Pediatric Alliance: A New Solution Built on Familiar Values

Empowering physicians with an innovative pediatric Accountable Care Organization
In the new health care landscape, pediatric physicians benefit from partnerships that set them apart—building a new model of pediatric care for better care coordination, efficiency and quality. Our partnerships empower physicians to help secure a strong, independent position in the community.

BEYOND THE TRADITIONAL MODEL OF CARE

Children’s HealthSM Pediatric Alliance is a physician-led, innovative pediatric Accountable Care Organization (ACO). We are a network of doctors, hospitals and other organizations that work together under the shared responsibility of providing coordinated care to children—driven by our Triple Aim for the North Texas pediatric population:

• Improve the health of children
• Reduce cost and increase efficiency of health care delivery
• Improve the patient experience and quality of care

As one of the nation’s first pediatric ACOs, this is a forward-thinking approach to today’s health care challenges:

• Moving from a fee-for-service system to a value-based system
• Creating unique efficiencies found with enhanced care coordination
• Driving quality initiatives specifically tailored to pediatric populations
• Building a cohesive care team with improved physician/family communication
EMERGING TRENDS BRING NEW OPPORTUNITIES
With emerging market pressures, we believe in empowering the independent practice and helping to find new market opportunities for our physician partners:

• Narrow Networks: Participation in this pediatric ACO will bring expanded patient networks to physicians’ doors. These networks continue to expand as Pediatric Alliance continues to secure agreements with payers, employers and other ACOs.
• Shared Savings: From care management to data analytics, the supporting services provided have the potential to generate increased revenue with the opportunity for shared clinical savings.
• Value-Based Payments: With strong data analytics drawn from an expanded network, services can be refined for quality, and financial incentives and arrangements can align with these clinical outcomes.

THE MODEL: PHYSICIAN-LED/PATIENT-CENTERED
Physicians are the crucial force that drives Pediatric Alliance, from primary care physicians to specialists and the leadership of our ACO.

STRENGTH THROUGH UNITY: THE PRIMARY CARE AND SPECIALIST TEAM
• The primary care physician serves as the leader of this team-based health care delivery system providing comprehensive quality care with the goal of achieving improved health outcomes.
• Member physicians can call on the support of the resources, infrastructure and technology of the entire ACO.
• Specialist members participating with the ACO are Board certified or eligible with the highest level of training in their respective fields.
• From the patient perspective, the goal is to create a better experience from the primary care to the specialist physician.

This model of care facilitates closer, more effective relationships between the family and the physicians involved in patient care. Coupled with the comprehensive services of Pediatric Alliance, this team provides the resources and expertise families need to achieve healthier lives.

The result isn’t just a stronger, independent practice. The result is better outcomes, lower costs, improved patient experiences and most importantly, a stronger community.
COMMITMENT TO QUALITY

Pediatric Alliance is not only structured to continuously enhance quality, but it also strives to improve the means by which we measure it.

- We utilize clinical pathways and protocols as defined by the collective experience and expertise of physician leaders and participants.
- Outcomes are measured in compliance with NCOA Healthcare Effectiveness Data and Information Set (HEDIS), a tool used by more than 90% of America's health plans to measure performance. This allows performance to be measured against peers and national standards.
- We provide detailed reporting metrics to encourage and support patient compliance.
- Pediatric Partners, our physician-led network supported by Children's Health, is striving to achieve clinical integration, an initiative driven by physician engagement and quality improvement.
- We're building a private Health Information Exchange (HIE) to provide physicians with real-time, actionable data and a clear picture of a patient's health across the continuum of care. This allows for multiple opportunities to improve the quality of care delivery.

POWERFUL PARTNERSHIPS

Our physician partners bring unique value and strengths to Pediatric Alliance. All partners contribute and mutually benefit from the contributions of this comprehensive team.

PEDIATRIC PARTNERS

Pediatric Partners is a physician-led network developing ongoing clinical initiatives to improve the quality and maximize the cost efficiency of health care. This network of more than 300 independent primary care and specialty providers builds the foundation for improving and aligning quality health care initiatives in North Texas.

CHILDREN’S HEALTH: ACCESS THROUGH AFFILIATION

Our physician partners are part of one of the leading pediatric health systems in the country, backed by more than 100 years of expert pediatric experience.

- **Children’s Medical Center**: Children's Medical Center Dallas and Children's Medical Center Plano consist of inpatient hospitals and medical campuses with physicians and specialists providing care in a variety of specialty areas.

  Children's Medical Center Dallas is home to the first designated Level I trauma center for pediatrics in Texas, and Children's Medical Center Plano extends the world-class care of Children's Health throughout North Texas. Children's Medical Center Plano sits on the Leapfrog Group’s list of Top Hospitals, one of the most competitive awards that a hospital can receive for its excellence of safety and quality.

- **Specialty Centers: Dallas, Plano, Southlake and Park Cities**: These outpatient specialty centers offer more than 30 subspecialties ranging from allergies and diabetes to surgery.

- **Pediatric Partners**: Pediatric Partners, supported by Children’s Health, is an integrated regional pediatric network, giving pediatricians the advantages of group membership with the flexibility to operate independently. Rapidly growing and currently comprising more than 300 pediatricians and specialists, Pediatric Partners provides measurable best practice care for children while successfully navigating the changing health care environment.
Our approach helps to improve patient-family dynamics and empowers families throughout the continuum of care.

ROBUST CARE MANAGEMENT
The primary care physician is the central, crucial element of better care coordination. Our approach helps to improve patient-family dynamics and empowers families throughout the continuum of care. It’s about providing the additional support patients need without leaving home, work or school.

This approach includes clinical expertise as well as the support of a social worker to address family life issues that may impact a child’s health. The goal of these programs is to be viewed through patient eyes as an extension of their primary care physician practice.

POST-HOSPITALIZATION FOLLOW-UP*
A member of our Care Management team will follow-up with families within one business day of notification after a hospitalization. This gives patients access to expert assistance, identifies gaps in care and helps ensure the patient is reconnected with the primary care physician so they can oversee the patient’s recovery.

EMERGENCY DEPARTMENT FOLLOW-UP*
A member of our Care Management team contacts the caregivers for a holistic review of the ED visit to proactively ensure the health and well-being of the patient. This directs patient families back to the central hub of care at their physician’s office.

NEWBORN FOLLOW-UP PROGRAM*
A Registered Nurse provides education and support to parents with newborns. The goal of this program is to help foster the initial connection and value of a primary care physician relationship.

PHARMACEUTICAL MANAGEMENT PROGRAM*
A licensed pharmacist serves as a personal consultant to caregivers on medication – from education, medication adherence and consolidation to finding programs to lower the cost of prescriptions for patients.

INJURY PREVENTION
In addition to enhancing quality of life and protecting children, the Injury Prevention Service at the Level 1 Trauma Center at Children’s Medical Center Dallas uses comprehensive education tools, hospital-based interventions and community-based services to keep children safe from injuries.

DISEASE MANAGEMENT
According to recent statistics, North Texas is among the national leaders in the prevalence of dangerous chronic pediatric conditions. Empowered by the experience and infrastructure of Children’s Health, this program effectively classifies patients, targets their needs relative to their specific condition and delivers an individualized treatment plan to patients.

Asthma Management Program**
In partnership with the family’s primary care physician, this comprehensive plan includes a personal consultation and home visits from a team of registered nurses and a registered respiratory therapist. One-on-one education is provided via home visits and evaluations to identify asthma triggers, as well as biweekly phone calls from a Care Manager.

* This service is an extension of ACO network participation.
Although this service does not require a referral, physicians may refer ACO-attributed patients to receive these services.
**Weight Management Program**
Collaborating with the primary care physician and YMCA of Dallas, Children’s Health offers “Get Up and Go,” a 9-week weight management program for children and their parents.

Designed to create awareness and understanding of how lifestyle choices affect health, this program increases the entire family’s knowledge and skills to improve health behaviors.

**Behavioral Health Program**
Coordinated by Licensed Behavioral Health clinicians to provide behavioral and psychosocial screenings with a focus on issues such as ADHD and depression, this program works with private practitioners and community organizations for effective behavioral health interventions across the community.

**PEDIATRIC TO ADULT TRANSITION OF CARE**
At Children’s Health, the Office of Patient Transition supports clinical programs to provide patient families with the skills, knowledge, and tools required for teens and young adults to maximize the independent management of their health care needs and successfully transition their care into the adult health care system.

**BETTER OUTCOMES, BETTER PATIENT EXPERIENCES**
Building a healthier community and meeting the future needs of families in the new health care environment requires strong partnerships with physicians across our region. This comprehensive vision strives to achieve better clinical outcomes, improved financial models and a superior patient experience. We’re excited to have your practice share this vision with us, and we look forward to building a stronger practice and healthier communities together.

**Physicians will need to refer patients to access this service.**