Population Health Strategies of Critical Access Hospitals

Flex Monitoring Team

Briefing Paper #36

August 2016

John Gale, MS
Andrew Coburn, PhD
Karen Pearson, MLIS, MA
Zachariah Croll, BA
George Shaler, MPH

Maine Rural Health Research Center
Muskie School of Public Service
University of Southern Maine

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

ABOUT

This project was supported by the Federal Office of Rural Health Policy (FORHP), Health Resources and Services Administration (HRSA), U.S. Department of Health and Human Services (HHS) under PHS Grant No. U27RH01080. The information, conclusions and opinions expressed in this paper are those of the authors and no endorsement by FORHP, HRSA, HHS, or the University of Southern Maine is intended or should be inferred.

For more information on this study, please contact John Gale at *john.gale@maine.edu*

ACKNOWLEDGEMENTS

The authors thank the many dedicated people who volunteered their time to talk with us about their population health initiatives.

THE MEDICARE RURAL HOSPITAL FLEXIBILITY PROGRAM

The Medicare Rural Hospital Flexibility Program (Flex Program) is a Federal initiative that provides funding to State Governments to strengthen rural health. It allows small hospitals the flexibility to be licensed as Critical Access Hospital (CAHs); offers cost-based reimbursement for Medicare acute inpatient and outpatient services; encourages the development of rural health networks; and offers grants to States to help implement a CAH program in the context of broader initiatives to strengthen the rural health care infrastructure.

The Flex Program was created by Congress in 1997. Participating states are required to develop a State rural health care plan that provides for the creation of one or more rural health networks; promotes regionalization of rural health services in the State; and improves access to hospital and other health services for rural residents of the State. Consistent with their rural health care plans, states may designate rural facilities as CAHs.

CAHs must be located in a rural area (or an area treated as rural); be more than 35 miles (or 15 miles in areas with mountainous terrain or only secondary roads available) from another hospital or be certified before January 1, 2006 by the State as being a necessary provider of health care services. CAHs are required to make available 24-hour emergency care services that a State determines are necessary. CAHs may have a maximum of 25 acute care and swing beds, and must maintain an annual average length of stay of 96 hours or less for their acute care patients. CAHs are reimbursed by Medicare on a cost basis, i.e., for the reasonable costs of providing inpatient, outpatient and swing bed services.

The legislative authority for the Flex Program and cost-based reimbursement for CAHs are described in the Social Security Act, Title XVIII, Sections 1814 and 1820, available at http://www.ssa.gov/OP_Home/ssact/title18/1800.htm

TABLE OF CONTENTS

EXECUTIVE SUMMARY iii

INTRODUCTION 1

BACKGROUND 1

- Defining "Population Health" 2
- What Is Driving Expanded Hospital Involvement in Population Health and Community Health Improvement? 2

APPROACH 3

A PROFILE OF POPULATION HEALTH AND COMMUNITY HEALTH IMPROVEMENT INITIATIVES 4

- Iowa: Kossuth Regional Health Care 4
- Maine: Redington-Fairview General Hospital and Somerset Public Health 5
- Montana: Beartooth Billings Clinic 6
- Montana: Community Hospital of Anaconda 7
- Pennsylvania: Fulton County Medical Center 8
- South Carolina: Abbeville Area Medical Center 9
- Vermont: Mt. Ascutney Hospital and Health Center 10
- Wisconsin: Essentia Health St. Mary's Hospital-Superior 11

KEY FINDINGS AND OBSERVATIONS 12

- CAHs are engaged in a wide range of population health initiatives developed in response to unique hospital and community circumstances 12
- Population health initiatives stem from relationships hospitals have built with community stakeholders 13
- An early focus on public health provides a foundation for future population and community health improvement initiatives 15
- Strong leadership is critical 16
- Funding is always a problem and most programs have developed and survived based on grant funding 16
- Structure and infrastructure are important to success 18

IMPLICATIONS FOR THE FLEX PROGRAM 19

WORKS CITED 22

APPENDIX: INTERVIEW PARTICIPANTS 24

EXECUTIVE SUMMARY

Hospitals and health systems, including those serving rural communities, are increasingly embracing population health strategies as they move toward accountable care models of health care delivery and financing and seek to re-focus their community benefit activities to improve the overall health of their communities, demonstrating their accountability to local stakeholders. This paper looks at the population health strategies of a geographically diverse set of Critical Access Hospitals (CAHs) to identify key challenges, opportunities, and lessons that could inform the efforts of other CAHs and state Flex Programs.

This paper provides examples of eight CAHs and communities that have made substantial commitments to population health and community health improvement. Key themes that emerged from the qualitative interviews of the selected CAHs highlight the collaborative nature and the high level of community involvement of the various initiatives. Important factors include:

- a responsiveness to community health needs assessment;
- a strong board and hospital leadership;
- a well-developed infrastructure;
- skilled and dedicated staff;
- an organizational and governance strategy that allows for community partnerships; and
- a willingness to share responsibility, resources, and credit with community partners.

State Flex programs can support the development or expansion of population health and community health improvement initiatives in CAH communities in a number of ways. Connecting CAHs to public health agencies and other community organizations is one way to help them strategically identify and address local skill and capacity deficits. Flex programs can also be instrumental in helping CAHs by providing focused technical assistance in the areas of accessing funding opportunities and creating structured opportunities for knowledge sharing and learning from other CAHs. Building the evidence base on what works and what doesn't will be important for demonstrating the business case for CAH involvement in population health and health improvement, and Flex programs can play an important role in helping CAHs access, interpret, and track data on the health needs of their communities and regions.

INTRODUCTION

As they move toward accountable care models of health care delivery and financing, hospitals and health systems, including those serving rural communities, are increasingly embracing or seeking to re-focus their community benefit strategies to improve the health of their communities and demonstrate their accountability to local stakeholders. The Medicare Rural Hospital Flexibility (Flex) Program, administered by the Federal Office of Rural Health Policy (FORHP), Health Resources and Services Administration, Department of Health and Human Services, provides funding to state Flex Programs to support Critical Access Hospitals (CAHs) and their community partners to develop local systems of care. In its 2015 Competing Continuation Funding Announcement,[1] FORHP strengthened its emphasis on population health by encouraging state Flex Programs to develop initiatives that enhance communication and collaboration between different health care providers, improve patient experience when transitioning from one care setting to another, build emergency medical services capacity to best serve CAHs and their communities, and improve the health of rural communities through population health management. It further reinforced this emphasis by re-framing the Health System Development and Community Engagement (HSD/CE) program area as Population Health Management and Emergency Medical Services Integration.

The Flex Monitoring Team (FMT) at the University of Southern Maine has developed monitoring and evaluation systems to help CAHs, their communities, state Flex Programs, and FORHP track the performance of CAHs and understand hospital and community needs. The FMT's health system development and population health monitoring work has focused on identifying and quantifying the impact of CAHs on their communities, examining the community benefit activities of CAHs (including charity care and uncompensated care), the use of community health needs assessments, and CAH involvement in community population health.

Building on this work, this study sought to assess the population health strategies and models that CAHs have undertaken, the challenges they have faced, and the factors that have contributed to their successes. To this end, this paper discusses the initiatives and experiences of eight CAHs, offering a set of population health opportunities and challenges for CAHs and state Flex Programs based on these hospitals' experiences. The paper concludes with a discussion of how state Flex Programs, the Technical Assistance and Services Center (TASC), and others can assist and support CAHs with population health and community health improvement initiatives.

BACKGROUND

In 2007, the FMT published a policy brief on the community involvement and impact of CAHs and the Flex Program.[2] In addition to offering a framework for identifying and assessing different dimensions of community impact, the brief provided examples of CAH community engagement and community health improvement activities from hospital and community site visits conducted in six rural communities. Since that brief was published, there has been growing attention to the expanding role that hospitals, including CAHs, are playing in population and community health.[3-9] This interest has been driven by a variety of factors, including the push for greater accountability on the part of tax-exempt hospitals to identify and address community

health needs and increasing acknowledgement of population health as a critical component of new financing and delivery system models such as Accountable Care Organizations (ACOs).

Defining "Population Health"

The term "population health" has multiple meanings and uses in the context of healthcare financing and delivery system reform. Most healthcare providers use this term to refer to a defined population of patients for whom a healthcare provider might be responsible under value-based payment models, such as ACOs or shared savings programs.[10] In this usage, populations include cohorts of patient with chronic conditions, such as diabetes or asthma, whose care providers monitor and manage to achieve quality and/or cost outcomes. Public health and some hospital professionals use the term "population health" quite differently to refer to the health outcomes of groups of individuals whose group status is defined by geography (e.g. communities/regions), disability, socioeconomic status or other characteristics. [11] In this context, the term refers to a broader community-oriented versus patient focus.

This study identified and explored strategies and initiatives of CAHs that fit both definitions of "population health." To distinguish between the different initiatives and strategies tied to these definitions we use the term "population health" to refer to care management and other strategies and initiatives CAHs employ to better manage patient populations. In describing strategies and initiatives targeted to the broader community, we use the term, "community health improvement."

What Is Driving Expanded Hospital Involvement in Population Health and Community Health Improvement?

A number of forces are driving interest in population health and community health improvement in rural hospitals and communities. Tax-exempt and publicly owned hospitals are seeing growing expectations of greater accountability to address the unmet needs of their communities. These expectations are reflected in the Internal Revenue Service's (IRS's) 2007 revisions to its *Form 990—Return of Organization Exempt From Income Tax, Schedule H- Hospitals*—which established a mandatory community benefit reporting framework for 501(c)3, tax exempt hospitals.[12] They are also embodied in the 2010 Affordable Care Act requirement (Section 9007) specifying that tax exempt hospitals conduct triennial community health needs assessments (CHNAs) (with input from public health experts and other community stakeholders) and develop implementation strategies to prioritize and address the unmet health needs identified through their CHNAs. Even though hospitals cannot be held solely responsible for eliminating health challenges, many are calling on hospitals, including CAHs and rural hospitals, to be part of the solution by working with community partners and others to develop substantive evidence-based community health improvement strategies and initiatives that move beyond the simple counting of activities inherent in the community benefit guidelines. Given the scarce resources in many rural communities, hospitals are being encouraged to leverage the central role they typically play within their communities to engage and build partnerships with public health organizations, other healthcare providers, social service agencies, schools, municipal government, employers, and others to address community health needs.

The pressing health improvement needs of many of the communities in which CAHs are located are also compelling expanded involvement in community health improvement.[13] As noted in a recent *HealthLeaders* Magazine article:

> *Despite significant challenges, rural healthcare leaders are embracing population health as their future—not because it offers economic salvation (it doesn't), but because it makes perfect sense for their mission: to provide care for the community.*[14]

And finally, a growing number of CAHs and rural hospitals are becoming involved in health improvement activities through their own employee health and wellness programs as they try to manage their health benefit costs. These programs often serve as a gateway into broader community health improvement strategies and initiatives. Hospitals are also challenged to meet the needs of uninsured and low-income individuals using their emergency departments and others services. Due to local access barriers, these individuals often delay seeking care until their illnesses are at a more acute and expensive-to-treat stage. The development of targeted population health and community health improvement interventions can help hospitals to better manage their charity care and bad debt costs while improving the health of these populations.

The business case for becoming involved in population health and community health improvement initiatives is challenging for some hospitals, especially in the context of current financing arrangements that reward hospitals based on acute care encounters rather than for health improvement activities and emphasis volume over value. Yet, this business case is changing as CAHs contemplate or become involved in value-based, accountable care arrangements such as the Medicare Shared Savings Program[15] and Medicaid Accountable Health Communities initiatives.[16] In the near term, value-based payment models are creating incentives for hospital and other providers to develop improved care management systems for high need patients. At the same time, there is a clear business case for addressing the health needs of the two populations (i.e., employees and low-income individuals) for whom hospitals already have a financial obligation. With expanded care management and efforts to address more complex patient populations, there is increasing recognition, however, of the need to integrate health and social and supportive services to effectively address the underlying determinants of patients' complex health needs.

APPROACH

This study had two principal objectives. First, we sought to profile different population health and community health improvement approaches and initiatives of a geographically-diverse set of CAHs. Second, we aimed to use the experience and insights of these hospitals to identify key challenges, opportunities, and lessons that could inform CAHs and state Flex Programs as they consider strategies for improving the health of rural populations and communities.

The study includes a small, purposively-drawn sample of geographically-diverse CAHs. These hospitals were chosen to represent different population health and community health improvement strategies and programs, including community engagement, care management, wellness, and health improvement. The hospitals include both independent and system-affiliated CAHs. To identify and select the hospitals, we asked the 45 Flex Program directors to nominate

CAHs that have undertaken initiatives in the broad areas of: *care management* (e.g., disease care or chronic care management; worksite wellness; management of charity care; high cost users); *community engagement* (e.g., collaborative CHNAs; health promotion outreach to schools; stakeholder involvement; collaboration with non-traditional healthcare partners); or *integration* (e.g., collaboration on program development and implementation, sharing of resources, joint action plans, sharing of data across participants). Flex Coordinators nominated over 40 CAHs. Based on reviews of hospital and other websites, we selected 24 hospitals which we contacted to learn more about their initiatives. From these screening calls, we selected eight hospitals for in-depth follow-up interviews and information collection. Using a semi-structured interview protocol, we spoke with the hospital CEO and typically one to three other staff more directly involved in the hospital's initiatives. The interviews generally focused on obtaining details regarding the hospital's specific initiative(s) as well as information on the broader hospital and community. All interviews were recorded and transcribed in order to identify common themes across interviews and sites.

A PROFILE OF POPULATION HEALTH AND COMMUNITY HEALTH IMPROVEMENT INITIATIVES

This section describes the eight Critical Access Hospitals interviewed and their population health and community health improvement strategies and initiatives.

Iowa: Kossuth Regional Health Care

Kossuth Regional Health Care is located in Algona, a small city of 6,000 people in northeast Iowa and the county seat to Kossuth County which is home to roughly 15,000 people. Kossuth Regional Health Center (KRHC) is a county-owned CAH managed by Mercy Medical Center in Mason City, Iowa. KRHC is one of eight rural primary care hospitals managed by the Mercy Health Network – North Iowa. KRHC provides comprehensive primary care, health promotion, and education to its patients. In addition, it provides other services including acupuncture, emergency services, inpatient care, pharmacy, laboratory services, obstetrics, rehabilitation, surgery, and telemedicine.

The Kossuth Wellness Initiative is a well-established program in the community that brings together employers, city officials, hospital board members and staff, and other community leaders. Hospital and other leaders meet quarterly to discuss and plan strategies and specific initiatives to improve the health of the community, including health fairs, supporting the development of walking trails, and conducting health screenings. When the initiative started to lose energy, the CEO of KRHC decided to "kick start" a new phase in the program by linking it to Anthem's "Blue Zone" initiative. Launched in 2012, the Blue Zone initiative sought to mobilize communities to improve health through changes in lifestyle choices and behavior, physical and social environments, and policy. The hospital, together with other Kossuth employers, signed on to the initiative and became an official Blue Zones Worksite in the fall of 2013. Since then, the hospital and its partners have sponsored Blue Zone events in the community and have worked with elected officials to make local policy changes.

In addition to the hospital's and community's adoption of the Blue Zones initiative, the hospital has worked with the Mercy Health Network to build its care management capacity

"Regardless of whether Blue Zones came online or not, the hospital already had a fledgling community-wide wellness initiative in place. That's the key – hospitals should ask themselves 'What are we doing to reach out to other businesses and community organizations to make a difference in your own community's health?' That said, if it hadn't been for the Blue Zone framework, we never would have been able to make an impact in a lot of the most important areas. Blue Zone allowed us to take a more holistic approach."

–Scott Curtis, CEO, Kossuth Regional Health Care

and activities in preparation for the rollout of various accountable care organization (ACO) initiatives. Through the Mercy network, KRHC is participating in a Medicare Shared Savings ACO, a Blue Cross/Blue Shield ACO, and a Medicaid ACO. To participate, the hospital has teamed up with the Mercy network to build patient registries, establish a population health management office that provides health coaches, and develop a team to manage care transitions both within the Mercy system and with area nursing homes and other providers.

Maine: Redington-Fairview General Hospital and Somerset Public Health

Redington-Fairview General Hospital (Redington-Fairview) located in Skowhegan, Maine, is an independent CAH serving over 30,000 people in 21 towns and unorganized territories in its primary service area of Somerset County, in northwest Maine. In addition to its core hospital inpatient and outpatient services, Redington-Fairview supports a broad portfolio of community health improvement initiatives through Somerset Public Health (SPH), a local public health partnership organization funded by the hospital as well as federal, state, foundation, and other sources.

Redington-Fairview is actively engaged with its local communities and has catalyzed partnerships with community organizations to support the development of a wide variety of population health and community health improvement initiatives and programs. In 1998, the hospital's medical director led the development of a cardiovascular health task force and in 2001 the council became a broader based community coalition outreach program with support from the State of Maine's tobacco settlement program. The program director, hired by the hospital, developed a broad-based partnership of municipal, business, and community organizations throughout the county to undertake a wide variety of health improvement initiatives. The hospital is the organizational home to SPH, and partially funds and employs SPH's Executive Director and an administrative assistant. In addition, Redington-Fairview provides human resource support to employ staff, pays for the SPH's office space, and serves as the fiscal agent for grants and other funding. The Director of SPH reports to the hospital's Director of Education, and a hospital board member sits on SPH's Advisory Board.

Through this arrangement, SPH has secured funding for a wide variety of community health initiatives, including:

- The Move More Kids program supports the Healthy Kids Pack Project that sends kindergarten students home on the weekends with a healthy snack, breakfast, and lunch and also provides support for nutrition and physical activity policy and environmental

changes in schools and communities for area children. This effort includes Food Cupboards in many of the local school systems. The program was developed and funded in partnership with the New Balance Foundation and the local New Balance company.

- The *Micro Wellness Project for Small Businesses* offers worksite support to small businesses of 20 employees or less. Local policy and environmental changes to support substance abuse prevention, healthy nutrition and physical activity along with health screenings, weight management, oral health, and tobacco cessation services throughout Somerset County.
- The *Somerset Senior Strong Committee,* which includes the Area Agency on Aging and many other organizations, engages the elderly population in conversations around aging in place in highly rural areas. Food security, transportation and hospice services are among the issues being addressed.
- *Somerset Explorer Bus Service*, a local public transportation system development of SPH in partnership with the Kennebec Valley Community Action Program, local businesses, municipalities and New Balance to improve community access to health and recreational facilities, grocery stores, and other vital services.
- The *Student Intervention and Reintegration Program (SIRP)* for which SPF funds a school coordinator to support Prime for Life Education classes for students who have in-school suspensions related to substance abuse.
- The regional *Partnerships to Improve Community Health (PICH)* in which SPH collaborates with Eastern Maine Medical Center, MaineGeneral Hospital, and Health Reach Community Health Centers providing support for SPH's evidence-based chronic disease prevention programs.

Building on their work around nutrition, diabetes prevention, and healthy eating, Redington-Fairview and SPH helped secure grant funding to support a food bank and community-supported agricultural (CSA) program which have increased local access to healthy foods and boosted entrepreneurship in the area.

Montana: Beartooth Billings Clinic

Beartooth Billings Clinic (Beartooth), an affiliate of the Billings Clinic system, is an integrated CAH and physician clinic located in the small town of Red Lodge, Montana. With a population of approximately 2,500, Red Lodge is the seat of 2,000-square-mile Carbon County, located in the south-central region of the state with a total population of 10,000. Following successful establishment of a shared management arrangement with the Billings Clinic in 2002, the community-owned hospital and physician group practice moved to a newly-constructed medical campus in 2010. In addition to its inpatient and outpatient services, Beartooth manages Carbon County's public health contract and runs a local nonprofit children's center serving both hospital and community members.

Over the years, Beartooth has undertaken a wide variety of population health programs and community health improvement initiatives. Some, like cancer screening initiatives, are developed and led by hospital staff. Other initiatives, such as the hospital's tobacco prevention programs, are part of the Montana Tobacco Use Prevention Program funded by the state's Tobacco Master

Settlement Agreement. Other programs and initiatives developed and/or managed by the hospital have included:

- School nursing services for seven Carbon County schools, provided through the hospital's public health contract.
- The *Slide Safe Dress Smart* program, a safe winter activities program for area children operated by the hospital's trauma services coordinator in partnership with Red Lodge Mountain, a local ski area. The program serves approximately 20 schools in a 200-mile area and was awarded the National Ski Areas Association Helmet Safety Program of the Year in 2014.
- *Beartooth Billings Clinic's Children's Center*, the only state-licensed childcare center in Red Lodge, providing daycare, playschool, preschool, summer programming, and after-school services to over 100 students from local families.
- The *Re-Engineering Community Care: CrossTX Care Coordination Pilot* allowed the hospital to implement communication software that complements the health system's internal electronic medical record, facilitating coordination with outside health and social service providers. The pilot was part of the larger Frontier Medicine Better Health Partnership initiative funded by a CMS Innovations Grant and involves 24 CAH communities throughout the state.
- Beartooth's scholarship fund supports students and hospital/clinic staff seeking to pursue or further develop skills in a medical field.

Montana: Community Hospital of Anaconda

The Community Hospital of Anaconda (CHA) provides a full range of inpatient, outpatient, specialty, and rehabilitative services, as well as long-term services and supports, to the more than 9,000 residents of Anaconda-Deer Lodge County in southwestern Montana. The hospital has been recognized as one of the top 100 CAHs by the National Rural Health Association and as a baby-friendly hospital by UNICEF and the World Health Organization, and is a ten-time recipient of the Mountain Pacific Quality Health Foundation's Quality Achievement Award.

CHA's population health and health improvement initiatives have centered on its employee health and wellness program through which it engages the community. CHA offers a range of wellness initiatives that target hospital staff and their families, with some diffusion into the broader community. This work has focused largely on smoking cessation, breastfeeding, nutrition, and physical activity, with funding from the Montana Office of Rural Health, Montana's Department of Health and Human Services, and the hospital's human resources budget. CHA has supported a walking club, a "Battle of the Bulge" weight loss competition with a nearby hospital, one-on-one nutritional counseling for employees, and a healthy eating program that increased the availability of healthy food options in the hospital and local nursing home cafeterias.

In 2013, CHA implemented a diabetes prevention program (DPP) targeted to employees but also open to community members. The DPP is an intensive, 10-month program that uses the Centers for Disease Control and Prevention's National Diabetes Prevention Program curriculum

including food and exercise diaries and weight, blood pressure, and BMI monitoring to help participants achieve healthier lifestyles and reduce the onset and/or complications of diabetes. The hospital charges $125.00 to participate in the program but offers scholarships for people who cannot afford the fee. The program averages 50 attendees per year, with community members representing approximately three-quarters of the participants. The DPP has benefited from the support of physician champions who provide referrals to the program.

Pennsylvania: Fulton County Medical Center

Fulton County Medical Center (FCMC) is a non-profit corporation that operates a 21-bed CAH and 67-bed nursing home in McConnellsburg, Pennsylvania. FCMC provides a range of acute inpatient, long-term care, rehabilitation, home health, surgical, wound care, respiratory, cardiopulmonary, and emergency care services. The related FCMC Foundation funds health and wellness-oriented projects for the community, provides grants to local community organizations, scholarships for graduating high school seniors and current college students pursuing healthcare related careers and post-graduate stipends to students pursuing a clinical career.

FCMC operates a wide range of population health and community health improvement programs, including a community wellness and exercise program for seniors, monthly blood pressure checks at senior and employer locations, sponsorship of community gym night, Zumba and yoga classes. Fulton County Family Partnership, in which FCMC participates, administers the Pennsylvania Area Youth Survey in local 6th, 8th, 10th, and 12th grade classes to identify youth health risk and needs.

With funding from the Pennsylvania Flex Program and its own resources, FCMC contracted with the Healthy Communities Institute, a healthcare information technology company, to develop a Community Health Needs Assessment Dashboard to support its population and community health improvement activities. The dashboard provides data on initiatives in six priority areas:

- Children, youth, and families
- Quality of life for adults over 65
- Diet, obesity, and inactivity
- Diabetes
- Heart disease
- Alcohol, tobacco, and other drugs.

Data sources for these areas include secondary data entered by the Health Communities Institute and Pennsylvania-specific data entered by FCMC staff. The dashboard also provides a resource directory of evidence-based practices and potential funding sources. FCMC shares access to this information freely with other community providers and organizations. According to hospital staff, the dashboard facilitates coordination among the partners and helps to ensure that they are all working in the same direction.

As part of its population health and community benefit activities, staff from FCMC meet monthly with members of the Fulton County Family Partnership, a coalition of 20 local agencies.

Members use data from the dashboard to review progress on priorities areas with a focus on one of six priority areas during each monthly meeting. This allows a coordinated approach to local priority issues and provides a framework for engagement. The hospital plans to use the dashboard to facilitate collaboration during the next community health needs assessment to help identify priority areas of focus for the next three-year cycle.

South Carolina: Abbeville Area Medical Center

Abbeville Area Medical Center (AAMC) provides health care to the more than 15,000 residents of Abbeville and McCormick counties and the surrounding communities of northern South Carolina. According to Census statistics, Abbeville County residents tend to be poorer and less educated than those in other counties in South Carolina—two significant predictors of poor health outcomes. AAMC's population health and community health improvement initiatives involve substantial community engagement. In 2006, the hospital built a new 25-bed facility, and in addition to inpatient and outpatient services, AAMC offers a diabetes self-management program, sleep disorders clinic, outpatient rehabilitation services, and wellness and education programs. AAMC's population and community health improvement strategies are driven by its 2015 community health needs assessment. This assessment was conducted with broad community input and has resulted in the development of strategies to address issues related to nutrition/access to healthy foods, behavioral health, smoking, diabetes, and access to primary care.

AAMC is engaged in two major community health improvement initiatives: the Healthy Outcomes Plan (HOP) and its Community Paramedicine (CP) pilot program. HOP is sponsored by South Carolina's Medicaid program and calls for South Carolina hospitals to coordinate care and provide a medical home for a pre-determined number of low-income, uninsured residents who visited the emergency department at least five times in the last year and suffer from a chronic condition. The CP pilot is a joint venture between the AAMC, Abbeville County EMS, and the South Carolina Office of Rural Health. It provides care coordination and home-based monitoring for patients in the hospital's service area to reduce avoidable readmissions and ER visits by providing in-home monitoring and other services. These two programs, although distinctly separate, are closely intertwined with AAMC. The CP program serves as an extension of the HOP program and the free clinic by providing in-home monitoring and other services to the clinic's patients. As of June 2015, an evaluation of the CP program reported a 58.7 percent decrease in ER utilization.[17] Additionally, the United Christian Ministries of Abbeville County's Free Medical Clinic (UCMAC) serves the pre-identified HOP patients as well as other populations in Abbeville County.

> *"The predominant area where the community paramedic and the HOP fit in, in terms of population health management, is really in our [low-income, uninsured] populations. There's a lot of barriers to their care and so the community paramedic program and the HOP program have served to diminish those barriers. The CP piece has been a huge resource in terms of putting somebody in the home that can serve as an extension of the free clinic. That has been a huge benefit."*
>
> *-Chris Oxendine, MD, Medical Director of the UCMAC Free Clinic*

Vermont: Mt. Ascutney Hospital and Health Center

Mt. Ascutney Hospital and Health Center (Mt. Ascutney) is a non-profit entity affiliated with the Dartmouth-Hitchcock system located in Windsor, Vermont. Mt. Ascutney provides a wide range of inpatient, outpatient, long-term care, alternative complementary medicine, and rehabilitation services as well as the Windsor Community Health Clinic, a free clinic at its Windsor location. It also provides outpatient primary care and specialty services to the community of Woodstock, Vermont through the Ottauquechee Health Center. Mt. Ascutney has a long history of community services for which it and its staff have received state and national recognition, including the American Hospital Association's Foster G. McGaw Prize for community service in 2011.

Mt. Ascutney provides leadership, staffing, and resource support for several community initiatives, many of which have involved the development of local partnerships. In its role as a convener, the hospital has sought to build and maintain relationships among community providers and agencies and widely shares credit for the success of these initiatives among participants. The hospital has also played a leadership role in securing grant and other funding for many initiatives, again distributing that funding to participating partners.

> *"Part of what we have built into our strategy over the years has been a firm dedication to assessment and validation. We felt right from the beginning you can do programs to make you feel good, but for lasting changes we really wanted to use a best practice approach and evaluate the outcomes of what we'd done."*
>
> *-Jill Lord, RN, MS, Director of Patient Care Services / CNO, Mt. Ascutney Hospital and Health Center*

Since 1993, Mt. Ascutney has built its extensive population and community health improvement portfolio, resulting in the formation of a substantial community health infrastructure. Recent examples include:

- The development of a local partnership of health care providers, social service agencies, and other organizations whose goal is to integrate health and other community services under the *Vermont Health Care Innovation Project's Accountable Communities for Health* Initiative (Accountable Communities for Health). Mt. Ascutney Hospital was chosen to participate with 10 other Vermont communities. The initiative has been led by Mt. Ascutney under Vermont's State Innovation Models initiative for its Health Service Area.
- The Mt. Ascutney Hospital Community Health Committee, a subcommittee of the Board of Trustees, is dedicated to the hospital's mission of improving the lives of those served by the hospital by promoting population health and well-being.
- The *Windsor Area Community Partnership,* a coalition of community agencies and providers, convened by Mt. Ascutney, that facilitates strategic planning, ongoing communication, and local oversight in promoting the health of the community.
- The *Windsor Connection Resource Center* which provides for the physical co-location of local social services, and is a resource for community members to easily access needed services

and information, referral, advocacy, and case management services. Mt. Ascutney led the development of the Resource Center.

- The *Mt. Ascutney Prevention Partnership* and the *Windsor Area Drug Task Force*, substance abuse initiatives focusing on policy and environmental strategies to shift community attitudes and norms regarding alcohol, tobacco, and drug use. The hospital has been a leader and catalyst for both initiatives.
- The *PATCH community services* network, led by Mt. Ascutney, is an interagency collaboration of local providers supporting local development of the *Windsor Accountable Community for Health* project, providing an integrator function, shared strategies for population health improvement, community resident engagement, data sharing capacity, use of multilevel evaluation metrics, and a focus on sustainability and outreach.
- The Windsor Health Service Area (HSA) Coordinated Care Committee (CCC), is an interagency leadership collaborative dedicated to the triple aim. This leadership group integrates health and human service agencies representing ACO One Care Vermont and the Blueprint for Health striving to reach the triple aim.

An integral part of Mt. Ascutney's evolving community and population health improvement strategy has been a commitment to assessment and validation. Data is used as part of the community health needs assessment process to identify priority community needs as well as to assess the impact of interventions designed to address them. Given limited resources, established community health metrics and existing quantitative data from sources such as the Behavioral Risk Factor Surveillance System and the Youth Risk Factor Surveillance System, supplemented by qualitative data, are used to track the impact of the hospital's community health improvement strategies over time.

Wisconsin: Essentia Health St. Mary's Hospital-Superior

St. Mary's Hospital-Superior, Wisconsin is one of Essentia Health's many Catholic facilities in the upper Midwest, providing health care to the residents of Douglas County and surrounding communities in northern Wisconsin. The hospital provides a range of emergency, inpatient, and outpatient services. The hospital's more formal and strategic involvement in population health and health improvement initiatives dates back to 2012 when, through its IRS-mandated community health needs assessment, community stakeholders identified the acute lack of behavioral health providers in the Superior community as a priority health problem. At the time, residents needing mental health and/or substance abuse services had to travel to Duluth, Minnesota. Working with area behavioral health providers and community task groups, St. Mary's assessed the scope of the problem and the community's current capacity.

With this information, the hospital staff, in collaboration with the Essentia Institute for Rural Health (EIRH), developed a proposal for a Wisconsin Office of Rural Health (WORH) Rural Community Grant in July 2013 to support the development of an integrated behavioral health program at the hospital and in its primary care clinics. Diverting patients from the emergency room and keeping them in the Superior area was a key goal of the plan. The model called for the implementation of an evidence-based screening tool, the PHQ-9, by primary care providers to identify patients with behavioral health issues. Patients identified through the screening process are referred to the behavioral health practitioners, hired with funding and support from

the EIRH. Funds from the WORH Community Grant funded the evaluation component of the intervention and initially supported a portion of the salary of an EIRH scientist and, later, a portion of the salary of an EIRH biostatistician.

In the course of developing and implementing the integrated model, the hospital expanded its partnerships with non-behavioral health providers and community agencies to ensure patients access to a broader set of health and social services. The hospital also established a dashboard of metrics to track implementation progress.

KEY FINDINGS AND OBSERVATIONS

CAHs are engaged in a wide range of population health initiatives developed in response to unique hospital and community circumstances

Most of the CAHs interviewed for this briefing paper conducted a community health needs assessment to identify priorities in the communities they serve. This is not surprising given the ACA-mandated changes to the Internal Revenue Service's tax code requiring tax-exempt hospitals to conduct triennial needs assessments and develop an implementation strategy to address identified needs. Regardless, these findings highlight the importance of community health needs assessments as part of a population health and community health improvement strategy.

All eight of the study hospitals are involved in initiatives that lie on different points on the population health and community health improvement continuum. Many of these initiatives have traditionally been the domain of local public health programs. Some have chosen to develop interventions to improve access to and coordinate the delivery of care (e.g., Abbeville's HOP and community paramedicine program); develop essential community services that would otherwise be unavailable (e.g., Saint Mary's integrated behavioral health program); implement programs to address the higher rates of chronic conditions in many rural communities (e.g., Community Hospital of Anaconda's diabetes and hypertension programs); develop community and employer-oriented wellness programs (e.g., Kossuth's Blue Zone Program and Redington-Fairview's wellness program for small employers), or manage and support the local public health infrastructure (e.g., Beartooth and Redington-Fairview).

Others are focused on developing collaborative planning and organizing infrastructures (e.g., Mt. Ascutney, Fulton County, Redington-Fairview, and Kossuth) that engage local providers and stakeholders to provide a platform for the development of local solutions to vexing population and community health issues plaguing their communities. Still others seek to share key resources to develop population health and community health improvement initiatives (e.g., Mt. Ascutney's and Redington-Fairview's commitment of grant writing staff to develop funding streams and Fulton County's sharing of its community health dashboard and data to organize collaborative local planning efforts).

These interventions necessitate that hospital staff engage with a wide range of community providers and stakeholders in developing and implementing population health and community health improvement strategies that extend beyond the hospital doors into the community at

large. Not only does this require hospital leadership to share power, credit, and control with other community providers and stakeholders, it requires hospital leadership to think more globally about the outcomes of their community-oriented strategies and to move away from the traditional fee-for-service mindset that has been at the core of hospital management for many years. These are not easy changes for some hospital administrators and boards to make.

Population health initiatives stem from relationships hospitals have built with community stakeholders

Hospitals with well-established population health initiatives emphasized the importance of relationship building with key community stakeholders. Stakeholders from Redington-Fairview, M.t Ascutney, Beartooth, and Fulton County—four CAHs with long histories of community health improvement activity—noted that outreach and engagement around community health issues and proposed population health and community health improvement interventions can increase buy-in and participation among local providers, organizations, and residents. Importantly, the long term viability of initiatives can be strengthened by promoting shared ownership and strategically leveraging the available infrastructure and financial resources of partner organizations. It may be particularly important for independent CAHs to engage community stakeholders and outside agencies, as they typically lack the resources and infrastructure of CAHs that are affiliated with larger health systems. For example, CAHs that lack the internal capacity or staff time to pursue grant funding for population health improvement efforts can benefit greatly from partnerships with stakeholders that have experience in fundraising and grantsmanship. CAH-based population health initiatives are better able to launch and sustain themselves when administrators and staff purposively engage and build lasting partnerships with key community stakeholders.

Interviewees pointed to several key organizational and community attributes that have enabled hospitals like Redington-Fairview of Skowhegan, Maine, and Mt. Ascutney in Windsor, Vermont to build strong and lasting working relationships with a range of local stakeholders. These include a critical mass of dedicated leaders and champions in the hospital, public health, and other social service organizations; long-established relationships between hospital administrators, staff, and local residents; open and frequent communication among key partners and the community; hospital participation in collaborative meetings, nonprofit boards, and statewide community health needs assessments; and the cultivation of trust and rapport developed though the sharing of effort, resources, and credit for local success. The investments made by hospitals in providing staffing and infrastructure for population health initiatives have come to be seen as not only the right thing to do to improve the health of their community, but also as a viable strategy in the face of larger health system trends away from the fee-for-service system and towards payment and delivery models that incentivize prevention, chronic disease management, and quality.

> *"One of the other hallmarks of what we've done in our journey has been to create partnerships and give away credit. We knew early on that it was critical to develop a sense of partnership and to build trust, respect, and community ownership of programs."*
>
> *-Jill Lord, RN, MS, Director of Patient Care Services / CNO, Mt. Ascutney Hospital and Health Center*

Interviewees at these hospitals emphasized the critical role that open communication and outreach have played in building widespread trust in the work of the hospital, public health, and community health systems. They stressed the importance of allowing for joint leadership of community projects and widely sharing credit for success with local partners. They also noted that the development of trust and respect takes time and must be nurtured carefully. Interviewees at Mt. Ascutney explained that community stakeholders were initially skeptical of the hospital's motivations for engaging in community and public health improvement activities. The hospital was able to overcome this skepticism through transparent operations, open and regular communication, the sharing of hospital resources such as grant writers to support program development, and a willingness to recognize and promote the role of local providers in program success.

Interviewees from Fulton County Medical Center made similar observations in the development of the Fulton County Family Partners, a group of 20 local providers that meets monthly to review progress on six priority health issues. Fulton County freely shares access to the data from its Community Health Needs Assessment Dashboard with members of the Fulton County Family Partners, other local organizations, and members of the community, and believes that the process of sharing and reviewing the data provides a common framework to improve the health of its community.

CAH staff play an important role in bridging relationships with community organizations through their service on local boards, participation in local planning groups, and engagement with community service programs and activities. Through our interviews, we found numerous examples of CAH staff involvement in building relationships and partnerships with community organizations, community members, and provider organizations and demonstrate the connection of these CAHs to their communities. For example, the head of Redington-Fairview's education department also manages community outreach work around prevention and wellness care. Similarly, Mt. Ascutney's Director of Patient Care Services and Chief Nursing Officer has been widely recognized for her role in community organizations such as area task forces focused on opioid issues and was named the Vermont Medical Society's Citizen of the Year for 2014 for her contributions to the health of Vermonters. Hospital leaders from Kossuth Regional Health Care are active in the Kossuth Wellness Initiative that brings together a wide range of employers, community leaders, government officials, hospital staff, and others to plan strategies to improve the health of the community. Beartooth is an active participant in the Frontier Medicine Better Health Partnership involving 24 CAH communities throughout Montana. Fulton County meets monthly with 20 other local agencies through the Fulton County Family Partnership to discuss progress on meeting identified health priorities. Both Abbeville Medical Center and Essential Health St. Mary's Hospital-Superior engaged a wide range of community stakeholders through their community health needs assessments and used their input to develop targeted community health improvement initiatives.

Hospital board members also play an important role in developing community relationships through their multiple roles as citizens, providers, employers, civic leaders, and hospital representatives. Redington-Fairview, for example, maintains a 15-member Board of Directors with representatives from towns throughout the CAH's service area. Importantly, at Redington-Fairview almost all board members participate on subcommittees and taskforces designed to

address key community health issues such as substance abuse, physical activity and nutrition, and other priority areas of their comprehensive health improvement plan. These subcommittees and taskforces also include external community members and stakeholders.

An early focus on public health provides a foundation for future population and community health improvement initiatives

Early community health improvement efforts by CAHs can lay important groundwork for future collaboration and partnerships. For example, the earliest population health work by health leaders in Skowhegan (including physicians, hospital and public health administrators) originated within the context of a cardiovascular public health task force that was formed in the early 1980s and brought the local provider community and public health together to increase community awareness around cardiovascular health issues and boost the visibility of hospital nursing staff. This initial work provided a foundation for Redington-Fairview to work with key stakeholders to address community health issues and build linkages with a wide network of actors including local employers, schools, healthcare providers, and various nonprofit organizations.

> *"If you're pursuing the Triple Aim, you have to be thinking about health, and then health automatically brings you out into the social determinants. So, certainly, if the funding system moves us to responsibility for health in communities, then public health and those kinds of efforts are going to be crucial to success."*
>
> *-Roger Renfew, MD, formerly of Redington Fairview General Hospital*

Similarly, Beartooth Billings Clinic's role in managing their county public health contract and children's health center provided a natural entry point for the health system to launch efforts to increase immunization rates among local children. The hospital's public health activities, which include everything from maternal and child health to school nursing to emergency and disaster preparedness, have fostered close linkages with a variety of community stakeholders including local schools, employers, and other healthcare and social service providers. Despite the fact that operation of the children's center and public health contract have a negative impact on the hospital's Medicare cost report (by adding non-Medicare expenses and reducing the share of fixed and overhead costs attributable to the Medicare program), these initiatives continue to be prioritized because program leaders, hospital administrators, and board members view them as a fundamental community obligation.

And finally, since the early 1990s, Mt. Ascutney has supported the development state, regional and community focused partnerships to integrate health and other community services under the Mt. Ascutney Hospital Community Health Foundation and the Windsor Area Community Partnership. The Windsor Area Community Partnership facilitates strategic planning, ongoing communication, and local oversight in promoting the health of the community; the Mt. Ascutney Prevention Partnership and the Windsor Area Drug Task Force to shift community attitudes and norms regarding alcohol, tobacco, and drug use; and the PATCH community services network, an interagency collaboration of local providers supporting the Windsor Accountable Community for Health project. These partnerships have resulted in the development and coordination of a number of community health initiatives.

Strong leadership is critical

According to a recent report by the American Hospital Association, hospitals that are moving to a value-based environment are also focused on the broad goals of population health management.[5] These goals include improving the overall health of their communities by promoting integrated care, reducing readmissions, providing increased access to primary care, and tackling health challenges. Hospital boards, then, will be at the forefront of this effort and work to strengthen community collaborations and strategic partnerships.

The importance of strong executive and board leadership in developing collaborative population health and community health improvement strategies was a common theme that emerged from our interviews. Mt. Ascutney's community health improvement efforts, for example, date back to the early 1990s when the hospital's senior leadership recognized that they needed to do more than treat the sick and injured. As a community facility, they believed that it was Mt. Ascutney's mission to change the health status of the community and to meet its residents' needs. Given its ties to the community, these hospital leaders believed that it should be possible for Mt. Ascutney to achieve these goals. At their request, the hospital's board committed resources to engage other community providers and organizations, develop partnerships and networks, implement collaborative projects, and prepare grant applications to fund this ongoing work. Stakeholders describe the challenging, long-term tasks of building and maintaining respect, trust, and rapport among community organizations that might be suspicious of the hospital's motives in developing new programs and services.

Hospital leaders at Redington-Fairview, Beartooth, Kossuth, and Fulton County raised similar points about the importance of executive leadership and board support. Interviewees from Beartooth noted board support was critical since their public health and children center activities were not self-supporting. Beartooth's CEO described the hospital as having a "very proactive leadership culture" and the board as forward-looking ("visionary"). The board maintains a standing agenda item, "the interactive dialog," during its meeting that is built around a shared culture of community leadership—looking for ways that Beartooth can position itself as a good citizen in the community. Redington-Fairview's CEO also acknowledged that some of its public health activities are not profitable but are the "right thing to do" given the needs of their service area. Bi-monthly board meetings typically include a designated "missions moment" where attendees are reminded of their joint mission and encouraged to share examples of work going on in the community.

Funding is always a problem and most programs have developed and survived based on grant funding

Among the hospitals interviewed, external funding (primarily through grants) was important to developing and implementing projects. Although many of the participating hospitals relied on grants for their population health initiatives, some respondents expressed concern that doing so for long-term sustainability can be problematic. In some cases, grant funding was primarily used during the development and implementation phase of an initiative. Examples include the development of behavioral health services by St. Mary's Hospital in Superior, Wisconsin that received support from the Essentia Institute for Rural Health to hire clinicians for the program and from the Wisconsin Flex Program to support evaluation and tracking of the initiative; the implementation of the Healthy Communities Institute Dashboard by Fulton County Medical

Center that received support from the Pennsylvania Flex Program to help fund the annual fees for the Dashboard; and the Kossuth Regional Health Center's Blue Zone project which received initial grant funding from Wellmark BlueCross BlueShield and access to a dedicated part-time advisor to work with the community as a program coach. The CEO noted the Blue Zone grant funding has been essential to their population health strategies.

In other cases, such as Mt. Ascutney, Redington-Fairview, and Beartooth, grant writing forms a significant part of the hospital's overall population health funding strategy. Early on, Mt. Ascutney's leadership recognized the importance of grants to the development of population health and community health improvement strategies and dedicates a significant amount of staff time in exploring different funding opportunities and preparing applications for funding. Part of Mt. Ascutney's strategy is to disseminate grant funds to community partners to support their participation in collaborative population and community health improvement initiatives. The Director of Patient Care Services/CNO estimates that at least one-third of her time is dedicated to grant writing, program management and evaluation. The costs for her time and other administrative support are considered in-kind contributions by the hospital. Although this can be difficult at times due to the hospital's financial position, the Board and administration recognize these contributions as part of the hospital's community responsibilities.

Mt. Ascutney also receives other funding that support population health activities including the receipt of per-member/per-month payments from Medicare, Medicaid, and other third party payers for its community health teams as a result of its status as a Blueprint for Health community achieving National Committee for Quality Assurance (NCQA) recognition as a patient centered medical home. Respondents also noted that Vermont is like a "petri dish" for experimentation with health reform. As a result, they feel like they have "a foot in two different canoes – one reimbursing the hospital through traditional fee-for-service mechanisms and one representing health reform payment systems under Vermont's Blueprint for Health." They noted that negotiating the transition between the two systems very is difficult for the hospital.

Beartooth provides another example of a CAH's population health strategy supported through multiple funding sources including grants and contracts. Beartooth manages the county's public health functions under a long-standing contract authorized by the County Commissioners for Stillwater County. Although the contract operates at a loss to the hospital, the Board and administration recognize the value of this service to the community and absorb the loss. The individuals interviewed at Beartooth raised a very important concern regarding the impact on hospital financing of population health and community health improvement initiatives, particularly those not provided to Medicare beneficiaries. These non-Medicare focused initiatives, many of which are not reimbursable by third party payers, draw fixed and overhead costs away from the hospital's Medicare cost center thereby reducing share of fixed and overhead costs attributable to the delivery of Medicare services.* This creates additional funding and reimbursement challenges that impact program sustainability. Interviewees also raised concerns

* CAHs are reimbursed at 101% of all direct and indirect (overhead) costs attributable to the delivery of services to Medicare beneficiaries. Indirect costs (e.g., administration, patient accounting, information technology, environmental services, utilities, etc.) represent the overhead costs of operating the hospital and all related services and are not directly attributable to the operation of any one specific service. The delivery of services and programs to non-Medicare beneficiaries, such as population health programs targeting children or employee wellness, consume a portion of the hospital's indirect (overhead) costs. This has the effect of reducing the share of indirect (overhead) costs reimbursed by Medicare.

about reliance on grant funding due to the challenges of sustaining programs following the end of grant funding.

Another important source of support involves in-kind contributions of staff time and hospital resources to support activities such as grant writing, program development and management, meeting coordination and scheduling, and community health assessment activities. While this support frequently does not entail direct cash outlays, it does represent a commitment of hospital resources to provide administrative and leadership support. For example, the Director of Patient Care Services/CNO of Mt. Ascutney serves on several boards and in leadership roles for a number of community organizations and initiatives. The CEO at Kossuth noted that many community stakeholders erroneously assume that the hospital has deep pockets. In reality, Kossuth's provides in-kind meeting and administrative support for external Blue Zone related activities but they manage these expenses carefully. Although in-kind costs supporting community benefit and population health activities are frequently not recoverable by the hospital, many of these costs can be reported as part of the hospital's annual IRS's community benefit reporting obligations on IRS Form 990.

Structure and infrastructure are important to success

Staffing: In each of the hospitals interviewed, having a dedicated and skilled staff working on their population health initiatives was critical to success. Each noted that having a consistent staff with the dedicated time, responsibilities, and appropriate skills was essential, regardless of whether the initiative involved developing and managing an employee wellness program or collaborating with community partners on specific community-level health improvement projects. For example, the CEO of Redington-Fairview General Hospital noted that the hiring of the Director of Somerset Public Health was a critical step in moving to a sustainable set of community health programs. The hospital's commitment to this position sent a clear signal to the community that the hospital was serious in its commitment to community engagement and to Somerset Public Health. The CEO also noted that having someone with community engagement, fund raising, proposal writing, and other skills and experience has made a significant difference in their collective ability to form a strong hospital-community partnership and to generate projects that represent community priorities and are fundable by state, foundation, and other sources. As in the Redington-Fairview example, Mt. Ascutney's population health strategy and initiatives have been aided by having a dedicated staff who have provided critical leadership in building the community partnership, designing community health programs, and securing the necessary funding to implement and sustain them.

Administrative Support: The hospitals interviewed have each played a key role in providing necessary administrative support for building and managing population health initiatives. In many rural communities, the hospital is the one community organization with the financial management, human resources, and other management infrastructure needed to hire staff and receive and manage grant funding. Although the hospital may be viewed suspiciously by some community agencies, these perceptions can be overcome, as noted earlier. In the case of Redington-Fairview, having the Director of Somerset Public Health as a hospital employee reporting to a senior member of the hospital leadership was a strategic choice for both the hospital and the community partners. In addition to reducing the administrative burden for the community partners who tend to be small social service agencies, this arrangement has enhanced

communications between the community and the hospital. To further enhance the partnership nature of this arrangement, a member of the community board of Somerset Public Health was invited to sit on the hospital board.

Organization and Governance: The administrative and governance approaches taken by Redington-Fairview and Somerset Public Health and Mt. Ascutney exemplify the importance of establishing a formal organizational structure that supports both the hospital's and the community's needs. In both instances, a key element of the organization has been the goal of establishing a formal entity that could support the broad range of population health initiatives envisioned by the community partners. Creating such an entity entailed risk with questions about the extent to which these strategies could be supported long term but it also reflected the seriousness of purpose and goals that the community partners had embraced.

Organizational structure also carries with it the opportunity and need to sort out accountability and governance systems. As noted, both Redington-Fairview and Mt. Ascutney have established organizations with shared governance structures that maintain the independence of the hospital and the community entity but also include board membership arrangements that promote communication, coordination, and collaboration across the hospital and community organization.

Not all population health initiatives require such elaborate organizational arrangements. In many instances, such as Essentia Health in Wisconsin, the hospital-community collaboration may be more narrowly focused on specific organizations in the community. In this example, Essentia Health worked closely with a small, yet dynamic consortium of behavioral health care providers to integrate primary care and behavioral health services in Douglass County.

Goals, Strategy, and Expected Outcomes: As the National Rural Health Resource Center notes in its guide to population health for CAHs,[18] accountability through the use of formal measures and dashboards can be critical for a variety of reasons. First, and most importantly, the development of measures and a dashboard requires that the hospital and community partners formally establish a plan that specifies goals, objectives, and expected outcomes. Not only does this reinforce the serious purpose of these activities, but it is also consistent with the IRS CHNA-related requirements. Success is very motivating, and these goals, objectives, and dashboard measures can encourage and maintain community partners' engagement. They can also be vital in making the case to funding partners to invest in or continue to fund population health initiatives. Metrics and dashboards help track when targets are not met, allowing for reflection and corrective action. Fulton County Medical Center's CHNA Dashboards have been instrumental in targeting community health needs in their service area and providing a vehicle around which to organize collaborative efforts to address identified priorities.

IMPLICATIONS FOR THE FLEX PROGRAM

As noted earlier, the most recent guidance from the Federal Office of Rural Health Policy focuses the Flex Program on three priority areas, including Population Health Management and Emergency Medical Services.[1] This re-focused emphasis on population health responds to the increasingly important opportunities for addressing serious challenges in the health of rural populations and communities across the country. It also reflects the growing movement toward

accountable, value-based payment and delivery system arrangements which require health providers and systems to better manage patients' health and chronic conditions.

Although community engagement has been a staple of rural hospital management, the new emphasis on population health and community health improvement is relatively recent and often unfamiliar to many administrators. Tax-exempt rural hospitals are subject to the same regulatory requirements under the IRS's community benefit reporting and community health needs assessment requirements, but rural hospitals often lack the resources and capacity of larger urban hospitals to invest in and sustain population and community health initiatives. Indeed, some rural hospital administrators and boards argue that without explicit payment for such programs, it makes little sense to pursue them. In some ways, this argument is shortsighted given the accountability that tax-exempt and public hospitals have to their communities for either the tax benefits or public financing and support they receive. As has previously been discussed, there is a strong business case for hospitals to implement population and community health improvement strategies targeted to their employees and the low-income, uninsured populations served through their charity care and financial assistance programs. In addition, many hospitals already have an investment in a range of community benefit activities and that investment could be re-programmed to better improve the health of their communities and residents.

In support of these arguments and as demonstrated in this paper, CAHs and communities have made compelling, substantial commitments to population health and community health improvement, sometimes at the expense of their bottom line. Why? As reported earlier, one administrator answered this question by saying, "Because it's the right thing to do." Moreover, a number of the hospitals interviewed noted that engagement in population health and community health improvement has helped them strengthen their relationship with the community in ways that support their core inpatient and outpatient services.

So how can state Flex programs support the development or expansion of population health and community health improvement services and programs in CAH communities? These hospitals' experiences indicate that building (or making available) the requisite population health and health improvement skills to develop and maintain these programs is essential. To do this, state Flex programs can connect CAHs to state and/or local public health agencies to work with CAHs and their communities to strategically identify and address their skill and capacity deficits. As demonstrated by the CAHs that participated in the study, substantive collaboration along with shared leadership, resources, and credit are critical to the implementation and operation of strong community-based interventions. State Flex Programs can support CAH and community collaboration through facilitation support, technical assistance, and the sharing of governance and resource documents and materials. They can also provide technical assistance to support hospitals and community partners in conducting collaborative community health needs assessments, prioritizing key needs, identifying and scaling successful interventions used by other hospitals and communities, and developing required strategy plans to address those needs.

Through technical assistance and grant writing support, state Flex programs can also help CAHs and their communities, access funding opportunities that are critical to mounting effective programs. Although some CAH administrators are cautious about not wanting to take on grant funded programs that they cannot sustain, the hospitals' experiences in Vermont, Maine and

elsewhere suggest that this fear may be unfounded. It appears that success often breeds success and that grant-funded projects are stepping stones to larger programs.

In their convening and education role, state Flex programs can also create structured opportunities for knowledge sharing and learning, as they have done successfully in many states around patient safety and quality improvement. Even when CAH administrators are committed to developing or expanding their population health and community health improvement initiatives, they often don't know where and how to start. Learning from other CAHs, together with focused technical assistance, can often help overcome the paralysis associated with not knowing how to begin.

Finally, building the evidence base on what works and what doesn't will be important for demonstrating the business case for CAH involvement in population health and health improvement. In addition to contributing to the evidence base for successful population health initiatives implemented by small rural hospitals, CAHs can shape their population health strategies by selecting and adapting existing evidence-based programs targeting the priority health needs and conditions in their communities. CAHs can draw on a variety of evidence-based population health resources assembled by organizations such as the Community Preventive Services Task Force,[19] the U.S. Preventive Services Task Force,[20] the New York Academy of Medicine and Trust for America's Health,[21] the Centers for Disease Control and Prevention's Prevention Research Centers,[22] and the Substance Abuse and Mental Health Services Administration.[23]

Flex programs can play an important role in helping CAHs access, interpret, and track data on the health needs of their communities and regions. Setting quantifiable targets for health improvement, enabling CAHs to benchmark key indicators at comparable hospitals and communities, identifying strategies to address community health priorities, and even evaluating population health and health improvement initiatives are all important roles for state Flex programs.

WORKS CITED

1. Federal Office of Rural Health Policy. Medicare Rural Hospital Flexibility Grant Program. Funding Opportunity Announcement. Rockville, MD: U.S. Department of Health and Human Services, Health Resources and Services Administration; February 3, 2015. HRSA-15-038.
2. Gale JA, Coburn AF, Freeman V, Gregg WR, Slifkin R. The Community Impact of Critical Access Hospitals. Portland, ME: Flex Monitoring Team;2007. Policy Brief #2.
3. American Hospital Association. Engaging Health Care Users: A Framework for Healthy Individuals and Communities. Chicago, IL: AHA; January, 2013.
4. American Hospital Association. Your Hospital's Path to the Second Curve: Integration and Transformation. Chicago, IL: Health Research and Educational Trust; January, 2014.
5. American Hospital Association. Leadership Toolkit for Redefining the H: Engaging Trustees and Communities. 2015.
6. Institute of Medicine. Population Health Implications of the Affordable Care Act: Workshop Summary. Washington, DC: The National Academies Press 2013.
7. Institute of Medicine. The Role and Potential of Communities in Population Health Improvement: Workshop Summary. Washington, DC: The National Academies Press; 2014.
8. National Quality Forum. Multistakeholder Input on a National Priority: Improving Population Health by Working with Communities: Environmental Scan and Analysis to Inform the Action Guide. Washington, DC: NQF; December 20, 2013.
9. National Quality Forum. Multistakeholder Input on a National Priority: Improving Population Health by Working with Communities—Action Guide 1.0. Washington, DC: NQF; August 1, 2014.
10. Halfon N, Long P, Chang DI, Hester J, Inkelas M, Rodgers A. Applying a 3.0 Transformation Framework to Guide Large-Scale Health System Reform. *Health Aff* (Millwood). November 2014;33(11):2003-2011.
11. Kindig D, Stoddart G. What Is Population Health? *Am J Public Health*. Mar 2003;93(3):380-383.
12. Internal Revenue Service. Instructions for Schedule H (Form 990): Hospitals. Washington, DC: IRS;2009.
13. Meit M, Knudson A, Gilbert T, et al. The 2014 Update of the Rural-Urban Chartbook. Bethesda, MD: NORC Walsh Center for Rural Health Analysis; October, 2014.
14. Cummins J. Population Health Poses Unique Challenges in Rural Areas. [Web Page]. 2015, October 28. Available at: http://www.healthleadersmedia.com/community-rural/population-health-poses-unique-challenges-rural-areas. Accessed April 29, 2016.

15. Centers for Medicare and Medicaid Service. Medicare Shared Saving Program. [web page]. 2015, December 2. Available at: https://www.cms.gov/Medicare/Medicare-Fee-For-Service-Payment/sharedsavingsprogram/index.html. Accessed June 14, 2016.

16. Centers for Medicare and Medicaid Service. Accountable Health Communities Model. [web page]. 2016, May 18. Available at: https://innovation.cms.gov/initiatives/AHCM. Accessed June 14, 2016.

17. Bennett KJ, Yuen MW. Abbeville Community Paramedicine Evaluation Report. Columbia, SC: University of South Carolina Rural Health Research Center; November 6, 2015.

18. Technical Assistance and Services Center, Stratis Health. Improving Population Health: A Guide for Critical Access Hospitals. Duluth, MN: National Rural Health Resource Center;2014. Critical Access Hospital Population Health Summit, March 25-26, 2014.

19. Community Preventive Services Task Force. Guide to Community Preventive Services. [web page]. 2015, April 6. Available at: http://www.thecommunityguide.org/. Accessed August 26, 2016.

20. U.S. Preventive Services Task Force. USPSTF Home Page. [web page]. 2016. Available at: http://www.uspreventiveservicestaskforce.org/. Accessed August 29, 2016.

21. New York Academy of Medicine, Trust for America's Health. A Compendium of Proven Community-Based Prevention Programs. 2013. Available at: http://healthyamericans.org/report/110. Accessed August 24, 2016.

22. Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion. Prevention Research Centers. [web page]. 2016, June 13. Available at: http://www.cdc.gov/prc/. Accessed August 29, 2016.

23. Substance Abuse and Mental Health Administration. Prevention of Substance Abuse and Mental Illness. [web page]. August 9. Available at: http://www.samhsa.gov/prevention. Accessed August 29, 2016

APPENDIX: INTERVIEW PARTICIPANTS

Iowa: Scott Curtis, Administrator, Kossuth Regional Health Care, Algona

Maine: Bill Primmerman, Director, Somerset Public Health; Roger Renfrew, MD; Dick Willett, CEO Redington-Fairview Hospital, Skowhegan

Montana (Beartooth Billings Clinic): Kelly Evans, Chief Administrative Officer; Kevin Larson, Director of Clinic Services, Red Lodge

Montana (Anaconda): Meg Hickey-Boynton, VP, Human Resources; JoEllen Villa, RN & VP, Quality & Regulatory Compliance, Community Hospital of Anaconda

Pennsylvania: Misty Hershey, Director of Community Relations and Benefit, Fulton County Medical Center, McConnellsburg

South Carolina: Chris Oxendine, MD, Abbeville

Vermont: Jill Lord, RN, MS, Director of Patient Care Services and CNO; Melanie Sheehan, Director of Community Health Outreach, Mt. Ascutney Hospital and Health Center, Windsor

Wisconsin: Diane Holiday Welsh, Operations Administrator; Karly Madill, Clinical Administrator; Terry Jacobson, Vice President, Essentia Health-St. Mary's Hospital, Superior