

Keeping the in your hometown A Population Health Approach



Presentation to: 2017 Flex Program Reverse Site Visit

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Hospitals and Healthcare Systems face many challenges

- Shifting demographics of patients and the workforce
- Drive toward cost efficiency; access to capital for investments needed
- Transition to value-based reimbursement focused on outcomes
- Greater focus on population health management approaches
- Increasing demand for cost and quality data transparency
- Continuous advances in technology and increasing adoption speed
- Increasing focus on physician leadership, alignment and engagement
- Challenging variations in care
- Need for clinical integration and care coordination
- Growing demand for patient and family engagement

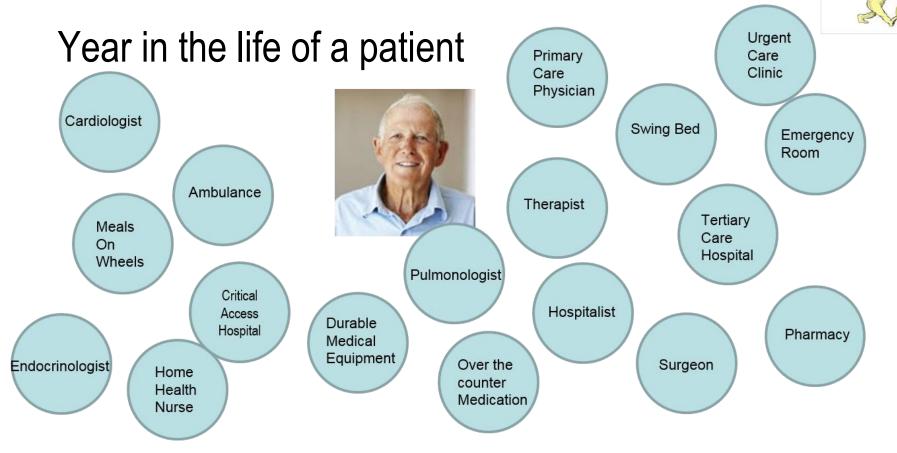


National Quality Strategy Alignment

- Better Care: Improve the overall quality of care by making healthcare more patient-centered, reliable, accessible, and safe.
- Healthy People, Healthy Communities: Improve the health of the U.S. population by supporting proven interventions to address behavioral, social, and environmental determinants of health in addition to delivering higher-quality care.
- **Affordable Care**: Reduce the cost of quality healthcare for individuals, families, employers, and government.



Fragmented healthcare delivery



Disconnected communication among providers fuels uncertainty and often non-adherent behaviors



Many stakeholders believe: "Population health management is the way out of the crisis"



"There is nothing more important [in healthcare] than the transition from traditional medicine to population health and the implications that will have.

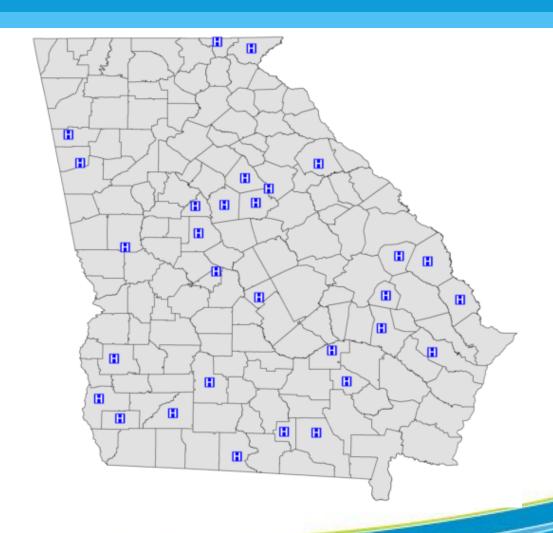
No outcome, no income."

Dr. David Nash

Founding Dean, Jefferson School of Population Health

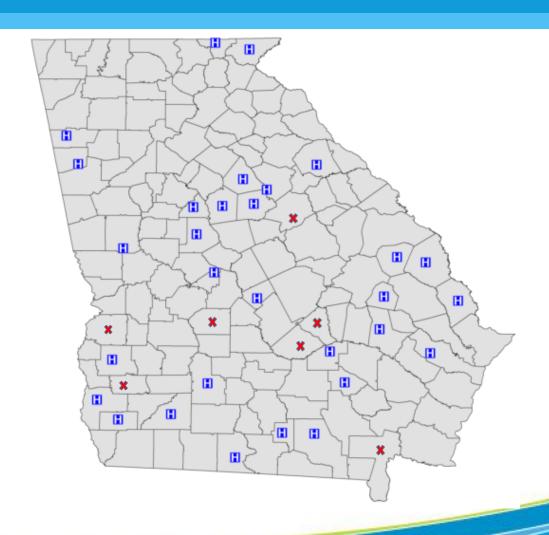


Georgia's 30 Critical Access Hospitals





Georgia's Hospital Closures since 2001





Getting started in Population Health

- Project officer support for change in project scope
- Limited budget
 - Engage a vendor with expertise
- Focus on recruiting a representative sample of CAHs
 - ✓ 501(c)3 or "like" entity with a completed Community
 Health Needs Assessment
 - ✓ Governance
 - ✓ Geographic



2017 Project Participants

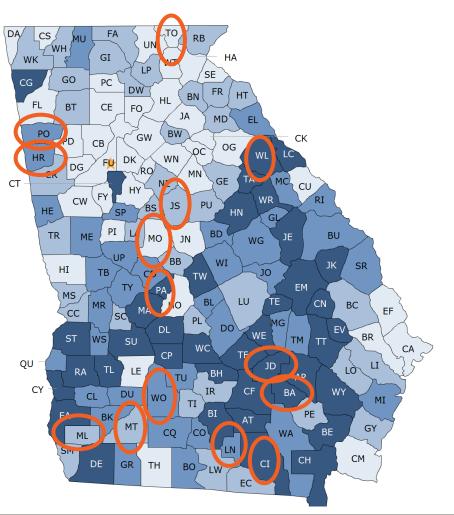
Hospital	County	Participation
Bacon County Hospital and Health System	Bacon	Full
Clinch Memorial Hospital	Clinch	Assessment
Higgins General Hospital	Haralson	Full
Jasper Memorial Hospital	Jasper	Declined
Jeff Davis Hospital	Jeff Davis	Declined
SGMC, Lanier Campus	Lanier	Full
Miller County Hospital	Miller	Declined
Mitchell County Hospital	Mitchell	Declined
Monroe County Hospital	Monroe	Full
Medical Center of Peach County	Peach	Full
Floyd Polk Medical Center	Polk	Full
Chatuge Regional Hospital, Inc.	Towns	Full
Wills Memorial Hospital	Wilkes	Full
Phoebe Worth Medical Center	Worth	Full

Full participation indicates the hospital completed assessment and key informant interviews





Georgia Population Health Findings



Out of 159 total counties in Georgia, the hospitals in the report area:

- 2 counties rank 1-40
- 3 counties rank 41-80
- 4 counties rank 81-119
- 5 counties rank 120-159

Source: (2015 Health Factors, County Health Rankings & Roadmaps)

Rank 1-40 ■ Rank 41-80 ■ Rank 81-119 ■ Rank 120-159



How Is RHI Helping GA Move Towards Population Health?

Methodology:

- ✓ Conducted key stakeholder interviews
- ✓ Surveyed Critical Access Hospitals' readiness via the Population Health Readiness Assessment tool
- ✓ Analyzed Secondary data
- ✓ Developed community health profiles
- ✓ Identify priorities and recommendations
- □ Conduct regional educational workshops for CAHs in July

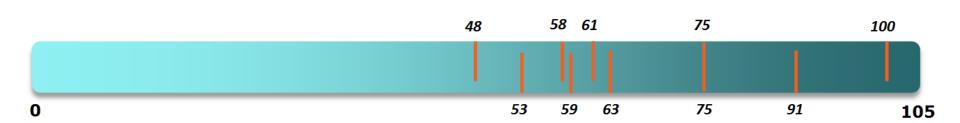
7 Critical Success Factors = Population Health





Why Population Health Matters In Rural GA

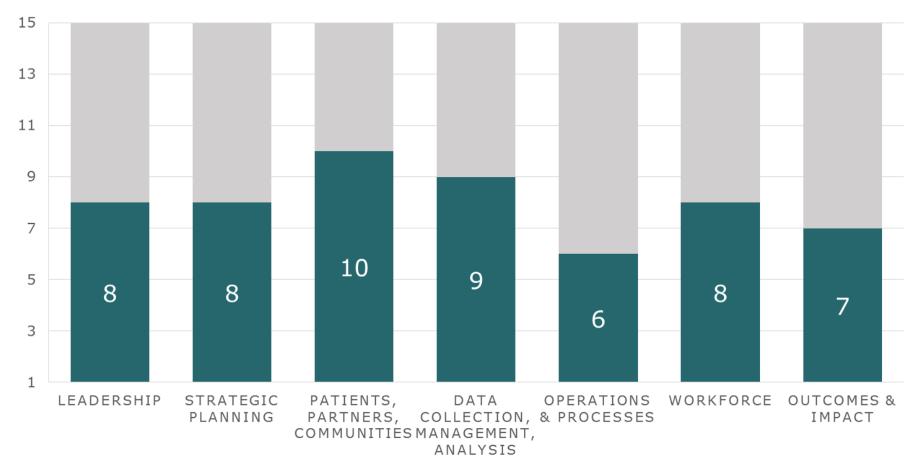
Average Score: 68 out of 105





Where Georgia CAHs Are On The Journey

CRITICAL SUCCESS FACTORS: 10 GEORGIA CAH AVERAGE SCORES





Summary and Recommendations



Key Identified Assets

- Assessment reported that the organization's board and leadership team support its population health strategies.
- Respondents reported that their organizations analyze data (actuarial, clinical, Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS), etc.) to improve patient care and efficiency.
- Respondents noted that their organizations engage in ongoing cycles of performance improvement based on data collected for improving the health and quality of care.
- Key informant interviews highlighted successful and engaged leadership that are dedicated to improving the health and well-being of the community.
- Key informant interviews also noted many positive new and historical community partnerships in each of the communities interviewed.



Top Health Concerns

- The report area has a culture of poverty, low education and low literacy.
- The report area has a higher rate of Years of Potential Life Lost compared to Georgia and the US.
- Almost ¼ of adults report they are in fair or poor health.
- Over 1/3 of adults in the report area are obese (BMI >30).
- The teen birth infant mortality rates in the report area are higher than the state and US.
- 1/3 of Medicare beneficiaries have heart disease and the heart disease death rate is higher than the state and US.
- The rate of preventable hospital readmissions by use of preventative care is higher in the report area than the state and US.
- Based on its population and number of providers, the report area has lower availability of primary care physicians, dentists and mental health care providers compared to the state and US.

 Innovations

Overall Recommendations

- Ensure hospitals' boards, leadership teams and medical staff communicate
 the organizations' visions and strategies for transitioning to population
 health to all staff. If the visions and strategies are not concretely defined,
 organizations should prioritize dedicated development time. Population
 health approaches should be incorporated as part of ongoing strategic
 planning processes.
- Articulate the visions of the hospitals' contributions 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. Provide staff with ongoing education and support to effectively complete transitions of care.
- Educate staff on electronic health record capabilities for managing population health.
- Prioritize staff education on providing safe, high quality, person-centered care.