NATIONAL RURAL HEALTH RESOURCE CENTER

Inspiring Community Partnerships to Transform Population Health Needs
Part One

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June 17-18, 2019

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

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Today's Agenda

- Overview: Defining health and population health
- Prioritizing population health needs in your community
- What is collaboration?
- Identifying potential partners
- Develop a plan for collaboration

Workshop Objectives (Parts 1 & 2)

Participants will:

- Identify a specific population health need to focus on in their community
- Identify a population to target and track
- Begin to identify key community partners to bring to the table
- Be able to communicate the value proposition to key community partners
- Construct communication strategies for addressing their specific population health need
- Learn best practices for encouraging community partner buy-in, engagement, and sustainability

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 on22 July 1946 by the representatives of 61 States (Official Records of the World Health Organization, no. 2, p. 100) and entered into force on7 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

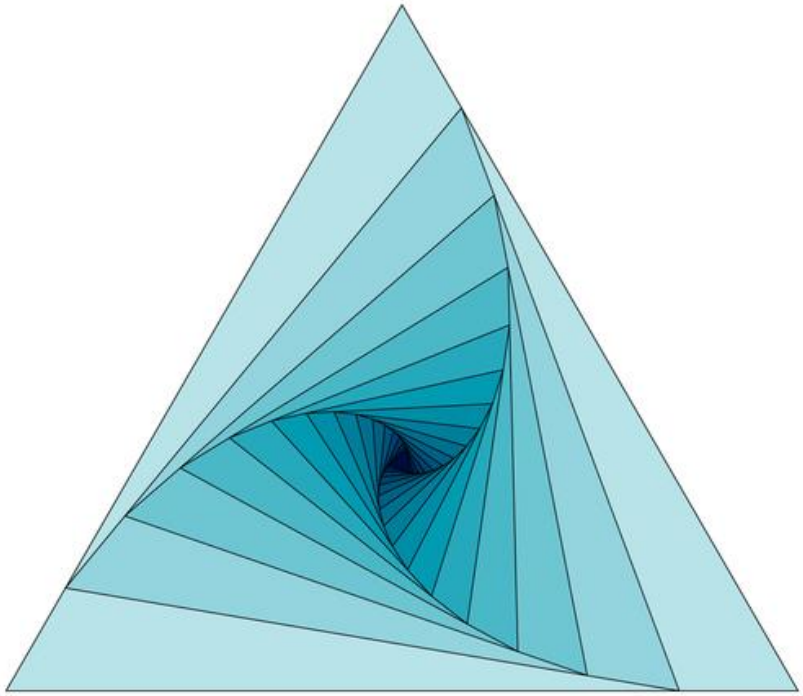
Clarifying Population Health

"Population Health" used interchangeably for:

- Targeted population: 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

The Need to Demonstrate Value



CMS Quality Strategy

Three Aims

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

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

CMS Quality Strategy: Six Priorities

1. Make care safer by reducing harm caused in the delivery of care
2. Strengthen person and family engagement as partners in their care
3. Promote effective communication and coordination of care
4. Promote effective prevention and treatment of chronic disease
5. Work with communities to promote best practices of healthy living
6. Make care affordable

Focus on Value is Not Diminishing

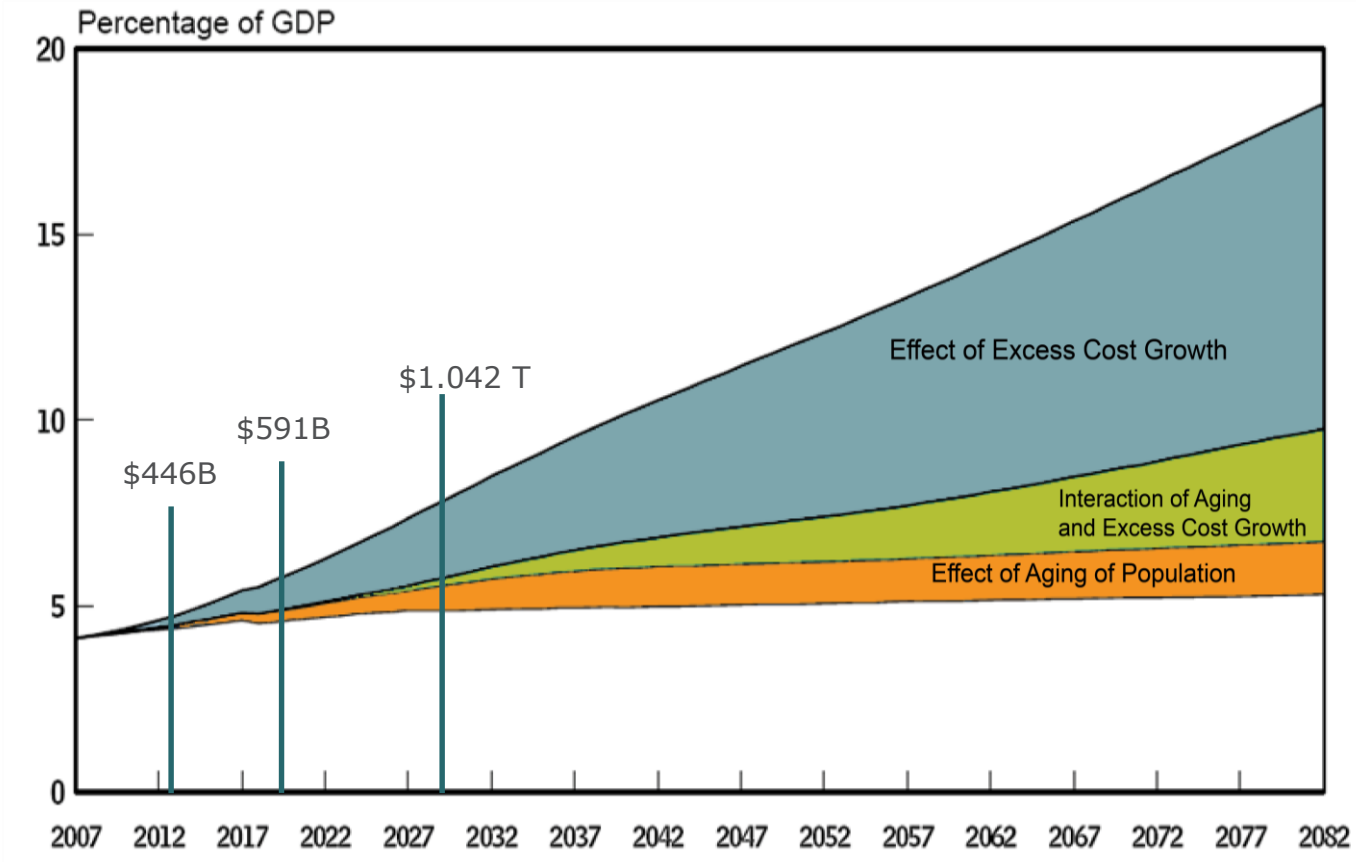
"There is no turning back to an unsustainable system that pays for procedures rather than value. In fact, the only option is to charge forward — for HHS to take bolder action, and for providers and payers to join with us."

Alex M. Azar II, Secretary of HHS,
March 5, 2018
(Remarks to the Federation of American Hospitals)

Source: https://www.hhs.gov/about/leadership/secretary/speeches/2018-speeches/remarks-on-value-based-transformation-to-the-federation-of-american-hospitals.html

Industry and Market Trends

Projected Federal Spending on Medicare and Medicaid



Source: National Rural Accountable Care Consortium

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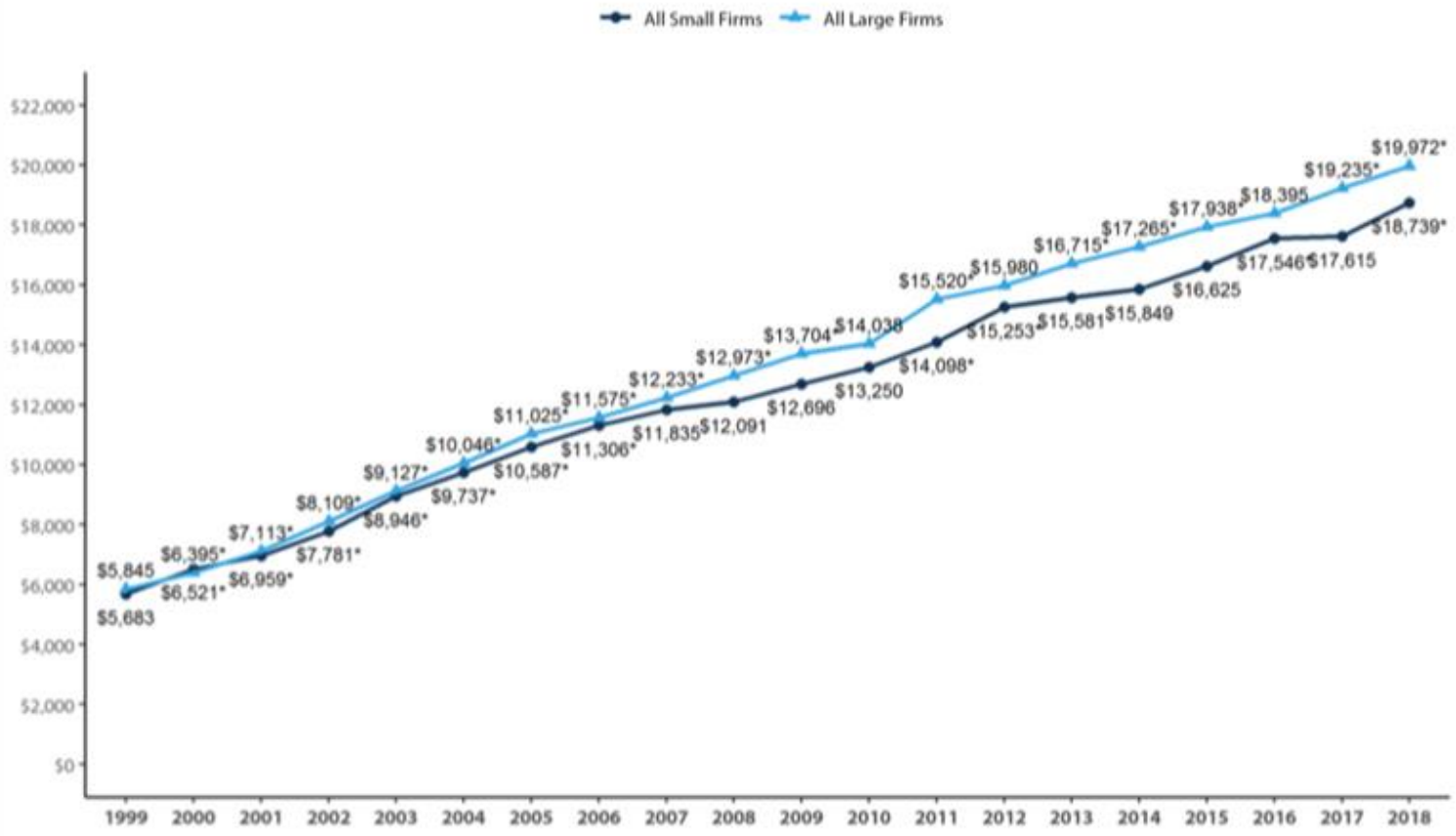
Call to Action: Insurance Premiums

STROUDWATER

Figure 1.12

Average Annual Premiums for Covered Workers with Family Coverage, by Firm Size, 1999-2018



* Estimate is statistically different from estimate for the previous year shown ($p < .05$).

NOTE: Small Firms have 3-199 workers and Large Firms have 200 or more workers.

SOURCE: KFF Employer Health Benefits Survey, 2018; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 1999-2017

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Employer Health Benefits

2018

ANNUAL SURVEY

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Call to Action: Growth of High Deductible Plans

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THE KAISER FAMILY FOUNDATION

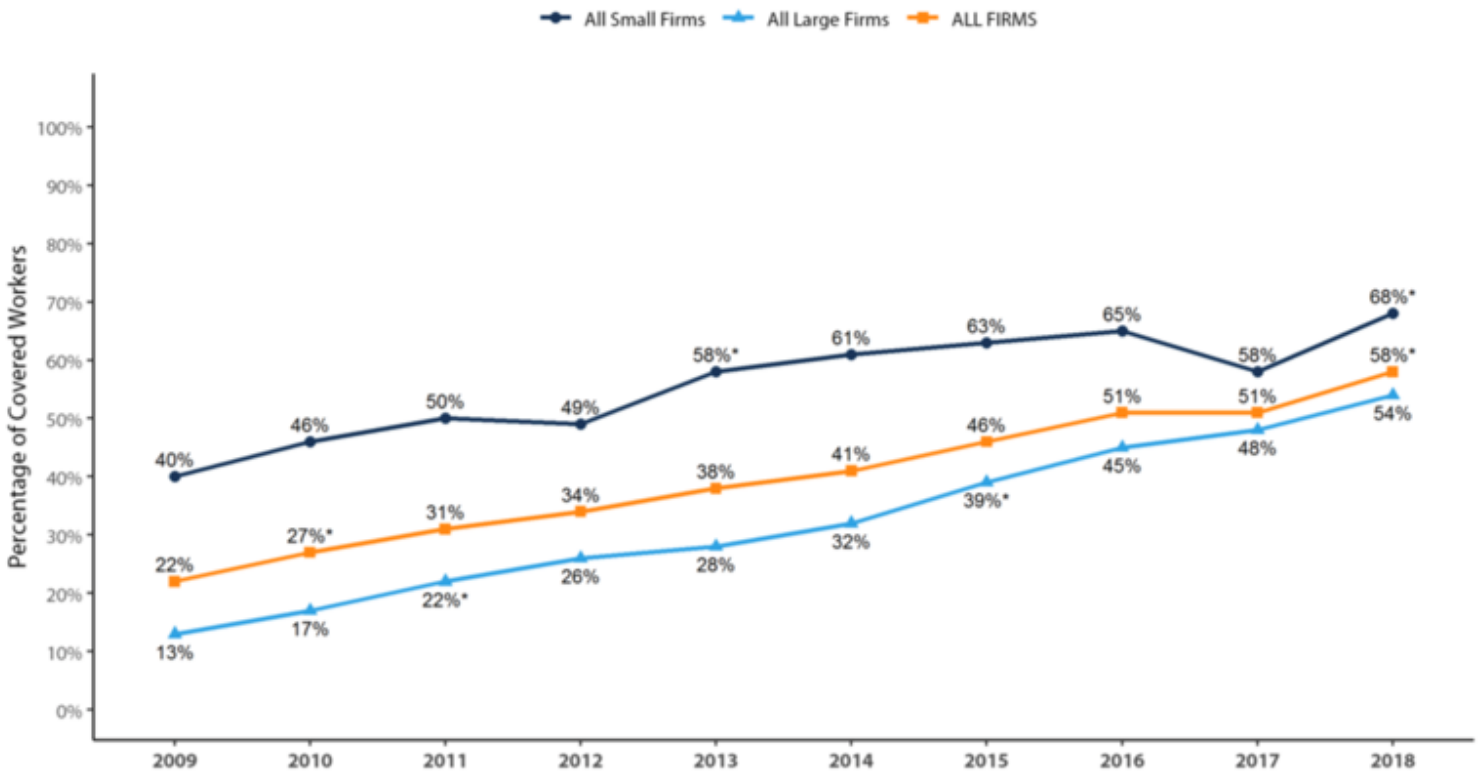
Employer Health Benefits

2018

ANNUAL SURVEY

Figure 7.13

Percentage of Covered Workers Enrolled in a Plan with a General Annual Deductible of $1,000 or More for Single Coverage, by Firm Size, 2009-2018



* Estimate is statistically different from estimate for the previous year shown ($p < .05$).

NOTE: Small Firms have 3-199 workers and Large Firms have 200 or more workers. These estimates include workers enrolled in HDHP/SOs and other plan types. Average general annual deductibles are for in-network providers.

SOURCE: KFF Employer Health Benefits Survey, 2018; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2009-2017

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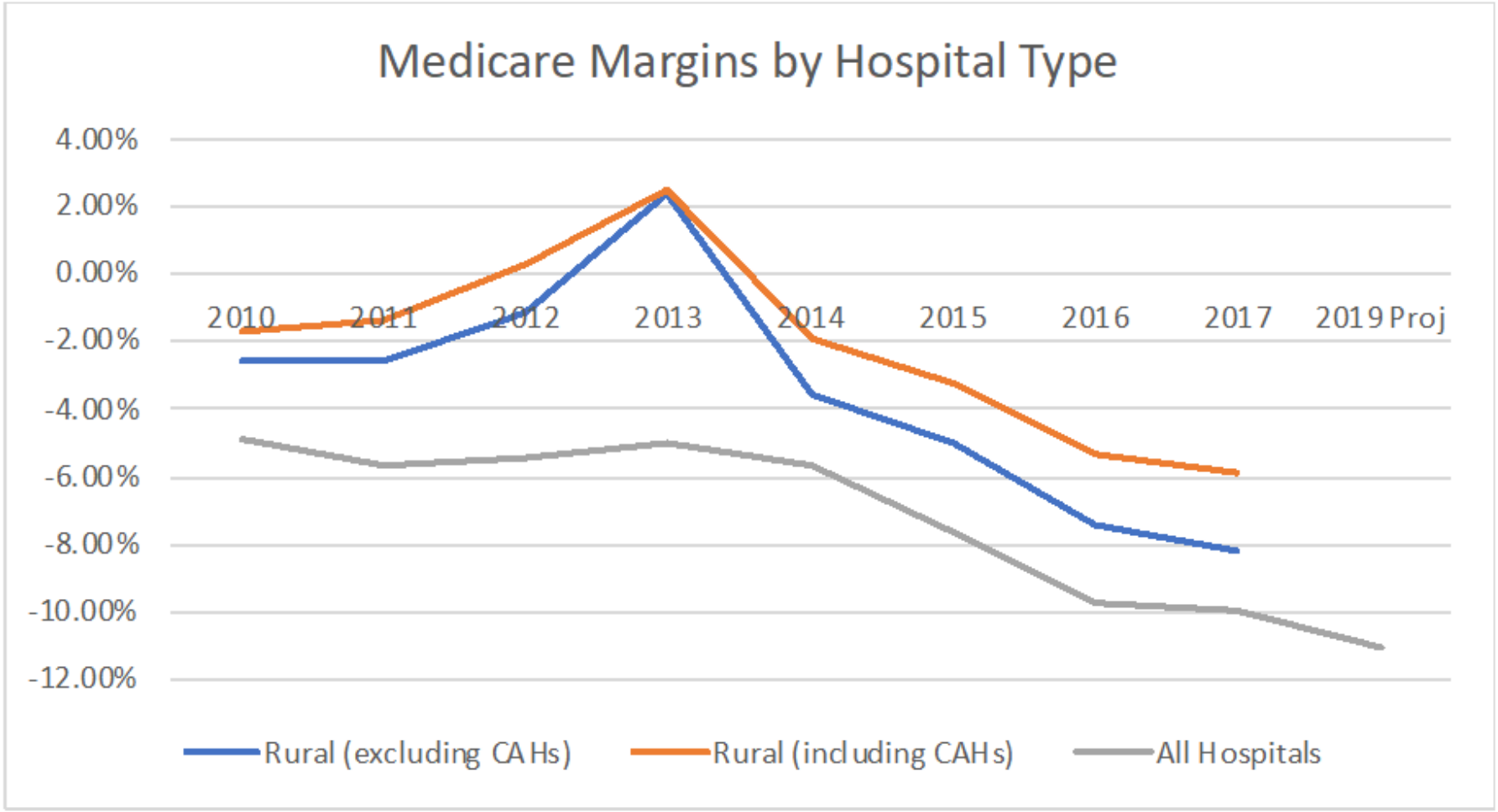
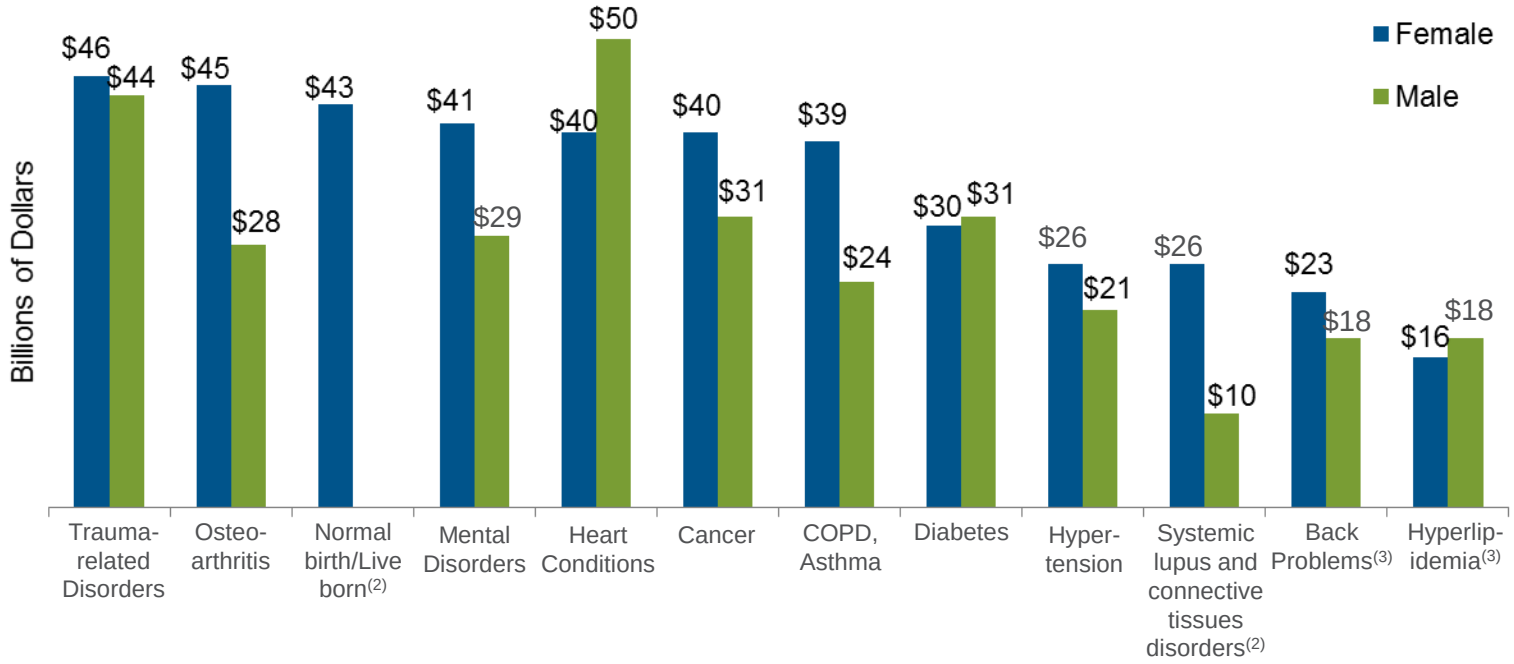
Call to Action: Declining Medicare Margins



Source: MedPac Report to Congress, March 15, 2019

Drivers of Cost

Chart 7.24: Total Expenses on Top 10 Most Costly Conditions Among Adults(1) by Sex, 2013



Source: Agency for Healthcare Research and Quality. Center for Financing, Access, and Cost Trends. Household Component of the Medical Expenditure Panel Survey, 2013. Available at: https://meps.ahrq.gov/mepsweb/.

(1) Only includes adults ages 18 and older.

(2) Normal birth/live born and systemic lupus and connective tissues disorders are not included among the top ten most costly conditions for males.

(3) Back Problems and Hyperlipidemia are not included among the top ten most costly conditions for females.

Chart added in Chartbook 2016.

Mental Health Impacts Clinical Conditions

Physical Diagnosis

29%

of adults with medical conditions also have mental health conditions

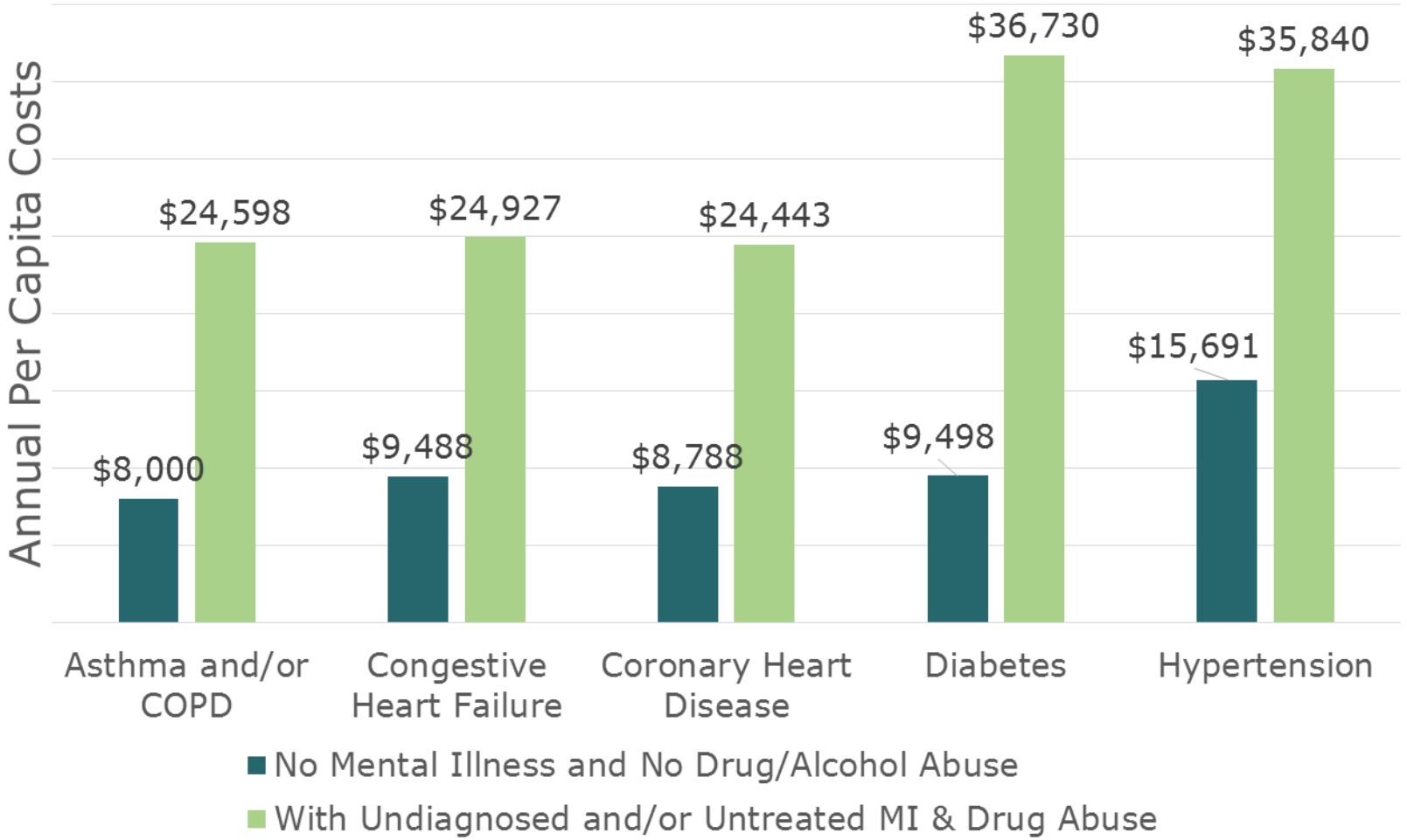
Mental Diagnosis

68%

of adults with mental health conditions also have medical conditions

Data source Epstein Becker Green

Impact on Chronic Health Care Costs



Data source: Epstein Becker Green

Why Integrate Behavioral Health?

- 26% of Americans 18 years + suffer from a diagnosable mental disorder
- 2 million people discharged from hospitals have a primary behavioral health diagnosis
- States cut $5 billion from mental health services nationwide from 2009-2012
- US lost 10% (4,500) public psychiatric beds 2009-2012
- Only a handful of CAHs provide inpatient psychiatric units nationwide
- 9 out of 10 ED physicians report that psychiatric patients were being held in their ED
- 28% of patient re-admissions are due to mental illness

Data source: http://www.trusteemag.com/articles/918-three-ways-hospitals-are-improving-behavioral-health-ca

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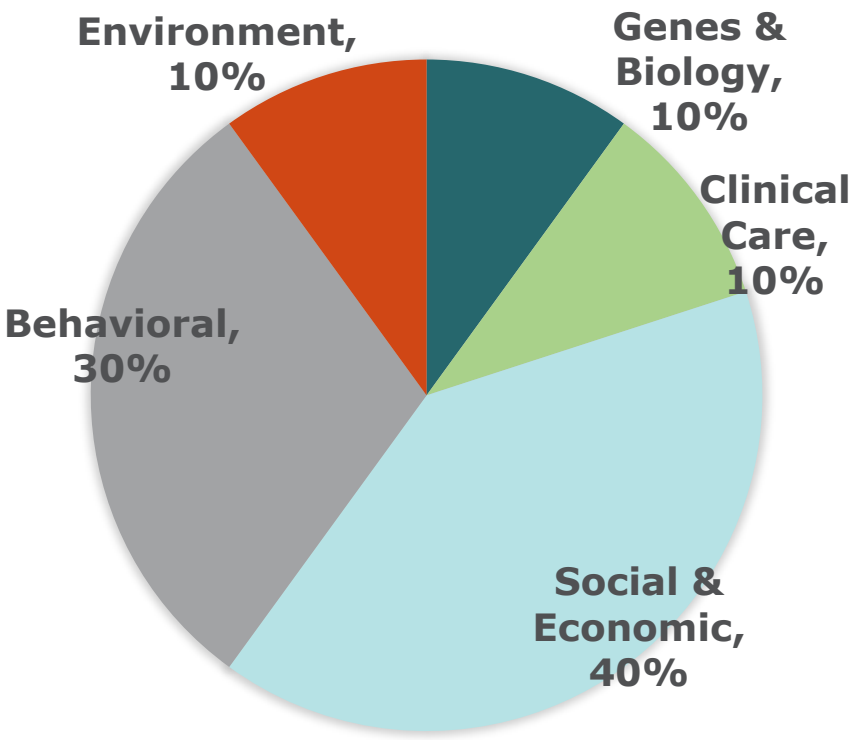
Predictors That Affect Health Outcomes



***The ah-ha*:**

Health care providers cannot change the US health outcomes alone

Source: Determinants of Health Model based on frameworks developed by: Tarlov AR. Ann N Y Acad Sci 1999; 896:281-93; and Kindig D, Asada Y, Booske B. JAMA 2008; 299(17): 2081-2083

Population Health has Many Partners

Tip of the Societal Disparities Iceberg

Source: Assistant Commissioner, MN Dept of Health, Jeanne Ayers speech to the MN Community Health Workers Alliance Meeting, May 23, 2016

Food

Nash Health Care
Rocky Mount, NC

Rev. Richard Joyner, head of hospital chaplaincy at Nash Health Care started a community garden in a small rural town where he teaches kids to grow vegetables.

Watch the Video!

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Housing

St. Joseph Health
Humboldt County, CA

Care Transitions Program: a medical respite program for chronically homeless individuals

Featured in the AHA Guide, *Social Determinants of Health Series: Housing and the Role of Hospitals*

Transportation

Grace Cottage Family Health & Hospital
Townshend, VT

Recognizing that many patients were unable to access care due to some type of transportation barrier, the hospital's community health team initiated the volunteer driver program in 2016.

Featured in the AHA Guide, *Social Determinants of Health Series: Transportation and the Role of Hospitals*

Table Conversation

- What are the opportunities to improve the health of a population in your community?
  - Describe the health need
  - Describe the population (targeted vs. total)
  - What are the levers?
  - What are the blocks?

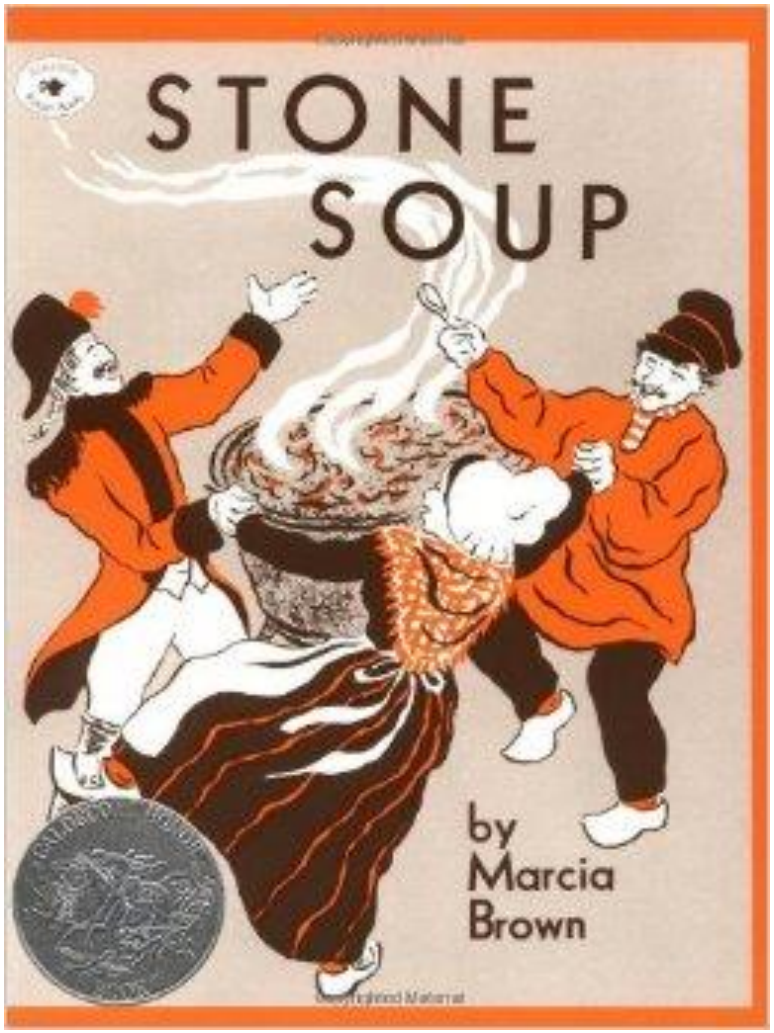
Inspiring Collaboration

"Collaborate" Defined

According to Merriam-Webster, "collaborate" (verb) is defined:

- to work jointly with others or together especially in an intellectual endeavor
- to cooperate with or willingly assist an enemy of one's country and especially an occupying force
- to cooperate with an agency or instrumentality with which one is not immediately connected

Why Should We Partner?



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Define your Potential Partners

- Patient or caregiver advocacy groups
- Not-for-profit community organizations
- Tertiary and outpatient providers
- Local EMS
- Local and county government agencies
- Schools and other educational institutions
- Home health or long-term care organizations
- Faith-based organizations
- Local businesses and business networks

Questions?

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Get to know us better:
http://www.ruralcenter.org

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Part Two

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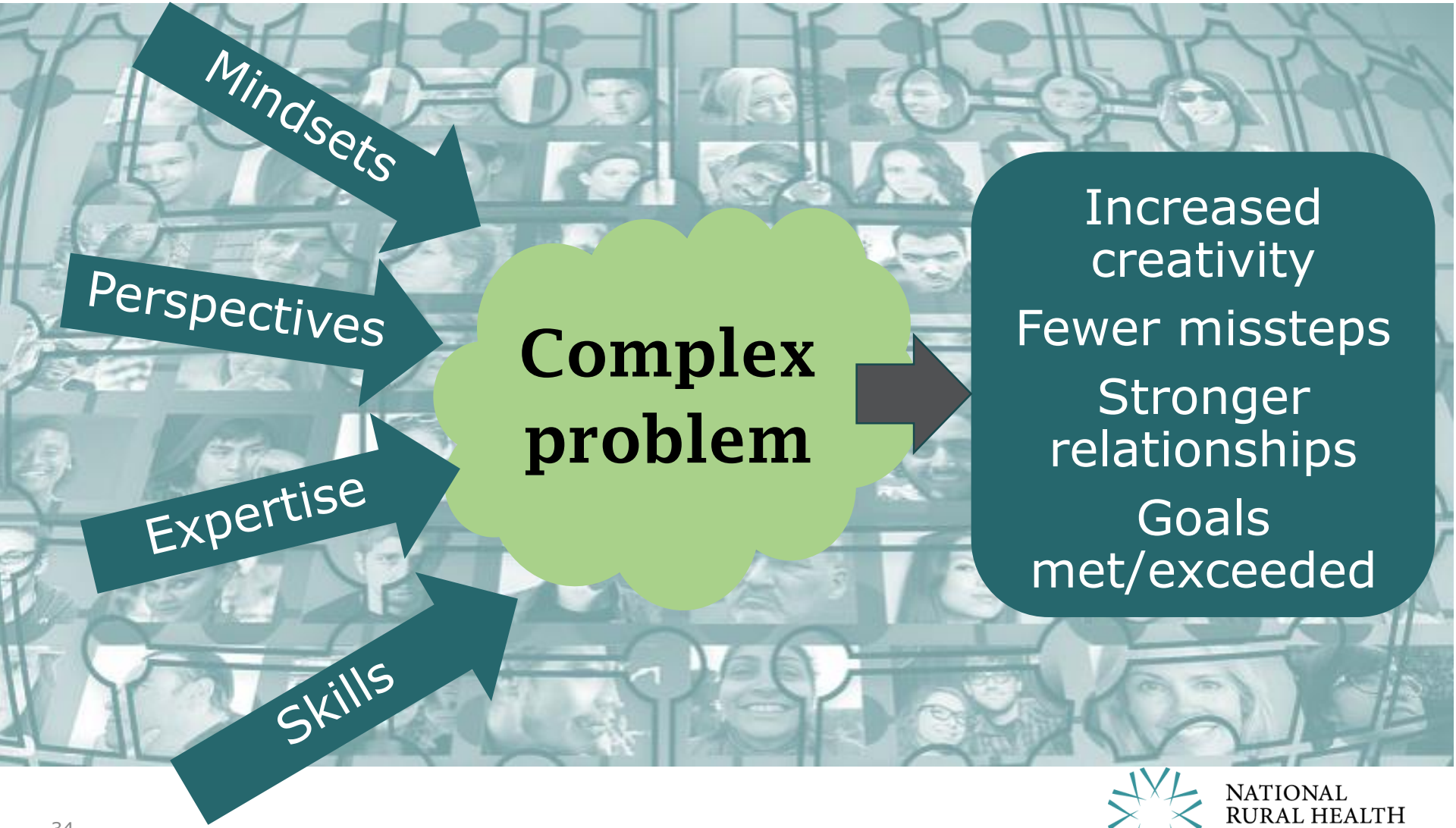
June 17 & 18, 2019

Diverse Groups Do More



Your Role in All This

Set up the environment to increase the odds that others will feel and do what you're hoping for

How Do I Do That?

Unified vision

Clearly defined roles

Alignment of group goals and individual priorities

Let's Agree...

Stakeholder

A group or individual who can affect or is affected by an issue

An individual, group or organization who may affect, be affected by, or perceive itself to be affected by a decision, activity or outcome of the project.

Source: Project Management Institute

Let's Agree...

Engagement

Commitment to the goals of the initiative and a willingness to participate in activities that help achieve goals

How do you know someone is engaged?

What Does Engagement Look Like?

SAY	Speak positively about the project
	Advocate for the project
STAY	Continue to participate in meetings and activities after initial launch
STRIVE	Speak up in meetings
	Propose ideas
	Volunteer to contribute
	Follow through on commitments

Source: Aon Hewitt

Stakeholder Analysis

What is Stakeholder Analysis?

A range of methodologies for analyzing stakeholder interests

Make a concrete connection between the stakeholder and the work of the project

Explicit, not implicit

When Might I Use Stakeholder Analysis?

- Early in a project, initiative, or relationship
- During a project, initiative, or relationship
- After a project, initiative, or relationship

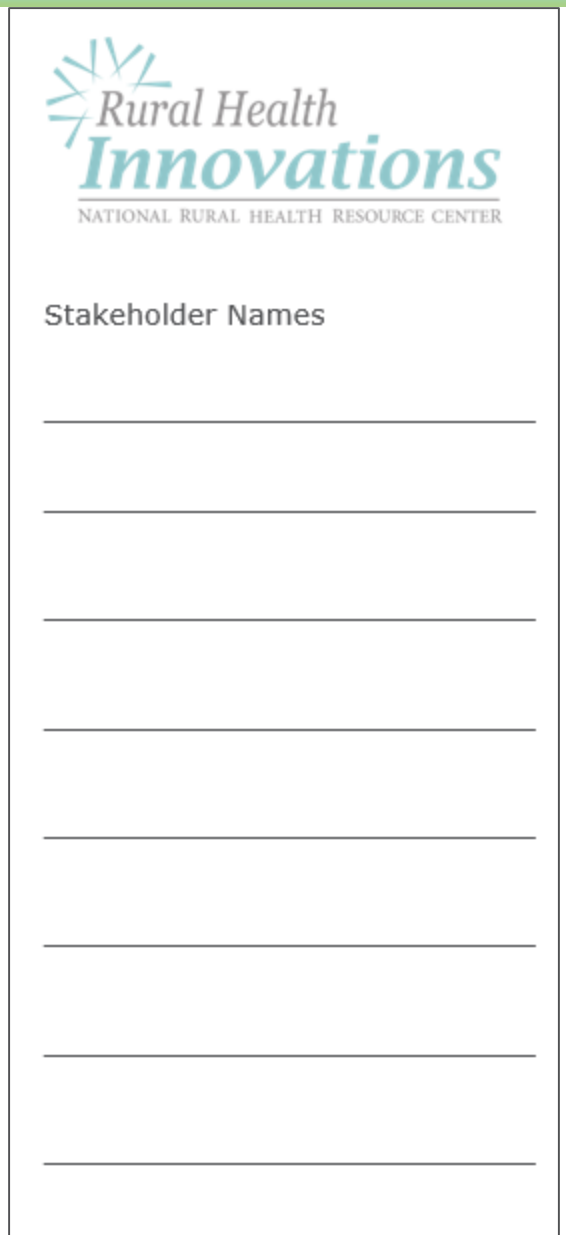
Group or individual

1. Map
2. Analysis

1. Map

2. Analysis

List All Stakeholders



Stakeholder: An individual, group or organization who may affect, be affected by, or perceive itself to be affected by a decision, activity or outcome of the project.

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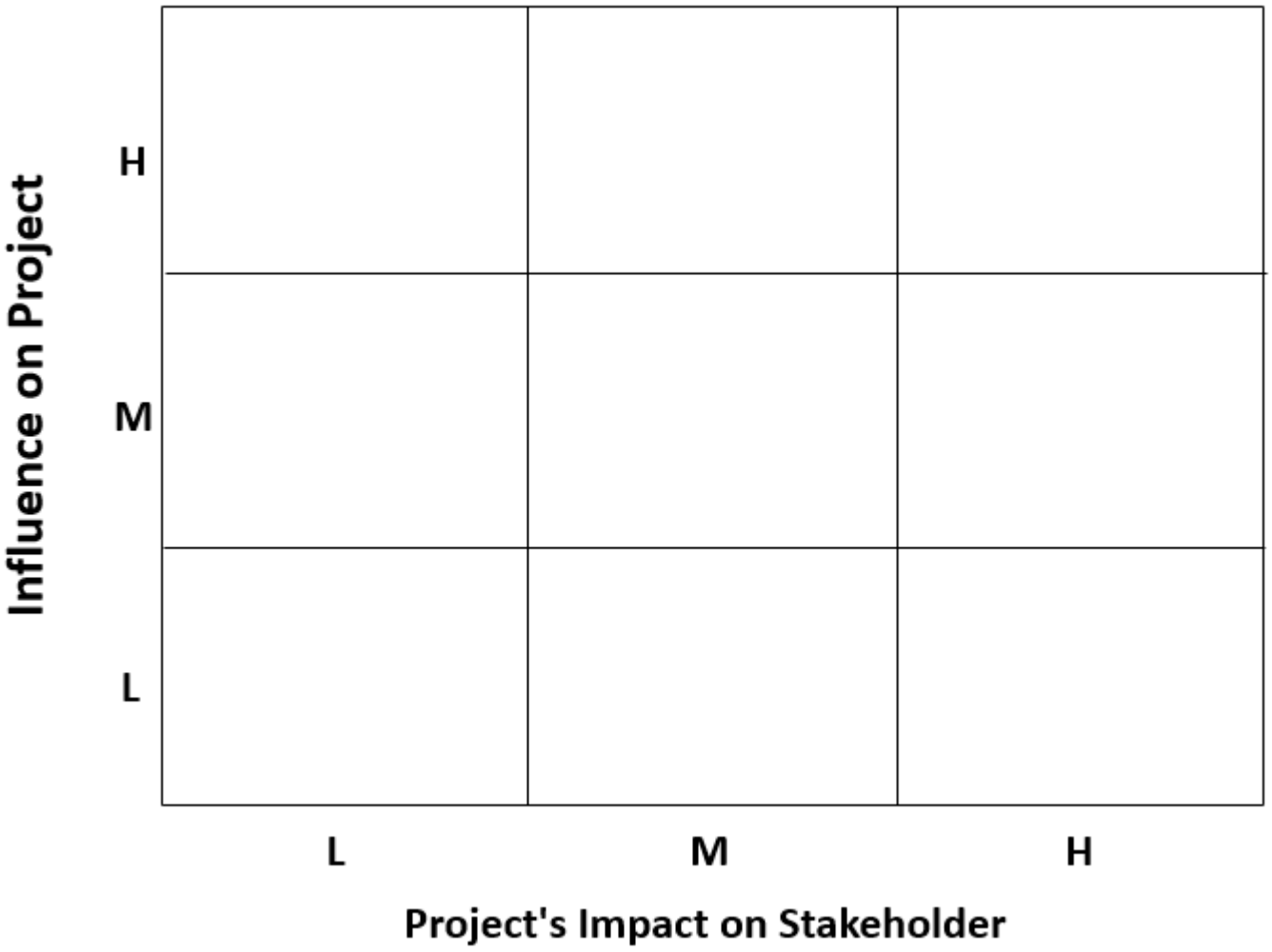
Stakeholder Mapping



Enthusiast

Neutral

Opponent

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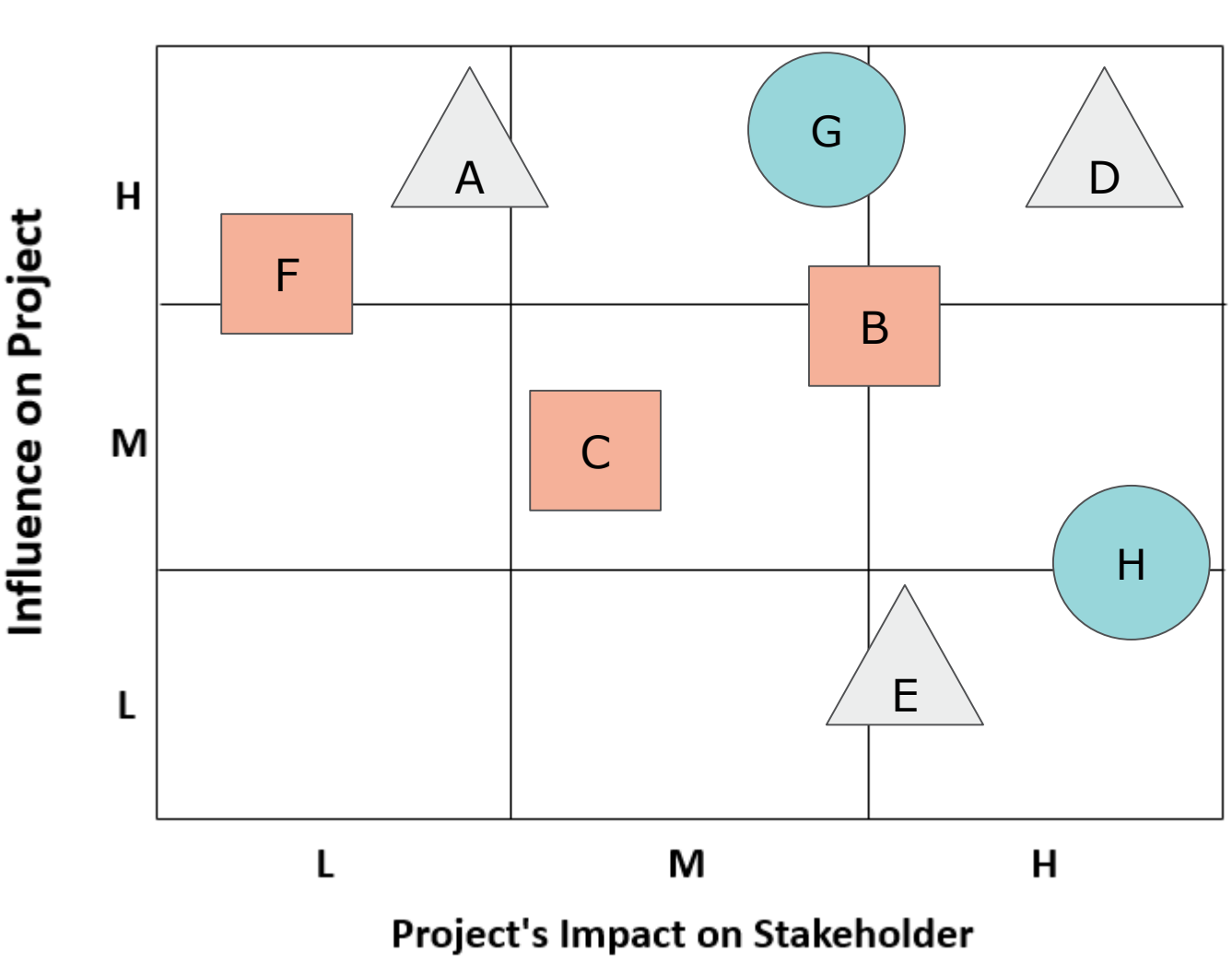
Stakeholder Mapping



Enthusiast

Neutral

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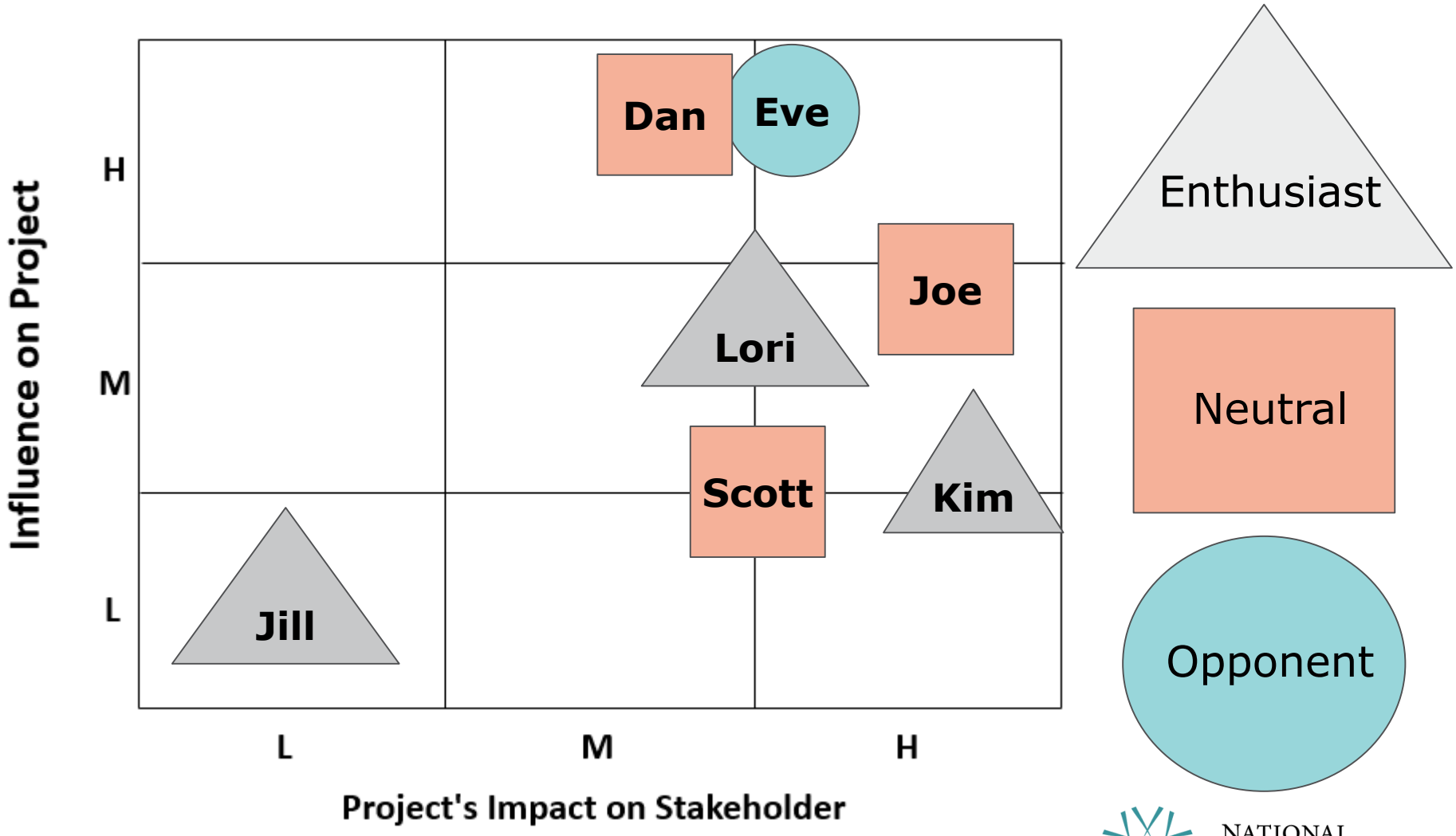
Center State Community Health Stakeholders

Eve	Chief of Police
Dan	CEO, Tri-County Memorial Hospital
Lori	Superintendent, Center School District
Scott	Manager, Tri-County Clinic
Kim	ED, Substance Use Treatment Center
Joe	ED, Community Housing Agency
Jill	Director, Center State Library

Stakeholder Mapping Example



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Try it!

1. Map

2. Analysis

Stakeholder Analysis Questions

1. What's important to him/her?
2. What does the group need from him/her?
3. How will the work of this project help him/her with what's important to him/her?
4. How can I (or others) more clearly communicate the connection between the project and what's important to him/her?
5. How can I (or others) modify what we're doing to more fully connect the work to what's important to him/her?
6. How will I know I'm making progress?

Hint: Say, Stay, and/or Strive!

Stakeholder Analysis Example
Eve: Center City Chief of Police

1. What's important to Eve?	Officer safety and labor cost
2. What does the group need from her?	Training commitment
3. How will the work of the project help Eve with what's important to her?	Fewer arrests; less paperwork for officers; improved officer safety
4. How can I (or others) more clearly communicate the connection between the project and what's important to her?	Highlight lower labor cost and increased officer safety in a comparison program
5. How can I (or others) modify what we're doing to more fully connect the work to what's important to her?	Plan training schedule collaboratively to minimize overtime
6. How will I know I'm making progress?	Increased attendance at meetings, asking more questions

Stakeholder Analysis Example
Dan: CEO, Tri-County Memorial Hospital

1. What's important to Dan?	Financial outcomes and patient outcomes -
2. What does the group need from him?	Funding commitment
3. How will the work of the project help Dan with what's important to him?	Improved patient outcomes related to behavioral health
4. How can I (or others) more clearly communicate the connection between the project and what's important to him?	Share a sample workflow and highlight outcomes of comparison program
5. How can I (or others) modify what we're doing to more fully connect the work to what's important to him?	Pilot program targeting substance use disorder
6. How will I know I'm making progress?	Actively voicing concerns, asking questions about needed funding

Try it!

References & Resources

Aon Hewitt: Engagement
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