Practical Strategies to Engage CAHs in Population Health

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Learning Objectives

• Setting the stage:
  ▪ Defining population health
  ▪ Community Needs Assessments, Community Benefits, and Population Health
  ▪ Defining population health
  ▪ Opportunities for alignment

• Learning from current examples
The Burden of Illness in Rural Communities is Significant

See: M. Meit et al. The 2014 Update of the Rural-Urban Chartbook, NORC Rural Health Research Center
Defining Population Health

• Population health:
  ▫ “health outcomes of a group of individuals, including the distribution of such outcomes within the group” (Kindig, What is Population Health?)

• Groups include geographic, racial, ethnic, linguistic, or other communities of people.

• Focus: health outcomes; the “determinants” of those outcomes; and policies and interventions that can improve outcomes.
Hospital Accountability

• Shifting focus from volume to value encourages hospitals to re-conceptualize their missions:
  ▫ Transformation programs - hospitals assume risk for the health and health care costs of an enrolled population
  ▫ Evolution of traditional community benefit programs into strategies for improving community health

• If integrated and aligned, the two paths to hospital accountability can build on and support each other
IRS Expectations

• Annual community benefit reports
  ▫ Report the dollar value of defined community benefit activities
  ▫ Not all community benefits are equally valuable:
• Required community health needs assessments
  ▫ Conducted every three years
  ▫ Required strategy plans implementing interventions to address identified needs
  ▫ Conduct evaluation of past activities and report progress
HRET’s Community Responsive Hospital

• Expanding from delivery of medical care to role of hospital in the following:
  o Community issues-substance abuse, domestic violence
  o Critical health issues-oral health, mental health, obesity
  o Health care equity-barriers to access, health disparities
  o System barriers-limited public health infrastructure
  o Community's role in process-involve residents in addressing above issues, reducing risky behaviors

From: Where Do We Go from Here? The Hospital Leader’s Role in Community Engagement (2007) by the Health Research and Educational Trust.
Redefining the Blue H – 2014

- Washington Department of Health and Washington State Hospital Association (similar to AHA project)

- Objectives:
  - Ensure access to prevention, 24/7 ER, primary care, behavioral health, oral health, long term care, home care, hospice, social services
  - Enable aging in place
  - Address rural health disparities
  - Achieve the triple aim in rural communities
Population Health: The Unifying Link

Community Benefit

Population Health

Hospital Accountability

Accountable Care
Opportunities for Alignment
Build on Access Initiatives

• A priority for most community benefit programs
• Population health management programs are more likely to succeed when more persons are insured.
  ▫ Expand enrollment strategies for uninsured and underinsured persons
  ▫ Revise financial assistance policies to reduce barriers for low income individuals
Coordinate Prevention and Health Promotion Programs

- Community benefit programs often offer health screening programs
- Use expertise and connections for addressing tobacco, alcohol and other drug use, unhealthy eating, inactive lifestyles and other risky behaviors
Share Relationships

• Build on community relationships that community benefit programs have established
• Enhance referral networks to community-based program
• Support community-wide coalitions
• Contribute staff time and expertise
• Offer technical assistance
Address Determinants of Health

- Work with partners to work on improving determinants of health:
  - Reduce violence
  - Support low-income housing
  - Address community issues – substance use/opioids
  - Support economic development in distressed communities
  - Work to change community attitudes and practices related to health behaviors
Exchange/Use Information for CHNAs

- Use findings from community benefit programs' CHNAs (community health needs assessment)
- Contribute information from population health data sources and analyses
- Work with public agencies and community organizations to assess and address community health needs and to identify community assets
Learning by Example
Cardiac Care: New Ulm Medical Center

- Heart of New Ulm Project applied evidence-based practices
- Reduce # of heart attacks over 10 years
- Collaboration with Minneapolis Heart Institute Foundation, local employers and providers
- Results: Improvements in consumption of fruits and vegetables, taking daily aspirin, participation in exercise
Cardiovascular Health:
Franklin Memorial Hospital

• Initiatives dating back to the 1970s in a low income rural Maine county
• Collaboration with the hospital, providers, employers, and other community organizations
• Efforts focused on hypertension detection/control, hyper-cholesterolemia, tobacco, diet, physical inactivity, and diabetes
• Organizations changed - key players remained consistent
Partnering and Leadership: Mt. Ascutney Hospital and Health Center

- Partnering-support community health infrastructure
- Goal-address fragmented/decentralized services
- 14 health promotions implemented, trust improved
- Challenges—skepticism over control/management
- Mission-promote community health/wellness
- Activities funded over time by different grants
- Key factors-assessment/evaluation, community health metrics
Measurement and Community Metrics: Fulton County Medical Center

- Implemented the Healthy Communities Dashboard
- Supports needs assessment/community reporting
- Reflects 6 priorities with community metrics
- Shares data with community, providers, agencies
- Evidence based resources to identify interventions
- Monthly meetings of Fulton County Partnership (20 local agencies) to review priorities, outcomes and progress
Workplace Wellness Programs: Redington Fairview General Hospital

• Redington Fairview houses the Greater Somerset Public Health Collaborative
• Developed community-based employee wellness program for very small businesses
• Small businesses can offer workplace wellness activities that would not normally be economically feasible for groups their size (cost is $2.00 annually per employee)
• Developed other programs with grant funding
Employee Wellness: Teton Medical Center

• Partners: High school, Teton Community Development Cooperative, County Extension Office, Great Falls Clinic, others
• Exercise programs, nutrition, health education, diabetes, stroke, and heart rehabilitation
• Special focus: health/fitness for students, firefighters, and persons with chronic illness
• Goal: wellness activities to younger residents
Mental Health: Essentia Health St. Mary’s

- Collaborative Care Mgt of Depression in Primary Care
- Priority need identified in CHNA
- Team approach- behavioral health specialist, psychiatric nurse practitioner, care coordinator
- Coalition of EH-St. Mary’s and community mental health professionals
- Community outreach and education
Mental Health: Wabash Valley Telehealth Network

- MH patients clogging EDs
- Hub & spoke model: CMHC (community mental health center) provides crisis services to 6 CAHs using 24/7 access center Standardized protocols/algorithms to assess pts
- CMHC prepares consultation report and disposition plan
- ED LOS (length of stay) reduced- 16-18 hours to 240 minutes
- CAHs pay a consulting fee per encounter
Mental Health: Nor-Lea General Hospital

- Created Heritage Program for Senior Adults in 2003
- Provides O/P mental health services to seniors
- Staff—psychiatrist, therapists, RN, and MH technicians
- Services: individual and/or family therapy and group therapy, both focus and process
- Van is available to transport clients to the hospital for services
Dental Health: Waldo County General Hospital

- Board stretch goal—create dental program in 2013
- Serves safety net clients only
- Staffing: Dental hygienist, employed dentist, private dentists. dental assistant, receptionist, Access-to-Care coordinator, CarePartners staff
- 700 individual patients, $203 average cost per visit, most had no dental care in 10 years
- Funding: hospital funds, grants, fundraising, in-kind contributions, patient co-pays, some Medicaid
Determinants of Health: Wrangell Alaska Medical Center

- Rural Health Careers Initiative
- Partnered with local education programs to develop certified nursing assistant program
- Recognized economic and social challenges of the community and the need for qualified CNAs
- Trained 200 students
- Students receive mentoring/financial assistance
- WMC employs the majority of graduates
Getting Started

• Target essential services needed in community
  o Mental health, primary care, oral health
• Develop program targeting hospital employees
  o Expand to other local employers
• Address needs of uninsured patients
  o Improve access to services, improve care management, link to primary care, revise financial eligibility standards to align with local needs
Conclusions & Implications

• Take a more holistic approach
  o Not all population health activities must be charitable or community benefit activities

• From value to outcomes: measure benefits/ROI

• Building successful partnerships and achieving results takes time and effort

• Hospital and community champions critical.

• Cash investment not essential (or possible in most cases)

• Grants are important sources of funding
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