Population Health
Success Strategies for
Critical Access Hospitals

Kami Norland, MA, ATR
Community Specialist II
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Purpose
The National Rural Health Resource Center is a nonprofit organization dedicated to sustaining and improving health care in rural communities. As the nation’s leading technical assistance and knowledge center in rural health, The Center focuses on five core areas:
• Performance Improvement
• Health Information Technology
• Recruitment & Retention
• Community Health Assessments
• Networking

Current Health Care Business Model is Based on Volume
The more you do, the more money you make
Current US Health Outcomes

- Highest cost
- Lowest quality
- Most limited access
- Highest rate of chronic illness
- Shortest life expectancy

Institute of Medicine, 2013

Future Health Care Business Model Based on Patient Value

"It's no longer about what we charge for a hospital visit but what it costs to keep an insured population healthy. We must help all reach highest potential for health and reverse the trend of avoidable illness."


The Challenge: Crossing the Shaky Bridge

What's the matter?

What matters to you?

Source: http://www.flickr.com/photos/67759198@N00/2974261334/sizes/o/in/photostream/
Goal: Achieve the Triple Aim

Goal: Achieve the Triple Aim

Defining Population Health

“Population Health” used interchangeably for:

- **Cohort Management/Population Medicine**: Improving health and reducing costs for specific groups of patients, often grouped by insurance type and focused on chronic disease (hospital definition)
- **Community Health/Total Population Health**: Health outcomes of an entire group of individuals, often geographically defined, including the distribution/disparities of outcomes within the group

*It’s Both/And Situational*

Mechanisms to Improve Population Health

Mechanisms to Improve Population Health

- Quality and Patient Safety
- Prevention
- Care Coordination

- Lower Per Capita Cost
- Better Population Health
- Better Patient Care

- Care Coordination
- Prevention
- Quality and Patient Safety

- Better Patient Care
- Better Population Health
- Lower Per Capita Cost

- Care Coordination
- Prevention
- Quality and Patient Safety
Opportunities for Quality-Driven Cost Reductions

Care-defect costs as % of total cost by condition/procedure

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Source: HealthCare Incentives Improvement Institute, Inc. Prometheus Payment 2009 www.hci3.org

Geisinger Case Study: Care Coordination

ProvenHealth Navigator advanced medical home with 33,000 patients; Case managers are embedded in Primary Care practices to facilitate improved quality and coordination of care

Results:
- **Better care:** 18.2% decrease in acute admissions; 20% decrease in readmissions
- **Lower costs:** 7.1% reduction in the total cost of care over five years
- **Estimated savings:** $16,600,000
- **Estimated # PCPs (FTE) to produce:** 14

Source: hci3.org

CDC Case Study: Prevention

**Nutrition**
- Residents in rural Montgomery County, AL created 9 community gardens in schools/parks

**Physical Activity**
- ~86,000 Duluth, MN residents benefit from an increased usability of streets for all ages/abilities

**Tobacco**
- ~136,000 Savannah GA residents benefit from smoke-free zones in public buildings, parks

Source: CDC
CAH Population Health Summit

- Convened a “think tank” to recognize critical success factors for managing the change towards population health
- Identified how States Flex Programs can best support critical access hospitals (CAHs) in addressing the population health transition
- Created a Guide identifying Summit participant recommendations on managing population health

Summit Recommendation: Understand WHY

Focusing on population health:
- Improves quality of care
- Increases access to care
- Improves quality of life (chronic disease prevention/management)
- Strives to reduce health care expenses

Why Should CAHs Care About Population Health Management?

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<tr>
<th>Survival</th>
<th>Community engagement</th>
<th>It is the right thing to do</th>
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<td>Publicity</td>
<td>Mission values</td>
<td>Meet Community Needs</td>
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<td>Increase Market Share</td>
<td>Financial Incentives</td>
<td>CAHs are community leaders</td>
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<td>Charity Care/Bad Debt</td>
<td>Value Based Purchasing</td>
<td>Healthy Workforce</td>
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Focusing on population health requires us to think differently about leadership.

The solutions to population health challenges lie with mobilizing resources not found in the healthcare system, but rather among the community’s assets.

Participate in collaborative relationships aimed at improving overall health.
Summit Recommendation:

Role model wellness

Summit Recommendation:
Strive for Performance Excellence

- Strategic Planning
- Workforce and Culture
- Leadership
- Patients, Partners & Communities
- Operations and Processes
- Measurement, Feedback & Knowledge Management

How Can CAHs Effectively Support Population Health?

- Critical success factors identified using on a systems based framework.
- What can Critical Access Hospitals (CAHs) do to practically apply the critical success factors?
Leadership – Success Factors

- Develop awareness and provide education on the critical role of population health.
- Shift hospital culture, processes, facilities, and business models to include a focus on population health.
- Lead the way and model behaviors. Participate in programs, be active in community outreach.

Strategic Planning

- Incorporate population health approaches as part of ongoing strategic planning processes.
- Engage multiple stakeholders and partners to coordinate strategies aimed at improving the population’s health.
- Prioritize – what are the one or two things that would make the biggest difference for your population?

Patients, Partners & Community

- “Not about hospitals fixing the problems – but engaging other leaders in the community to start addressing the problems.”
- Use the community health needs assessment (CHNA) process as an opportunity for community/patient engagement.
- Engage all types of health care and social service providers to coordinate care transitions and address underlying needs.
**Workforce & Culture**

Establish wellness programs for employees and role model these programs in the community.

Develop a culture that is adaptable to change in redesigning care to address population health.

Embed a community focused mind-set across the organization so engagement, coordination, and cooperation are expectations of staff interaction.

**Operations and Processes**

Maximize the efficiency of operational, clinical and business processes under current payment structures.

Utilize Health Information Technology (EHR, HIE, tele-medicine) to support population health goals.

**Data Collection, Management & Analysis/Outcomes and Impact**

Identify measurable goals that reflect community needs.

Utilize data to monitor progress towards strategic goals on population health.

Go public with goals and data, use it as an opportunity to engage partners and the community.
As a CAH, What Can You Do?

Build the case for population health
• Create alignment towards value-based reimbursement
• Frame the conversation in terms of charity care, bad debt, and community benefit
• Identify the impact on other priorities (recruitment/retention, satisfaction, care transitions)
• Be patient; changing culture takes time

As a CAH, What Can You Do?

• Put population health on the agenda
• Review claims data to identify service area priorities
• Answer the following questions:
  – How does population health align with strategic initiatives and health reform activities?
  – What is your role in addressing the two aspects of population health (cohort/community)?
  – What are next steps to implementing/integrating population health strategies?
  – What community needs are a priority and how they impact the hospital?

As a CAH, What Can You Do?

Look inside your own walls
• Apply employee wellness programs
• Implement case management/care coordination services for employees with chronic conditions
As a CAH, What Can You Do?

Reach out to the community
• Don’t wait to be asked
• Build on CHNA results and monitor progress
• Support staff involvement in community task forces
• Articulate roles/responsibilities in supporting community efforts
• Think beyond traditional partners

8 Steps of CAH Population Health

What can SORH do?
• Share state/local data to support population health strategies
• Collect best practices and lessons learned
• Facilitate networking opportunities
• Identify funding for innovations, research, demonstration of population health
• Provide facilitation training for CAH staff to support community outreach
• Offer technical assistance on care coordination
What Does It Really Take to Succeed?

No one organization can achieve population health, it takes communication and unity

COMMUNITY

Start where you are. Use what you have. Do what you can.

- Arthur Ashe

Kami Norland
Community Specialist II
National Rural Health Resource Center
600 East Superior Street, Suite 404
Duluth, MN 55802
(218) 727-9390 ext. 223
knorland@ruralcenter.org
www.ruralcenter.org