OREGON OFFICE of RURAL HEALTH

2023 Rural Population Health Webinar Series

OPPORTUNITY Just knock.

Welcome!

Setting Up Your Population Health Program

Emily Sullivan | Columbia Memorial Hospital
Brooke Pace | Wallowa Memorial Hospital and Medical Clinics
Paul McGinnis | Lake Health District

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2023 Rural Population Health Webinar Series

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Register for the series:

- August 9: What's Next? Learning From Each Other

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

Disclosures:

- The speakers have no conflicts to disclose.

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Speakers

Emily Sullivan is a board-certified ambulatory care pharmacist. Along with pharmacy manager Jeff Chow, Emily created a clinic pharmacist program which provides medication therapy management for patients at the CMH-OHSU primary care clinics in Astoria, Warrenton, and Seaside Oregon.

Brooke Pace is the Director of Communications and Experience at Wallowa Memorial Hospital and Medical Clinics in Wallowa County. Relatively new to healthcare, her commitment to the people in the community she was born and raised fuels her passion for the work she does in helping to improve their health and lives.

Paul B McGinnis, MPA has served rural health care needs for 40 years in the areas of community health development, practice facilitation, policy and peer reviewed research. He is currently the Population Health Advisor for Lake Health District.

Pharmacist Services at CMH-OHSU Primary Care Clinics

EMILY SULLIVAN, PHARMD, BCACP

ESULLIVAN@COLUMBIAMEMORIAL.ORG

JULY 6, 2023

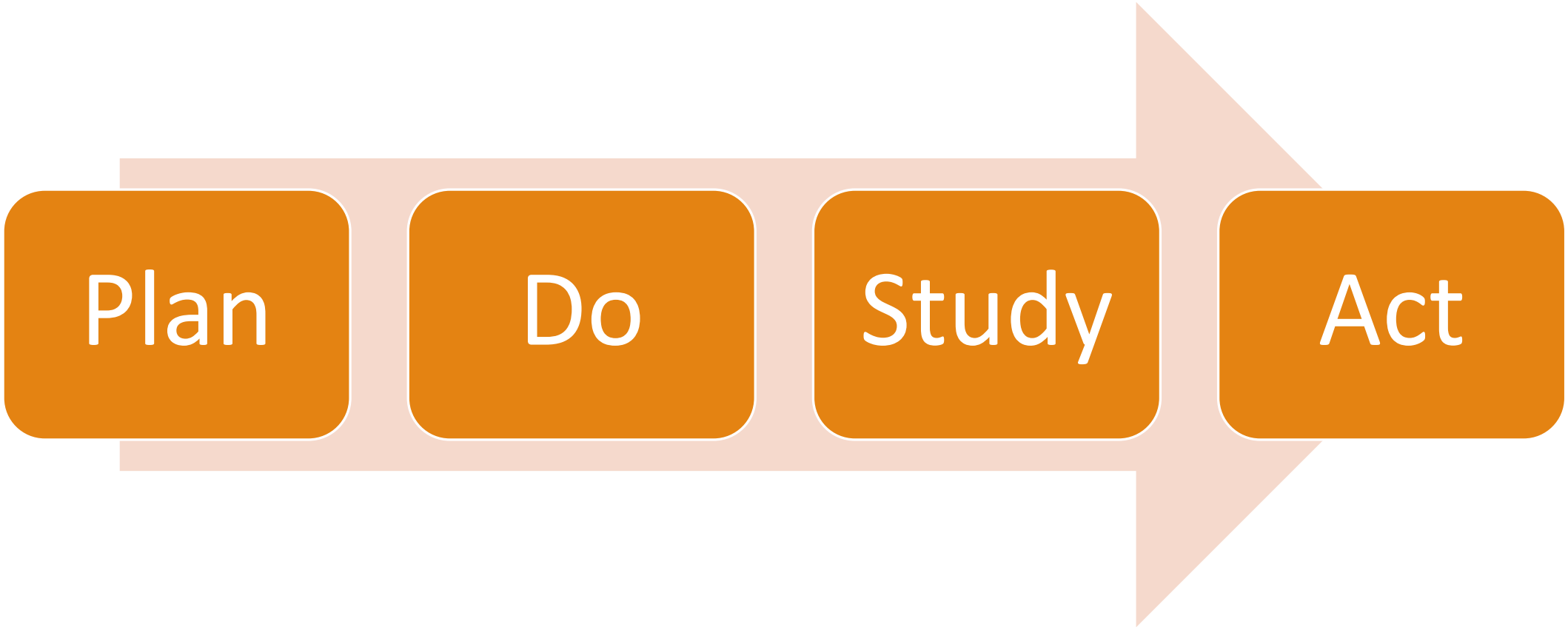
Current State

CMH-OHSU Primary Care

Pharmacist in one clinic five days per week

- Ten 40-minute appointment slots
- Telehealth
- Provider support
  - Drug info questions
  - Insurance problems

How did we get here? (And where do we go from here?)



Plan

Establish Partnerships

Assess Current State

- Provider Access
- Medicare Benchmark Metrics

Policies, Procedures, and Collaborative Practice Agreements

Avenues for Reimbursement

Interested Parties

- Administration
- Providers

Do: Start SMALL

Seaside Rural Health Clinic

August 2020 →

Seeing patients during pharmacy operations

Warrenton Rural Health Clinic

August 2021→ One dedicated clinic day/week

September 2022 →

Two dedicated days/ week

Astoria Rural Health Clinic

November 2022 → 3 dedicated clinic days/ week

May 2023 → 5 dedicated clinic days/ week

Health Outcomes

MIPS/ MACRA Data

Humanistic Outcomes

Patient satisfaction survey

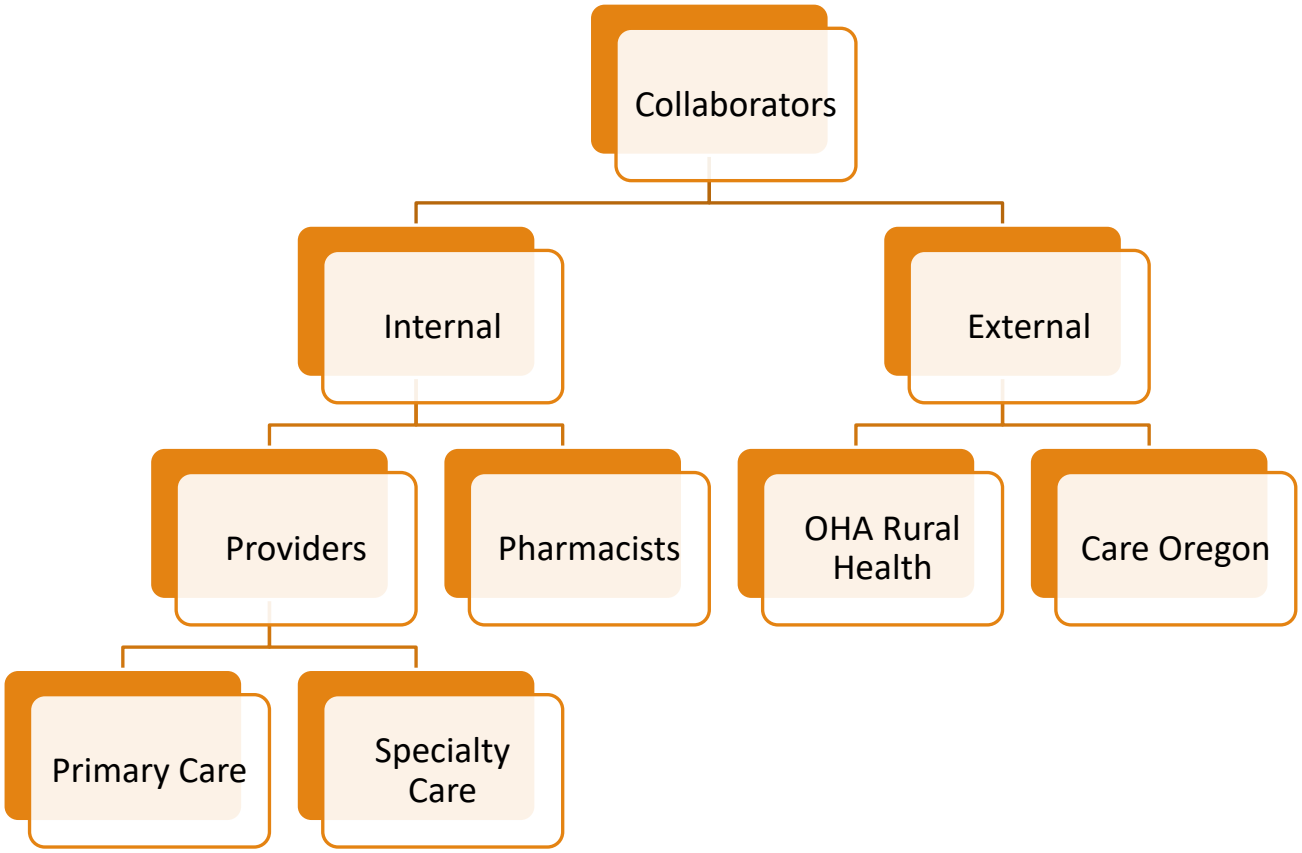
Provider feedback

Unexpected Outcomes

Community pharmacy business

Study

Act: Expand Program



Act: Expand Services

Initial Services

- Blood pressure
- Diabetes
- Behavioral Health

Additional Services

- Hepatitis C
- Pharmacogenomics

Future Services

- Refill Authorization
- 340B Copay Assistance

Act: Program Sustainability

POPULATION HEALTH

Outdoor fitness trail project discovery

Wallowa Memorial Hospital
We Treat You Like Family

"For he who has health has hope; and he who has hope, has everything."
– Owen Arthur

1 **COMMUNITY HEALTH NEEDS ASSESSMENT**

Identifies key health needs and issues through systematic, comprehensivedata collection and analysis.

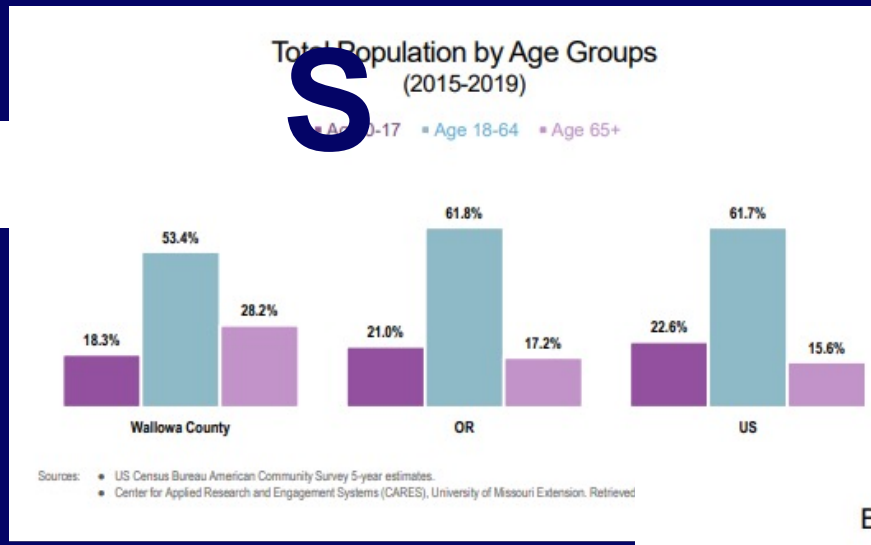
2 **QUALITY COUNCIL**

Group of senior directors tasked with compiling a strategic plan and working with leaders to make strides in working on our organizations initiatives

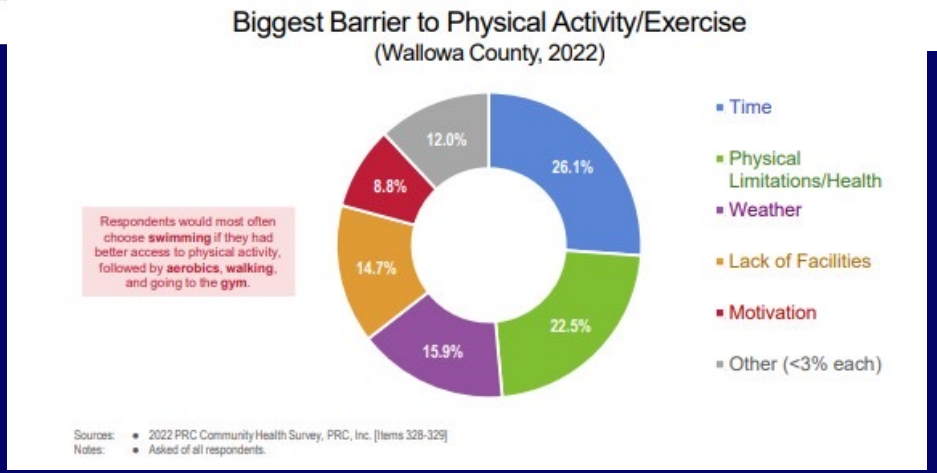
3 **CREATING THE PROGRAM**

Going beyond the numbers by listening to community feedback.

KEY INDICATORS



INJURY & VIOLENCE	Wallowa County	WALLOWA COUNTY vs. BENCHMARKS vs. OR	vs. US	vs. HP2030
Unintentional Injury (Age-Adjusted Death Rate)	67.2	47.2	51.6	43.2
[65+] Falls (Age-Adjusted Death Rate)	109.2	99.1	61.6	63.4
Violent Crime Rate	263.4	265.8	416.0	
% Victim of Violent Crime in Past 5 Years	2.4		6.2	
% Victim of Intimate Partner Violence	14.3		13.7	
		better	similar	worse



STRATEGIC PLANNING

1) Population Health (Community)

a. Analyze Community Health Needs Assessment
b. Identify the top 3 priorities for 2022
   i. Mental Health
   ii. Chronic Conditions
   iii. Healthy Behaviors
c. Partner with community stakeholders to create and achieve an actionable goal (smart goal in each of the three priority areas)

2) Cost Reduction Strategies (Finance)

a. Departments to stay under the 3.4% cost growth target
b. Standardization of purchasing of materials
c. Achieve a 5 Star CMS rating with a focus on the cost of care by condition

3) Coordination of Patient Care (Quality)

a. Survey comparable hospitals for discharge planning certification skills and abilities, job requirements, and outcomes metrics
b. Achieve industry and DNV standard of care for discharge planning
c. Include a discharge plan in the clinical review process, to include a review of cases in Quality Committee for adverse outcomes, such as emergency department or hospital readmissions.
d. Achieve target for bedside rounding rates

4) Streamlining of Processes (Service)

a. Three processes for improvement identified by the Quality Council that are

DEVELOPING THE PROGRAM

Collaboration/Working Outside of Departmental Silos

- Physical Therapy
- Quality

Spaghetti Method - How do you eat an elephant?

Challenges

Program evaluation

NEXT STEPS

1. Add equipment
2. Extend season of use
3. Analyze data
4. Begin planning for the next initiative

THANK YOU!

Wallowa Memorial Hospital

We Treat You Like Family

Lake Health District

Population Health Grant Summary

CARES – Controlling Abnormal Risk through Engagement and Screening

Paul B McGinnis, MPA

Population Health Advisor

July 6, 2023

Lake Health District

Quality Care Close to Home

Lake Health District

- CAH Hospital – Lake District Hospital
- Lake Health Clinic
- Lake Specialty Clinic
- Public Health- Lake County Public Health
- Community Mental Health Program- Lake District Behavioral Health
- Emergency Medical Services

Lake Health District
Quality Care Close to Home

How can we use “risk scores” to improve health?

- One score is provided by the Eastern Oregon CCO (high, moderate, low). Each EOCCO plan member has a risk score.
- Cerner EHR (Numerical value, with “1” being baseline in which the score goes up or down from there. Each patient in the EHR has an individual risk score).

Lake Health District
Quality Care Close to Home

PICO

- P- Population
- I- Intervention
- C- Control Group
- O- Outcomes

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Quality Care Close to Home

Population

- EOCCO members at moderate risk- 27 members
- No primary care utilization last 12 months
- Patients share four diagnoses 48% have hypertension, 22% have diabetes, 33% have anxiety, and 19% have depression

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Quality Care Close to Home

Intervention

- Re-establish relationship through outreach- phone, letters etc.
- Schedule and connect the patients to a Primary Care Provider
- Using a Traditional Health Worker(THW), implement the PRAPARE screening tool
- THW to connect them with health resources- Behavioral Health etc.
- THW to connect them to community resources for Social Determinants of Health – food, housing etc.
- Use EOCCO Flexible Service Funding if needs fall outside of traditional health insurance coverage

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Quality Care Close to Home

Control

- We randomly spilt the 27 moderate risk patients into two groups
- Half receive the intervention the others are left alone to behave as they would on their own

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Quality Care Close to Home

Outcome(s)

- We expect to see the intervention group NOT move into HIGH risk
- We will track movement of risk in both groups
- We expect better management and control of chronic conditions for the intervention group
- We will look at overall use of health services both groups
- We will look at overall health expenditures for both groups
- We will document connections to community-based resources

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Quality Care Close to Home

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Questions?

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Thank you!

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