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

0. **Pre-PHM**
Strictly pay-for-service. Care is largely episodic, and payers pressure for cost reduction.

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

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

3. **Provider-driven services**
Pop health management becomes payer agnostic. Laser focus on provider accountability and metrics. Collaborative care as differentiator. Process standardization.

4. **Patient engagement**
PHM and 24x7x365 patient engagement are standard competencies. Continuum of care includes medical resources and facilities, schools, employers, and community services.
Where are you?

Four Phases to PHM Maturity:

1. Financial Contribution & Margin Impact
2. Population Health Maturity
3. 
4. 

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Growth factors

**INTERNAL**
- Leadership Talent – Effectiveness
- Provider Alignment
- Financial Resources
- IT – Analytics Capability
- Provider Culture
- Clinical & Technical Staff

**EXTERNAL**
- Market Size – Population, Ages
- Market Status – Leading, Lagging
- Payer Mix – Private, Public
- Competitive Environment
- Market IT Infrastructure
- Regional Talent Pool
Payers’ risk stratification based only on claims

- Critical
- High utilizer
- Moderate risk
- Healthy
Fresh perspective on stratification

- **Hidden opportunity**
- **Critical**
- **Healthy & unknown**
- **High utilizers**

Clinical risk vs. PMPM (patient cost)
Dimensions of competency and challenges

- Physician alignment
- Leadership
- Clinical delivery model
- Care management
- Performance metrics
- Data analytics

FOUR PHASES TO PHM MATURITY
Pre-PHM
(PHASE 0)

Clinical specialty model

Volume, volume, volume
100% fee-for-service
Network leakage, referral management
Clinical delivery model
Care largely episodic
Lists from payers
Very low staffing ratios
Data analytics
Coding to maximize revenue
Overhead costs
Pre-PHM
(Phase 0)

Four Phases to PHM Maturity

- Physician alignment
- Coding to maximize revenue
- Overhead costs
- Focus on cure

Performance Metrics

Pre-PHM (Phase 0)

# appointments
# new patients
FOUR PHASES TO PHM MATURITY

Pilot (PHASE 1)

1. Clinical and delivery model
   - P4P vision
   - Population <10K
   - Negotiate for payer resources
   - Staffing ratios vary greatly
   - Little integration
   - Patient view ≠ 360°
   - Conflicting goals
   - Data analytics
   - One or few data sources
   - Stratification based on payer perception

Stafﬁng ratios vary greatly
FOUR PHASES TO PHM MATURITY

1. Pilot (PHASE 1)

Performance Management Metrics

- Physician alignment
- "Cost containment" message
- Focus on screenings
- Physician "blind" to metrics/data

Care Management

- Payer driven cohorts
- Disease management
- Focus on transitions

- Transition in care

Physician performance

- Care management
- Disease management
- Performance metrics

1. Pilot (PHASE 1)
Care programs (PHASE 2)

Clinical analytics

• Begins to standardize, streamline, and automate processes
• Population health, quality, and financial monitoring
• Adapts to appropriate data
• Staffing ratios vary by payer type

Data analytics

• Doing “more” with data, but not enough
• Population cost/quality analytics
• Adds socioeconomic data

Leadership

• Organizes for standardized care
• Inspires long-term focus
• Greater appetite for risk

Care programs

• Reimbursement models stand alone
• Somewhat increased coordination
• Public/semi-private HIE
Four Phases to PHM Maturity

1. Care programs
   (Phase 2)

   - Physician alignment
   - Systems aid closing gaps in care
   - Proactive outreach as a process

2. Performance Metrics

   - Patient satisfaction by payer
   - Revisits, readmissions, quality, costs
   - Adding high-impact processes

   Hidden opportunity
   Critical
   Healthy & unknown
   High utilizers
Provider-driven services

(PHASE 3)

Clinical analytics model

Start flight time to speed of job safety and productivity
- Shared risk
- Gaining momentum on objectives
- Staffing ratio per risk
- Data analytics
- Stratification by predictive analytics
- EHR + claims + socio-economic
- Physicians start aligning

Hidden opportunity
Critical
Healthy & unknown
High utilizers
Provider-driven services
(Phase 3)

Performance Metrics

- Expand the alignment of quality reporting across all payers.
- Pinpoint and address gaps in care.
- Predict high-cost episodes.

- Standardize quality reporting across payers.
- PMPM, outcomes, patient satisfaction.
- Staff high-risk patient episodes.

Four Phases to PHM Maturity
Patient engagement
(PHASE 4)

Clinical analytics very model

- Majority/professionals/national/alignment
- Mobile and home health technologies
- Closed-loop PHM analytics
- Insights drive staffing ratios

- Patient engagement
- Leadership
- Majority of population risk managed
- Collaborative, data-driven leadership
- "Healthcare consumer"
- Clinical delivery model
- Patient/provider accountability aligned
- Mastery of workflow, greater enjoyment
- Decentralized CM
- Data analytics
- EHR + claims + socio-economic + household
- Mobile and home health technologies
- Closed-loop PHM analytics
- Insights drive staffing ratios

Hidden opportunity
Critical
Healthy & unknown
High utilizers
Patient engagement

(phasE 4)

Performance Metrics

- ROI on care programs
- Performance against contracts

Data w/360° view
Closed loop population health execution

FOUR PHASES TO PHM MATURITY

- Patient engagement
- Utilization management
- Chronic care disease management
- Wellness management
- Care transitions management
- Analyze patient population
- Identify opportunities
- Design PHM programs
- Execute CM & wellness programs
- Track & report performance

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Patient experience as pop health matures

**P4S**

Doing something for the patient...

Doing something with the patient...

Doing something to the patient...

**P4P**
Meet Children’s Health

- **773,547** Patient encounters*
  - Dallas, Legacy, Southlake

- **169,635** ER visits
  - 2nd busiest among children’s hospitals\(^2\)

- **29,155** Pediatric admissions
  - 2nd most pediatric admissions in U.S.\(^2\)

- **3** Campuses
  - Dallas, Legacy, Southlake

- **562** Licensed beds
  - 6th largest pediatric hospital in U.S.\(^2\)

- **18** Children’s Health Pediatric Group
  - Primary care clinic locations

- **$24M** Charity care\(^2\)
  - (cost basis)

- **5,926** Employees*

- **$2,400M** Economic benefit\(^1\)
  - (cost basis)

- **$151M** Community benefits\(^2\)
  - (cost basis)

- **60%** Market share

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\(^1\) 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

- **Hospital / Acute Care**: $$$$$$$
- **Emergency Care**: $$$$$
- **Specialty Care**: $$$$$
- **Primary Care (PCP)**: $$$
- **Ancillary Care**: $$$
- **Virtual Health**: $$
- **HM**: $

**Current state**

**Future (ideal) state**

**Health Management Services**

- 5% High Risk
- 35-40% Medium Risk (Education/Manage to Controlled State)
- 50% Low Risk (Preventive Care, Education, Engagement to Maintain Path)

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Care management risk-based model

Low risk
- One chronic condition, controlled
- Newborns with prenatal care

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

High risk
- Uncontrolled chronic conditions
- No PCP
- Multiple hospital admissions or ER
- Newborns with no prenatal care
### Care management strategies and programs

<table>
<thead>
<tr>
<th>Low risk</th>
<th>Medium risk</th>
<th>High risk</th>
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<tbody>
<tr>
<td>• PCP</td>
<td>• Patient / family target interventions</td>
<td>• High touch coordination</td>
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<tr>
<td>• Patient / family education</td>
<td>• Disease-specific education</td>
<td>• Post discharge assessment and risk mitigation</td>
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<tr>
<td>• Address gaps in care where necessary</td>
<td>• Coordination for gaps in care</td>
<td>• High touch TOC</td>
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<td>• TOC</td>
<td>• Med management</td>
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Model in action: Pediatric weight management program continuum

**Low risk**
(normal weight, no comorbidities)

- Stand-Alone Nutrition Classes
- 4-, 6-, 8-Week Afterschool program
- Parent Nutrition Classes

**Moderate Risk**

- Open Gym
  - Harry Stone Recreational Center
- Planting Workshops
  - Paul Quinn College
- Cooking Demos
  - Cooking Matters

**High risk**
(overweight, comorbidities)

- Get Up & Go 9-Week Program
  - Partnering with YMCA of Dallas
- Support Groups – Plano, Coppell, Moorland

**Partnered programs**

- Cooking Classes
  - Local chefs & teachers
  - Chef Cassandra
  - Kids in the Kitchen
- Cooking Demos
- Planting Workshops
- Open Gym
- Parent Nutrition Classes

**Children’s Health programs**

- 1:1 Dietitian Counseling
- Eating Disorders Program
- Shared Medical Appts

**Model in action: Pediatric weight management program continuum**

- Hidden opportunity
- Critical
- Healthy & unknown
- High utilizers

**FOUR PHASES TO PHM MATURITY**

- AMGA IQL 2015 | National Harbor, MD
Program in action: asthma program continuum
Asthma ED visit rates over time

Crystal Charity Ball Grant Began
1st Home Visit
Crystal Charity Ball Grant Ended
Implemented CM tool

Asthma Volume: Down 43%
ACSC Volume: Down 29%
ED Volume: Up 14%
Asthma Rate (% of ED Visits): Down 50%

Statistical shift correlates with timing of several major initiatives.

All numbers exclusive of trauma patients as well as other exclusions per DSRIP Category 3 Guidelines for IT-9.3
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

- diabetes
- late prenatal care
- tobacco use
- maternal age
- low birth weight
- rural area
- race
- no prenatal care
- hypertension
- obese pregnancy
- Medicaid

Prenatal care and TOC for baby and mother
Inventory of CHST Population Health Assets

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

CHST Population Health Programs

CHST Population Health Assets

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%
FFS
(including SSP/GS)
MSSP ACO, PCMH

5%
Full risk
MA

20%
FFS
At risk for quality care

-48%
Regional
2014 MSSP ACO results

-17%
National
2014 MSSP ACO results
Our journey

**Volume → More integration → Value**

**FFS**
- FFS
- Service = Payment

**P4P**
- FFS
- Performance Bonus
- Upside Only
- Quality Incentives
- Utilization Incentives
- Coordinated Care Management to clinics by insurance then to group oversight.

**PCMH/GS**
- FFS
- PMPM CM
- Gain Share
- Upside Only
- Gain Share – PMPM CM
- Quality base - incentives
- Coordinated Care Management by groups – variable reimbursement.
- Credentialing

**Risk**
- % of Premium
- PCP Cap
- Upside & Downside
- Quality Gates / Bonus
- CM/UM/DM
- Credentialing
- Reinsurance

FOUR PHASES TO PHM MATURITY
Care process improvements

- Decentralized care management nurses; added health coaches
- Patient care conferences / HC program
- Redesigned specialist / PCP interaction
Four Phases to PHM Maturity

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”
Joe’s care coordination team

- PCP
- RN Case Manager, certified and embedded at key locations
- Centralized Clinical quality MA’s
- Health coaches and on-site clinics
- Centralized LVN’s
- Social worker
Care coordination benefits to Joe with USMC TOC program

- Continuum of Services
- Avoid Duplication-Best Utilization of Services
- Encourage Self-Management
- Minimize Fragmentation
- Improve Outcomes
- Increase Patient Satisfaction
- Improve Access to Mental Health/Social Services
- Successful Hand-off-Seamless Transitions
- Ensuring Access to Preventative Health Services
Mrs. W’s doing much better
Watch-outs and “gotchas”

0. Delaying for “all” the data

1. Consulting trap
   Naysayers
   Divided leadership attention

2. Loosely coupled “best-of-breed” applications
   Clinical integration chaos
   Data confusion
Watch-outs and “gotchas”

3. Physician performance saturation
   Inadequate recognition and rewards
   Physician metric burnout

4. Leadership adaptability to “health consumer”
   Integrated care execution
   Patient privacy
We want to hear about your pop health efforts!

Come talk with us in the exhibit hall – #215 with VitreosHealth!