Critical Access Hospital Population Health Summit

Improving Population Health: A Guide for Critical Access Hospitals

Bloomington, Minnesota
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Executive Summary

The U.S. health care industry is undergoing profound change in financing and service delivery, as it shifts from a financial system that rewards "volume" to one that is based on "value". Driven by the health marketplace itself, the new health industry goals are articulated in the Institute for Health Improvement's Triple Aim: better population health, better health quality and lower health costs. Today, small rural hospitals face the challenge of being successful in their current payment systems, while preparing for the various value-based models that are being rolled out across the country. For rural hospital leaders, the quality and cost challenges are familiar, they generally understand that in the immediate future they will be called upon to provide better quality for less reimbursement. The population health management challenge, however, is new and perplexing for most rural hospitals, and payers are increasingly factoring in population health outcomes into reimbursement formulas.

To begin to address the issue of the rural hospital's role in population health management, the National Rural Health Resource Center, with funding from the Federal Office of Rural Health Policy, hosted a Critical Access Hospital Summit meeting in Minnesota in March, 2014. The Summit participants included leaders from hospitals, state health departments, universities, medicine and quality and health networks. The group identified a series of critical success factors to help articulate guiding steps and needed resources to support rural hospitals and their rural communities in improving population health. They also provided suggestions and identified resources for the 45 state Medicare Rural Hospital Flexibility (Flex) Programs that, in turn, support the nation's 1,332 critical access hospitals.

The Summit suggestions for rural hospitals as to what they could do to begin to improve population health in their service areas included the following:

- Hospital leadership, including boards, medical staff, senior leaders and managers should fully understand and begin to build a case for population health management. In other words, to effectively communicate the "why"
- Hospitals should put population health on their meeting agendas, including board, management, quality improvement, health

information technology, medical staff, business office and general staff, thereby giving it ongoing attention
- Hospitals should look within their own walls and initiate employee wellness programs, as well as care management and chronic illness management programs for their employees
- Hospitals should reach out to their communities, discovering health program wants and needs and identifying reasons for outmigration for care, as well as expanding the hospital's wellness and care management programs to citizens in the service area

Other suggestions from the Summit dealt with the education and alignment of leadership, population-based strategic planning, creating partnerships with other health and social service organizations, data collection, management and analysis, workforce and culture, process improvement and documentation and communication of outcomes. Summit participants identified an array of opportunities and potential tools that could support use of the population health framework by rural hospitals including aligning resources, gathering best practices, identifying relevant population health metrics, and supporting training and education and building collaboration in community engagement strategies. The Summit report will be disseminated widely for use by rural hospitals, state rural health programs, including Medicare Flex, and rural health networks.

Summit Participants

- Sally Buck, National Rural Health Resource Center
- John Gale, University of Southern Maine, Flex Monitoring Team
- Terry Hill, National Rural Health Resource Center
- Harry Jasper, Southern Humboldt Community Healthcare District
- Kristin Juliar, Montana Office of Rural Health
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- Michelle Mills, Colorado Rural Health Center
- Tracy Morton, National Rural Health Resource Center
- Kami Norland, National Rural Health Resource Center
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- Pat Schou, Illinois Critical Access Hospital Network
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Purpose and Process

The U.S health care industry is undergoing profound change in financing and service delivery as it shifts from a financial system that rewards "volume" to one that is based on "value." Value-based payment systems are being designed to address a three-prong approach known as the Triple Aim of providing better care, improving health and lowering costs. Today, small rural hospitals face the challenge of being successful in their current payment systems, while preparing for new value-based payment systems that are being rolled out in various forms across the country. Critical access hospitals (CAHs) are increasingly in the spotlight of federal policy makers as the cost-based reimbursement system is viewed as a potential opportunity to reduce overall spending[1]. Thus, it is more important now than ever for CAHs to participate in efforts such as implementing population health strategies to help demonstrate the quality and value they provide rural residents.

The improving health component in striving for the Triple Aim is commonly referred to as "population health." Population health encompasses a cultural shift from a focus on providing care when individuals are sick to a more comprehensive view which includes enhancing and improving the health of communities across a spectrum of ages and conditions.

As part of the 2014 work plan, the Technical Assistance and Services Center (TASC) for the Medicare Rural Hospital Flexibility (Flex) Grant Program, a program of the National Rural Health Resource Center (The Center), hosted a CAH Population Health Summit meeting in Bloomington, Minnesota on March 25 and 26, 2014. The event was funded by the Federal Office of Rural Health Policy (FORHP). The goal of the Summit was to assemble national rural hospital and population health experts to create recommendations for CAHs and small rural hospitals on actions and activities to address population health needs in their communities using a systems-based framework to ensure a holistic approach. The group sought to identify critical success factors to help articulate guiding steps and identify existing or needed resources to support CAHs, their rural communities, and state Flex Programs in improving population health. The results of this Summit are summarized in the guide that follows.

> *"If you don't help your community to thrive and grow – How will your organization thrive and grow?"*

[1] Department of Health and Human Services, Office of the Inspector General Report: http://oig.hhs.gov/oei/reports/oei-05-12-00080.pdf

The Guide is intended to be a tool for rural hospital leaders to support incorporation of population health principles and programs into strategic planning and operations. Challenges are addressed, resources are provided and quotes reflecting the Summit discussion are highlighted throughout the Guide's components. Included in the supplemental portion of this document are additional ideas and recommendations from Summit participants, resources, references and suggestions for TASC and state Flex Programs to support CAH engagement in implementing population health strategies.

Population Health – Background

Once considered the domain of public health agencies, the term "population health" has recently become wide-spread among health care providers. Recognition that volume-based purchasing for health care services is fueling unsustainable growth in costs, there has been a renewed focus among payers and policy advocates to address underlying issues such as uncoordinated care, poor chronic disease management and unhealthy behaviors that can drive up utilization and costs. Population Health is also a key component of the health care Triple Aim of better care, better health and lower costs. Thus, care delivery and payment systems are shifting focus to keeping populations well, rather than only caring for the sick.

Before one can focus on improving population health, it is important to consider what a healthy population looks like. Healthy People 2020[2], a federal initiative that develops 10-year national objectives for improving the health of all Americans, states it's vision as "*A society in which all people live long, healthy lives.*" Over-arching goals that are crucial to reaching that vision include implementing strategies that:

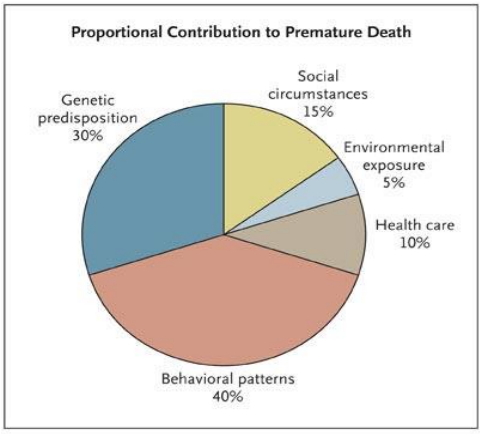
- Attain high-quality, longer lives free of preventable disease, disability, injury and premature death
- Achieve health equity, eliminate disparities, and improve the health of all groups
- Create social and physical environments that promote good health for all
- Promote quality of life, healthy development and healthy behaviors across all life stages

Access to high-quality medical care is a key component in supporting a healthy community, and is one of the reasons that CAHs are so vitally important in overall wellbeing of rural communities. However, delivery of health care services accounts

[2] Healthy People 2020. http://www.healthypeople.gov/2020/about/default.aspx

for only about 10 percent of the overall determinants of health. An additional 30 percent is attributable to genetics. The remainder is impacted by the complex interplay between social circumstances, behavior patterns, and environmental factors (Figure 1: Determinants of Health and Their Contribution to Premature Death).

Figure 1. Determinants of Health and Their Contribution to Premature Death



Schroeder NEJM 2007:357:1221-1228

Population health and health improvement has traditionally been the purview of public health departments, often with little or no connection to the health care delivery system. Recognition of the critical role of improving health to lowering health care costs has led policy makers and payers to drive increased responsibility for the health of populations to health care providers, often blurring the lines between traditional public health and health care delivery roles. Strong partnerships at a community level between local public health agencies and health care providers are essential to the overall success of improving population health through alignment of goals and resources.

It is important to note that population health should address all age spectrums in a community. Strategies that address needs across that wide spectrum make local partnerships even more critical as the most effective approaches to improving health engage the population where they live, work and play. For example, an approach to healthy eating for pregnant women and young children may include a different set of activities and partners than a strategy that focuses on increasing activity levels in seniors.

Even as this recognition and focus of broader health and wellness needs is becoming more widespread, there is often confusion by what is meant by the term "population health."

As part of the Triple Aim focus of better care for individuals, better health for populations and lower per capita costs, the Institute of Healthcare Improvement (IHI) has been using this widely accepted definition:

> ***The health outcomes of a group of individuals, including the distribution of such outcomes within the group;*** *These groups are often geographic populations such as nations or communities, but can also be other groups such as employees, ethnic groups, disabled persons, prisoners or any other defined group.*
> (Source: Kindig, DA, Stoddart G. (2003). What is population health? *American Journal of Public Health*, 93, 366-369)

This definition provides a broad platform for action while including a specific focus on disparities. Yet it is important to acknowledge that the term "population health" is currently used to describe two separate but related concepts:

- **Cohort Management or Population Medicine** is a focus on improving health and reducing costs for specific groups of patients, often grouped by insurance type and focused on chronic disease
- **Community Health or *Total* Population Health** addresses outcomes of an entire group of individuals, often geographically defined, including the distribution/disparities of outcomes within the group.

Although these two aspects of population health are interconnected, they lead to different operational strategies. Rather than get caught up in this difference and how to select a direction, Summit participants recommended that CAH leaders acknowledge this dichotomy, and recognize the need for strategies that address both aspects.

Population Health - Why should CAHs care?

Hospitals are in the business of caring for the sick; a shift to focusing on health and wellness is a cultural adjustment that is not particularly intuitive. After all, if the health of the population improves, won't that keep people out of the hospital? Summit participants cited a wide variety of reasons why it is necessary for CAHs to implement a strategic focus on population health strategies.

Reasons CAHs should implement population health strategies:

- Facilitating community engagement activities leads to increased awareness of local health care services
- Building customer trust and loyalty increases market share
- Aligning mission/vision/values of the CAH towards wellness is the "right thing to do"
- Creating a healthier workforce leads to increased productivity and reduced absenteeism
- Investing in the well-being of staff promotes retention and a desirable work environment for recruitment
- Improving employee health by implementing wellness programs internally reduces insurance costs
- Capitalizing on financial incentives driven by value-based purchasing promotes organizational sustainability
- Promoting care coordination can prevent hospital readmissions and reduce charity care/bad debt
- Implementing robust strategies to address findings from community health needs assessments (CHNA) helps prove the benefits CAHs provide in their community.

Summit participants, March, 2014

Although many CAHs are still predominately reimbursed in a fee-for-service environment, there is wide recognition that payment structures that rely on quality, satisfaction and reducing costs will continue to spread. There is increasing scrutiny by policy makers of the current cost-based reimbursement structure for CAHs, and adjustments that align payment more closely with quality and value, similar to what is happening for larger hospitals, are likely in the near future.

"Altruism and financial viability are not opposites."

The American Hospital Association (AHA) recognized this shift back in 2007 in a strategic framework called *Health for Life: Better Health, Better Health Care*:

> "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 highest potential for health and reverse the trend of avoidable illness." (AHA, Health for Life: Better Health, Better Health Care, August, 2007)

Rural hospitals, which are inherently linked to the community they serve, are well positioned to thrive in the changing marketplace by developing population health strategies that have both short- and long-term impact on operational viability. The nature of CAHs as a hub for local health care services lends naturally to broader development of partnerships and programs to keep populations healthy and ultimately reduce overall health care spending.

Population Health – Where should CAHs start?

CAHs are uniquely positioned to address population health challenges in the communities they serve through a broad system-based approach outlined in this Guide. Because an integrated operational focus on population health is new territory for most CAHs, summit participants identified a set of four activities to start the journey towards population health:

As a CAH leader, what can *you* do to improve population health?

1. Understand/build the case for population health

- Align with the shift towards value-based purchasing
- Identify the potential to increase community presence/engagement (marketing!)
- Get the chief financial officer (CFO) engaged, framing the conversation in terms of charity care, bad debt and community benefit
- Organize your data and seek assistance with analysis of claims, health status and community needs
- Recognize the impact on other organizational priorities (for example: recruitment/retention, employee satisfaction and care transitions)
- Provide facility wide education about the determinants of health to help engage staff in conversations about the non-medical influences on wellness
- Dispel the notion that population health = cash outlay. Population health strategies may take time, but not necessarily involve writing a check

As a CAH leader, what can *you* do to improve population health?

2. Put population health on the agenda

- Include population health on the agenda for meetings across all levels of the organization (such as board, management, quality improvement, health information technology, business office and staff).
- Provide education and have discussion regarding:
    - How does population health align with your 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 they impact your hospital?

3. Look inside your own walls

- Develop and/or implement employee wellness programs that encourage healthy behaviors
- Implement case management/care coordination services for employees with chronic conditions
- Consider starting with a focus on uninsured that you are already serving. Manage charity care and bad debt policies so that you can better support those populations and address needs before they reach the emergency room or inpatient unit

4. Reach out to the community

- Don't wait to be asked. Offer and engage in conversation with a wide variety of community partners and leaders
- Build on CHNA results and monitor implementation of action plans
- Set expectations and support staff involvement in community workgroups, committees and task forces that address population health needs
- Identify and articulate role(s) your hospital can fill in supporting community efforts
- Think beyond traditional health care partners to identify opportunities for coordination and collaboration (for example: parks and recreation departments, senior centers, schools, fitness facilities and libraries).

Rural hospitals across the country cover a wide spectrum regarding the journey towards integrating population health as a strategy, but there are actions that can be taken by everyone:

- For those new to the concept of population health, developing awareness of population health concepts and providing education regarding health determinants is an excellent starting point
- For those that have been implementing care coordination or disease management strategies, meaningful incorporation of community-based resources into referral processes and broader discussions about opportunities to improve the health of the community may be in order
- For those that have been dabbling in a variety of population health activities, focus on integration of population health concepts into strategic planning, and prioritization of community health issues for action. Then align activities to focus on those key areas
- For those incorporating a broad integrated approach, helping illustrate the business case and sharing best practices to identify future opportunities and strategies

The system based approach described in the rest of this guide can help your CAH identify the critical success factors to integrating population health strategies. A starting point is reviewing and discussing the system-based key success factors with key leadership including the board of directors, management and medical staff.

Population Health - A Systems Based Approach for CAHs

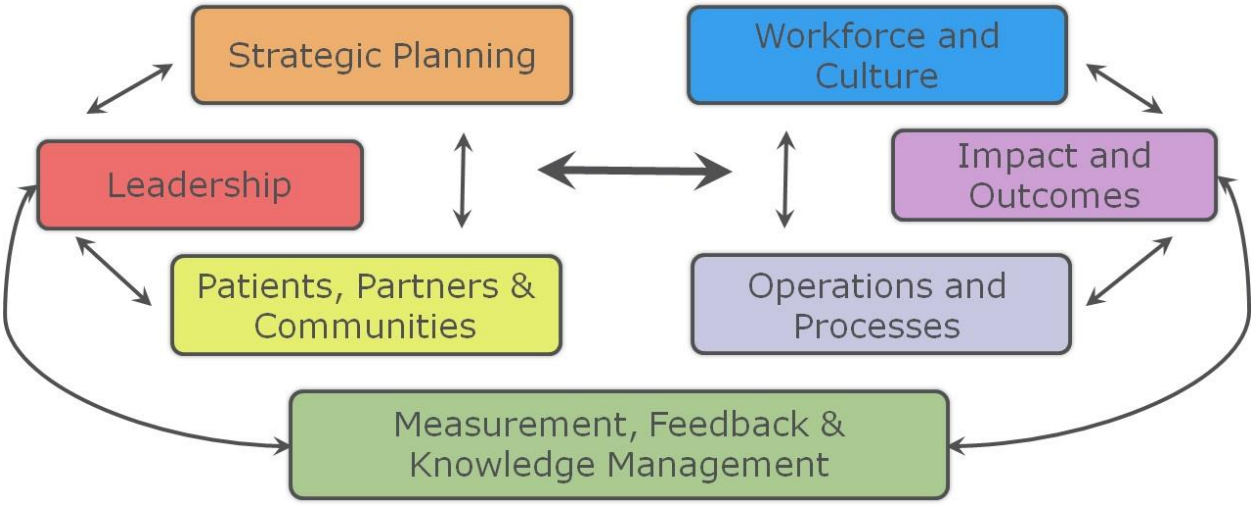
Care delivery models that support effective population health management is uncharted territory for many health care systems. Small rural hospitals may embrace population health at the conceptual level, but struggle on where to get started on an operational level. They also may struggle with maintaining balance and fiscal responsibility between the current illness model (with volume-based payment) and the more recent wellness model (with value-based purchasing). Therefore, this Guide aims to assist CAH leaders and state Flex Programs in proactively supporting healthier patients and communities and lowering overall health care costs.

The Center has long encouraged adoption of a systems-based approach modeled after the Baldrige Framework for Performance Excellence in managing hospital complexities and striving towards excellence in quality and safety. The Baldrige Framework provides a proven approach towards managing the crucial elements of organizational excellence desperately needed in this rapidly changing health care environment. This comprehensive approach, which includes the ability to measure

and show value, can also help hospitals frame the essential components for adoption of population health as an integral strategy. Without using a framework to provide a comprehensive systems-based approach, hospitals often struggle to:

- Align leadership
- Conduct meaningful strategic planning
- Assess customer, community and partner needs
- Measure progress and review relevant information to address problems
- Engage and motivate staff
- Streamline processes
- Document outcomes

A systems approach provides hospitals a framework to address all of the essential components, and avoid breakdowns in other component areas that are not managed effectively. Meaningful work must be done in all these component areas to maximize a hospital's chance of achieving the transition towards a wellness model of care. Adhering to a performance excellence framework, such as Baldrige is a useful tool for achieving sustainability in a CAH setting. The image below demonstrates the key inter-linked components of the Baldrige Framework.



Performance Excellence Framework. Critical Access Hospital Blueprint for Performance Excellence: http://www.ruralcenter.org/tasc/resources/critical-access-hospital-blueprint-performance-excellence

Adapted from Baldrige Criteria for Performance Excellence: www.nist.gov/baldrige/index.cfm

A systems-based approach to population health for CAHs follows the design of this framework highlighting CAH relevant success factors that align with the interlinked components. The framework components are each highlighted below including

highlights and comments from Summit participants as well as relevant case studies. For the complete list of Population Health Critical Success Factors see Appendix B.

Leadership

Critical Success Factors

- Develop awareness and provide education on the critical role of population health in value-based reimbursement
- Shift hospital culture, processes, facilities and business models to include a focus on population health
- Lead the way and model behaviors. Participate in programs, be active in community outreach

Summit participants strongly agreed that leadership is a driving factor for CAH engagement in population health. Leadership is critical to helping organizations understand the "what and why" of population health. One of the top strategies recommended is for rural hospital leaders to develop awareness and provide education about the role of population health in the changing payment environment to develop a shared understanding among staff and community partners for this new role. Visible participation by hospital leadership both in community engagement and hospital supported health and wellness activities is strongly encouraged as a model of the behavior and systems change needed to support population health activities. For example, if a CAH implements a wellness program that focuses on healthy eating and moderate exercise, it sends a powerful message if the hospital leadership opts not to participate.

> *"By participating in Population Health, you are creating a social movement. Become a movement leader."*

The day-to-day trials of running a rural hospital can absorb leadership attention. Turnover at a CEO and trustee level add to the challenges of a cultural shift towards population health. However, understanding and articulating the business case can help keep boards and managers from viewing population health as an extraneous activity outside of the scope of core operational functions.

Strategic Planning

Critical Success Factors

- 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 the population you serve

The majority of CAHs participate in a community health needs assessment (CHNA) process required by the Patient Protection and Affordable Care Act (ACA). Summit participants strongly recommend that CAHs use the CHNA process as a starting point to inform strategic planning activities and to help link strategic goals and objectives directly to community needs which often reflect population health priorities. Engagement of stakeholders and partners in understanding the impact of priority issues can help identify a sense of urgency, shape a vision and establish strategies for improvement.

> *"How do you create a bigger population of well people?"*

Prioritization of just one or two issues for action planning is critical in order to focus resources and make meaningful progress. Many rural hospitals are already participating in a variety of population health related activities such as supporting local fun runs or having educational booths at fairs and events, but these activities can often be haphazard and are frequently not consciously aligned to address specific priorities identified by the organization. Incorporating population health principles into strategic planning for the organization can ensure strategies are embedded in organizational operations and that outreach efforts are focused towards organizational and community population health goals. For example, if a CAH has decided that improving access to fruits and vegetables is a priority in their community, efforts to support community gardens, farmers markets or donations of locally grown produce to food shelves would align more directly with that goal than having educational materials on healthy eating at a local event.

Engaging Patients, Partners, and Communities

Critical Success Factors

- Use the community health needs assessment (CHNA) process as an opportunity for community and patient engagement
- Articulate vision of hospital contributing to population health based on community conversations
- Engage all types of health care and social service providers to coordinate transitions of care and address underlying needs

Engagement of patients, partners, and the community is the underpinning of successful population health improvement strategies. Meaningful engagement can be a challenge and takes time and resources. Engagement of health care and social service providers to improve coordination and help address non-medical needs of patients as they leave the hospital can be an excellent starting point towards building relationships and developing processes that connect and align resources to better meet community needs.

The CHNA process is a key opportunity to engage partners and the community. Alignment of hospital CHNA activities with assessment and planning requirements for local public health entities is one option to help develop relationships and common understanding of population health issues. Working with community partners to articulate the role of the hospital in supporting population health improvement is a vital step to developing trust.

> *"Help leaders develop an understanding of their communities and of the community's history and values. Asking these questions and actively listening to the community is key towards moving that needs of change towards wellness."*

Hospital roles and the community's health needs may vary over time, but the effort in identifying how organizations coordinate and collaborate is critical to successful partnerships. Hospitals need to dispel the notion that being a partner in community activities only involves an outlay of cash. Staff time, expertise, facility space and visibility are also meaningful assets for community-based partnerships.

Workforce and Culture

Critical Success Factors

- Establish wellness programs for employees and role model these programs in the community
- Develop a workforce 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

Summit participants agreed that one of the most immediate actions CAHs could take to start the journey towards a focus on population health is to establish wellness programs for their own employees. CAHs can either design and implement their own program or work with their health insurer or other external partner to utilize an already established program. For maximum effectiveness, wellness programs should include both a focus on healthy behaviors for the entire workforce, as well as targeted support or case management for those with multiple chronic illness and high health care costs. Rural hospitals can be a role model for local employers in supporting worksite wellness, but also a potential provider of these programs in their community.

> *"We need to help employees be healthier as part of the culture changes towards population health."*

Embedding population health principles, such as coordination with community based services or promoting healthy behaviors into rural hospital operations is a cultural shift. Leaders will need to use change management strategies to engage and empower staff in this new way of thinking (see Appendix D: Population Health as Change Management). Alignment of policies and expectations that support community engagement and coordination can support this shift. For example, participation in at least one community workgroup or advisory committee could be an expectation for staff in management level positions.

> *"Leaders need to evaluate and plan their approach for changing culture."*

Operations and Efficiency

Critical Success Factors

- Maximize the efficiency of operational, clinical, and business processes under current payment structures
- Utilize health information technology (HIT) (such as electronic medical records, health information exchange and telemedicine) to support population health goals

Although recognition of the changing reimbursement environment is essential to understanding the role of population health, Summit participants stressed the crucial importance of maximizing reimbursement under the current system to allow financial "breathing room" to develop and implement population health strategies. Utilization of performance excellence tools such as Lean training was cited as being very important, as was sharing best practices between CAHs through workshops, network collaborations, roundtables and discussion forums. CAHs are advised to identify an improvement method that staff can understand and incorporate into their daily work rather than dabbling in a variety of methodologies. External revenue cycle assessment is also recommended as it may uncover other operational opportunities for improvement.

The use of HIT as a tool to support wide variety population health strategies was also acknowledged. Some examples include:

- Using electronic health record (EHR) data to identify high-risk populations for outreach and coordination referrals through health information exchange can improve effectiveness and efficiency
- Data collection related to socioeconomic status, race, ethnicity and language (REL) factors can be used to help stratify populations and identify disparities and opportunities for focused outreach
- Telemedicine can be used to address a wide variety of population health activities such as chronic disease management and mental health services while reducing patient travel and increasing local access
- Use of EHR patient portals to support care coordination has significant potential for many families, and electronic apps to track and promote health behaviors

Measurement, Feedback & Knowledge Management, Impact & Outcomes

Critical Success Factors

- Identify measurable goals that reflect community needs
- Utilize data to monitor progress towards strategic goals on population health
- Publicly share goals, data and outcomes. Use it as an opportunity to engage partners and the community

Measurement is central to effective improvement efforts, and Summit participants encouraged CAHs to consider what types of data and information can be utilized to support improvement in population health and to broadly publish goals and progress as an opportunity to engage partners and the community. (See Figure 2: Health Factors and Categories of Measures for Population Health).

Figure 2:

Health Factors and Categories of Measures for Population Health

Health Concerns
- Alcohol and Drug Use
- Diet and Exercise
- Sexual Activity
- Tobacco Use

Clinical Care
- Access to care
- Quality of care

Social and Economic Factors
- Community Safety
- Education
- Family and Social Support
- Income

Physical Environment
- Air and Water Quality
- Housing and Transit

Source:
www.countyhealthroadmaps.org

As the utilization of outcome measures such as morbidity and mortality become increasingly common measures of quality and value for health care organizations, the importance of factors relating to social determinants of health are just beginning to be acknowledged. A recent statement by the National Quality Forum indicated it plans to develop recommendations for quality measures related to risk-adjustment for factors of socioeconomic factors such as income, education, and homelessness which are strongly linked to health outcomes (NQF, March 18, 2014). Although risk-adjustment for these factors will make broad comparison of quality measures more "fair," it also highlights the importance and need to address such factors as part of a strategy for improving health in our rural communities.

Data and measures on a community level can be challenging to identify and monitor as published measures are often out of date and/or not available at a rural community level,

particularly in frontier areas. Despite these challenges, Summit participants encouraged rural hospitals to consider incorporating broad community level goals into their strategic measures, such as monitoring high school graduation rates, literacy rates or unemployment rates.

What organizations and communities measure often determines what they pay attention to and says much about what they value. In conjunction with community partners, rural hospitals are encouraged to think broadly about what areas are priorities for improving health in their community and consider intermediate measures that help monitor implementation of strategies. For example, one Summit participant shared that his hospital has identified a long term goal of helping improve high school graduation rates in their community as a broad opportunity to improve overall health. One measure they are monitoring as an interim step is the percent of kindergarten age children who have established a medical home and are receiving appropriate well-child care. Finally, claims data from payers for the CAH service area population reveals the presence of chronic health conditions and special health needs that impact the population.

> *"Be persistent and stay with your strategic plan since the impact of population health will take a while to see change."*

Conclusion

There is growing recognition that improving the health of the population is a vital component of core operations for a high performing hospital. This role may be even more critical for small rural hospitals where survival of the organization is intertwined directly with that of the community it serves. For CAHs to embrace population health strategies it will take support and resources to help navigate the cultural shift to expand the focus from treating the sick to helping improve health across the community.

> *"State Flex Programs should be sure to teach facilitation skills and leadership trainings when assisting hospitals with engaging their communities; these skill sets should be included as part of any population health curriculum."*

Summit participants identified an array of opportunities and potential tools that could support use of the population health framework by rural hospitals. These suggestions include:

- Align state and federal resources and messages to encourage and support rural hospitals in engaging communities and addressing population health
- Gather and share best practices and case studies of successful population health initiatives and innovations in rural hospitals
- Identify relevant population health metrics for rural hospitals and provide support for collecting, analyzing and using data to support monitoring and evaluation of population health goals and strategies
- Provide models and examples for CAHs regarding making the business case for a focus on population health strategies
- Facilitate rural hospital networks to pool data, technical expertise, payer contracting and quality improvement strategies
- Support training, education, and resources on leading organizational change, building collaboration, leadership skills and community engagement strategies

For more information on specific suggestions for Flex Coordinators see Appendix C.
A brief list of identified relevant resources is included in Appendix A.
Case studies for each Performance Excellence component in population health for CAHs are included in Appendix E.

As additional tools and resources are developed they will be will be disseminated by the National Rural Health Resource Center and available at:
www.ruralcenter.org/tasc

Appendix A: Tools, Resources, and Suggested Reading

- **American Hospital Association Call to Action: Creating a Culture of Health** This report is a call to action for hospitals to be leaders in creating a culture of health and highlights hospital best practices and seven "how-to" recommendations for the field. (http://www.aha.org/research/cor/content/creating-a-culture-of-health.pdf)

- **Community Tool Box** Created to help people build healthier communities and bring about the changes they envision. More than 300 educational modules and tools to help people work together to make their communities what they dream they can be. Developed and managed by the University of Kansas. http://ctb.ku.edu/en/toolkits

- **County Health Rankings and Roadmaps** County-by-county information on health outcomes and health factors. Each county is ranked within its state. Includes data related to length of life, quality of life, clinical care, health behaviors, social and economic factors that impact health and the physical environment. Also includes examples of how the rankings have been used and of effective programs and policies to improve health. Supported by collaboration between the Robert Wood Johnson Foundation and the University of Wisconsin Population Health Institute. http://www.countyhealthrankings.org/

- **A Guide to Measuring the Triple Aim: Population Health, Experience of Care, and Per Capita Cost** Developed by the Institute for Healthcare Improvement (IHI). This white paper provides suggested measures for the three dimensions of the Triple Aim, accompanied by data sources and examples. *Note:* A free account will need to be set up to download the full document. http://www.ihi.org/Engage/Initiatives/TripleAim/Pages/Materials.aspx

- **Improving Population Health** A blog hosted by the University Of Wisconsin Department of Population Health Sciences explores current thinking in policy, practice, and research in population health improvement. Intended as a forum for discussion and a call for action—across all sectors - for improving the health of our communities www.improvingpopulationhealth.org

- **Mobilizing Community Partnerships in Rural Communities: Strategies and Techniques** Building partnerships among hospitals, health care providers, local health departments (LHDs), social services agencies, non-profit organizations, and the private sector is essential to meet the needs of rural communities. The National Association of County and City Health Officials (NACCHO) developed this guidebook describing how rural communities can

develop and maintain partnerships and provides examples from the field. http://www.naccho.org/topics/infrastructure/mapp/framework/clearinghouse/upload/MobilizingCommunityPartnerships_7-29.pdf

- **A Practical Playbook: Public Health & Primary Care Together** Developed by the de Beaumont Foundation, Duke Community and Family Medicine, and the Centers for Disease Control and Prevention, this interactive web-based resource helps primary care and public health professionals collaborate to achieve population health improvement and reduce health care costs https://practicalplaybook.org/

- **Population Health Framework** Under contract from the federal Department of Health and Human Services, the National Quality Forum (NQF) is developing a common framework for communities that will offer practical guidance for improving population. As of Spring 2014, a draft action guide and background materials are available. http://www.qualityforum.org/Population_Health_Framework/

- **The Role of Small and Rural Hospitals and Care Systems in Effective Population Health Partnerships** Part of the *Hospitals in Pursuit of Excellence Series*, describes how small and rural hospitals and care systems can develop effective population health partnerships that balance the challenges and opportunities encountered in providing health management. American Hospital Association. http://www.hpoe.org/Reports-HPOE/The_Role_Small_Rural_Hospital_Effective_Population_Health_Partnership.pdf

- **Unnatural Causes...Is Inequality Making Us Sick?** A documentary series developed by PBS that explores racial and socioeconomic disparities in health. Video clips and discussion guides can be used for education and awareness. The site also includes action guides, resources and case studies to support action to impact health disparities. http://www.unnaturalcauses.org/

- **Using Data to Understand Your Community** Developed by the Rural Health Value Project. For rural communities or organizations seeking to increase value, using data to better understand your community's population can be a useful starting point. Includes useful websites (and how you might best use them) that include demographic, population, health and other data for ZIP code, city, county and state-level geographic areas. http://cph.uiowa.edu/ruralhealthvalue/education/Data/Using%20Data%20to%20Understand%20Your%20Community.pdf

Suggested Reading

- *Healthcare's Blind Side: The overlooked connection between social needs and good health*. Robert Wood Johnson Foundation, 2011. http://www.rwjf.org/en/research-publications/find-rwjf-research/2011/12/health-care-s-blind-side.html
- *Managing Healthy Communities in Rural Illinois*. Illinois Critical Access Hospital Network, 2013, http://www.icahn.org/files/White_Papers/ICAHN_PopHealthManagement_Print_FINAL.pdf
- *Managing Population Health: The Role of Hospitals.* The Health Research and Educational Trust, 2012. http://www.hpoe.org/Reports-HPOE/managing_population_health.pdf
- *Our Iceberg Is Melting: Changing and Succeeding Under Any Conditions* by John Kotter, Holger Rathgeber, Peter Mueller, and Spencer Johnson. http://www.kotterinternational.com/our-principles/our-iceberg-is-melting
- Population Health Implications of the Affordable Care Act. Institute of Medicine (IOM), 2014. http://nap.edu/openbook.php?record_id=18546
- *Population Health in the Affordable Care Act Era*. Academy Health, 2013. http://www.academyhealth.org/files/AH2013pophealth.pdf
- *What is population health?* Kindig, DA, Stoddart G. (2003). *American Journal of Public Health*, 93, 366-369). http://ajph.aphapublications.org/doi/pdf/10.2105/AJPH.93.3.380

Appendix B: Population Health Success Factors by Category

A systems-based approach to population health for CAHs follows the design of the Performance Excellence Blueprint framework. The Population Health Critical Success Factors within the framework components are listed below:

Leadership

- Develop awareness and provide education on the critical role of population health in the value-based reimbursement
- Shift hospital culture, processes, facilities and business models to include a focus on population health
- Lead the way and model behaviors. Participate in programs, be active in community outreach

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

Patients, Partners & Community

- Use the community health needs assessment (CHNA) process as an opportunity for community/patient engagement
- Articulate vision of hospital contributing to population health based on community conversations
- Engage all types of health care and social service providers to coordinate transitions of care and address underlying needs

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

Operations & Processes

- Maximize the efficiency of operational, clinical and business processes under current payment structures
- Utilize health information technology (electronic health records, health information exchange, telemedicine) to support population health goals

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

Appendix C: Additional Input from Summit Participants

As a Flex Coordinator, What can *you* do to improve population health?

1. Understand/build the case for population health

- Understand and be able to articulate the shift towards value-based reimbursement at a federal (Medicare) and state (Medicaid) level, and the importance of population health as part of that change
- Identify and share relevant state/local level data sources to support the need for population health strategies in critical access hospital (CAH) communities
- Help CAHs recognize the impact of population health on other organizational priorities (for example: recruitment/retention, employee satisfaction and care transitions)
- Gather and share best practices to help support a norm that CAHs should be in the business of supporting population health

2. Put population health on the agenda

- Include population health on the agenda for meetings across all interactions with CAHs including Flex advisory committees and workgroups
- Provide education and have discussions regarding:
    - Determinants of health including the impact of socioeconomic and community factors in influencing health outcomes and wellbeing
    - How population health can align with CAH strategic initiatives and health reform activities
    - The CAH role in addressing the two aspects of population health (cohort/community)
    - Best practices and examples of how CAHs are implementing/integrating population health strategies
    - The link between community health needs assessments (CHNA) and population health strategies
    - Facilitate networking opportunities for CAHs to discuss strategies, challenges and lessons learned in implementing population health strategies

As a Flex Coordinator, What can *you* do to improve population health?

3. Look inside your own walls

- As appropriate, include population health as a key area of focus for state grants provided through Flex funding
- Set expectations and support Flex staff involvement in community workgroups, committees and task forces that can help CAHs address population health needs
- Help identify funding for innovation, research and demonstration of population health initiatives

4. Reach out to the community

- Engage a wide variety of state level partners in discussions regarding coordinated support and resources for CAH population health. For example, work with your state chronic disease and prevention staff to help align resources for implementation of strategies at a local level
- Provide training for CAH leaders and staff to support development of community partnerships such as facilitation skills, community engagement strategies and collaborative planning/development
- Provide support and education for CAHs in using internal and external data sources to identify population health needs and monitor/evaluate implementation of population health strategies
- Provide technical assistance/trainings on use of charity care/financial assistance policies to improve population health through increasing access to primary care and reducing potentially avoidable use of high cost services through early intervention and/or prevention

Participants at the CAH Population Health Summit had a plethora of ideas, suggestion, and insights to share - but limited time. In order to capture additional information, Summit participants were provided blank sheets of paper and encouraged to jot down notes, suggestions and ideas and post them to a 'sticky wall' in the meeting room in the corresponding section of a grid that included each of the framework components and spaces for tools, resources and advice for the TASC team. The compilation of that input follows:

Framework Category	Tools (1)	Resources (2)	Advice for Flex (3)
Leadership (L)	• Create sustainability of business models for population health • Provide tools for physicians to help them serve patients with social outreach • Retain the hospital CEO • Offer physician and hospital leadership development trainings • Clarify roles and responsibilities of each team member in a community health coalition • Establish leadership round tables for other leaders in the hospital	• Leadership Trainings • Facilitation Guides	• Identify critical access hospital (CAH) best practices by state • Engage primary care, physician assistants, advanced practice nurses • Provide knowledge on how to work with hospital systems • Build leadership skills where there is energy for supporting population health, which may not rely on hierarchy • Define population health
Strategic Planning (SP)	• Build a financial approach for managing the transition towards value-based care, focus on the CFOs • Include value-based care and population health planning into strategic plans	• How to guides on effective collaboration • Data analytics	• Network CAH leadership • Create networks to learn, benchmark and support • Do not divide hospitals, communities, public health and other providers • Offer CAH

			governing board retreats • Identify and disseminate best practices • Teach CAHs how to use their own population health data • The patient is a partner, not an object to be managed
Patients, Partners and Community (PPC)	• Implement a community planning and decision making process with a community council/steering committee • Administer partner satisfaction surveys • Utilize hospital foundations to engage the community • Address barriers of cost-based reimbursement of non-covered medical services (utilize foundation leadership time to coordinate) • If hospital leadership wants help from the community to	• Toolkit for community based providers to engage physicians MD link: partnering physicians with community organizations • Blue Zone for patients (model that has identified best practices of centurions) • http://www.va-srhp.org/	• Recognize how CAH leadership is already in engaged in the community professionally and personally • Encourage CAHs to target relationship-building with populations impacted by lower health outcomes • Redefine "caring for your neighbor" to include population health • Strengthen communities to create their own health

	improve health goals/outcomes; offer community health education		
Data Collection, Management and Analysis (DC)	• Evaluate the following measures: high school graduation rate, literacy rate, percent of population reporting good health, history of community participation in initiatives, measures focused on chronic disease • Establish a scorecard and support initiatives to move towards community health goals • Consider establishing transition measures (for funders/payers) • Establish a claims data base (outpatient) (access and analysis) • Link chronic care models to social attributes (availability of parks/ recreational	• Resource needed: rural relevant standards on population health measures • Guides on data analysis: electronic health records, claims, community health needs assessments • www.Healthy communities institute.com dashboard	• Measure community engagement and participation rates • Facilitate discussions between CAH and communities on data analysis • Share standards for population health data and how to effectively translate data into action

	activities, safety, transportation, etc.)		
Workforce and Culture (WC)	• Identify community or CAH workforce champions for improving population health (no state Flex personnel; this needs to be a local person) • Participate in a worksite wellness program: engage staff as role models of wellness and health	• Worksite wellness programs	• Encourage worksite wellness programs
Operations and Processes (OP)	• Devote a portion of every board meeting to review population health metrics as part of a balanced scorecard • Add board members who have a specific interest in improving overall health and wellness measures • Create a population health sub-committee on CAH boards with the focus of partnering with	• Rural Wisconsin Health Cooperative (RWHC) work plan: Advocacy 1) Advocate rural sensitive/relevant implementation of the Affordable Care Act (ACA) 2) Specific marketing campaigns re: "Keep Local Care Local" 3) Support rural sensitive quality reporting and value-based purchasing Shared service 1) Collaborate with other providers e.g. "accountable care organization (ACO)-like" contracting issues 2) With other hospitals, implement a quality improvement residency	• Provide technical assistance/trainings on use of charity care/financial assistance policies to improve access to care and reduce the use of high cost services through early intervention • Access Flex Monitoring Team reports on capacity of flex programs to manage population health • Help identify funding for

	other organizations on population health • Consider CAH employees and other employees of proactive local employers as a "community" to develop interventions to improve health • Organize CAH boards to include members who understand population health • Utilize tele-health to support population health measures	program 3) Continuation of the RWHC Safety Reporting portal 4) Collaborate with state quality improvement organization (QIO) regarding quality improvement opportunities 5) Collaborate with state QIO regarding information technology (IT) improvement initiatives 6) Provide ongoing leadership development 7) Offer ongoing Leanworkshop sponsorship and participation 8) Sponsorship/participation cost champion award • Lean for performance improvement • Helfrich et all Med Care Res Rev 2007; 64:279-303 (implementation framework): champions, innovation and values and resources leads to-management support; implementation policy and practices; implementation climate; implementation effectiveness	innovation, research, and demonstration of population health initiatives • Help bring state and local stakeholders together
Outcomes and Impact (OI)	• Measure patient/person engagement and health confidence • Measure physical activity levels • Measure self-perception of health status		

Appendix D: Population Health as Culture Change

Summit participants recognized that for rural hospitals to adopt and integrate population health principles it will entail a cultural shift. The steps recommended by participants to engage hospital staff, boards and communities mirror those steps for implementing change as outlined by John Kotter, a leading author and expert on helping leaders manage organizations. Hospital leaders are strongly encouraged to have their leadership team, board and staff read and discuss Kotter's short book "My Iceberg is Melting," a fable that uses the story of penguins facing change to highlight key steps and barriers to any organizational change.

A summary of how the steps of change align with rural hospitals and population health follows:

1. *Create a Sense of Urgency:* Education and awareness regarding the importance of health determinants and the need for improving health of the community
2. *Build a Guiding Team:* Engage partners and community leaders regarding opportunities to improve the health of the population
3. *Develop a Change Vision and Strategy:* Identify population health improvement goals and strategies for reaching them
4. *Communicate the Vision for Understanding and Buy-in:* Participate and lead discussions with a broad set of internal and external stakeholders and partners. Ensure a common vision and plan is agreed upon as well as clear roles and responsibilities
5. *Empower Broad Based Action:* Identify barriers and remove obstacles for staff engagement. Align policies, expectations, and incentives for implementation of population health strategies
6. *Celebrate Short-Term Wins:* Improving population health takes time. Identify and celebrate short-term wins and interim steps such as community engagement and participation
7. *Don't Let Up - Be Relentless*: To be effective, population health strategies need to employ long term goals and activities. Continued focus from leadership is needed to recognize and embed population health principles
8. *Create a New Culture - Make it stick*: Prove that the new way is superior and success needs to be visible and well communicated. Keep change in place by creating a new, supportive and sufficiently strong organizational culture that embraces population health as a way that the rural hospital does business

Sources:
AHRQ Team STEPPS curriculum, Change Management Module;
http://www.ahrq.gov/professionals/education/curriculum-tools/teamstepps/instructor/fundamentals/module8/igchangemgmt.html
Kotter International: Eight Step Process for Leading Change;
http://www.kotterinternational.com/our-principles/changesteps/changesteps

Appendix E: Population Health CAH Case Studies

Leadership: Clearwater Valley Hospital in Idaho is utilizing a dyad management model which is a two-pronged approach to physician/hospital integration. This model places the organization's leadership under the management of qualified physician and non-physician teams aimed to incorporate the concept of value into health care decision-making where departments have been restructured to meet patient needs in both the inpatient and outpatient settings. This facility has received multiple awards for incorporating this management model. For more information: http://healthandwelfare.idaho.gov/Portals/0/Health/Rural%20Health/Orofino%20Case%20Study%20November%202011.pdf

Strategic Planning: Essentia Health Fosston in Minnesota incorporated community health needs assessment findings to improve the health of the community toward retaining a quality and viable agricultural industry. For more information: http://www.ruralcenter.org/tasc/resources/applying-community-health-assessments-rural-hospital-strategy

Partners, Patients, Community: The Community Connector Program was established by Tri County Rural Health Network in Helena, Arkansas which aims to increase access to home and community-based services by creating alternatives to institutionalized living and improving the quality of life for elderly and adults with physical disabilities while maintaining or decreasing costs. The return on investment was $3 of every $1 invested, or a 23.8 percent average reduction in annual Medicaid spending per participant, for a total reduction in spending of $2.619 million over three years. For more information: http://cph.uiowa.edu/ruralhealthvalue/innovations/Profiles/CommunityConnectors.pdf

Workforce and Culture: Mason District Hospital in Indiana is implementing a three tiered approach to a worksite wellness program which includes a care coordination plan for employees with multiple chronic illnesses. After two years, the hospital has seen nearly $360,000 in reduced employee health care costs and has started offering the program to local businesses which both improves health locally and provides an additional revenue stream for the program. For more information: http://www.icahn.org/files/White_Papers/ICAHN_PopHealthManagement_Print_FINAL.pdf (page 19)

Operations and Efficiency: Mercy Health Network in Iowa has adopted a Process Excellence tool modeled after Lean to improve operations, efficiency and patient safety. Each hospital in the network was assigned accountabilities, selected process improvements and helped educate the hospital board. After 18 months, process

improvements results in a 51 percent decrease in patient falls and a 37 percent decrease in medical errors. For more information: http://cph.uiowa.edu/ruralhealthvalue/innovations/Profiles/MercyHealthNetwork.pdf

Measurement, Feedback, & Knowledge Management, Impact & Outcomes: Marcum & Wallace Memorial Hospital in Hazard, Kentucky has adopted the Performance Excellence Blueprint as indicators for their system (Catholic Health Partnership) strategies. Leadership developed a dashboard to track program towards targets in each of the seven Performance Excellence Components. For more information: https://ruralcenter.org/tasc/resources/marcum-wallace-memorial-hospital-performance-excellence