Practical Strategies to Engage CAHs in Population Health

John Gale, MS, Research Associate

Maine Rural Health Research Center and Flex Monitoring Team

Flex Program Reverse Site Visit
Rockville, MD
July 20, 2016

UNIVERSITY OF SOUTHERN MAINE
Muskie School of Public Service

Acknowledgements

Support for the Flex Monitoring Team and the Maine Rural Health Resource Center is provided by the Federal Office of Rural Health Policy, Health Services and Resources Administration.

Project Team: John Gale
Karen Pearson
Andy Coburn
Zach Croll
George Shaler

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

<u>See:</u> 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

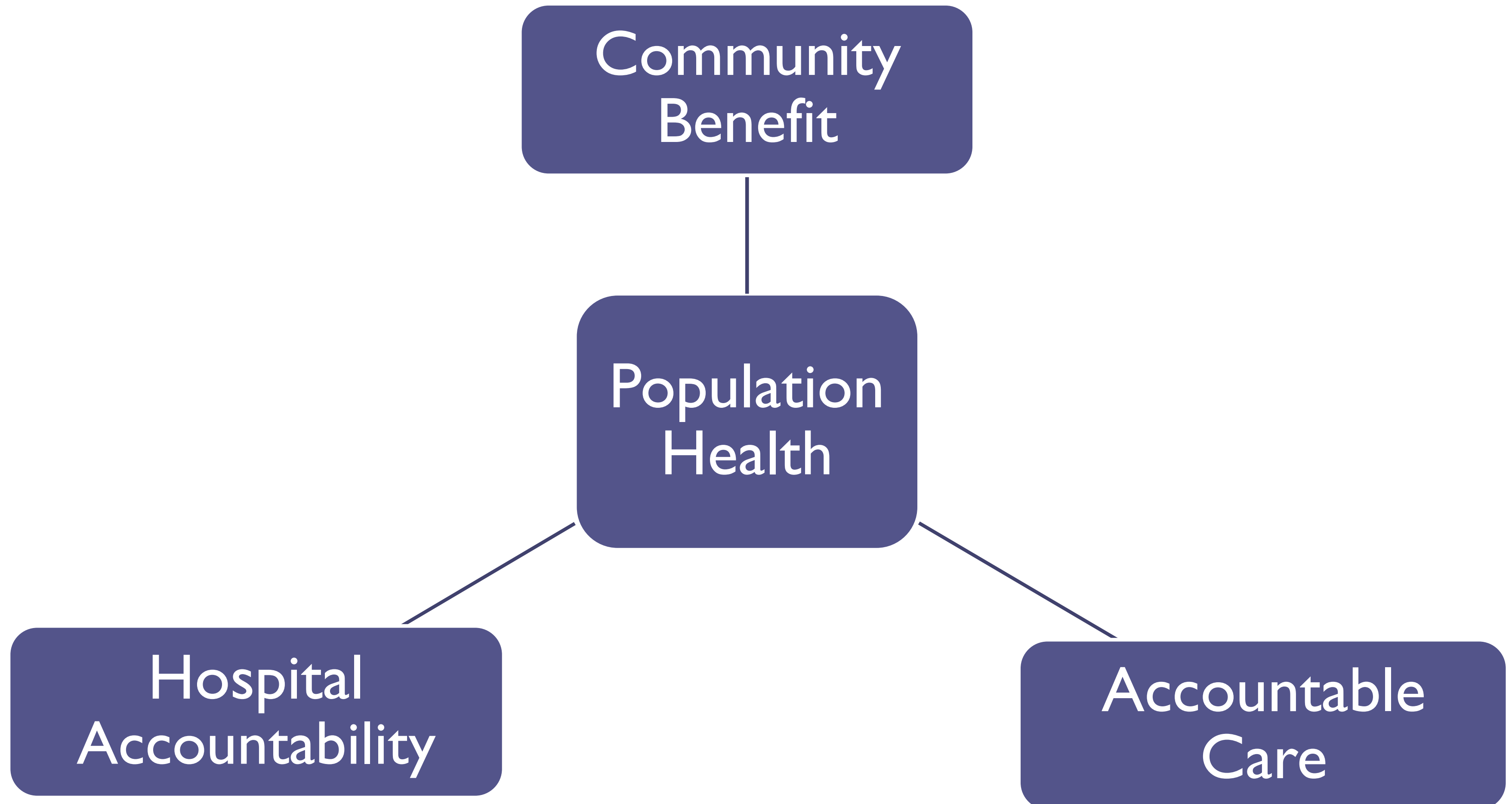
- Expanding from delivery of medical care to role of hospital in the following:
  - Community issues-substance abuse, domestic violence
  - Critical health issues-oral health, mental health, obesity
  - Health care equity-barriers to access, health disparities
  - System barriers-limited public health infrastructure
  - 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



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-cholesteroliemia, 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
  - Mental health, primary care, oral health
- Develop program targeting hospital employees
  - Expand to other local employers
- Address needs of uninsured patients
  - 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
  - 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

Contact Information

John A. Gale, MS
Research Associate
Maine Rural Health Research Center
Muskie School of Public Service
University of Southern Maine
PO Box 9300
Portland, ME 04104-9300

John.gale@maine.edu
207.228.8246

Maine
Rural Health
Research Center

UNIVERSITY OF SOUTHERN MAINE

Muskie School of Public Service