BREAKOUT 1C: POPULATION HEALTH: REVIEWING SUCCESSES

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POPULATION HEALTH BREAKOUT SESSION OBJECTIVES

By attending this breakout session, attendees will be able to:

WHAT IS POPULATION HEALTH?

- Population Health (CDC) is an interdisciplinary, customizable approach that promotes nontraditional partnerships among different sectors of the community to achieve positive health outcomes.
  - Ex: Public Health, Industry, Academia, Health Care, Local Government
- Population health brings health concerns into focus and addresses ways that resources can be allocated to overcome the problems that drive poor health conditions in the population.
  - Health Outcomes
  - Health Factors
  - Policies and Interventions
- Public Health vs. Population Health
  - *Public health* protects and improves the health of communities.
    - This is what we do collectively as a society to ensure the conditions in which people can live healthy lives.
      - Ex. Policy Recommendations, Health Education/Outreach, Research for Disease Detection and Injury Prevention
  - *Population health* provides an opportunity for health care systems, agencies, and organizations to work together in order to improve the health outcomes of the communities they serve.

WHY IS POPULATION HEALTH IMPORTANT?

The United States spends more on health care than almost any other country yet often underperforms on key health indicators, including:

RURAL COMMUNITIES: POPULATION HEALTH

- Chronic diseases are the leading causes of death and disability in America, and they affect some populations more than others.
- People who live in rural areas, for example, are more likely than urban residents to die prematurely from all of the five leading causes of death.
- Rural health disparities are caused by health behaviors, health care access, healthy food access, and demographic characteristics.
- In rural communities, population health approaches should involve:
  - Identifying the social drivers of health in the community
  - Engaging the community
  - Strengthening partnerships and collaboration
  - Identifying strengths, assets, challenges, and barriers
  - Coordinating and ensuring access to healthcare services through care coordination strategies, networks and coalitions, integrated services, and transportation.

IMPORTANT ROLE OF STATE OFFICES OF RURAL HEALTH

NOSORH

State Offices of Rural Health:
Inspiring innovation for a healthy rural America!

State Offices of Rural Health (SORH) are a unique federal-state partnership designed to be anchors of information and support for rural communities across the nation.

What Can a State Office of Rural Health Do for You?

- **Establish connections** between local, state, and national collaborators to share best practices that improve the health and well-being of rural communities.
- **Collect and disseminate** important rural health policies, projects, needs assessments, evaluations, and resources in your state or community.
- **Provide rural stakeholders** with technical assistance, grant writing support, education, and policy analysis to engage in innovative programs and funding opportunities.
- **Support training, recruitment, and retention** of the rural health workforce.

Rural Matters

60.8 million Americans live in rural areas

86% of the nation's land area is considered rural

SORH Structure

All 50 states have a SORH, varying in size, scope, structure, and services. Of the 50 SORH:

- **37** based in state government
- **10** part of academic institutions
- **3** independent non-profit organizations
- **28** manage a **State Loan Repayment Program (SLRP)**
- **33** co-located with a

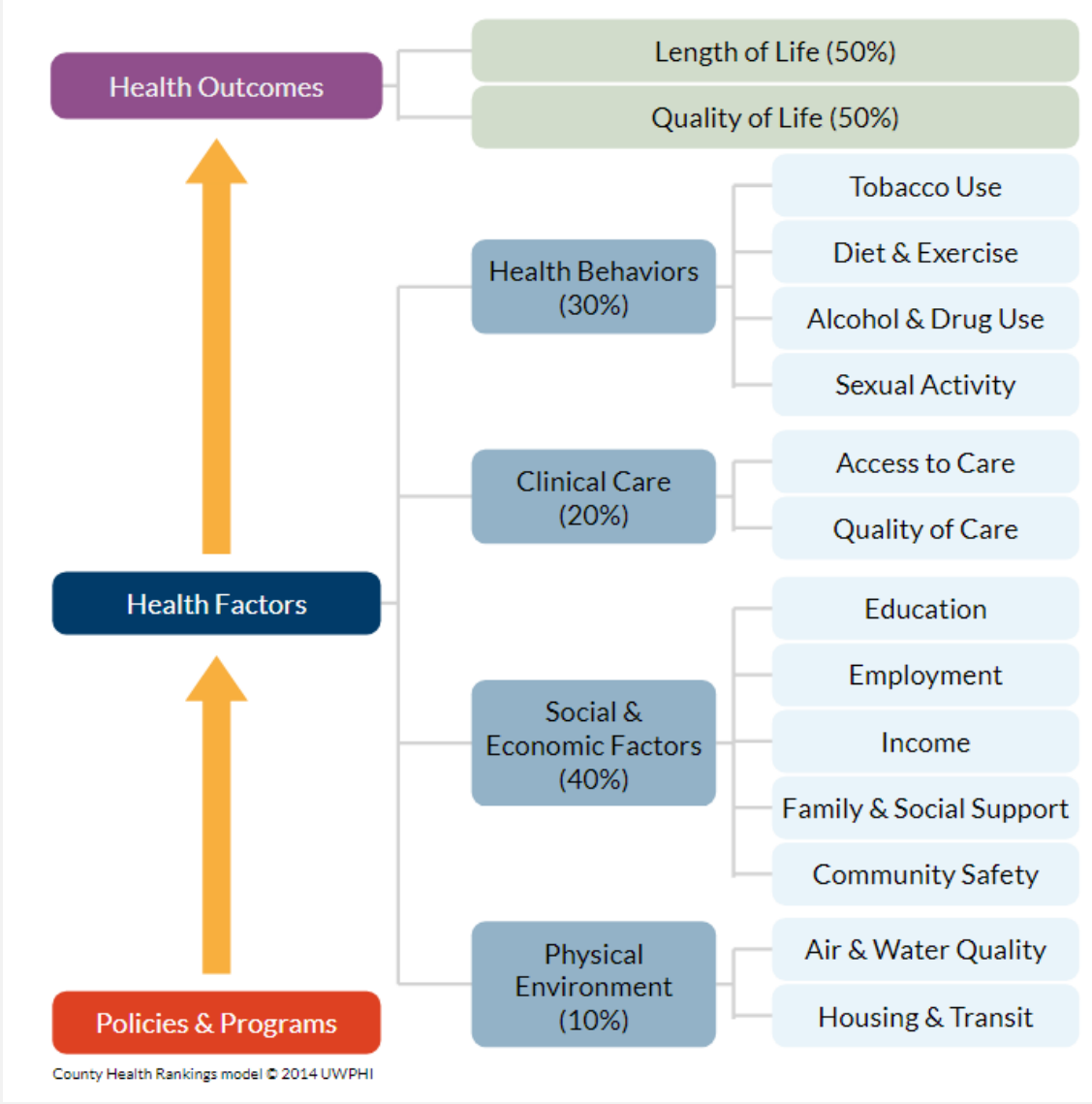
SORH IMPACT – SUCCESS STORY

91% of independent rural hospitals in Michigan are participating in an ACO.

MICHIGAN CENTER FOR RURAL HEALTH

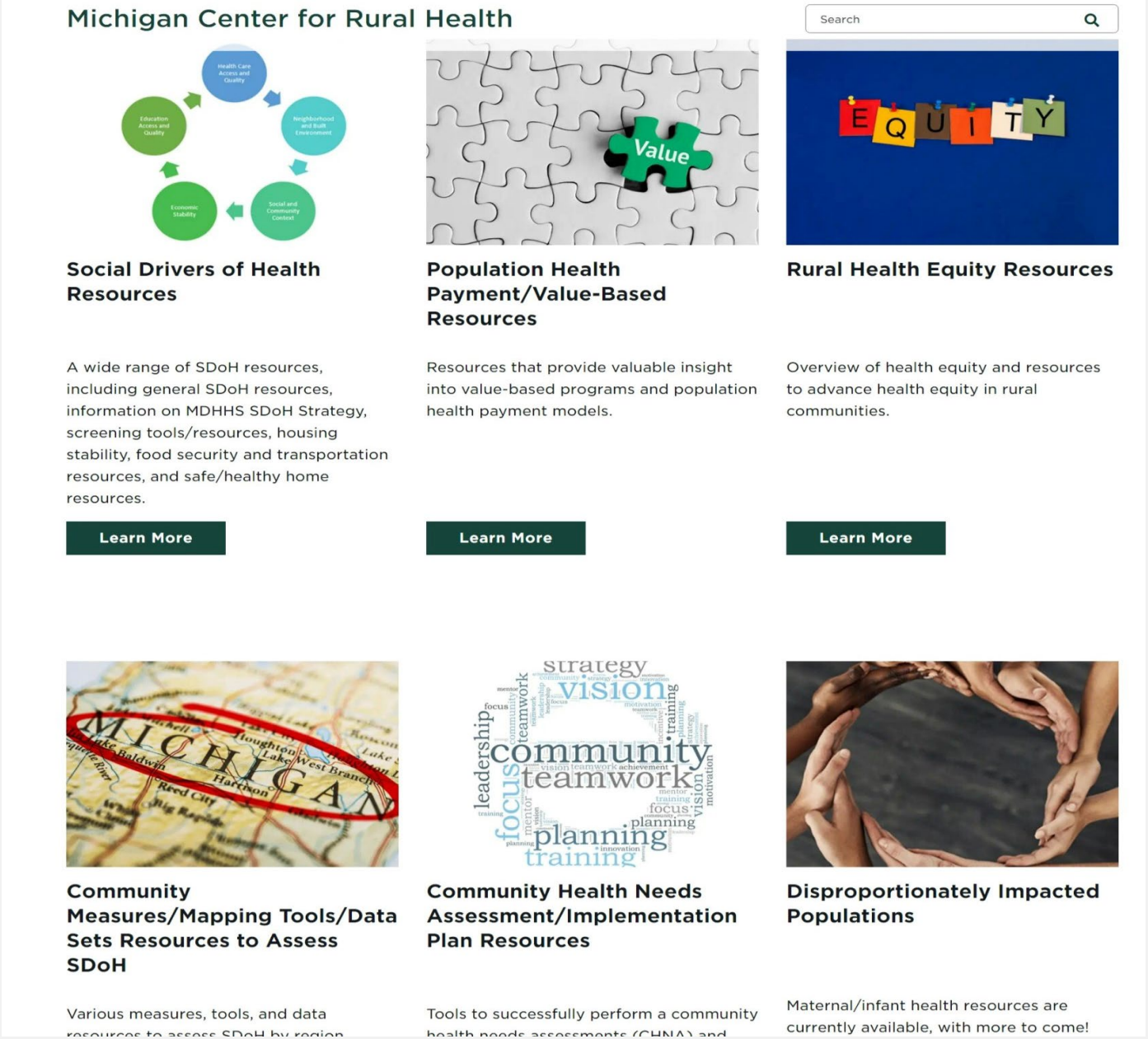
Our Mission: “To coordinate, plan, and advocate for improved health for Michigan's rural residents and communities.”

COUNTY HEALTH RANKINGS MODEL



RESOURCES ON THE WEBSITE FOR HEALTH CARE PROFESSIONALS

- Create a platform for rural health care providers to access SDOH resources.
- Regardless of where they are, we wanted to ensure there were resources to fit their needs
- Creating a space to promote valuable data sets and community assessment tools.



RURAL HEALTH EQUITY PLAN (RHEP)

- **Rural Health Equity Plan:** A supplement to the MDHHS SDoH Strategy focusing on the unique needs of Rural Michiganders.
  - Focuses on housing stability, food security & health equity
  - **Goal: Provide MDHHS a list of short-term and long-term rural specific recommendations that align with the current SDoH Strategy.**
  - Objectives of RHEP:
    - Understand the Rural Context of the MDHHS SDoH Strategy
    - Form Rural MDHHS SDoH Strategy Advisory Group
    - Understand and Review Data for Rural Areas
    - Assess Current State of Michigan Assistance Programs for Rural Areas
    - Develop a Written Report: Identifying recommendations

NEW CONNECTIONS MCRH HAS MADE

Northwest Coalition to End Homelessness	Food Bank Council of MI	Office of Rural Development	Area Agency on Aging Northern MI
MSU Migrant Services	Goodwill Northern MI	Human Development Commission	MSU Extension
Community-Based Organizations	Michigan Community Health Worker Alliance	National Kidney Foundation of MI	Food Bank Regions
Michigan Balance of State Continuum of Care	Contacts w/MI Bridges & 211	MSU Center for Regional Food Systems	Inter-Tribal Council of MI
Northern MI Community Health Innovation Region	Migrant Services Great Lakes Bay Health Center	MDHHS Policy & Planning	Catholic Charities of Michigan
Community Action Agencies	Michigan Economic Development Commission	MSU/Ferris MPH and MHA	Fair Food Network

RESOURCES

- CMS Issues New Roadmap for States to Address the Social Determinants of Health to Improve Outcomes, Lower Costs, Support State Value-Based Care Strategies | CMS
- Social Determinants of Health (SDOH) State Health Official (SHO) Letter (medicaid.gov)
- What is Population Health? | Population Health Training in Place Program (PH-TIPP) | CDC
- What Is Population Health? | AJPH | Vol. 93 Issue 3 (aphapublications.org)

Arizona Center for Rural Health

Population Health Initiatives

July 20, 2023

Population Health Under Flex

- Navigation for Health Insurance
- Community Health Needs Assessment

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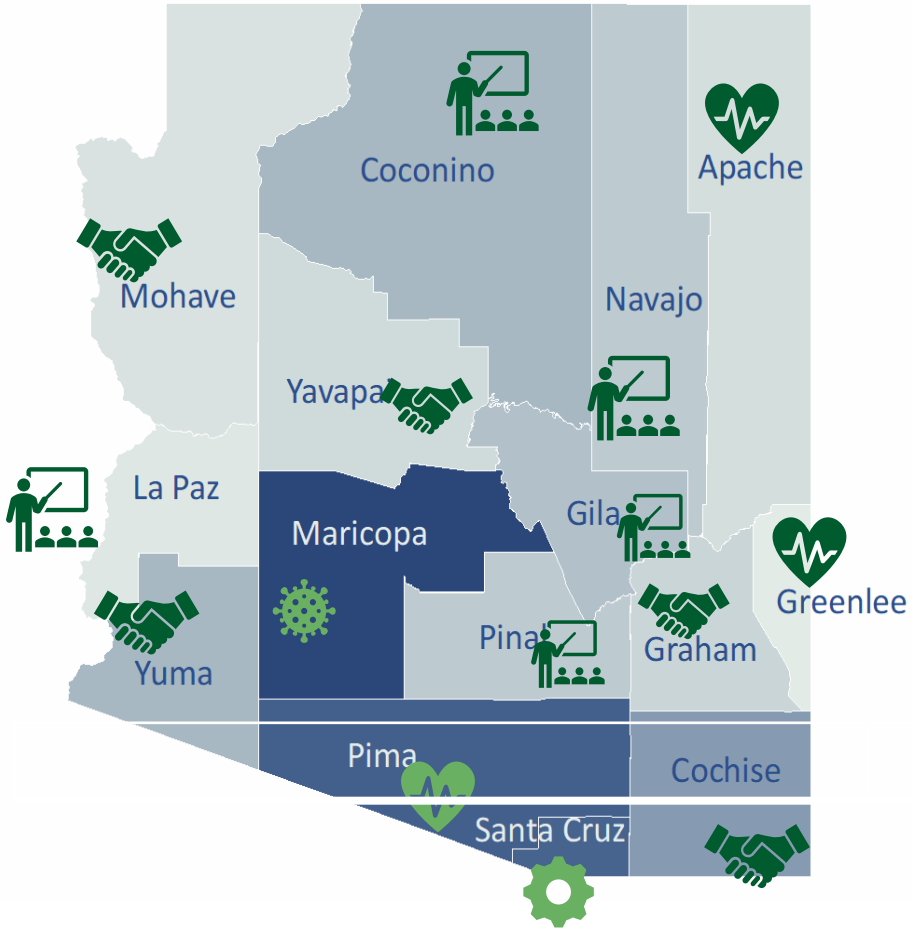
Advancing Health Equity, Addressing Disparities in Arizona (AHEAD) Program Activities (CDC Health Disparities Funding)



- Outreach and education
- Trainings, workshops and webinars
- Testing support
- Health screenings and wrap-around services
- Technical assistance

*Map illustrates concentration of engagement based on organizations' operational location

AHEAD AZ Projects

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MOVE UP (Mobile Outreach Vaccination & Education for Underserved Populations)	Mobile Health Unit delivering free services: administering vaccines, providing tests, conducting health screenings for blood pressure, cholesterol, diabetes, and body mass index, and issuing referrals.
Substance Use Disorder/Opioid Use Disorder	Development of education resources (e.g., naloxone administration training toolkit) and collaborative community engagement in various rural Arizona communities to address prevalence of SUD/OUD.
AZHEALTHTXT	Bilingual information-sharing platform disseminating expert-curated, health information tailored to the unique needs of Arizonans.
COVID Grand Rounds Webinar Series	Delivery of interactive synchronous and asynchronous COVID-19 information using the Arizona Telemedicine Program platform.
Provider to Provider Warmline (P2P)	Practitioner-to-practitioner COVID-19 support line to connect rural healthcare providers with clinical experts.
Public Health Workforce Assessment	Public health workforce assessment to understand the factors impacting public health capacity to respond and recover from the COVID-19 pandemic and future public health crises.

AHEAD AZ Projects cont…

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Partnerships with Area Health Education Centers (AHECs)	Supports Arizona AHECs with various initiatives that bolster public health and healthcare professionals in their capacity to effect interventions that decrease risk for COVID-19 and its collateral negative impact on public health. (E.g., training programs for Medical Assistants, hosting workshops on healthcare worker resilience)
White Mountain Regional Medical Center (WMRMC) Clinic Home Visit Program	In-home primary care services to geographically isolated community members who would otherwise have difficulty accessing care due to transportation and technological barriers. Aim is to support model replication to other Az CAHs.
National Parks Service/Southern Four Corners Group	Focuses on the principles of building a healthy tribal community, which contributes to improve public health infrastructure by using National Park Resources to educate the community about health and wellness practices that are based in Dine' cultural foundations.
Arizona Hospital and Healthcare Association (AzHHA) – Increasing Accessibility of ACP Educational Materials	With input and review from community members captured through focus groups, interviews, and surveys, AzHHA successfully redesigned its Advance Care Planning (ACP) educational documents to ensure greater accessibility to all Arizonans

AHEAD AZ Projects cont…

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Arizona Farmworkers Enumeration Study	Enumeration estimate (last updated in 2008) of Arizona's agriculture workers to inform allocation of emergency and health resources.
Public Health Champions – Community	In collaboration with the Arizona Library Association, this program supports programming by 'rural and small' AZ libraries to address health and health-related disparities and build community resilience.
Public Health Champions – Youth	Training program that aims to expose younger generations to the field of public health to spark interest in or supplement their future career path in STEM.
Statewide Benefits Navigation Landscape Analysis	Analysis of navigation models for accessing state benefits to inform the design and implementation of a cohesive 'one stop shop for statewide benefits.'
Project SHARE (Students Helping Arizona Register Everyone)	UA healthcare and public health students learn about navigating the healthcare system and acquire hands on experience assisting community members gain health insurance literacy.

AHEAD AZ Projects cont…

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Public Health Fundamentals Training	Prepares health navigators, community health workers, and other health professionals to acquire knowledge and develop practical skills that will enable them to connect community members with needed resources and services.
Healthy Homes Project	Led by UA Cooperative Extension, this capacity-building initiative is comprised of a school and home-based component and a mobile dog vaccination/tick prevention clinic with the goal of improving environmental health in indigenous communities in Arizona.
Critical Access Hospitals (CAHs) Support with CMS SDOH Measures (Z Codes)	Assist leadership at AzCAHs to review the five domains of CMS' Hospital Commitment to Health Equity Measures and provide guidance on updating hospital strategic plans to reflect prioritization of Domain 1 elements that include health equity goals.

Community Cares System Features

Contexture, Arizona's health information exchange (HIE), teamed up with the Arizona Health Care Cost Containment System (AHCCCS) — and in collaboration with 2-1-1 Arizona and Solari Crisis & Human Services — to implement a single, statewide referral system (CommunityCares) to address social determinants of health (SDOH) needs in Arizona.

https://contexture.org/communitycares/

Community Cares System Features cont..

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- Closed-loop referrals with outcome tracking
- No wrong door — easily connect clients to resources in one platform
- Screenings and assessments for identifying client needs
- Alerts and communications about client case progress
- Data dashboards, analytics and outcomes
- Resource directory

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Thank You!

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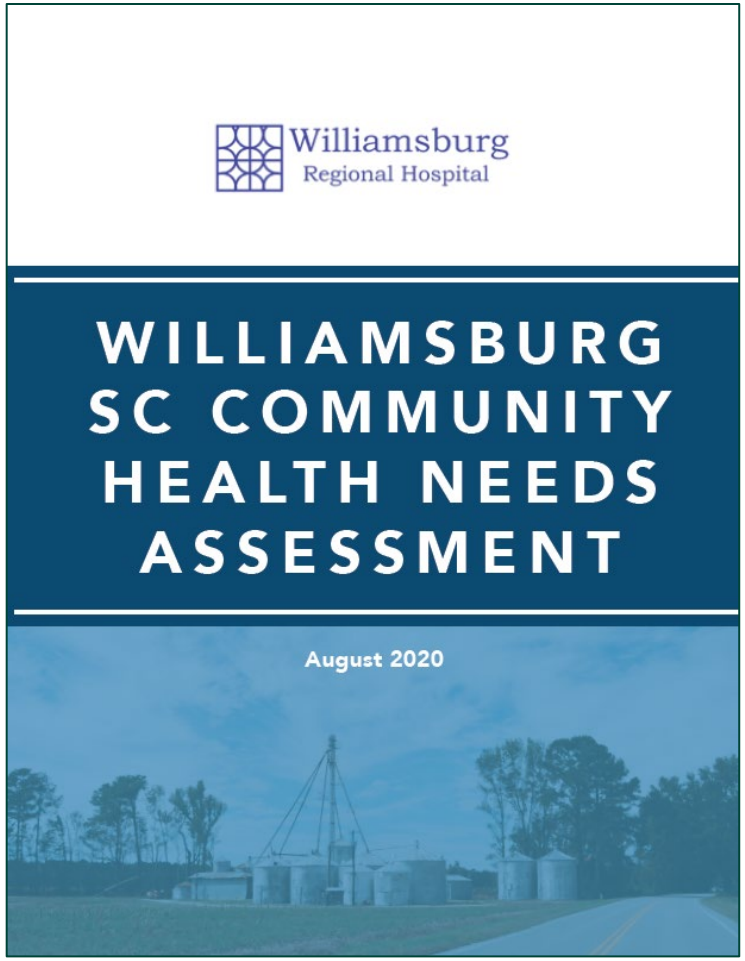
SOUTH CAROLINA OFFICE OF

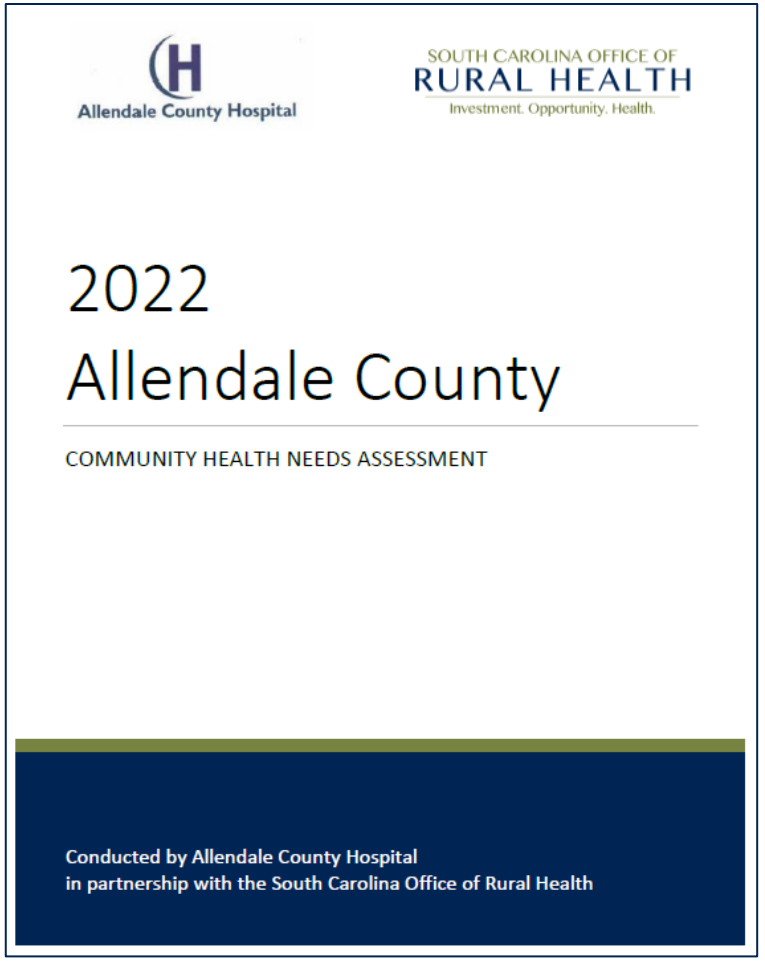
RURAL HEALTH

Investment. Opportunity. Health.

A non-profit organization with a mission to close the gap in health status and life expectancy between rural and urban communities in the Palmetto State. SCORH has been promoting investment, opportunity and health within rural communities since 1991.

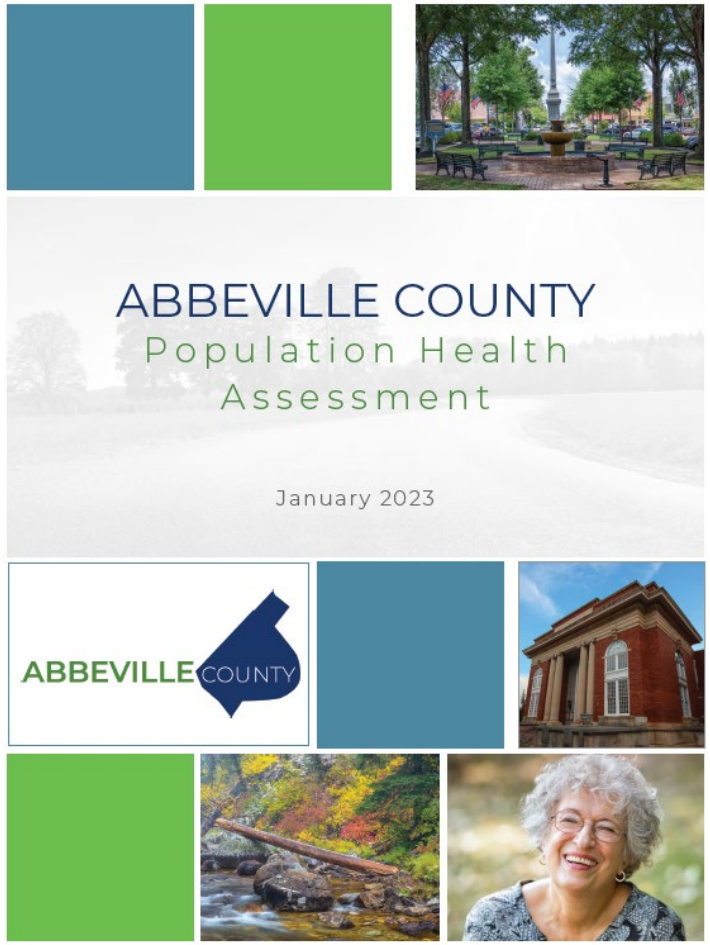
Community Health Needs Assessments



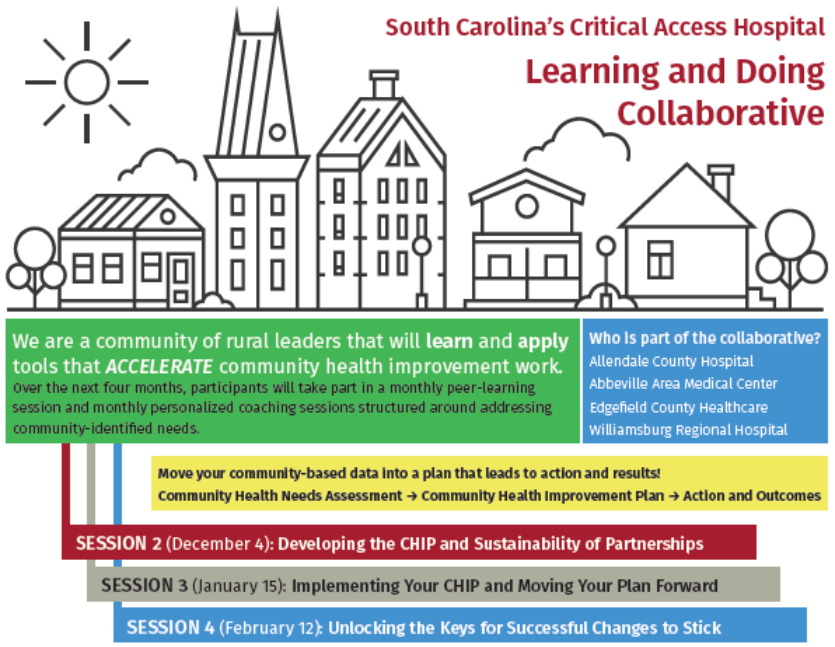


Population Health Assessments

- Scored evaluation of each CAH community
- Identify existing assets and activities
- Provide realistic recommendations

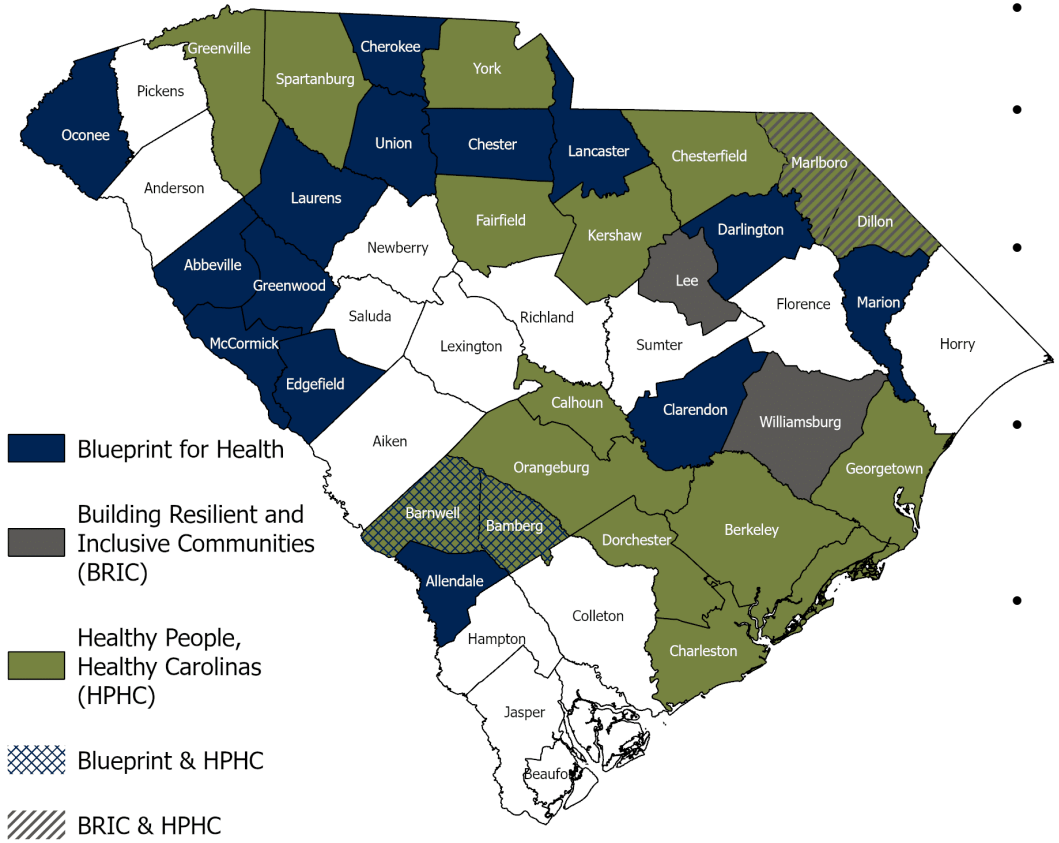


Learning & Doing Collaborative



- Successful initiatives that have been tested in other communities
- Deeper cross-sector partnerships and relationships
- Clarified goals and a shared vision
- Mindset shift from "deficit-focused" to one of "abundance-focused" and action oriented
- Understanding of skills and tools needed to drive action for improved community health outcomes

Community Services



Services Provided

- Blueprint for Health: Works with community coalitions to create a vision for community health
- Building Resilient and Inclusive Communities (BRIC): Focus on food access, physical activity and social connectedness
- Healthy People, Healthy Carolinas: Supports community coalitions in their efforts to improve population health through the collective impact model.
- Network Development: Encourages communities and their health and human services organizations to collaborate on systems of care that enable optimal access to healthcare services.
- Results-Based Accountability (RBA): Supports leaders using a data-driven decision-making process to help communities and organizations get beyond talking about problems to taking action to solve them. This framework incorporates population and performance accountability to improve the effectiveness of programs and create measurable change.

CDC Health Equity

- 660 Residents participated in digital literacy training and received a digital device upon completion.
- 20 Community gardens across 17 counties targeting seniors and low-income individuals.
- 15 Learning modules developed for rural healthcare providers to promote health equity in the community.
- 12 High tunnels for socially disadvantaged farmers.
- 9 Vaccine confidence grants to dispel COVID-19 misinformation.
- 5 Hospital capital improvement projects.
- 5 EMS community paramedic development and data optimization projects