Future of Population Health Efforts for Rural Health Systems

Becker's Hospital Review
10th Annual CEO + CFO Roundtable Conference
Chicago, Illinois
November 10, 2022

IOWA | Department of Health Management and Policy

Presented by Keith J. Mueller, Ph.D.

Director, Rural Policy Research Institute (RUPRI)

College of Public Health, University of Iowa

Population Health Defined

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.

Kindig, DA, Stoddart G. (2003). **What is population health?** ***American*** *Journal of Public Health*, 93, 366-369.

The University of Iowa rupri™ RURAL POLICY RESEARCH INSTITUTE

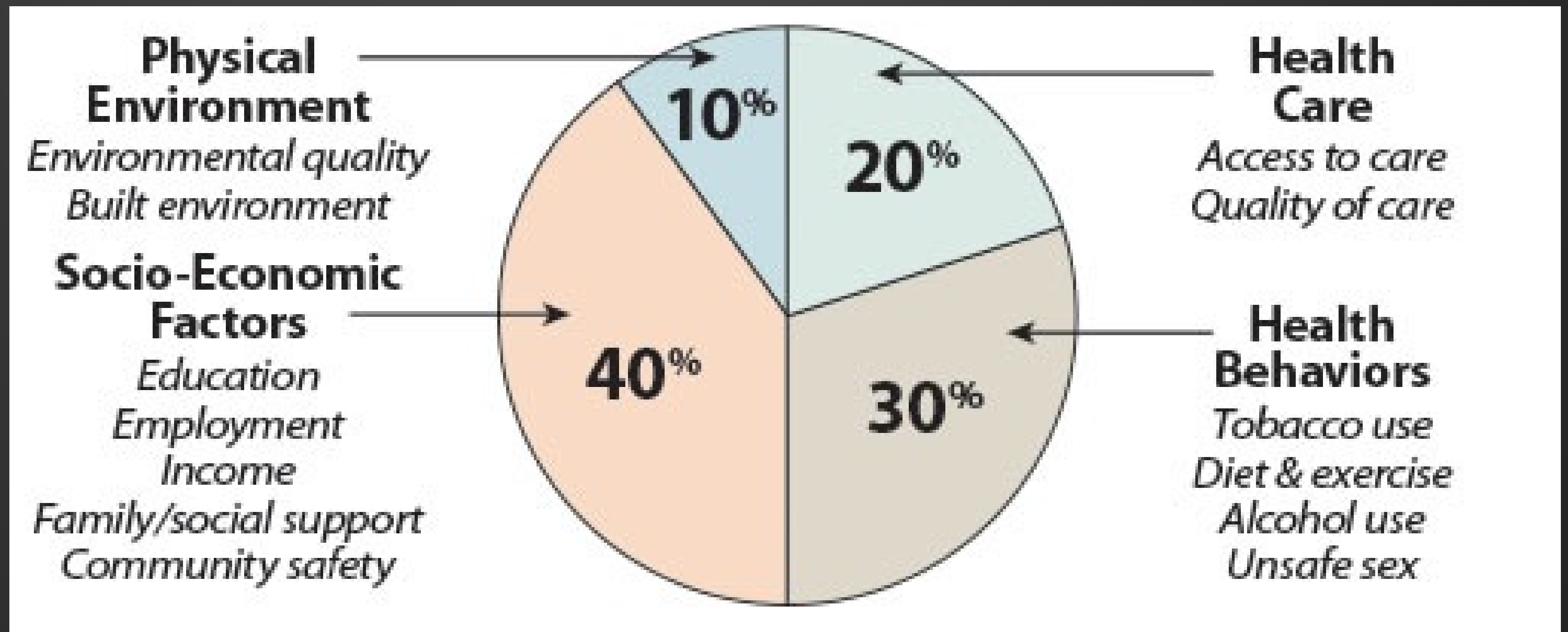
Hospital Perspective: American Hospital Association Definition

The distribution of specific health statuses and outcomes within a population; factors that cause the present outcomes distribution; and interventions that may modify the factors to improve health outcomes."

https://www.aha.org/system/files/hpoe/Reports-HPOE/managing_population_health.pdf

The University of Iowa rupri RURAL POLICY RESEARCH INSTITUTE

Population Health Determinants



Adapted from University of Wisconsin Population Health Model, 2010.

THE UNIVERSITY OF IOWA rupri RURAL POLICY RESEARCH INSTITUTE

Understanding Social Determinants of Health

- Doing so in the rural context: geography for example is entire community, but still "hot spots" within the community (example of rural hospital service area in Iowa)
- Education: attention to apprenticeships, training programs (perhaps in lay health workers)
- Employment: what are the markets in rural communities, how to sustain (hospital as employer, and as catalyst for others)

Addressing Social Determinants

- Screen for patient needs: includes food insecurity, transportation needs, housing (including utilities), interpersonal safety,
- Tools are available - (https://www.ruralhealthinfo.org/toolkits/sdoh/4/assessment-tools)
- Results of screening indicate service needs
- Connect patients to community services

Taking Action

- Assessment tools available from Rural Health Value web site: https://ruralhealthvalue.public-health.uiowa.edu/TnR/Community.php
- Collaborate with local farmers to create food clinics (ProMedica system in Ohio, Chippewa Health Improvement Partnership in Chippewa Falls, WI
- Partnerships for rural housing – Chadron Community Hospital & Health Services with Housing Authority in Chadron, NE

The University of Iowa rupri RURAL POLICY RESEARCH INSTITUTE

Tools and Resources

- Finding Statistics and Data Related to Rural Health – This guide by Rural Health Information Hub will help you locate and use statistics and data in order to understand and communicate rural health needs.
- Evidence-Based Toolkits for Rural Community Health – These toolkits from Rural Health Information Hub provide step-by-step guides for many topics to help build effective community health, including resources and examples drawn from evidence-based and promising programs.
- Guide to Selecting Population Health Management Technologies for Rural Care Delivery - Better manage the health of existing patient populations by implementing technology with this guide from Rural Health Value that walks you through the process to plan for and implement the technology. (2017)
- Hospital Based Strategies for Creating a Culture of Health - Transform the hospital's culture to a "culture of health in your community" using these strategies from Health Research & Educational Trust. (2014)

The University of Iowa rupri™ RURAL POLICY RESEARCH INSTITUTE

Tools and Resources continued

- Pathways to Population Health: Getting Started Guide – Accelerating Population Health Progress – The Institute for Healthcare Improvement brings together various Pathways to Population Health (P2PH) tools and resources in a practical and actionable way to support health care professionals and organizations as they accelerate their progress toward the goals of population health, well-being, and equity. At the heart of the guide is the 10-Step Path to Progress. (2019)
- Population Health: A Self-Assessment Tool for Rural Health Providers and Organizations – Developed by the Rural Health Value team, designed to provide a preliminary review of critical success factors for rural organizations looking to develop, expand, or enhance a population health focused approach. Fillable MS-Word version (2020)
- Population Health Toolkit – Created by the National Rural Health Resource Center, provides a variety of tools and resources targeted towards supporting Critical Access Hospitals with population health strategies.

Tools and Resources continued

- Rural Community Health Gateway - Find resources to build effective community health programs and improve existing services in this Rural Health Information Hub tool.
- Rural Taxonomy of Population and Health-Resource Characteristics - A systematic tool created by Rural Health Value for classifying and identifying similar rural communities and places, using characteristics of community populations and health resources. (2015)
- Understanding the Social Determinants of Health: A Guide for Rural Health Care Leaders – Provides rural health care leaders and teams with foundational knowledge, strategies, and resources to understand the impact of social determinants of health (SDOH) on patients and communities and to recognize local needs and opportunities for action. (2021)
- Using Data to Understand Your Community - Address the Triple Aim© by using data to better understand your community's population using this Rural Health Value resource. (2020)

The University of Iowa rupri RURAL POLICY RESEARCH INSTITUTE

Taking Action

- Winona Wellbeing Collaborative in Winona MN
- Rural hospitals in Iowa: Blue Zones, Healthy Home Town, now addressing health disparities (healthy food, transportation, exercise pathways, art in the community)
- Promote wellness internally and with community partners
- Move toward person-centered health homes

Leverage CHNAs

- Collaborate across hospitals to collect and analyze the data: Illinois Critical Access Hospital Network model
- Collaborate with local public health departments in data collection, analysis, program development, and evaluation
- Use all means to engage the community: focus groups in creating CHNA, presence of the CHNA and strategic plan on hospital website (along with progress reports), social media

Source: "Advancing Population Health in Rural Places: Key Lessons and Policy Opportunities." RUPRI Health Panel (lead authors: Keith J. Mueller and Delaney P. Bounds). https://rupri.org/wp-content/uploads/Population-Health-Paper-Final-2021.pdf

Accountable Health Communities (AHCs)

- Framework
- Intake assessment done where patient presents – typically with a clinical provider
- Establish referral networks to meet identified needs
- Passive referral – making patients aware
- Active referral – treat as a prescription with follow up to be sure there was a connection and action taken

Accountable Health Communities (AHCs)

- Necessary ingredients
- Collaboration across organizations
  - Challenges to this working – historical antecedents, resource imbalance
  - Trust, trust, trust
  - Agreement on collection and disbursement of resources
  - Sharing burdens for data collection and analysis
- Shared resources over time

AHCs in Action

- Among the 28 participants 2017-2020: more than half of beneficiaries reported more than one core need – food insecurity mot commonly reported
- 74% of eligible beneficiaries accepted navigation, but only 14% of them completed full year of navigation and had need resolved
- Contributing to difficulty resolving: difficulties with data reporting, lost of contact, difficulty managing large caseloads, lack of transportation, insufficient community resources

Source: CMS. Accountable Health Communities: Evaluation of Performance Years 1-3; Findings at a Glance. https://innovation.cms.gov/data-and-reports/2020/ahc-first-eval-rpt-fg. Accessed October 26, 2022

Key Points from two AHCs

- From Ballad Health and Rocky Mountain Health Plan – screened 77,000+ rural beneficiaries in 2 years for unmet social needs
- Needs addressed include housing instability or housing quality; utility needs; food insecurity; interpersonal violence (safety); and transportation needs beyond medical transportation
- Implementation challenges include technology issues related to data management, and demonstration model creating expectations based on urban volume targets

Source: Accountable Health Communities Model – Two Rural Participants' Experiences. *Rural Innovation Profile* Rural Health Value. November, 2020. https://ruralhealthvalue.public-health.uiowa.edu/files/Rural%20AHC%20Profile.pdf

The University of Iowa rupri™ RURAL POLICY RESEARCH INSTITUTE

Sustaining the Momentum: Align Systems

- Framework suggested in RWJF Culture of Health work
- Align public health, health care, social services
- Important inputs: shared vision, shared and integrated data, financing, governance
- Considerations: community voices, equity, power dynamics, trust

Source: Petiwala A, Lanford D, Landers G and Minyard K (2021) Community voice in cross-sector alignment: concepts and strategies from a scoping review of the health collaboration literature. BMC Public Health 21:712. https://doi.org/10.1186/s12889-021-10741-9.

Resources from the AHC Experience: Leveraging Community Partnerships

- Form and use Advisory Board
- Encourage community member participation
- Identify gaps in addressing health-related social needs (HRSNs) and engage the Board with data
- Identify opportunities for improvement based on the data
- Focus on directed, flexible funding

Source: CMS. Leveraging Community Partnerships: How Advisory Boards Advance Screening, Referral, and Navigation Efforts. February, 2022. https://innovation.cms.gov/media/document/ahcm-focus-grp-summary. Accessed October 26, 2022.

Resources from the AHC Experience: Data sharing to address health-related social needs

- Data sharing among patients, navigators, referral systems, community-based organizations, providers
- Address equity by using the data
- Data use by health care providers: screening tools in HER systems with follow-up
- Data use by community-based organizations

Source: CMS. Cross-Sector Data Sharing to Address Health-Related Social Needs: Lessons Learned from the Accountable Health Communities Model. October 2022. https://innovation.cms.gov/media/document/ahcm-cross-sector-data-sharing. Accessed October 26, 2022

Sustaining the Momentum: Integrate into payment design

- Standard fee-for-service contracts with payers – an eligible expense
- An eligible medical loss ratio item for insurance plans
- An important reason for success in shared savings models
- A part of transformation plans
- Global budget models
- Other?

The University of Iowa ruPri™ RURAL POLICY RESEARCH INSTITUTE

Context: community sustainability

- Population health closely related to community health, sustainability
- Well-being of residents of the community a function of community prosperity
- Community prosperity a function of successful management of community assets, the components (capitals) of comprehensive wealth: financial, intellectual, human, social, cultural, political, physical, and natural) -- https://rupri.org/about-rupri/key-frameworks/
- Health systems a key players, leaders in local rural communities to achieve goals related to total community well-being

The University of Iowa rupri™ Rural Policy Research Institute