Texas Health Resources: Our Voyage Toward Population Health Management

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Texas Health Resources (THR)

- **One of the largest faith-based, nonprofit health care systems in the United States.**
- **Formed in 1997 with the assets and operations of Fort Worth-based Harris Methodist Health System and Dallas-based Presbyterian Healthcare Resources. Later that year, Arlington Memorial Hospital joined the THR system.**
- **Headquartered in the Dallas-Fort Worth health market.**
  - Primary service area: 16 counties in north central Texas, home to more than 6.3 million

Texas Health Resources (THR) Vital Statistics (1)

- **More than 21,500 employees**
- **25 acute care, transitional, rehabilitation and short-stay hospitals that are owned, operated, joint-ventured or affiliated with Texas Health Resources**
  - 17 acute-care hospitals
  - 6 short-stay hospitals
  - 1 transitional care hospital
  - 1 rehabilitation hospital
- **18 outpatient facilities and more than 250 other community access points**

Texas Health Resources (THR) Vital Statistics (2)

- **Texas Health Physicians Group with more than 500 employed physicians and more than 200 physician assistants and nurse practitioners.**
- **More than 3,800 licensed hospital beds (more than 3,200 operated/available beds)**
- **More than 5,500 physicians with active staff privileges**
- **$3.4 billion in total operating revenue (FY 2011)**
- **$4.6 billion in total assets (FY 2011)**

Mission, Vision, Values (1)

Texas Health Resources Mission Statement

•To improve the health of the people in the communities we serve.

Texas Health Resources Vision Statement

•Texas Health Resources, a faith-based organization joining with physicians, will be the health care system of choice.

Mission, Vision, Values (2)

Texas Health Resources: Our Faith-Based Values

•***Respect*:** Respecting the dignity of all persons, fostering a corporate culture characterized by teamwork, diversity, and empowerment.

•***Integrity*:** Conduct our corporate and personal lives with integrity; Relationships based on loyalty, fairness, truthfulness, and trustworthiness.

•***Compassion*:** Sensitivity to the whole person, reflective of God's compassion and love, with particular concern for the poor.

•***Excellence*:** Continuously improving the quality of our service through education, research, competent and innovative personnel, effective leadership, and responsible stewardship of resources.

Texas Health Resources: Our Promise

Individuals Caring for Individuals, <u>Together.</u>

- Anchored to the concept of “individuals,” easily lost in a large organization.
- Aligns the efforts of a diverse team (physicians, clinical staff, support and administrative staff, governing bodies) with our partners, creating a stakeholder experience which differentiates THR.

THR's 10 Year Strategic Focus 2007-16

***To deliver outstanding value to all stakeholders and be nationally recognized as an excellent and innovative health care system through a culture where exceptional individuals care for individuals, together*.**

•Expand our scope to include well care, preventive care and chronic and post acute care.

•Move from a hospital-centric mindset to a people- centric one, using population-based care models.

•Recognize physicians as leaders in managing care. Continually seek opportunities to join with physicians and other partners to support and coordinate care across the continuum.

Why Did We Choose to Change Now?

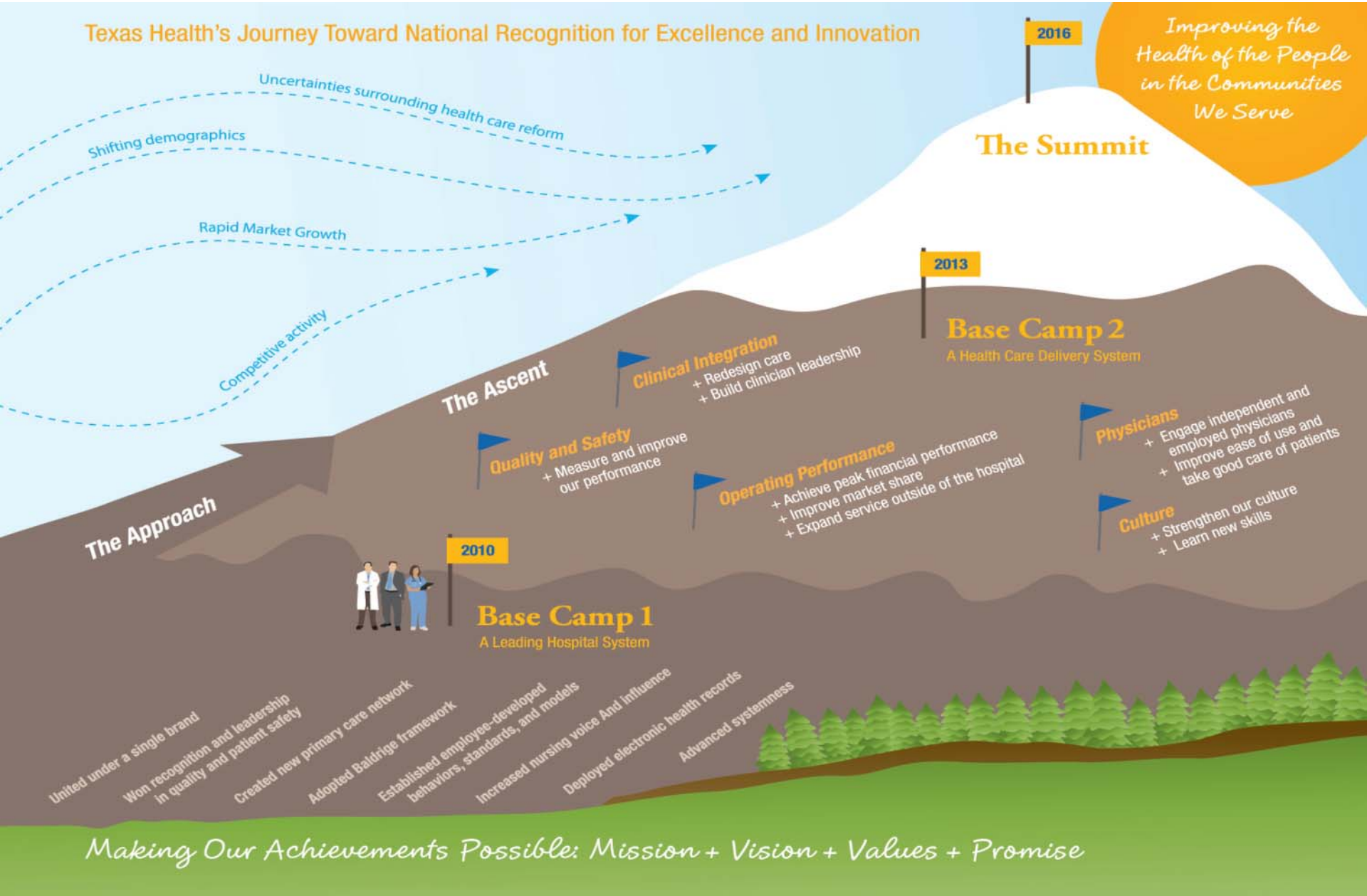
Our view of the future is to become a nationally recognized health system known for excellence and innovation through fully engaged physicians, nurses, and other caregivers redesigning and delivering coordinated patient care across the entire continuum of settings with exceptional results. This requires us to……

- Move our focus from a hospital-centric mindset to one that is patient-centric using population-based care models. Our emphasis will be on adding value for people seeking health care throughout the entire care continuum, and not only on adding hospital-based volume.
- Learn how to deliver highly coordinated care in a personalized manner and do so at a lower cost per capita than we do today.
- Engage clinicians in leadership, care redesign, quality and patient safety initiatives and following evidence based models of care.
- Improve our ability to motivate and encourage individuals to make healthy behavior changes.
- Develop the organization's ability to move along the financial risk continuum for healthcare (e.g., bundled payments, gainsharing). Develop capability to mitigate that risk by reducing variation, following evidence-based guidelines and controlling costs.
- Be bold and "be the future" by entering into aspects of financing and care delivery where elements of the industry (reimbursement, regulatory) may not yet be comfortable.
- Welcome clinicians into leadership positions at all levels of the organization.

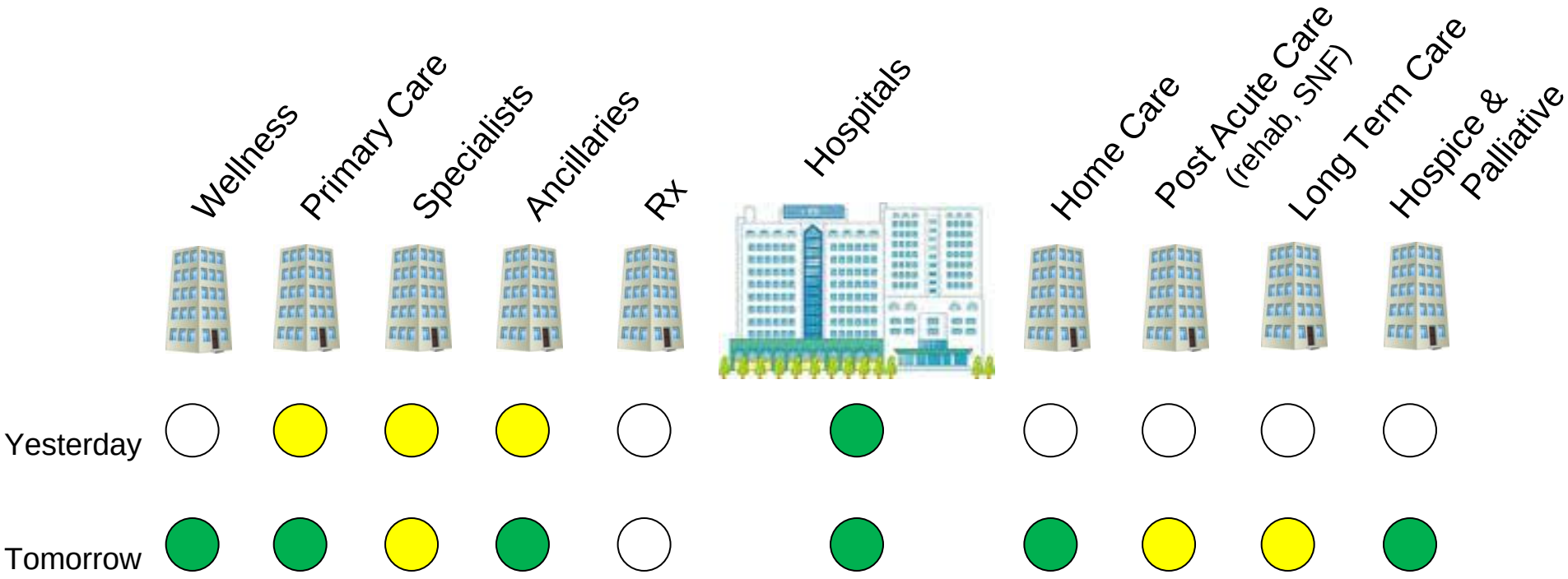
What Changes Have We Made?

- **These changes were developed by THR's senior executive team in consultation with a Transition Sub-Committee of the THR Board of Trustees, and approved by the THR Board on March 2, 2012.**
- **The changes support claiming a leading market position in population health management and creation of value-delivery through quality and patient safety work. Changes include:**
  - Aligning and advancing Executive Team functions resulting in a more focused, team through the elimination of three existing positions at executive team level and the creation of two new positions: Chief Operating Officer (COO) and a Chief Clinical Officer (CCO), forming a collaborative executive "dyad" overseeing the delivery of health services across the continuum
  - Consolidate entities and services across the care continuum into regions (zones) and extend dyad model so that zones are managed by Operational and Clinical leaders
  - Propose new zone and entity level governance that assures alignment, support and integration of Texas Health to increase value across the care continuum

This Future is Reflected in our Base Camp Two Strategic Objectives and Beyond to the Summit of Transformation Mountain

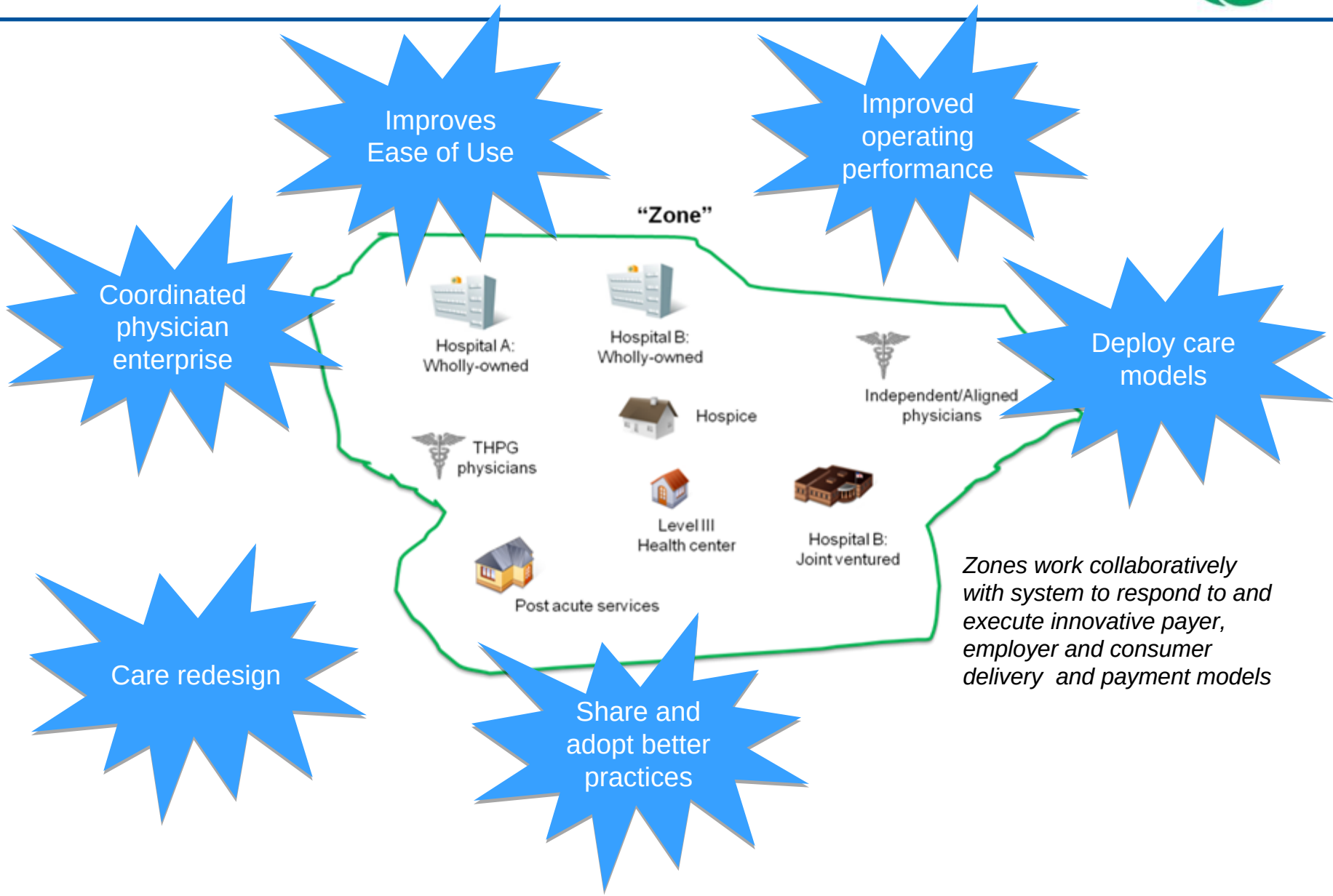


Shifting Focus: from Hospital System to Health System



Doing more, and doing it collaboratively, will require changes to people, processes and systems....including organization

Vision for How We Achieve These Aspirations

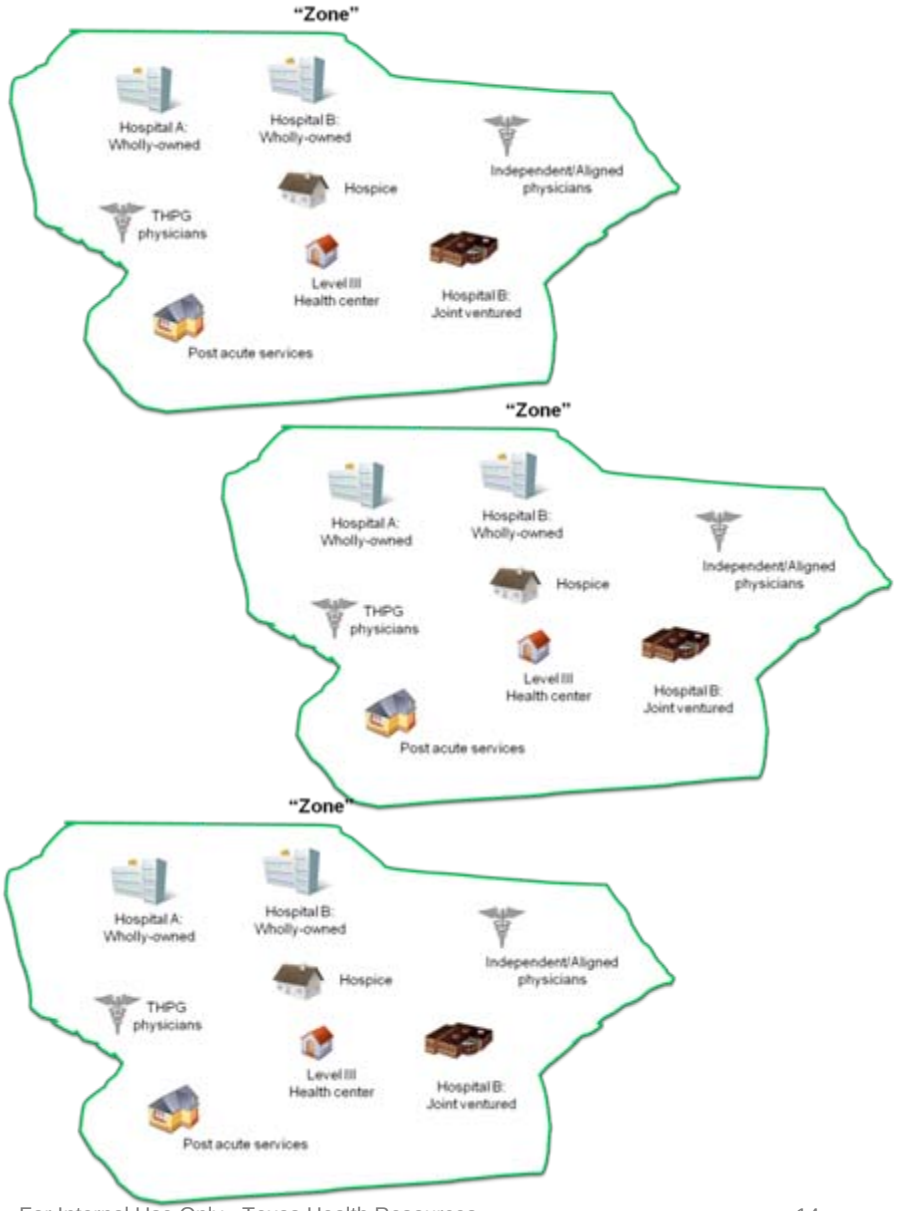


Zones work collaboratively with system to respond to and execute innovative payer, employer and consumer delivery and payment models

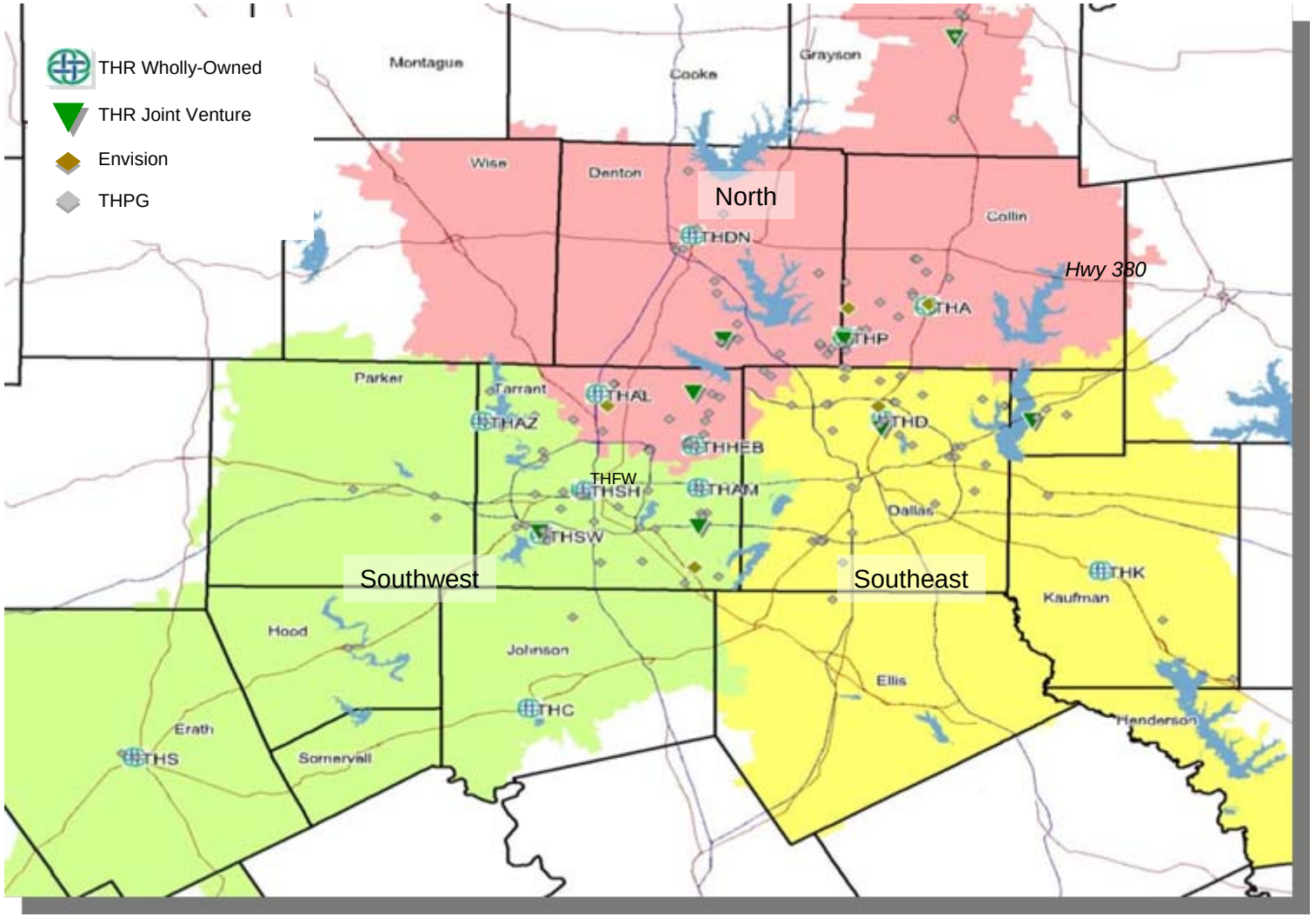
THR Remains an Actively Managed Operating Company that Collaborates and Innovates with Full Participation of the Zone

Operating intentions, strategy, infrastructure, governance, capital

Local market issues, engagement, thought-partnership, execution



A Three-Zone Structure Addresses Major Population Centers and Supports Growth Trends



- **Recommended zone definitions determined through analysis of several key factors (population, demographics, growth projections, market share, payor mix, etc.)**

How is care delivered in a zone? What's different?

UP TO & INCLUDING TODAY	FORWARD AND THE FUTURE
• Healthcare businesses are operated mostly independently ➢ Hospitals ➢ Joint Ventures ➢ Imaging, Labs and other diagnostic and testing services	• Intentional coordination within legal constraints (e.g. JVs have a board)
• Post acute services/partnerships managed by entity	• Increased THR partnering, managed at zone and system, with common service standards and high degree of coordination
• Physician group operated independently, with intentional collaboration across hospitals	• THPG will be "directed" within the Zone (as well as across zones)
• Hospitals compete against one another for share, doctors and resources	• Zones will be planned across all types of entities, with explicit collaboration
• Capital planning input by individual entity	• Zone input to capital plan

Implications on Executive Leadership

To achieve this has required Executive Leadership to redefine its agenda as follows:

- Organize enterprise-wide and regional care delivery systems around patient needs;
- Dismantle silos and manage change;
- Partner with doctors and clinicians through multi-disciplinary teams to redesign systems of care and improve outcomes;
- Improve processes to reduce cost, errors, and enhance the patient journey
- Measure performance less by how much we do, and more by how our patients fare;
- Deftly apply financial and behavioral incentives to reward performance across the continuum.

Implications on Executive Leadership

- **Create two new senior executive leadership roles:**
  - Chief Operations Officer
  - Chief Clinical Officer
- **The Chief Executive Officer, Chief Operations Officer, and the Chief Clinical Officer -- in partnership with other members of the Executive Leadership Team -- will lead and oversee this shift from *facility-focused delivery* to a *care continuum model* focused strategically on population health management and care redesign.**
- **In general, clinically oriented functions, roles and responsibilities such as Texas Health Physician Group, Chief Medical Officers, etc. are under the direction of the Chief Clinical Officer.**
- **Operational access points and entities are under the direction of a Chief Operating Officer.**

‘Zone Dyad’ Manages all Operational and Clinical Aspects of the Defined Market

- **A “dyad” is a paired set of leaders, likely one clinician and one administrative/operational leader.**
- **The zone-based dyad reports jointly to the system-based COO/CCO dyad.**
- **Zone dyad leadership will not have roles at a hospital, another service site or within THPG.**
- **The dyad, working with leaders responsible for all elements of the continuum (owned or partnered), pursues *alignment and commitment to the integration and coordination of care across the continuum*; across hospitals; the physician organizations; and with organizations that partner with us to fill continuum gap.**
- **The dyad is responsible and accountable for changing the mindset of leaders from managing components in isolation, to managing the enterprise in it’s entirety, engaging all stakeholders.**

Zone Dyad Responsibility

- Lead execution of deployment of system strategies, tactics, action plans.
- Lead transformation to patient centered, population health managed, physician partnered, clinically integrated accountable organization.
- Participate in development of overreaching system strategies and measures of success. (Attract and deploy key talent, information systems solutions, care model redesign, brand experience, medical staff and physician engagement, standard of care, approaches to population management and disease management.)
- Fully engage physicians and operational leaders, nurses and other caregivers in redesigning and delivering coordinated patient care across the entire continuum of care settings to eliminate waste, decrease cost, improve quality and safety and satisfaction.
- Plan the coordination & deployment of resources, access points, settings and providers within the zone.
- Reduce variation and improve ease of use.
- Inspire understanding and execution of a culture of shared leadership.

Zone Dyad Responsibility

- Continue to integrate THPG physician enterprise. Standardize and improve practice management, financial management, care integration, referral management and continuum coordination/transitions of care.
- Integrate independent, affiliated physicians and physician organizations. Transform the style of engagement with physician and transform the culture.
- Assure the capability to share clinical and business information between management, physicians, hospital and other care partners is in place to improve continuity and value.
- Execute and deploy system strategies and tactics that

    1) result in tighter integration of owned/managed/joint ventured hospitals, outpatient and support services,

    2) result in tighter integration of employed and independent physicians, and

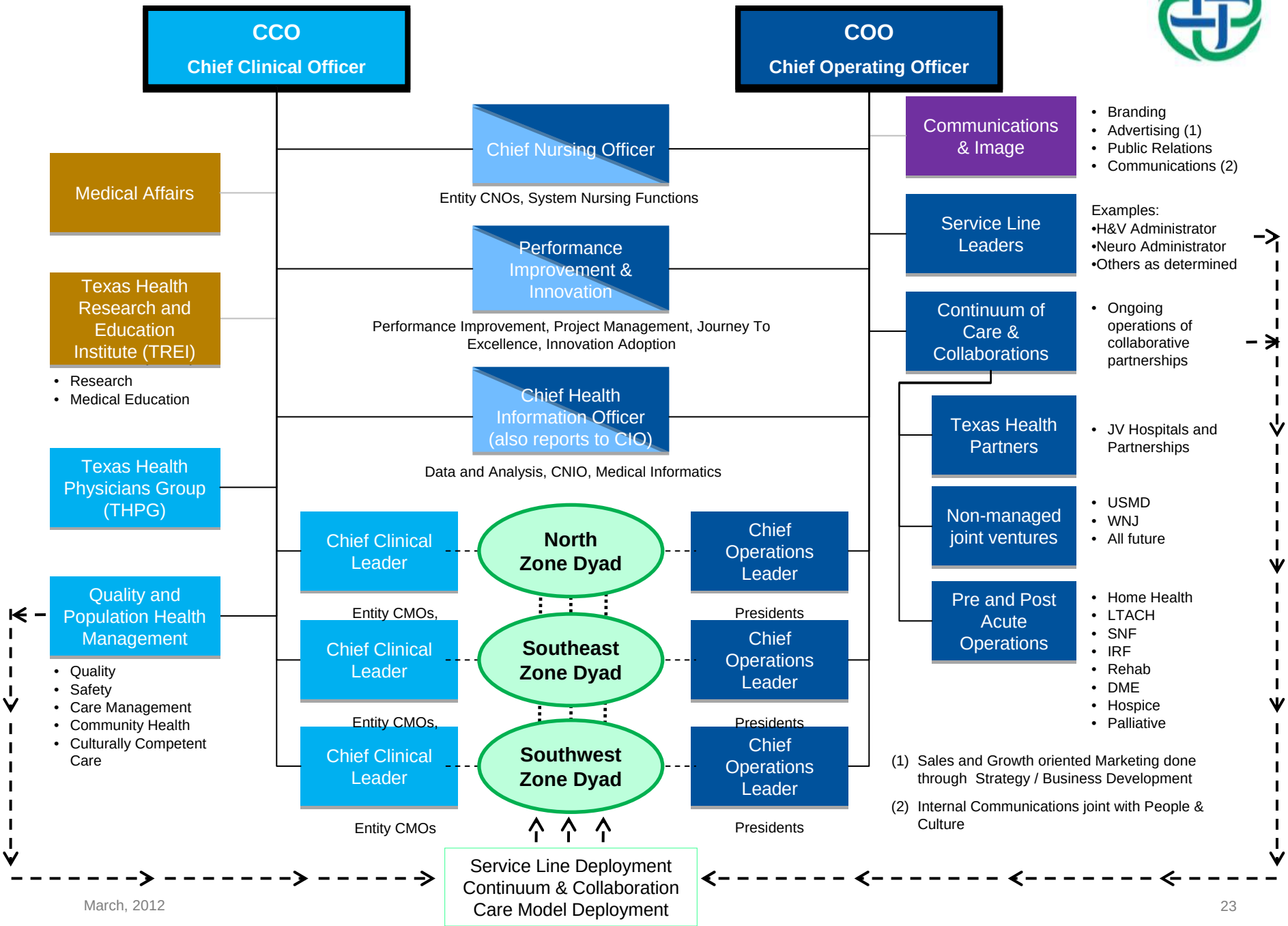
    3) the integration of physicians and facilities.

- Assure process literacy is widespread in all settings of care.

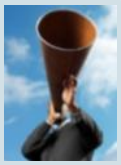
Chief Medical Officers

- **Chief Medical Officers reporting directly to the Zone Clinical Leader and with the following areas of responsibility:**
  - Quality & Patient Safety
  - Medical Staff & Physician Affairs
  - Employed Hospital Physicians (e.g., hospitalists, intensivists, medical directors, physician advisors)
  - Case Management
  - Physician Recruitment and Physician Contracting
  - Service Line, clinical program, and clinical protocol development
- **CMO responsibilities lie within the individual hospitals and do not extend to the zone or system level**
- **CMO joins withHospital President and Hospital Chief Nursing Officer to form "*The Triad*"; this triad has oversight of the hospital and its clinical/operational processes**
- **Works together with the THR EVP of Quality & Population Management, without direct reporting relationship**

Organization Structure of Proposed COO & CCO Dyad



“OVIS” Framework Clarifies Who Makes Decisions at the Specific Activity Level When Accountability is Shared

	Decision role	Which stakeholders should play this role
Own 	Ultimately making the call • May be a joint decision between parties	Individuals or committees primarily and/or jointly accountable for the outcome of a decision
Veto 	Right of veto or refer for reconsideration	Individuals whose legal liability or management responsibility could be impacted by a decision
Influence 	Has information relevant to the decision Will have to execute on the decision	Individuals whose input should affect the decision Individuals who are not accountable for the decision, but are typically key implementers
Support 	Individuals kept up to date during decision process and can opt to become participants	Individuals who may be affected or who may have pertinent information

Source: BCG

Defining Population Health

Nash, Reifsynder, Fabius, Pracilio, Population Health, Creating a Culture of Wellness, Jones and Bartlett Learning, LLC, 2011:

"A cohesive, integrated, and comprehensive approach to health care that considers:

1. The distribution of health outcomes within a population,
2. The health determinants that influence distribution of care, and
3. The policies and interventions that impact and are impacted by the determinants."

Capabilities Necessary for Population Health Management

1. Predictive Modeling
2. Risk Stratification
3. Patient Centered Prevention
4. Care Coordination

Health is more than just the absence of illness

"Health is a state of complete physical, mental and social

well-being

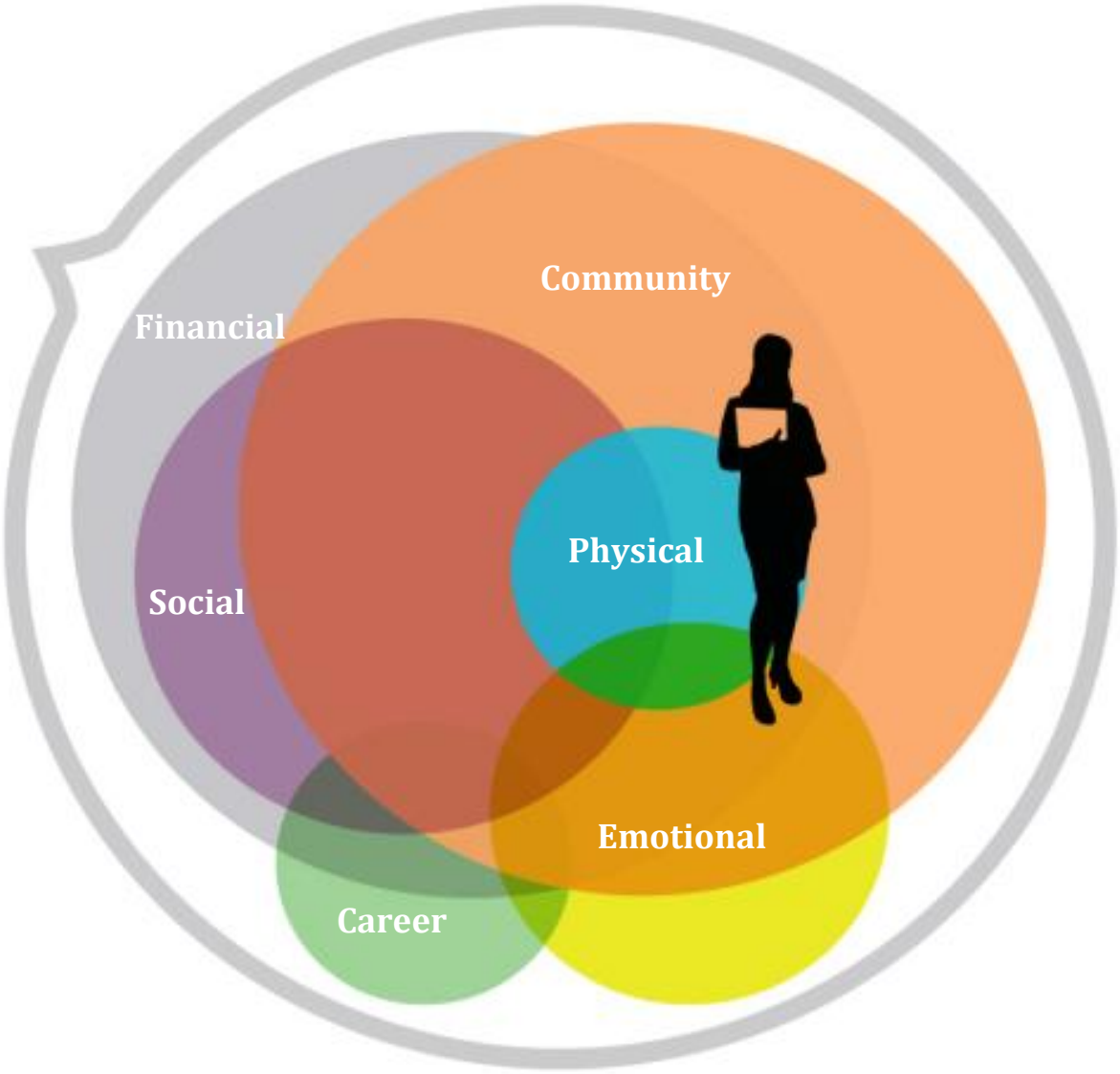
and not merely the absence of disease or infirmity."

World Health Organization

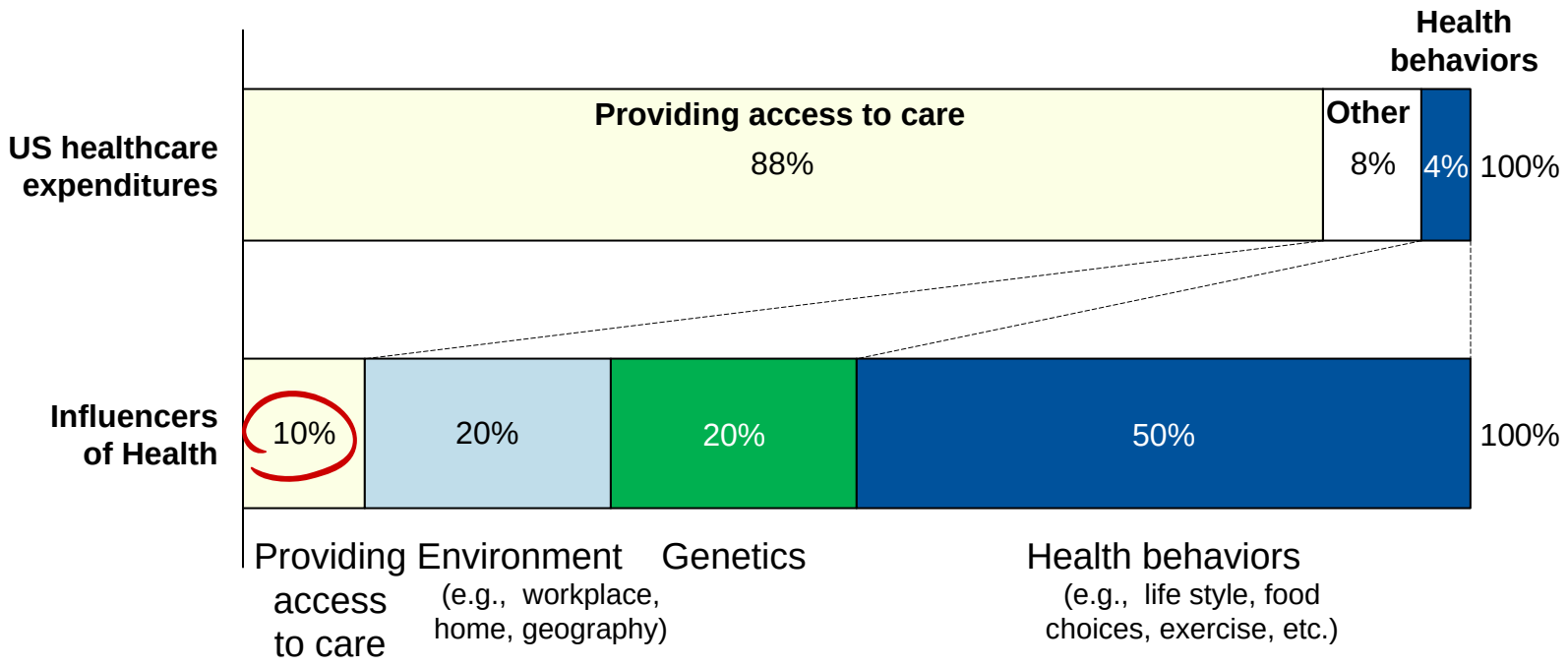
April, 1948

Preamble to the Constitution of the World Health Organization as adopted by the International Health Conference, New York, 19-22 June, 1946; signed on 22 July 1946 by the representatives of 61 States (Official Records of the World Health Organization, no. 2, p. 100) and entered into force on 7 April 1948.

A person's well-being is what is ‘good for’ them; the notion of how well a person's life is going for that person



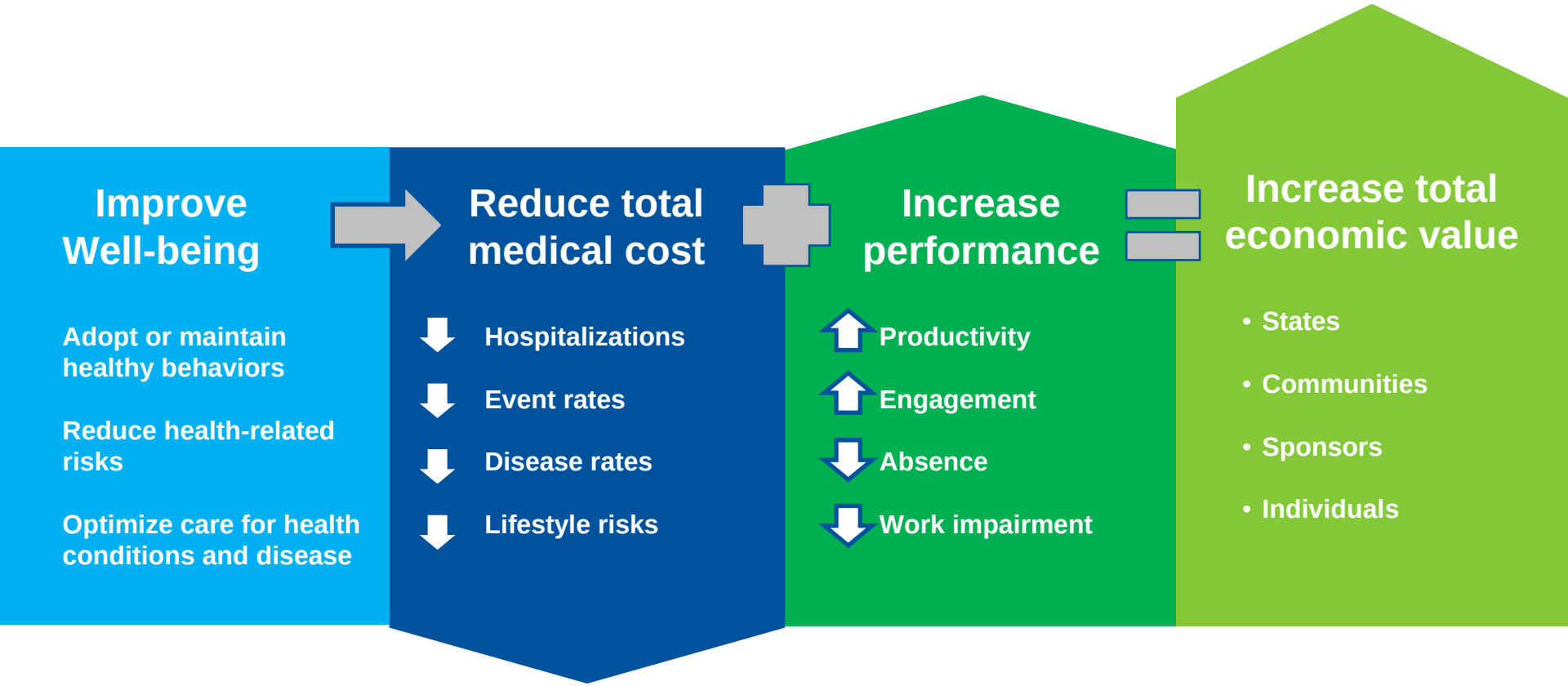
Unfortunately, providing access to care only impacts ~10% of those factors that influence overall health



Source: Centers for Diseases Control and Prevention, University of California at San Francisco, Institute for the Future

Healthcare providers are best positioned to address health behaviors, but our historical spend has been primarily focused on access

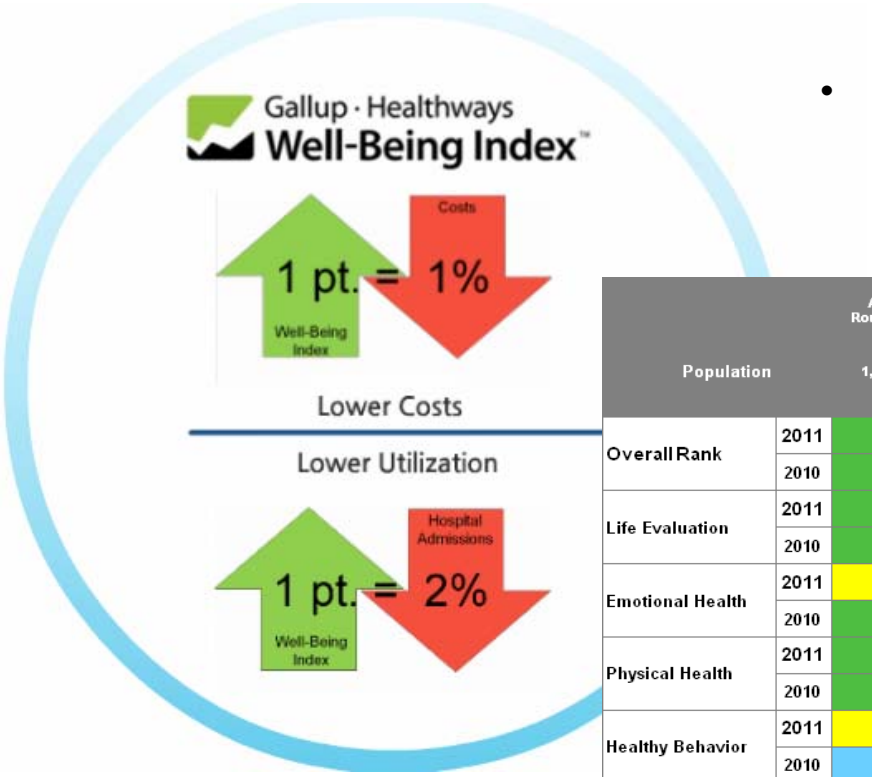
Value proposition: Individuals with higher well-being cost less and perform better



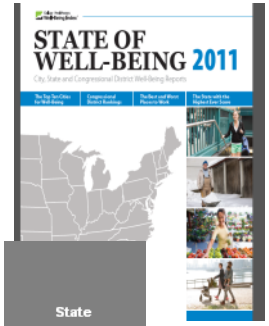
Economic drivers

- Prevent or delay next new case of disease or condition
- Prevent or reduce impact of the next new episode of care
- Enhance one's ability to actively manage their well-being

Well-being can be measured through the research and science behind the Well-Being Index™



- More than 1,000 new interviews with U.S. adults each day



Population		Austin, Round Rock 1,716,289	San Antonio 2,142,508	Dallas, Fort Worth, Arlington 6,371,773	Houston, Sugar Land, Baytown 5,946,800	Corpus Christi 428,185	Lubbock 284,890	State
Overall Rank	2011	36	55	64	68	78	137	27
	2010	11	60	56	84	161	N/A	27
Life Evaluation	2011	33	13	34	40	36	29	14
	2010	8	15	40	33	21	N/A	9
Emotional Health	2011	101	99	86	43	97	172	24
	2010	19	84	88	83	168	N/A	19
Physical Health	2011	19	100	37	28	120	80	24
	2010	13	95	55	42	71	N/A	18
Healthy Behavior	2011	103	121	137	125	159	188	37
	2010	46	100	142	152	175	N/A	32
Work Environment	2011	41	79	71	62	30	146	19
	2010	48	96	44	59	183	N/A	20
Basic Access	2011	73	111	114	160	142	110	45
	2010	76	138	115	163	179	N/A	44

Top Quintile | 2nd Quintile | 3rd Quintile | 4th Quintile | 5th Quintile

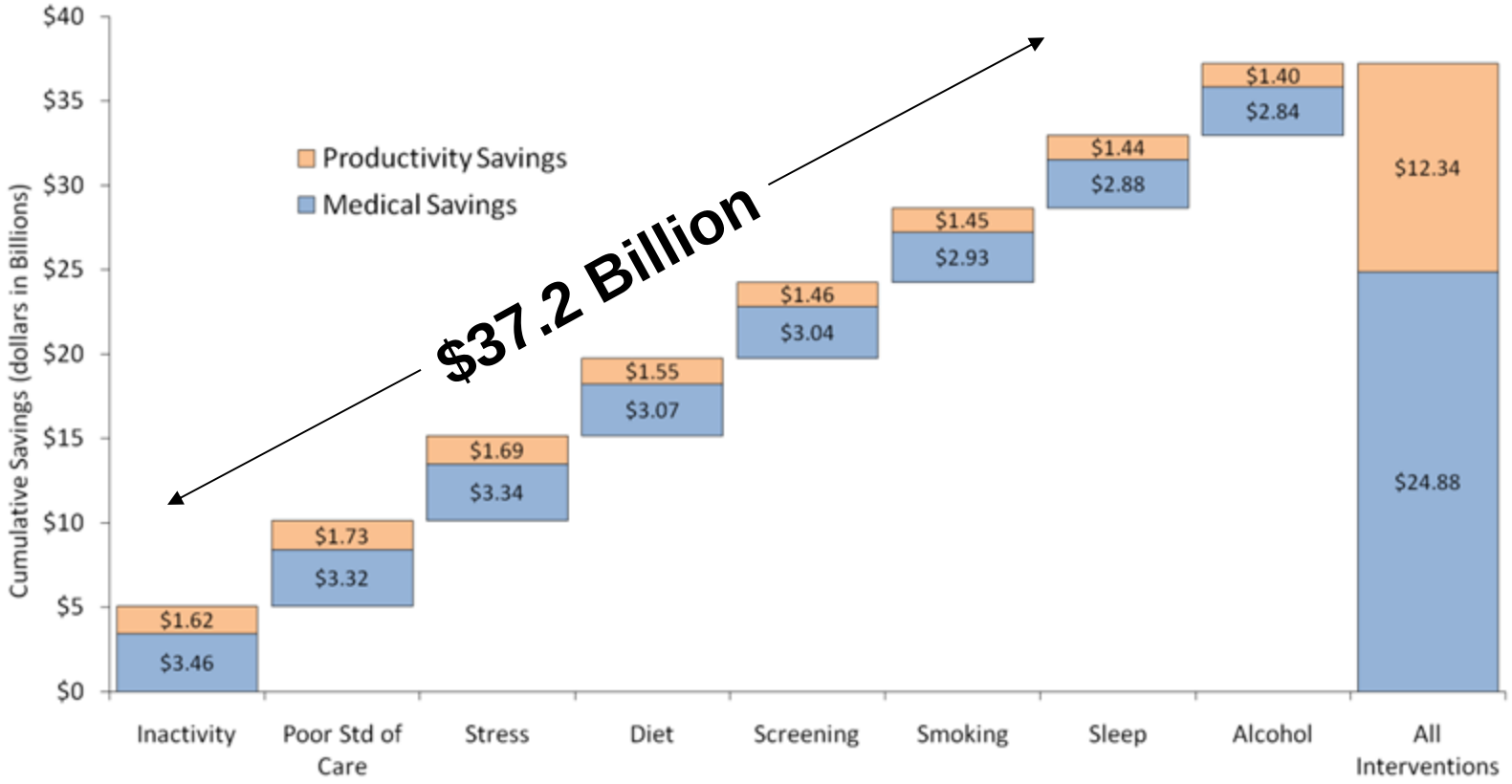
Within state of Texas

Source: 2011 Gallup-Healthways WBI Community Data

Improving well-being has economic benefits

Five-year, cumulative cost savings through interventions in modifiable behaviors

- Each intervention contributes to incremental savings
- By introducing comprehensive wellness programs that address all eight behaviors:
  - Medical costs reduced by **13.40%**
  - Productivity costs reduced by **8.06%**
  - Total costs reduced by **10.99%**



Source: Healthways

Changing behaviors can begin with physician/clinician-led interventions

Meet Janet

Today

“Managing <u>cases</u>”

A physician’s schedule has 25, 10 minute appointments with no system to manage the entire panel…

•Physician has limited time to see patient
•One major complaint is addressed, i.e. low back pain
•Brief examination reveals the need for a couple of prescriptions, i.e., muscle relaxant and pain relief
•Not enough time to discuss issues of weight, stress, or other concerns
•Janet leaves with issues not addressed; physician/clinician feels rushed

Future

“Managing <u>causes</u>”

With evidenced-based care plans and a system to support…

•The physician reviews appointment schedule to identify areas that need special attention
•Janet receives counseling and loses 8 lbs. through a weight loss coaching program.
•Physician reminds Janet that it was really good she was able to reduce her level of stress and get into an exercise program.
•Behavior change becomes the new focus of the office visit. Janet feels her physician really cares about her overall health and not just her back pain. The physician feels he is really making a difference, not only for this patient but for all his patients.

THR and Healthways, partnering with physicians, is making this vision come alive in N. Texas

Assess the population

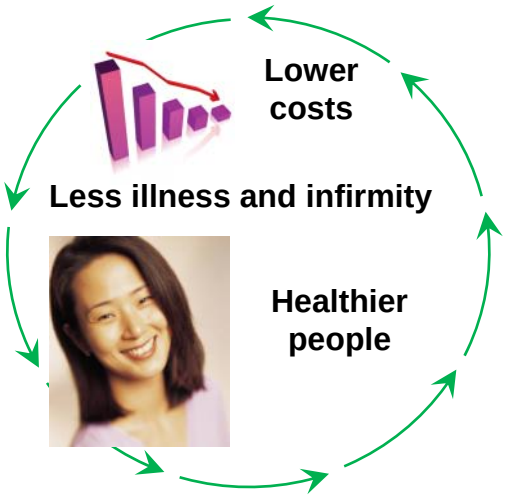
1. High cost claimants
2. Mitigable events
3. Disease mgmt.

- Keep well people well
- Treat chronic disease
- Take care of problems

Define the most important **actions** and **interventions**

Provide clinicians with **tools/ resources** to better understand patient population and workflow

Clinician creates **customized care plan** with interventional support



Truly improving the health of a population will require engagement of multiple stakeholders

Customer: "Any person or institution that takes risk for healthcare outcomes"

Consumers

"I keep myself healthy using THR tools and programs"

Employers

Plans

Exchanges

Communities

"I control my healthcare costs using THR tools and programs"

One need in common across all: Mitigating healthcare risk by improving health and well-being

10 Year Partnership with Healthways

- Multiple workstreams:
  - Physician Directed Population Health—Physician Quality Committee as a key component of the Clinically Integrated Organization, leadership structure within employed physician group.
  - Care Transitions—Care Coordination and Readmission Avoidance
  - Diabetes Service Line—Inpatient Glucose control extending across the continuum.
- Tools to aid in managing these workstreams—registries, databases, predictive modeling.
- Zone led coordination of multi-professional and multi-disciplinary teams.