

Population Health Management for Critical Access Hospitals

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National Organization of State Offices of Rural Health

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

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Overview

- Defining population health in practical terms
- Drivers behind growing focus on population health
- Role of the ACA in promoting population health
- Opportunities for CAH-based population health activities
 - Addressing the needs of uninsured and other vulnerable populations, chronic disease management, wellness and prevention, community building
- Examples of CAH population health initiatives
- Population health resources for CAHs

HRET's Description of a Community Responsive Hospital

- Community responsive hospitals look beyond delivery of medical care to role of hospital leadership in the following:
 - Community issues (e.g., substance abuse, domestic violence, etc.)
 - Critical health issues (e.g., oral health, mental health, obesity, etc.)
 - Health care equity (e.g., barriers to access or health status disparities among vulnerable populations)
 - System barriers (e.g., limited public health infrastructure, limited integration of providers and services, etc.)
 - Community's role in process (e.g., involve residents in addressing above issues, reducing risky behaviors, partnering with schools, etc.)

From: *Where Do We Go from Here? The Hospital Leader's Role in Community Engagement* (2007)
by the Health Research and Educational Trust.



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What is Population Health?

- In simplest terms: *“the health outcomes of a group of individuals, including the distribution of such outcomes within the group”* (David Kindig, MD, PhD)
- Essential for quality of life & single most effective way to reduce health care costs
- Actualizing this definition quickly becomes more complicated
 - Focus on groups of people or geography?
 - Differing perspectives and language – health care and public health
 - More than a sum of individual parts – holistic focus required
 - Complex interaction of acute health care delivery systems, public health interventions, health disparities/inequities, and socioeconomic factors

Population Health in Practical Terms

- *“A strategic platform to improve health outcomes of a defined group of people; focused on three related stages” (HRET, 2012):*
 - Distribution of specific health statuses and outcomes within defined populations;
 - Factors that cause the present outcomes distribution; and
 - Interventions that may modify the factors to improve health outcomes.
- Improving population health requires effective interventions to:
 - Increase prevalence of evidence-based preventive health services and preventive health behaviors;
 - Improve care quality and patient safety; and
 - Advance care coordination across the health care continuum.



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Mechanisms to Improve Population Health (Source: 2012 AHA)





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Population Health Facts

- Accountability for population health is where we are headed
- Hospital leaders must think outside of the hospital walls
- More than a nice mission statement—action is required
- Must be part of strategic priorities: resources and commitment
- Foundation: Identifying/tracking target populations and analyzing preventive and interventional needs
- Physician leadership is key—new skills and orientation required



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Population Health Facts (cont.)

- Hospitals can't do this alone - must leverage local resources
- Prioritization is required to best use existing limited resources and maximize possible impact
- We are in a transition period – demonstration are beginning but current reimbursement systems haven't changed to reflect new demands
- New skills are need to meet the challenge – Many systems are not prepared for the coming changes



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Population Health Realities

- Population health depends on the interaction of many factors, entities, organizations, and interests
- Population health is a shared responsibility and requires community engagement
- Participating entities must be accountable for the actions they take to improve population health -performance measures must be developed and monitored

Key Partnership/Collaboration Strategies

- Partnerships/Collaborations
 - Focus on patients, families, and communities
 - Mix of partners will vary based on mission and resources available
 - Can focus on large or small subgroups of patients/community members
 - Should span the care continuum to insure that populations are receiving the right services in the right location and at the right time
 - Physician partnerships are critical to facilitating care coordination, reducing unnecessary admissions, improving access to evidence-based care
 - Hospital/payer collaborations are necessary to advance care coordination
 - Partnerships with businesses provide access to large portion of patients
 - Public health, government, community, and social service partners expand system capacity and reach

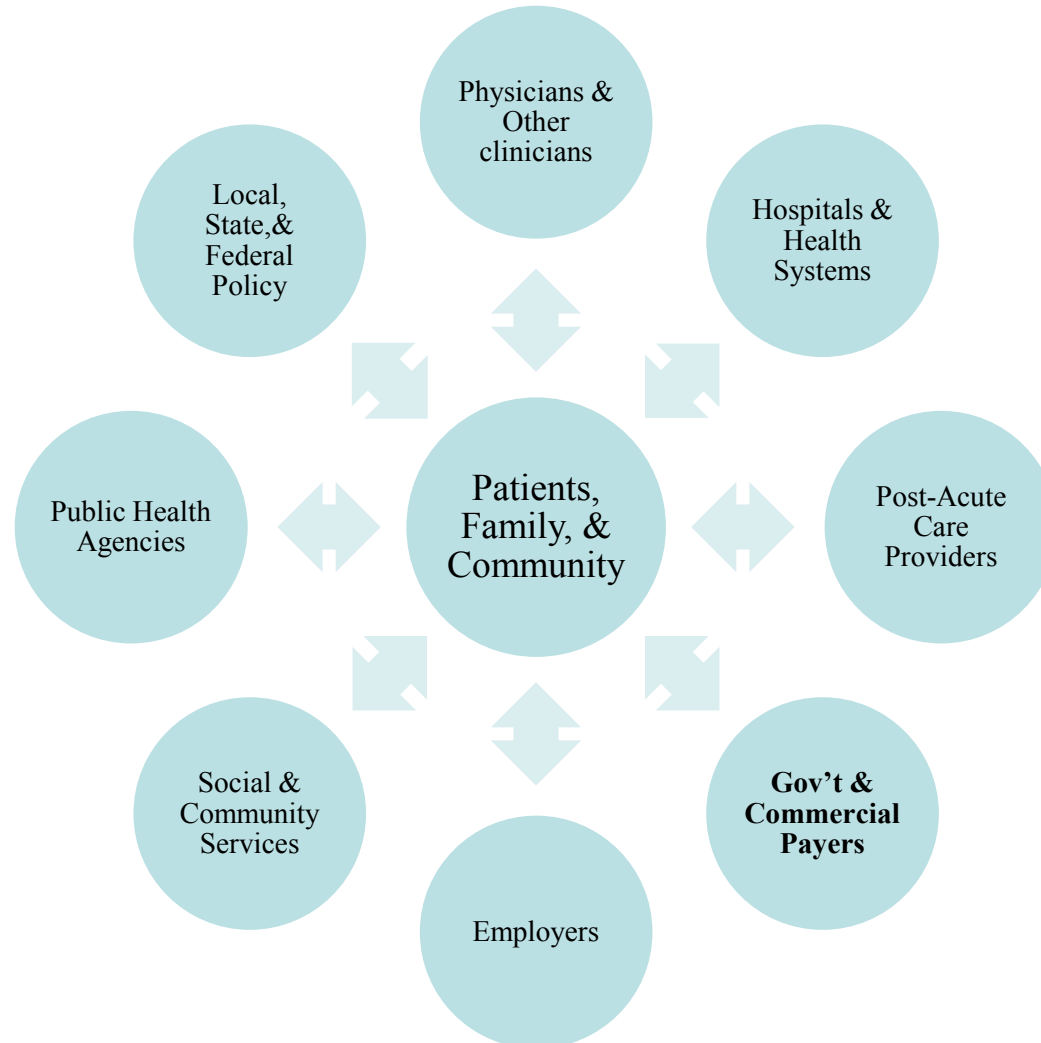


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Population Health Partnerships



Driving Forces

- Realization that acute care system alone cannot ensure health
- IOM Triple Aim - population health, experience, & affordability
- Demand forces
 - Aging population
 - Increasing life expectancy
 - Demands for treatment at home
 - Gap between physician supply and demand
 - Population diversity
 - Rising rates of chronic disease
 - Increasing # of insured individuals
- Performance forces
 - Technological advances
 - Shift to outpatient care
 - Shared risk structures with payers
 - Emphasis on evidence-based care
 - Volume-based reimbursement



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Population Health in the ACA

- Expanding insurance coverage to improve access to services
- Improving quality of care
- Eliminating payments for unnecessary readmissions
- Developing payment pilots to increase accountability for care outside of hospital walls
- Encouraging hospital/community organization partnerships
- Funding investment in preventive and public health programs
- Expanding coverage for and reducing out-of-pocket costs of preventive and wellness services
- Requiring 501c3 hospitals to conduct triennial needs assessments



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Factors Influencing Population Health

- Outside health care system – Societal factors
 - Food safety
 - Housing conditions
 - Open space/recreation options
 - Disease prevalence
 - Poverty rates
 - Unemployment rates
 - Median age
 - Race/ethnicity
 - Care seeking behaviors
 - Patient choice
 - Transportation availability
 - Healthy food availability
 - Neighborhood violence
 - Genetic inheritance
 - Income levels
 - Geographic location
 - Uninsured/uninsured rates
 - Gender
 - Pharmacy availability
 - Health literacy
 - Morbidity rates



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Factors Influencing Population Health

- Related to health care system – Care delivery
 - Quality of care
 - Access
 - Health IT availability
 - Provider supply
 - Payer contracts
 - Disease management
 - Advanced technology
 - Behavioral health availability
 - Efficiency
 - Physician training
 - Distance to/number of providers
 - Physician mix (primary care/spec.)
 - Physician employment/payment
 - Population sub-group disparities
 - Care integration/coordination
 - Cultural and linguistic access



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Factors Influencing Population Health

- Related to health care system – Regulatory environment
 - Medicare payment rates and policies
 - Medicare and Medicaid care delivery innovations
 - CON regulation
 - Medicaid/CHIP policies (payment rates/eligibility)
 - Implementation of ACA
 - Local coverage determinations
 - Other local, state, federal laws impacting the way care is delivered

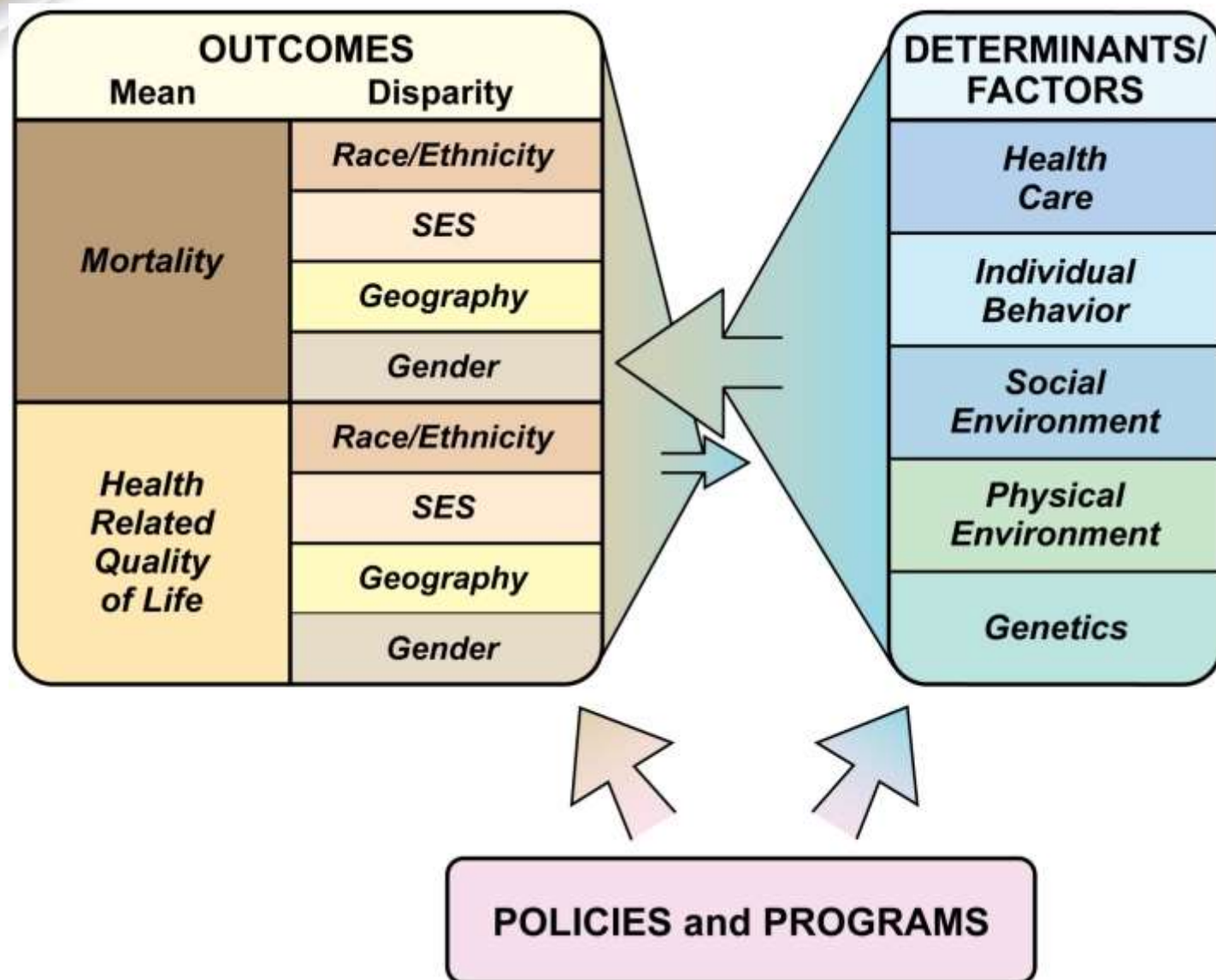


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Source: Kindig 2010





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10 Essential Elements to Improve Population Health

- A self-assessment about readiness to engage in this work
- Leadership across the region and within organizations
- An organizational planning and priority-setting process
- A community health needs assessment and asset mapping process
- An agreed-upon, prioritized set of health improvement activities
- Selection and use of measures and performance targets
- Audience-specific strategic communication
- Joint reporting on progress toward achieving intended results
- Indications of scalability
- A plan for sustainability

ACHI 2012 Survey Findings

- Rural hospitals are more likely than urban hospitals to run population health programs through the administrative-executive office (22% vs 10 %)
- Rural hospitals have fewer (compared to urban hospitals):
 - FTEs dedicated to population health programs (3.6 FTEs vs 11)
 - Established partnerships dedicated to population health (7.8 vs 7.8)
 - Programs for heart/lung/diabetes (60% vs 73%)
 - Community clinics (66% vs 74%)

Must Do Strategies

- Align hospitals, physicians, and other providers across the care continuum
- Utilize evidence-based practices to improve quality and patient safety
- Improve efficiency through productivity and financial management
- Develop integrated information systems
- Join/grow integrated provider networks and care systems

From AHA Committee on Performance Improvement Report: “Hospitals and Care Systems of the Future”

Must Do Strategies (cont.)

- Educate/engage employees and physicians to create leaders
- Strengthen finances to facilitate reinvestment and innovation
- Partner with payers
- Advance through scenario-based strategic, financial and operational planning
- Seek population health improvement through pursuit of the “triple aim”

From AHA Committee on Performance Improvement Report: “Hospitals and Care Systems of the Future”

Barriers

- Current volume-based reimbursement system does not provide funding for population health initiatives
- System in transition from volume-based to population health reimbursement – transition taking place very slowly
- Difficulties 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
- Population demographics – greater disparities



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Opportunities to Engage in Population Health Management

- Accountable Care Organizations provide opportunities to participate in managing the health of defined populations
 - Conceptualized as an important path for achieving the triple aim
- Patient Centered Medical Homes create a patient-centered environment, address preventive and chronic care needs, and provide care management services
 - PCMHs are at the heart of ACOs
- Community benefit activities focused on addressing the needs of low income and uninsured individuals
 - Community health assessments to establish areas for population health
 - Services to reduce unnecessary utilization and uncompensated care



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Community Benefit Obligations and Population Health

- Most hospitals have significant amount of charity/discounted care provided to low income and uninsured individuals
- These individual account for unnecessary (and often uncompensated emergency department and inpatient utilization
- Using CHNA results, hospitals can satisfy community benefit obligation by focusing on activities to address issues related to access, coordination of care, chronic disease, and unmet health needs

Examples of Rural Initiatives

- **Northeast Oregon Network (NEON)**
 - Rural/frontier collaboration led by public health/human service organizations
 - Focused on the coordination/efficiency of needed services
- **Rural Health Network of South Central New York**
 - Region-wide collaboration to offer programs to assist families in enrolling in health insurance programs for which they are eligible, pharmacy assistance, and wellness and school-based education
- **Montana's Community Health Services Development Process**
 - Identify and address community health needs, measure perception of local quality of care, involve health professionals in the community, engage community members in the future of their health systems



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Examples of CAH Initiatives

- Regional Medical Center
 - Development of a continuum of mental health services in three rural Iowa counties - currently re-organizing to provide behavioral health services through provider-based RHCs
- Weiser Memorial Hospital's WACHAT Program
 - Washington/Adams County Health Action Team provides primary care for uninsured individuals
 - A collaboration of 18 community organizations, social service agencies, and providers in Weiser, Council, and Cambridge.

Examples of CAH Initiatives

- **Nor-Lea General Hospital**
 - Created the Heritage Program for Senior Adults in 2003 to provide outpatient mental health services to seniors
 - Staffed by a psychiatrist, therapists, a registered nurse, and mental technicians
- **Teton Medical Center' Wellness Program**
 - Collaboration with the high school, Teton Community Development Cooperative, County Extension Office, Great Falls Clinic, and others
 - Services include exercise programs, nutrition, health education, diabetes, stroke, and heart rehabilitation
 - Serves general community and has a special focus on health and fitness for high school students, firefighters, and persons with chronic illness

Examples of CAH Initiatives

- Wrangell Alaska Medical Center-Rural Health Careers Initiative
 - Partnered with local education programs to develop certified nursing assistant program – 1 year program
 - Trained 200 students – Wrangell pays 100% of costs for employees
 - Challenges – increasing community interest, improving educational performance
- Yuma Hospital District – Patient Centered Medical Home
 - Worked with local safety net clinics to become PCMHs
 - 5 year demonstration by Colorado Community Health Network
 - Created teams to encourage transformation and work with clinics
 - Led to invitation to participate in the Medicaid Regional Care Coordination Organization –pay for performance
 - Targeted a pool of high risk people

Examples of CAH Initiatives

- Mt Ascutney Hospital & Health Center
 - Partnered with local partners to support community health infrastructure
 - Goal - address fragmented and decentralized care services
 - 14 major health promotions implemented, trust/collaboration improved
 - Challenges – skepticism from partners over control and management
- New Ulm Medical Center –Heart of New Ulm Project
 - Reduce # of heart attacks in New Ulm over 10 years
 - Collaboration with Minneapolis Heart Institute Foundation, local employers and local providers (36 member steering committee)
 - Applied evidence-based practices
 - Results: Improvements in consumption of fruits and vegetables, taking daily aspirin, participation in exercise

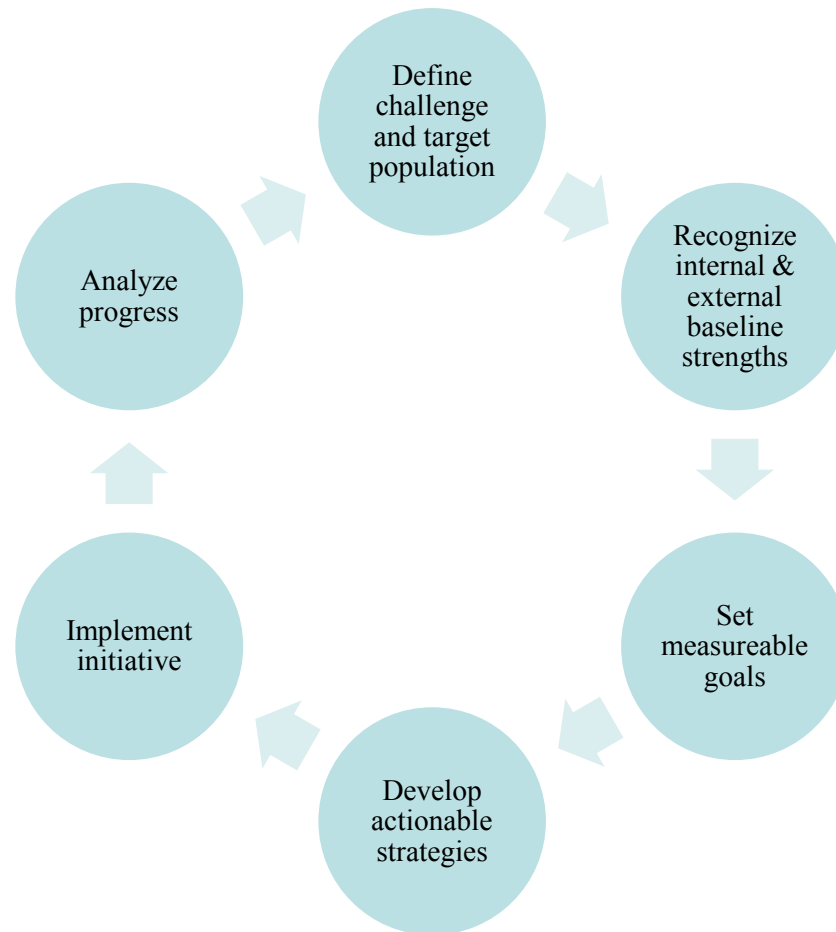


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Framework for Population Health Improvement





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