost Drivers: standardization within commodity service lines; procurement and vendor policies; utilization review programs; etc.
Spend Piers

- Prospective payments – e.g. bundle payments – shift risk of inefficiency to providers...best tool for single events
- ACO’s – CINs
- PCMH
- Multi-Specialty Clinic, Medical Home on Steroids, and Medical Neighborhoods
- Complex Case Management
- Transitional Care Management
Care Management

Who and Why
An overwhelming majority of population spending comes from a very small minority of the people.

The sickest 5% of the population spends *fifty times as much per person* as the healthy majority.

**Spend Management Quite Different from Population Management**

- **U.S. Health Spending**
  - 50%
  - 35%
  - 15%

- **U.S. Population**
  - 75%
  - 20%
  - 5%

**Source:** AHRQ, August 2013. "Differentials in the Concentration in the Level of Health Expenditures across Population Subgroups in the U.S., 2010"
NPCC: Care Management Delivery System

• Over 75 care managers (licensed and non-licensed) covering 6 counties providing home-based care management for several different populations:
  – Connecting Moms and children to medical home and following up on unnecessary utilization of the ED, annual visits and immunizations as well as chronic conditions, e.g. asthma medication adherence;
  – Socially and medically complex patients - assessment and patient goal setting with social services, medical and behavioral health provider;
  – Hospital transitions of care - reviewing with patient discharge summary, medication plan and follow up appointment with specialty clinic and medical home;
  – Assist patients with chronic disease management from referrals by medical home.

• Several primary care embedded case management programs:
  – For example: The Duke DOC clinic Homebase Program has an NPCC case manager assigned to a NPCC funded Duke Med Psych physician providing case management to a “familiar face” population with psych and addiction issues. The case manager has permission from Duke Compliance to use her automobile to transport patients to and from the clinic to avoid an ED admission.

• Palliative Care Initiated in the home - Population identified by CCNC algorithm and assessed by Care Manager. Program includes patient assessment, initiation of palliative care conversation and care management follow up with patient and Medical Home provider.

• Two NPCC owned Telephonic Coaching applications:
  – 1) Patients with Diabetes and Hypertension
  – 2) Hydroxuria adherence with Sickle Cell patients.
Complex Patients Require Comprehensive Clinical Networks

Medical Home & Medical Neighborhood

CHF with history of high inpatient/ED use
Costs $10k above similar clinical cohorts
Limited PCP interaction
3 High risk meds and compliance issues

Social deficits in transportation, budget, self-advocacy skills, equipment, and motivation

Care Manager & Community Resources
Challenges in Controlling Medicare Spending: Treating Highly Complex Patients

ABSTRACT
Complex patients with many comorbid conditions are among the highest-cost users of Medicare, and they constitute an important source of growth in Medicare expenditures. This paper analyzes the universe of 2009 Medicare claims to characterize the complexity of patients with multiple comorbid conditions. The analysis finds that such patients cannot be placed into a small number of clinical bins; instead, the number of different combinations of comorbid conditions is staggering and there are often very few patients with any particular combination of conditions. Furthermore, Medicare expenditures on patients grow non-linearly with the number of comorbid conditions afflicting patients. The results have important implications for existing risk adjustment methods used by Medicare, which do not sufficiently account for the way interactions among comorbid conditions tend to increase costs. Finally, the results suggest that disease management and care coordination programs will face a difficult challenge in coping with the heterogeneity of patient health conditions.

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1 Professor, Department of Economics, and Senior Fellow, The Hoover Institution, Stanford University, Stanford, CA 94305; and Senior Research Associate, Acumen LLC, Burlingame, CA 94010.
2 Associate
Community Care of North Carolina
Care Management (CM) Impactability Score:
General Overview of Methodology

“Risk” predicts where a person is expected to be in the future.

“Impactability” predicts how much change can be expected when intervened.
Impactability scores range from 0 – 1,000 and the score represents the incremental dollar savings PMPM in the follow-up period when the patient receives the highest-intensity transitional care intervention (including a home visit) relative to no transitional care intervention.

For example, if a patient has an impactability score of 500, it reflects the intervention will result in a savings of $500/month for the next 6 months.
The same investment in care managing 5,000 patients yields VERY different results depending on who you choose to manage.
# NPCC Transitional Care Impactability Score

<table>
<thead>
<tr>
<th>Peer Group</th>
<th>0</th>
<th>1-199</th>
<th>200-499</th>
<th>500 and above</th>
<th>Grand Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Internal Med</td>
<td>4148</td>
<td>294</td>
<td>211</td>
<td>90</td>
<td>4743</td>
</tr>
<tr>
<td>Family Med</td>
<td>23999</td>
<td>1010</td>
<td>612</td>
<td>294</td>
<td>25915</td>
</tr>
<tr>
<td>OB/GYN</td>
<td>1082</td>
<td>30</td>
<td>19</td>
<td>10</td>
<td>1141</td>
</tr>
<tr>
<td>Peds</td>
<td>23031</td>
<td>373</td>
<td>223</td>
<td>96</td>
<td>23723</td>
</tr>
<tr>
<td>FQHC</td>
<td>9205</td>
<td>419</td>
<td>258</td>
<td>111</td>
<td>9993</td>
</tr>
<tr>
<td>Grand Total</td>
<td>61465</td>
<td>2126</td>
<td>1323</td>
<td>601</td>
<td>65515</td>
</tr>
</tbody>
</table>
Most illness and care occur in the community

- 1000 persons
- 800 report symptoms
- 217 visit a physician's office (113 visit a primary care physician's office)
- 21 visit a hospital outpatient clinic
- 14 receive home health care
- 13 visit an emergency department
- 8 are hospitalized
- 3 are intensely care managed
- 1 is hospitalized in an academic medical center

Modified from:
Green LA, Fryer GE Jr, Yawn BP, Lanier D, and Dovey SM.
Ecology of Medical Care Revisited, NEJM 344:2021-205. June 28, 2001
CURRENT STATE QUALITY PROGRAM

Is not a Bridge Pier - It’s the Road
Involves Strategies that Engage all patients and Providers
The Road
Scope is Wide and Scale is Shallow

Singular center piece within the walls of the Medical Home

Success depended upon Team Care and Engineered Workflow
Current Cost of Quality

Recent Health Affairs – reports that the annual cost to meet Quality metrics through Primary care and 3 specialty providers equates to a $15 Billion dollar annual cost.
Current Value Base Environment

• A Quality and Risk driven payer environment creates conflicting demands on each provider and practice
  – A primary care provider is being compensated to assume complete responsibility of each psychosocial and medically complex patient which requires knowing the whole person (class, gender, race, class, education and sexuality) through authentic conversations with the patient and their other providers
  – And a Primary Care provider is being required to perform additional routine prevention screens and care guidelines (two thousand clicks a day) on every patient that walks through his or her door.
Industrial Engineering to Produce Products and Services That are Consistent and Without Waste

Engineering primary care to efficiently meet Careguidelines

Patient – Centered Care (Longitudinally Oriented and Coordinated across Multiple Services and Shared Decision Making)

The need for patient and provider understanding and dialogue and not just information
“The April issue of *Health Affairs* examines issues related to engaging patients more fully in decisions about health care delivery. Patient-centered care calls for a better understanding of patient goals, better methods for engaging patients in their care, and better measures of outcomes that have meaning for patients....”
Current State
The Culture Clash

Can LEAN Engineering tenets guide us to creating environments in which meaningful patient-to-care team member and care team member-to-care team member relationships develop at the patient-level, for coordinated, longitudinal, cost-effective and patient centered care delivery?”
Can you mass customize meaningful relationships?

https://www.theguardian.com/technology/2016/feb/26/mercedes-benz-robots-people-assembly-lines

“Yet the same industries have also tended to devalue those employees……”  -Atul Gawande
Current State

ACCESS AND PREVENTION
SITS PARTIALLY
OVER THE ROAD AND LAND
“ACCESS IS THE TIMELY USE OF PERSONAL HEALTH SERVICES TO ACHIEVE THE BEST POSSIBLE HEALTH OUTCOMES.” IOM

EMR - My Chart
Face time, Email, Urgent Care, Neighborhood clinics, home visits, texting
Prevention

• Health and Wellness
  – Employer or Public Agency initiated
  – Population Specific Programs; e.g. Nutritional classes for patients with diabetes or obesity

• Community Resources
TRANSFORMATIVE - FUTURE STATE
ADVANCING POPULATION HEALTH IMPROVEMENT

The Pole on the bridge
Poles are grounded to the bridge and support the Cables
Future State - 2017

- Alignment of Clinical and Community Services
- Compliments classic efforts of Public Health
- Focus on Social Determinants and Place
- Transformative Cross Sectoral Platform that Enables Providers and Patients to Fully Realize the Triple Aim
- Capacity to Design, Implement and Integrate Community/Placed Based Quality, Access and Prevention Interventions
Advancing Population Health Improvement – Community Health

- Patient Center Medical Home can identify situations whose origins are driven by circumstances: poverty, racism, social isolation as well as relational, particularly with children. Circumstances outside the scope of a Patient Center Medical Home and Hospital.

- Patient Center Medical Home and Hospital can try to address individual circumstance with referrals, care management, family therapy, accenting positive relationships.

- Patient Center Medical Home and Hospital historically did not conduct Root Cause Identification, Analysis and Solutions.
Community Health systematically looks for Root Causes.

Community Health systematically integrate solutions into clinical and or community setting.

Community Health approaches Community and Health Leaders utilizing four core attributes - Poles

Community Health enables Academic Health Centers and other health institutions reach out and develop community partnerships to promote health and fulfil their roles as “health” centers and not “disease” center
4 Core Poles

• Goal oriented

• Research and Evaluation

• Context and Construct

• Polarity Management
Pole 1 - Goal Oriented

What is your Goal?

• Health - Primary and Secondary Prevention
  – E.g. - Pediatrics: Millennium Morbidities
• Addressing Social Determinants
• Addressing Social Equity
• Engaging Community – Engaging Community Leaders (two different models)
• Community Capacity Building
• Community Resiliency and Adaptability
• System Change
Pole 1 - System Change

• Involves multiple relationships and networks

• Moves toward collective action

• Shifts the way a community makes decision about policies, programs and resources

• Role - Affect System Change (Catalyst and or Advocate)
Primary and Secondary Prevention
21st Century Morbidities

• 20\textsuperscript{th} century “New Morbidity” called on pediatricians to address chronic and developmental conditions such as behavioral and emotional disorders, functional distress, learning disabilities, and educational needs.

• 21\textsuperscript{st} century “Millennial Morbidities” such as violence, obesity, family distress, and poverty call on pediatricians to change the social and physical environments in which children live.
  – E.g. Increase in Non Alcoholic Fatty Liver Disease
Intersection of Health, Place & Equity
Millennial Morbidities

Health
Environment - Place
Equity
### Place Matters

<table>
<thead>
<tr>
<th>Southwest Central Durham</th>
<th>2010 Tract ID</th>
<th>Average age at death</th>
</tr>
</thead>
<tbody>
<tr>
<td>Morehead Hills</td>
<td>7</td>
<td>73.1</td>
</tr>
<tr>
<td>Tuscaloosa &amp; Lakewood</td>
<td>6.00, 20.15</td>
<td>70.9</td>
</tr>
<tr>
<td></td>
<td></td>
<td>79.6</td>
</tr>
<tr>
<td>Lakewood</td>
<td>05.00, 06.00</td>
<td>74.2</td>
</tr>
<tr>
<td>Lyon Park</td>
<td>5</td>
<td>74.2</td>
</tr>
<tr>
<td>Burch Avenue</td>
<td>05.00, 07.00</td>
<td>74.2</td>
</tr>
<tr>
<td>West End</td>
<td>05.00, 06.00</td>
<td>74.2</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Northeast Durham</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Old Five Points</td>
<td>22</td>
<td>61.8</td>
</tr>
<tr>
<td>Cleveland-Holloway</td>
<td>11</td>
<td>63.3</td>
</tr>
<tr>
<td>Eastway-Albright</td>
<td>09.00, 10.01</td>
<td>65.1</td>
</tr>
<tr>
<td></td>
<td></td>
<td>61.8</td>
</tr>
<tr>
<td>East Durham</td>
<td>10.01, 10.02</td>
<td>65.1</td>
</tr>
<tr>
<td></td>
<td></td>
<td>61.2</td>
</tr>
<tr>
<td>Wellons Village</td>
<td>10.02</td>
<td>61.2</td>
</tr>
<tr>
<td>Hoover Road</td>
<td>10.02, 10.01</td>
<td>61.2</td>
</tr>
<tr>
<td></td>
<td></td>
<td>65.01</td>
</tr>
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</table>
# Durham Diabetes Coalition

## A1c Monitoring

<table>
<thead>
<tr>
<th>Year</th>
<th>Durham</th>
<th>NC</th>
</tr>
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<tbody>
<tr>
<td>2012*</td>
<td>84%</td>
<td>89%</td>
</tr>
<tr>
<td>2013</td>
<td>86%</td>
<td>88%</td>
</tr>
<tr>
<td>2014</td>
<td>87%</td>
<td>88%</td>
</tr>
<tr>
<td>2015</td>
<td>90%</td>
<td>89%</td>
</tr>
<tr>
<td>2016**</td>
<td>91%</td>
<td>89%</td>
</tr>
</tbody>
</table>

*Diabetes prevalence 9%  
**Diabetes prevalence 10%
Pole 2 - Research and Evaluation

- Research
  - Community Engagement
  - Community Needs Assessment
  - Data “Lake”

- Evaluation
  - Developmental and Principle Guideline Models look to address Root Cause, Goal oriented, can include adaptive and equity evaluation models;
  - Collective Impact Model
  - Any of the Three models include the following:
    - Summative and Formative Models are utilized in evaluating a specific program, targeting a specific population that address a specific problem with a specific identifiable solution) typically include Logic Models.
    - Track long term community outcomes such as reduction in poverty rate (in 2013 almost 200,000 people in the Triangle were below the federal poverty level; more than 60,000 were children.)
    - Track intermediate outcomes such as increase in the percentage of low income children reading at grade e level
Pole 3 - Understand Your Community Context and Construct

- Intersection of Health, Place and Equity

- Racism – Discrimination; particularly perceived and anticipated

- Common Language

- Self Interest, Mutual Interest, Enlightened Self Interest
Racial Discrimination and Negative Outcomes in African Americans

Studies indicate three emerging elements

– 1) Unhealthy social space (segregated communities) serve as a “structural lattice” for maintaining discrimination

– 2) Intergenerational and life-span effects of race-discrimination result in pernicious effect on health despite better opportunities and environments
Race Based Discrimination

3) Chronicity and Magnitude, both actual and perceived.

- Life long vigilance (never feeling totally safe from a fight or flight environment) due to the fear of expecting an adverse action because of skin color.
- “Being excluded from social groups ranks among the most aversive of human experiences” (Labonte 2004)

• Sets in motion a process of physiological responses:
  - Elevated BP, production of biochemical reactions, hypervigilance resulting in disease and mortality
## Establishing a Common Language

<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Equality</td>
<td>The quality or state of being equal.                                                                                           Source: Merriam-Webster, m-w.com</td>
</tr>
<tr>
<td>Equity</td>
<td>The concept that everyone should have a fair opportunity to attain their potential.</td>
</tr>
<tr>
<td>Race Equity Lens</td>
<td>Brings into focus the ways in which race and ethnicity shape experiences with power, access to opportunity, treatment, and outcomes, both today and historically. Assessing racial equity in our institutions involves analyzing data and information about race and ethnicity; understanding disparities and learning why they exist; looking at problems and their root causes from a structural standpoint; and naming race explicitly when talking about problems and solutions</td>
</tr>
<tr>
<td></td>
<td>Source: Grantcraft, “Grantmaking with a Racial Equity Lens” (2011)</td>
</tr>
</tbody>
</table>
## Establishing a Common Language

<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
<th>Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>Disproportionality</td>
<td>The over- or under- representation of a particular group (e.g., racial/ethnic, gender, age, jurisdiction, etc.) compared to their representation in the general population.</td>
<td>Source: Myers 2010</td>
</tr>
<tr>
<td>Disparity</td>
<td>Disparity is the condition or fact of being unequal and refers to the difference in outcomes and conditions that exist among specific population groups as compared to other groups due to unequal treatment or services. Source: Agency for Healthcare Research and Quality, US Department of Health &amp; Human Services</td>
<td></td>
</tr>
<tr>
<td>Health Disparity</td>
<td>Preventable differences in the burden of disease, or availability of opportunities to achieve optimal health that are experienced based on gender, race or ethnicity, education or income, disability, or living in various geographic localities.</td>
<td></td>
</tr>
<tr>
<td>Disproportionate Minority Contact</td>
<td>The disproportionate number of minority youth that come into contact with the juvenile justice system.</td>
<td></td>
</tr>
<tr>
<td>Achievement Gap</td>
<td>The observed disparity on a number of educational measures between the performance of groups of students.</td>
<td></td>
</tr>
<tr>
<td>Implicit Bias</td>
<td>The attitudes or stereotypes that affect our understanding, actions, and decisions in an unconscious manner</td>
<td>Source: Kirwan Institute</td>
</tr>
</tbody>
</table>
Self Interest

• Self Interest

• Mutual Self Interest

• Enlighten Self Interest
Pole 4 - Polarity Management

• Balancing competing interdependent conflicting problems

Examples:
– Cost and Quality
– Acute care and Preventive Care
– Net (Profit) and Responsibility
Industrial Engineering to Produce Products and Services That are Consistent and Without Waste

Engineering primary care to efficiently meet Careguidelines

Patient – Centered Care (Longitudinally Oriented and Coordinated across Multiple Services and Shared Decision Making)

The need for patient and provider understanding and dialogue and not just information
It’s not an Either/Or
It’s Both
It’s Polarity Management

Better methods in engaging the patient includes methods in engaging the entire community.
Future State

CMS Quality Measure Development Plan

Transparent Quality Performance  (from 2015 until Dec, 31 2018)

• Increase/decrease in Medicare payments based upon physician costs and quality scores – (as much as a 9% decrease in 2017)

• MACRA sun setting MU and PQRS

• MACRA takes 3 physician performance programs into one single program
VITAL SIGNS
Core Metrics for Health and Health Care Progress

To achieve better health at lower cost, all stakeholders — including health professionals, payers, policy makers, communities, and members of the public — must focus on what matters most. What are the core measures that will yield the clearest understanding of health and well-being in America? Vital Signs, a 2015 report from the Institute of Medicine, proposes a set of 15 core measures for health and health care. Explore the infographic to see examples for each measure.
Advancing Population Health Improvement - Community Health

Requires the Alignment of Clinical and Community Services

Source: Public Health Institute

Requires the Alignment of Clinical and Community Services
Look beyond clinical care partnerships to improve access to care and other necessary community services.
Work with public health agencies, the government, and other partners to achieve improved health care outcomes
Frequency of Partnerships for Intervention by Community Need

Source: HRET, 2014.
Connect and Secure Bridge to Land

Invent our future

Community Integrated Health Care
Cables
Wide Cables Anchor Clinic, Hospital and Health System to Community

• 1) Health system infrastructure that systematically screens items and the collection of data form detecting health – related social needs * Highlighted by a recent IOM report.

• 2) Gap Analysis – CMS considers the Community Health Needs Assessment (required by the IRS) the foundation document of a gap analysis.
  – Would include “Health Indicators” data highlighting incidences and prevalence of chronic conditions by neighborhood.

• 3) Navigators/Integrators/Organizers (shepherds) - Assisting city and county public and private leadership in identifying and implementing community wide strategies.
Cables - Intersection of Health, Place & Equity

Health facilities
Schools/Child care
Community Safety/violence
Transportation Traffic patterns
Work environments
Parks/open space/playgrounds
Housing
Access to healthy food
Advancing Population
Health Improvement
TRIPLE AIM

All at the same time

Quality

SPEND
Spend
SPEND
Spend

Neighborhood
Towns
County
Cities

Access

Health & Wellness

Neighborhood
Towns
County
Cities
Some Hospitals are Moving Past Medicine and into the Community

- Improving the built environment
- Developing local regulations to establish smoke free public areas
- Creating access to healthy foods and produce through community gardens
- Providing safe and affordable low-income housing
Some health systems are getting it?

IF OUR BEDS ARE FILLED, IT MEANS WE’VE FAILED.
NPCC: External Programs and Partnerships/Relationships

18 Year Relationship with Safety-Net Systems and Services: Public Health; Social Services; Housing; Transportation; Criminal Justice; Non-Profits; and Behavioral Health Providers.

Examples of Specific County-Wide Populations and Programs Include:

• **Durham Crisis Collaborative** - ED Familiar Faces, aggressive patients and incarcerated patients. Assessment and coordinated care by multiple agencies and the securing of a medical, behavioral health home, and typically stable housing.

• **Project Lazarus** – Patients with substance abuse history. Outreach to medical home, first responders and criminal justice system to distribute Naloxone kits.

• **Healthy Futures** - collaboration with Durham Public Schools and the Durham County Health Department, a new model for delivering well child visits and immunizations by using ERNs placed in elementary schools.

• **Foster Kids** - Children under 21 who are wards of the County. Comprehensive assessment and securing of a medical home and provider to follow up on issues identified in the assessment. Assist DSS case worker in follow up with Foster Parent regarding health issues.

• **Community Pharmacy Enhanced Services Network** - Pharmacies provide clinical counseling to patients and place medication reviews in care management system.
Future State
Aligning Clinical Services with Community Wide Prevention

Chronic disease prevention, to be most effective, must occur in multiple sectors and across individuals’ entire life span.

Prevention encompasses health promotion activities that encourage healthy living and limit the initial onset of chronic diseases. Prevention also embraces early detection efforts, such as screening at-risk populations, as well as strategies for appropriate management of existing diseases and related complications.

With community-based public health efforts that embrace prevention as a priority, we can become a healthier community.
Well-child clinics open at 5 Durham elementary schools

Last week, officials with Durham Public Schools, the Durham County Department of Public Health and the Duke Division of Community Health came together at Oak Grove Elementary School to celebrate the official launch of Healthy Futures Durham Schools.

The preventive care program, which is open to any child under 18 who is living in Durham County, operates in five DPS elementary schools.

Read more here:
Create Your Future

Design and Secure Poles and Cables

Clinics, hospitals and health systems hospitals survival in Value Based - Capitated Payer model environment requires alignment of clinical and community services - Community Health.

“Advancing Population Health Improvement”
Contact Information

Michelle J. Lyn
Michelle.Lyn@duke.edu
919-681-3192

Fred Johnson
f.johnson@dm.duke.edu
919-681-4220