Small Rural Hospital Transition (SRHT) Project Guide

A Guide for Rural Hospitals to Identify Populations and Shift to Population Health

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NATIONAL RURAL HEALTH RESOURCE CENTER

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PREFACE

This guide was developed to provide rural hospital executive and management teams with a practical approach to understanding population health essentials and the data needed for population health initiatives. Hospital teams will learn how to identify key patient populations by examining the small portion of the population that is responsible for a very large percentage of total health spending. Hospital teams will gain a greater understanding of how to determine which patient populations to target, their initiatives, and where to direct resources to improve quality and outcomes and reduce the cost of care. This guide will provide hospitals a process to initiate population health for a targeted group and integrate population health initiatives as part of an organization's strategy. The guide is also designed to assist State Offices of Rural Health directors and Flex Program coordinators in gaining a better understanding of the best practices so that they may develop educational training to further assist rural hospitals with transition of health care to value-based payment models.

The information presented in this guide is intended to provide the reader with general guidance. The materials do not constitute, and should not be treated as, professional advice regarding the use of any particular technique or the consequences associated with any technique. Every effort has been made to assure the accuracy of these materials. The National Rural Health Resource Center (The Center), the Small Rural Hospital Transition (SRHT) Project, Stroudwater Associates 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 particular fact situation, and should independently determine the correctness of any particular planning technique before recommending the technique to a client or implementing it on a client's behalf.

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PURPOSE OF THE GUIDE

The health care environment has experienced considerable change in the last 24 months, with an increased focus on payment systems transitioning from volume to value; increased weight on quality and patient outcomes; and a greater emphasis on population health. Delivering the right care at the right time in the right setting requires highly coordinated patient-care teams connected by real-time data acting prospectively as well as understanding patient needs. Every patient is unique. Stratification of patient populations with customized care solutions for each group is the new imperative.

This guide contains four key objectives.

1. Develop a practical approach to population health for rural hospitals;
2. Evaluate an organization's readiness to move forward with population health initiatives;
3. Learn five ways boards can be educated and engaged; and
4. Understand how the results from a robust population health assessment can be used within a framework to sustain gains with targeted population health initiatives.

The guide is developed to provide rural hospital executive and management teams with a practical approach to understanding population health data and management. Hospital teams will learn how to identify key patient populations by examining that small portion of the population that is responsible for a very large percentage of total health spending. Hospital teams will gain a greater understanding of how to determine which patient populations to target, their initiatives, and where to direct resources to improve quality and outcomes and reduce the cost of care. A population health readiness assessment is included to inform executive teams of the organization's readiness to transition to the new health care environment and move forward with population health initiatives effectively. The readiness assessment will let rural hospitals determine their starting point and allow them to understand the characteristics of well-positioned rural hospitals to initiate population health and their readiness to move forward.

This guide will provide hospitals a process to initiate population health for a targeted group and integrate population health initiatives as part of an organization's strategy. The role of a hospital's board in understanding

population health as a strategic theme is discussed, and board education is key to evolving a population health strategy. Empowering board members to improve population health through value-based care is one objective of this guide.

This guide will also assist rural hospitals transitioning to being paid for value instead of volume. The timing is absolutely critical because transitioning the delivery system must coincide with the transitioning payment system of rural hospitals. Rural hospitals must survive the gap between pay for volume and pay for performance. The delivery system has to remain aligned with the current payment system while the hospital seeks to move to a population health framework. Board, executive team and provider education and engagement are crucial if population health is to be an organizational priority.

BACKGROUND

Why rural hospitals need to move to the new health care environment

In the past 24 months, the health care field has experienced considerable change. On January 26, 2015, Centers for Medicare and Medicaid Services (CMS) revealed Better Care, Smarter Spending, Healthier People: Paying Providers for Value Not Volume. The CMS fact sheet states: "When it comes to improving the way providers are paid, we want to reward value and care coordination, rather than volume and care duplication." In partnership with the private sector, the Department of Health and Human Services (HHS) is testing and expanding new health care payment models that can improve health care quality and reduce its cost. HHS has adopted a framework that categorizes health care payment according to how providers receive payment to provide care.[1]

Category 1: fee-for-service with no link of payment to quality

Category 2: fee-for service with a link of payment to quality

[1] http://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2015-Fact-sheets-items/2015-01-26-3.html

Category 3: alternative payment models built on fee-for-service architecture

Category 4: population-based payment

Value-based purchasing includes payments made in categories 2 through 4. Moving from category 1 to category 4 involves two shifts: (1) increasing accountability for both quality and total cost of care and (2) a greater focus on population health management as opposed to payment for specific services. Overall, HHS seeks to have 85 percent of Medicare fee-for-service payments in value-based purchasing categories 2 through 4 by 2016 and 90 percent by 2018."[2] When CMS adopts a health care payment system based on value and population health, other payors will follow suit. In addition to the HHS Fact Sheet, we can anticipate the following:

- Federal health care reform passed in March 2010 will include more substantive changes similar to the 2015 HHS Fact Sheet;
- State Medicaid programs are moving toward managed care models or reducing fee-for-service payments to balance state budgets;
- Commercial insurers are consolidating and steering patients to lower cost options;
- Retail medicine will be a major disruptive attribute and include organizations such as Walmart and CVS with highly distributed networks and well positioned delivery sites;
- High deductible health plans will increase;
- Inpatient use will decease;
- Bundled payment and value-based purchasing initiatives will grow; and
- The number of Accountable Care Organizations (ACOs) will rise.

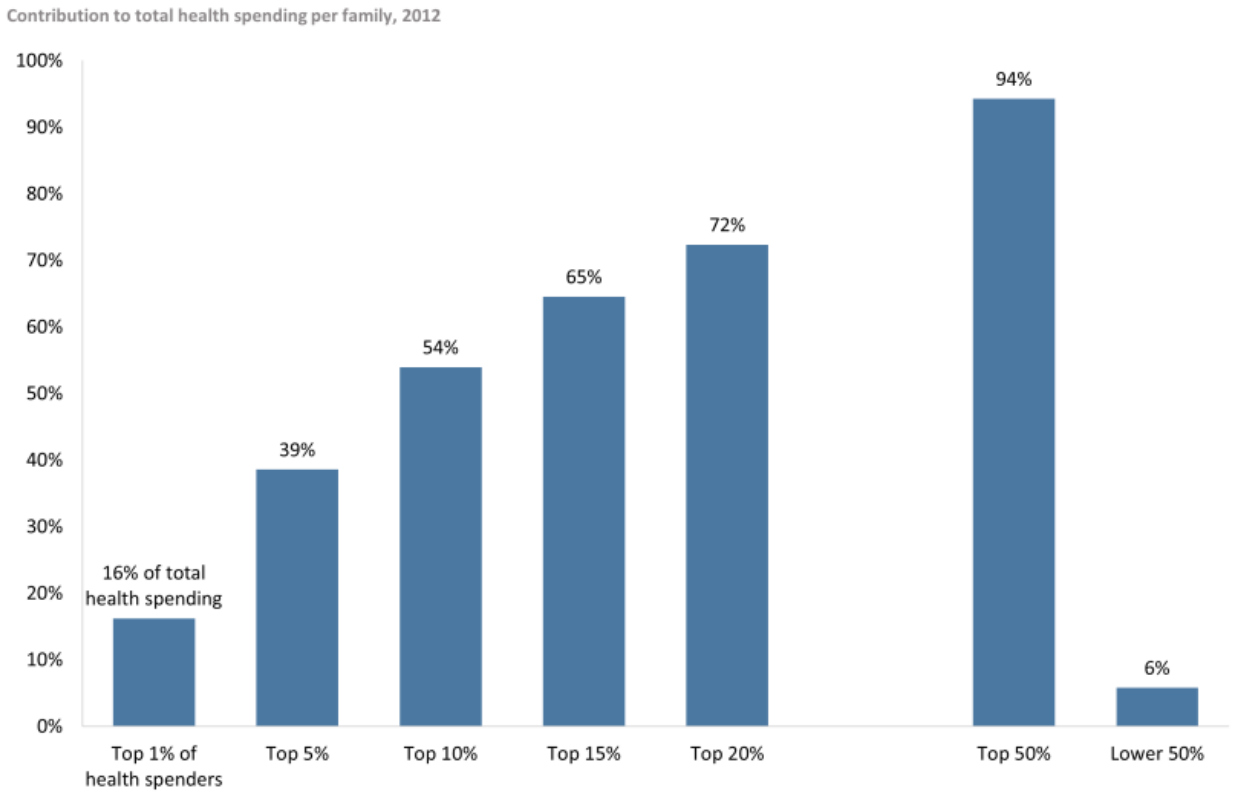
The implications for rural hospitals are significant. For the future, it is clear that quality, lower per capita spending and population health will be required as rural hospitals move to the new health care environment.

[2] http://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2015-Fact-sheets-items/2015-01-26-3.html

Review of Kaiser Family Foundation Analytics on Health Care Spending by Age Cohort

According to the Kaiser Family Foundation, in a given year, a small portion of the population is responsible for a very large percentage of total health spending. The following graphics explore the variation in health spending across the population through an analysis of the 2012 Medical Expenditure Panel Survey (MEPS) data. Graph 1 shows that the 5% of the population with the highest spending accounted for over one-third of health spending (39%) and that the top 10% of the population is responsible for over half of all spending.

Graph 1: Contribution to Total Health Spending Per Family (2012)

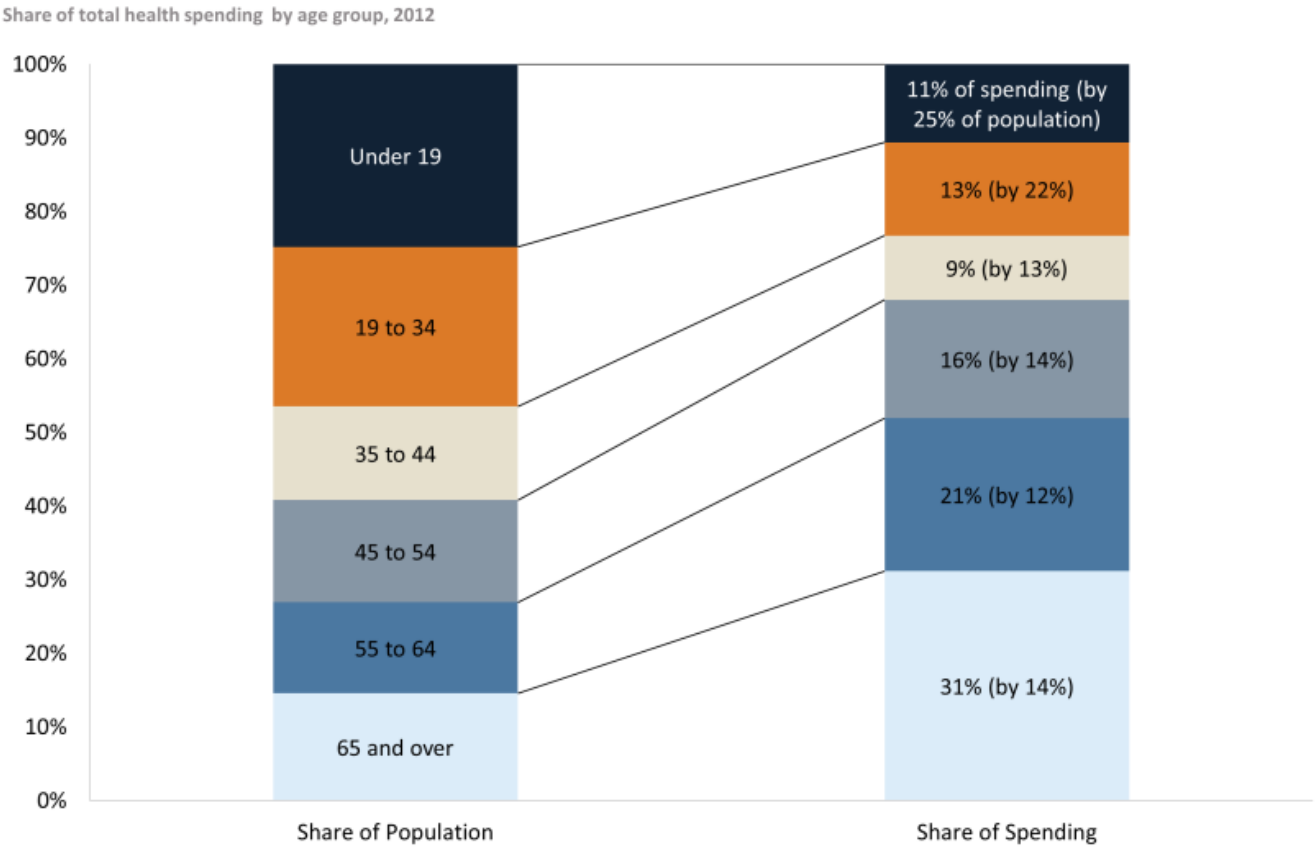


Source: Kaiser Family Foundation analysis of Medical Expenditure Panel Survey, Agency for Healthcare Research and Quality, U.S. Department of Health and Human Services

Peterson-Kaiser Health System Tracker

Graph 2 examines spending variation across various demographic and health factors, including age, gender, race, insurance status and presence of certain health conditions. The key to understanding population health is knowing this variation in health spending across cohorts. This spending variation can be replicated in many settings and is critical to defining population health and our patients at most risk.

Graph 2: Share of Total Health Spending by Age Group (2012)



Source: Kaiser Family Foundation analysis of Medical Expenditure Panel Survey, Agency for Healthcare Research and Quality, U.S. Department of Health and Human Services

Peterson-Kaiser Health System Tracker

POPULATION HEALTH IDENTIFICATION PROCESS

Step 1: Define the Determinants of Population Health

According to David Kindig, MD, PhD, population health is defined as the health outcomes of a group of individuals, including the distribution of such outcomes within the group. These groups are often geographic populations or communities, but can also be other groups such as employees, age cohorts, disease categories or any other defined group. There are generally five determinants of population health.

Health care determinants typically include access, cost, quantity and quality of health care services. Each of these has an impact on the health status of the populations we serve and each rural hospital needs to gain an understanding of the access, cost and quality issues in the communities it serves.

Individual behavior determinants include choices about lifestyle or habits such as diet, exercise and substance abuse. We know that these are the contributors to the leading causes of death and most often are the underlying determinants of chronic diseases. As you will see later in this guide, the high-risk and high-cost patients often have five or more chronic diseases.

Genetic determinants include the genetic composition of individuals or populations. Genetic factors account for approximately 40% of an individual's health status.

Social environment determinants include elements of the social environment such as education, income, occupation, class and social support. Sometimes, the fundamental underlying determinant of health status relates to the social environment.

Physical environment determinants include elements of the natural and built environment such as air and water quality, lead exposure, and the design of neighborhoods.

Hence, rural hospitals can have a significant impact of population health. Rural hospitals' primary care base positions them to coordinate care globally, understand the determinants of health, and have a significant positive impact on the underlying causes of disease.

According to *A Healthier America 2014*, millions of Americans suffer from diseases that could have been prevented:

- Chronic diseases, such as type 2 diabetes and heart disease, are responsible for seven out of 10 deaths, 75 percent of the $2.5 trillion spent on U.S. medical care costs and billions of dollars in lost productivity each year.
- Infectious diseases, from the antibiotic-resistant superbugs to salmonella to the seasonal flu, disrupt lives and communities and result in more than $120 billion in direct costs and enormous indirect costs.
- More than half of Americans are living with one or more serious, chronic disease, ranging from type 2 diabetes to cancer. Those rates are expected to increase significantly over the next two decades, particularly due to the obesity epidemic.
- Each rural hospital should have its own definition of population health and define the subsets of the population that need the greatest care. Often, these are patients who suffer from diseases that could have been prevented.

Understand the New Language of Insurance and Population Health and Use Analytics Effectively to Manage Population Health

Staying current on the new language of insurance and population health presents significant challenges to boards and executive teams. Fortunately, there are some useful resources accessible via the internet. A book by Peter R. Kongstvedt, Health Insurance and Managed Care, Fourth Edition, 2015 published by Jones and Bartlett Learning is recommended. Another helpful source is a Health Care Terminology Glossary. ,. The new language and terminology are extremely important and can be more complex in health care than in other industries. In the new health care environment, rural hospitals will be responsible for population cohorts, so it is important to identify populations at high risk in the following categories:

- Children
- Adults
- Elderly

Assess each population by selecting a risk tool for each cohort and intervene by drilling down into each population and choosing appropriate interventions. Analytics, using public, private, hospital and payor data to manage population health, are critical.

Step 2: Conduct a Population Health Readiness Assessment

The fundamental role of a hospital is changing rapidly, moving away from a physical location where patient care is provided to the centerpiece of a highly integrated rural health system for residents of a rural community. To be successful, health systems of the future will assume financial, quality, satisfaction and population health accountability for their communities and will take on a new set of strategies, philosophies and performance metrics. An early adopter of population health is viewed as a leader in developing and implementing novel (and advantageous) reimbursement models based on value (cost and quality) and other parameters specific to the health system. Payer contracting capabilities are viewed as a strategic advantage rather than a process where the health system plays a subordinate role to third-party payers. Short-term opportunities include public and commercial shared savings programs and population health initiatives related to care management, Patient Centered Medical Homes and the use of informatics to identify high-risk and high-cost patients.

The Transition Framework Self-Assessment in Appendix B assists organizations in determining readiness. It sets forth the characteristics of a rural system/hospital that is well positioned to assume responsibility for population health. Once an organization understands the new language of insurance and analytics to manage population health, it is critical to determine the organization's readiness to shift to population health.

Step 3: Provide Board Education

Rural hospital boards have every reason to feel overwhelmed by the challenge of moving from fee-for-service to value-based care. Value-based care places greater emphasis on primary care and population health. Population health and value-based care require boards to be engaged and educated. Five ways to ensure that boards are engaged and educated follow.

Boards must understand that the health care environment has changed

The payment system is transitioning from volume-based to value-based reimbursement with an increased emphasis on quality as a payment and market differentiator. The new environmental challenges are the Triple Aim, including board priorities around per capita cost, experience of care and population health.

Boards must understand the challenges affecting rural hospitals

There are several factors that will have a significant impact on rural hospitals over the next five years. Given the aging of the medical staff, rural hospitals will find it difficult to recruit providers and may struggle to pay market rates. There is increasing competition from other hospitals and providers for limited revenue opportunities. Market competition is based on a new economic driver of health care, patient value and understanding the segment of our patient population that represents the highest risk and consumes most of the cost.

Boards must develop a plan to transition to the new delivery system

Transitioning the delivery system must coincide with the transitioning payment system because without adequate reserves, rural hospitals will be at financial risk. It is necessary for hospitals to remain aligned with the current payment system while seeking to implement population health initiatives.

Boards must adopt an implementation framework

A strategic framework has been developed to assist organizations to transition from a payment system dominated by the fee-for-service payment model to one dominated by population-health-based payment models. This strategic framework is outlined in Appendix A. The evolution of the payment system in each hospital's market requires the creation of an integration vehicle so that providers can contract for covered lives, create value through active care management and monetize the creation of value.

Boards must integrate population health into the hospital's strategic plan

Boards have the ultimate responsibility to set the organization's preferred future or vision. Every rural hospital should include five key initiatives in its strategic plan to ensure a successful transition to population health.

Step 4: Strategy Integration

Every strategic plan should identify the transition to population health as a priority and should include the following 5 themes:

Operating efficiencies, quality and patient engagement

Each rural hospital should commit to delivering high quality, safe, patient-centered care by integrating continuous performance improvement, evidence-based medicine and customer-focused service into every aspect of the system.

Primary care network alignment

Every rural hospital should develop a coordinated, seamless primary care system that provides a high quality experience for patients, caregivers and providers. Understanding the primary care needs of patients is critical to population health.

Clinical service network alignment

Each rural hospital should align/partner with high quality providers to ensure appropriate access to specialists, technology and facilities to meet community population health needs in the future.

Care management organization

Each rural hospital must work locally and throughout the region to develop a cohesive care management model that will ultimately integrate care delivery and financing. This model will aim to improve the health of community members, leading to a successful population health model and caring for the highest risk and most expensive patients.

Transition and align payment systems

Each rural hospital board commits to proactively transitioning from fee-for-service to a population-based approach of reimbursement, maintaining alignment between payment and delivery system/community care organization transitions.

Board education and engagement in these five areas form the backbone for the organization's population health strategy. Board governance will profoundly change with the complete departure from the fee-for-service model to value-based population health. The initial challenge will be for boards to think outside the four walls of the hospital. This requires leadership that takes the long view, identifies the care gaps and provides an integral care coordination role so our most costly and sickest patients receive evidence-based care. Finally, a new language emerges in the boardroom that shifts the focus from episodic care to population health.

Step 5: Develop Your Five-Year Insurance Projections

In order to understand the population health market, two sets of analytics need to be reviewed. The first set of analytics is a five-year insurance projection (refer to Figure 1 below). In a traditional sense, think of this as analogous to inpatient and outpatient market share, except we are considering a different market. Hospitals now have care coordination responsibility for a number of covered lives regardless of where care is managed or delivered. This is a much more expansive marketplace.

The first set of analytics to understand is your hospital's market's five-year insurance projections of covered lives. These five-year insurance projections become more important when you determine the total annual revenue

estimates for the market, which is calculated by multiplying the per member per month (PMPM) revenue times the number of lives in each insurance category. This revenue and care coordination opportunity often exceeds the net revenue of a rural hospital. Below is an example of five-year insurance projections for Greater Portland, Maine.

Figure 1: Five Year Insurance Projections

Greater Portland

Five Year Population Projection	2014 Estimate	2019 Projection	2014-2019 Abs. change	2014-2019 % change
00-17	*45,293*	*43,531*	*-1,762*	*-4%*
18-44	*77,941*	*76,574*	*-1,367*	*-2%*
45-64	*67,930*	*67,964*	*34*	*0%*
65+	*34,394*	*40,600*	*6,206*	*18%*
	225,558	228,669	*3,111*	*1%*

2014 Household Income: $61,116

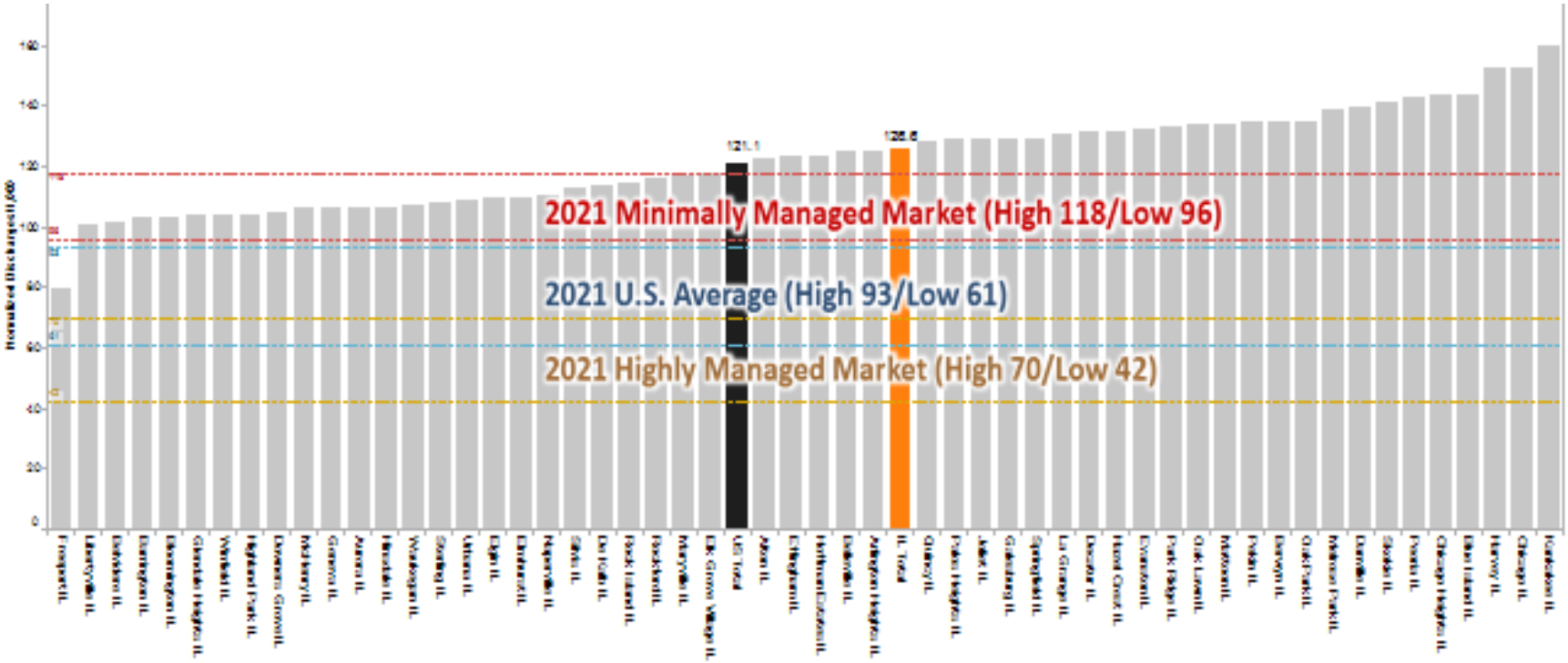
Ten Year Insurance Projection	2014 Lives	2024 Lives	2014 Lives % of Total	2024 Lives % of Total
Medicaid	35,590	33,221	15.78%	14.31%
Medicaid Expansion Population	0	0	0.00%	0.00%
Medicare	27,841	37,069	12.34%	15.97%
Medicare Dual Eligible	9,191	11,284	4.07%	4.86%
Private - Direct	9,785	9,333	4.34%	4.02%
Private - ESI	121,457	118,592	53.85%	51.09%
Private - Exchange	4,449	12,997	1.97%	5.60%
Uninsured	17,246	9,618	7.65%	4.14%
Grand Total	225,558	232,114	100.00%	100.00%

Source:Truven Health Analytics

Age normalized use rate comparisons

The second set of analytics to understand is age normalized use rates locally, statewide and nationally. Graph 3 below show the use rates for the State of Illinois compared to the United States with regional comparisons. This analysis gives a rural hospital an excellent idea of the type of managed care market in which they are located and an understanding of the discharges that may be at risk for significant reductions. Understanding the level of managed care today and through 2021 is fundamental to understanding population health.

Graph 3: Age Normalized Use Rate Comparisons – Discharges/1,000



Step 6: Conduct a Population Health Assessment

A population health assessment is used to assess community health status and to identify disparities in care coordination. It is also used to promote a shared understanding of the wide range of factors that can influence health and mobilize collaborative partnerships to work together to improve population health. A robust population health assessment identifies the underlying factors that determine health. An ideal place to begin a population health assessment is to review the 2015 CDC Community Health Status Indicators (CHSI).

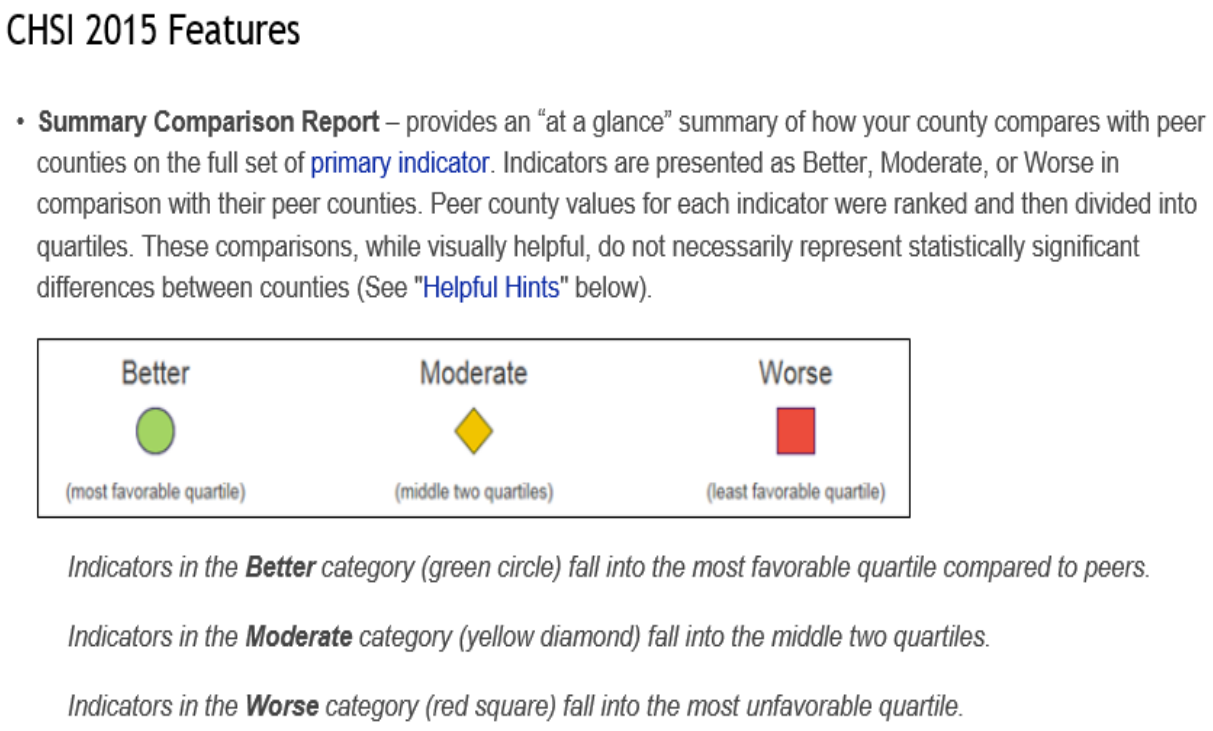
CDC Community Health Status Indicators (CHSI) and Target Setting

"CHSI 2015 is an interactive web application that produces health profiles for all 3,143 counties in the United States. Each profile includes key indicators of health outcomes, which describe the population health status of a county and factors that have the potential to influence health outcomes, such as health care access and quality, health behaviors, social factors and the physical environment."

The CHSI 2015 category of health outcomes includes specific indicators of mortality and morbidity, which represent the aggregate disease burden in a community. The 2015 CHSI indicators that have the potential to influence health outcomes include health care access and quality, health behaviors, social factors and physical environments. CHSI 2015 does not include a category of genetic endowment because genetic actors are not typically modifiable.

One of the great features of the CHSI reports, beyond their being available at no cost, is the summary comparisons, which is outlined in Figure 2 below.

Figure 2: CHSI 2015 Features of the Summary Comparison Report



CHSI 2015 Features

- **Summary Comparison Report** – provides an "at a glance" summary of how your county compares with peer counties on the full set of primary indicator. Indicators are presented as Better, Moderate, or Worse in comparison with their peer counties. Peer county values for each indicator were ranked and then divided into quartiles. These comparisons, while visually helpful, do not necessarily represent statistically significant differences between counties (See "Helpful Hints" below).

Better	Moderate	Worse
(most favorable quartile)	(middle two quartiles)	(least favorable quartile)

*Indicators in the **Better** category (green circle) fall into the most favorable quartile compared to peers.*

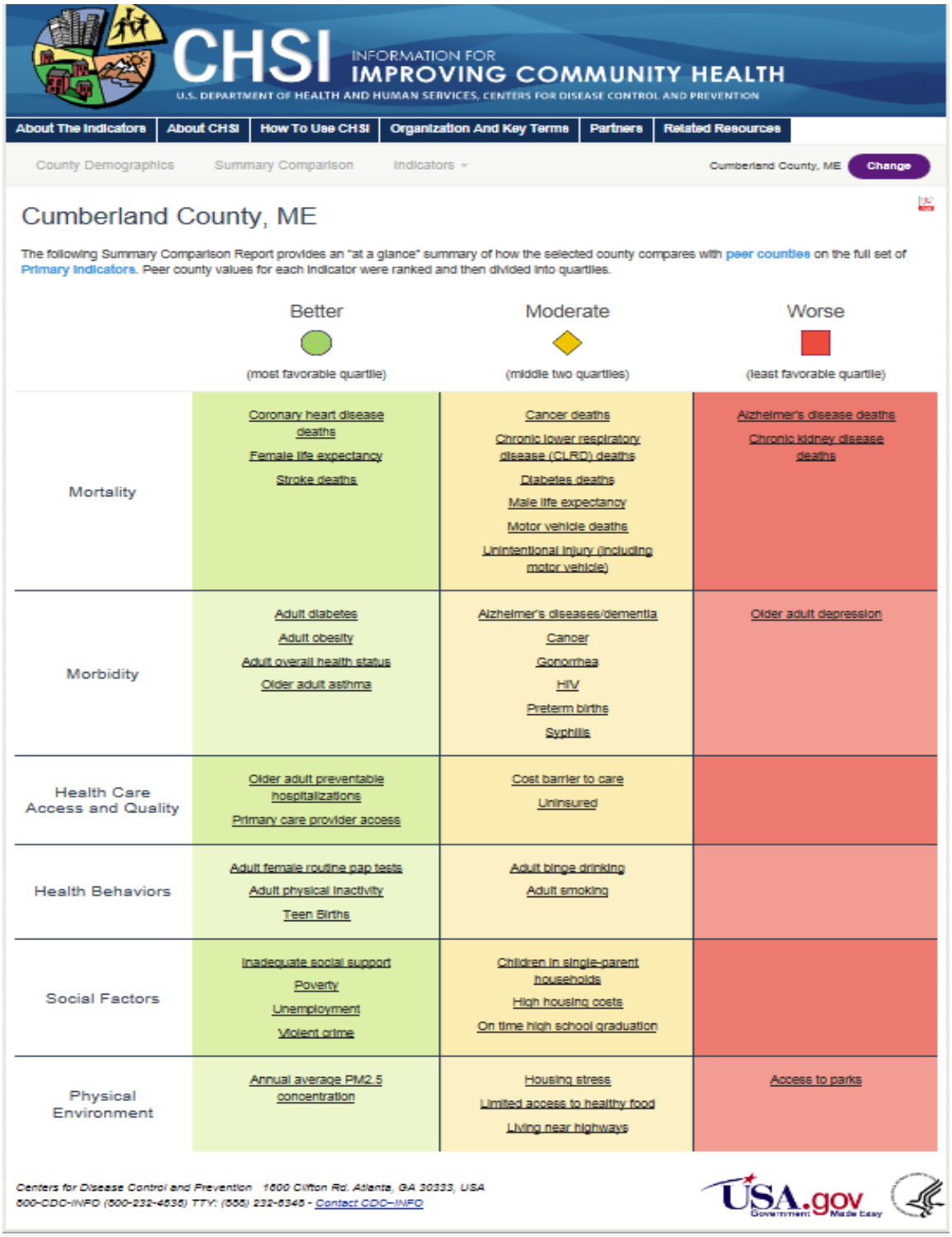
*Indicators in the **Moderate** category (yellow diamond) fall into the middle two quartiles.*

*Indicators in the **Worse** category (red square) fall into the most unfavorable quartile.*

The summary reports show peer counties, indicator downloads with descriptions, census track maps and median values for all US counties as well as *Healthy People 2020* targets. Figure 4 below provides an example of a CHSI summary report reviewing Cumberland County in Maine, which includes the city of Portland.

Population health priorities can be set using the results from the bottom three quartiles. CHSI can assist a hospital to begin the population health priority assessment process. In addition, population health targets can be set utilizing the *Healthy People 2020* feature of CHSI.

Figure 4: Primary Indicators - Peer County Report Example[3]



CHSI INFORMATION FOR IMPROVING COMMUNITY HEALTH

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, CENTERS FOR DISEASE CONTROL AND PREVENTION

About The Indicators | About CHSI | How To Use CHSI | Organization And Key Terms | Partners | Related Resources

County Demographics | Summary Comparison | Indicators | Cumberland County, ME | Change

Cumberland County, ME

The following Summary Comparison Report provides an "at a glance" summary of how the selected county compares with peer counties on the full set of Primary Indicators. Peer county values for each indicator were ranked and then divided into quartiles.

	Better (most favorable quartile)	Moderate (middle two quartiles)	Worse (least favorable quartile)
Mortality	Coronary heart disease deaths Female life expectancy Stroke deaths	Cancer deaths Chronic lower respiratory disease (CLRD) deaths Diabetes deaths Male life expectancy Motor vehicle deaths Unintentional injury (including motor vehicle)	Alzheimer's disease deaths Chronic kidney disease deaths
Morbidity	Adult diabetes Adult obesity Adult overall health status Older adult asthma	Alzheimer's diseases/dementia Cancer Gonorrhea HIV Preterm births Syphilis	Older adult depression
Health Care Access and Quality	Older adult preventable hospitalizations Primary care provider access	Cost barrier to care Uninsured	
Health Behaviors	Adult female routine pap tests Adult physical inactivity Teen Births	Adult binge drinking Adult smoking	
Social Factors	Inadequate social support Poverty Unemployment Violent crime	Children in single-parent households High housing costs On time high school graduation	
Physical Environment	Annual average PM2.5 concentration	Housing stress Limited access to healthy food Living near highways	Access to parks

Centers for Disease Control and Prevention 1600 Clifton Rd. Atlanta, GA 30333, USA
800-CDC-INFO (800-232-4636) TTY: (888) 232-6348 - Contact CDC–INFO

USA.gov Government Made Easy

[3] Centers for Disease Control and Prevention, Community Health Status Indicators

Chronic Illness and Population Health Priorities

More than 125 million Americans suffer from one or more chronic illnesses and 40 million are limited by them. Despite annual spending of nearly $1 trillion and significant advances in care, one half or more of patients still do not receive appropriate care. Gaps in quality care lead to thousands of avoidable deaths each year. Best practices could eliminate an estimated 41 million sick days and more than $11 billion annually in lost productivity. Patients and families increasingly recognize the defects in their care. Chronic diseases and conditions such as heart disease, stroke, cancer, diabetes, obesity, and arthritis are among the most common, costly, and preventable of all health problems. Seven of the top ten causes of death are chronic diseases. The link between population health priorities and chronic illness is a very good place to organize initiatives because these chronically ill patients represent both high risk and high cost.

Blue Zones

National Geographic writer Dan Buettner has traveled the globe to uncover the most effective strategies for longevity and happiness. He identified Blue Zones—places that have the greatest life expectancy and where more people reach age 100 than anywhere else. Working with a team of experts, Buettner distilled their secrets into nine common denominators he calls Power 9®. Dan debunks the most common myths and offers a science-backed blueprint for the average American to live an additional 12 quality years.

In 2009, Albert Lea, Minnesota, a statistically average American city, completed a one-year community health experiment that raised life expectancy by three years, trimmed a collective 12,000 pounds off waistlines and dropped health care costs of city workers by some 40%. USA Today, Good Morning America, AARP, ABC Nightline, CNN and U.S. News and World Report all covered the story. Harvard's Dr. Walter Willett, writing in Newsweek magazine, called the results "stunning." Dan Buettner, founder and director of the AARP/Blue Zones Vitality Project, created a "perfect storm" of health that transformed a city. On his website, he tells the fascinating story of how one typically obese American city of 18,000 reversed the trend and also got happier.

Step 7: Adopt a Population Health Framework

There are two excellent population health frameworks. The National Rural Health Resource Center framework takes a systems-based approach to population health and the National Quality Forum uses a four-step process from health risk assessment to intervention and evaluation.

The National Rural Health Resource Center Performance Excellence Framework for Population Health

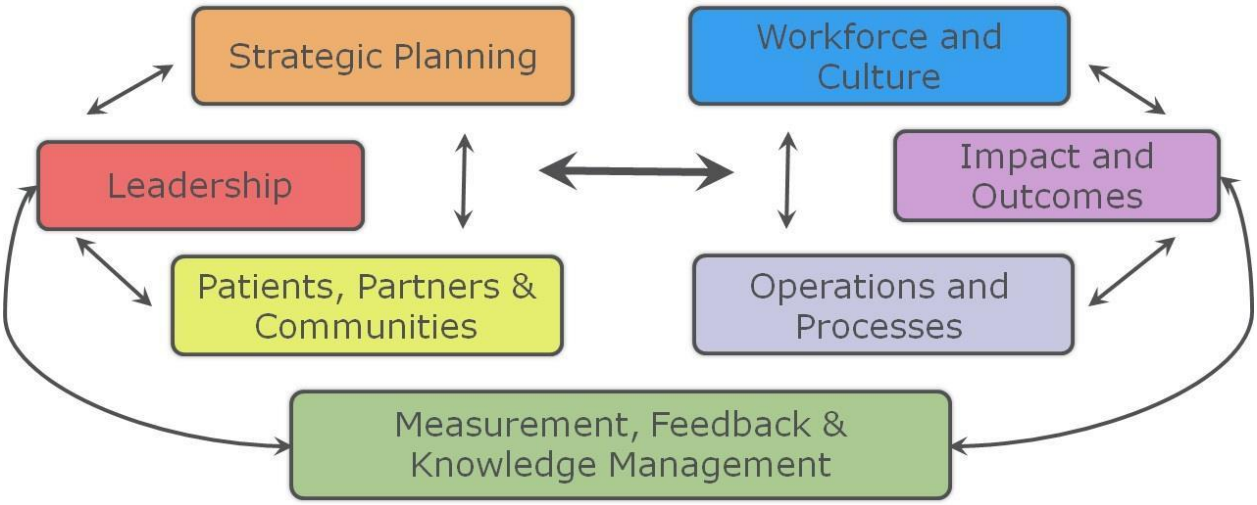
The National Rural Health Resource Center (The Center) has encouraged the adoption of a systems-based approach modeled after the Baldrige Framework for Performance Excellence in managing hospital complexities and striving toward excellence in quality and safety. The Center's Performance Excellence Blueprint provides a proven approach to managing the crucial elements of organizational excellence desperately needed in this rapidly changing health care environment. This comprehensive approach, which includes the ability to measure and show value, can also help hospitals frame the essential components for adoption of population health as an integral strategy. Without using a framework to provide a comprehensive systems-based approach, hospitals often struggle to:

- Align leadership
- Conduct meaningful strategic planning
- Assess customer, community and partner needs
- Measure progress and review relevant information to address problems
- Engage and motivate staff
- Streamline processes
- Document outcomes

A systems approach provides hospitals a Blueprint to address all of the essential components and avoid breakdowns in other component areas that are not managed effectively. Meaningful work must be done in all these component areas to maximize a hospital's chance of achieving the transition to a wellness model of care. A performance excellence framework such as Baldrige is a useful tool for achieving sustainability in a rural setting. Figure

5 below demonstrates the key inter-linked components of the Baldrige Framework.

Figure 5: Performance Excellence Blueprint[4]



The Center suggests a number of critical success factors:

- Develop awareness and provide education on the critical role of population health in value-based reimbursement
- Shift hospital culture, processes, facilities and business models to include a focus on population health
- Incorporate population health approaches as part of ongoing strategic planning processes
- Engage multiple stakeholders and partners to coordinate strategies aimed at improving the population's health
- Prioritize – what are the one or two things that would make the biggest difference for the population you serve?
- Use the community health needs assessment (CHNA) process as an opportunity for community and patient engagement

[4] http://www.ruralcenter.org/tasc/resources/critical-access-hospital-blueprint-performance-excellence
Adapted from Baldrige Criteria for Performance Excellence: www.nist.gov/baldrige/index.cfm

- Articulate vision of hospital contributing to population health based on community conversations
- Develop a workforce culture that is adaptable to change in redesigning care to address population health
- Utilize health information technology (HIT) (such as electronic medical records, health information exchange and telemedicine) to support population health goals
- Identify measurable goals that reflect community needs
- Utilize data to monitor progress towards strategic goals on population health

A comprehensive systems approach to population health aligns leadership, engages providers and staff, collects relevant information and documents outcomes.

The National Quality Forum Framework

The National Quality Forum Framework is a four-step process from health risk assessment to intervention and evaluation. According to the National Quality Forum[5], an effective population health framework addresses as many as possible of the following nine key criteria elements:

1. An organizational planning and priority-setting process
2. A health risk assessment process
3. An agreed-upon, prioritized subset of population health improvement activities
4. Leadership in population health improvement activities
5. Selection of a set of measures or indicators and performance targets
6. Use of the prioritized indicators
7. Joint reporting on progress toward achieving the intended results
8. A plan for sustainability
9. Indications of scalability

[5] http://www.qualityforum.org/Population_Health_Framework/

A four-step process from health risk assessment to intervention and evaluation.

Step 1: Health Risk Assessment: Provide a Baseline

Understand the severity or likelihood of an adverse health outcome due to an exposure to environmental, biological or social conditions.

First, grade the risk in terms of either severity or likelihood. Severity can be measured in terms of premature mortality, years of healthy life lost, or even the amount of dollars that will be spent on individuals at higher risk.

Second, even though we acknowledge that exposure to risk may not always result in adverse outcomes, determine if there is ample evidence to support assessing specific issues that are related to specific adverse outcomes.

Third, some exposure to unhealthy risk is obviously unavoidable; also, there can be complex interactions between environmental, biological and social conditions.

Step 2: Disease Avoidance or Delay

Disease avoidance and delay can be accomplished in a large population by moving high-risk individuals to low-risk.

If you manage the risks, you manage the costs.

The model of reducing costs by reducing risks holds true for all age groups, even among the most expensive elderly segment of the population (Wellsource 2015).

Step 3: In order to achieve disease avoidance or delay the onset, individuals must be engaged and empowered!

Preliminary research suggests that patient-centered care may reduce use of health care services while improving health status and patient satisfaction.

Step 4: Plan an Intervention and Evaluation Strategy

- Report to stakeholders
- Intervene

- Address key health issues that were identified. Regardless of who actually tackles the interventions, some key questions would include:
- How will you reach the defined target population?
- What resources and funding will be required?
- Who needs to partner with you? Collaboration with care coordination initiatives is important to reducing risk and cost.
- Evaluate
- An evaluation component should be included whenever an implementation is planned

Step 8: Adopt a Comprehensive Transition Framework Moving to Population Health

Population Health Transition Framework in Appendix A assists organizations in transitioning from a payment system dominated by fee-for-service to one dominated by population-based payments. The Population Health Transition Framework is built around the initiatives that must be designed and implemented to make the transition successfully. Each initiative is developed within phases that correspond to payment system changes, with each phase requiring work on its successive initiatives to prepare for implementation as the payment system requires.

Breaking down initiatives by payment system transition phases allows organizations to focus their efforts on preparing and implementing at the most beneficial moment for the organization, thus avoiding getting ahead of the payment system while proactively managing an orderly transition of the delivery system.

THE FOUR INITIATIVES FOR TRANSFORMING THE DELIVERY SYSTEM

Initiative I: Operating Efficiencies, Quality and Patient Engagement

All providers increasingly will compete on quality. Providers also must be able to operate as efficiently as possible and demonstrate their quality and patient engagement initiatives. Aggressively focusing on these dimensions is critical in all phases of the transition and in the future state of population-based payments. Initiative I is a growing priority for providers.

Initiative II: Primary Care Network Alignment

To be successful in a population-based health system, providers must be aligned with their primary care network. This is critical because revenue is tied to covered lives under a population-based payment system, and covered lives are assigned to primary care providers. Hospitals not aligned with a primary care network in their service area will be effectively treated as cost centers, and will be pressured to reduce both service volume and price. Initiative II is implemented in Phase II of the payment system transition.

Initiative III: Service Network Rationalization

Phase III of the payment transition will bring increasing pressure on providers to deliver high-value care to their attributed patient populations. In this phase, providers bear risk for providing care to a defined population within a budget. Low- value providers will become less financially viable, with the imperative at this point in the transition to lower fixed costs of the provider network. Rationalization of the service network means that there will be need-based balancing of specialty care providers, with service delivery driven by providing access to the appropriate care within the network instead of providing the same services in each network location.

Initiative IV: Integrated Delivery and Payment System

To survive and thrive in the world of population-based payment, providers must develop the capability to manage care within full risk capitated plans. Four important design criteria for this management function are as follows:

1. Develop care management/data analytics
2. Develop payor and network contracting
3. Develop the infrastructure to accept risk and manage the care of patients across the network and its providers
4. Structure payment incentives to network providers to provide care within the budget

Most hospitals or physician groups do not possess these functions or capabilities. The challenge facing providers is to develop these capabilities concurrently with the payment system transition. The organizational vehicle that must be created to carry out these functions is a "Community Care Organization" (CCO) representing an evolution beyond the contemporary PHO to include partnerships with insurers that are willing to participate in supporting the CCO's infrastructure development.

This comprehensive population heath transition framework encourages new economic models, creation of patient value, and the move to population health.

CONCLUSIONS

This guide was developed to provide rural hospital executive and management teams a practical approach to understanding population health essentials and the data needed for population health initiatives. The guide began with a series of two Health Education and Learning Program (HELP) Webinar presentations supported by the Small Rural Hospital Transitions project to support rural hospitals undergoing the critical transition to population health. Based on the experience of advising hundreds of rural hospitals, there are seven important conclusions:

1. Population health and value-based care require boards to be engaged and educated about the changing health care environment and the importance of population health.
2. Health care leaders must understand the new language of insurance, population health and data analytics.
3. Every rural hospital's strategic plan needs to include population health as a strategic theme and adopt four key initiatives:
    a. Operating efficiency, quality and patient engagement
    b. Primary care network alignment
    c. Service network rationalization
    d. Integrated delivery and payment system
4. Primary care alignment and development of a seamless primary care network are requirements of population health.
5. Hospitals should conduct a population health assessment utilizing public and proprietary data.
6. Adopt a population health framework and engage multiple stakeholders and partners to coordinate and implement strategies aimed at improving population health.
7. At your next retreat, adopt a population health strategic framework; identify the strategic initiatives and goals to achieve the triple aim and share this transformation vision and action plan internally and externally. This can be achieved during one full day of intensive collaboration and work.

References

National Rural Health Resource Center Webinars and links

- A Strategic Framework for Assisting Rural Hospitals to Move to Population Health
- Using Analytics to Manage Population Health

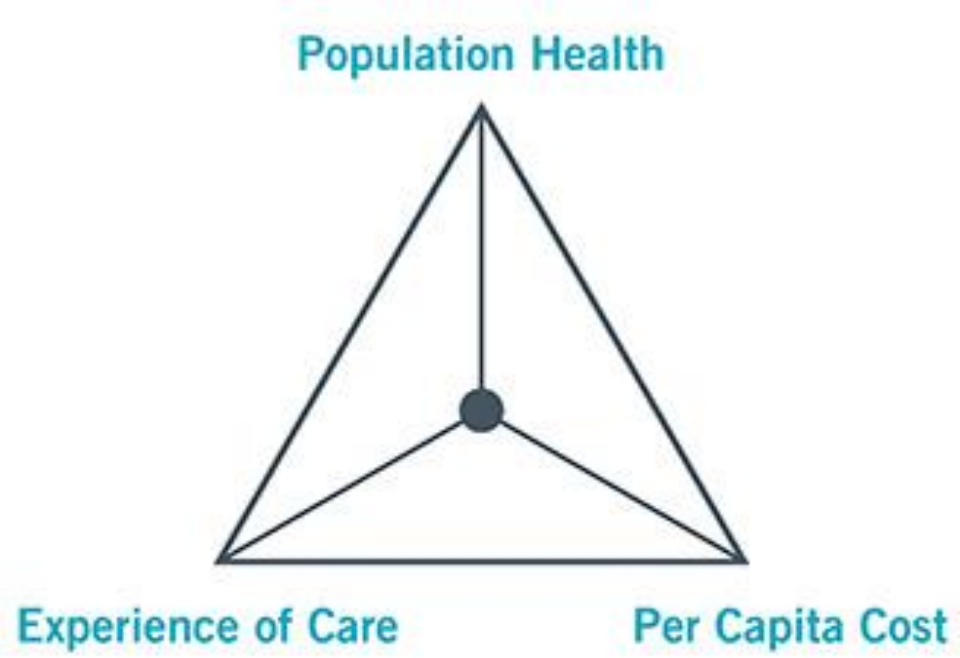
Additional References

- The County Health Rankings and Roadmaps (www.countyhealthrankings.org)
- Blue Zones (www.bluezones.com)
- 2015 CDC Community Health Status Indicators (www.cdc.gov/community health)
- United Health Foundation's America's Health Rankings (www.americashealthrankings.org)
- State of the USA Health Indicators (www.stateoftheusa.org)
- The Health Indicator's Warehouse (www.healthindicators.gov)
- Canadian Index of Wellness (www.atkinsonfoundation.ca)
- Healthy People 2020 (www.healthypeople.gov)
- National Prevention strategy (www.surgeongeneral.gov/initiatives/prevention/strategy/report.pdf)
- Annie E. Casey Foundation's KIDS COUNT (datacenter.kidscount.org)
- Fact Sheets: Better Care, Smarter Spending, Healthier People: Paying Providers for Value, Not Volume.(www.cms.gov/Newsroom/MediaReleaseDatabase/FactSheet)
- Kindig D, Asada Y, Booske B. (2008). A Population Health Framework for Setting National and State Health Goals. *JAMA,* 299, 2081-2083
- Glossary of Terms: www.usamco.com/pdf/glossary.pdf

APPENDICES

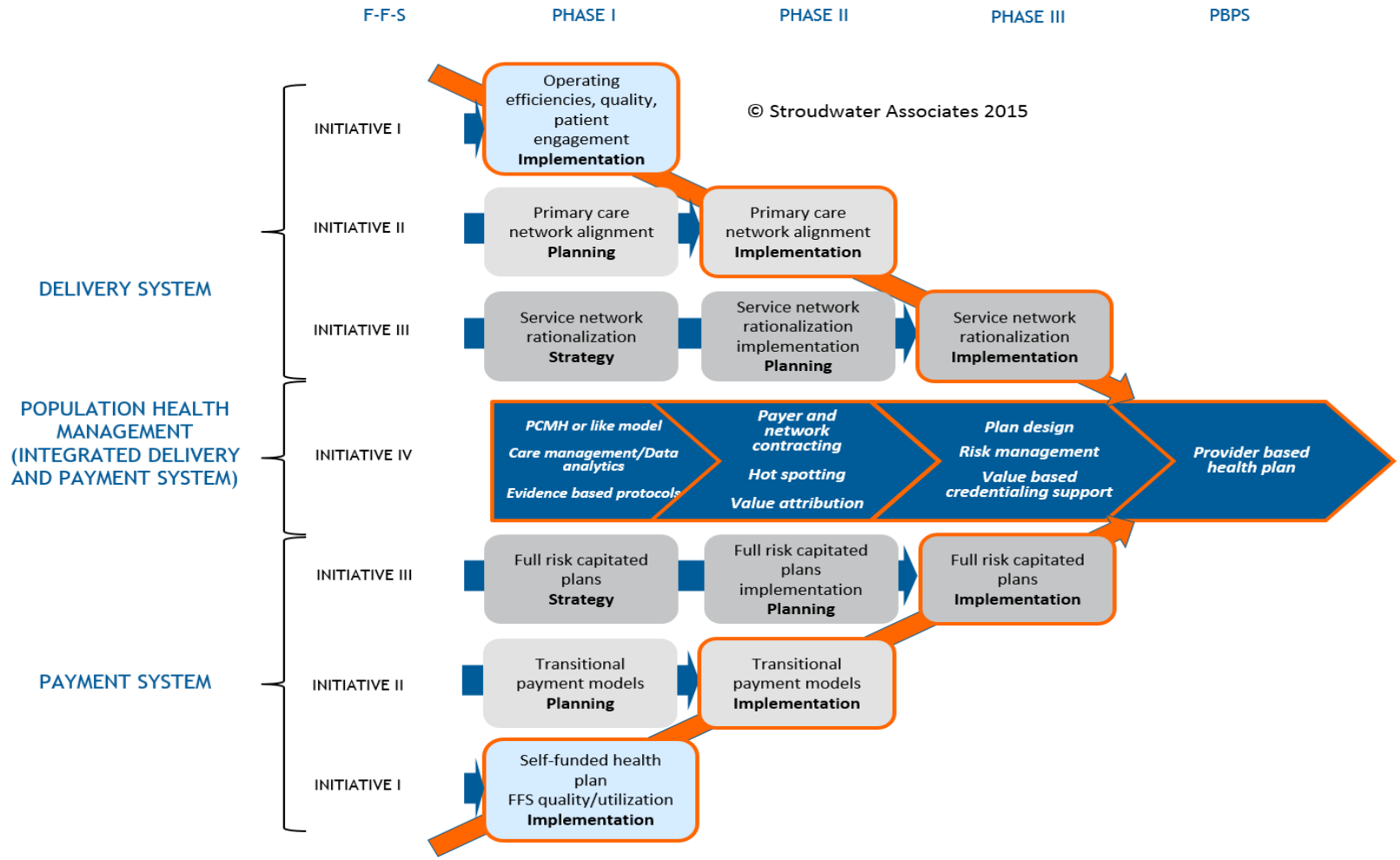
Appendix A: Population Health Transition Framework

Institute for Health care Improvement's (IHI) Triple Aim



The health care system in the United States is experiencing an unprecedented shift from a volume-based to a value-based payment system. As we move into this new environment, quality will be a driver for payment and a value differentiator for patients. Health care providers will have to be able to compete on quality. Ultimately, the goal of any rural health system is the Triple Aim of improving quality, the health of our population, and efficiencies in the system. The diagram below illustrates the phases a rural hospital will move through to reach the goal of the Triple Aim. This strategic framework will help us match our movement toward a value-based system with changes in the payment models to help ensure sustainability. It allows us to develop specific strategies to transform the delivery system, payment system and population health management systems simultaneously.

Population Health Transition Framework[6]

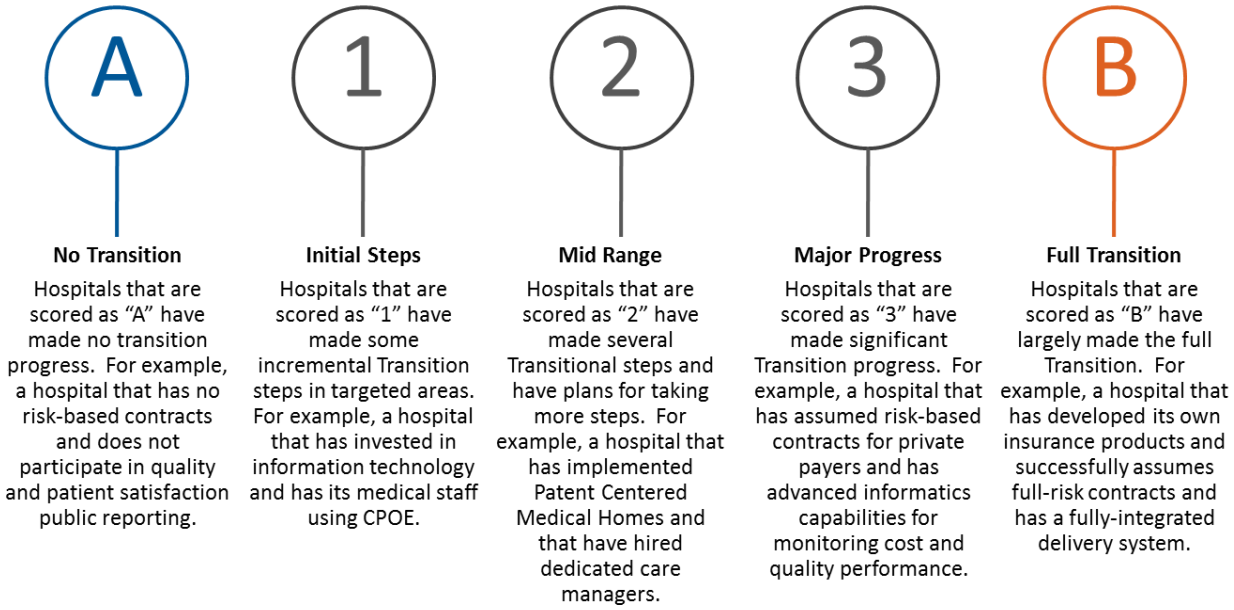


[6] Stroudwater Associates, 2015

Appendix B: Transition Framework Self-Assessment[7]

How to use the Transition Framework Self-Assessment

Each category has a 5-point scale



[7] Stroudwater Associates, 2015

Transition Framework Self-Assessment

Delivery						Characteristics of the Rural Health System of the Future
Operations	A	1	2	3	B	Clinical and business operations are "efficient" and tightly integrated resulting in easy access to care, low wait times, minimal re-work and availability of information at all care points .All leaders and managers understand the importance of unit cost management, maintaining appropriate patient services, effective billing and collections, including at the point of service, and exploring new sources of revenue within an efficient cost structure.
Quality and Engagement	A	1	2	3	B	The rural delivery system participates in public reporting programs (State, Federal and Private), monitors provider performance using industry-standard metrics and demonstrates better quality than its local competitors. The quality of care is well known throughout the community and results in a high degree of confidence for using services locally, with limited out migration. Quality is recognized as "everyone's job" and is visibly supported by leadership.
Primary Care Alignment	A	1	2	3	B	The rural delivery system's population has access to local primary care services (whether through employed PCPs, independent practices, rural health clinics and/or FQHCs). This provider network has shared incentives that are aligned with the health system's mission and strategy incorporation functional, contractual and governance connections. Employed primary care is supported with effective practice management services that help practitioners grow and manage their local panel size and address primary care needs efficiently.
Specialty Alignment	A	1	2	3	B	The rural delivery system evaluates patient demand for services using informatics and recruits specialists to match population-based supply with demand. Primary care to specialist relationships are developed and monitored based on the health system's clinical standards. Specialists actively work with primary care providers to coordinate across the continuum of patient needs, with services always provided locally when clinically appropriate.
Facilities	A	1	2	3	B	Investments in sites, buildings and equipment are right-sized and provide the rural delivery system optimal flexibility to adapt to changing requirements. Facilities enable the rural system strategy and support efficient operations, high quality and the transition of care from inpatient to ambulatory settings.

						Decision-making criteria take into account expected changes in health service utilization, system integration and payment trends.
Health System Alignment	A	1	2	3	B	The rural delivery system has a regional alignment strategy that includes other providers and/or payers to ensure patients receive all necessary services at the optimal time, place, quality and cost. The rural system's partners recognize the value of the rural delivery system, have processes to enhance it, and attribute value back to the primary care site(s). The scale provided through its partnership(s) enable the rural system to access transitional and population-based payment approaches that enhance sustainability.
Population Health						**Characteristics of the Rural Health System of the Future**
Care Management	A	1	2	3	B	The rural delivery system employs and/or contracts with dedicated care managers who partner with the community's primary care providers to coordinate patient care across the entire health care system. Care managers actively monitor overall patient health and wellness and are evaluated on their ability to minimize unnecessary care, improve health status, and manage total costs by payer.
Patient Centered Medical Home	A	1	2	3	B	The rural health system has led or facilitated the development of PCP-based Patient Centered Medical Homes and has established value-based payment models with commercial payers to fund care coordination, reduce total patient costs, implement preventive care initiatives, support community-based patient engagement and provide financial rewards for achieving improved patient outcomes at lower PMPM cost.
Informatics / Claims Analysis	A	1	2	3	B	The rural delivery system has a culture that embraces data and analytics, understands the value of measurement, and uses an array of provider scorecards to evaluate cost, quality and patient engagement while leveraging public and private data to evaluate internal and external performance in the market. A key objective is to receive and manage claims-level data to enable PMPM analysis and risk management for population-based contracting strategies and to use the data for attributing performance to where it is created in the system.

Market and Payment						Characteristics of the Rural Health System of the Future
Consumer Behaviors	A	1	2	3	B	Consumers in the market utilize publically-reported quality and pricing information to explore options for where to receive care. Prior to using services, they query providers on the price of their services. They partner with providers to assist them in navigating the health care system and manage their out of pocket and/or high-deductible spending. Consumers express confidence in the practitioners who help them manage and improve their health status over time.
Employers	A	1	2	3	B	Employer involvement in managing health care costs is seen as a strategic issue managed by leadership versus a benefits issue managed by HR. Companies seek to manage overall health care spending by creating incentives for employees to improve their health, negotiating with select providers, and directing care to high quality, low cost providers.
Private Payers	A	1	2	3	B	Insurance companies transition away from contracting based on a percentage of charges and increase incentives for quality and managing overall utilization. Third party payers create narrow networks based on value and incentivize consumers to seek care at the lowest cost. Payers create budget-based payment systems and may partner with select health systems for developing provider-sponsored health plans.
Medicare / Medicaid	A	1	2	3	B	Governmental payers minimize the increases to overall cost of care by providing a mix of discounts on PPS prices and bundling of ancillary services. More services are paid for using shared savings program and bundled payment initiative with governmental payers use budget-based payments to cap total spending, whether through state Medicaid initiatives and/ or additional emphasis on Medicare Advantage penetration.

Culture						Characteristics of the Rural Health System of the Future
Physician Leadership	A	1	2	3	B	The rural delivery system's medical staff and regional providers are closely aligned with the organization's mission and strategy, collaborate well as a team and actively embrace system-wide change to preserve the organization's mission and to fulfill the overarching goal of optimal health outcomes for the community. Key members of the medical staff have assumed leadership roles in the organization and have buy-in from other members of the medical staff.
Governance	A	1	2	3	B	The rural delivery system's Trustees are well educated on the future challenges and impending changes, have endorsed and are monitoring a formal strategy to prepare for the future and are equipped to facilitate and support the management team's decision making process. Trustees understand and execute their fiduciary responsibility consistently. The rural health system has led or facilitated the development of PCP-based Patient Centered Medical Homes and has established value-based payment models with commercial payers to fund care coordination, reduce total patient costs, implement preventive care initiatives, support community-based patient engagement and provide financial rewards for achieving improved patient outcomes at lower PMPM cost.
Change Management	A	1	2	3	B	Change is viewed as a natural, positive phenomenon that signals the vitality of the rural health system. Staff, physicians and Trustees all embrace the opportunity to improve processes and to grow in ways that are respectful, effective, equitable and efficient. Communication across the system flows seamlessly (vertically and horizontally) based on intentional Organizational Design principles that balance incentives, performance monitoring and decision rights. Growth occurs intentionally with empowered managers who operate as "pitchers" versus "catchers".