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Rural Hospital Strategies for Population Health Improvement

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Rural Hospital Strategies for Population Health Improvement

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Population Health: What’s This All About and What’s Driving It?
Overview

- Setting the stage:
  - The state of rural health
  - Health system transformation: where are we headed?
  - Defining population health
  - Drivers and obstacles

- Re-imagining the rural *health* system: financing and governance models

- Changing role of Critical Access Hospitals

- Learning from current examples
The Rural Burden of Illness

- Mortality rates: infants, children/young adults, working age
- Condition-specific mortality often significantly higher
- Chronic conditions
- Functional status
- Accidents
- Behaviors: smoking, alcohol, drugs
- Environment and occupation
- Access to insurance, healthcare, preventive services, and public health

Source: M. Meit et al. *The 2014 Update of the Rural-Urban Chartbook*, NORC Rural Health Research Center
Health Delivery System Transformation

Acute Health Care System 1.0
- High quality acute care
- Accountable care systems
- Shared financial risk
- Case management and preventive care systems
- Population-based quality and cost performance
- Population-based health outcomes
- Care system integration with community health resources

Coordinated Seamless Health Care System 2.0
- High quality acute care
- Accountable care systems
- Shared financial risk
- Case management and preventive care systems
- Population-based quality and cost performance
- Population-based health outcomes
- Care system integration with community health resources

Community Integrated Health Care System 3.0
- High quality acute care
- Accountable care systems
- Shared financial risk
- Case management and preventive care systems
- Population-based quality and cost performance
- Population-based health outcomes
- Care system integration with community health resources

Source: Neal Halfon, UCLA Center for Healthier Children, Families & Communities
Populations health 3.0:

“health outcomes of a group of individuals, including the distribution of such outcomes within the group” (Kindig, *What is Population Health?*)

“Groups” include geographic, racial, ethnic, linguistic, or other communities of people.

Focus: (1) health outcomes, (2) the “determinants” of those outcomes, and (3) polices and interventions that can improve outcomes.
## Factors Contributing to Health

<table>
<thead>
<tr>
<th>Outside Health Care System</th>
<th>Related to the Health Care System</th>
<th>Regulatory Environment</th>
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</thead>
<tbody>
<tr>
<td><strong>Societal Factors</strong></td>
<td><strong>Care Delivery</strong></td>
<td><strong>Medicare payment rates and policies</strong></td>
</tr>
<tr>
<td>• Food safety</td>
<td>• Quality of care</td>
<td>• Medicare and Medicaid care delivery innovation</td>
</tr>
<tr>
<td>• Healthy food availability</td>
<td>• Efficiency</td>
<td>• CON regulation</td>
</tr>
<tr>
<td>• Housing conditions</td>
<td>• Access</td>
<td>• Medicaid/CHIP policies (payment rates, eligibility)</td>
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<td>• Neighborhood violence</td>
<td>• Physician training</td>
<td>• Implementation of ACA</td>
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<td>• Open space and parks/ recreation availability</td>
<td>• Health IT system availability</td>
<td>• Local coverage determinations (LCDs)</td>
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<tr>
<td>• Genetic inheritance</td>
<td>• Distance to and number of hospitals, primary and urgent care centers, retail clinics, etc.</td>
<td>• Other local, state, and federal laws that impact the way health care is delivered and which treatments are provided</td>
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<tr>
<td>• Disease prevalence</td>
<td>• Physician mix (primary versus specialty care)</td>
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<tr>
<td>• Income levels</td>
<td>• Payer contracts</td>
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<tr>
<td>• Poverty rates</td>
<td>• Physician employment and payment structure</td>
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<tr>
<td>• Geographic location</td>
<td>• Disease management</td>
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<tr>
<td>• Unemployment rate</td>
<td>• Population subgroup disparity</td>
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<tr>
<td>• Uninsured/underinsured rate</td>
<td>• Advanced technology availability</td>
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<tr>
<td>• Median age</td>
<td>• Care integration and coordination</td>
<td></td>
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<tr>
<td>• Sex</td>
<td>• Behavioral health availability</td>
<td></td>
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<tr>
<td>• Race/ethnicity</td>
<td>• Cultural and linguistic access</td>
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<tr>
<td>• Pharmacy availability</td>
<td></td>
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<tr>
<td>• Care-seeking behaviors</td>
<td></td>
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<tr>
<td>• Health literacy</td>
<td></td>
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<tr>
<td>• Patient choice</td>
<td></td>
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<tr>
<td>• Morbidity rates</td>
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<tr>
<td>• Transportation availability</td>
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</tbody>
</table>

Source: Hospital Research Education Trust, *Managing Population Health, The Role of the Hospital, AHA, 2012*
Another Way to Look at Factors Affecting Health

Health Outcomes
- Length of Life (50%)
- Quality of Life (50%)

Health Factors
- Health Behaviors (30%)
  - Tobacco Use
  - Diet & Exercise
  - Alcohol & Drug Use
  - Sexual Activity
- Clinical Care (20%)
  - Access to Care
  - Quality of Care
- Social & Economic Factors (40%)
  - Education
  - Employment
  - Income
  - Family & Social Support
  - Community Safety
- Physical Environment (10%)
  - Air & Water Quality
  - Housing & Transit

Source: County Health Rankings, 2014
Transition to Health System 3.0

- Accountability framework changing: from Accountable Care Organizations to Accountable Health Communities.

- Addition of population-level measures.

- Moving outside of the hospital walls:
  - More than a nice mission statement: requires action.
  - Strategic priority, leadership, resource commitment, and new partnerships with the community.
It Takes a Village to Improve Health

Transition to Health System 3.0

- Starting point: Identifying/tracking target populations, community health needs, and aligning interventions.

- Hospitals can’t do this alone - must leverage local resources.

- In a transition period: demonstrations are beginning but current reimbursement systems inadequate.

- New skills needed to meet the challenge.
What’s Driving the Shift to Population Health?

- Demand forces: aging population, chronic disease;
- Institute for Healthcare Improvement, Institute of Medicine: operationalizing the population health arm of the Triple Aim;
- “Accountable Care”/performance measurement and incentives, new “value-based” insurance models, employer wellness programs.
- It’s the right thing to do!
What’s Driving the Shift to Population Health?

- ACA: Patient Centered Medical Home, Health Home, and Accountable Care Organization (ACO) models;
- Community Benefit requirements;
Barriers

- Volume-based reimbursement system does not provide funding for population health initiatives
- Transition from volume-based to population health reimbursement – taking place very slowly
- Determining which population health factors hospitals can address with their limited resources
- Limited financial, technical, human, and data resources
- Lack of collaborative partnerships with community organizations and providers
Health System 3.0 in the Rural Context: Financing and Governance Issues
Defining “community”: breadth of partners/stakeholders

Organizing the delivery system: who does what and how is it integrated from a consumer and provider perspective?

How do we re-design payment models to invest in upstream population health services without harming existing core services?

Governance and accountability
Payment and Resource Models

- Membership dues, philanthropy, employer contributions;
- Re-aligning community benefit activities/spending;
- Expanding care management capacity: community health workers, community paramedicine;
- Shared savings models: 1% of shared savings to fund social service infrastructure;
- Population-based global payments/budgets;
- Health and wellness trusts;
- Community development financing
Governance Issues

- Top down versus bottom up approaches
  - Colorado versus Humboldt County, CA
Governance Issues

- Scope of governance functions in complex community partnerships:
  - Legal authority
  - Policy development
  - Shared leadership
  - Resource stewardship
  - Performance and quality improvement
  - Public engagement and collaboration
Cardiac Care – Franklin Memorial Hospital

- Long history of community health improvement initiatives dating back to the 1970s in a low income rural Maine county
- Collaboration with the hospital, providers, employers, and other community organizations
- Efforts focused on hypertension detection/control, hypercholesterolemia, tobacco, diet, physical inactivity, and diabetes
- Organizations changed - key players remained consistent
- Significant improvements in cardiovascular outcomes over time; however the gap between Franklin and the rest of the state narrowed over time
Population Health Activities:
Critical Access Hospitals
Partnerships to support community health infrastructure

Goal - address fragmented and decentralized care services

14 health promotions implemented, trust/collaboration improved

Challenges – skepticism over control and management

Long standing mission to promote the health and wellness of the community

Activities funded over time by different grants

Key factors-assessment/evaluation, community health metrics

Create partnerships and give away credit, open communication, develop network and sense of partnership, decentralization
- Implemented the Healthy Communities Dashboard – a tool that centralizes data and evidence based resources
- Supports needs assessment and community reporting
- Dashboard reflecting six priorities with community metrics
- Data shared with the community and other providers/agencies
- Used evidence based resources to identify interventions
- Monthly meetings of Fulton County Partnership (20 local agencies) to review priorities, outcomes and progress
- Working to develop data to “prove” and support outcomes
Expanding from delivery of medical care to role of hospital in the following:

• Community issues (substance abuse, domestic violence)
• Critical health issues (oral health, mental health, obesity)
• Health care equity (barriers to access, health disparities)
• System barriers (limited public health infrastructure)
• Community's role in process (involve residents in addressing above issues, reducing risky behaviors)

From: *Where Do We Go from Here? The Hospital Leader’s Role in Community Engagement* (2007) by the Health Research and Educational Trust.
Washington Department of Health and Washington State Hospital Association (similar to AHA project)

Objectives:

- Ensure access to prevention, 24/7 ER, primary care, behavioral health, oral health, long term care, home care, hospice, social services
- Enable aging in place
- Address rural health disparities
- Achieve the triple aim in rural communities
Promote comprehensive local community assessment, planning, and system development

- Traditional health care and “non-traditional partners – schools, employers, economic development agencies
- Align incentives and plans,
- Develop tools for community engagement and planning
- Incorporate patient navigator concepts
- Require joint assessment and planning for DOH programs
ACHI 2012 Survey Findings

- Rural hospitals are more likely than urban hospitals to run population health programs through the administrative-executive office (22% vs 10%)

- Rural hospitals have fewer (compared to urban hospitals):
  - FTEs dedicated to population health programs (3.6 FTEs vs 11)
  - Established population health partnerships (7.8 vs 7.8)
  - Programs for heart/lung/diabetes (60% vs 73%)
  - Community clinics (66% vs 74%)
Survey of Policy Congress members

- 68% somewhat prepared to adapt to population health
- 23% somewhat or very unprepared to adapt
- 68% have implemented at least a few programs

Key needs to adapt to population health payments

- Funding to support transition
- Increased reimbursement (care coordination, diabetes control)
- Education of providers
- Education of trustees
Getting Started

- Target essential services needed within community
  - Mental health, primary care

- Develop program targeting hospital employees
  - Expand to other local employers

- Address needs of uninsured patients using system
  - Improve access to services, improve care management, link to primary care, revise financial eligibility standards to align with local needs
Mental Health-Essentia Health St. Mary’s

- Collaborative Care Mgt of Depression in Primary Care

- Priority need identified in CHNA - initial funding with grant from Office of Rural Health

- Depression care within primary care setting Screens primary care patients using PHQ-9 by a team that includes a behavioral health specialist, a psychiatric nurse practitioner, and a care coordinator

- Coalition of EH-St. Mary’s and community mental health professionals

- Community outreach and education
Mental Health-Wabash Valley Telehealth Network

- MH patients clogging EDs
- Hub & spoke model: CMHC provides crisis services to 6 CAHs using 24/7 access center (LCSW/LMH staff and psychiatrist)
- Standardized protocols/algorithms used to assess patients
- CMHC prepares consultation report and disposition plan
- ED LOS reduced from 16-18 hours to 240 minutes
- Savings (lower ED LOS), fewer unnecessary hospitalizations
- CAHs pay a consulting fee per encounter
Mental Health-Nor-Lea General Hospital

- Created the Heritage Program for Senior Adults in 2003 to provide outpatient mental health services to seniors
- Staff - psychiatrist, therapists, RN, and mental technicians
- Need identified through focus groups and hospital chaplains
- Initial assessment - measures of cognitive ability, home environment, resources to develop master treatment plan
- Services: individual and/or family therapy and group therapy, both focus and process
- Van is available to transport clients to the hospital for services
Mental Health–Regional Medical Center

- Developed 3 county continuum of mental health services in response to a state de-institutionalization initiative
- Primary funding through Medicaid
- Outpatient counseling, crisis, supported community living, children’s day treatment
- Medicaid funding cuts triggered re-organization
- Providing integrated behavioral health services in two provider-based RHCs using licensed mental health counselors
- Serves children, adolescents, adults, seniors, and couples
Addressing Socioeconomic Determinants of Health

- Wrangell Alaska Medical Center-Rural Health Careers Initiative
- Partnered with local education programs to develop certified nursing assistant program – 1 year program
- Recognized the economic and social challenges of the community and the need for qualified nursing assistants
- Trained 200 students – Wrangell pays costs for employees
- Challenges – increasing community interest, improving educational performance
- Students receive mentoring and financial assistance
- WMC employs the majority of graduates
Heart of New Ulm Project applied evidence-based practices
Reduce # of heart attacks in New Ulm over 10 years
Collaboration with Minneapolis Heart Institute Foundation, local employers and local providers
Results: Improvements in consumption of fruits and vegetables, taking daily aspirin, participation in exercise
Success factors: clear vision, mission and values; culture of collaboration; clear goals and objectives; organizational structure; dedicated leadership; effective partnership operations; demonstrated outcomes and sustainability; and solid metrics for performance evaluation and improvement
Employee Wellness-Teton Medical Center

- Partners: high school, Teton Community Development Cooperative, County Extension Office, Great Falls Clinic, others
- Services: exercise programs, nutrition, health education, diabetes, stroke, and heart rehabilitation
- Special focus on health and fitness for high school students, firefighters, and persons with chronic illness
- Goal – wellness activities to younger community residents
- Construction of the Wellness Center on the high school campus – funded by donations from the local bank, community, and the Teton Community Development Cooperative
Redington Fairview General Hospital houses the Greater Somerset Public Health Collaborative.

- Developed community-based employee wellness program for very small businesses.
- Small businesses can offer workplace wellness activities that would not normally be economically feasible for groups their size (cost is $2.00 annually per employee).
- Environmental scan of the worksite, recommend policy and recommendations, assistance in developing policies, and workplace wellness toolkit.
Worked with local safety net clinics to become PCMHs under a five year demonstration by Colorado Community Health Network

Created teams to encourage transformation and work with clinics

Led to invitation to participate in the Medicaid Regional Care Coordination Organization – pay for performance

Targeted a pool of high risk people
PCMH-Pella Regional Health Center

- Health Partners
- Comprehensive chronic care program developed as part of PCMH recognition process – COPD. Hypertension, diabetes, depression
- Serves 60 and above, post-hospital discharge
- Reductions in re-admissions
- Tracks patients using EHR