Quality Measurement, Population Health and Payment Reform

The Move from Volume to Value

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Chief Quality Officer – OU Physicians

September 12, 2015
Outline

• The inevitability of healthcare transformation
• Changing models of healthcare payment
• Performance measurement in primary care and impact on payment
• Assessing population health
The healthcare system is changing....
..it was inevitable
Healthcare Transformation was Inevitable!

Figure 4. Historical Growth Trajectory of National Health Expenditures, 1970-2011

National health expenditures as % of gross domestic product

Annual growth rate of national health expenditures (adjusted for inflation³)

Disconnect Between Spending and Outcomes

Spending on Health Care

- United States:
  - $8,233
- Norway:
- Switzerland:
- Netherlands:
- Luxembourg:
- Denmark:
- Canada:
- Austria:
- Germany:
- France:
- Belgium:
- Sweden:
- Ireland:
- Australia:
- United Kingdom:
- Iceland:
- Finland:
- Spain:
- Japan:
- New Zealand:
- Italy:
- Greece:
- Portugal:
- Slovenia:
- Israel:
- Korea:
- Chile:

Life Expectancy

- Japan:
- Switzerland:
- Spain:
- Italy:
- Australia:
- Israel:
- Iceland:
- Sweden:
- France:
- Norway:
- Ireland:
- New Zealand:
- Canada:
- Netherlands:
- Austria:
- Korea:
- Luxembourg:
- Greece:
- United Kingdom:
- Germany:
- Belgium:
- Finland:
- Portugal:
- Slovenia:
- Denmark:
- Chile:
- United States:

78 years
Where do we spend our healthcare dollar?

Hospitals and other care facilities, along with professional services are the primary target of most efforts to reign in healthcare spending.
Rising “Consumerism” around Health Care

• Consumer groups increasingly demanding data about the quality and costs of care ("transparency")
  – Rising co-pays and deductibles
  – Costs for insurance growing much faster than incomes
  – Increased lay reports about quality issues in healthcare

• Legislators responded
Growing Recognition

• US had the best “sick care” (not chronic care) system in the world
  – High tech
  – Complex care
  – Heavily hospital- and specialty-based
  – Very costly

But.........

• Our population is not healthy
Good Morning Dr. Dale Bratzler. Here are today’s top stories.

Thursday, September 10, 2015

Leading the News

Half of US adults have diagnosed diabetes or prediabetes, study finds

The Los Angeles Times (9/9, Netburn) reported that approximately “half of all Americans have either diabetes or pre-diabetes, according to a new” study published Sept. 8 in the Journal of the American Medical Association. The study also indicates that after about 20 years “of linear growth, the prevalence of diabetes in” the US has “finally” begun to level off.

The AP (9/9, Tanner) reported that “overall, 12 percent to 14 percent of adults had diagnosed diabetes in 2012,” the majority of which had type 2 diabetes. Nearly “40 percent have pre-diabetes,” researchers found.

The New York Daily News (9/9, Engel) pointed out that “diabetes was most prevalent in Hispanics (23%), blacks (22%) and Asians (21%), and that 11% of whites had the disease.” The study also took a “first look at diabetes prevalence in Asian-Americans, who had the highest percentage of undiagnosed cases – 51%.”

The NBC News (9/9, Fox) website explained that “Andy Menke of global health research company Social & Scientific Systems, Baltimore, pointed out the National Institutes of Health and Disease Control and Prevention are tracking the disease in Asian-Americans for the first time.”
One Hundred Eleventh Congress
of the
United States of America

AT THE SECOND SESSION

Began and held at the City of Washington on Tuesday,
the fifth day of January, two thousand and ten

An Act

Entitled The Patient Protection and Affordable Care Act.

Be it enacted by the Senate and House of Representatives of
the United States of America in Congress assembled,

SECTION 1. SHORT TITLE; TABLE OF CONTENTS.

(a) SHORT TITLE.—This Act may be cited as the “Patient Protec-
tion and Affordable Care Act”.

(Note: This print is of the Patient Protection and Affordable
Care Act ("PPACA"; Public Law 111–148) consolidating the amend-
ments made by title X of the Act and the Health Care and Education
Reconciliation Act of 2010 ("HCERA"; Public Law 111–152). The
Many Quality and Payment Provisions in the ACA

• Required by law....
  – Public quality reporting:
    • Hospitals, dialysis units, nursing homes, home health agencies, physician practices, cancer centers.....
  – Value-based payment
    • Reward high quality care – penalize poor quality care
  – Hold providers accountable for overall costs of care (“efficiency”)

Medicine
Healthcare quality is in the public domain for most settings of care!
Move to “Value”

Value = Quality (and Service)/Costs

Goal: We want the highest quality of care (and service) at the lowest costs.
Incremental FFS payments for value

Bundled payments for acute episode

Bundled payments for chronic care/disease carve-outs

Accountability for Population Health

Current State: Payments for Reporting

Range of Models in Existence or Development

Increasing assumed risk by provider

Increasing coordination/integration required

From…. ..get paid more for doing more

To…. ..profiting by keeping your population of patients healthy, delivering high-quality care, and doing so at less cost
Physician Quality Reporting System (PQRS)

<table>
<thead>
<tr>
<th>Year</th>
<th>Successful</th>
<th>Not Successful</th>
</tr>
</thead>
<tbody>
<tr>
<td>2009</td>
<td>2.0%</td>
<td>--</td>
</tr>
<tr>
<td>2010</td>
<td>2.0%</td>
<td>--</td>
</tr>
<tr>
<td>2011</td>
<td>1.0%</td>
<td>--</td>
</tr>
<tr>
<td>2012</td>
<td>0.5%</td>
<td>--</td>
</tr>
<tr>
<td>2013</td>
<td>0.5%</td>
<td>--</td>
</tr>
<tr>
<td>2014</td>
<td>0.5%</td>
<td>--</td>
</tr>
<tr>
<td>2015</td>
<td>No Incentive</td>
<td>-1.5%</td>
</tr>
<tr>
<td>2016+</td>
<td>No Incentive</td>
<td>-2.0%</td>
</tr>
</tbody>
</table>

For 2014, a practice could avoid the penalty by submitting at least 3 PQRS measures, and could receive the incentive by submitting at least 9 measures.

~ 254 PQRS measures currently listed by CMS for 2015

Nine percent (9%) of a physician’s Medicare payment in 2017 is tied to performance on PQRS measures, meaningful use, and the physician value modifier for care provided in 2015.
## 2013 MEDICARE FEE-FOR-SERVICE
### QUALITY AND RESOURCE USE REPORT

**BOARD OF REGENTS OF THE UNIVERSITY OF OKLAHOMA-OU PHYSICIANS**

Last Four Digits of Your Taxpayer Identification Number (TIN):

<table>
<thead>
<tr>
<th>ABOUT THIS REPORT FROM MEDICARE</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>WHAT</strong></td>
</tr>
<tr>
<td>This Quality and Resource Use Report shows your physician group’s value-based payment modifier for Medicare Physician Fee Schedule reimbursements in 2015. This report also includes performance information on new measures that will be used in the value-based payment modifier for 2016.</td>
</tr>
<tr>
<td><strong>WHO</strong></td>
</tr>
<tr>
<td>The Centers for Medicare &amp; Medicaid Services (CMS) is phasing in a value-based payment modifier under the Medicare Physician Fee Schedule in 2015 and 2016.</td>
</tr>
<tr>
<td>○ In 2015, physician groups of 100 or more eligible professionals that submit claims to Medicare under a single Taxpayer Identification Number (TIN) will be subject to the payment modifier, based on their performance in calendar year 2013.</td>
</tr>
</tbody>
</table>
Quality and Resource Use Report (QRUR)

- Majority of metrics on costs and quality based on Medicare claims data.
- Reports do now include PQRS self-reported measures
- Moving to inclusion of CG-CAHPS data as more groups collect and submit
Medicare Access and CHIP Reauthorization Act of 2015 (MACRA)
“The repeal of the SGR is the carrot; the far-reaching payment reforms that the legislation facilitates are the stick.”

Steinbrook R. JAMA April 17, 2015.
TITLE I—SGR Repeal and Medicare Provider Payment Modernization

• 0.5% payment increase for the last 6 months of 2015

• 0.5% increase per year for 2016 through 2019
  – Payment rates fixed at 2019 rates through 2025

• PQRS, the VBM, and MU are unchanged through 2018

http://www.gpo.gov/fdsys/pkg/BILLS-114hr2enr/pdf/BILLS-114hr2enr.pdf
TITLE I—SGR Repeal and Medicare Provider Payment Modernization

- PQRS, VBM, and EHR Meaningful Use all “sunset” at the end of 2018
- Replaced with the Merit-based Incentive Payment System (MIPS) in 2019
  - (likely first year of performance data on your practice will be CY 2017)
TITLE I—SGR Repeal and Medicare Provider Payment Modernization

• Creates incentives to use alternate payment models (APMs)
  – ACOs
  – Medical Homes
  – Bundled payment arrangements
  – Other (being developed)

• Financial incentives to participate in APMs as well as exclusion from the MIPS assessment

http://www.gpo.gov/fdsys/pkg/BILLS-114hr2enr/pdf/BILLS-114hr2enr.pdf
Alternate Payment Mechanisms
• “Substantial portion” of revenues* from “approved” alternate payment models
  ▪ 5% bonus each year from 2019-2024
  ▪ 0.75% increase per year beginning in 2026

Merit-based Incentive Payment System†
• Providers receive a score of 0-100
• Each year, CMS will establish a threshold score based on the median or mean composite performance scores of all providers
  ▪ Providers scoring below the threshold will be subject to payment reductions (capped at 4% in 2018, 5% in 2019, 7% in 2020, and 9% in 2021 to 2023).
  ▪ Providers scoring above the threshold will receive bonus payments (up to three times the annual penalty cap).

*25% of Medicare payments 2019-2020
50% of Medicare payments 2021-2022
75% of Medicare payments 2023 and beyond

†Scores will be posted to Physician Compare website
MIPS Scoring

- Up to 25 points for meeting meaningful use objectives (Use of a certified EMR)
- Up to 30 points based on PQRS and VM quality measures (Quality)
- Up to 30 points for the resource use VM metrics (Efficiency)
- Up to 15 points for clinical practice improvement activities (Performance improvement)
Scoring under MIPS

*Threshold established by CMS annually based on prior performance

Threshold* (No Payment Adjustment)

Maximum Penalty

Points

Additional Incentive

4% in 2018, 5% in 2019, 7% in 2020, and 9% in 2021 to 2023
Alternate Payment Models

ACO Performance Metrics
Medicare Shared Savings Program

• Before an ACO can share in any savings created under this new payment model, the ACO must demonstrate that it meets the quality performance standard for that year.
  – 33 performance measures that fall into four key domains
## Domain: Patient/caregiver Experience

<table>
<thead>
<tr>
<th>ACO #</th>
<th>Measure title</th>
<th>NQF #</th>
<th>Measure steward</th>
<th>Data collection</th>
</tr>
</thead>
<tbody>
<tr>
<td>ACO-1</td>
<td>CAHPS: Getting timely care, appointments, and information</td>
<td>0005</td>
<td>AHRQ</td>
<td>Survey</td>
</tr>
<tr>
<td>ACO-2</td>
<td>CAHPS: How well your providers communicate</td>
<td>0005</td>
<td>AHRQ</td>
<td>Survey</td>
</tr>
<tr>
<td>ACO-3</td>
<td>CAHPS: Patients’ rating of provider</td>
<td>0005</td>
<td>AHRQ</td>
<td>Survey</td>
</tr>
<tr>
<td>ACO-4</td>
<td>CAHPS: Access to specialists</td>
<td>N/A</td>
<td>CMS</td>
<td>Survey</td>
</tr>
<tr>
<td>ACO-5</td>
<td>CAHPS: Health promotion and education</td>
<td>N/A</td>
<td>CMS</td>
<td>Survey</td>
</tr>
<tr>
<td>ACO-6</td>
<td>CAHPS: Shared decision making</td>
<td>N/A</td>
<td>CMS</td>
<td>Survey</td>
</tr>
<tr>
<td>ACO-7</td>
<td>CAHPS: Health status/functional status</td>
<td>N/A</td>
<td>CMS</td>
<td>Survey</td>
</tr>
</tbody>
</table>
## Domain: Care coordination/Patient Safety

<table>
<thead>
<tr>
<th>ACO #</th>
<th>Measure title</th>
<th>NQF #</th>
<th>Measure steward</th>
<th>Data collection</th>
</tr>
</thead>
<tbody>
<tr>
<td>ACO-8</td>
<td>Risk-standardized all condition readmission</td>
<td>1789*</td>
<td>CMS</td>
<td>Claims</td>
</tr>
<tr>
<td>ACO-9</td>
<td>Ambulatory sensitive conditions admissions: COPD or asthma in older adults</td>
<td>0275</td>
<td>AHRQ</td>
<td>Claims</td>
</tr>
<tr>
<td>ACO-10</td>
<td>Ambulatory sensitive conditions admissions: heart failure</td>
<td>0277</td>
<td>AHRQ</td>
<td>Claims</td>
</tr>
<tr>
<td>ACO-11</td>
<td>Percent of PCPs who successfully qualify for an EHR program incentive payment</td>
<td>N/A</td>
<td>CMS</td>
<td>Claims and EHR</td>
</tr>
<tr>
<td>ACO-12</td>
<td>Medication reconciliation</td>
<td>0097</td>
<td>AMA-PCPI/NCQA</td>
<td>WI†</td>
</tr>
<tr>
<td>ACO-13</td>
<td>Falls: screening for future fall risk</td>
<td>0101</td>
<td>AMA-PCPI/NCQA</td>
<td>WI†</td>
</tr>
</tbody>
</table>

*Adapted from NQF 1789
†Web-interface
## Domain: Preventive Health

<table>
<thead>
<tr>
<th>ACO #</th>
<th>Measure title</th>
<th>NQF #</th>
<th>Measure steward</th>
<th>Data collection</th>
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</thead>
<tbody>
<tr>
<td>ACO-14</td>
<td>Preventive care and screening: influenza vaccination</td>
<td>0041</td>
<td>AMA-PCPI</td>
<td>WI*</td>
</tr>
<tr>
<td>ACO-15</td>
<td>Pneumococcal vaccination for older adults</td>
<td>0043</td>
<td>NCQA</td>
<td>WI*</td>
</tr>
<tr>
<td>ACO-16</td>
<td>Preventive care and screening: BMI screening and follow-up</td>
<td>0421</td>
<td>QIP†</td>
<td>WI*</td>
</tr>
<tr>
<td>ACO-17</td>
<td>Preventive care and screening: Tobacco use – screening and cessation intervention</td>
<td>0028</td>
<td>AMA-PCPI</td>
<td>WI*</td>
</tr>
<tr>
<td>ACO-18</td>
<td>Preventive care and screening: Screening for clinical depression and follow-up plan</td>
<td>0418</td>
<td>QIP†</td>
<td>WI*</td>
</tr>
<tr>
<td>ACO-19</td>
<td>Colorectal cancer screening</td>
<td>0034</td>
<td>NCQA</td>
<td>WI*</td>
</tr>
<tr>
<td>ACO-20</td>
<td>Breast cancer screening</td>
<td>N/A</td>
<td>NCQA</td>
<td>WI*</td>
</tr>
<tr>
<td>ACO-21</td>
<td>Preventive care and screening: BP screening and follow-up</td>
<td>N/A</td>
<td>QIP†</td>
<td>WI*</td>
</tr>
</tbody>
</table>

*Web-interface
†Quality Insights of Pennsylvania
## Domain: At-risk Population

<table>
<thead>
<tr>
<th>ACO #</th>
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<th>NQF #</th>
<th>Measure steward</th>
<th>Data collection</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Diabetes</strong></td>
<td></td>
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<td></td>
<td></td>
</tr>
</tbody>
</table>
| ACO-22-26 | Diabetes all-or-nothing composite  
- High blood pressure control  
- LDL-C control  
- Hemoglobin A1c control (< 8.0%)  
- Daily aspirin or antiplatelet agent for diabetics with IVD  
- Tobacco non-use | 0729  | MCM†            | WI*             |
| ACO-27   | Diabetes: Hemoglobin A1c poor control (> 9.0%)                                | 0059  | NCQA            | WI*             |
| **Hypertension** |                                                                          |       |                 |                 |
| ACO-28   | Controlling high blood pressure                                              | 0018  | NCQA            | WI*             |

*Web-interface  
†Minnesota Community Measurement
## Domain: At-risk Population

<table>
<thead>
<tr>
<th>ACO #</th>
<th>Measure title</th>
<th>NQF #</th>
<th>Measure steward</th>
<th>Data collection</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td><strong>Ischemic vascular disease (IVD)</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>ACO-29</td>
<td>IVD: Complete lipid panel and LDL-C control</td>
<td>0075</td>
<td>NCQA</td>
<td>WI*</td>
</tr>
<tr>
<td>ACO-30</td>
<td>IVD: Use of aspirin or another antithrombotic</td>
<td>0068</td>
<td>NCQA</td>
<td>WI*</td>
</tr>
<tr>
<td></td>
<td><strong>Heart failure</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>ACO-31</td>
<td>Heart failure: beta-blocker for LVSD</td>
<td>0083</td>
<td>AMA-PCPI</td>
<td>WI*</td>
</tr>
<tr>
<td></td>
<td><strong>Coronary artery disease</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>ACO-32</td>
<td>Coronary artery disease all-or-none composite:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Lipid control†</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Prescribe ACEi/ARB if the patient has diabetes or LVSD</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>ACO-33</td>
<td></td>
<td>0074</td>
<td>AMA-PCPI</td>
<td>WI*</td>
</tr>
<tr>
<td></td>
<td></td>
<td>0066</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Web-interface

†Overall percentage of patients with an LDL-C less than 100 mg/dL and with an LDL-C greater than or equal to 100 mg/dL with a documented plan of care to achieve LDL-C less than 100 mg/dL, including at a minimum the prescription of a statin.
Accelerating the move from Volume to Value
“Our goal is to have 85% of all Medicare fee-for-service payments tied to quality or value by 2016, and 90% by 2018. Perhaps even more important, our target is to have 30% of Medicare payments tied to quality or value through alternative payment models by the end of 2016, and 50% of payments by the end of 2018. Alternative payment models include accountable care organizations (ACOs) and bundled-payment arrangements………”

Sylvia M. Burwell, January 26, 2015
Target percentage of payments in ‘FFS linked to quality’ and ‘alternative payment models’ by 2016 and 2018

- Alternative payment models (Categories 3-4)
- FFS linked to quality (Categories 2-4)
- All Medicare FFS (Categories 1-4)

### Historical Performance
- **2011**
  - 0%
  - 68%
- **2014**
  - 22%
  - 85%
- **2016**
  - 30%
  - 85%
- **2018**
  - 50%
  - 90%

### Goals
- **2016**
  - 30%
  - 85%
- **2018**
  - 50%
  - 90%
Major providers, insurers plan aggressive push to new payment models

By Melanie Evans | January 28, 2015

(Story updated at 12:30 p.m. ET.) Several of the nation’s largest health systems and insurers are joining together in a new task force with the goal of shifting 75% of their business to contracts with incentives for quality and lower-cost healthcare. The Health Care Transformation Task Force includes some of the largest U.S. health systems, including Ascension, St. Louis, and Trinity Health, Livonia, Mich., and insurance giants Aetna and Health Care Service Corp. Employer Caesars Entertainment and the Pacific Business Group on Health also are involved. The task force members said they would reach their target by January 2020. Also in

“…..shifting 75% of their business to contracts with incentives for quality and lower-cost healthcare.”
How do we get to value?
Population Health: The New Buzzword

• Fundamentally about linking what happens inside the clinic to the conditions outside the clinic

• Social and behavioral determinants of health as cost drivers

• Requires partnerships and teams!
My Public Health Slide: The Health Impact Pyramid

Examples

- Eat healthy, be physically active
- Medication for high blood pressure, high cholesterol, diabetes
- Immunizations, brief intervention, cessation of treatment, colonoscopy
- Fluoridation, 0g trans fat, iodization, smoke-free laws
- Poverty, education, housing, inequality

Smallest Impact

Largest Impact
Under fully deployed value-based contracts, the goal (and profit margin) is in promoting health, not additional health care.

Assume now that you work in a system where you are paid to keep your patients healthy, and are not paid more for doing more.
Starting to Change the Way we Think About Health

• If you have too many asthmatics in your practice that are having to use the ED or are being admitted
  – Optimize controller medications for asthma
  – ? Hire an exterminator to kill roaches in the patient’s home

• If you have frequent hospitalizations of a low-income patient who is now homeless
  – Enroll them in care management to try to reduce admissions
  – Rent them an apartment?
It’s being done

• Without permanent supportive housing the LA Department of Health Services spends $70 million/year on inpatient costs for homeless patients. Placing previously homeless individuals in permanent supportive housing led to cost savings for LA DHS of $32,000 per person per year and a 77% reduction in emergency room visits, 77% reduction in inpatient admissions and an 85% reduction in inpatient days.
Hennepin Health Social Accountable Care Organization

• Reduced spending for some of the program’s top 200 users of medical services. County has reinvested $1 million in savings to fill service gaps and providing even better, cost-saving, care.

  – Savings have been reinvested in sobering center, vocational services for high-risk behavioral health patients, leasing transitional housing as an alternative to hospitalization for medically complex homeless patients.
We’re at the intersection....

Costs of Care

Population Health (Social Determinants and “Context”)

Quality of Care

Accountability
What do population metrics look like?

• Outcomes (mortality, hospitalization, functional status)
• Health behaviors (diet, physical activity, smoking, etc)
• Easy access to care
• Preventive services
• Community health improvement activities
• Address disparities and social determinants
### BOX

**Core Measure Set with Related Priority Measures**

1. **Life expectancy**
   - Infant mortality
   - Maternal mortality
   - Violence and injury mortality

2. **Well-being**
   - Multiple chronic conditions
   - Depression

3. **Overweight and obesity**
   - Activity levels
   - Healthy eating patterns

4. **Addictive behavior**
   - Tobacco use
   - Drug dependence/illicit use
   - Alcohol dependence/misuse

5. **Unintended pregnancy**
   - Contraceptive use

6. **Healthy communities**
   - Childhood poverty rate
   - Childhood asthma
   - Air quality index
   - Drinking water quality index

7. **Preventive services**
   - Influenza immunization
   - Colorectal cancer screening
   - Breast cancer screening

8. **Care access**
   - Usual source of care
   - Delay of needed care

9. **Patient safety**
   - Wrong-site surgery
   - Pressure ulcers
   - Medication reconciliation

10. **Evidence-based care**
    - Cardiovascular risk reduction
    - Hypertension control
    - Diabetes control composite
    - Heart attack therapy protocol
    - Stroke therapy protocol
    - Unnecessary care composite

11. **Care match with patient goals**
    - Patient experience
    - Shared decision making
    - End-of-life/advanced care planning

12. **Personal spending burden**
    - Health care-related bankruptcies

13. **Population spending burden**
    - Total cost of care
    - Health care spending growth

14. **Individual engagement**
    - Involvement in health initiatives

15. **Community engagement**
    - Availability of healthy food
    - Walkability
    - Community health benefit agenda

---

Paying for Prevention
A Novel Test of Medicare Value-Based Payment for Cardiovascular Risk Reduction

The Center for Medicare & Medicaid Innovation recently announced a large, novel model test to determine whether financially rewarding reductions in 10-year predicted risk for atherosclerotic heart disease (defined as initial myocardial infarction or stroke) across a physician’s patient population is an effective model for value-based prevention.
The MH Model employs a randomized controlled design. CMS will enroll up to 720 practices into the model. Half of the enrolled practices will be randomized to the intervention group, and half to the control group. All practices will be eligible for additional funding for participation in the model.
Hip and knee replacements are some of the most common surgeries that Medicare beneficiaries receive. In 2013, there were more than 400,000 inpatient primary procedures in Medicare, costing more than $7 billion for hospitalization alone.
Current state

- Clinical & medical services
- Human & social services
- Community Health services

Health care delivery system

Public health system
dale-bratzler@ouhsc.edu