Rural Hospital Strategies for Population Health Improvement

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National Rural Health Association Annual Conference
April 15, 2015
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
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
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

<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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<tbody>
<tr>
<td><strong>Societal Factors</strong></td>
<td><strong>Care Delivery</strong></td>
<td><strong>Medicare payment rates and policies</strong></td>
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<td>Food safety</td>
<td>Quality of care</td>
<td>Medicare and Medicaid care delivery innovation</td>
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<td>Healthy food availability</td>
<td>Efficiency</td>
<td>CON regulation</td>
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<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/</td>
<td>Health IT system availability</td>
<td>Local coverage</td>
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<td>recreation availability</td>
<td>Distance to and number of hospitals, primary and urgent care centers, retail clinics, etc.</td>
<td>determinations (LCDs)</td>
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<td>Genetic inheritance</td>
<td>Provider supply (MDs, RNs, 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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<td>Disease prevalence</td>
<td>Physician mix (primary versus specialty care)</td>
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<td>Income levels</td>
<td>Payer contracts</td>
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<td>Poverty rates</td>
<td>Physician employment and payment structure</td>
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<td>Geographic location</td>
<td>Disease management</td>
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<td>Unemployment rate</td>
<td>Population subgroup disparity</td>
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<td>Uninsured/underinsured rate</td>
<td>Advanced technology availability</td>
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<td>Median age</td>
<td>Care integration and coordination</td>
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<td>Sex</td>
<td>Behavioral health availability</td>
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<td>Race/ethnicity</td>
<td>Cultural and linguistic access</td>
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<td>Pharmacy availability</td>
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<td>Care-seeking behaviors</td>
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<td>Health literacy</td>
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<td>Patient choice</td>
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<td>Morbidity rates</td>
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<td>Transportation availability</td>
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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
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, 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
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
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%)
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
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
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
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