Rural Hospital Partnerships for Health Improvement

Financing, Governance, Models

Andy Coburn, Director
Maine Rural Health Research Center

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UNIVERSITY OF SOUTHERN MAINE
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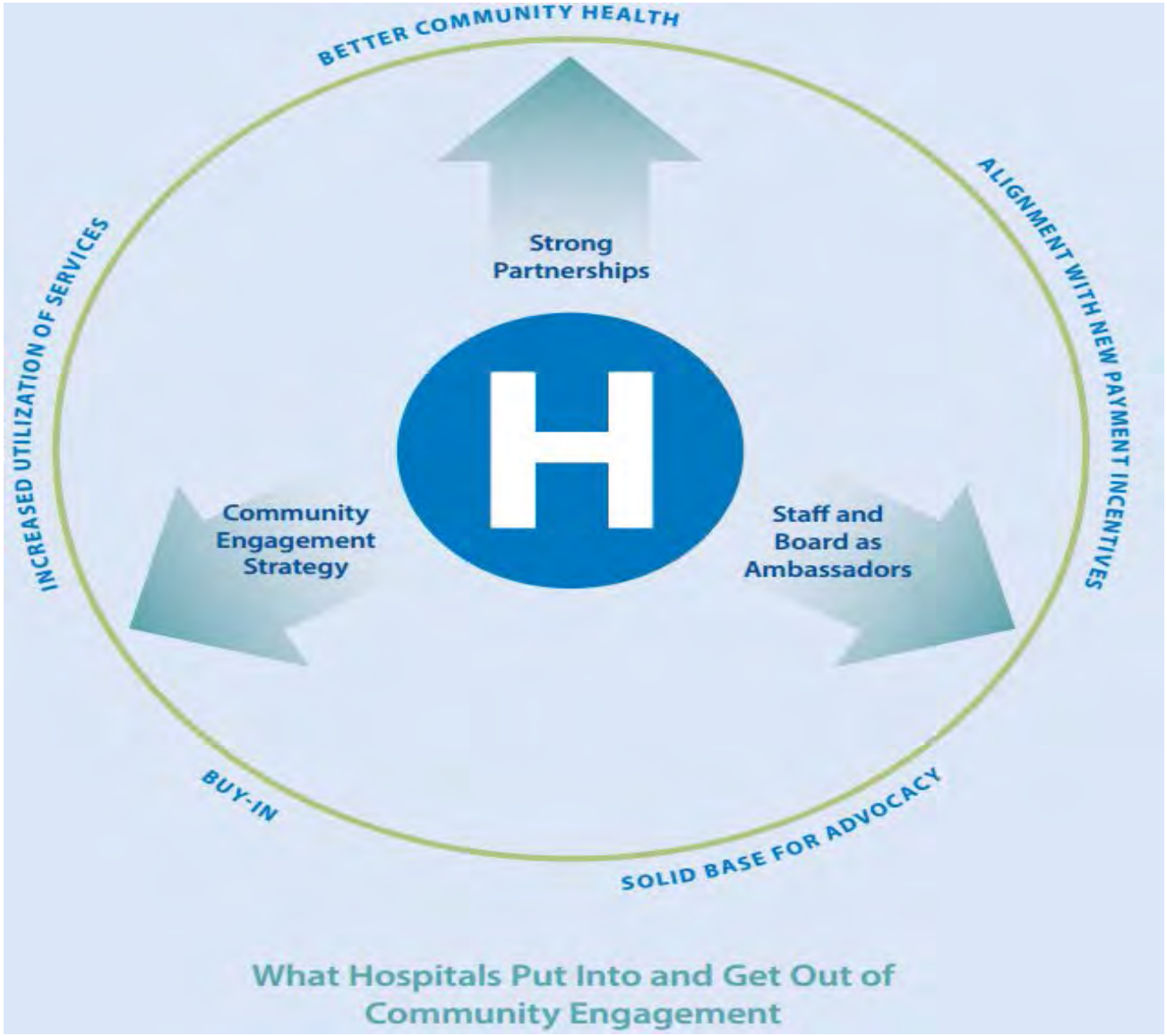
Rural Policy Research Institute's, Health Panel

Washington State: Redefining the Blue H



Outline

- 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
- Learning from current examples

Research

Original Investigation

Community-Wide Cardiovascular Disease Prevention Programs and Health Outcomes in a Rural County, 1970-2010

N. Burgess Record, MD; Daniel K. Onion, MD, MPH; Roderick E. Prior, MD; David C. Dixon, MD; Sandra S. Record, RN; Fenwick L. Fowler, BA; Gerald R. Cayer, BS, MPH; Christopher I. Amos, PhD; Thomas A. Pearson, MD, PhD, MPH

IMPORTANCE Few comprehensive cardiovascular risk reduction programs, particularly those in rural, low-income communities, have sustained community-wide interventions for more than 10 years and demonstrated the effect of risk factor improvements on reductions in morbidity and mortality.

OBJECTIVE To document health outcomes associated with an integrated, comprehensive cardiovascular risk reduction program in Franklin County, Maine, a low-income rural community.

Editorial page 139

Supplemental content at jama.com

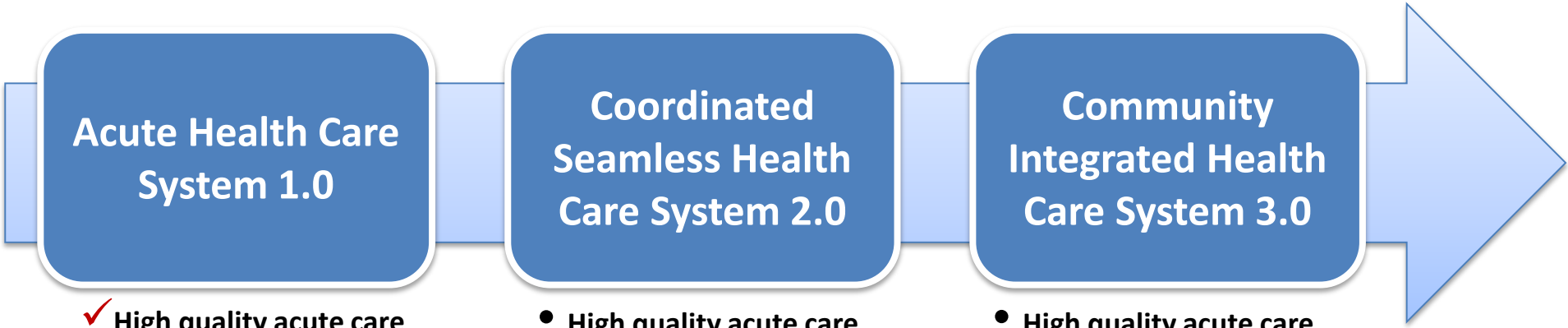
CME Quiz at jamanetworkcme.com and CME Questions page 196

Source: JAMA, January 2015

The Burden of Illness in Rural Populations and Communities is Significant

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

Health Delivery System Transformation



Acute Health Care System 1.0

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

Coordinated Seamless Health Care System 2.0

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

Community Integrated Health Care System 3.0

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

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

Health System 3.0: Population Health

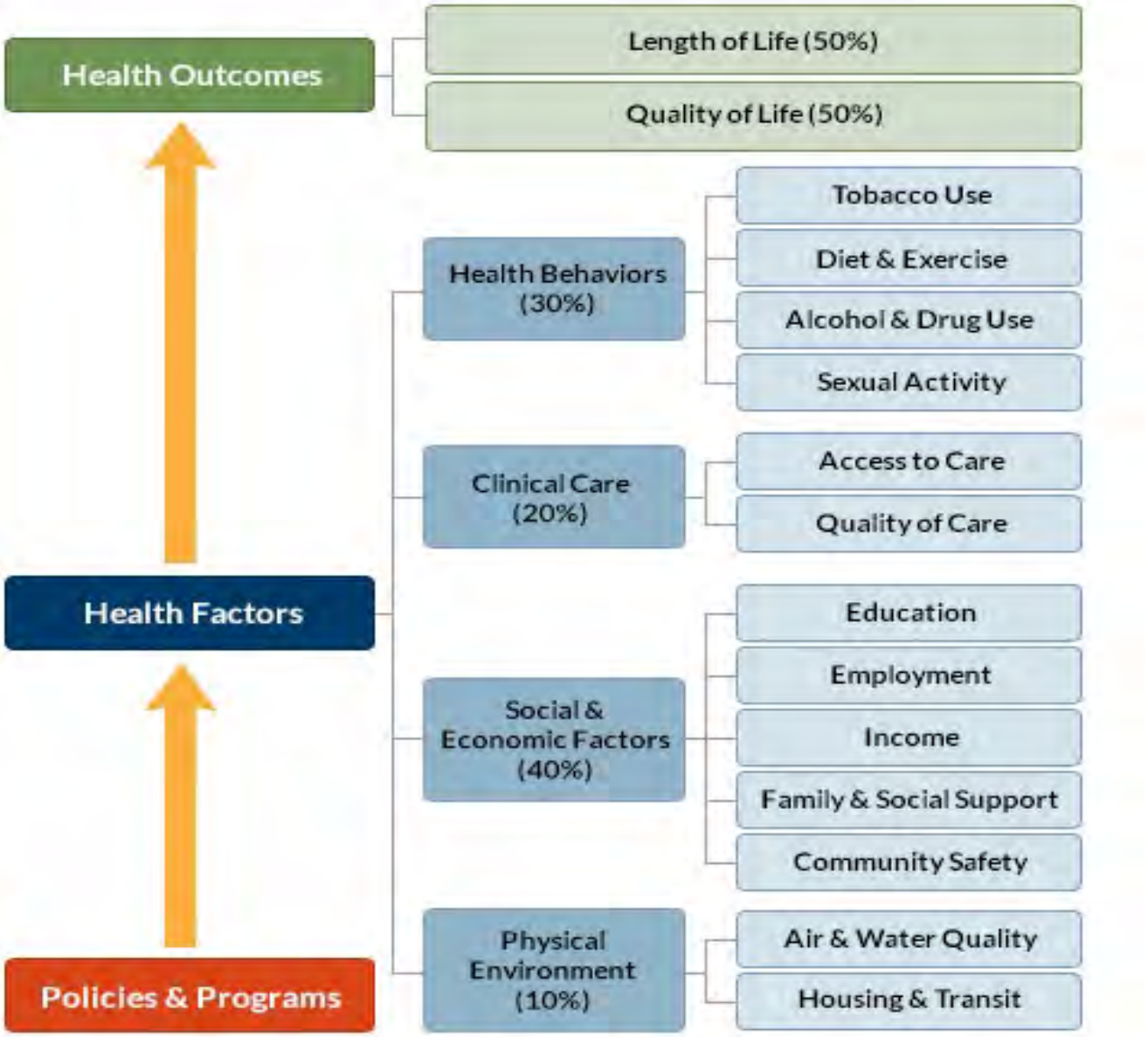
- Population health 3.0:
  - *"health outcomes of a group of individuals, including the distribution of such outcomes within the group"* (Kindig, *What is Population Health?*)
- "Groups" include geographic, racial, ethnic, linguistic, or other communities of people.
- Focus: (1) health outcomes, (2) the "determinants" of those outcomes, and (3) policies and interventions that can improve outcomes.

Factors Contributing to Health

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

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

Another Way to Look at Factors Affecting Health



Source: County Health Rankings, 2014

Transition to Health System 3.0

- 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.

Transition to Health System 3.0

- Accountability framework changing: from ACOs to ***Accountable Health Communities***.
- Addition of population-level measures.
- Moving outside of the hospital walls:
  - More than a nice mission statement: requires action.
  - Strategic priority, leadership, resource commitment, and new partnerships with the community.

It Takes a Village to Improve Health

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

What's Driving the Shift to Population Health?

- Demand forces: aging population, chronic disease;
- "Accountable Care"/performance measurement and incentives, new "value-based" insurance models, employer wellness programs;
- ACA: Patient Centered Medical Home, Health Home, and Accountable Care Organization (ACO) models;
- Medicaid transformation and state reform: new Accountable Health Community models, State Innovation Models (SIM).

What's Driving the Shift to Population Health?

- Community Benefit requirements;
- It's the right thing to do!

The Barriers Are Well Known

- 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

- 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.

Payment and Resource Models

- Shared savings models: 1% of shared savings to fund infrastructure;
- Population-based global payments/budgets;
- Health and wellness trusts;
- Community development financing.

Partnerships: Governance Functions

❖Scope of governance functions in complex community partnerships:

- Legal authority
- Policy development
- Shared leadership
- Resource stewardship
- Performance and quality improvement
- Public engagement and collaboration

Governance

- Governance can be driven by state policy (top down) or locally constructed (bottom up), or some combination of the two
  - Colorado
  - Humboldt County, CA
  - Vermont

Learning by Example

Improving Cardiac Care and Outcomes-New Ulm Medical Center

- 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: solid metrics for performance evaluation and improvement

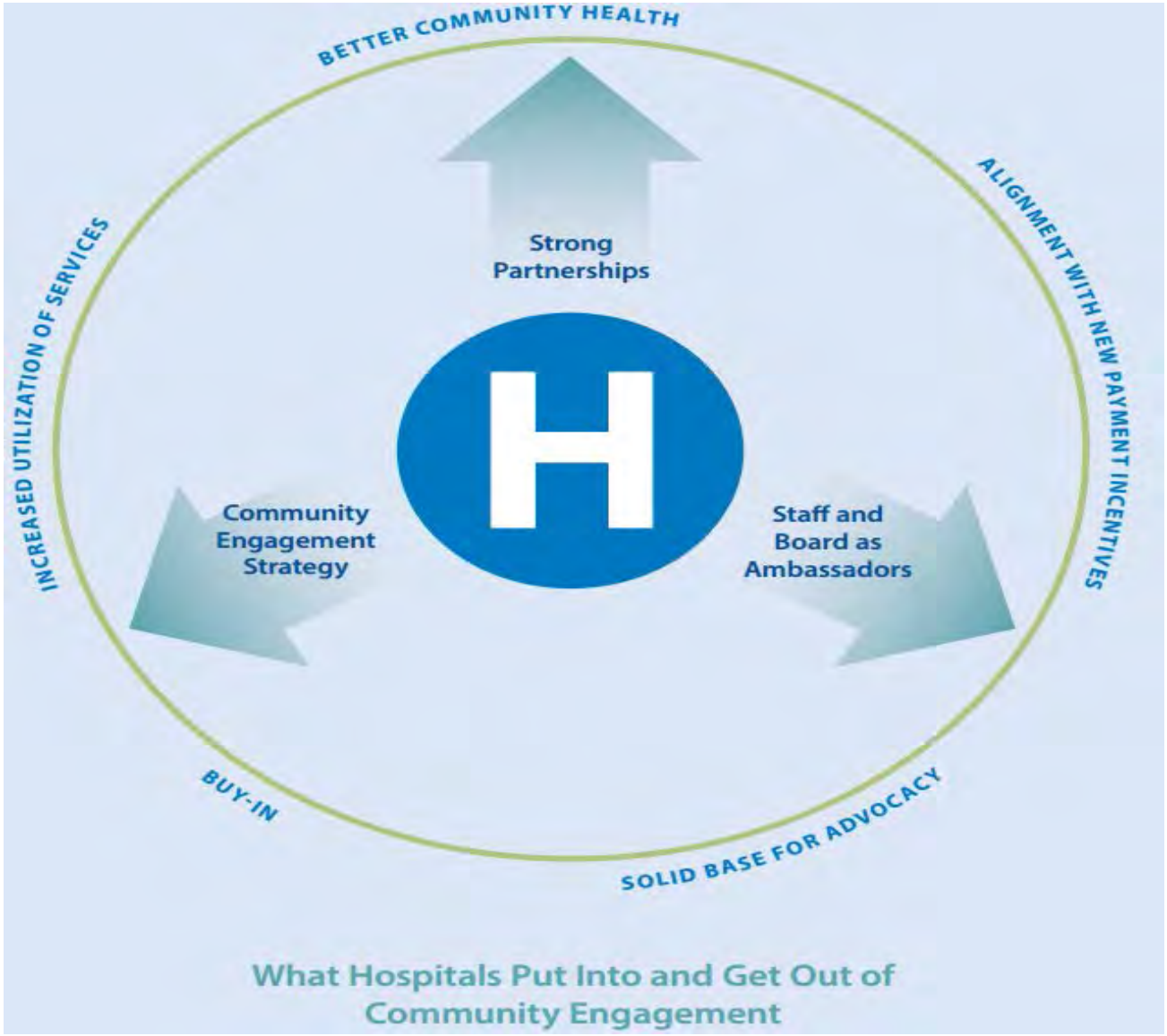
Building a Partnership Infrastructure: Mt. Ascutney Hospital and Health Center

- Clear, consistent dedication to mission
- Grant entrepreneurship
- Create partnerships, give away credit, promote open communication, decentralized control.
- Document and measure progress.

Health Improvement Starts at Home-Redington Fairview

- Focusing on employers, including hospital: worksite wellness that engages the community.
- Environmental scan of the worksite, recommend policy and recommendations, assistance in developing policies, and workplace wellness toolkit

Washington State: Redefining the Blue H



Local Community Assessment, Planning, And System Development

- Partnerships: schools, employers, economic development agencies;
- Aligning incentives and plans,
- Tools for community engagement and planning;
- Incorporate patient navigators;
- Joint assessment/planning for DOH programs.

CDC Community Health Improvement Navigator

CHI Navigator Home
Making the Case for Collaborative CHI
Tools for Successful CHI Efforts +
Database of Interventions
CHI Navigator Resources +
Frequently Asked Questions

Our health and well-being are products of not only the health care we receive and the choices we make, but also the places where we live, learn, work, and play. **Community health improvement (CHI) is a process to identify and address the health needs of communities**. Because working together has a greater impact on health and economic vitality than working alone, CHI brings together health care, public health, and other stakeholders to consider high-priority actions to improve community health.

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Rural Health Value
UNDERSTANDING AND FACILITATING RURAL HEALTH TRANSFORMATION.

StratisHealth

Population Health: A Self-Assessment Tool for Rural Health Providers and Organizations

Population health encompasses a cultural shift from a focus on providing care for a panel of patients when individuals are sick, to a more comprehensive view, which includes enhancing and improving the health of all individuals in a community across a spectrum of ages and conditions.

This self-assessment tool is designed to provide a preliminary review of critical success factors for rural organizations looking to develop, expand, or enhance a population health focused approach. For more information on these critical success factors and on population health for rural providers, see *Improving Population Health: A Guide for Critical Access Hospitals* from the National Rural Health Resource Center.

Conclusions & Implications

- From value to outcomes: measuring benefits and ROI.
- Magic doesn't just happen: building successful partnerships and achieving results takes time and effort.
- Hospital and community champions critical.
- Cash investment not essential (or possible in most cases).

Contact Information

Andy Coburn, PhD
Professor and Director
Maine Rural Health Research Center
Muskie School of Public Service
University of Southern Maine
PO Box 9300
Portland, ME 04104-9300

andyc@usm.maine.edu
207.780.4435

Maine Rural Health Research Center

UNIVERSITY OF SOUTHERN MAINE
Muskie School of Public Service