NATIONAL RURAL HEALTH RESOURCE CENTER

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Population Health Strategies

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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

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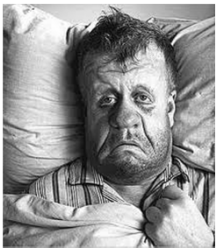
When you or a loved one are sick, what do you want?



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What does it take to keep a population healthy?

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Current Health Care Business Model is Based on Volume

The more you do, the more money you make

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Current US Health Outcomes

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

Institute of Medicine, 2013

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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 our highest potential for health and reverse the trend of avoidable illness**."

Patient Value =

Health for Life, Better Health, Better Health Care, American Hospital Association, August, 2007.

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The Challenge: Crossing the Shaky Bridge

Source: http://www.flickr.com/photos/67759198@N00/2974261334/sizes/o/in/photostream/

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Goal: Achieve the Triple Aim

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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
- 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

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Mechanisms to Improve Population Health

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Prevention

Mason District Hospital, Indiana

- Established a worksite wellness program
- Focused on employees with multiple chronic illnesses

Patient Value =

After 2 years: $360,000 in reduced employee health care costs and is now offering this program to local businesses which provides an additional revenue stream

Source:http://www.icahn.org/files/White_Papers/ICAHN_PopHealthManagement_Print_FINAL.pdf

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Quality and Patient Safety

Mercy Health Network, Iowa

- Identified clinical process improvements
- Educated the board

After 18 months: process improvements resulted in a 51% decrease in patient falls and a 37% decrease in medical errors

Source:
http://cph.uiowa.edu/ruralhealthvalue/innovations/Profiles/MercyHealthNetwork.pdf

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Care Coordination

Tri-County Rural Health Network, Arkansas

- Goal of reducing hospital admissions/re-admissions
- Aimed to increase access to home/community-based services to enhance quality of life

After 3 years: a 23.8% reduction in annual Medicaid spending per participant; $3 was earned for every $1 spent; with a total reduction of $2.6 million

http://cph.uiowa.edu/ruralhealthvalue/innovations/Profiles/CommunityConnectors.pdf

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Rural Care Coordination Model: What we're Learning

- Carefully define the patient population to be coordinated
- Mental health focus is very important
- Hospitals struggle with integration of care, e.g., Communicating with other provider types
- Physician buy-in and partnership is essential
- Most rural care-coordination providers are being cautious "crossing the shaky bridge"

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Rural Care Coordination Model: What we're Learning

- Claims data is key to producing savings and assessing quality
- Medical provider/insurance provider partnerships are emerging
- Good data analysts are necessary but rare in rural hospitals

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Rural Care Coordination Model: What we're Learning

- HIEs are often still in early development
- Different EHRs are problematic to information management
- Care-coordination is usually done by nurses and sometimes social workers
- Care-coordination models are proving successful and gathering momentum

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Strategies for Succeeding in the Value- Based System

- Effectively manage shared savings programs to maximize reimbursement
- Improve operating costs to deliver care more efficiently (eliminate waste)
- Capture an increased number of patients: payers and patients are looking for the "highest performers"

Attracting a high volume of patients is the key to counterbalancing the loss of procedure volume

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Goal: Capture Full Market Share

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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

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Summit Recommendation: A Change in Perspective is Needed

Focusing on population health requires us to think differently about leadership

"If you don't help your community to thrive and grow – how will your organization thrive and grow"

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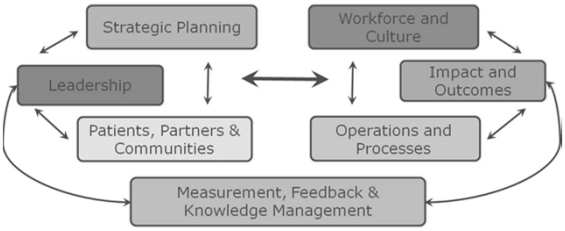
Summit Recommendation: Strive for Performance Excellence



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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 role model wellness. Be active in community outreach

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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

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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

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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

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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

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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

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As a CAH, What Can You Do?

- 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 do they impact the hospital?

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Strengths of Rural

- Primary care physicians are the base
- Rural is more agile
- Health care is cheaper in rural
- Patient satisfaction is higher in rural
- Greater cooperation in rural
- SORH, Flex Program infrastructure

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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

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What can you do?

Culture is changed through consistent actions

What are 2-3 actions you could do to drive population health in your state?

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