Rural Care Coordination and Population Health Management Summit

Summit Findings

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NATIONAL RURAL HEALTH RESOURCE CENTER

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Preface

With the support of the Federal Office of Rural Health Policy (FORHP), the National Rural Health Resource Center (The Center) held a summit to consider how community care coordination plays a key role in assisting health care leaders in preparing for population health management. This report is designed to assist rural hospitals, clinics and network leaders in considering key actions that they can undertake to incorporate community care coordination planning as a strategy to help position the organization for population health. The report is also intended to assist state Medicare Rural Hospital Flexibility (Flex) Programs and state offices of rural health (SORH) by offering timely information to help them develop tools and educational resources that support hospitals and networks in the transition to value-based payment models. This 2019 summit and report builds upon the knowledge gained from previously convened summit meeting with nationally recognized subject matter experts, which includes *2016 Financial Leadership* and *Rural Provider Engagement Summits*, the *2017 Value-Based Strategic Summit* and *2018 Rural Hospital and Clinic Financial Summit.*

The information presented in this report provides the reader with general guidance. The materials do not constitute, and should not be treated as, professional advice regarding the use of any technique or the consequences associated with any technique. Every effort has been made to assure the accuracy of these materials. The Center and the authors do not assume responsibility for any individual's reliance upon the written or oral information provided in this guide. Readers and users should independently verify all statements made before applying them to a situation and should independently determine the correctness of any strategy before recommending the technique to a client or implementing it on a client's behalf.

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Executive Summary

In May 2019, the National Rural Health Resource Center's (The Center) Small Rural Hospital Transition Project (SRHT) hosted a national summit in cooperation with the Health Resources and Services Administration's (HRSA) Federal Office of Rural Health Policy (FORHP) to develop strategic initiatives that rural communities can utilize in preparing for population health management. The purpose of the Summit was to identify key initiatives that leaders and providers can take to better coordinate care at the local level. The Summit objectives included the following:

- Examine next steps that leaders and providers should undertake to support the ongoing development of the local infrastructure that creates a platform for future care delivery;
- Explore opportunities for leaders to undertake that position their hospitals and community partners in managing population health in the future; and
- Gain a better understanding of the potential financial and operational impact of community care coordination on the hospital and local providers.

Summit Participants developed nine strategies that rural health care leaders may utilize to improve care coordination within their communities. These initiatives provide rural leaders with a roadmap in developing a community care coordination plan that results in better transitions of care and positions the organization for population health. The nine high-level recommended strategies include the following:

1. Perform internal and external readiness assessments
2. Obtain internal buy-in from leadership, management and physicians
3. Optimize processes and resources to drive toward success
4. Begin conversations with payor community about meaningful reimbursement strategies to drive health improvement
5. Maximize quality and availability of primary care
6. Incentivize physicians and other providers
7. Develop community -based population health management strategies
8. Develop an external communication strategy
9. Leverage community assets

The Center and the Summit Participants hope to see this work converted into actionable progress in rural communities that affects the lives of our neighbors and friends in a profound way.

Introduction

The movement of rural hospitals into value based and population health payment models started slowly, but recently has accelerated. In 2019, hundreds of rural hospitals have joined Accountable Care Organizations (ACOs) and many more participate in various alternative payment models.[1]Initial evidence, however, indicates that little has been done to improve the health of the populations overall, with most emphasis to date on the sickest and most costly patients. The long-term financial success of these models requires hospitals to place greater emphasis on improving the overall health of all segments of the population. Improving the health of the population begin with increased collaboration with community leaders and other healthcare providers and better coordination of care across the continuum of community services. The goal for community joint partners is to address social determinants of health (SDOH) such as poverty, mental health, housing, transportation, and chronic illnesses, to increase coordination of local services and improve overall health outcomes.

According to the World Health Organization (WHO) and Centers for Disease Control and Prevention (CDC), *social determinants of health (SDOH) are the conditions and circumstances in which people are born, grow, live, work, and age. These circumstances are shaped by a set of forces beyond the control of the individual such as economics and the distribution of money, power, social policies, and politics at the global, national, state, and local levels.*

The health care payment and delivery systems continue to evolve as the industry moves towards managing the health of large groups of people to address SDOH. These emerging health care delivery systems will become platforms for managing population health of the future. The industry forces at work are giving rural providers and leaders an opportunity to rethink their care management processes, especially transitions of care and care coordination. To stay relevant in this changing landscape, it is important for hospitals and community partners to take steps now toward creating a community care coordination plan, which will be essential for managing the population health of their communities in the

[1] Center for Medicare & Medicaid Innovation

future. There are steps rural health care leaders can take now, even with limited resources and time, to begin to plan and develop the new delivery systems and position communities for population health management.

In May 2019, the Small Rural Hospital Transition Project (SRHT) a program of the National Rural Health Resource Center (The Center), hosted the National Summit in cooperation with the Health Resources and Services Administration's (HRSA) Federal Office of Rural Health Policy (FORHP) to evaluate what rural hospitals, clinics and networks should consider as next steps in developing community care coordination capabilities. The goal of the Summit was to convene a panel of field and subject matter experts (SME) to develop a strategic road map of ideas that rural communities can utilize in preparing for population health management from the perspective of transitions of care. The purpose of the Summit was to identify key actions that leaders and providers can take to further develop a local infrastructure to manage population health in the future. The objectives of the Summit included:

- Build on current community care coordination planning strategies that initiate the development of a local continuum of care;
- Determine next steps that leaders and providers should undertake to support the ongoing development of the local infrastructure that creates a platform for future care delivery;
- Identify opportunities for leaders to undertake that position their hospitals and community partners in managing population health in the future; and,
- Gain a better understanding of the potential financial and operational impact of the new care delivery system on the hospital.

To this end, the Summit Participants identified a path for rural health care leaders and providers to operationalize community care coordination planning in the movement toward population health management.

Summit Participants

The Summit Participants consisted of field and subject matter experts from various organizations, which included nationally recognized consultants specializing in rural hospitals and quality of care. Summit Participants represented rural hospitals, clinics and networks, as well as SORH, hospital

associations and FORHP. The 2019 Summit Participants include the following field experts (refer to Appendix A for contact information).

- Bethany Adams, National Rural Health Resource Center
- Rhonda Barcus, National Rural Health Resource Center
- Steve Barnett, McKenzie Health System
- Larry Baronner, Pennsylvania Office of Rural Health
- Sallay Barrie, Federal Office of Health Policy
- Dawn Bendzus, Roosevelt General Hospital
- Shannon Calhoun, National Rural Accountable Care
- Jessica Camacho, Roosevelt General Hospital
- Angie Charlet, Illinois Critical Access Hospital Network
- Terry Hill, National Rural Health Resource Center
- Rebecca Jolley, Rural Health Association of Tennessee
- Jennifer Lundblad, Stratis Health and RUPRI
- Alyssa Meller, National Rural Health Resource Center
- Tracy Morton, National Rural Health Resource Center
- Katie Peterson, Pender Community Hospital
- Toniann Richard, Health Care Collaborative of Rural Missouri
- Adam Strom, Eide Bailly
- Cynthia Wicks, Stroudwater Associates

Population Health

Background

In December 2010, the Department of Health and Human Services launched Healthy People 2020[2], which has four overarching goals:

- 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; and

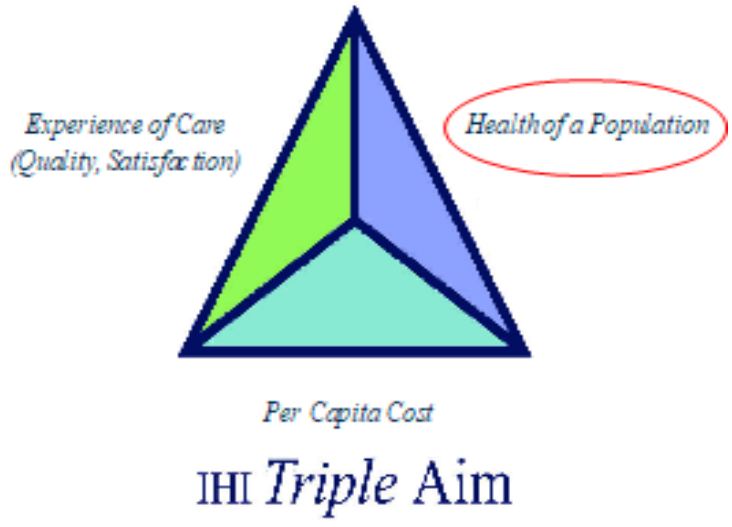
[2] Healthy People 2020. http://www.healthypeople.gov/2020/about/default.aspx

- Promote quality of life, healthy development, and healthy behaviors across all life stages.

The launch of this program and a progressive move within the health care industry moved the term "population health" out of the domain of the public health agencies and made it a wide-spread term among health care providers. Over the past decade, there has been a recognition that volume-based purchasing for health care services is fueling unsustainable growth in the cost of delivery of care. This has led to a focus among payors and policy advocates to address the underlying issues that drive up utilization and the costs of health care.

Population health also became a key component of Institute for Healthcare Improvement's (IHI) Triple Aim. Triple Aim is defined by IHI as 'better care of individuals, better health for populations, and lower per capita costs.' According to IHI, 'Triple Aim framework serves as the foundation for organizations and communities to successfully navigate the transition from a focus on health care to optimizing health for individuals and populations."[3] Figure 1 below illustrates the concept of IHI's Triple Aim framework and how it support population health. Refer to IHI's Pathways to Population Health for more information.

Figure 1: Institute of Healthcare Improvement Triple Aim Framework



[3] Institute of Healthcare Improvement; Triple Aim of Populations

With respect to the Triple Aim concept, it's important to consider essential components that support population health management. These essential components focus on maintaining the wellness from a comprehensive and systematic approach to delivery of care. Figure 2 below summarizes the essential components of population health.

Figure 2: Essential Components of Population Health

Although the term "population health" has progressively become more widespread among health care providers, there is a recognition in the industry that the adoption rate and the acceptance of an industry shift toward value-based care has not been consistent across the nation. Recognition that fee-for-service is fueling unsustainable growth in costs, there has been a renewed focus among payors and policy advocates to address underlying issues such as uncoordinated care, poor chronic disease management and unhealthy behaviors that increase utilization and costs. However, rural providers have generally not seen the payors come to the table in a meaningful way to sustain low volume hospitals.

For example, the growth of ACOs has become a widely recognized mechanism to monetize value by increasing quality and reducing cost. Due to rural areas limited population base, there have been greater adoption rates in urban centers. It is important to acknowledge that the term

"population health" is frequently used to describe two separate, but related concepts:

- **Cohort Management or Targeted Population Medicine:** 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**: Health 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 and competing priorities for the payor community. Rural health care leaders acknowledge this dichotomy, and recognize the need for strategies that address both aspects.

Population Health and Community Care Coordination Definitions

For the Summit to move forward with developing a meaningful roadmap of strategies to recommend for rural community adoption, some common definitions were evaluated and revised to be rural relevant. According to the Institute for IHI, population health is defined as ***"the health outcomes of a group of individuals, including the distribution of such outcomes within the group."***[4] *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."* The Summit Participants agreed that the IHI's definition does provide flexibility, but does not reflect accountability nor does it define what group in a community to provide service to.

[4] Institute for Healthcare Improvement (IHI)

Next the Summit Participants focused on clearly defining "Community Care Coordination" to develop a baseline understanding of work being performed at the 'local level'. According to Stratis Health, community care coordination is "a *partnership among health care professionals, clinics and hospitals, specialists, pharmacists, mental health professionals, community services and other resources working together to provide patient-centered, coordinated care."*[5] The Participants agreed the definition should focus on 'person-centered care' to reflect the community at large, and not just on 'the patient-centered' with the responsibility falling solely on the hospitals and clinics. Therefore, they revised the definition to "*a collaboration among health care professionals, clinics, hospitals, specialists, pharmacies, mental health, community services, and other resources working together to provide person-centered coordinated care"*. Figure 3 below depicts the concept of community coordination that integrates local organizations in the delivery of person-centered care.

Community Care Coordination is the collaboration among health care professionals, clinics, hospitals specialists, pharmacies, mental health, community services, and other resources working together to provide person-centered coordinated care.

Figure 3: Community Care Coordination[6]

[5] Stratis Health; Community-based Care Coordination – A Comprehensive Development Toolkit

[6] National Rural Health Resource Center; Network Technical Assistance (TA)

For population health to be successful, the community partners must come together and take "ownership" of managing the health of the local population. Thus, person-centered coordinated care places an emphasis on a shared system that engages community partners and improves efficiency. The synergistic effect of the coordinated system of care within a rural community results in the delivery of higher functioning services than each individual agency would be able to provide by working alone. Coordination of local services not only supports an enhanced system that delivers better care to the community, but also benefits the rural hospitals, clinics and networks and other partners. Care coordination promotes effective communication among providers and social service agencies, increases effective utilization of local resources, and builds community awareness of available services. Most importantly, it positions the organizations and the community for population health of the future. Figure 4 below summarizes key benefits of community care coordination.

Figure 4: Benefits of Community Care Coordination[7]

[7] National Rural Health Resource Center; Delta Region Community Health Systems Development (DRCHSD) Program

Barriers and Strengths to Community Care Coordination

A local coordinated system of care will be a critical factor for rural communities as it supports the infrastructure for managing population health in the future. Barriers and strengths are considered for rural community leaders to draw upon when developing a community care coordination plan.

Rural Barriers to Community Care Coordination

Rural communities bring both strengths and barriers to the challenge of developing effective community care coordination systems. The panelists first identified a list of potential barriers. These barriers include lack of clarity as to who takes the lead in the community, as well as ambiguity about:

- Who has the power?
- Who has local control?
- Who is accountable?
- Who has formal or informal power in the community?

The answers to these questions will vary by community depending upon local resources and the willingness of partners to collaborate. Sometimes the question will be how to initiate and fund the collaboration? Is there a willingness to relearn the way various community partners interact with each other during the collaboration phase? It is important for a collective knowledge of community resources to be known and cataloged plus an awareness of resources available at the state level that can be leveraged at the local level. Additionally, a mechanism to identify organization and community buy-in of local entities that could direct leaders to the identification of a natural convener to begin driving toward progress is essential.

It is also important to identify the barriers in relation to the rural context; the interrelated conditions in which something exists or occurs such as the environment or setting. Often the rural context represents a unique set of challenges, situations and circumstances impacting rural communities that can include the:

- Culture of a rural organization or community;
- History of relationships and the ability to develop trust at the community level;
- Impact of small populations or low volume;

- Language and culture differences driven through community level diversity;
- Political environment at the state or local level;
- Access to primary and specialty health care services; and
- Knowledge of available community-based resources.

Organizational barriers could include the willingness or ability to invest capital in population health. Other organizational barriers could include items such as:

- Provider resistance;
- Inability to allocate needed resources toward project execution;
- Lack of staff buy-in
- Turnover in leadership and low workforce retention rates; and,
- Lack of leadership awareness and understanding of the future of health care.

The availability of financial resources can also be identified as a barrier with the current climate of increased rural hospital closures and decreases in the availability of certain service lines. Rural hospital financial resources are extremely limited and a strong return on investment must be identifiable if population health is going to move forward. It is also clear that the current environment around the buy-in of the payor community is inconsistent and varies from state to state. With limited data to truly understand the positive impact of care coordination on patients and finances, commercial payors appear to be less invested in rural than urban areas, though this may vary from region to region. Limited provider buy-in is probably attributable to the limitations of available data. Provider buy-in is also impacted by the inability of leaders to analyze and communicate the information effectively in a timely manner to make it actionable.

Rural Strengths to Community Care Coordination

In discussion of strengths, Summit Participants overwhelmingly agreed that mission alignment is the overarching theme for all other strengths in that rural health care is mission driven. In addition, it was agreed that the flexibility of small rural hospitals and their communities provides opportunities for rapid course corrections that do not exist in larger markets. Simply put, rural health care is nimble, which is a strength reflecting a lean hierarchy. This lean hierarchy allows for rapid decision-making, implementation and course correction.

Participants also agreed that leaders do have access to many rural relevant resources specifically designed to prepare for population health. Such rural specific online resources include the *Population Health Toolkit* and *Value-Based Care Assessment Tool*. The Population Health Portal provides access to an online readiness assessment and data, and provides suggested resources for next steps. The Value-Based Care Assessment Tool is an online tool that is well-developed and tested, and available to communities at no cost. Both tools provide a report back to the user. Other online tools are available to determine the health care status of a community and can pinpoint key target populations.

The advances of health system resources such as telehealth and health care technology presents greater opportunities to expand services and analyze data. Another key strength can be found in overall workforce engagement and their willingness to 'lean in'. Rural health care delivery teams seem to be more creative due to limitations of resources.

In rural, health care collaboration is usually a way of life. With smaller numbers of people in rural communities, collaboration is at times easier to accomplish. There often exists a culture of collaboration that naturally creates stability for transformation. The rural hospital is often found to be the natural community convener and may have resources to support local collaboration.

The Summit Participants also discussed the current window of opportunity that exists through rural policy momentum to cooperatively address a health issue aimed at ensuring 'rural has a seat at the table'. It is imperative that rural health care responds to this window of opportunity to leverage positive change. It is clear that rural health care policy is currently on the Federal radar and gaining attention in many states as well. Rural communities must be aware of and leverage special free resources and help from programs such as the Small Rural Hospital Transition (SRHT) Project, Medicare Rural Hospital Flexibility (Flex) Program, Rural Health Network Development, Small Health Care Provider Quality Improvement and the Small Rural Hospital Improvement Grant Program (SHIP). These programs offer value added services, programs and educational events that are targeted toward rural health care delivery.

Finally, there exists a community capital through pride in our rural communities reflected through community buy-in, support and social capital. In all of our rural communities there is a small town feel of neighbors and friends taking care of each other. There is often a greater level of community

intimacy that equates to a greater level of community investment by local citizens and community-based organizations. This level of by-in creates gains and small wins that drive synergies to build upon and develop greater levels of trusted relationships.

Community Care Coordination Strategies for Rural Hospitals and Communities

The following initiatives are designed to assist rural leaders in developing a community care coordination plan. These initiatives are outlined as prioritized action steps to move the community toward population health. Because communities vary in the degree of care coordination, it is anticipated that some may begin with step one while others may be further along the spectrum. Rural community leaders will find benefit from a thorough review of these recommended initiatives. Leaders are encouraged to self-assess the current level of community care coordination based on these step-by-step initiatives. The self-assessment should assist leaders identifying next steps to improve transitions of care and care coordination.

Step-by-step Initiatives

1. **Perform internal and external readiness assessments**
    a. Perform an internal and external environmental scan of current population health projects, identified areas of concern and opportunities for future collaboration. This will also include discussion around identifying potential future population health champions. Leaders should utilize community health needs assessments (CHNA) and population health data when available.
    b. Inventory community resources through the lens of identifying ways to maximize efficiency and eliminate duplication.
    c. Evaluate service line costs to establish a baseline and areas of opportunity.
    d. Evaluate level of understanding and engagement of leadership in population health.
    e. Assess community stakeholder relationships and identify opportunities for collaboration. Include natural partners that are

already engaged in collaborative projects, but also look beyond that to identify new partners that can add value.

f. Evaluate local and regional provider relationships keeping in mind that these relationships may not always be hospital based.
g. Compile information on possible external resources that are available through health system, contract services and/or rural funding programs.
h. Define what organization will act as the lead by identifying a key stakeholder that has available bandwidth, passion and ability to convene at the community level
i. Evaluate existing and potential roles of the collaborating community stakeholders

2. Obtain internal buy-in from leadership, management and physicians

a. Determine and obtain in-house buy-in from the board of directors (BOD), management team, physicians and staff. It is imperative to have stakeholders at the table from the beginning and engaged in the conversation in a meaningful way. This will help to ensure current and future buy-in.
b. Evaluate physician and provider commitment to population health, recognizing that different members of the provider community will have strong opinions on this topic. Have the difficult conversations on the front end to have an accurate assessment of buy-in and develop an early list of innovative approaches that will fit the unique qualities of the community.
c. Educate and engage the BOD on the future of health care. This is an ongoing process, but ensuring that proper board education is provided on the current and future realities of health care delivery, will strengthen the organization and any population health programs that are developed.
d. Establish realistic staff expectations and hold leadership accountable. Communicate, track and report out. Documenting expectations and tracking progress against them is key to transformational success.
e. Establish administrative, staff and physician champions. These champions will drive toward success while ensuring that there is energy necessary to get through the transitional road bumps.
f. Celebrate small wins! Recognize each success and celebrate it!

3. **Optimize processes and resources**
    a. Choose one health issue to address and pilot care coordination. Learn from that, then move onto another topic while refining the first one. Ideally, this could be a topic identified from the CHNA implementation plan.
    b. Consider initial first steps from operational perspective that includes change management process to support transition to population health. The purpose is to evaluate what processes are in place for proceeding with plan and identifying gaps in current process.
    c. Optimize and monitor financial and quality performance organization wide to include both hospital and clinics.
    d. Establish clear care management roles and responsibilities
    e. Consider new roles of staff in population health management. For example, discharge planning may now be extended to further support community care coordination activities. Other new roles could include a community paramedic and/or community health worker.
    f. Develop creative approaches to re-allocate resources to support transition of activities. Consider options to increase efficiency by optimizing current resources such as LEAN.
    g. Prepare to adopt evidence-based practices.

4. **Begin conversations with payors about meaningful reimbursement strategies to drive health improvement**
    a. Evaluate the current impact of value-based payor contracts.
    b. Reach out to payors for data, programs, initiatives, and possible value-based contract options and collaborations. Be informed on what each payor is currently contracted to pay for that is value based. Engage payors in conversation around data to further support performance improvement based on key indicators and quality measures.
    c. Identify all potential coding and billing opportunities under population health model and align with payors value-based metrics.
    d. Consider joining a non-risk ACO, while possible.

5. **Maximize quality and availability of primary care**
    a. Prepare to adopt evidence-based clinical practice guidelines with the intent of reducing practice variation.

i. Adopt PCMH or other team-based care models for primary care where your facility is able to utilize staff at the top of their license and staff work in teams to deliver the care.
ii. Care delivery must be patient centered with the entire team (including the patient) having a voice in the care process.
iii. Consider utilizing emerging types of health care workers to contribute to the primary care team, e.g., community health workers, community paramedics, mid-level providers, and telehealth.
iv. Continue to build internal capacity by providing physician and staff education and training.

b. Annual visits with proper clinical documentation and hierarchical condition category (HCC) coding. HCC coding must be done every year to communicate to payors the severity of patient illness.
c. Create a fun environment for annual wellness visits and promote to community. Create healthy competition within providers to complete annual wellness visits with patients.
d. Ensure accuracy of information and data collected
    i. Population Health Data – Predictive Analytics must be:
        1. Real-time
        2. Actionable
        3. Delivered to point of care
    ii. In a value-based environment, physicians need the data at the point of care so they can impact gaps in care and improve outcomes.
    iii. The best data will be at the EHR level, so evaluating how robust your system and the availability of integrated evidence-based data will be crucial.
    iv. Identify staff with IT skills or recruit staff that can access and analyze internal data.

6. Incentivize physicians and providers

a. Provide physicians with contract incentives to improve quality and productivity.
b. Consider provider compensation incentives that are based on new reimbursement models.

c. Establish physician champion to provide leadership and to educate peers regarding value-based care reimbursement and the need to align contract incentives.

7. Develop community-based population health management strategies

a. Evaluate how SDOH impact the local community and delivery of services.
b. Identify community joint partners that can support the deliver the appropriate services to address SDOH.
c. Collaborate with community joint partners to develop a continuum of care that delivers better coordinated care to community.
d. Assess the following key considerations:
    i. What are the community's most pressing SDOH issues based on population health data?
    ii. Identify and align health care services based on the needs of the local population?
    iii. Define which community joint partners should deliver what services to maximize community resources.
    iv. How should coordinated services be aligned to meet the needs of the community?
    v. How should community joint partners collaborate to create a local continuum of care that addresses SDOH and aligns services with community needs?
    vi. Evaluate how to best include both post-acute care and the home care services when developing strategies.
e. Plan community wellness programs based on population and community needs.
f. Integrate community care coordination plan within organization's strategic plan to operationalize population health strategies and support sustainability.

8. Develop an internal and external communication strategy

a. Assess the level of understanding of employees and draft a communication strategy to build internal capacity.
b. Promote an internal communication strategy so that employees and representatives speak with one united voice.
c. Develop external communication strategy to build public awareness and ownership of timelines and expectations.

d. Communicate and engage to establish local partners in support of improving community health (e.g., community-based organizations, social services, public health, law enforcement).
e. Create a compelling message for the need of community care coordination and direct to all entities for community buy-in. Shift the community environment to support a culture of health.
f. Engage key stakeholders to obtain and include their ideas to support buy-in and acceptance of communication strategy.
g. Identify community champion, which can be other than local community partners.
    i. Consider other state partners and agencies such as the rural health association to act as a champion as these agencies provide connections and resources to further support activities and messaging.
h. Educate community in care coordination services. Throughout the community, engage residents in the culture shift toward transformation where making healthy choices become the easy choices.

9. Leverage community assets

a. Educate community organizations on current and future health care environment and help them understand their role.
b. Identify local and regional community assets. Inventory their services and strengths to promote synergy as resources are likely limited.
c. Engage community members to participate on an advisory council (it promotes community engagement, builds community support, provides opportunity to capture feedback, and increases transparency of activities).
d. Seek all available public funding options through state programs. To support collaboration in the community, hospitals and clinics should be at the table for community stakeholder conversations and initiatives.

Execution Strategies

To wrap up the Summit, Participants were asked the question, "What recommendations would you make to state rural hospital programs, and rural health networks, so that they can support small rural hospitals in executing these strategies and using these tools?" The following summary reflects the categorial responses to this question.

Rural Hospitals

- Identify successful leaders that could be mentors to other leaders that are struggling learning new models thus building a collaboration of peer-to-peer education platforms from trusted sources
- Identify successful examples and share your success stories with others
- Ensure consistency in messaging between state partners and successful leaders to build greater trust during this transition to population health

Rural Health Programs

- Leverage state partners (e.g. SORH and hospital associations) to assist in disseminating the information
- Ensure state partners understand the content and how it was developed
- Break down information into simple steps – clear actions to include suggestions for priority areas

Health Care Networks

- Onboard the physician leaders and establish the appropriate messaging to soften sensitive topics for providers – emphasize that this is about quality of care and new opportunity for funding / reimbursement through a value-based model
- Identify the network champion to lead
- Understand that leaders may be more willing to try new recommendations as a group as it reduces unknowns and risks

Conclusion

This Summit report enables rural health leaders to investigate key steps toward implementing critical strategies that will lead to the development of a coordinated local system of care. The Summit Participants reviewed key definitions of population health, as well as considered barriers and strengths of rural communities when developing a local continuum of care. Key tactics were identified that rural leaders should consider in developing a community care coordination plan. Recommended strategies outline action steps for leaders to take in initiating the development of a community care coordination plan to support a local system of care. Leaders are encouraged to consider these initiatives to execute key strategies for systematically coordinating services and developing a local system of care. Lastly, resources are listed to further assist leaders with next steps in developing a community care coordination plan.

Once a rural community has completed an assessment of their unique barriers and strengths, it is important to identify community-based champions to facilitate the conversation toward implementation of population health programs that are meaningful to the individual needs of each rural community. Summit Participants agreed that leveraging relationships at the state level through statewide health care trade associations is a great idea in gaining insight into other key initiatives that may be happening in the state or regionally to leverage and learn from. The key step in forward progress will be in identifying community partners and beginning to convene meaningful conversations about the impact that is desired at the community level. Resources are available to assist leaders in assessing readiness and developing roadmaps for population health management.

The Summit Participants hope to see this work converted into actionable progress in rural communities that affects the lives of our neighbors and friends in a profound way. We must act now to assure that rural communities will be healthier in the future.

Appendix A: Summit Participants

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Appendix B: Resources

Population Health Toolkit

Rural Health Value

Value-Based Care Assessment Tool

Rural Health Information Hub (RHIhub)

Rural Hospital Toolkit for Transitioning to Value-based Systems

Community-based Care Coordination – A Comprehensive Development Toolkit

SHIP Hospital Resources

Network Resources and Tools

Flex Monitoring Team

Healthy Communities Institute

Institute of Healthcare Improvement Pathways to Population Health

Health Landscape

UDS Mapper

County Health Rankings and Roadmaps