

Rural Path to Value

Rural Path to Value offers training, tools and resources to help rural hospitals address population health challenges in their own communities — to improve health outcomes and patient experiences, and lower costs for the entire health system.

Three-Year Project

Rural Path to Value's interactive workshops, webinars, one-on-one coaching calls and peer sharing calls are designed to provide hospital and clinic leaders with a **deeper understanding** of population health, and the **impact of social drivers of health and health access** on patient well-being and the health of their communities. The ultimate goal of Rural Path to Value is to **help hospitals make measurable improvements** in their community's health outcomes by building the **skills and confidence** to plan and carry out a population health project that's tailored to meet their community's needs.

One-Year Project

An abbreviated one-year Rural Path to Value project is also available and provides support to hospitals only during the planning stages of their population health project.

Hospital leaders learn how to:



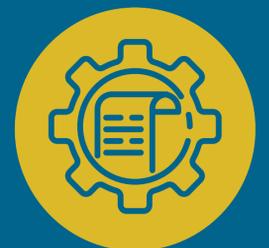
Identify a community health concern based on the needs of a focused population



Establish clear project goals and objectives



Implement a population health project and monitor its impact



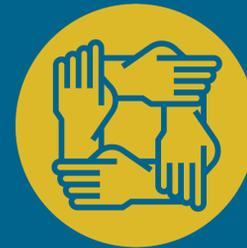
Develop and manage processes that better link the hospital with community partners



Plan for project sustainability



Develop a well-defined action plan



Build and strengthen relationships with key community partners

For More Information Contact

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I'm most proud that nine months ago we were at about 30.9% optimal care for our Spanish-speaking diabetic patients. And this morning we are sitting at about 38%. We'd like to get our optimal diabetic care up to 50%. So that's a very nice bump and a very worthwhile thought that we're making a move.

— Eric Gohman, Family Medical Director, CentraCare – Long Prairie Hospital



A Focus on Measurable Outcomes

All Rural Path to Value participants can expect to receive guidance on tracking measurable outcomes that can help demonstrate the impact projects and initiatives are having in a hospital's community.

Sample outcomes include:

- Increases in the number and percentage of patients receiving self-management education and support specific to their condition.
- Increases in the number and percentage of staff reporting increased understanding of the value of patient rosters and how to use them as part of the care management process.
- Increases in the number and percentage of patients receiving monthly check-ins, regular lab testing and early medical attention for complications.
- Reduction in readmission rates.
- Reduction in unnecessary emergency department utilization.

Past Rural Path to Value Projects

Past Rural Path to Value participants have carried out population health projects to meet a range of community needs, including projects that:

- Improved diabetic patients' care pathways.
- Established a falls prevention program for patients 65 and older.
- Developed and presented health education programming to area high school students.
- Developed and implemented an intervention to address social isolation and loneliness among clinic patients 65 and older.

The work we're doing right now is the foundation of how we start addressing social risk factors inside our walls, as well as leveraging community partnerships to create thriving communities. The tools of this project are not only helping us wrap our arms better around congestive heart failure, but it's really a framework that can be applied across various patient populations.

— Alicia Bauman, VP, Community and Population Health
Lakewood Health System



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