OREGON OFFICE of RURAL HEALTH

2023 Rural Population Health Webinar Series

OPPORTUNITY Just knock.

Welcome!

Population Health 101

Tracy Morton, PhD | National Health Resource Center

April 3, 2023

OREGON OFFICE of RURAL HEALTH

2023 Rural Population Health Webinar Series

OPPORTUNITY Just knock.

Register for the full series:

- April 3: Population Health 101
- April 25: Digging into Community Health Data
- May 25: Community Health Workers: Approaches to Health Equity and Payment Strategies
- June (Date TBA): Building Healthy Communities Through Strategic Partnerships
- July (Date TBA): Setting Up Your Population Health Program
- August 9: What's Next? Learning From Each Other

https://www.ohsu.edu/oregon-office-of-rural-health/2023-population-health-webinar-series

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Rural Population Health Grant Program

The Rural Population Health Grant is designed to support programs that address a specific population health need for an identified rural population. A strong application demonstrates an innovative, sustainable and scalable model with strong community partners. This initiative is currently open to Critical Access Hospitals (CAHs), CAH-owned Rural Health Clinics (RHCs), or organizations who are conducting programming in collaboration with a local CAH or CAH-owned RHC.

Request for proposals will be released June 12, 2023 for the 2023-2024 grant cycle.

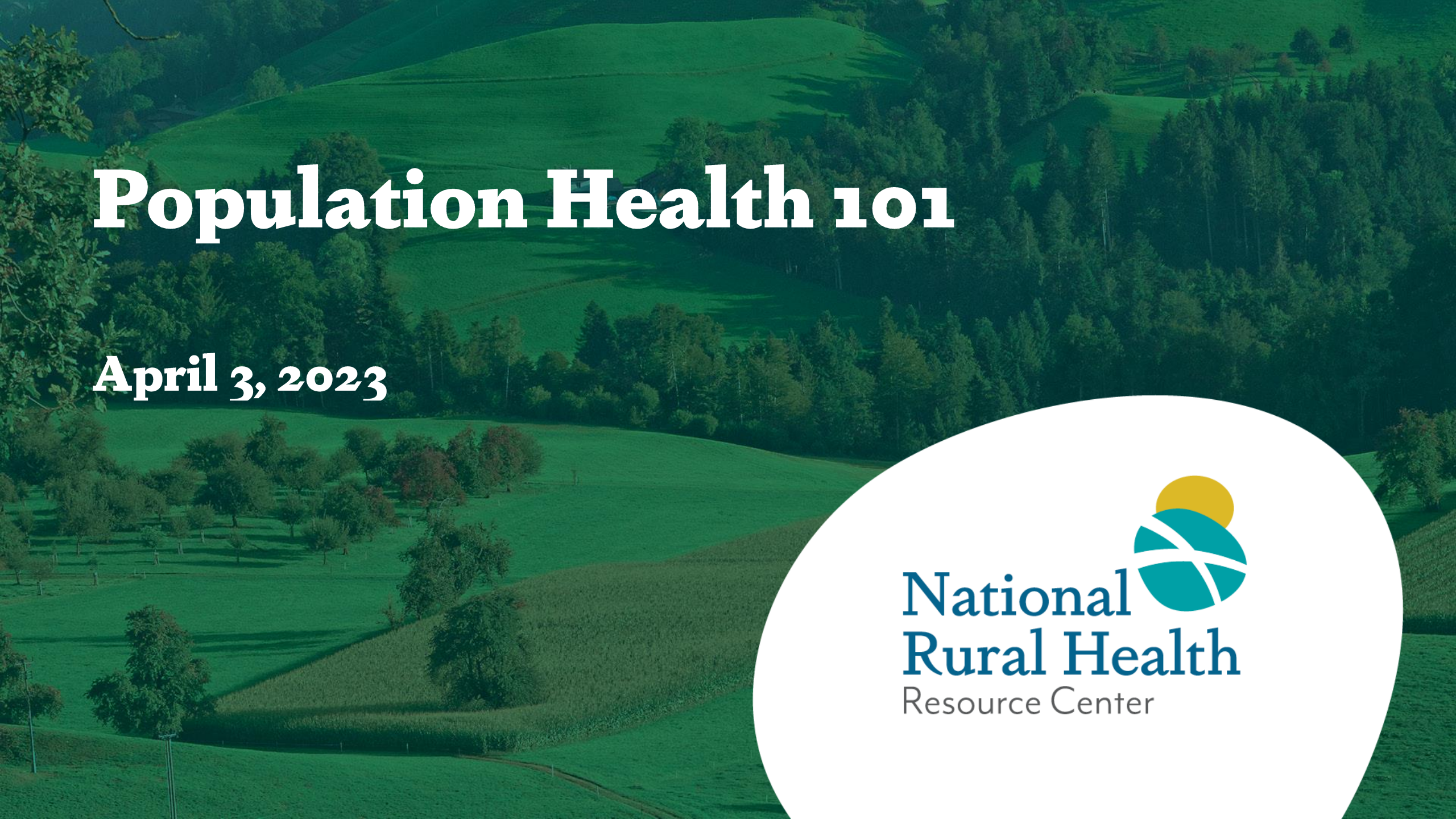
https://www.ohsu.edu/oregon-office-of-rural-health/rural-population-health-grants

Disclosures:

- Tracy Morton has no conflicts to disclose.

Population Health 101

April 3, 2023



National Rural Health Resource Center

The Center's Purpose

The National Rural Health Resource Center (The Center) is a nonprofit organization dedicated to sustaining and improving health care in rural communities. As the nation's leading technical assistance and knowledge center in rural health, The Center focuses on five core areas:

- Transition to Value and Population Health
- Collaboration and Partnership
- Performance Improvement
- Health Information Technology
- Workforce

Diversity, Equity, Inclusion, & Anti-racism

Building a culture where difference is valued.

The Center is committed to DEI and anti-racism. We create an environment that reflects the communities we live in and serve; a place where everyone feels accepted and empowered to be their full, authentic selves; and where everyone belongs.

We understand the impact of and seek to defeat racism and discrimination in ourselves, our workplace, and the world. This guides how we cultivate leaders, build our programs and resources, and deliver our technical assistance.

We are an organization that honors, celebrates, and respects all dimensions of diversity. These principles are central to our mission and to our impact.

Read more at ruralcenter.org/about/DEI

Today's Purpose

- Describe what is population health
- Explain why a rural health care organization should focus on population health
- Recall the basics of value-based models
- Interpret how population health relates to value-based models, social determinants of health, and health equity

What is population health?

What is Health?

"Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity."

Source: Preamble to the Constitution of the World Health Organization as adopted by the International Health Conference, New York, 19-22 June, 1946: signed on 22 July 1946 by the representatives of 61 States (Official Records of the World Health Organization, no. 2, p. 100) and entered into force on 7 April 1948.

Defining Population Health

Population Health serves as a strategic platform to improve the health outcomes of a defined group of people, concentrating on three stages:

- Distribution of specific health statuses and outcomes within a population
- Factors that cause the present outcomes distribution
- Interventions that modify the factors to improve health outcomes

Source: www.aha.org

Clarifying Population Health

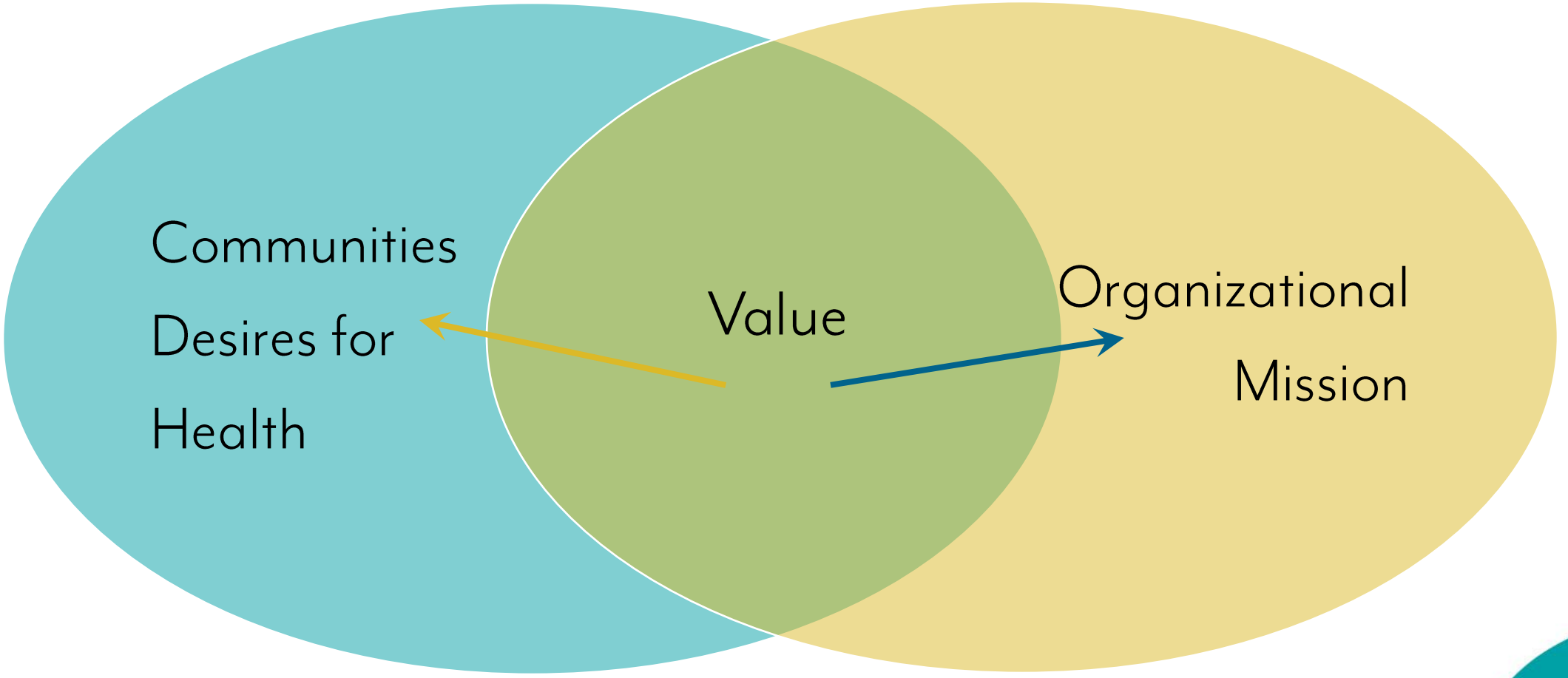
Population Health can be used to describe:

- **Targeted Population Health: Improving health and reducing costs for *specific groups of patients*, often grouped by insurance type and focused on chronic disease**
- **Total Community Health: Health outcomes of an *entire group* of individuals, often geographically defined, including the distribution/disparities of outcomes within the group**

It's Both/And Situational

Why focus on population health?

Population Health Aligns with...



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Windom Area Health, Windom, MN

- The Start 2020 – Spanish speaking families and/or workers in Windom with elevated blood pressure and risk for Type II diabetes

  Changes toward mental health as need arose during the pandemic. But why just Spanish speaking? All need assistance.

- The Pivot 2022 – Reduce the number of individuals who live or work in Windom and the surrounding area who present to the Emergency Department with mental health and substance use issues
- Establish a mental health walk-in clinic, opening 5/1/23
- Implement a referral process to the community care coordination team for Mental Health and substance abuse patients
- Using assessment toolkits in their EHR

Caribou Medical Center, Soda Springs, ID

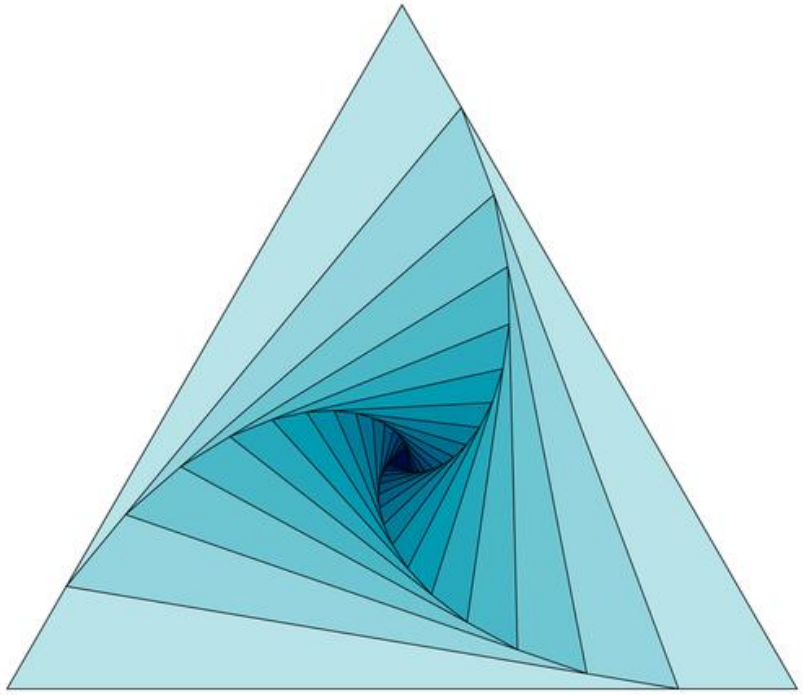
- Vision: Caribou County community members 65 years and over will have fewer falls and fall-related injuries, maximizing their independence and quality of like by establishing a falls prevention program
- Medicaid beneficiaries that are 65+ years with falls risk based on Emergency Department assessment or dual eligible beneficiaries that present in the Emergency Department or Clinic with falls risk
- Seeking to complete an immediate falls risk assessment in Emergency Department or Clinic for all of the intended population by August 31, 2023,
- Partnering with American Legion, memory care facility, home health agencies, senior center, Lions Club, Rotary Club, community faith leaders
- Implementing a 6-week program on education and exercise related to falls prevention, volunteers to teach the program
- Feedback loop into Annual Wellness Visit

The Destination...

A health system that links health care with community organizations and partners to create a network of organizations working together to improve population health.

The basics of value-based models

The Need to Demonstrate Value



CMS Quality Strategy

Three Aims

- ✓ Better Care
- ✓ Healthier People, Healthier Communities
- ✓ Smarter Spending

$$\text{Value} = \frac{\text{Quality + Experience}}{\text{Cost}}$$

Form Follows Finance

- How we deliver care depends on how we are paid for it.

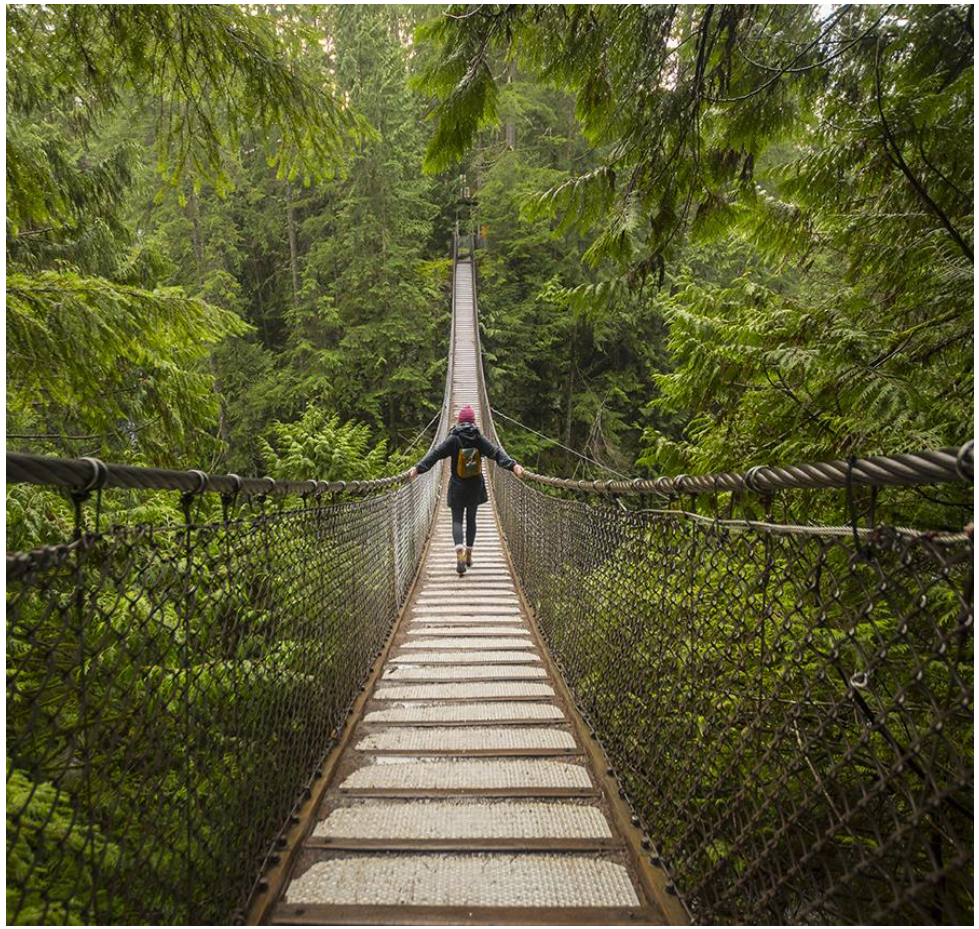
- So, what is changing?

  Both payment and delivery.

The Transition

- **Today: Fee-for-service**
  - Pays units of service
  - Rewards productivity and efficiency, not necessarily accuracy and outcomes
  - Contributes to high-cost health care
  - Decreased patient and provider satisfaction

- **Future (or even now): Value-based payment**
  - Rewards better care, efficiency, and outcomes
  - Increases health care quality
  - Reduces health care costs (?)
  - Improves patient and provider satisfaction



Rural Health Challenges

- Value-based health care payment models are a lagging in rural hospitals and clinics
- Shortage of healthcare workforce
- Limited broadband
- Housing and transportation gaps
- Lower employment, income and education
- Higher dependence on public programs
- Higher levels of chronic disease
- Hospital closures and loss of OB services

Rural Health Disruptors

Consumer driven options to access health care using non-traditional avenues

Impact on Access

Dramatic, focused social investment within rural communities to address health disparities through social determinants of health and build community connections

Impact on Access

Impact on Affordability

Impact on Quality

Increased attention on rural health vulnerability as exposed by the COVID-19 pandemic

Innovative rural population health care and payment models that ensure viable health services within rural communities and address financial pressures

New technologies integrated into health care that supplant or support traditional care

Impact on Affordability

Telehealth technology, payment and regulations that enable care providers to interact virtually with patients and community members

Impact on Access

Impact on Affordability

Building Blocks of Value-based Care

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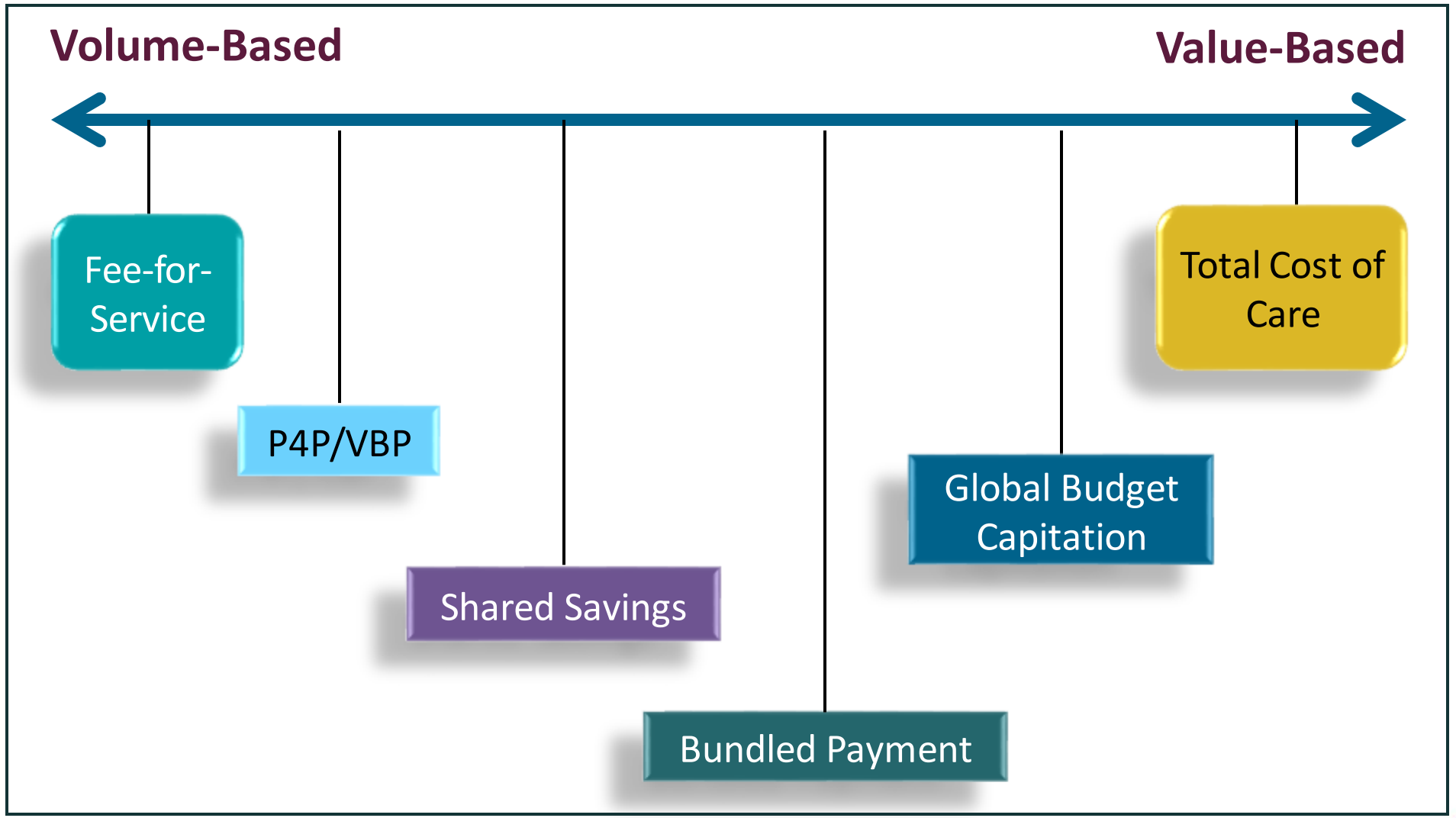
CMS Innovation Center's Strategic Objectives

Source: Centers for Medicare and Medicaid Services Innovation Center (CMMI)

What is value-based payment?

- Value Based Payment (VBP) is a method by which ***purchasers* of health care** (including government, employers, and consumers) and payers (public and private) ***hold the health care delivery system*** (physicians and other providers, **clinics, hospitals**) ***accountable* for both *quality and cost* of care.**
  - VBP rewards health care providers for keeping people healthy - and for providing the right care, at the right time, in the right place.

Payment Model Continuum



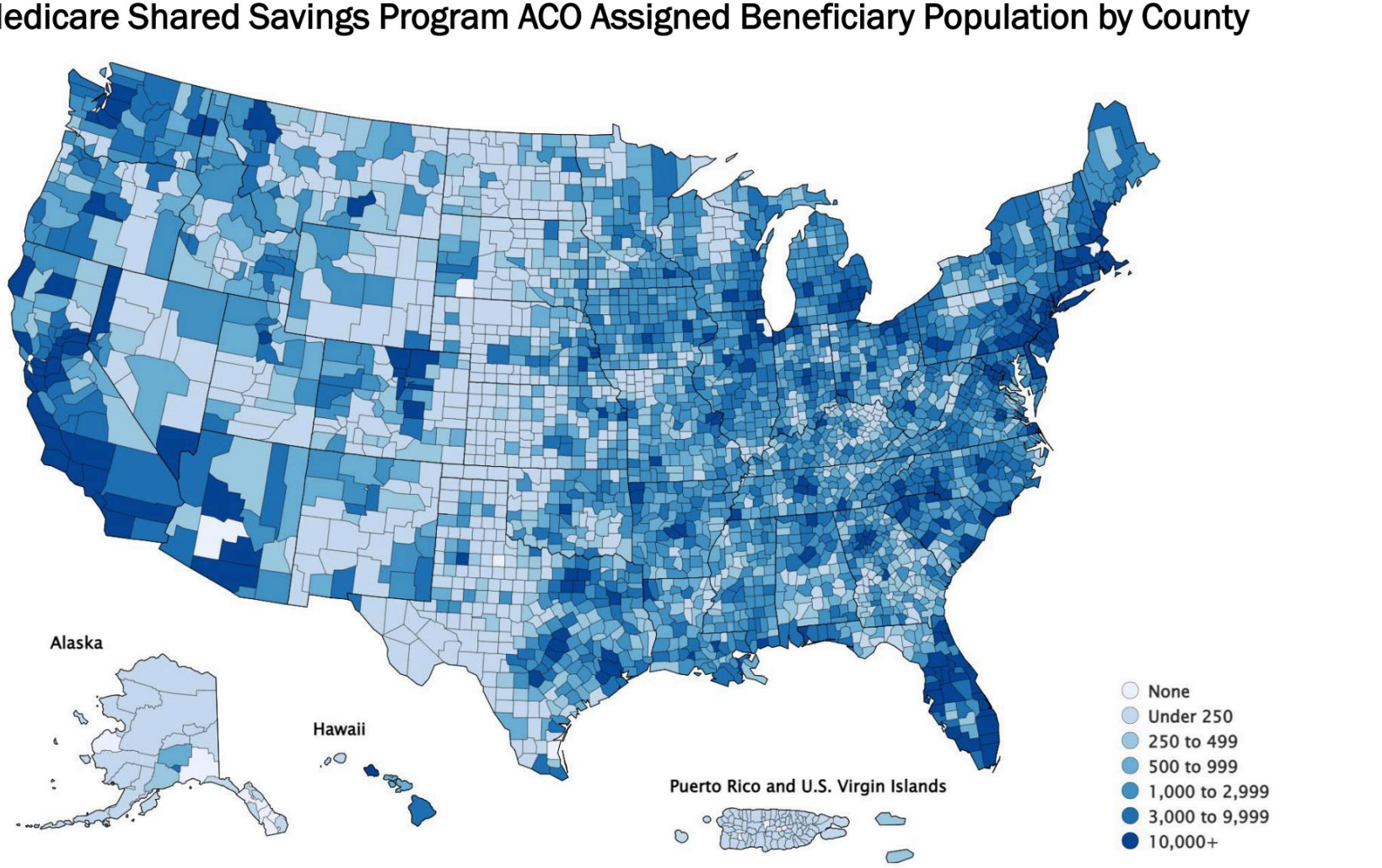
Pay-for-Performance/Value-based Payment

- **Incentives affecting small percentage of payment**
- **Retaining the FFS payment design**
- **Examples include:**
  - Pay-for-Reporting/Pay-for-Performance related to quality measures
  - Care Coordination Fees

Shared Savings

- **Accountable Care Organizations (ACO)**
  - A group of health care providers that takes responsibility for the cost and quality of care for a group of patients or individuals
- **Hospital or physician led**
- **Primary care physician agreement**
- **If costs are lower than target, savings shared between providers and insurer**
- **High quality is necessary for payment bonuses**

ACO Spread - 2023



Source: CMS - Medicare Shared Savings Program Fast Facts

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Why Participate in MSSP ACO

- Low- risk opportunity for rural organizations to try out value based strategies
- Opportunity for strategic investments using advance payment or other commitments
- Build delivery systems that can negotiate contracts with other payers

Marshall Browning Hospital, Du Quoin, IL

- Mindset shift – make sick people better → what can we do to keep you well
- Transitional care model, focused upon admission on discharge planning
  - Improved care coordination
  - Reduced readmissions
- Involved community support
- Re-wrote the mission with the community at the center
- Getting ahead of chronic conditions with preventative focus
- ACO participation as part of Illinois Rural Community Care Organization (IRCCO)

Marshall Browning Hospital, Du Quoin, Illinois | National Rural Health Resource Center (ruralcenter.org)

Pinckneyville Community Hospital, IL

- ACO participation as part of IRCCO
- Transitional care management nurse, demonstrated reduction in readmissions
- Created discharge medication instruction sheets, improved patient and provider satisfaction scores
- Reduced skilled nursing facility (SNF) spending
- Addressing many other community concerns including mental health, housing, and transportation issues via Community Champion

Pinckneyville Community Hospital, Pinckneyville, Illinois | National Rural Health Resource Center (ruralcenter.org)

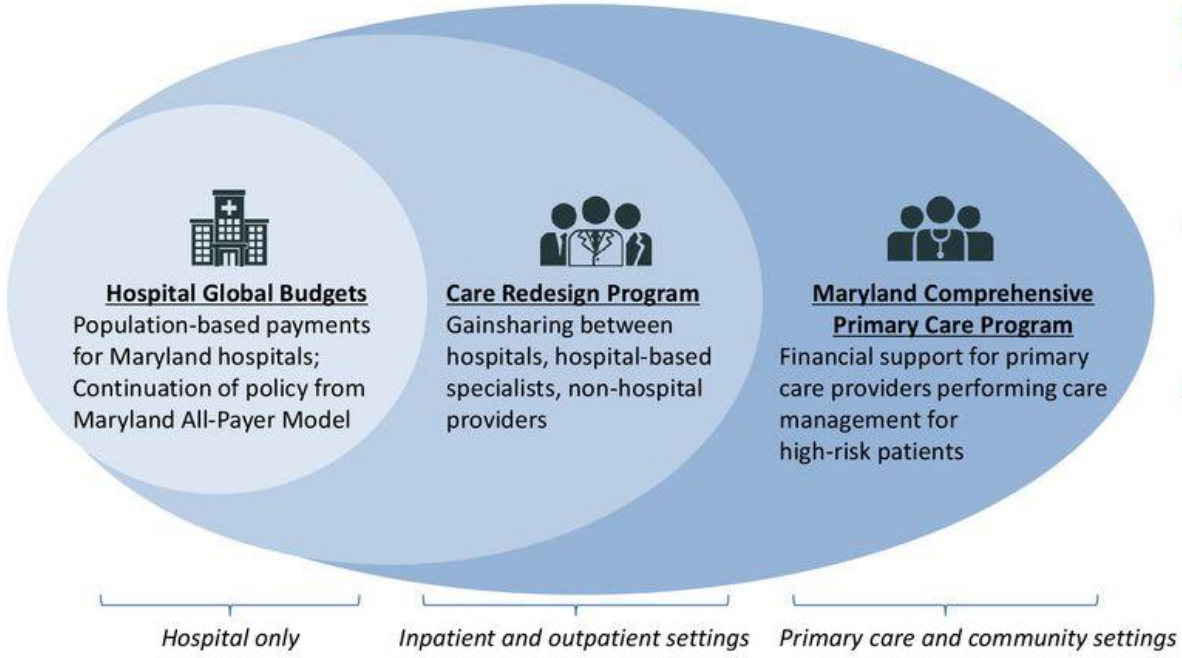
Pinckneyville Community Hospital Spotlight Video - YouTube

Maryland Total Cost Model

Maryland Total Cost of Care Model

New Model in Maryland Covering Full Continuum of Care

Components of Maryland Total Cost of Care Model



Benefits of TCOC Model

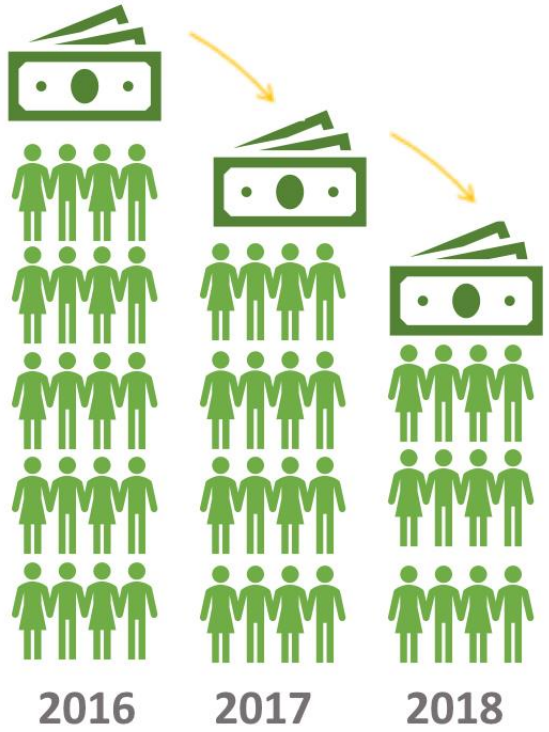
- ✓ Adds new providers and settings into care transformation effort
- ✓ Links disparate providers to create more patient-centered care
- ✓ Aligns incentives across providers to reduce hospitalizations and total cost of care

Performance Period begins January 1, 2019 and continues through 2026

Pennsylvania Rural Health Model

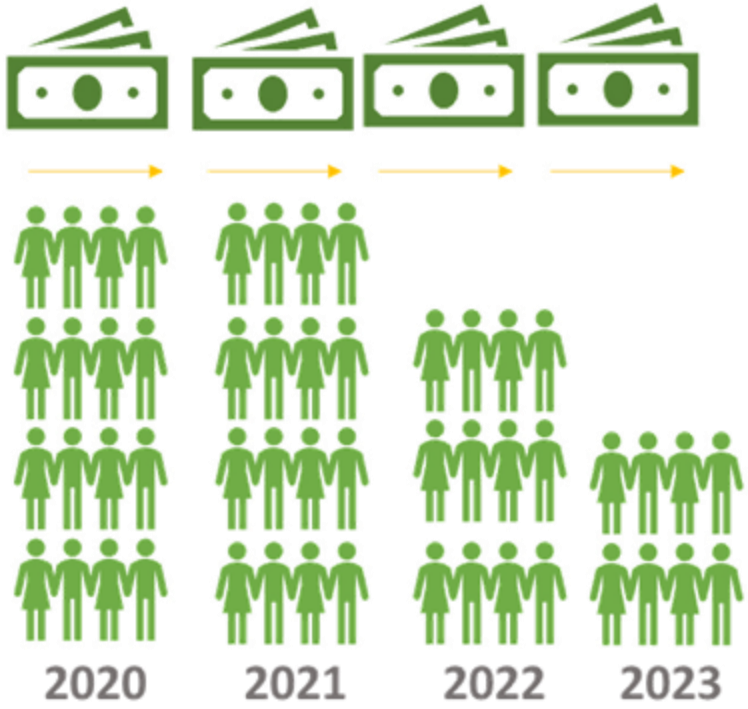
Fee for Service

Hospital is paid for the # of healthcare resources consumed by the community, but as the community is getting smaller, so is revenue.



Global Budget

Hospital is paid the same amount of money as historic NPR regardless of how many resources are consumed by the community.



Goal: Improve quality and address community health needs in 54 rural hospitals in 6 years; Focus: Reduce Potentially Avoidable Utilization (PAU), Increase operational efficiency, Align services with community needs

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Key Resources from Rural Health Value

Catalog of Value-Based Initiatives for Rural Providers

Medicare Shared Savings Program: Rule Changes and Implications for Rural Health Care Organizations

https://cph.uiowa.edu/ruralhealthvalue/InD/Briefs/

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Other Important Value-based Updates

- **Advanced Investment Payment Model**
  - Coming January 2021, lower risk
  - 5-year program, $250,000 in Q1, then capitated quarterly per beneficiary payments through Year 2
  - Focus on SDOH, care coordination, underserved populations
- **Medicaid ACOs**
- **Commercial ACOs + Medicare Advantage**

CMS - By 2030, all Medicare FFS and the majority of Medicaid beneficiaries will be in a care relationship with accountability for quality and total cost of care (7 years)

Rural ACO Advantages

- Rural health is primary care based
- Rural health is more community based, enabling partnerships with other providers and other segments of the community
- Rural health care delivery systems can change more rapidly than urban systems

Rural ACOs – What We've Learned

- Develop care coordination programs
- Pay attention to post-acute care
- Provide behavioral health support
- Improve HCC (Hierarchical Conditioning Coding)
- Expand clinic hours, implement pre-visit planning and focus on prevention quality processes and metrics
- Reduce out-migration & increase outpatient volume
- Increase use of telehealth & technology
- Engage and enlist physicians as partners
- Manage, analyze and act on patient information
- Manage downstream costs of patient care

How population health relates to value-based models, SDOH, and health equity

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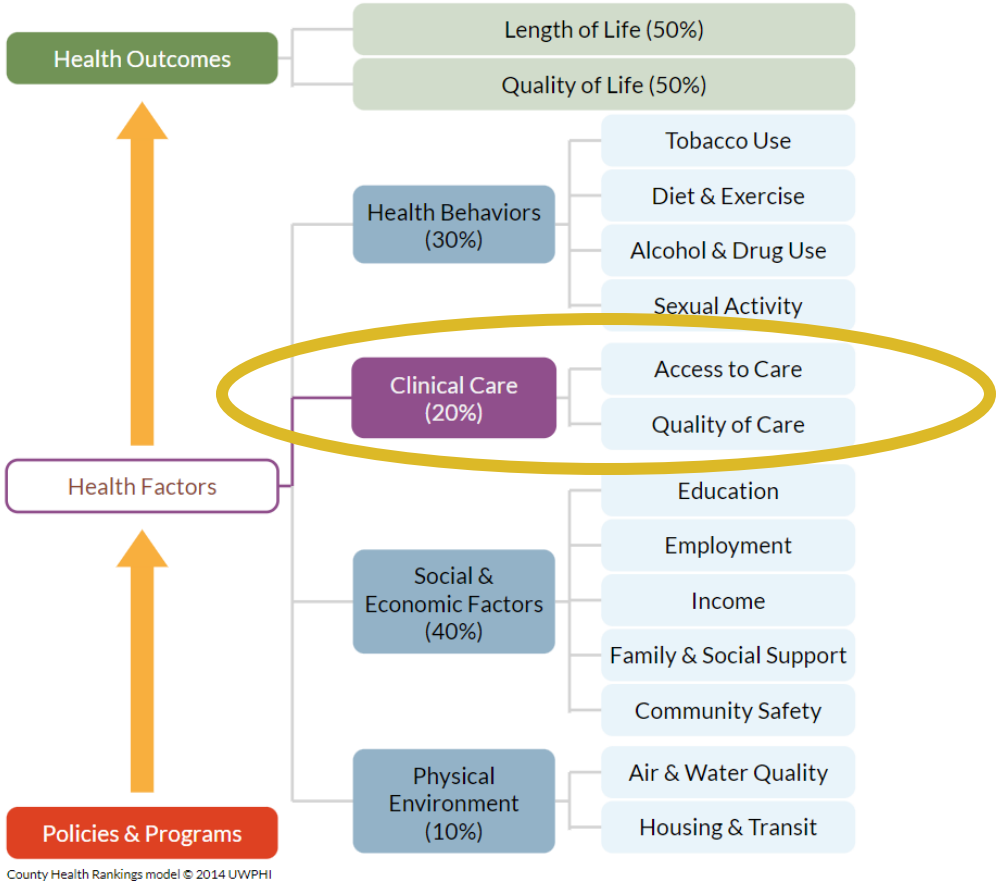
Social Determinants of Health (SDOH)



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: economics and the distribution of money, power, social policies, and politics at the global, national, state and local levels.

Clinical care impacts only 20% of county-level variation in health outcomes.

Source: County Health Rankings and Roadmaps
Definition adapted from: World Health Organization (WHO) and Centers for Disease Control and Prevention (CDC)

Health Equity

- **Health equity is the state in which everyone has a fair and just opportunity to attain their highest level of health. Achieving this requires ongoing societal efforts to:**
  - Address historical and contemporary injustices
  - Overcome economic, social, and other obstacles to health and health care
  - Eliminate preventable health disparities

Source: CDC

Health Related Social Needs (HRSN)

- **Unmet, adverse social conditions that contribute to poor health.**
  - Housing instability, food insecurity, lack of reliable transportation
- **Result of a community's underlying SDOH**
- **Can result in up to 50% of health outcomes**
- **Seek to address HRSN through:**
  - Care delivery
  - Quality measurement
  - Clinically supporting HRSN interventions
- **HRSN Screening Tool is a standard tool from CMMI (part of HEDIS)**

Source: https://aspe.hhs.gov/sites/default/files/documents/e2b650cd64cf84aae8ff0fae7474af82/SDOH-Evidence-Review.pdf

Understand Your Community How They Want to be Understood

- Race, Ethnicity, and Language (REL) has a specific code system for use to support individual's personal responses as best suits their identities. Race and ethnicity are social constructs, not biological categories.
- Sexual Orientation/Gender Identity (SO/GI) is recommended for data collection by the National Academy of Medicine and the Joint Commission.

For more info: CDC Race and Ethnicity 2022 Code System Prepared by the CDC's National Center for Health Statistics (November 2022)

Collecting Sexual Orientation and Gender Identity Information | For Health Care Providers | Transforming Health | Clinicians | HIV | CDC

It Takes a Community

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Rural Aging Action Network

[Rural Project Summary: Rural Aging Action Network - Rural Health Information Hub]

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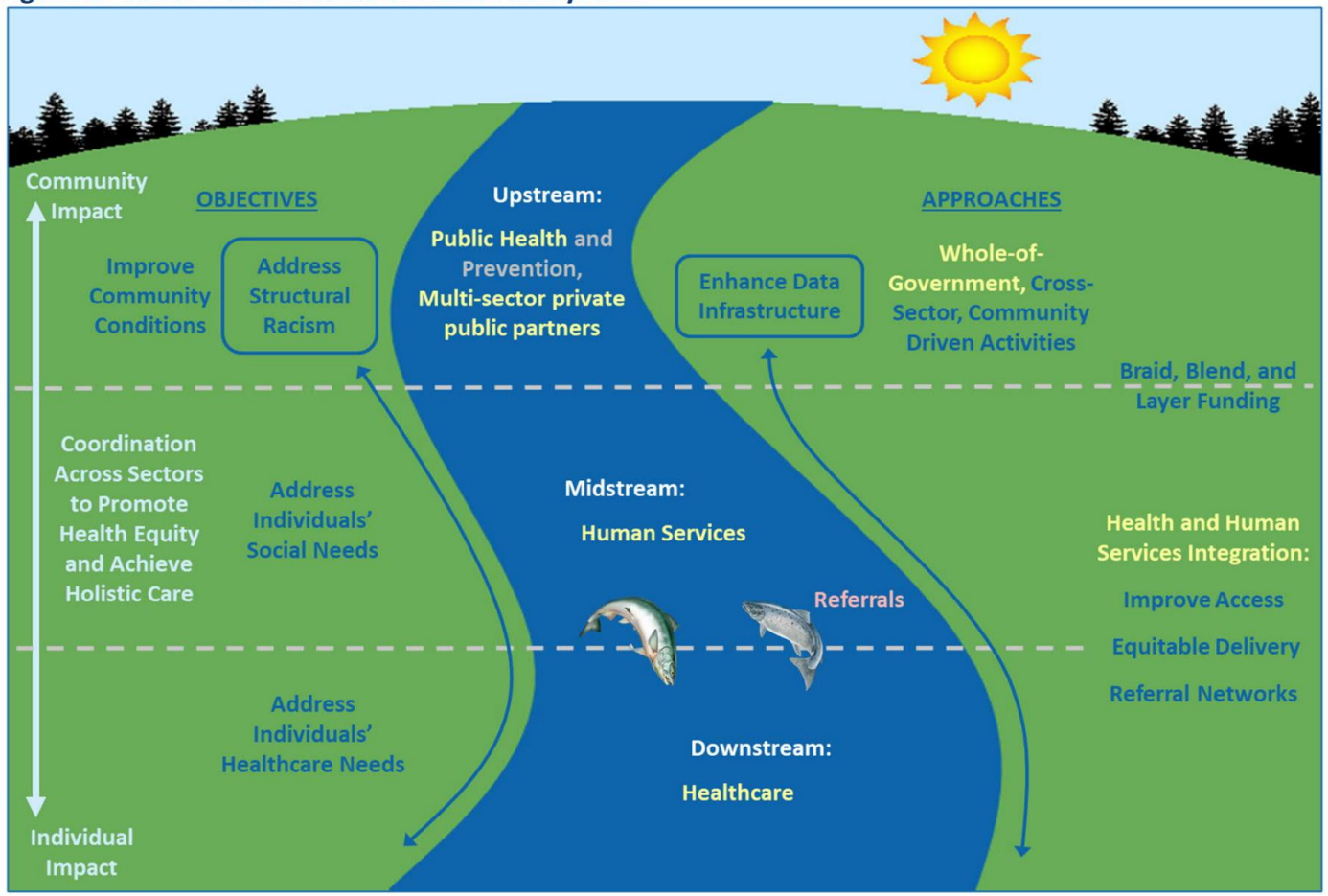
Pride in Idaho Care Neighborhoods

- Rural Project Summary: Pride in Idaho Care Neighborhoods - Rural Health Information Hub

Meeting in the Middle for Improved Health

Figure 1. Social Determinants of Health Ecosystem



Note: Adapted from Castrucci B, Auerbach J. Meeting Individual Social Needs Falls Short of Addressing Social Determinants of Health. Health Affairs Blog. January 16, 2019

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Source: https://aspe.hhs.gov/sites/default/files/documents/e2b650cd64cf84aae8ff0fae7474af82/SDOH-Evidence-Review.pdf

The Destination...

A health system that links health care with community organizations and partners to create a network of organizations working together to improve population health

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