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School of Population Health

GPBCH

Annual Conference

"Population Health as a Business Priority"

May 21, 2014

David B. Nash, MD, MBA
Dean
Jefferson School of Population Health
901 Walnut Street – 10th Floor
Philadelphia, PA 19107
(215) 955-6969 -Office (215) 923-7583 – Fax

david.nash@jefferson.edu http://jefferson.edu/population_health
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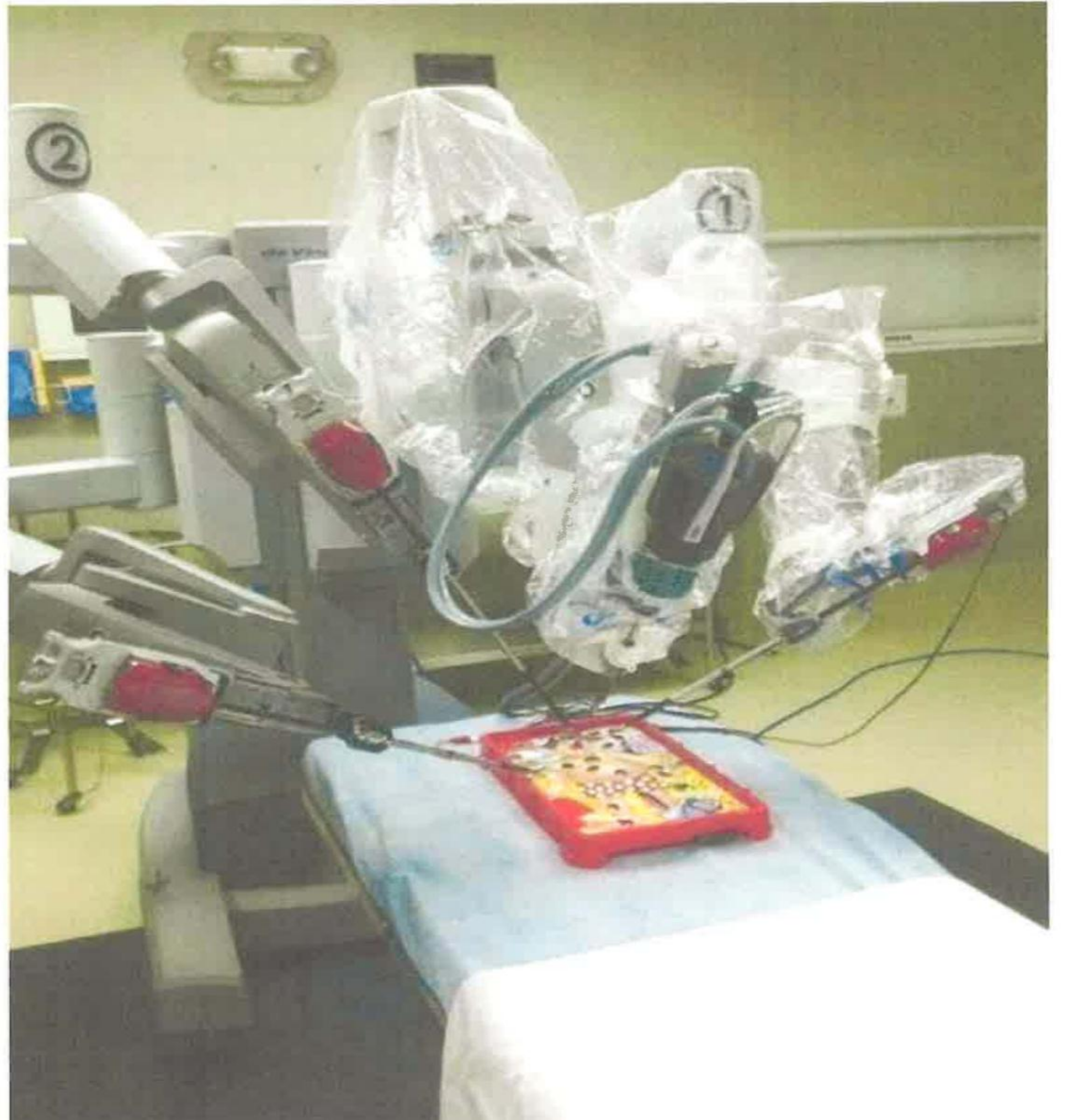
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INSIDE THIS WEEK: A 14-PAGE SPECIAL REPORT ON AGEING

The Economist

JUNE 27TH–JULY 3RD 2009 Economist.com

Iran's agony

The mystery of Mrs Merkel

Asia's consumers to the rescue?

The Greeks and those marbles

Evolution and depression

Reforming health care

This is going to hurt

"All the News That's Fit to Print"

The New York Times

VOL. CLXIII . . . No. 56,386
© 2014 The New York Times
SUNDAY, JANUARY 19, 2014

Patients' Costs Skyrocket; Specialists' Incomes Soar

When a Doctor Becomes an Entrepreneur, Small Procedures Offer Big Returns

By ELISABETH ROSENTHAL

CONWAY, Ark. — Kim Little had not thought much about the tiny white spot on the side of her cheek until a physician's assistant at her dermatologist's office warned that it might be cancerous. He took a biopsy, returning 15 minutes later to confirm the diagnosis and schedule her for an outpatient procedure at the Arkansas Skin Cancer Center in Little Rock, 30 miles away.

That was the prelude to a daylong medical odyssey several weeks later, through different private offices on the manicured campus at the Baptist Health Medical Center that involved a

by becoming more entrepreneurial, protecting their turf through aggressive lobbying by their medical societies, and most of all, increasing revenues by offering new procedures — or doing more of lucrative ones.

It does not matter if the procedure is big or small, learned in a decade of training or a weeklong course. In fact, minor procedures typically offer the best return on investment: A cardiac

PAYING TILL IT HURTS

The High Earners

REPORT BRIEF JANUARY 2013

INSTITUTE OF MEDICINE
OF THE NATIONAL ACADEMIES

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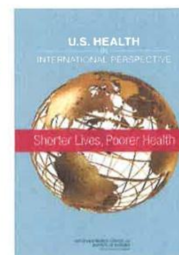
U.S. Health in International Perspective
Shorter Lives, Poorer Health



The United States is among the wealthiest nations in the world, but it is far from the healthiest. Although Americans' life expectancy and health have improved over the past century, these gains have lagged behind those in other high-income countries. This health disadvantage prevails even though the United States spends far more per person on health care than any other nation. To gain a better understanding of this problem, the National Institutes of Health (NIH) asked the National Research Council and the Institute of Medicine to convene a panel of experts to investigate potential reasons for the U.S. health disadvantage and to assess its larger implications. The panel's findings are detailed in its report, *U.S. Health in International Perspective: Shorter Lives, Poorer Health.*

For many years, Americans have been dying at younger ages than people in almost all other high-income countries. This disadvantage has been getting worse for three decades, especially among women.

A Pervasive Pattern of Shorter Lives and Poorer Health

The report examines the nature and strength of the research evidence on life expectancy and health in the United States, comparing U.S. data with statistics from 16 "peer" countries—other high-income democracies in western Europe, as well as Canada, Australia, and Japan. (See Table.) The panel relied on the most current data, and it also examined historical trend data beginning in the 1970s; most statistics in the report are from the late 1990s through 2008.

The panel was struck by the gravity of its findings. For many years, Americans have been dying at younger ages than people in almost all other high-income countries. This disadvantage has been getting worse for three decades, especially among women. Not only are their lives shorter, but Americans also have a longstanding pattern of poorer health that is strikingly consistent and pervasive over the life course—at birth, during childhood and adolescence,

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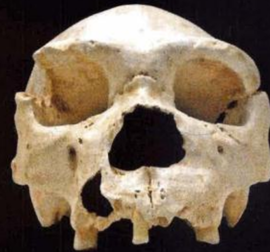
December 9 – December 15, 2013 | businessweek

Bloomberg Businessweek



350,000 B.C.
Dead relative
Eurasia

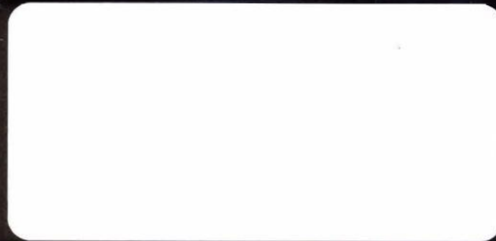
3600 B.C.
Sun-shaped disk
Nile Delta

2000 B.C.
Fearsome weapon
Americas

600 B.C.
Stopwatch
Assyria

1895 A.D.
Early hipster
Africa

2010 A.D.
Belt-fixed messaging tool
Canada



How BlackBerry Became A Relic

p54

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… all hospitals are accountable to the public for their degree of success…

If the initiative is not taken by the medical profession, it will be taken by the lay public.

1918 Am Coll Surg

Historical & Current Fee-For-Service
Value-Based Payment & Population Health Management
AIR-VENT SYSTEM 50 L
AIR-VENT SYSTEM 50 L

IMMIGRATION (P.35) | MILLER TIME (P.64) | P&G's BUZZ MOMS (P.32)

The McGraw Hill Companies

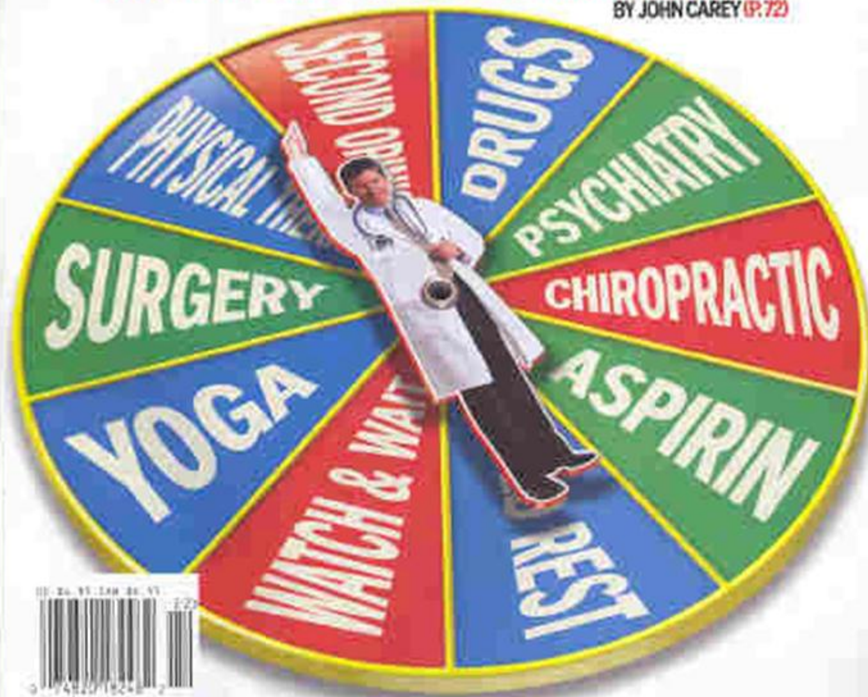
BusinessWeek

MAY 29, 2006 www.businessweek.com

Medical Guesswork

From heart surgery to prostate care, the medical industry knows little about which treatments really work

BY JOHN CAREY (P.72)



It is possible to improve care and dramatically lower costs.

Berwick Annals 2/98

Getting to 10%

CARE-RELATED COSTS

- Prevent medical errors
- Prevent avoidable hospital admissions
- Prevent avoidable hospital readmissions
- Improve hospital efficiency
- Decrease costs of episodes of care
- Improve targeting of costly services
- Increase shared decision-making

ADMINISTRATIVE COSTS

- Use common billing and claims forms

RELATED REFORMS

- Medical Liability Reform
- Prevent Fraud and Abuse

INSTITUTE OF MEDICINE
OF THE NATIONAL ACADEMIES
Advising the nation/Improving health

Definition of Quality
Institute of Medicine

"The degree to which health services for individuals and population increase the likelihood of desired health outcomes and are consistent with current professional knowledge."

Advance Copy Uncorrected Proofs

FIRST, DO NO HARM

BUILDING A SAFER HEALTH SYSTEM

INSTITUTE OF MEDICINE

The Wall Street Journal

September 21, 2012

How to Stop Hospitals From Killing Us

Medical errors kill enough people to fill four jumbo jets a week. A surgeon with five simple ways to make health care safer.

BY MARTY MAKARY

WHEN THERE IS a plane crash in the U.S., even a minor one, it makes headlines. There is a thorough federal investigation, and the tragedy often yields important lessons for the aviation industry. Pilots and airlines thus learn how to do their jobs more safely.

The world of American medicine is far deadlier: Medical mistakes kill enough people each week to fill four jumbo jets. But these mistakes go largely unnoticed by the world at large, and the medical community rarely learns from them. The same preventable mistakes are made over and over again, and patients are left in the dark about which hospitals have significantly better (or worse) safety records than their peers.

As doctors, we swear to do no harm. But on the job we soon absorb another unspoken rule: to overlook the mistakes of our colleagues. The problem is vast. U.S. surgeons operate on the wrong body part as often as 40 times a week. Roughly a quarter of all hospitalized patients will be harmed by a medical error of some kind. If medical errors were a disease, they would be the sixth leading cause of death in America—just behind accidents and ahead of Alzheimer's. The human toll aside, medical errors cost the U.S. health-care system tens of billions a year. Some 20% to 30% of all medications, tests and procedures are unnecessary, according to research done by medical specialists, surveying their own fields. What other industry misses the mark this often?

25%
Hospitalized patients who are harmed by medical errors
Source: New England Journal of Medicine

It does not have to be this way. A new generation of doctors and patients is trying to achieve greater transparency in the health-care system, and new technology makes it more achievable than ever before.

I encountered the disturbing closed-door culture of American medicine on my very first day as a student at one of Harvard Medical School's prestigious affiliated teaching hospitals. Wearing a new white medical coat that was still creased from its packaging, I walked the halls marveling at the portraits of doctors past and present. On rounds that day, members of my resident team repeatedly referred to one well-known surgeon as "Dr. Hodad." I hadn't heard of a surgeon by that name. Finally, I inquired. "Hodad," it turned out, was a nickname. A fellow student whispered: "It stands for Hands of Death and Destruction."

Stunned, I soon saw just how scary the works of his hands were. His operating skills were hasty and slipshod, and his patients frequently suffered complications. This was a man who simply should not have been allowed to touch patients. But his bedside manner was impeccable (in fact, I try to emulate it to this day). He was charming. Celebrities requested him for operations. His patients worshiped him. When faced with excessive surgery time and extended hospitalizations, they just chalked up their misfortunes to fate.

Dr. Hodad's popularity was no aberration. As I rotated through other hospitals during my training, I learned that many hospitals have a "Dr. Hodad" somewhere on staff (sometimes more than one). In a business where reputation is everything, doctors who call out other doctors can be targeted. I've seen whistleblowing doctors suddenly assigned to more emergency calls, given fewer resources or simply badmouthed and discredited in retaliation. For me, I knew the ramifications if I sounded the alarm over Dr. Hodad: I'd be called into the hospital chairman's office, a dread scenario if I ever wanted a job. So, as a rookie, I kept my mouth shut. Like the other trainees, I just told myself that my 120-hour weeks were about surviving to become a surgeon one day, not about fixing medicine's culture.

98,000
Annual deaths from medical errors in the U.S.
Source: Institute of Medicine

Hospitals as a whole also tend to escape accountability, with excessive complication rates even at institutions that the public trusts as top-notch. Very few hospitals publish statistics on their performance, so how do patients pick one? As an informal exercise throughout my career, I've asked patients how they decided to come to the hospital where I was working (Georgetown, Johns Hopkins, D.C. General Hospital, Harvard and others). Among their answers: "Because you're close to home";

Please turn to the next page

Researchers suggest 2 paths to get patients back on statins [PAGE 18]

Professional Issues

HEALTH CARE LITIGATION ■ MEDICAL EDUCATION ■ ETHICS ■ PROFESSIONAL REGULATION

4/22/13

TOP 10 ways to improve patient safety NOW!

A newly released evidence review narrows the field of targets to prevent harm. These are things hospitals should be doing to protect patients. { By Kevin B. O'Reilly }

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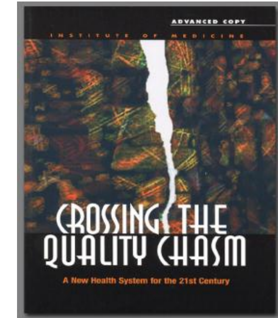
INSTITUTE OF MEDICINE

A New Health System for the 21st Century

Institute of Medicine Report 2001

Outlines Key Dimensions of the Healthcare Delivery System



- *Safe*: avoiding injuries to patients from the care that is intended to help them.
- *Effective*: providing services based on scientific knowledge to all who could benefit and refraining from providing services to those not likely to benefit (avoiding **underuse** and **overuse**, respectively).
- *Patient-centered*: providing care that is **respectful** of and responsive to individual patient preferences, needs, and values and ensuring that patient values guide all clinical decisions.
- *Timely*: **reducing waits** and sometimes harmful **delays** for both those who receive and those who give care.
- *Equitable*: providing care that does **not vary** in quality because of personal characteristics such as gender, ethnicity, geographic location, and socioeconomic status.
- *Efficient*: **avoiding waste, including waste of equipment, supplies, ideas, and energy**.

Source: Institute of Medicine 2001; 5-6

Achieving STEEEP Health Care

Baylor Health Care System's Quality Improvement Journey

David J. Ballard, MD, PhD,
Editor

Associate Editors:
Neil S. Fleming, PhD
Joel T. Allison, MHA
Paul B. Convery, MD, MMM
Rosemary Luquire, RN, PhD

Foreword by David B. Nash, MD, MBA

A PRODUCTIVITY PRESS BOOK

Is Population Health the Answer?

1. What's the question?

2. Where are we now?

3. Where are we going in the future?

Population Health: Conceptual Framework

Health outcomes and their distribution within a population

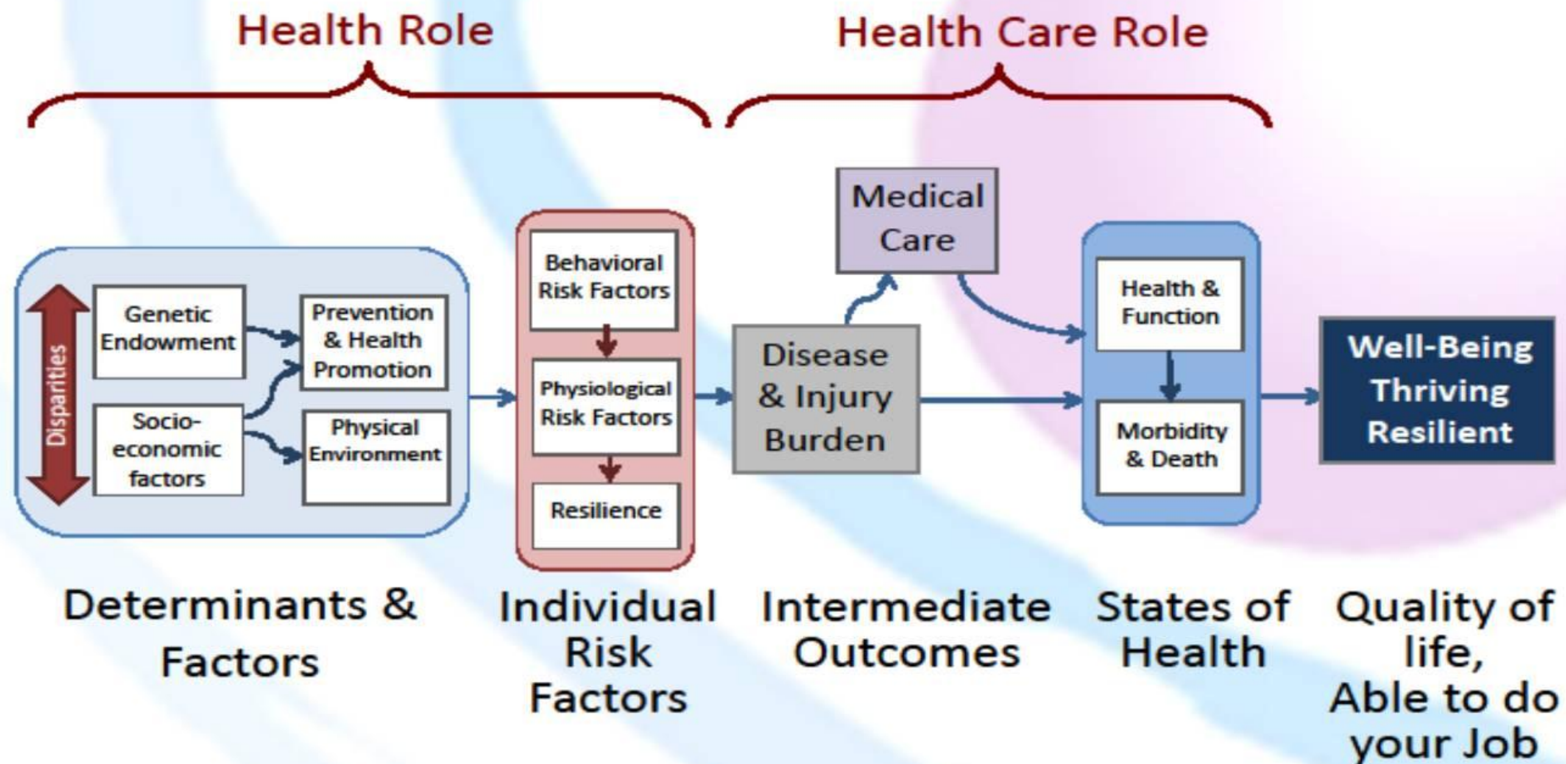
Morbidity
Mortality
Quality of Life

Health determinants that influence distribution

Medical care
Socioeconomic status
Genetics

Policies and interventions that impact these determinants

Social
Environmental
Individual

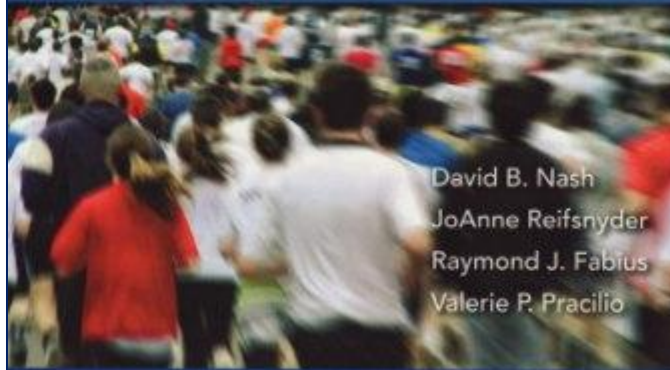

Broad View of Population Health
Health Role
Health Care Role
Disparities
Genetic Endowment
Socio-economic factors
Prevention & Health Promotion
Physical Environment
Behavioral Risk Factors
Physiological Risk Factors
Resilience
Medical Care
Disease & Injury Burden
Health & Function
Morbidity & Death
Well-Being Thriving Resilient
Determinants & Factors
Individual Risk Factors
Intermediate Outcomes
States of Health
Quality of life, Able to do your Job
15

Source: Bipartisan Policy Center, "F" as in Fat: How Obesity Threatens America's Future (TFAH/RWJF, Aug. 2013)

Available September 2010

POPULATION HEALTH

CREATING A CULTURE OF WELLNESS



VOLUME 14, NUMBER 2, APRIL 2011 ISSN: 1942-7891

Population Health Management

CONTENTS

- Lifestyle Behavior and Emotional Health
- Strategic Response by Providers
- Tobacco Dependence Treatment Guideline Implementation
- Theory-Based Telehealth and Patient Empowerment
- Health-Related Productivity Loss
- Quality of Care for Veterans with Chronic Diseases

Editor-in-Chief
David B. Nash, M.D., M.B.A.

Managing Editor
Deborah Meiris

The Official Journal of

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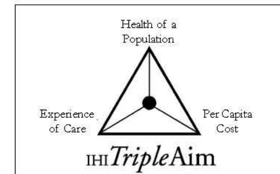
Institute *for* Healthcare Improvement



Innovation Series 2012

A Guide to Measuring the Triple Aim:

Population Health, Experience of Care, and Per Capita Cost

27

By Hilary K. Seligman, Ann F. Bolger, David Guzman, Andrea López, and Kirsten Bibbins-Domingo

DOI: 10.1377/hlthaff.2013.0096
HEALTH AFFAIRS 33,
NO. 1 (2014): 116–123
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Exhaustion Of Food Budgets At Month's End And Hospital Admissions For Hypoglycemia

Hilary K. Seligman (hseligman@medsfgh.ucsf.edu) is an assistant professor in the Department of Medicine, University of California, San Francisco (UCSF).

Ann F. Bolger is a professor in the Department of Medicine, UCSF.

David Guzman is a senior statistician in the Department of Medicine, UCSF.

Andrea López is a research analyst in the Department of Medicine, UCSF.

Kirsten Bibbins-Domingo is a professor in the Department of Medicine, UCSF.

ABSTRACT **One in seven US households cannot reliably afford food. Food budgets are more frequently exhausted at the end of a month than at other points in time. We postulated that this monthly pattern influenced health outcomes, such as risk for hypoglycemia among people with diabetes. Using administrative data on inpatient admissions in California for 2000–08, we found that admissions for hypoglycemia were more common in the low-income than the high-income population (270 versus 200 admissions per 100,000). Risk for hypoglycemia admission increased 27 percent in the last week of the month compared to the first week in the low-income population, but we observed no similar temporal variation in the high-income population. These findings suggest that exhaustion of food budgets might be an important driver of health inequities. Policy solutions to improve stable access to nutrition in low-income populations and raise awareness of the health risks of food insecurity might be warranted.**

In many households, particularly low-income ones, a "pay cycle" develops in which expenditures increase when money (from paychecks or benefits) becomes available, and they decrease just before the next check is due—the time when household budgets are most likely to be exhausted.[1-3] This pattern has been observed for generations. The US Department of Labor noted in 1930 that most factory wage earners spent 75–100 percent of their earnings "by the end of the day following pay day."[4]

More recently, it has been estimated that expenditures by Social Security beneficiaries increase by almost $50 on the day their check arrives—an 80 percent increase over average daily expenditures.[1] A 2009 Gallup poll showed that average daily spending among Americans paid monthly or semimonthly was $62 during weeks without a paycheck and $69 during weeks with a paycheck.[5]

A large proportion of Americans receive their paychecks or government benefits at the start of the month, although the precise percentage is difficult to determine. Some employers prefer to issue paychecks just once a month, to keep money earning interest for the employer for a longer time and reduce costs associated with administering paychecks. Employees who receive monthly paychecks are generally paid on the first days of the month.

Social Security checks arrive on the third day of the month for beneficiaries who retired and began receiving benefits before 1997. Temporary Assistance for Needy Families benefits (often called *welfare benefits*) are often distributed on the first day of the month, depending on the recipient's state of residence. Supplemental Nutrition Assistance Program (SNAP, formerly known as food stamps) benefits in California and many other states are distributed during the first ten days of the month.

Most fixed expenditures are also paid out in the early weeks of the month, leaving less money

Jefferson School of Population Health

Better Health

…He's back!

What Percentage of Adult Americans do the Following?

1. Exercise 20 minutes 3 x week
2. Don't smoke
3. Eat fruits and vegetables regularly
4. Wear seatbelts regularly
5. Are at appropriate BMI

Annals Int Med
April 2006

Determinants of Health

1. Smoking

2. Unhealthy diet

3. Physical inactivity

4. Alcohol use

Together, these account for 40% of all deaths.

Reforming Health Care or Reforming Health?

1. US spends under 2% of its health dollars on population health
2. Chronic Diseases, which comprise 80% of total disease burden, have no dedicated federal funding stream

PHYTEL
Help · Kevin Johnson

Population Management System

Search Patients | Go

Patients | Appointments | Outreach | Population Insight | Care Management | PQRS | Hospital Readmission | Reports

Condition Dashboard | Population Benchmarks | Comparison | Population Summary | Data Summary | Patient List | Configuration

Date Range:
Monthly
Quarterly

Recent Reports:
Annual HbA1C
Annual LDL-C testing
Physician Comparison

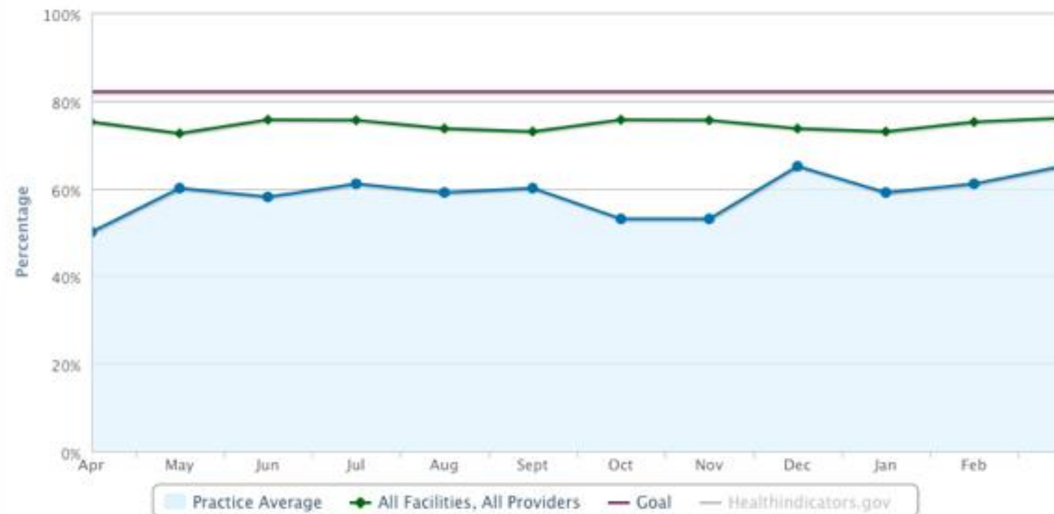
Group: Medical Center, Westside | Provider: 17 Providers

Population Benchmark Report

Export

Report: Quality Initiative | Diabetes | Operational | Annual HbA1C testing

Annual HbA1C testing



Diabetes	Benchmark	QTR 1 (2011)		QTR 4 (2010)		QTR 3 (2010)		QTR 2 (2010)		QTR 1 (2010)		Trend
Identified Population		2,183		2,167		2,180		2,166		2,168		
Measures	%	#	%	#	%	#	%	#	%	#	%	
Annual HbA1c testing	85.3	**1,773**	**80.1**	1,754	81	1,761	81.6	1,752	81	1,764	81.6	↑
HbA1c > 9.0	12.2	**220**	**13.0**	208	12.7	208	13.7	232	12.2	213	18.0	↔
HbA1c < 7.0	45.3	**862**	**40.8**	832	42.5	928	42.4	926	41.9	910	41.5	↓

SYNAPSE

Search... Search | Dan Bergner | Help & Training | Risk Stratification

Home | Chatter | Dashboards | Contacts | Diagnosis-Related Groups | ICD-10 Codes | Claims | Reports | Integration | +

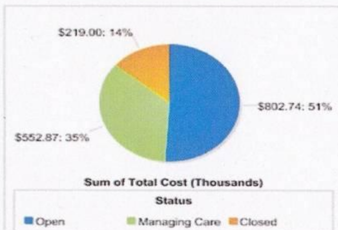
« Go to Dashboard List

Help for this Page

CHF & COPD Population Dashboard

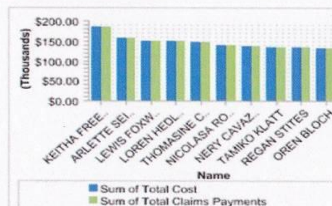
Find a dashboard... | Edit | Clone | Refresh | As of August 6, 2013 at 4:13 PM | Viewing as Dan Bergner

CHF & COPD Population by Status



CHF Population

COPD Population



10 Most Costly Claim Codes

DRG	Sum of Claim Payment Amount
AFTERCARE W/O CC/MCC	$1.5M
O.R. PROC W DIAGNOSES OF OTHER CONTACT W HEALTH SERVICES W/O CC/MCC	$1.5M
SIGNS & SYMPTOMS W MCC	$1.5M
REHABILITATION W/O CC/MCC	$1.3M
AFTERCARE W CC/MCC	$1.3M
SIGNS & SYMPTOMS W/O MCC	$1.2M
PULMONARY EMBOLISM W/O MCC	$1.2M
OTHER FACTORS INFLUENCING HEALTH STATUS	$1.1M
RESPIRATORY NEOPLASMS W CC	$1.1M
MAJOR CHEST TRAUMA W MCC	$1.1M
Total	$12.8M

Physicians with Most Costly Claims

Attending Physician	Sum of Claim Payment Amount
FRANK MCGEEHAN	$1.9M
ALFRED NUTT	$1.5M
ELIZA MARR	$1.5M
LUCILA BURRIS	$1.5M
FLO SPINO	$1.1M
HIRAM SHACKLEFORD	$1.1M
KARINA ACKLEY	$991K
ERIC DUNNEBACK	$952K
NATALIE RAGIN	$918K
AMAL MCMILLON	$861K
Total	$12.1M

Top 10 Physicians - AFTERCARE W/O CC/MCC

Attending Physician	Sum of Claim Payment Amount	Sum of No. Claims
HELENA PALMATIER	$41K	2
SEAN SWARTZ	$41K	1
AARON THIESSEN	$39K	1
LANI TOMBERLIN	$37K	1
LUCILA MASK	$35K	3
VESTA YOPP	$35K	1
ALFRED NUTT	$33K	3
KRAIG GAFFORD	$33K	2
SHAWANA BESSETTE	$32K	1
ZULEMA TANAKA	$28K	1
Total	$354K	16

Humana's Accountable Care Organization Pilot

- Unites expertise of Humana and Norton Healthcare of Louisville
- One of only five pilots in the U.S. authorized by Dartmouth and Brookings
- Accountability of measured outcomes, cost, and patient delivery
- Industry-standard performance measures including financial, quality, regulatory
- Core principles:
  - Integrated care delivery among provider teams
  - Defined patient population to measure
  - Pay-for-results based on improved outcomes and cost

BROOKINGS

Mission:

Improve the health of people in our region

Our vision:

St. Luke's Health System will transform healthcare by aligning with physicians and other providers to deliver integrated, seamless and patient-centered quality care across all St. Luke's settings.

Based on our vision we are compelled to deliver on the principles of Accountable Care:

Better Health, Better Care, Lower Cost

In order to achieve this, we must manage the health of populations. This means transitioning from volume to value. We will do this by achieving these strategic objectives:

Transform The Clinical Care Model	Transform The Business Model	Transform The Consumer Experience

Strategic initiatives that support our strategic objectives:

Align The SLHS System:
- Establish a clear, inclusive & effective governance structure
- Incorporate innovation, creativity & continuous learning into our culture.
- Develop leaders throughout the organization, including physicians
- Align provider compensation to enable the move from volume to value

Connect Ourselves & Our Communities:
- Maximize problem solving as close to the issue as possible
- Enhance the way consumers & partners interact with care providers
- Broaden St. Luke's brand from caring only for illness & injury to include partnering for health
- Partner with local community resources & employ community health needs assessments
- Promote philanthropic investment

Eliminate Waste:
- Accelerate TEAMwork-based (Lean) reduction of waste, irrational variance & cost in operational & clinical areas
- Mobilize utilization management capability
- Maximize the use of every organizational asset

Create a Clinically Integrated Network:
- Transition our business (lives & contracts) from fee-for-service to accountable care.
- Create a system of clinical accountability across all providers in the network
- Engage a sufficient number of committed & aligned independent providers
- Evaluate & execute strategic relationships that expand care continuum capability

Become a National Quality Leader:
- Be a national quality & consumer satisfaction leader based on national benchmarks
- Drive safety toward zero harm
- Develop coordination & transitions of care disciplines, including new care models (e.g., Team Based Care)

Expand Patient Centeredness:
- Promote a patient centric approach to care
- Engage people in their health
- Promote the patient's partnership in managing their care
- Incorporate effective & proven approaches to preventative & end of life care

Establish Information-Driven Decision-Making:

Foundational to these initiatives, we must fuel adoption of data and analytics to make evidence-based management and clinical decisions, and objective decisions on how we prioritize our resources & understand risks.

Our workforce embodies the St. Luke's Values of ICARE as we deliver the following pledge:

Create Exceptional Experiences	Create Exceptional Outcomes

By Susan DeVore and R. Wesley Champion

Driving Population Health Through Accountable Care Organizations

DOI: 10.1377/hlthaff.2010.0935
HEALTH AFFAIRS 30,
NO. 1 (2011): 41-50
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ABSTRACT **Accountable care organizations, scheduled to become part of the Medicare program under the Affordable Care Act, have been promoted as a way to improve health care quality, reduce growth in costs, and increase patients' satisfaction. It is unclear how these organizations will develop. Yet in principle they will have to meet quality metrics, adopt improved care processes, assume risk, and provide incentives for population health and wellness. These capabilities represent a radical departure from today's health delivery system. In May 2010 the Premier healthcare alliance formed the Accountable Care Implementation Collaborative, which consists of health systems that seek to pursue accountability by forming partnerships with private payers to evolve from fee-for-service payment models to new, value-driven models. This article describes how participants in the collaborative are building models and developing best practices that can inform the implementation of accountable care organizations as well as public policies.**

Susan DeVore (susan_devore@premierinc.com) is president and chief executive officer of the Premier healthcare alliance, in Charlotte, North Carolina.

R. Wesley Champion is a senior vice president at Premier Consulting Solutions, in Charlotte.

Lucky 7

Population Health TO DO LIST:

1. What about your own associates? (HRAs, Wellness & Prevention)

2. Keep the well, well!

3. PCMH's (who will lead?)

4. Registries (not in current EMRs yet)

5. Retail clinics (Walgreens, CVS)

6. Managed Care Partners

7. Leadership Training

The

THE TIPPING POINT

How Little Things Can Make a Big Difference

MALCOLM GLADWELL

What Does This All Mean?

Major Themes Moving Forward

1. Transparency
2. Accountability
3. No outcome, No income

How Might We Get There?

Change the Culture

1. Practice based on evidence
2. Reduce unexplained clinical variation
3. Reduce slavish adherence to professional autonomy
4. Continuously measure and close feedback loop
5. Engage with patients across the continuum of care

Multistakeholder Input on a National Priority: Improving Population Health by Working with Communities

Environmental Scan and Analysis to Inform the Action Guide

DECEMBER 20, 2013

This report is funded by the Department of Health and Human Services under contract HHSM-500-2012-00009I task order 4.

Environmental Scan: Identifying Frameworks and Initiatives

Key informant strategy, face validity with experts from HHS and the Advisory Group, then rated using initial criteria and descriptions

- Assessment and Analyisis of 40 Frameworks and Initiatives in the Enviromental Scan
- Individually Scored 72 Frameworks and Initiatives Against the Nine Criteria
- Narrowed to 72 Frameworks based on Expert Guidance and Emphasis on Programs Supported by a National Structure
- 700+ National, State and Local Frameworks and Initiatives Initially Identified

CHA

Implementation Strategy

Provisions in the Affordable Care Act require a tax-exempt hospital to:

- ✓ Adopt an implementation strategy to meet community needs identified in the CHNA
- ✓ Describe how it is addressing needs identified in the CHNA
- ✓ Describe any needs identified in the CHNA that are not being addressed and the reasons for not addressing them

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46.9% return
22.8% return
13.8% return
Obamacare stock fund
S&P 500
Repeal Obamacare stock fund
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Retail Senior Segment
Medical Management of Members Across a Continuum on Needs

We are focused in managing high cost / high acuity patients both Acute and Chronic

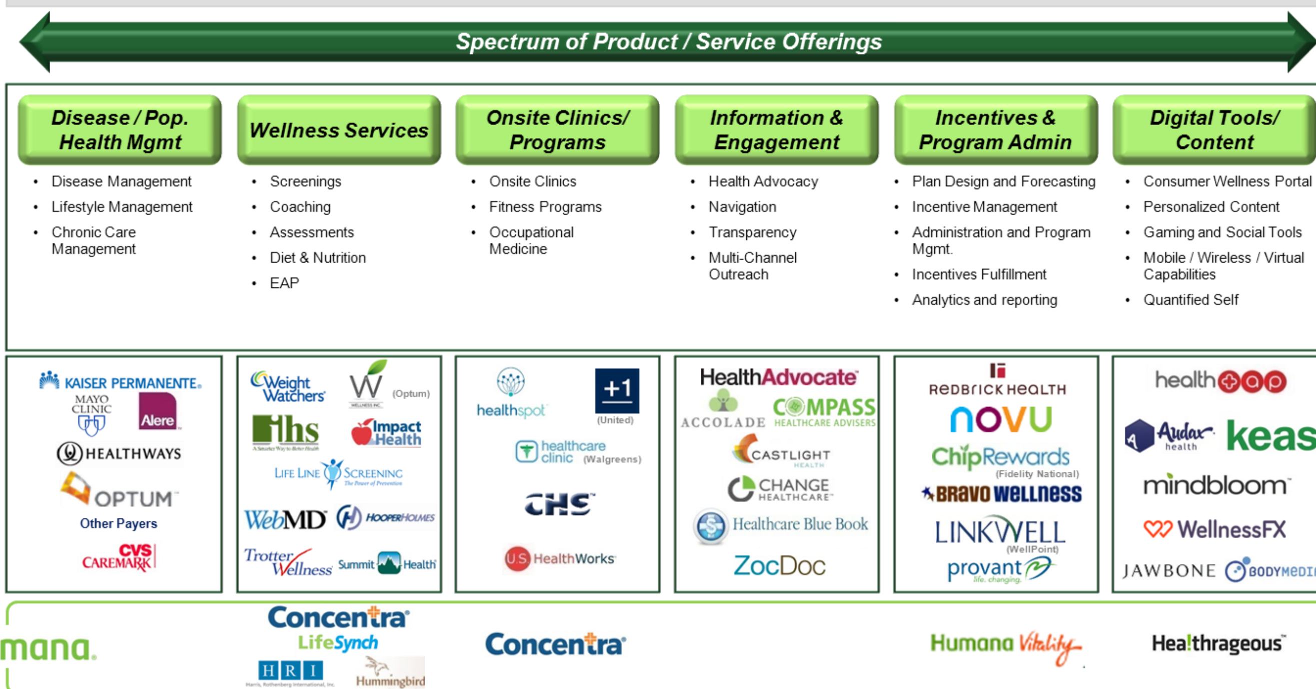
Percent of Members	Percent of Total Costs	Engagement Methods
5%	41%	**Humana Cares,** Integrated Medical-Behavioral Health, Medication Therapy Management, SeniorBridge, Model of Care, Disease Management, Humana Active Outlook, Seminars, Web and Print Guidance
15%	34%	**Integrated Medical-Behavioral Health**, Medication Therapy Management, SeniorBridge, Model of Care, Disease Management, Humana Active Outlook, Seminars, Web and Print Guidance
30%	18%	**Medication Therapy Management, Disease Management, SeniorBridge,** Model of Care, Humana Active Outlook, Seminars, Web and Print Guidance
30%	6%	**Model of Care,** Humana Active Outlook, Seminars, Web and Print Guidance
20%	1%	**Humana Active Outlook, Seminars, Web and Print Guidance**

Must manage both ACUTE episodes and CHRONIC conditions

Humana

Note: Senior Bridge deal is pending

Market Landscape of Health & Wellness



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JOURNAL REPORT

HEALTH CARE

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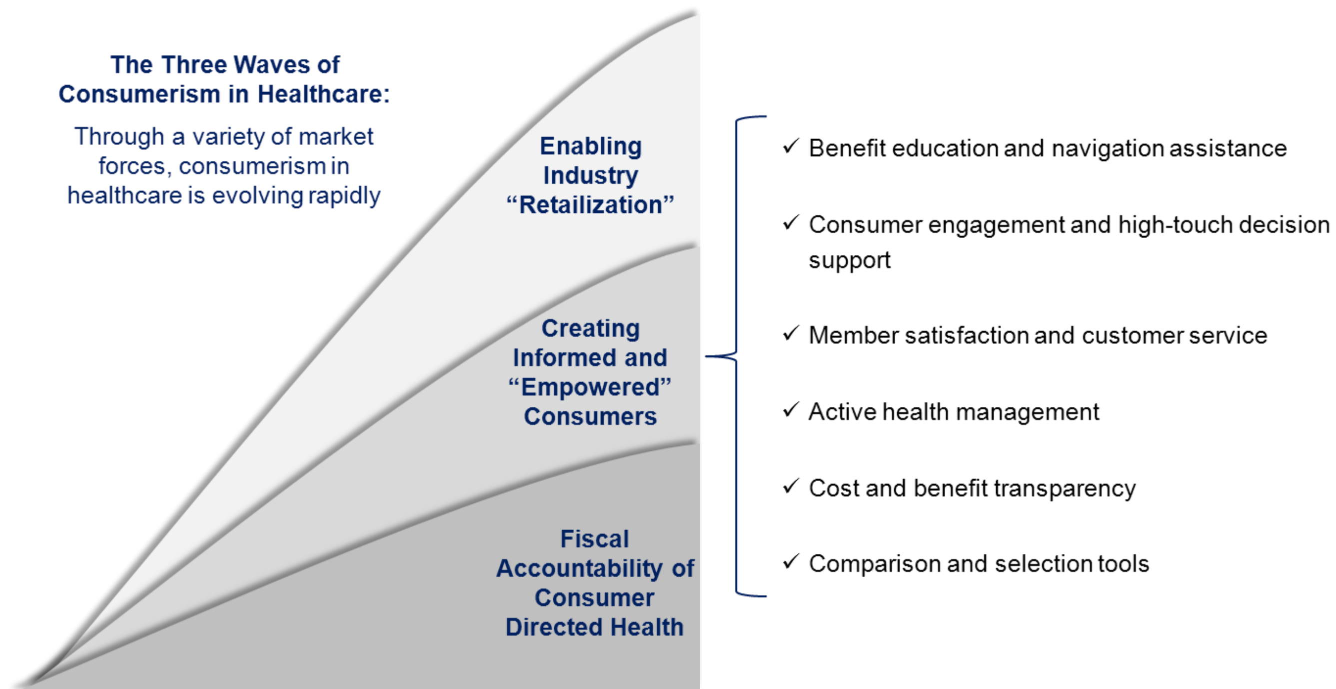
THE WALL STREET JOURNAL. Monday, February 24, 2014 | R

How to Bring the Price Of Health Care Into the Open

There's a major effort under way to make sure patients know what they'll have to pay—*before* they make any decisions about treatment. Some people think it will make all the difference.

Consumers Need Decision Making Support

The rise of consumerism creates demand for individual control and decision support that accommodates a B2B2C "retail experience" not previously delivered in US healthcare.



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Master of Science in Healthcare Quality and Safety

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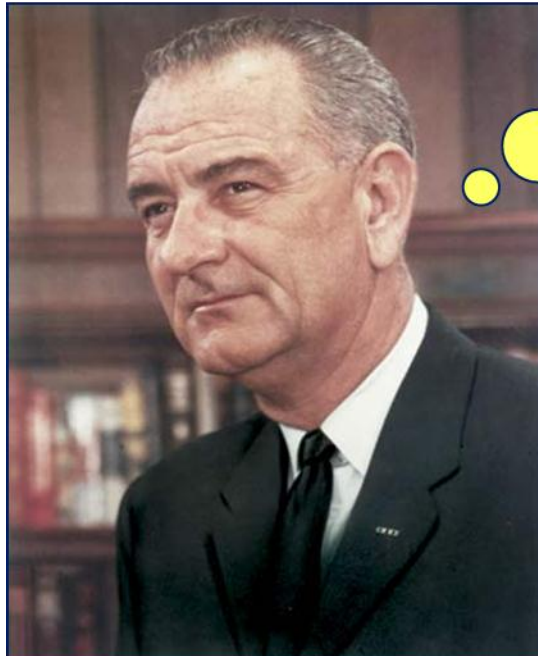
“It’s always better to have them in the tent pissing out, than outside the tent pissing in.”



President, L.B. Johnson