ACOs, CINs, and Integrated Care

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HFMA and CHEF’s Managed Care Meeting
Update on Changes and Challenges

February 4, 2016
Disclosures

• Forward Health Group
• Advisory Committee on Transplantation
Objectives

• Help audience members understand features of the US health care environment that have prompted attention to integrated care
• Acquaint audience members with fundamental aspects of CINs and ACOs
• Propose building blocks to what is next for coordinating care
Healthcare is local

Dartmouth Atlas

Medicare inpt days

County Health Rankings, RWJ Foundation, 2015

HbA1C levels 2012
Medicare Rapidly Evolving: Chicago Market

In Chicago market, Medicare FFS expenditures for hospital inpatient services declining, driven by 4.8% annual decline inpatient days per 1,000 beneficiaries, = emptying 455-bed hospital. Outpatient services and expenditures increased driven by a 1.7% annual increase in outpatient visits per 1,000 beneficiaries.

Source: CMS Office of Information Products & Data Analytics Geographic Variation Public Use File, Chicago Hospital Referral Region (HRR)
The transition is beginning to happen

Value-Driven Health Care
- High quality, low cost
- Encourages care coordination
- Right care, right place, right time
- Patient centered
- Rewards health and prevention
The Triple Aims of Health Care

Improve health of population
Improve experience of care
Reduce healthcare costs

The New Trend: CINs/ACOs

Financing and Insurance

Consumers/Patients

Clinically Integrated Network

Key Attributes:
- Patient Centered
- Coordinated Care
- Quality and Cost Focus
- Information Sharing
- Aligned Incentives

CIN/ACO

Accountable Care Organization
“Clinically Integrated Network”
- Provider network
- The “team” for clinical integration

“Clinical Integration”
- What the CIN does
- Participants collaborate on care
- Game plan and rules
- Operational and legal concepts

“Accountable Care Organization”
- Market and payor engagement
- Clinical integration to achieve goals
- Population health management
- Shared savings and/or risk
What a CIN is

Identify metrics & targets that meaningfully impact all network physicians & align with hospital initiatives to improve quality and provide value across care continuum.

**Examples of Performance Improvement**

<table>
<thead>
<tr>
<th>Element</th>
<th>Description</th>
<th>Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Variance &amp; Cost Reduction</strong></td>
<td>Minimize variable physician performance not related to patient characteristics</td>
<td>• Minimize orthopedics supply chain cost</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Staffing and productivity opportunities</td>
</tr>
<tr>
<td><strong>Unnecessary Care Reduction</strong></td>
<td>Reduce avoidable, unproductive and duplicative services</td>
<td>• Prostate cancer screenings for elderly patients</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Reduce Readmissions</td>
</tr>
<tr>
<td><strong>Clinical Restructuring</strong></td>
<td>Ensure treatment in most optimal setting with most appropriate level of provider</td>
<td>• Early step down from an IP to SNF bed</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Partnerships with a local retail clinic to offer non-urgent care</td>
</tr>
<tr>
<td><strong>System Optimization</strong></td>
<td>Shift focus to upstream, preventative care with emphasis on CI and population health</td>
<td>• Disease-based medical homes</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Patient engagement strategies using telehealth</td>
</tr>
</tbody>
</table>

Source: Sg2 Analysis
What a CIN does

Clinical Integration Program Structure

- Infrastructure & Education: 9 measures
- Chronic Disease Care: 54 measures
- Health & Wellness: 37 measures
- Efficiency: 16 measures
- Care Coordination & Patient Safety: 29 measures
- Patient Experience: 12 measures

2015 Value Report Advocate Health Care
What a CIN does

Data / Metrics / Care Management

- Includes 3,900 Physicians
  - Employed < 200
  - University of Texas ≈ 650
  - Clinically Integrated ≈ 2400 (> 500 PCP's)

- Average Practice Size = 1.8 Physicians
- 24 Member All-physician Board of Directors
What a CIN does

Summary data: patient groups, i.e. risk adjusted pmpm

Summary data: physician specific parameters, e.g. acute care performance

Construct incentive payments and hospital efficiency agreements to align physicians around performance and improvement
UCM Medicare Performance & Chicago Market Trend

Medicare Risk-Adjusted Inpatient Days per 1,000 Population

- UCM PCP Medicare
- UCM PCP Care/Caid Duals
- Chicago HRR Population

Adjusted to Chicago HRR Average HCC Risk Score = 1.15

Chicago Referral Region Medicare Population & Inpatient Utilization Trend

Inpatient Census

2007: 267
2008: 2,033
2009: 1,654
2010: 1,500
2011: 1,250
2012: 1,000
2013: 750

Population (1,000)

- Medicare Population
- Medicare Inpatient Census

Source: CMS Medicare HRR Data, 2015
UCM Experience with Commercial Populations

**Impact of Risk, PCP Management on UCM Commercial Populations**

- **Inpatient Days/1,000 for Select UCM Commercial Populations**
  - All Patients: 246, 427
  - Cancer Patients: 809, 955
  - GI Patients: 1,765, 680
  - GI Patients with PCP: 2,024

**Market Opportunity - Work with South Side Employers to Better Manage Patients with Multiple Chronic Conditions**

- **Number of Chronic Conditions**
  - 0 CC: 47, 51, 52
  - 1 CC: 60
  - 2 CC: 47, 31, 33
  - 3 or More CC: 12, 9, 6

- **Chronic Conditions in UCM Large PPO Patients**
  - Largest Employer: 16
  - UChicago Employees: 12
  - Other Employers: 6, 6, 4
  - UCMC Employees: 10

- **UCHP**
- **Large PPO w/o PCP**: 0
- **Large PPO w PCP**: 0
Using relevant data: Rx data from UCHP

<table>
<thead>
<tr>
<th>UTILIZATION</th>
<th>RETAIL</th>
<th>MAIL</th>
<th>DIRECT</th>
<th>SPECIALTY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Avg. Eligible Employee / Month</td>
<td>6,051</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Avg. Eligible Members / Month</td>
<td>12,006</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Avg. Utilizing Members / Month</td>
<td>3,210</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>% Utilizing Members</td>
<td>26.7%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total New Rx</td>
<td>27,712</td>
<td>26,242</td>
<td>975</td>
<td>25</td>
</tr>
<tr>
<td>Total Refill Rx</td>
<td>20,915</td>
<td>18,969</td>
<td>1,631</td>
<td>0</td>
</tr>
<tr>
<td>Total Rx</td>
<td>48,627</td>
<td>45,211</td>
<td>2,606</td>
<td>25</td>
</tr>
<tr>
<td>% of Claims</td>
<td>100.00%</td>
<td>92.98%</td>
<td>5.36%</td>
<td>0.05%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Drug Name</th>
<th>Specialty Drug Classification</th>
<th>Total Utilizers</th>
</tr>
</thead>
<tbody>
<tr>
<td>HUMIRA</td>
<td>RHEUMATOID ARTHRITIS</td>
<td>22</td>
</tr>
<tr>
<td>REVLIMID</td>
<td>ONCOLOGY</td>
<td>2</td>
</tr>
<tr>
<td>GILENYA</td>
<td>MULTIPLE SCLEROSIS</td>
<td>4</td>
</tr>
<tr>
<td>ENBREL</td>
<td>RHEUMATOID ARTHRITIS</td>
<td>10</td>
</tr>
<tr>
<td>ATRIPLA</td>
<td>HIV</td>
<td>10</td>
</tr>
</tbody>
</table>

Relevant data from UCHP identifies basic levels of adherence, customer preference, and for some patients, high-cost medications.

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- Provider network
- The “team” for clinical integration

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- Market and payor engagement
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- Population health management
- Shared savings and/or risk
An ACO per CMS

- Accountable Care Organizations (ACOs) are groups of doctors, hospitals, and other health care providers, who come together voluntarily to give coordinated high quality care to their Medicare patients.
- The goal of coordinated care is to ensure that patients, especially the chronically ill, get the right care at the right time, while avoiding unnecessary duplication of services and preventing medical errors.
- When an ACO succeeds both in delivering high-quality care and spending health care dollars more wisely, it will share in the savings it achieves for the Medicare program.
- Medicare Shared Savings Program
- Advance Payment ACO Model
- Pioneer ACO Model (2012-4)
ACO growth across the U.S. from 2011-2015

Estimated % population in an ACO March 31, 2015

Almost no correlation between overall quality scores and savings among the MSSP ACOs.

Unlike the Pioneer Program in which average shared savings per ACO increased year to year, average shared savings for MSSP ACOs declined from first to second years, from nearly $6 million in 2013 to $4 million in 2014.

McClellan, Kocot, White Health Affairs Blog 11/5/15
How have ACOs performed

Exhibit 4. Average ACO Savings in States with At Least 5 MSSP Participants

McClellan, Kocot, White Health Affairs Blog 1/20/15
Pioneer ACO performance

Average savings per ACO and quality score increasing over time for Pioneer ACOs, leading to increase in total savings per year despite decline in participating ACOs.

Losses of ACOs declined with some Pioneer ACOs leaving, while savings relative to benchmark increased slightly. Possibility of shared losses relative to benchmarks--driving factor for some ACOs exit the program, with remaining ACOs increasingly likely to achieve savings relative to benchmarks.

McClellan, Kocot, White Health Affairs Blog 11/5/15
MSSP performance

Exhibit 2: Quality Measures Differentiating MSSP Organizations With And Without Savings

<table>
<thead>
<tr>
<th>Quality Domain/Measure</th>
<th>Savings</th>
<th>No Savings</th>
<th>p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient and Caregiver Experience</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Health Promotion, Education</td>
<td>58.9 ± 0.40</td>
<td>58.1 ± 0.23</td>
<td>0.06</td>
</tr>
<tr>
<td>Health, Functional Status</td>
<td>70.6 ± 0.30</td>
<td>71.3 ± 0.14</td>
<td>0.02</td>
</tr>
<tr>
<td>Care Coordination</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>ASC Admissions: COPD, Asthma</td>
<td>1.2 ± 0.05</td>
<td>1.1 ± 0.02</td>
<td>0.05</td>
</tr>
<tr>
<td>% EHR Incentive</td>
<td>72.8 ± 2.24</td>
<td>78.2 ± 1.10</td>
<td>0.03</td>
</tr>
<tr>
<td>Preventive Health</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Adult wt, screen, follow-up</td>
<td>71.5 ± 1.61</td>
<td>65.6 ± 1.02</td>
<td>0.01</td>
</tr>
<tr>
<td>Tobacco use, intervention</td>
<td>89.0 ± 0.98</td>
<td>86.3 ± 0.98</td>
<td>0.06</td>
</tr>
<tr>
<td>Depression screen</td>
<td>43.7 ± 2.41</td>
<td>38.2 ± 1.47</td>
<td>0.05</td>
</tr>
<tr>
<td>At-Risk Population</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>DM: LDL &lt;100 mg/dL</td>
<td>59.0 ± 0.98</td>
<td>56.4 ± 0.66</td>
<td>0.04</td>
</tr>
<tr>
<td>HTN: BP &lt;140/90</td>
<td>69.7 ± 0.88</td>
<td>67.9 ± 0.58</td>
<td>0.09</td>
</tr>
<tr>
<td>IVD: Lipid profile and LDL &lt;100 gm/dL</td>
<td>60.2 ± 1.08</td>
<td>57.0 ± 0.71</td>
<td>0.02</td>
</tr>
<tr>
<td>CAD: Rx for LDL</td>
<td>77.9 ± 1.27</td>
<td>72.9 ± 1.10</td>
<td>&lt;0.01</td>
</tr>
<tr>
<td>CAD: ACEi, ARB for CAD, DM, &amp;/or LVSD</td>
<td>77.6 ± 1.04</td>
<td>75.0 ± 0.77</td>
<td>0.05</td>
</tr>
<tr>
<td>CAD Composite</td>
<td>70.8 ± 1.34</td>
<td>65.5 ± 1.08</td>
<td>&lt;0.01</td>
</tr>
</tbody>
</table>

Mean and standard error of mean are shown for the 92 ACOs that received savings and the 241 ACOs that did not receive savings.

ACOs reporting a zero or a missing value on any quality measure were excluded from calculating the statistics for that measure.

ACS=Ambulatory Care Sensitive; COPD=chronic obstructive pulmonary disease; wt=weight; DM=diabetes mellitus; LDL=low density lipoprotein cholesterol; HTN=hypertension; BP=blood pressure; IVD=insulin dependent vascular disease; CAD=coronary artery disease; Rx=pharmacotherapy; ACEI=angiotensin converting enzyme inhibitor; ARB=angiotensin receptor blocker; LVSD=left ventricular systolic dysfunction; CAD composite=Drug therapy for lowering LDL plus drug therapy for patients with CAD and DM and/or LVSD

Per-member benchmark, accounted for nearly 1/3 (31%) of variance in savings generated. Remaining variables: pt’s rating of doctor (inverse relationship), BP control DM, assigned beneficiaries (inverse relationship), health status/functional status (inverse relationship), LDL cholesterol control DM, & CAD composite score (inverse relationship). These 8 factors accounted for almost 60% of variance in savings per member.
How have ACOs performed

Savings concentrated among 86 successful ACOs: 5 ACOs earned > $60 million shared savings; 30 earned > $200 million. Physician-based ACOs did better than hospital-based ACOs, and those with a federally qualified health center (FQHC) or a rural health clinic (RHC) performed better still.

The number of beneficiaries served in successful ACOs was not a determining factor.

Intracoso and Berger Health Affairs Blog 2015
Next Gen ACO

• New Medicare ACO model introduced by CMS in March 2015
• Offers participants higher risk, reward than available in MSSP\(^1\), Pioneer ACO
• Provider requirements:
  – At least 10,000 Medicare beneficiaries aligned to ACO (7,500 for providers in rural areas\(^2\))
  – Majority of ACO’s patients covered under outcomes-based contracts by end of first PY\(^3\)
  – Simultaneous participation in NextGen and Pioneer ACO, MSSP, prohibited

Key Differences From Existing Medicare ACO Models (MSSP, Pioneer)

1. Higher levels of risk, reward
2. Upgraded benchmark calculation
3. Expanded payment arrangement options
4. Three new benefit enhancement waivers
5. Enhanced attribution methodology, patient engagement
6. Greater control of provider network

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1) Medicare Shared Savings Program.
2) ACO is considered rural if any of its primary service areas are located in a rural county. All counties that are not designated as parts of Metropolitan Areas (MAs) by the Office of Management and Budget (OMB) are considered rural counties.
3) Performance Year.

Source: Centers for Medicare and Medicaid Services, "Next Generation ACO Model Fact Sheets," March 10, 2015; Advisory Board Company interviews and analysis.
ACO’s: the Eye of the Beholder

- **An IPA**: better coordinated care, not integration
- **A medical group**: integration for employed physicians, not affiliates
- **A hospital system**: developing an equal partnership between physicians and hospital
- **An integrated delivery system**: culture change, not structural change

### Evidence based care improvement tactics

<table>
<thead>
<tr>
<th>Access to care</th>
<th>Primary Care</th>
<th>Specialty Care</th>
<th>Hospital Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient portal/physician portal</td>
<td></td>
<td></td>
<td>Access program</td>
</tr>
<tr>
<td>Extended hours/same day appointments</td>
<td></td>
<td></td>
<td>Reduced low acuity admissions</td>
</tr>
<tr>
<td>Expand virtual visit options</td>
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</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Design of care</th>
<th>Primary Care</th>
<th>Specialty Care</th>
<th>Hospital Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Defined process standards in priority conditions (multidisciplinary teams)</td>
<td></td>
<td></td>
<td>Re-admissions</td>
</tr>
<tr>
<td>High risk care management</td>
<td>Shared decision making</td>
<td></td>
<td>Hospital Acquired Conditions</td>
</tr>
<tr>
<td>100% preventive services</td>
<td>Appropriateness</td>
<td></td>
<td>Hand-off and continuity programs</td>
</tr>
<tr>
<td>Chronic condition management</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Measurement</th>
<th>Primary Care</th>
<th>Specialty Care</th>
<th>Hospital Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>EHR with decision support and order entry</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Variance reporting/performance dashboards</td>
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<td></td>
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<tr>
<td>Quality metrics: clinical outcomes, satisfaction</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Incentive programs</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Costs/population</td>
<td></td>
<td></td>
<td>Costs/episode</td>
</tr>
</tbody>
</table>

Care that delivers more

- What about care delivered outside of the formal medical enterprise, e.g. in the home?
- What about social determinants of health?

<table>
<thead>
<tr>
<th>WHAT DETERMINES HEALTH?</th>
</tr>
</thead>
<tbody>
<tr>
<td>GENETICS</td>
</tr>
<tr>
<td>20%</td>
</tr>
</tbody>
</table>

Taylor et al. BlueCross Foundation, 2015

- Housing support
- Early childhood education
- Case management
- Nutritional assistance

- What about behavioral health integrated into care
  - A Family Guide Integrating Mental Health and Pediatric Primary Care
  - IMPACT (Improving Mood—Providing Access to Collaborative Treatment)
  - Cherokee Health Systems
  - DIAMOND (Depression Improvement Across Minnesota Offering A New Direction)
  - Vermont Blueprint for Health
  - Massachusetts Child Psychiatry Access Project (MCPAP)
  - Integrated Behavioral Health Project (IBHP)
“Clinically Integrated Network”
- Provider network
- The “team” for clinical integration

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Effective Care Communities
Classic chronic care model (Wagner)

Community Care NC care model for high risk patients
## Moving to managing a population

<table>
<thead>
<tr>
<th>Trend Drivers</th>
<th>PHM Program</th>
<th>Cost of Program</th>
<th>Potential Impact on Trend</th>
</tr>
</thead>
<tbody>
<tr>
<td>Care delivered in primary care settings can be more efficient (depending on clinical issues).</td>
<td>Patient-Centered Medical Home (PCMH)</td>
<td>$$</td>
<td>+</td>
</tr>
<tr>
<td>Expenses are concentrated in a small % of patients with multiple chronic conditions.</td>
<td>Intensive Care Management Program (iCMP)</td>
<td>$$$</td>
<td>+ + ++ ++ ++ ++ ++</td>
</tr>
<tr>
<td>Mental/Behavioral health problems increase the costs of patients with chronic illness 3-5x.</td>
<td>Depression – Consultation, Assistance with Resources and Education (D-CARE)</td>
<td>$</td>
<td>++ ++ ++ ++ ++ ++</td>
</tr>
<tr>
<td></td>
<td>Collaborative Care for Depression (e.g. IMPACT model)</td>
<td>$$</td>
<td>++ ++ ++ ++ ++ ++</td>
</tr>
<tr>
<td></td>
<td>Internet Cognitive Behavioral Therapy (iCBT)</td>
<td>$</td>
<td>+ + + + + +</td>
</tr>
<tr>
<td>Specialty visits and services are the largest fraction of costs in commercial population.</td>
<td>eConsults</td>
<td>$</td>
<td>++ + + + +</td>
</tr>
<tr>
<td></td>
<td>Virtual Visits (Synchronous &amp; Asynchronous)</td>
<td>$$</td>
<td>++ ++ ++ ++ ++</td>
</tr>
<tr>
<td>Large variation in visit rates, testing rates, procedure rates among specialists.</td>
<td>Variation reporting</td>
<td>$</td>
<td>++ ++ ++ ++ ++</td>
</tr>
<tr>
<td></td>
<td>Procedure Decision Support (PrOE)</td>
<td>$$</td>
<td>+ + + + + +</td>
</tr>
<tr>
<td>Demonstrating the value of our specialists requires metrics that are sensitive to clinical issues.</td>
<td>Patient Reported Outcome Measures (PROMs)</td>
<td>$</td>
<td>n/a n/a n/a n/a</td>
</tr>
</tbody>
</table>

*Adapted from Ferris 2016*
## Moving to managing a population

<table>
<thead>
<tr>
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</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Care Continuum</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patients frequently seek care in Emergency Departments because they do not have alternatives.</td>
<td>Congestive Heart Failure (CHF) Tele-monitoring</td>
<td>$$</td>
<td>+</td>
</tr>
<tr>
<td>Mobile Observation Unit</td>
<td>$$</td>
<td>+</td>
<td>+++</td>
</tr>
<tr>
<td>Patients in the Northeast are more likely to use post-acute care than any other region in the US.</td>
<td>SNF 3 Day Waiver and SNF Collaborative</td>
<td>$</td>
<td>+</td>
</tr>
<tr>
<td>More than 50% of the variation in cost of Medicare beneficiaries is in the use of post-acute.</td>
<td>iCMP Palliative Care</td>
<td>$$</td>
<td>+</td>
</tr>
<tr>
<td>Patients at the end of life often experience uncoordinated care that is inconsistent with their wishes, resulting in non-beneficial treatments and unnecessary costs.</td>
<td>Physician Payment for Goals of Care Conversation</td>
<td>$</td>
<td>+</td>
</tr>
<tr>
<td><strong>Patient Engagement</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Keeping care within your system is better care (continuity) and fiscally prudent.</td>
<td>Shared Decision Making</td>
<td>$</td>
<td>+</td>
</tr>
<tr>
<td>Primary Care Office Insight (resource library of patient education materials)</td>
<td>$</td>
<td>+</td>
<td>+</td>
</tr>
<tr>
<td>Patient Engagement Videos</td>
<td>$</td>
<td>+</td>
<td>+</td>
</tr>
<tr>
<td>Virtual Patient Communities</td>
<td>$</td>
<td>+</td>
<td>+</td>
</tr>
</tbody>
</table>

Adapted from Ferris 2016
Building Blocks Community Health Care Management System

Community population-based needs assessment

Identification of community assets, capabilities, and resource requirement

Alignment of service providers, managers, and governance within and across medical, health, and community sectors

Knowledge about desired end states

Results

Strategies, action plans

Continuous quality improvement

Capability Wheel

Community Health Assets

Community
A group of individuals with sense of shared space, responsibilities, and perceived interdependence

Population-Based Health Continuum Goal: Creating Chronically Well

Chronically well  Sporadically well  Sporadically ill  Chronically ill

Education  Healthcare Delivery System  Religious Organization  Physical and Social Environment  Housing  Jobs  Family Support Services

Thank you