Expanding the Value Conversation for Rural Hospitals

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A Performance Monitoring Resource for
Critical Access Hospitals, States, and Communities

Flex Monitoring Team | University of Minnesota
University of North Carolina at Chapel Hill
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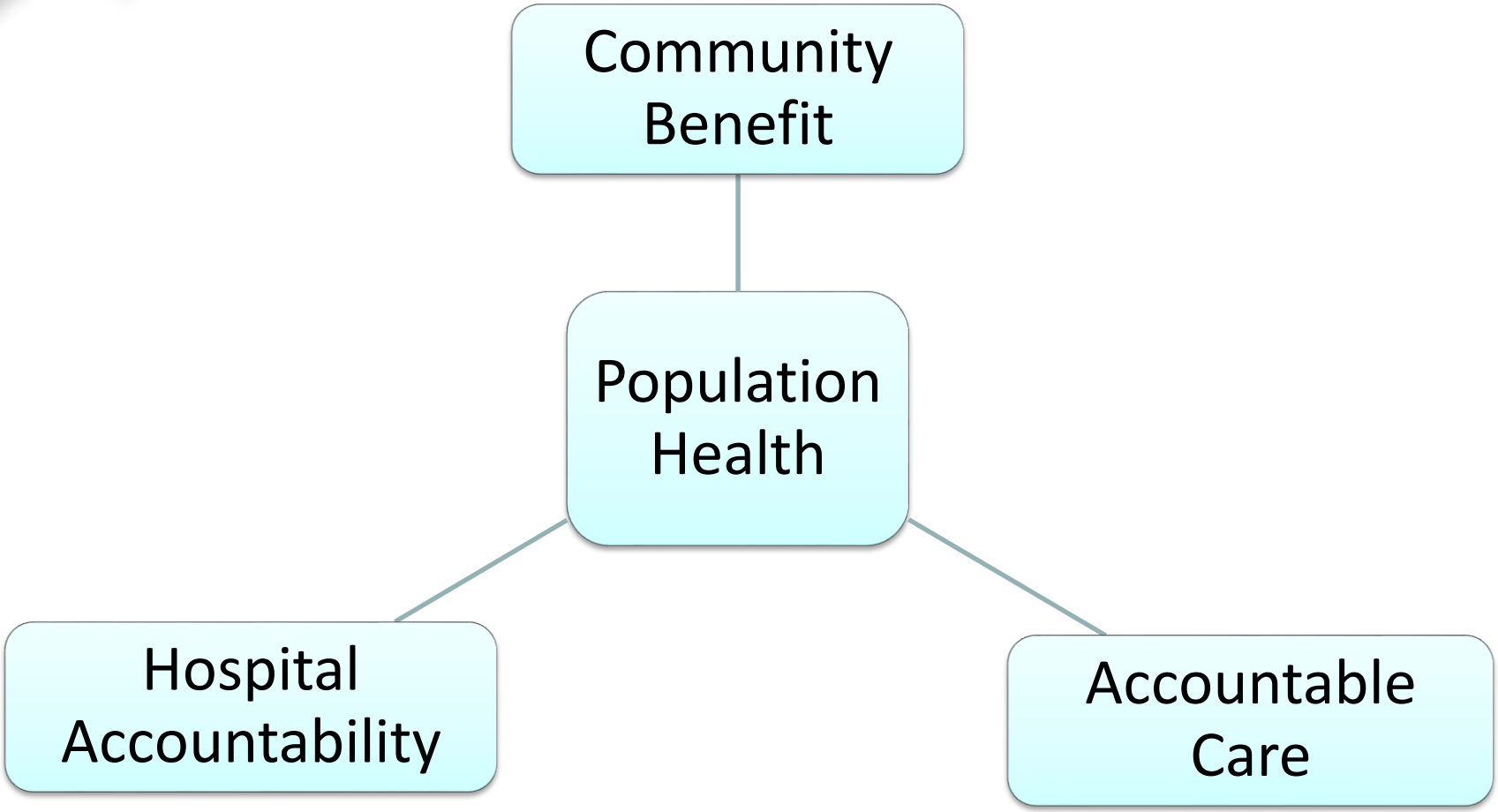
Adopting a Broad View of Value

- Discussions of hospital value typically focus on value-based purchasing and pay for performance
  - These discussions typically take place within the context of accountable care organizations (ACOs) and other transformation initiatives
  - These are important areas of focus but not sufficient for hospitals
- Hospitals should also focus on the value to their communities by:
  - Focusing on population health
  - Addressing the unmet needs of communities
  - Concentrating on the drivers of health
  - Serving vulnerable populations
- These two perspectives on value are not mutually exclusive

Population Health: The Unifying Link



Community Benefit and National Health Reform

PAYMENT MODELS			
Fee for Service	Episode-Based Reimbursement	Partial---Full Risk Capitation	Global Budgeting
INCENTIVES			
Conduct Procedures Fill Beds	Evidence-Based Medicine Clinical PFP	Expanded Care Management Risk-adjusted PFP	Reduce Obstacles to Behavior Change Address Root Causes
METRICS			
Net Revenue	Improved Clinical Outcomes Reduced Readmits	Reduced Preventable Hospitalizations/ED Reduced Disparities	Aggregate Improvement in HS and QOL Reduced HC Costs

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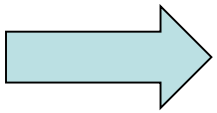
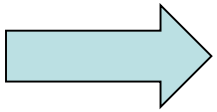
Business Model for CHNAs and Community Benefit

Phase 1	Phase 2 (Where we are now)	Phase 3
Align program and services with the needs/location of insured populations	Focus on health disparities	Evidence-based seamless continuum of care
Proprietary model	Emphasis on social determinants	Comprehensive, intersectoral approach to programs
Random acts of kindness	Limited relevance to clinical services	Institutional financial incentives aligned
	Lack of financial incentives	One player in a balanced portfolio of investments
	Collaboration with community stakeholders	Collaboration with all Stakeholders





Hospital Accountability

- 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.

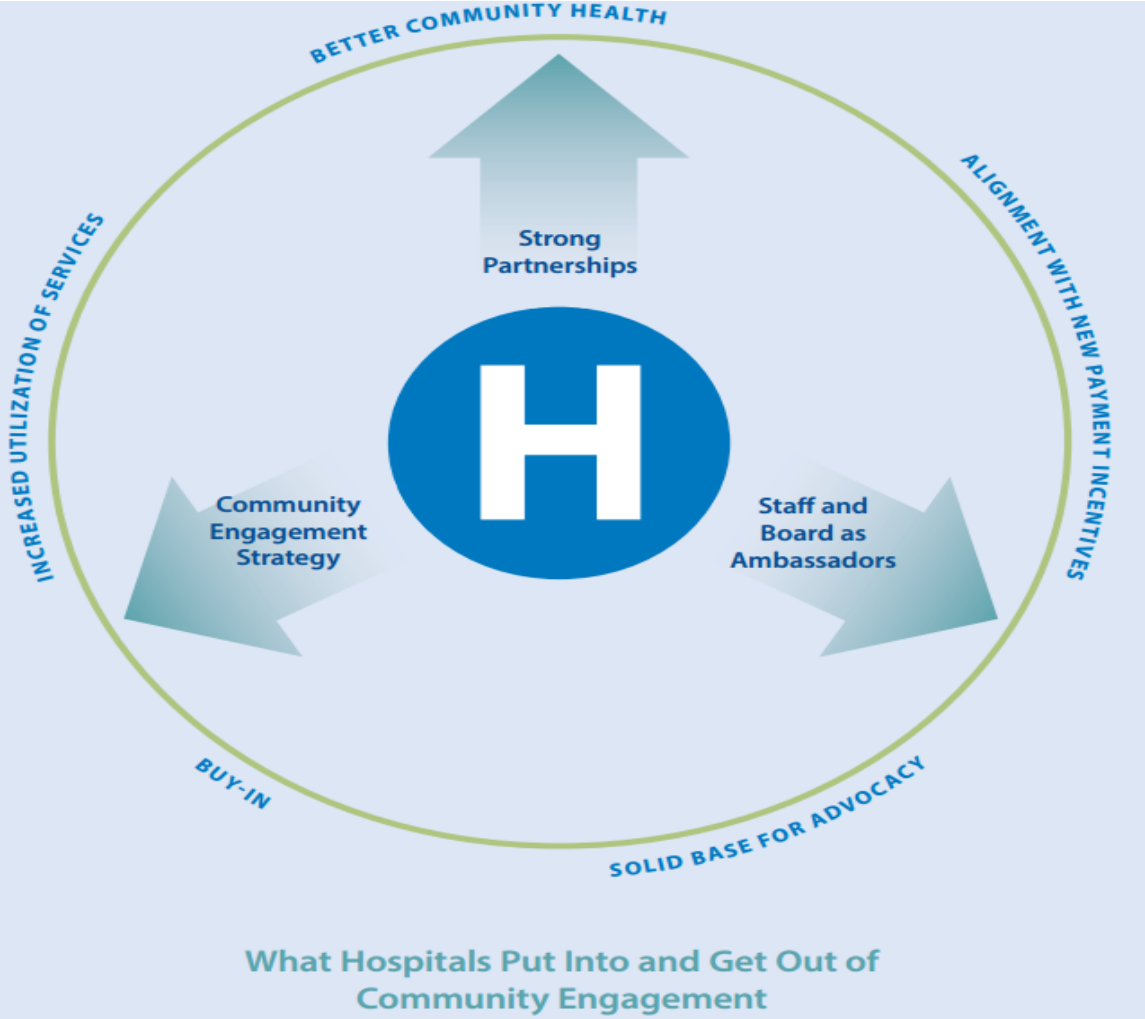
Two Paths to Accountability

- 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 accountability can build on and support each other

Redefining the Blue H – 2014

- Washington Department of Health (DOH) and Washington State Hospital Association
- 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

Redefining the Blue H



Redefining the Blue H – Strategies

- Promote comprehensive local community assessment, planning, and system development
  - Traditional health care and "non-traditional partners – schools, employers, economic development agencies
  - Align incentives and plans,
  - Develop tools for community engagement and planning
  - Incorporate patient navigator concepts
  - Require joint assessment and planning for DOH programs

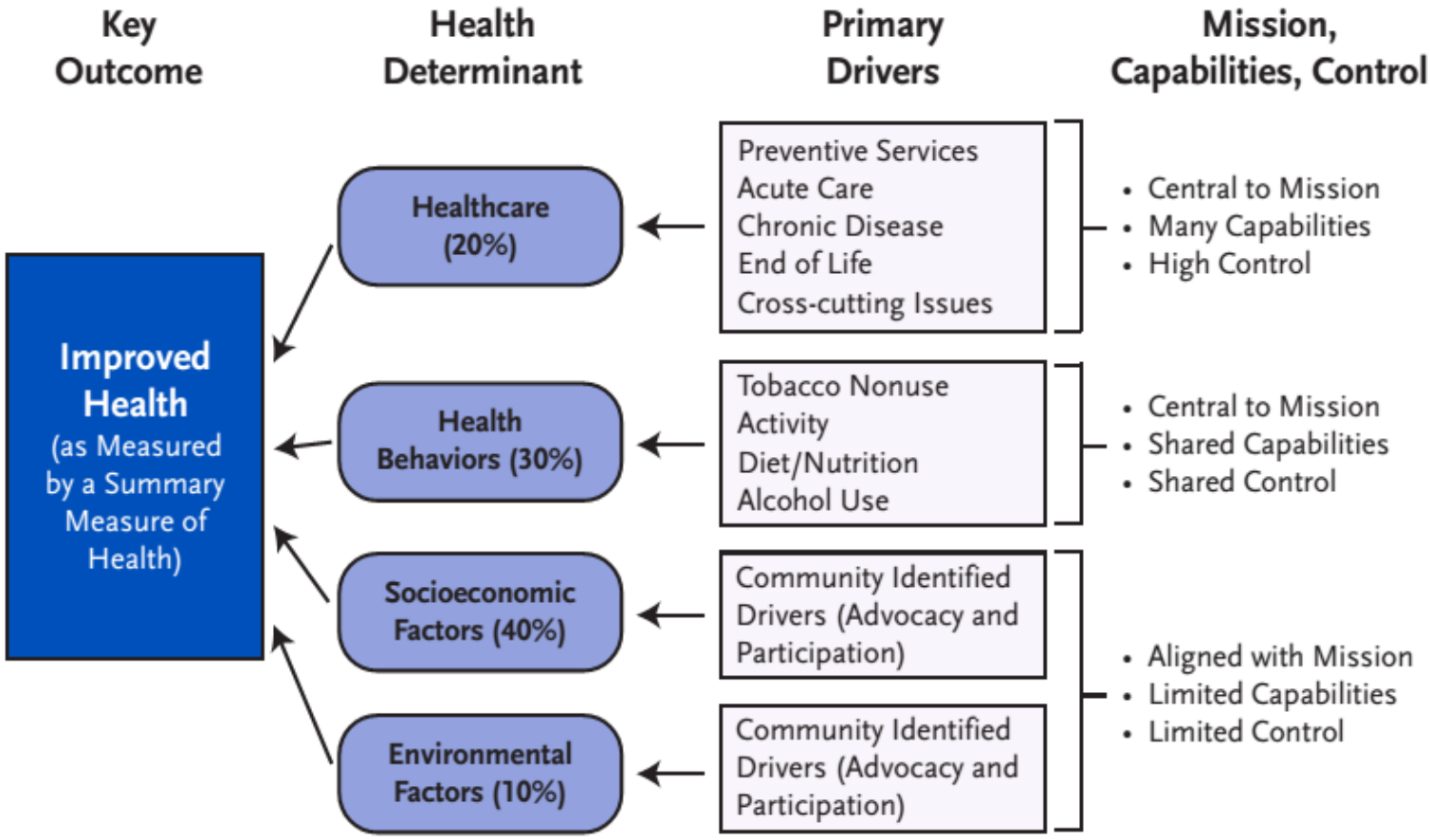
Target Priority Issues

- Base activities on a current needs assessment
- Review utilization data and base initiatives around the data
- Focus on expanding access to care and vulnerable populations
- Engage board, staff, docs, clinicians, and community
- Establish leadership and accountability
- Work collaboratively to identify priorities and solutions
- Plan, manage, and measure
- Establish business case for programs where possible
  - Value to the community
  - Reduction in local health care delivery costs

Delivery System Transformation

- Identify/track target populations and community health needs
- Align interventions
- Leverage local resources
- Develop new skills needed to meet the challenge
- Move from ACOs to Accountable Health Communities
- Address the “drivers” of health
- Add population-level measures
- Move outside of the hospital walls:
  - More than a nice mission statement: requires action
  - Strategic priority, leadership, resource commitment, and new partnerships within the community

Health Partners Drivers Program



Source: Kindig, D. A., & Isham, G. (2014). Population health improvement: A community health business model that engages partners in all sectors. Frontiers of Health Services Management, 30(4), 3-20.

Conclusions & Implications

- Take a more holistic approach
  - Not all population health activities must be charitable or community benefit activities
- A broad-based population/community health improvement strategy can build community support and demonstrate hospital commitment
- From value to outcomes: measure benefits/ROI
- Building successful partnerships and achieving results takes time and effort
- Hospital and community champions are critical

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