4-15-2015

Rural Hospital Strategies for Population Health Improvement

Andrew F. Coburn PhD
University of Southern Maine, Muskie School of Public Service, Maine Rural Health Research Center

John A. Gale MS
University of Southern Maine, Muskie School of Public Service, Maine Rural Health Research Center

Recommended Citation

Coburn, A., & Gale, J. (2015, April 15). Rural hospital strategies for population health improvement Presented at the National Rural Health Association Annual Conference, Philadelphia, PA.

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Andy Coburn, Ph.D. and John A. Gale, M.S.
Maine Rural Health Research Center
University of Southern Maine

National Rural Health Association Annual Conference
April 15, 2015

A Performance Monitoring Resource for Critical Access Hospitals, States, and Communities

Flex Monitoring Team | University of Minnesota
University of North Carolina at Chapel Hill
University of Southern Maine

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

Overview

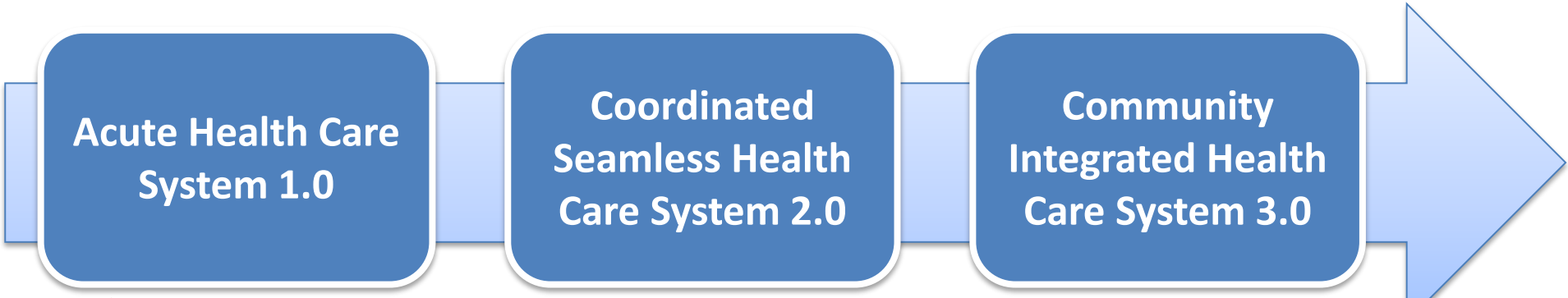
- Setting the stage:
  - The state of rural health
  - Health system transformation: where are we headed?
  - Defining population health
  - Drivers and obstacles
- Re-imagining the rural *health* system: financing and governance models
- Changing role of Critical Access Hospitals
- Learning from current 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	Coordinated Seamless Health Care System 2.0	Community Integrated Health Care System 3.0
✓ High quality acute care	• High quality acute care	• High quality acute care
• Accountable care systems	✓ Accountable care systems	• Accountable care systems
• Shared financial risk	✓ Shared financial risk	• Shared financial risk
• Case management and preventive care systems	✓ Case management and preventive care systems	• Case management and preventive care systems
• Population-based quality and cost performance	✓ Population-based quality and cost performance	• Population-based quality and cost performance
• Population-based health outcomes	• Population-based health outcomes	✓ Population-based health outcomes
• Care system integration with community health resources	• Care system integration with community health resources	✓ Care system integration with community health resources

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

Health System 3.0: Population Health

- Population 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.

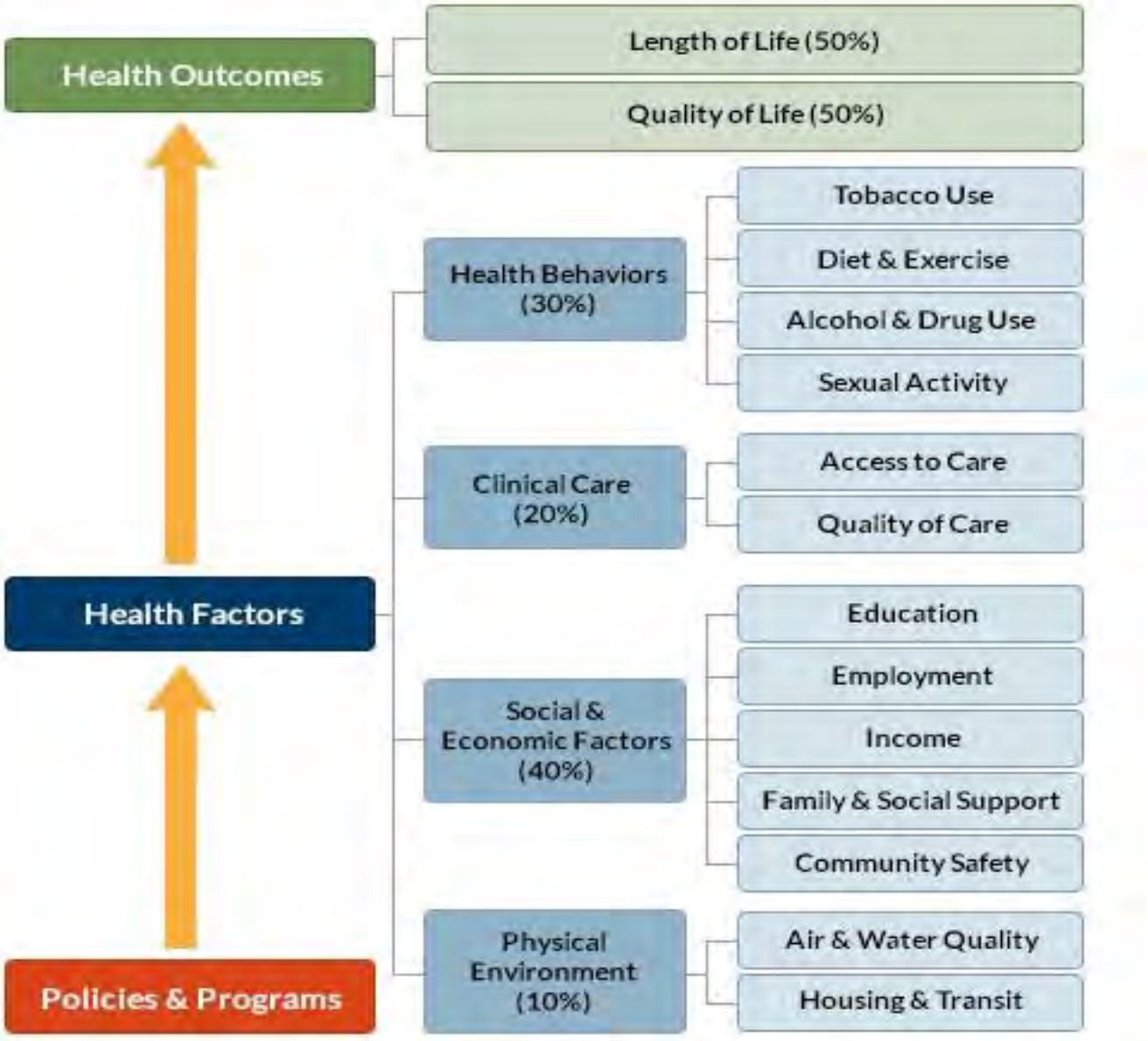
- Focus: (1) health outcomes, (2) the "determinants" of those outcomes, and (3) polices and interventions that can improve outcomes.

Factors Contributing to Health

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

Source: Hospital Research Education Trust, *Managing Population Health, The Role of the Hospital, AHA, 2012*

Another Way to Look at Factors Affecting Health



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

Source: Hospital Research Education Trust, *Managing Population Health, The Role of the Hospital, AHA, 2012*

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;
- Medicaid transformation and state reform: new Accountable Health Community models, State Innovation Models (SIM).

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

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Health System 3.0 in the Rural Context: Financing and Governance Issues

Population Health Models: Core Ingredients

- 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, hyper-cholesteroliemia, 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

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Population Health Activities: Critical Access Hospitals

Leadership-Mt. Ascutney Hospital and Health Center

- 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

Measurement/Data-Fulton County Medical Center

- 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

HRET: Community Responsive Hospital

- 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.

Redefining the Blue H – 2014 - Rural Hospitals

- 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

Redefining the Blue H – 2014 - Strategies

- 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%)

NRHA 2015 Population Health Survey

- 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

Cardiac Care-New Ulm Medical Center

- 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

Employee Wellness- Redington Fairview

- 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

PCMH-Yuma Hospital District

- 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