Four Phases to Population Health Maturity

How Care Delivery Models Evolve With Each Phase

Meet the speakers

Children's Health
Pediatric Health System

Make life better for children. Not-for-profit hospital system serving North Texas families for >100 years.

Karen Kennedy
Sr. VP Family Health Network

"Focusing on family care and wellness to improve kids' health and well being."

Stephanie Copeland, M.D.
Chief Quality Officer

"I am a part of each patient's family, and they are a part of mine. Isn't that what medicine is all about?"

USMD Health System
Medical System

The patient's best interest isn't a factor. It's the only factor. Patient-focused health care home serving DFW.

The agenda

1 Get to know it

2 Take a deep dive

3 See it in action

4 Let's discuss it

The foundation

Pre-PHM

Strictly fee-for-service. Care is largely episodic, and payers pressure for cost reduction.

Pilot

Organization articulates commitment to PHM. Evaluating readiness, capabilities, requirements. Laser focus on portion of patient / member population.

Care programs

More variety in shared savings contracts. More budget for competencies. Marketing pop health successes inside and outside the organization.

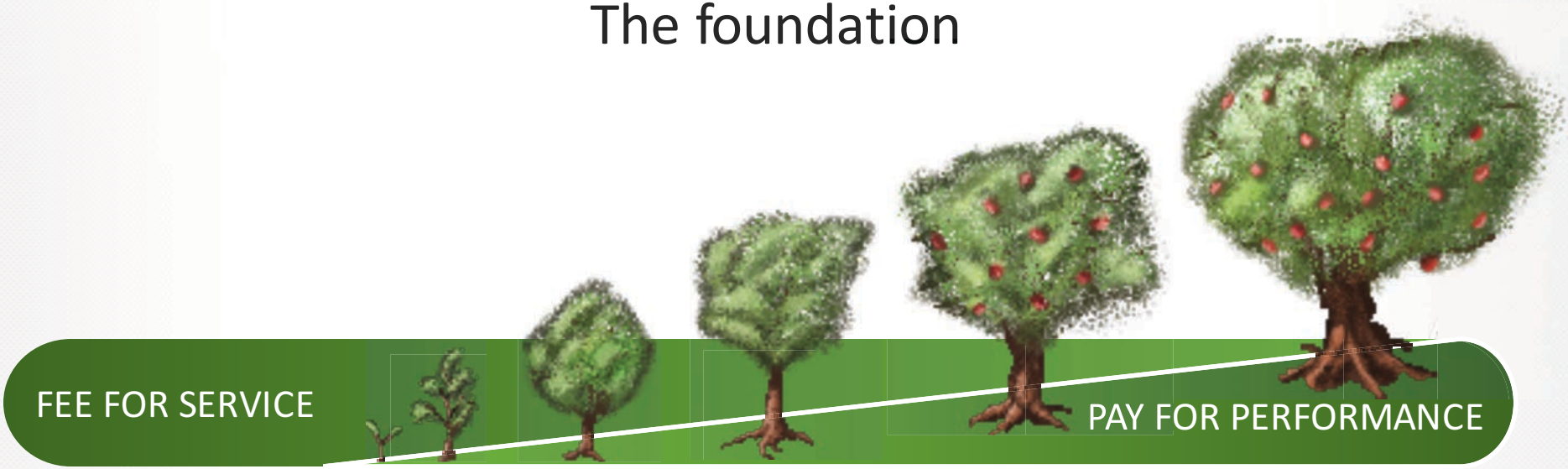
Provider-driven services

Pop health management becomes payer agnostic. Laser focus on provider accountability and metrics. Collaborative care as differentiator. Process standardization.

Patient engagement

PHM and 24x7x365 patient engagement are standard competencies. Continuum of care includes medical resources and facilities, schools, employers, and community services.

The foundation



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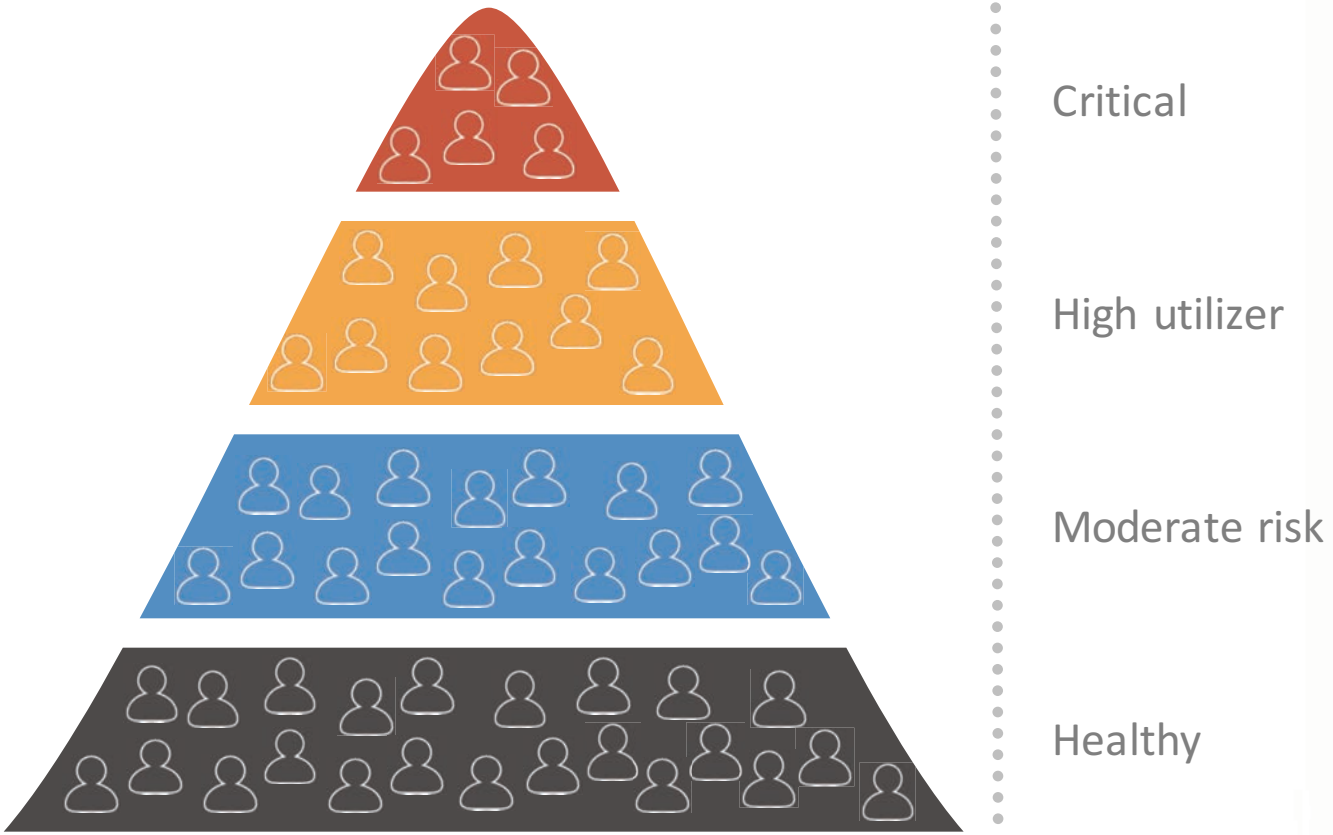
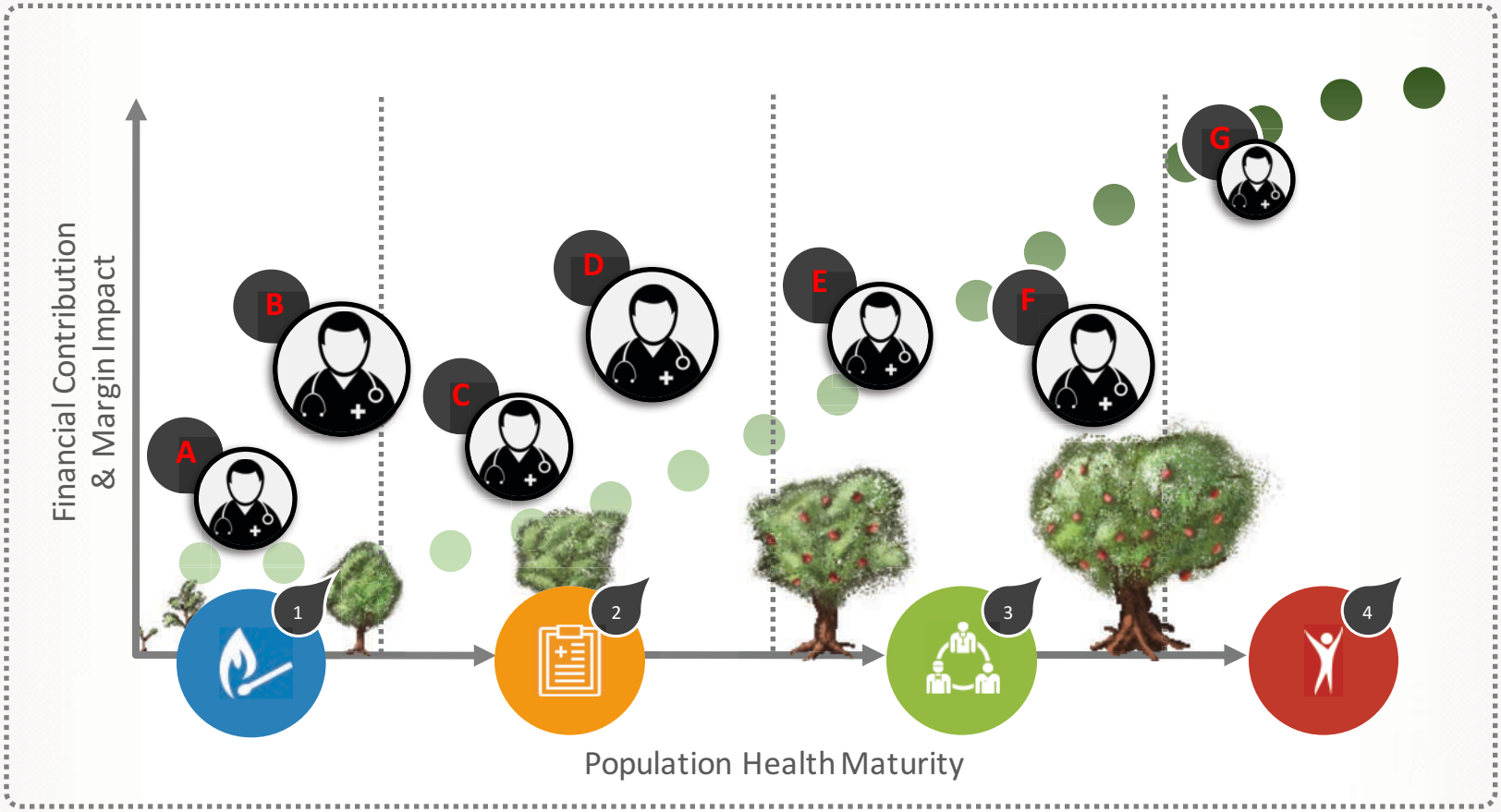
Payers' risk stratification based only on claims

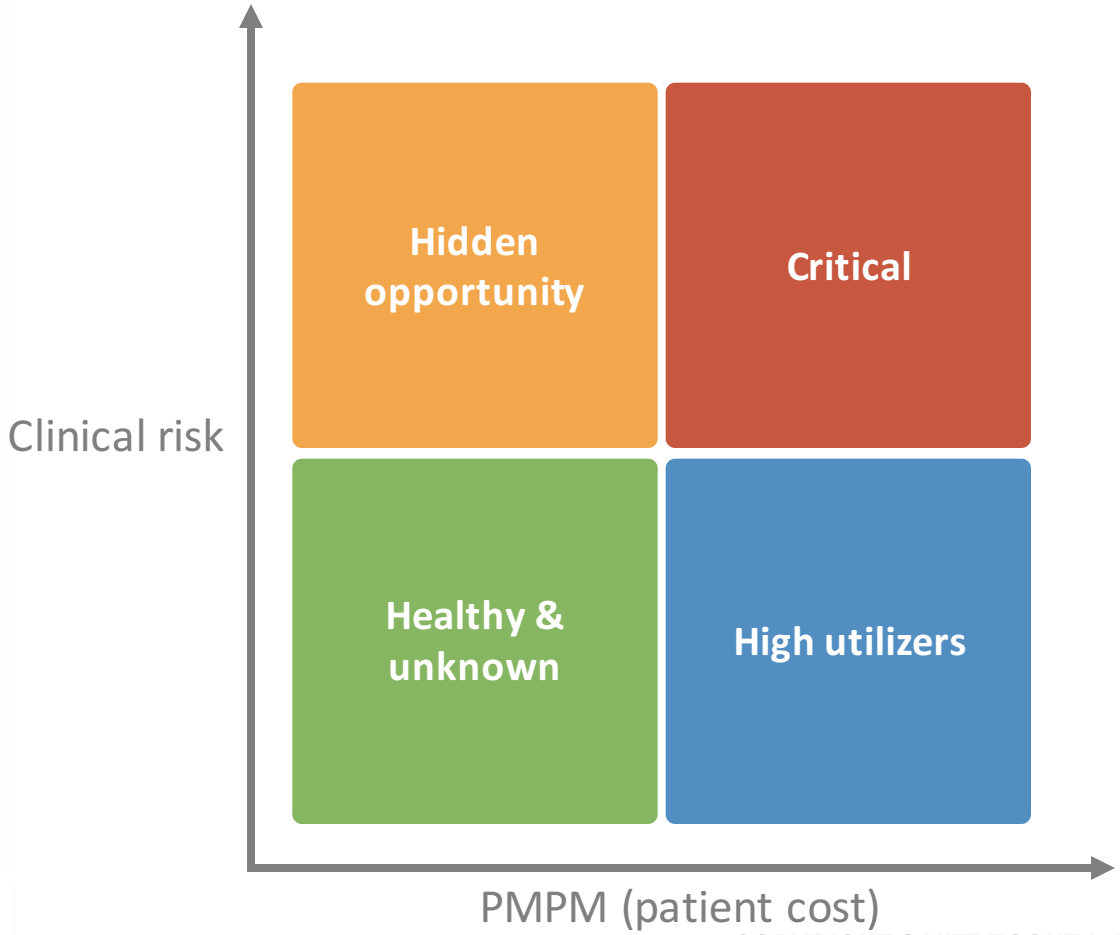


Growth factors

Where are you?



Fresh perspective on stratification



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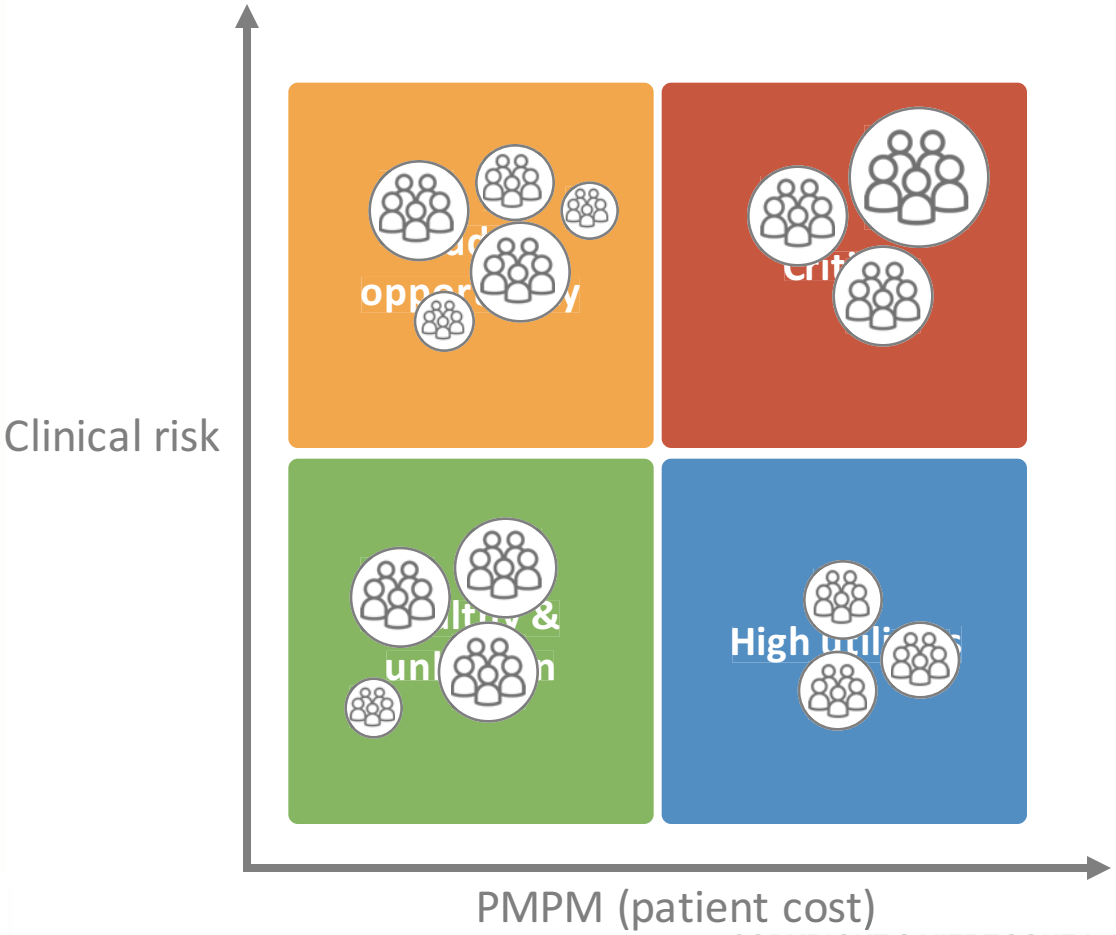

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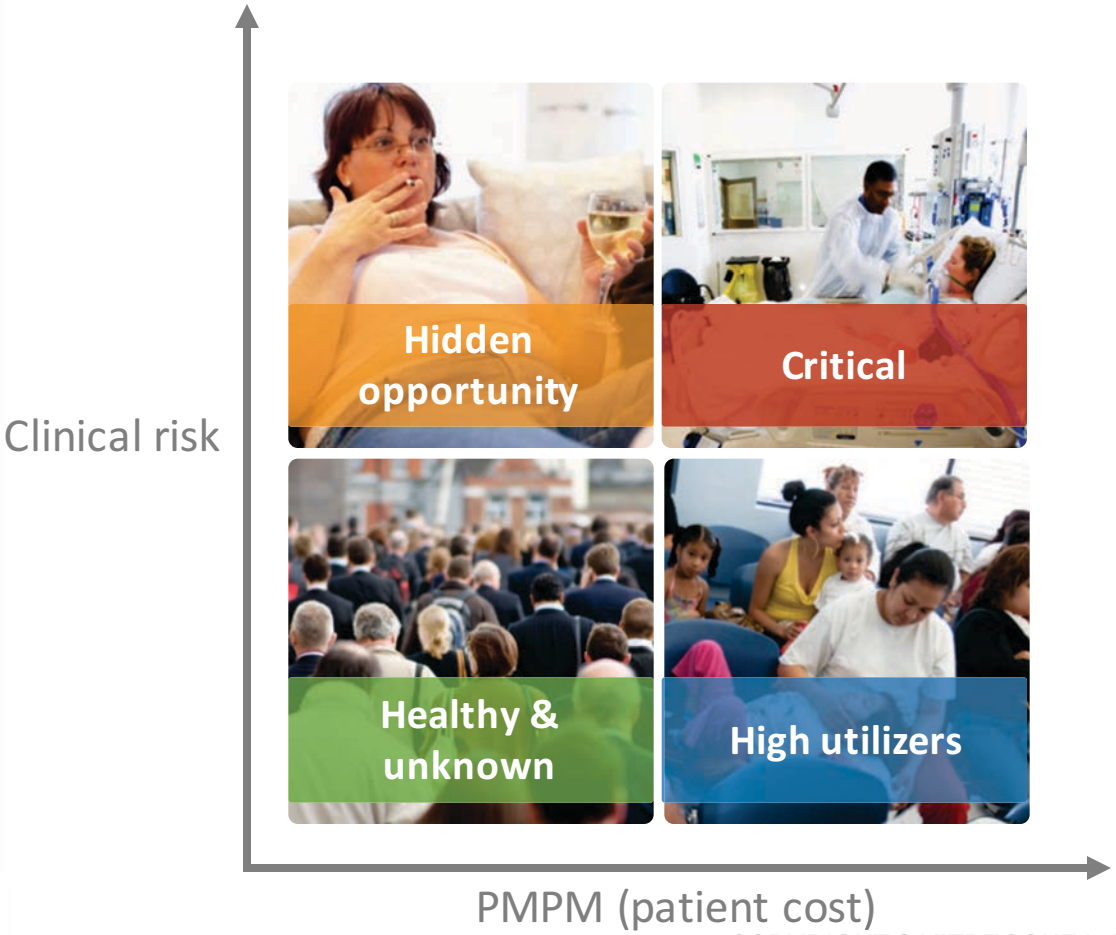


Dimensions of competency and challenges

Pre-PHM

(PHASE 0)

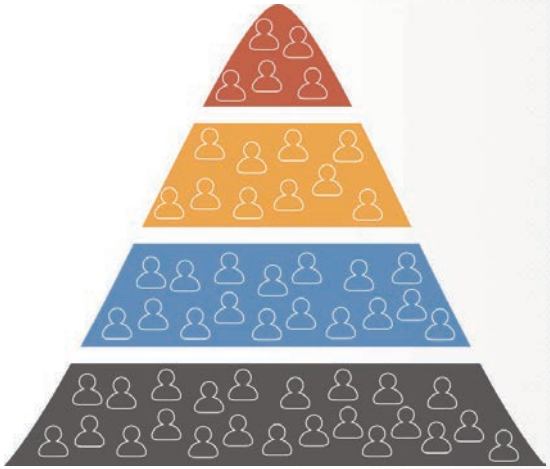
0

Leadership

Volume, volume, volume

100% fee-for-service

Network leakage, referral management



Pre-PHM

(PHASE 0)

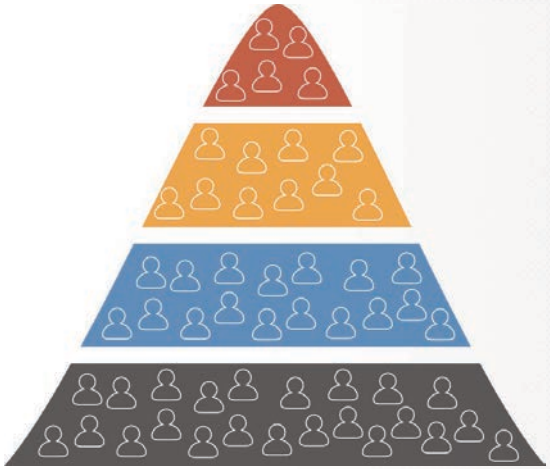
0

Clinical delivery model

Care largely episodic

Lists from payers

Very low staffing ratios



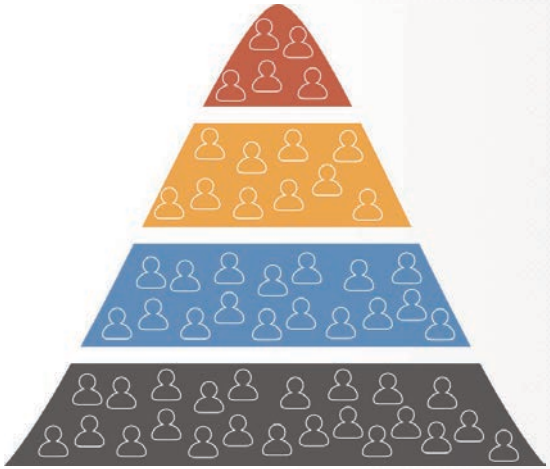
Pre-PHM

(PHASE 0)

Data analytics

Coding to maximize revenue

Overhead costs



Pre-PHM

(PHASE 0)

Physician alignment

Coding to maximize revenue

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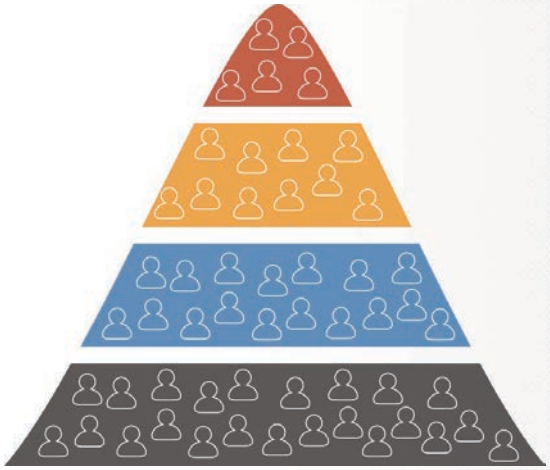


Pre-PHM

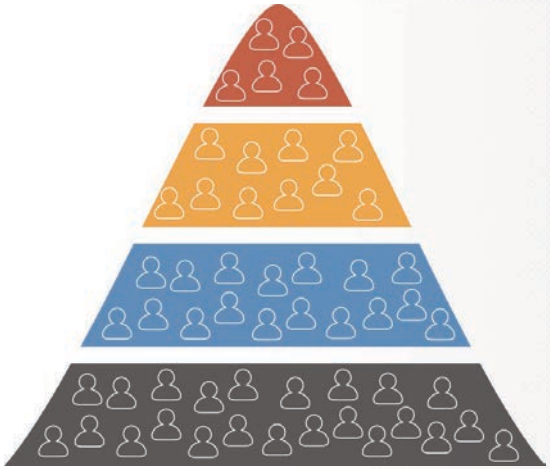
(PHASE 0)

0

Care management

Focus on cure

Minimal proactive CM



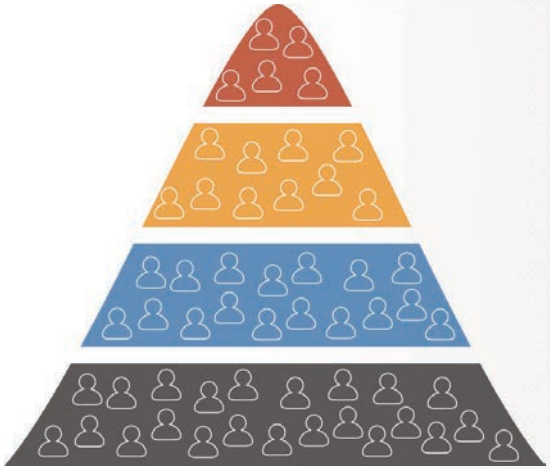
Pre-PHM

(PHASE 0)

Performance Metrics

appointments

new patients



Pilot
(PHASE 1)

Leadership

P4P vision

Population <10K

Negotiate for payer resources

Pilot

(PHASE 1)

Clinical delivery model

Little integration

Patient view ≠ 360°

Conflicting goals

Staffing ratios vary greatly

Pilot

(PHASE 1)

Data analytics

One or few data sources

Stratification based on payer perception

Quality reporting largely ad-hoc

Pilot

(PHASE 1)

Physician alignment

"Cost containment" message

Focus on screenings

Physician "blind" to metrics/data

Pilot

(PHASE 1)

Care management

Payer driven cohorts

Disease management

Focus on transitions-in-care

Pilot

(PHASE 1)

Performance Metrics

screenings, vaccinations, immunizations

Disease-specific lab results for cohorts

Care programs

(PHASE 2)

2

Leadership

Organize for standardized care

Inspire long-term focus

Greater appetite for risk

Care programs

(PHASE 2)

2

Clinical delivery model

Reimbursement models stand alone

Somewhat increased coordination

Public/semi-private HIE

Staffing ratios vary by payer type

Care programs

(PHASE 2)

Data analytics

Doing "more" with data, but not enough

Population cost/quality analytics

Add socio-economic data

Care programs

(PHASE 2)

2

Physician alignment

Patient starting to move toward center

Systems aid closing gaps in care

Proactive outreach as a process

Care programs

(PHASE 2)

2

Care management

Focus on processes

CM tends to be centralized

Adding high utilizers

Care programs

(PHASE 2)

2

Performance Metrics

Disparate quality metrics by payer

ER visits, admissions, quality, costs

Still measuring processes

Provider-driven services

(PHASE 3)

Leadership

Use PHM to entice self-insured employers

>30% population shared-risk

Inspire appetite for risk

Cultural transformation

Provider-driven services

(PHASE 3)

Clinical delivery model

Gaining momentum on objectives

Developing risk-sharing reimbursement

Move toward private HIE

Staffing ratio per risk

Provider-driven services

(PHASE 3)

3

Data analytics

Stratification by predictive analytics

EHR + claims + socio-economic

Collaborative care emerging

Physicians start aligning

Provider-driven services

(PHASE 3)

3

Physician alignment

Complete alignment

Providers accountable for care

Care delivery paradigm △

Provider-driven services

(PHASE 3)

3

Care management

Expand the care team outside “4 walls”

Pinpoint and address gaps in care

Predict high-cost episodes

Provider-driven services

(PHASE 3)

Performance Metrics

Standardize quality reporting across payers

PMPM, outcomes, patient satisfaction

Staff absenteeism

Patient engagement

(PHASE 4)

Leadership

Majority of population risk-managed

Collaborative, data-driven leadership

"Healthcare consumer"

Patient engagement

(PHASE 4)

4

Clinical delivery model

Patient/provider accountability aligned

Mastery of workflow, greater enjoyment

Decentralized CM

Patient engagement

(PHASE 4)

4

Data analytics

EHR + claims + socio-economic + household

Mobile and home health technologies

Closed-loop PHM analytics

Insights drive staffing ratios

Patient engagement

(PHASE 4)

4

Physician alignment

Integrated care across facilities and resources

Shared reimbursement on shared risk

Data w/360° view

Patient engagement

(PHASE 4)

4

Care management

Patient collaboration in care and wellness

Employer involvement in program design

Patient engagement

(PHASE 4)

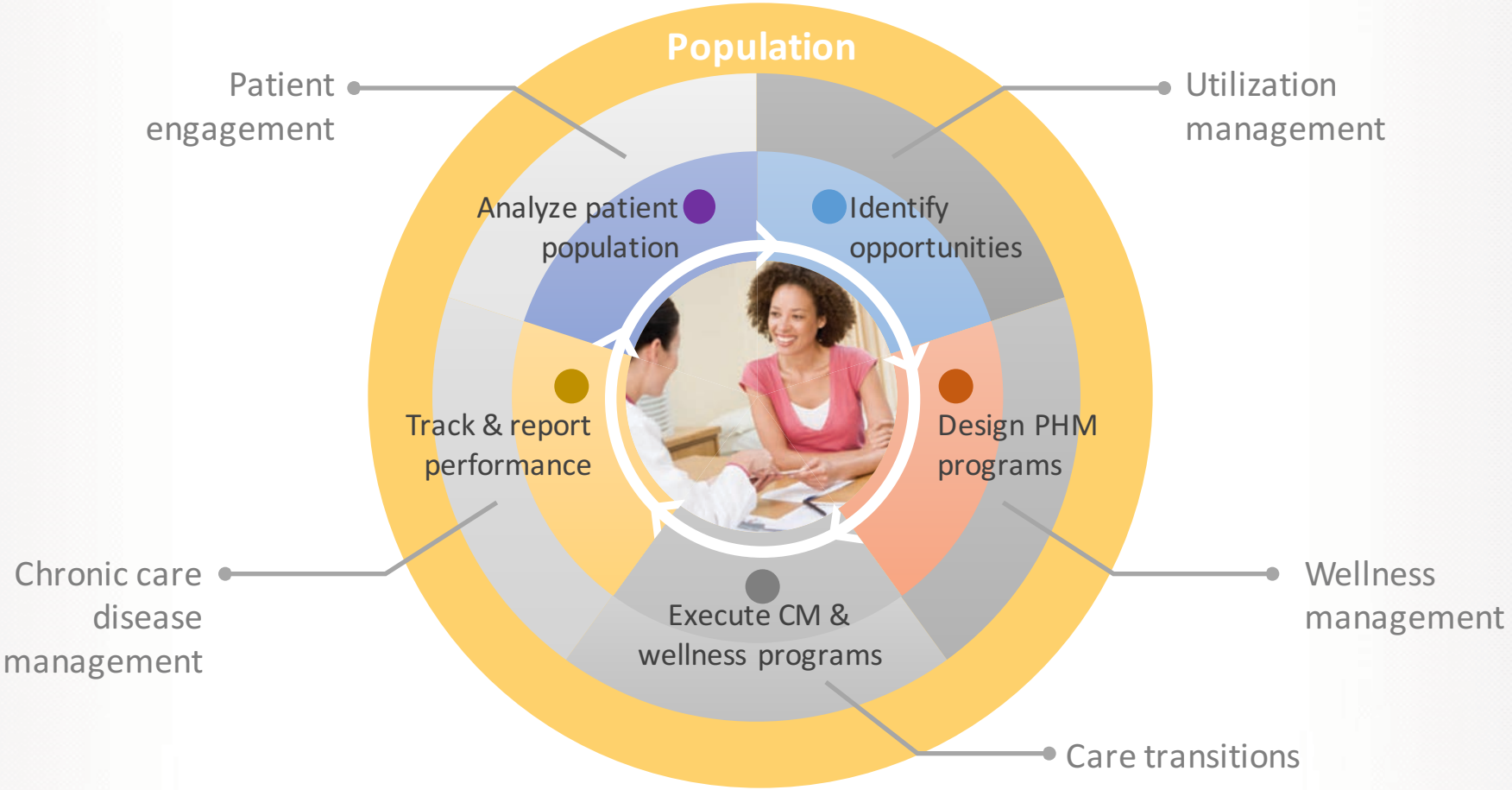
4

Performance Metrics

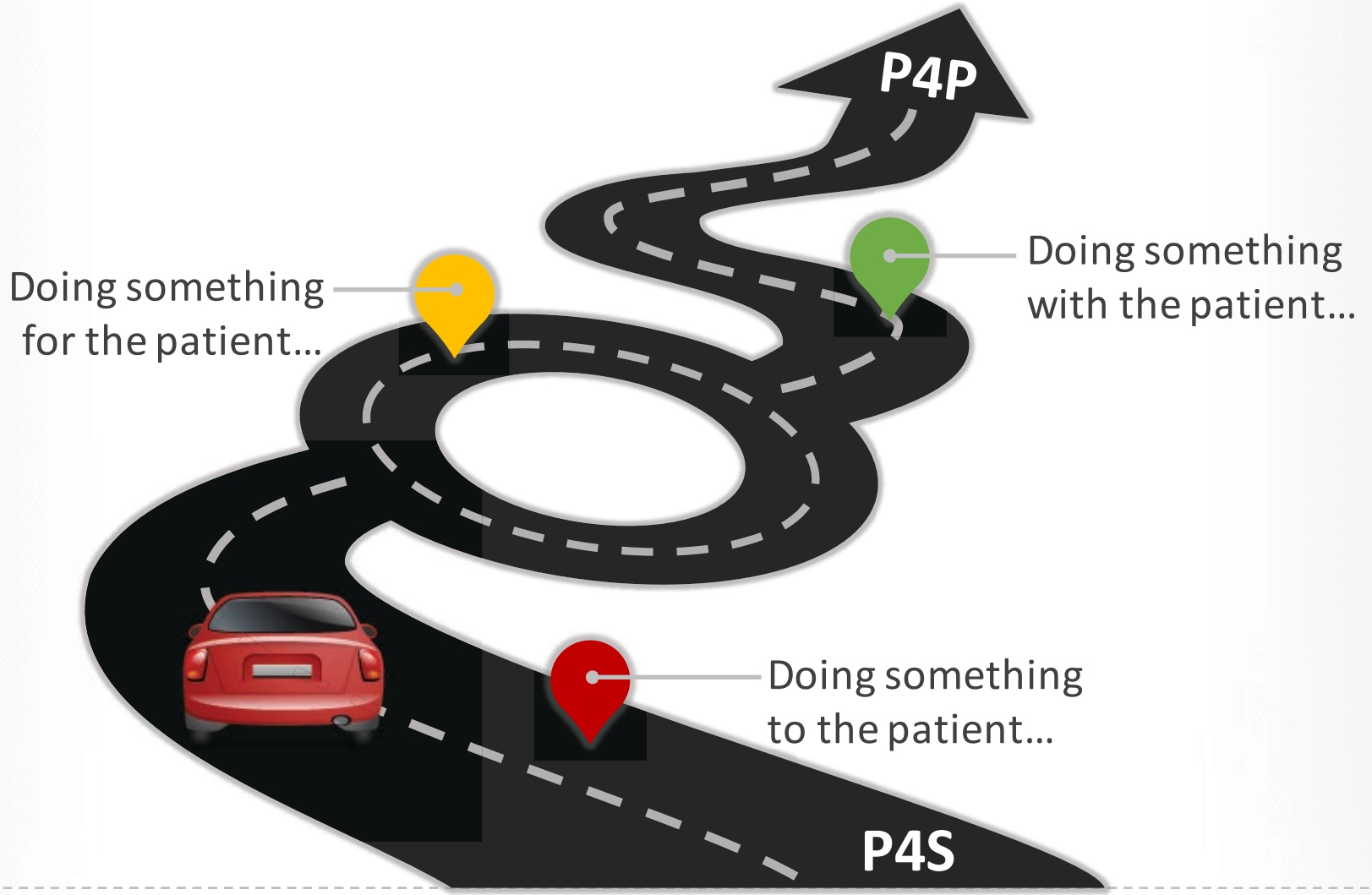
ROI on care programs

Performance against contracts

Closed loop population health execution



Patient experience as pop health matures



Meet Children's Health

773,547
Patient encounters*
Dallas, Legacy, Southlake

3
Campuses
Dallas, Legacy, Southlake

$24M
Charity care[2]
(cost basis)

5,926
Employees*

169,635
ER visits
2nd busiest among children's hospitals[2]

562
Licensed beds
6th largest pediatric hospital in U.S.[2]

$2,400M
Economic benefit[1]
(cost basis)

60%
Market share

29,155
Pediatric admissions
2nd most pediatric admissions in U.S.[2]

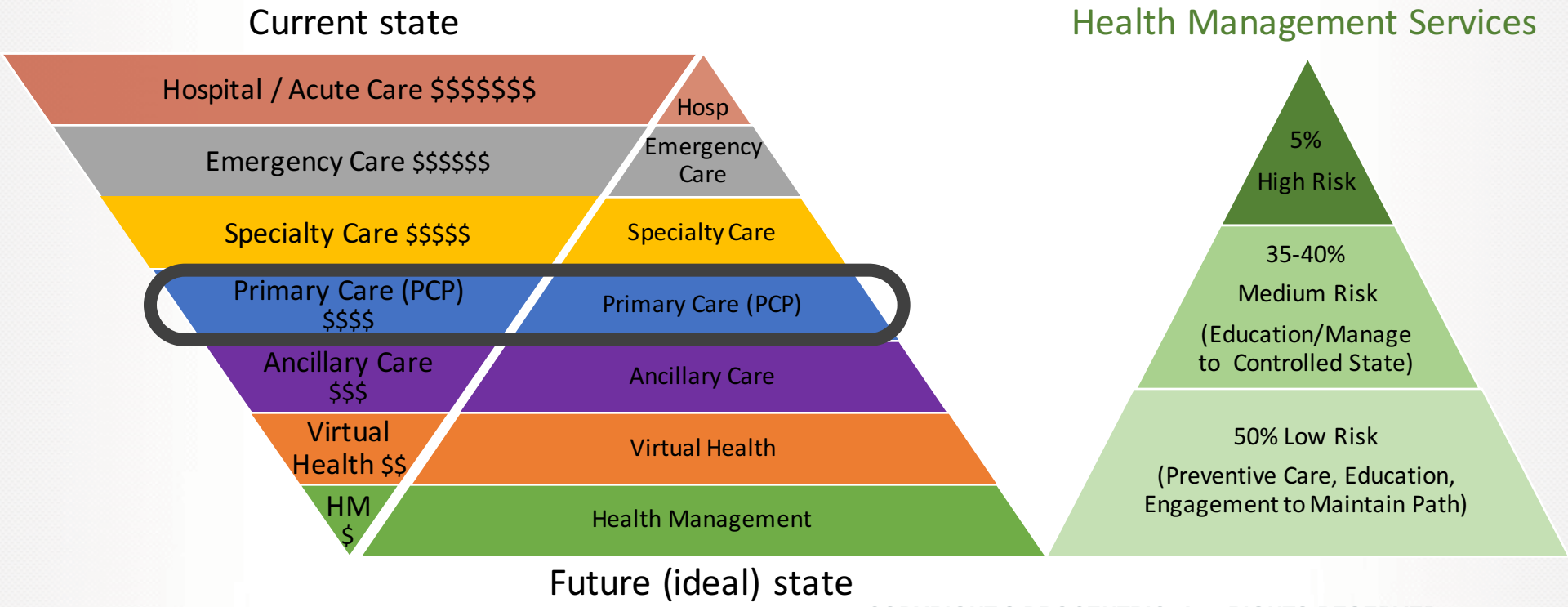
18
Children's Health Pediatric Group
Primary care clinic locations

$151M
Community benefits[2]
(cost basis)

[1]Based on 2012 data
[2]Based on 2013 data
**Operating statistics are projected for 2014*

Meet Children's Health

Location and delivery method of care matters



Care management risk-based model

- One chronic condition, controlled
- Newborns with prenatal care

- >1 chronic conditions
- Multiple medications
- Multiple physicians
- Hospital or ER visit
- Newborns with minimal prenatal care

- Uncontrolled chronic conditions
- No PCP
- Multiple hospital admissions or ER
- Newborns with no prenatal care

Care management strategies and programs

Low risk	Medium risk	High risk
• PCP • Patient / family education • Address gaps in care where necessary	• Patient / family target interventions • Disease-specific education • Coordination for gaps in care • TOC • Med management	• High touch coordination • Post discharge assessment and risk mitigation • High touch TOC • Med management

Model in action: Pediatric weight management program continuum

Partnered programs

Children's Health programs

Family navigator

Low risk
(normal weight, no comorbidities)

Moderate Risk

High risk
(overweight, comorbidities)

Cooking Classes
•Local chefs & teachers
•Chef Cassandra
•Kids in the Kitchen

Open Gym
Harry Stone Recreational Center

Planting Workshops
Paul Quinn College

Cooking Demos
Cooking Matters

Get Up & Go 9-Week Program
Partnering with YMCA of Dallas

Stand-Alone Nutrition Classes

4-, 6-, 8-Week Afterschool program

Parent Nutrition Classes

Type II Diabetes Prevention

Support Groups – Plano, Coppell, Moorland

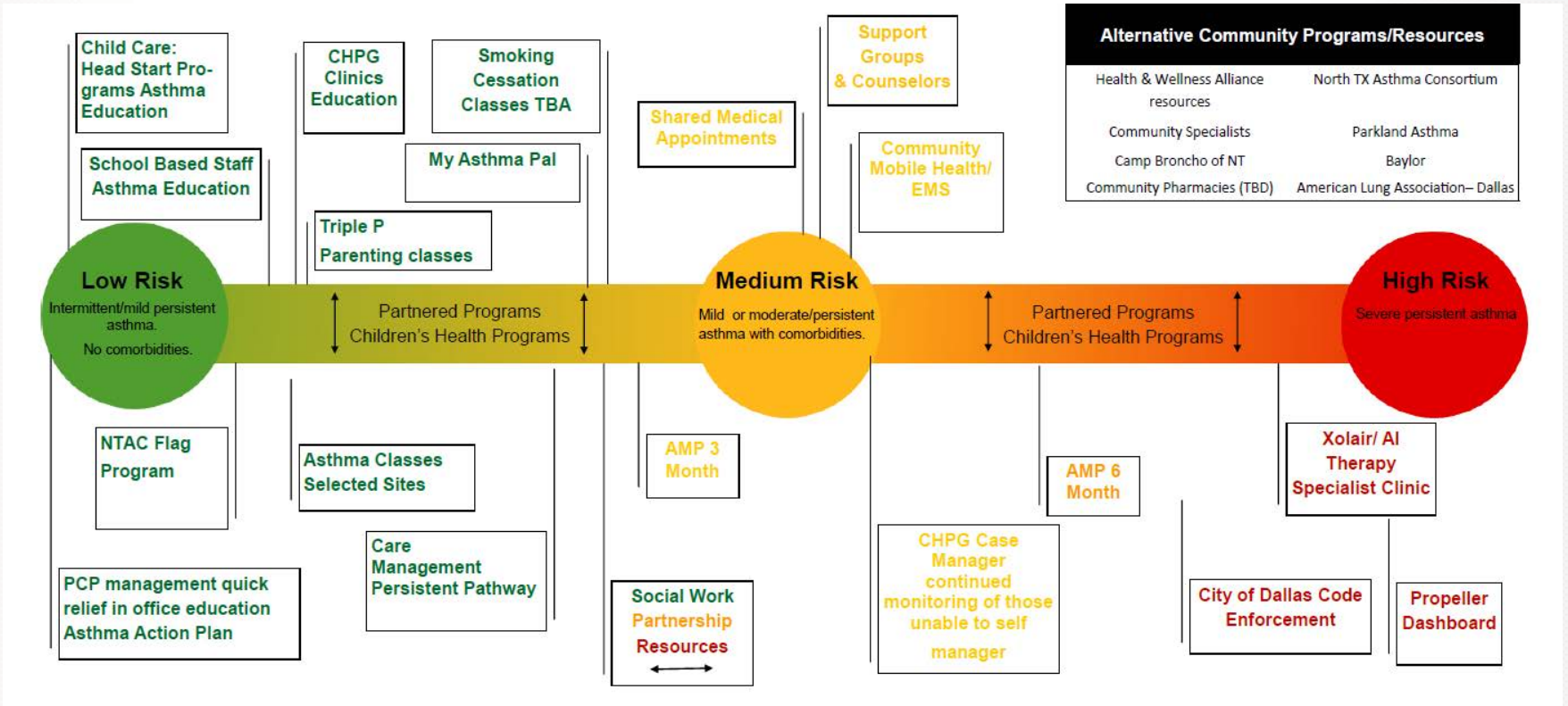
1:1 Dietitian Counseling

Shared Medical Appts

Eating Disorders Program

COACH Clinic

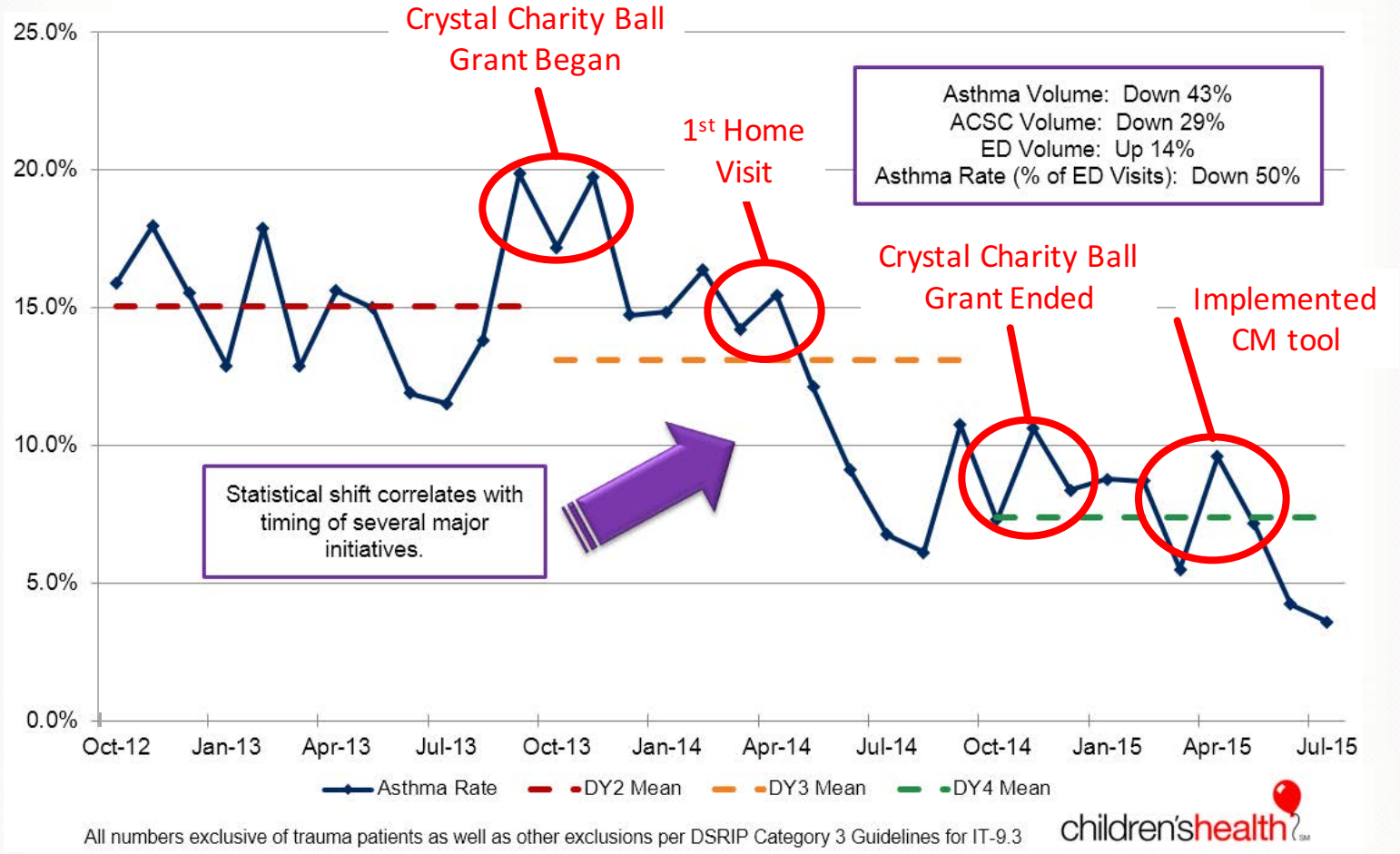
Program in action: asthma program continuum



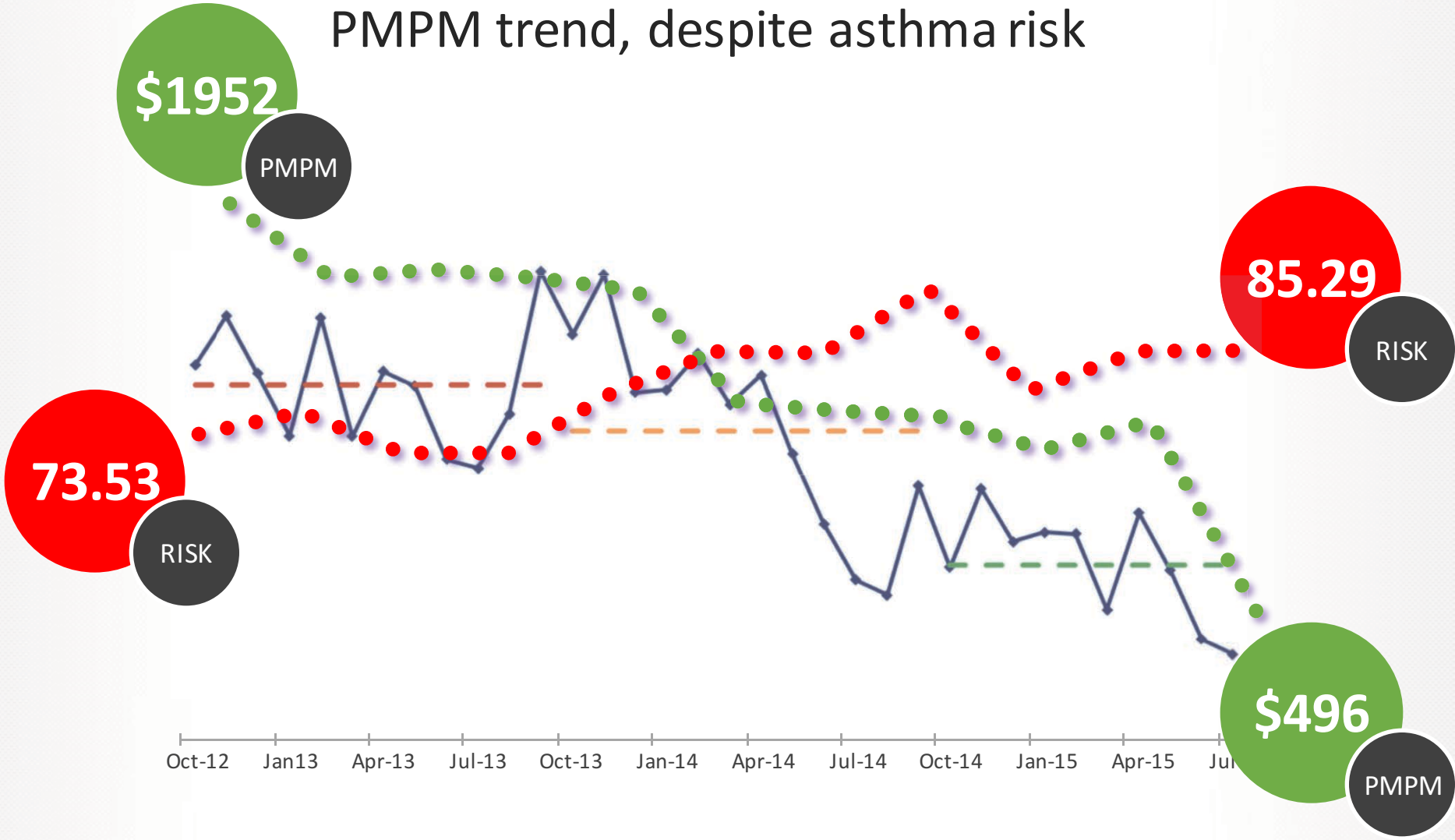
Family navigator

Care management

Asthma ED visit rates over time



PMPM trend, despite asthma risk



Maternal characteristics associated with low birth rate and preterm birth, Texas 2012

Opportunity to effect positive change with coordinated disease management, transitions of care, early clinical interventions and ongoing education…SMART HEALTH

Prenatal care and TOC for baby and mother

diabetes

maternal age

hypertension

low birth weight

late prenatal care

obese pregnancy

rural area

tobacco use

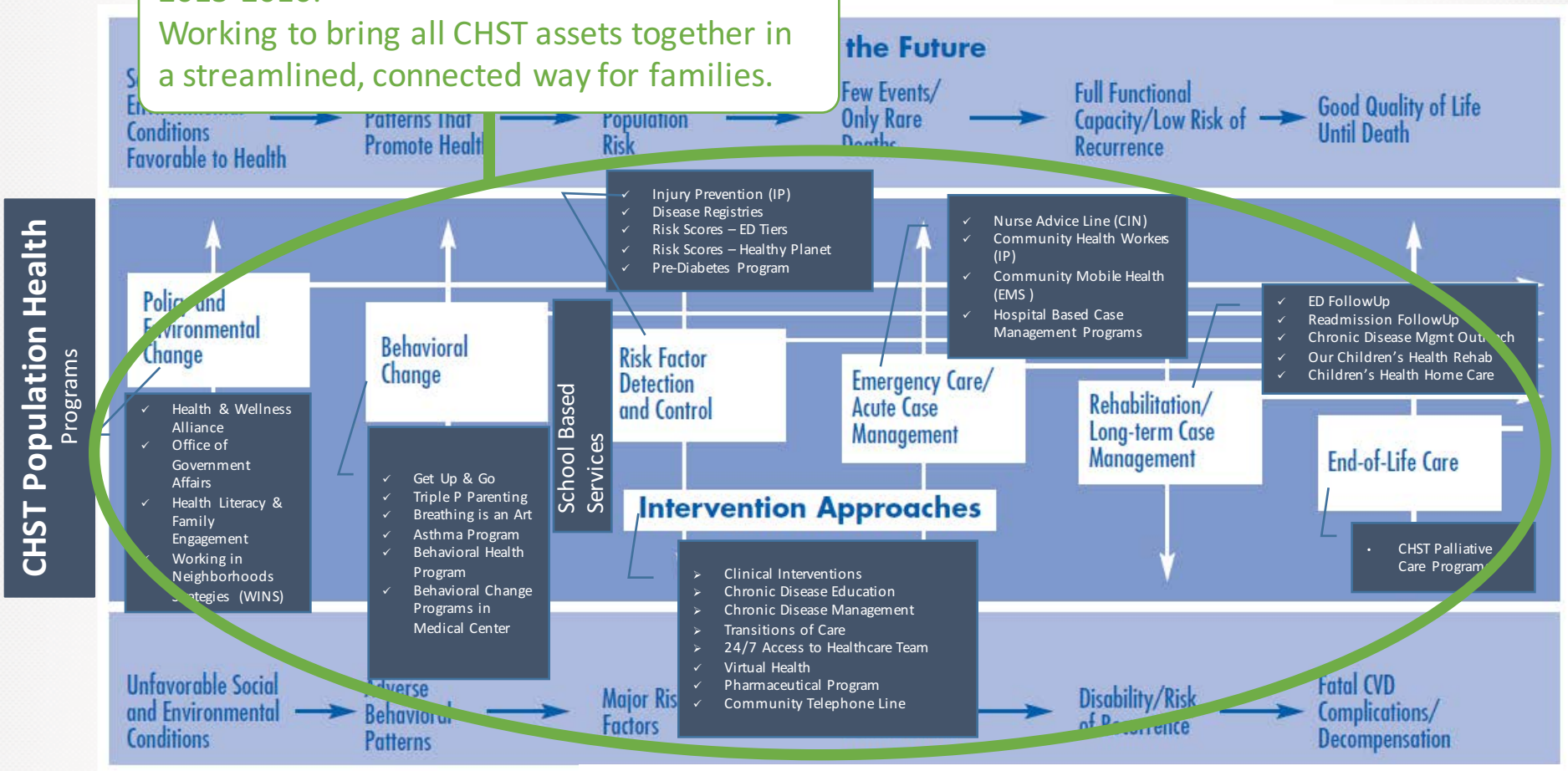
race

Medicaid

no prenatal care

Inventory of CHST Population Health Assets

2015-2016:
Working to bring all CHST assets together in a streamlined, connected way for families.



CDC – "A PUBLIC HEALTH ACTION PLAN TO PREVENT HEART DISEASE AND STROKE"
HTTP://WWW.CDC.GOV/DHDSP/ACTION_PLAN/PDFS/ACTION_PLAN_FULL.PDF

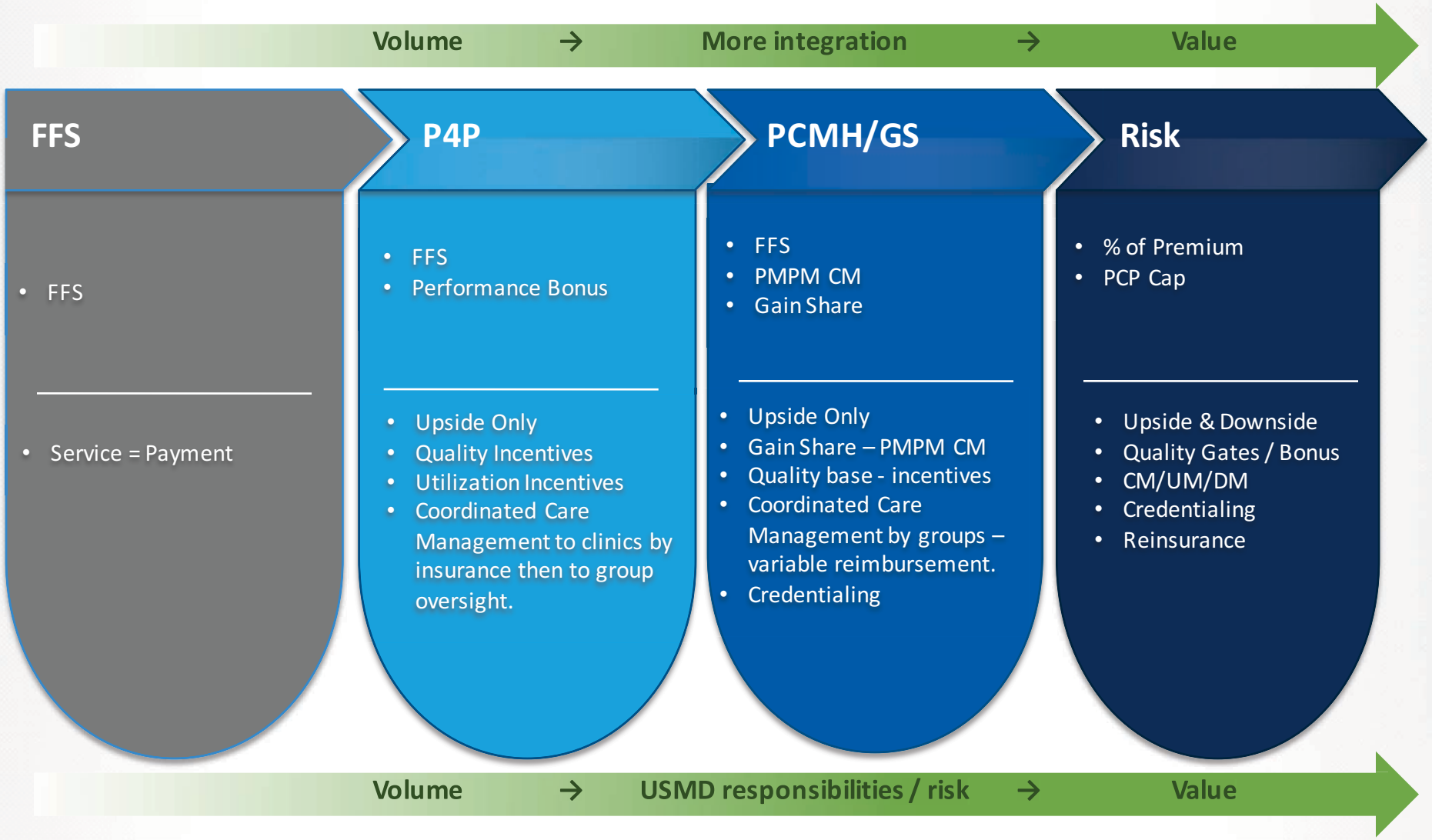
Meet USMD

We didn't just connect the docs.

We **united** them.

95%	5%	20%	-48%	-17%
FFS (including SSP/GS) MSSP ACO, PCMH	Full risk MA	FFS At risk for quality care	Regional 2014 MSSP ACO results	National 2014 MSSP ACO results

Our journey


Volume → More integration → Value
FFS
P4P
PCMH/GS
Risk
• FFS
• Service = Payment
• FFS
• Performance Bonus
• Upside Only
• Quality Incentives
• Utilization Incentives
• Coordinated Care Management to clinics by insurance then to group oversight.
• FFS
• PMPM CM
• Gain Share
• Upside Only
• Gain Share – PMPM CM
• Quality base - incentives
• Coordinated Care Management by groups – variable reimbursement.
• Credentialing
• % of Premium
• PCP Cap
• Upside & Downside
• Quality Gates / Bonus
• CM/UM/DM
• Credentialing
• Reinsurance
Volume → USMD responsibilities / risk → Value

Care process improvements

Resource mix and distribution	Communication	Collaboration
		
Decentralized care management nurses; added health coaches	Patient care conferences / HC program	Redesigned specialist / PCP interaction

Care management team

Site health coaches

Central social workers

Central and site RN case managers, central LVNs

Central quality team MAs

Transition of care program (TOC)

Meet “Joe”

You Decide: What will impact Joe the most?

Meds Education

More education on diabetes medications

Learn Disease Consequences

Understand how high blood sugar creates end organ damage

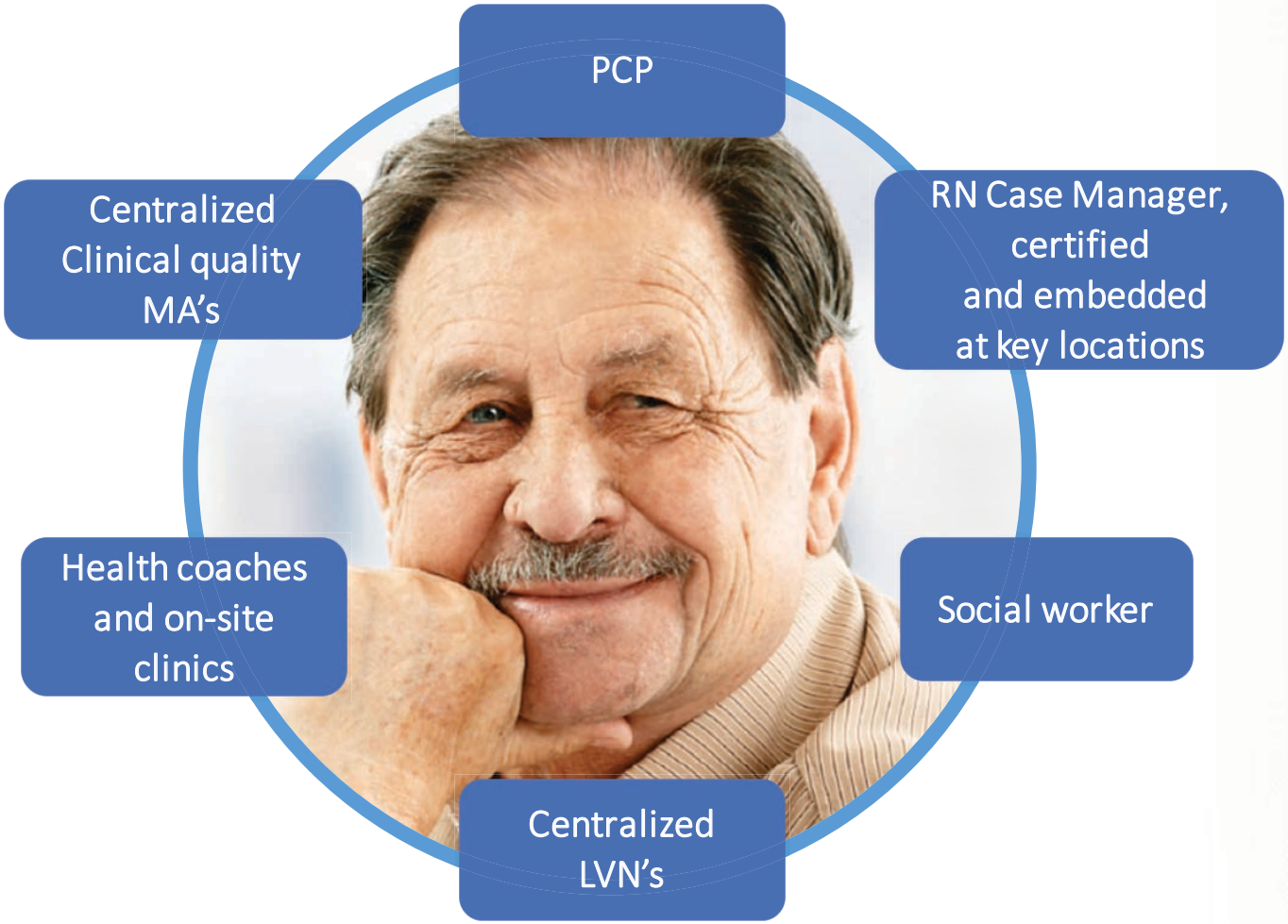
Financial & Behavioral Help

Receive assistance with financial and mental health needs

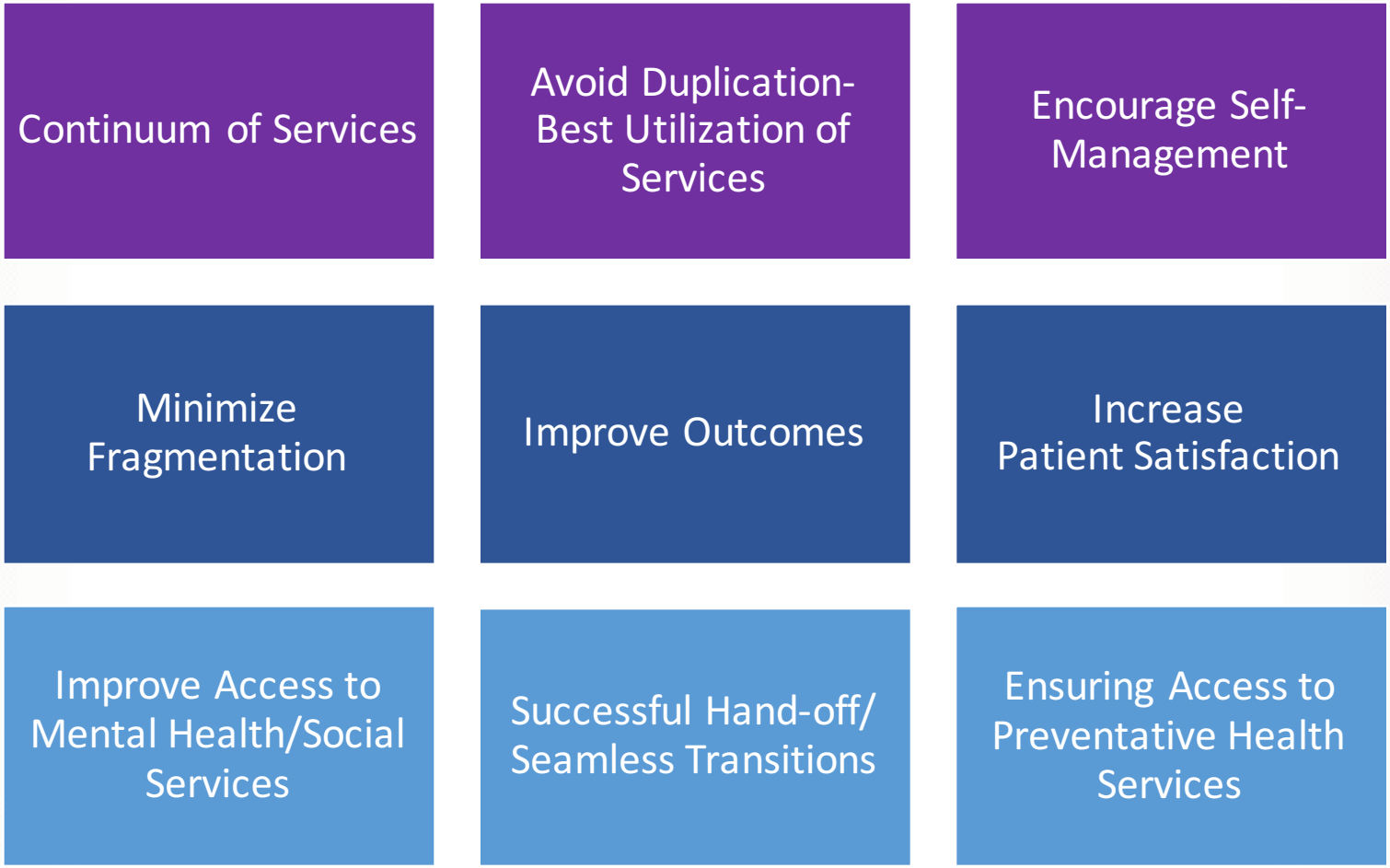
Annual Discussion

Receive annual "lecture" from physician on poor labs

Joe's care coordination team

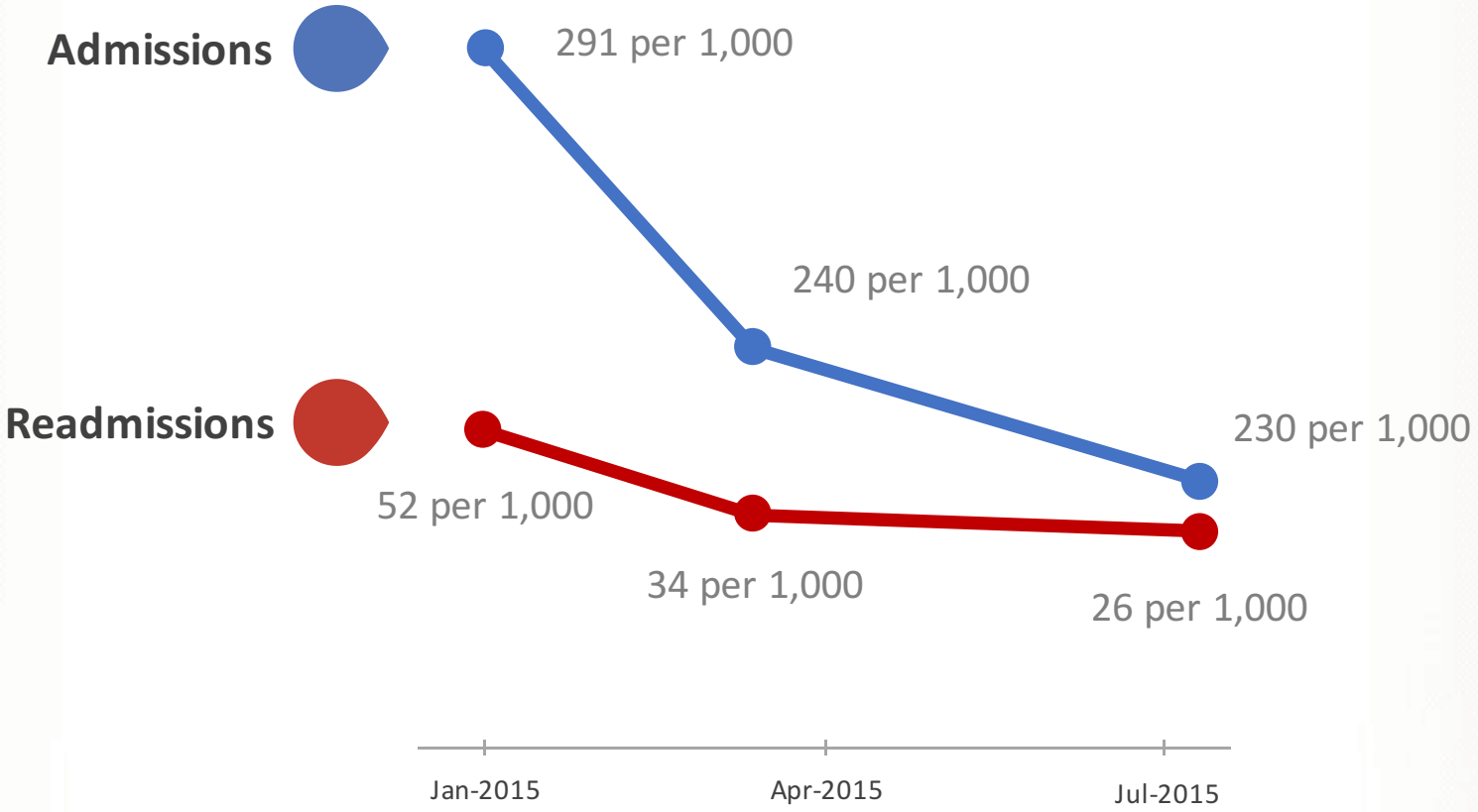


Care coordination benefits to Joe with USMD TOC program

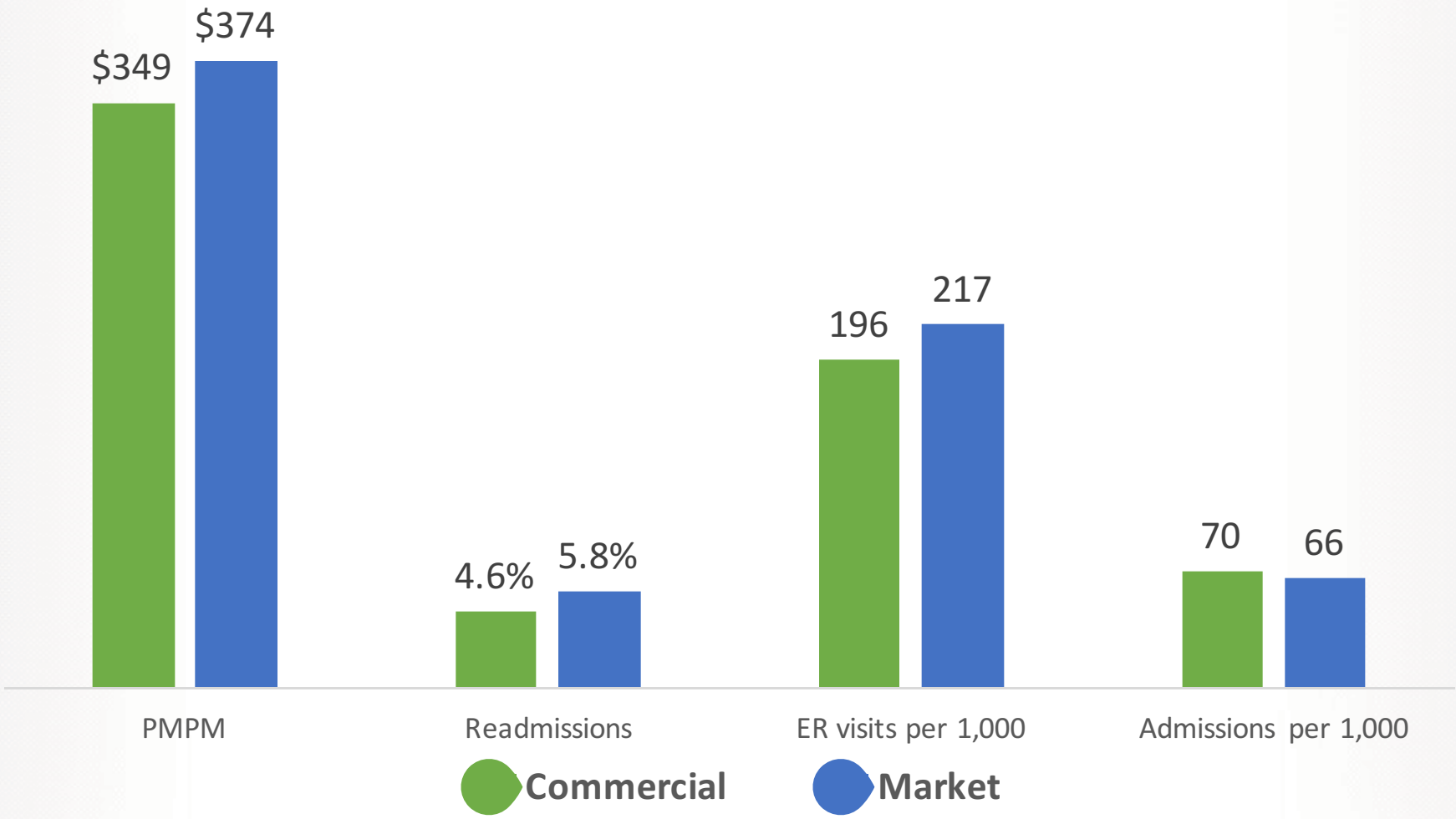


Mrs. W's doing much better

Medicare TOC program early results



Payer results

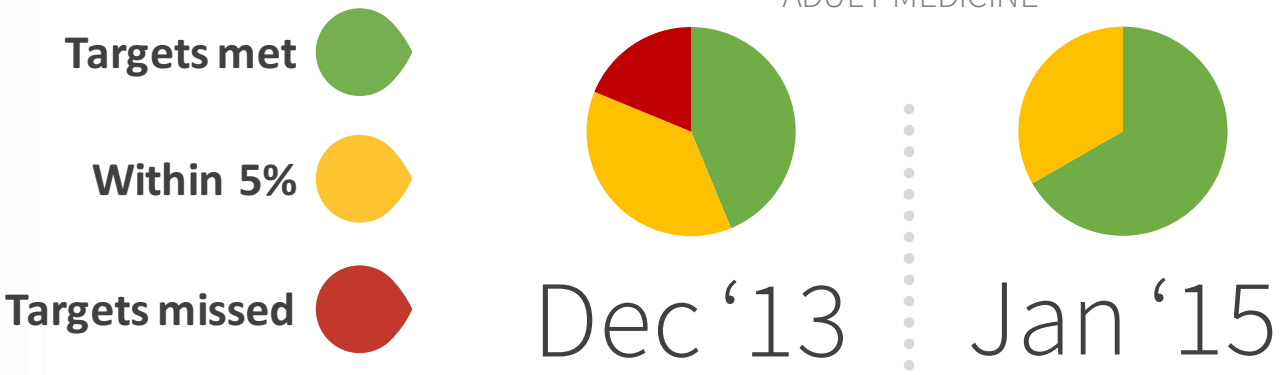


Momentum on metrics for HEDIS and HOS

Star ratings: 2.3 to 4 in 18 months

PCMH Aggregate Clinical Performance

ADULT MEDICINE



Watch-outs and “gotchas”

Delaying for “all” the data

Consulting trap
Naysayers
Divided leadership attention

Loosely coupled “best-of-breed” applications
Clinical integration chaos
Data confusion

Watch-outs and “gotchas”

Physician performance saturation
Inadequate recognition and rewards
Physician metric burnout

Leadership adaptability to “health consumer”
Integrated care execution
Patient privacy

We want to hear about your pop health efforts!