Pediatric Focus

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Children's Hospitals' Role (and Responsibility) in Population Health

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Population health is often discussed in the context of large, adult-focused healthcare systems, yet children make up nearly a quarter of the U.S. population—and children represent one of the most vulnerable and important population segments. Children's hospitals, guided by their boards, can play a critical role in managing the health of the youth community. Among many benefits, this can establish preventive care habits and patterns early and thus improve individuals' overall quality of life and reduce lifetime cost of care. This article describes several approaches that have yielded positive results in managing children's health.

Key Board Takeaways

1. Don't wait for the large adult health systems to develop population health approaches and techniques. Children's hospitals have opportunities to identify gaps in the health of the youth population and engage parents, caregivers, and schools to deploy innovative tools and programs that can dramatically improve young people's lives.
2. Reexamine your organizational design to ensure the children's hospital is adequately integrated with employed health professionals, as well as affiliated providers. Employment alone (or a loosely defined network) is often insufficient to align strategic and financial incentives.
3. Ensure adequate capital investment in information technology so health professionals can promptly access integrated clinical, financial, and operational data. Without this, providers simply cannot manage the health of the population, costs will rise, and—in many markets—children's hospitals will be at a significant competitive disadvantage.
4. Push your leadership teams to assess opportunities to approach payer contracting with Medicaid MCOs on a TCOC basis, and/or consider whether your market is appropriate for the development of a provider-sponsored Medicaid health plan.
5. Actively seek opportunities to get deeper into the mother–child health interface. Obstetric care is not a feeder; it needs to be a partnership based on an imperative to improve care for families as well as children.

What Is Population Health?

Population health can be viewed in many ways, from a payer contracting model, to a model for the operation of a clinic, to the overarching model for the structure of a health system. Asking three people for a definition of population health is likely to yield four different answers.

We define population health as the process by which a provider community manages the health of a defined patient population (in this case children) to lower the total cost of care (TCOC), improve the patient experience, and enhance the lives of those patients. Several conditions must be met for this to be practical:

1. The individuals whose health the system is managing must be identifiable, either individually, geographically, or in some aggregation that is stable over time.
2. Health risk in the population must be understood clearly through data collection and analytic sophistication that enables identification of cost-effective intervention opportunities. Resource constraints invariably require that efforts be focused on a subset of patients.
3. The provider system must be financially incentivized to drive health, not medical care—which generally implies that it is at risk for a substantial portion of the cost of care.
4. The "provider community" must be broader than the traditional hospital–physician dyad, because more than 40 percent of healthcare costs are related to social determinants of health (the percentage is even higher for the youth population).

If children's hospitals and their employed and affiliated health professionals are adequately

integrated with aligned financial incentives, they can make significant strides in improving the quality and managing the cost of healthcare for the youth community. The high percentage of Medicaid in the payer mix, combined with minimal local competition in many markets, creates an opportunity for children's hospitals to define the population health model for a large geographic region or even across a state. To do so, however, requires a dramatic departure from the traditional volume-driven medical model with which many children's hospitals are accustomed to (see **Exhibit 1**).

Exhibit 1: Volume-Based Management vs. Population Health Management

	Volume-Based Management	Population Health Management
Objective	Maximize utilization	Maintain health; minimize illness
Target Population	High-cost/high-use patients	At-risk populations
Functional Orientation	Treatment of acute illness	Prevention of acute illness
Context	Incident-based	Anticipatory
Scope of Work	Within a single organization providing medical care	In the community or home

How Children's Hospitals Are Getting Results

A population-based approach to health involves numerous well-known complications for the hospital or health system, most of which stem from reimbursement systems that incentivize treating illness. In the case of children's hospitals, however, taking control of the payment model in Medicaid arrangements has allowed some providers to innovate in ways that have real impact on lives and outcomes.

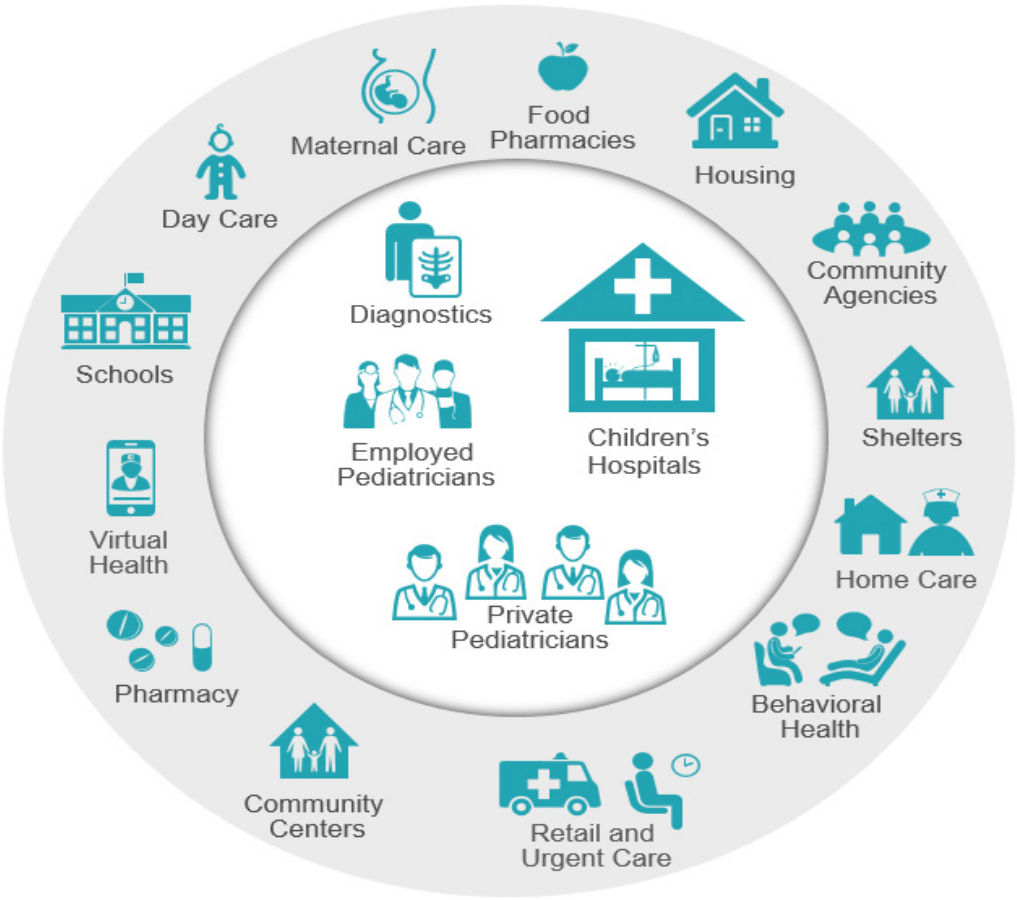
A key transformational challenge is that we must address the populations for which we are responsible across a broader front than we have traditionally. It is no longer adequate to just deal with the patients who cross the threshold of the clinic or hospital, because by the time they show up, it is too late to intervene in the most cost-effective way. Our interactions with patients must often begin *before* they seek care. For this reason, the definition of our "system"—whether that is based on ownership or management alignment—must become broader. It may begin to include such traditionally separate and diverse participants as community centers, clergy, and fitness centers.

The traditional physician–hospital model of a hospital or health system must be expanded to include concepts such as food pharmacies, housing, schools, community centers, and day care (see **Exhibit 2** on the following page). Ownership of these elements is not necessary, but management and integration of the services will be. Intelligent partnerships and integrated communication and access will be essential, and the hospital or health system will likely need to organize this, even if it does not own all the services. A substantial component of technology support will likely be necessary, as well as a virtual health platform to deliver it. Strategies that target the Medicaid population through the use of smartphones have consistently exceeded expectations in the past decade. Below are examples of children's hospital boards and leadership teams that are taking bold steps (and making significant investments) to launch targeted population health-related programs.

Driscoll Children's Hospital developed a program that supports prenatal care for higher-risk Medicaid beneficiaries. Driscoll maintains its own provider-sponsored Medicaid plan in Texas and hosts baby showers for its CHIP- and STAR-enrolled mothers where they are provided access to pediatricians; enrolled in WIC and prenatal, breastfeeding, and birthing classes; and provided with smartphone apps that support their connection to the system.[1] Participants' rates of underweight infants, NICU admissions, and perinatal complications are at least 15 percent lower than the state average.

1 Driscoll Health Plan, "Cadena de Madres" (available at http://driscollhealthplan.com/services/cadena-de-madres) and "Value-Added Services (STAR)" (available at http://driscollhealthplan.com/programs/star/value-added-services).

Exhibit 2: Expanding the Traditional Model of Care



CHOC Children's (formerly Children's Hospital of Orange County) has had full at-risk responsibility for a managed Medicaid population of over 150,000 children for the past 20 years.[2] CHOC studied a Hispanic, inner-city subset of the population and found that significant bronchial asthma was present in over 20 percent of the children (more than double the national average). Asthma is one of the leading causes of hospitalization and emergency department visits for children and is the leading cause of school absenteeism (40 percent of children with asthma in Orange County miss five or more days of school per year due to the condition). CHOC implemented a cloud-based population health management platform to establish an asthma registry that has resulted in a 47 percent increase in documented asthma control tests. CHOC also got creative and invested in RV-style clinics that travel to 22 schools and community sites across the county to provide asthma care, diagnosis, and education. For children with asthma, the Breathmobile program has resulted in an 80 percent decrease in school absenteeism and a 60 percent decline in ED visits. Today, approximately 75 percent of CHOC's patient population with asthma has the condition well controlled (more than double the national average).

Nationwide Children's Hospital is raising the bar on population health with its Partners for Kids program.[3] Through arrangements with Medicaid managed care organizations (MCOs) in Ohio,

2 William Feaster, "Improving Pediatric Care with Population Health Management," Cerner, May 10, 2017 (available at www.cerner.com/blog/improving-pediatric-care-with-a-population-health-management-strategy).

3 Nationwide Children's, "Partners for Kids: Pediatric Accountable Care" (available at www.nationwidechildrens.org/impact-quality/partners-for-kids-pediatric-accountable-care).

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Nationwide is taking full subcapitation for all children in 33 counties. This enables the organization to invest in programs that make sense from an outcomes perspective rather than focusing on service volume as a revenue driver. Through a clinically integrated network of 1,000-plus pediatricians, Nationwide achieves superior quality scores on HEDIS and internal metrics—and delivers these results at costs 10 percent lower than every other pediatric Medicaid provider in the state. Examples include significantly lower asthma admission rates as well as a decline in inpatient days for complex neurological cases with feeding tubes. Nationwide's outstanding quality performance, combined with a reimbursement model that rewards it for managing cost, allows it to reinvest further in children's health through programs such as School-Based Asthma Therapy, teenage contraception and prenatal care, and behavioral health transition programs for teenagers.

The common thread in all of this, of course, is that the reimbursement model must align toward population health to avoid penalizing providers for their efforts. In most cases, this will require that pediatric providers be willing to own the cost risk for their Medicaid populations. For this to succeed, organizations will need access to data and a commitment to changing the dynamic of the market in their conversations with physicians, payers, and the community.

The Governance Institute thanks Scott J. Cullen, M.D., Principal, and Christopher T. Collins, M.H.A., Principal, ECG Management Consultants, for contributing this article. They can be reached at ccollins@ecgmc.com and sjcullen@ecgmc.com.