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Population Health 101

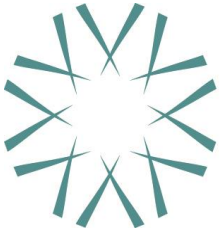
Tracy Morton

Director of Population Health

April 28, 2021

RHI's Purpose

Rural Health Innovations (RHI), LLC, is a subsidiary of the National Rural Health Resource Center (The Center), a non-profit organization. Together, RHI and The Center are the nation's leading technical assistance and knowledge centers in rural health. In partnership with The Center, RHI connects rural health organizations with innovations that enhance the health of rural communities.



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Learning Objectives

- Describe the 'why' behind population health
- Explain the benefits of population health for your organization
- Explain the benefits of population health for your community
- Recall actions a rural hospital can take to adopt population health strategies
- Recognize the relationship of population health strategies to the pandemic response

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Complete the Pre-Webinar Poll Question

What is your confidence in explaining the benefits of population health to others in your organization?

- Not confident
- Slightly confident
- Moderately confident
- Confident in my knowledge
- Extremely confident

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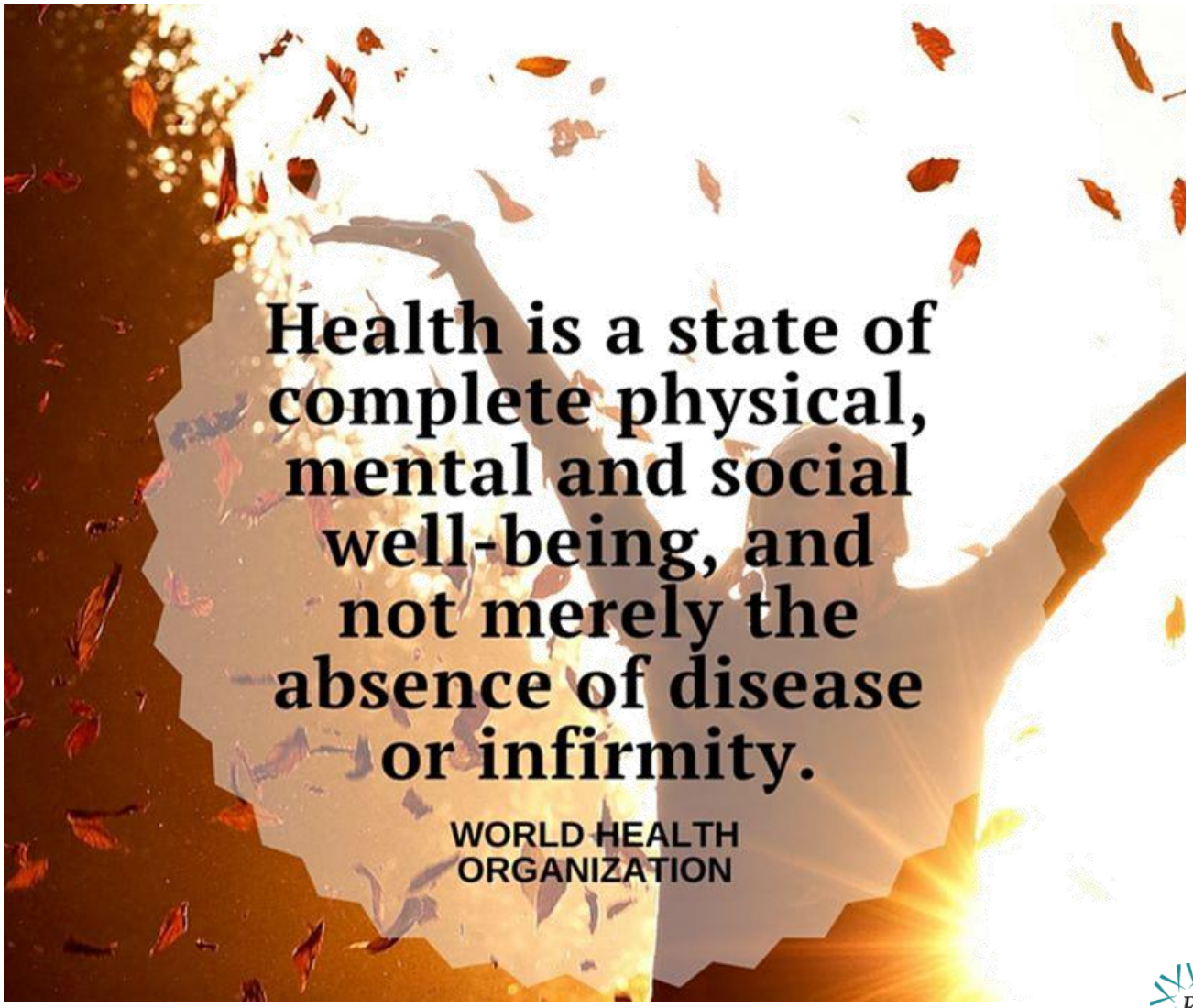
What is Health?



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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:

- **Target 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

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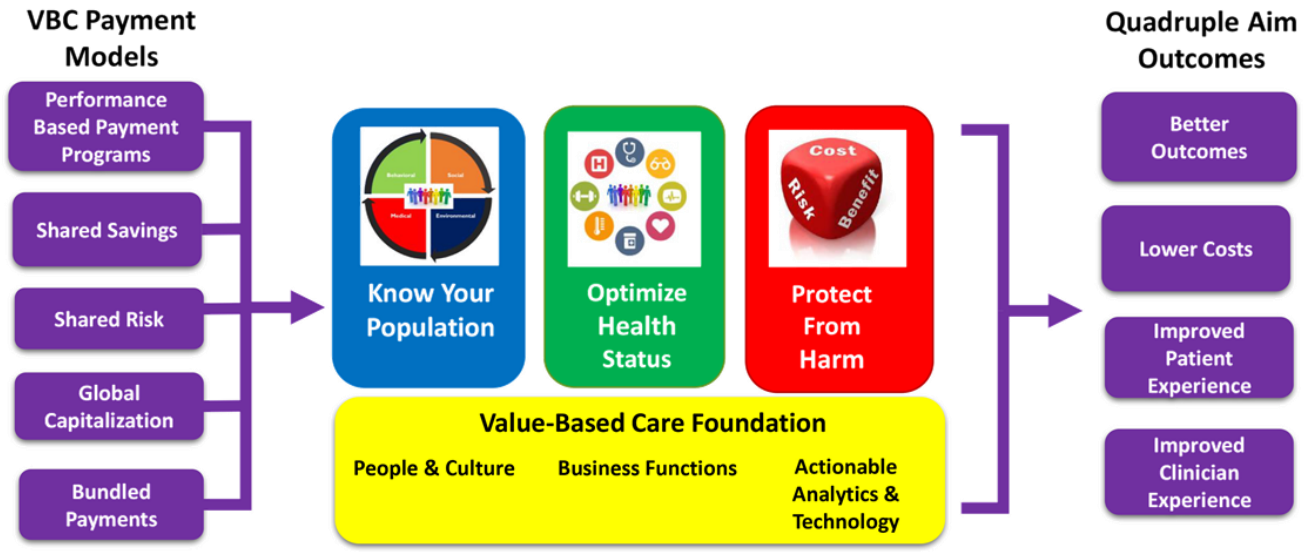
Population Health Management

The process of improving clinical health outcomes of a defined group of individuals through improved care coordination and patient engagement by appropriate financial and care models.

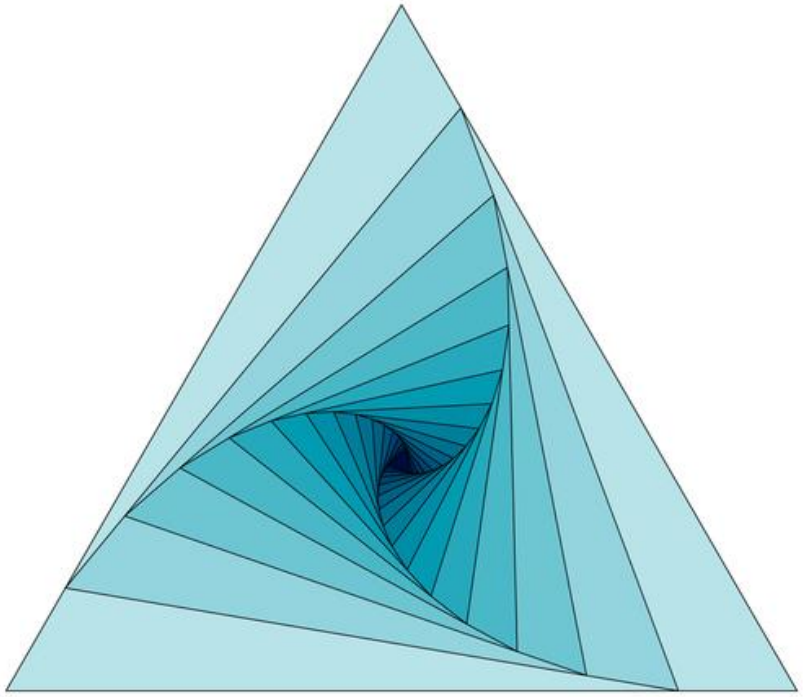


Source: HIMSS Clinical & Business Intelligence for Population Health Task Force, "Population Health Management and IT Capabilities Model." 2017 at http://www.himss.org/library/population-health-management-and-it-capabilities-model

Definition Source: www.aha.org

©2017 by the Healthcare Information and M

The Need to Demonstrate Value



CMS Quality Strategy

Three Aims

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

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

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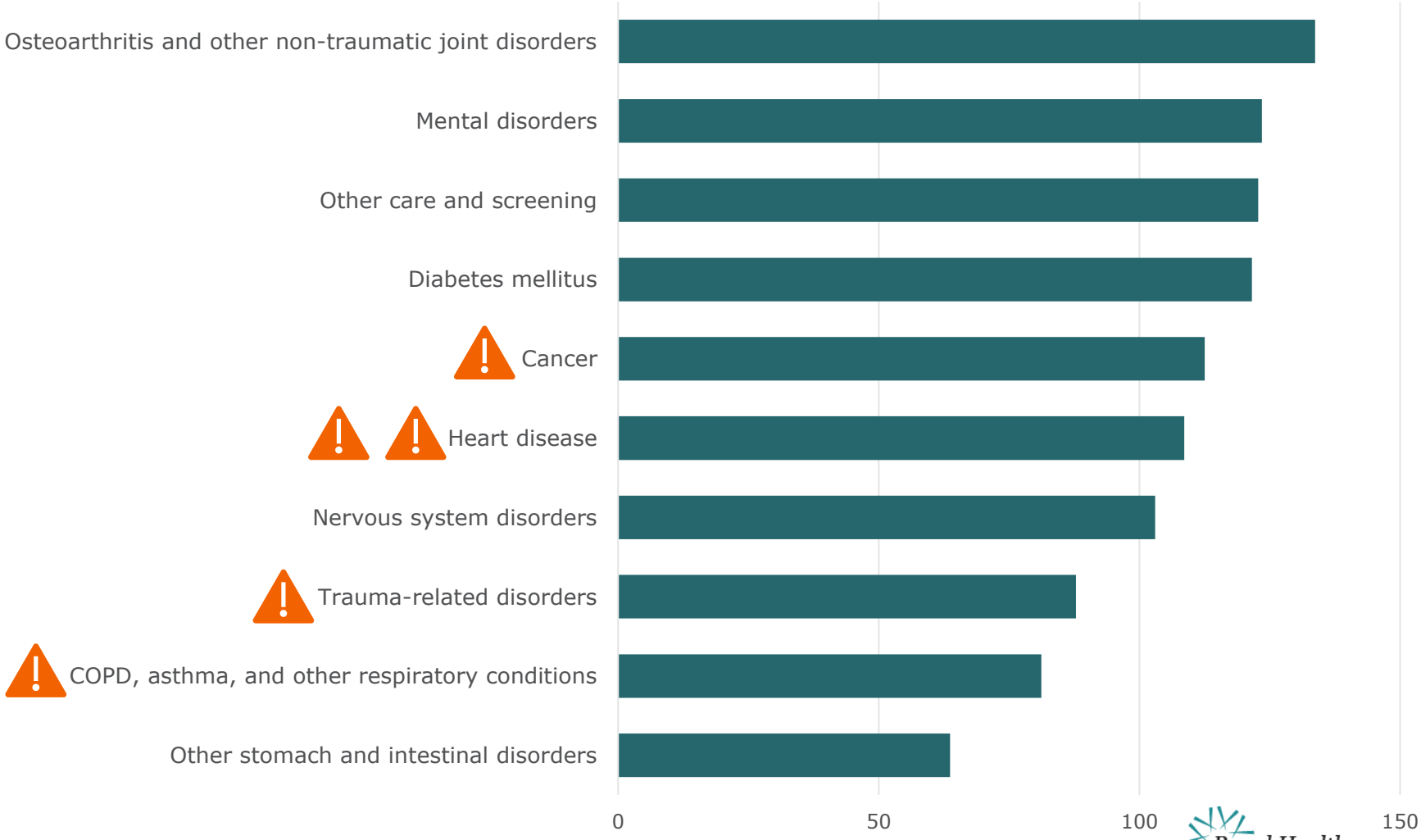
Drivers of Cost

Total expenditures in millions by condition, United States, 2018



Source: Agency for Healthcare Research and Quality. Total expenditures in millions by condition, United States, 2016-2018. Medical Expenditure Panel Survey.

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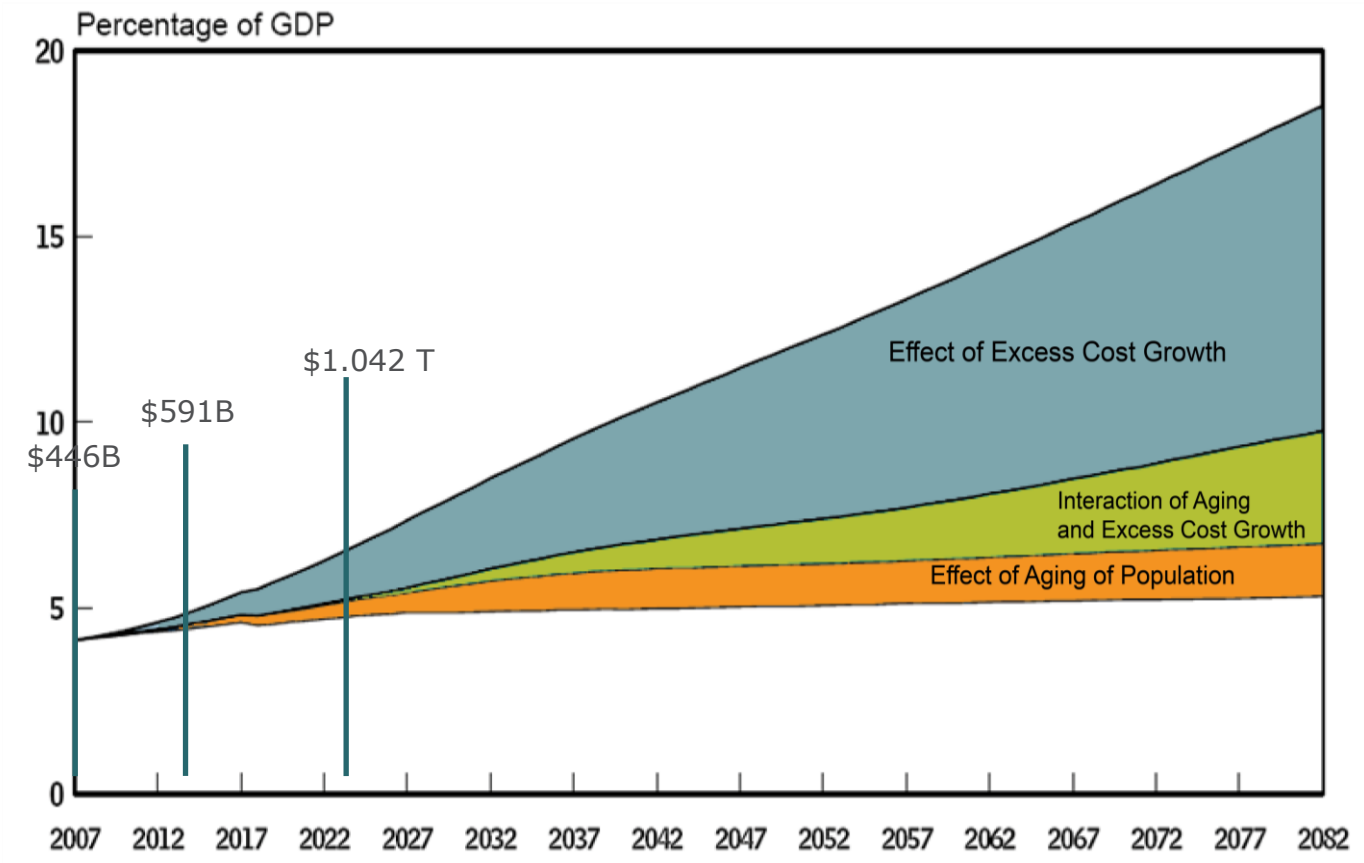
Industry and Market Trends

Projected Federal Spending on Medicare and Medicaid



Source: National Rural Accountable Care Consortium

Premiums Impacted by Health Outcomes

Call to Action: Insurance Premiums

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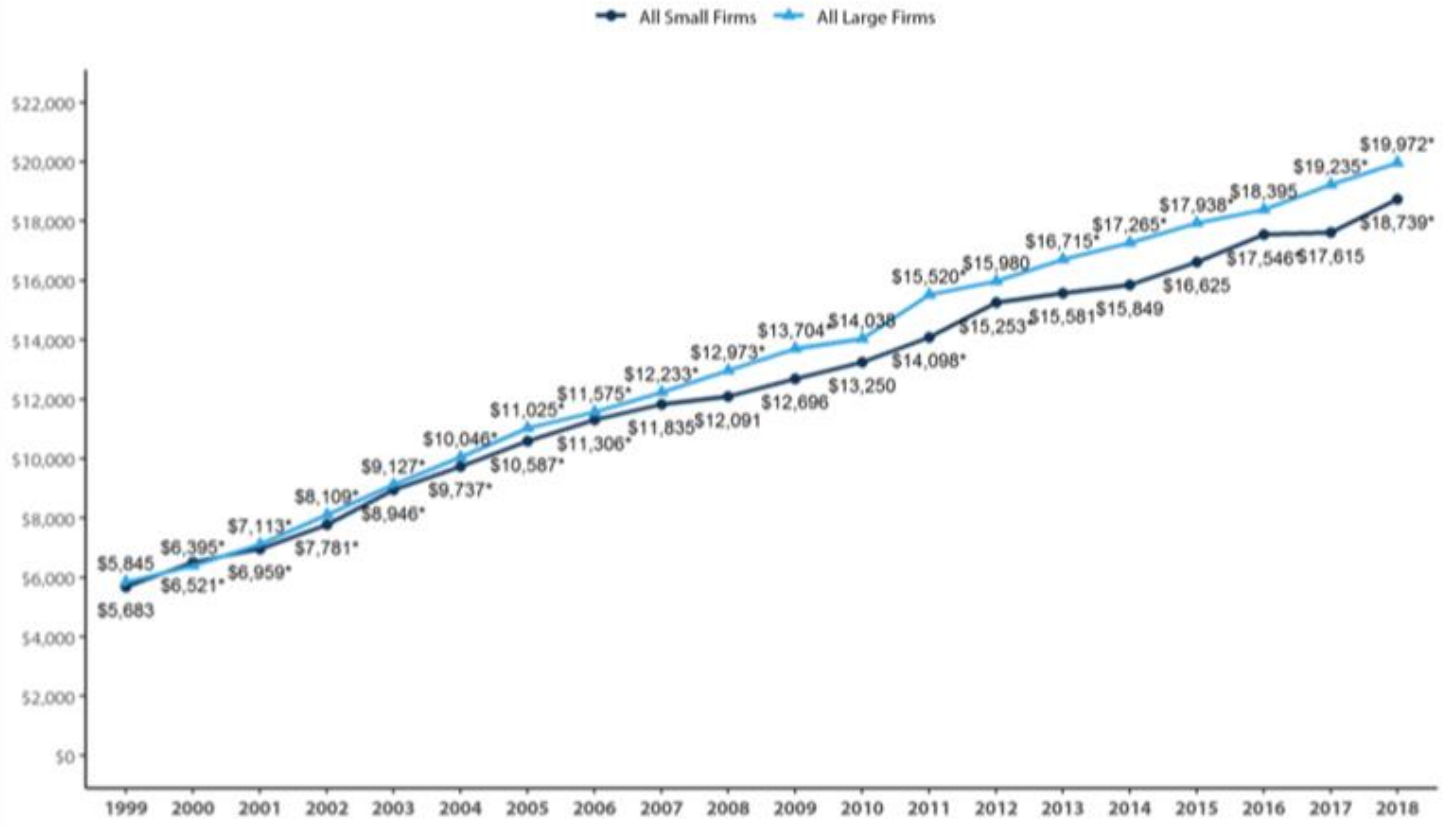
Figure 1.12

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

Deductibles are Increasing

Call to Action: Growth of High Deductible Plans

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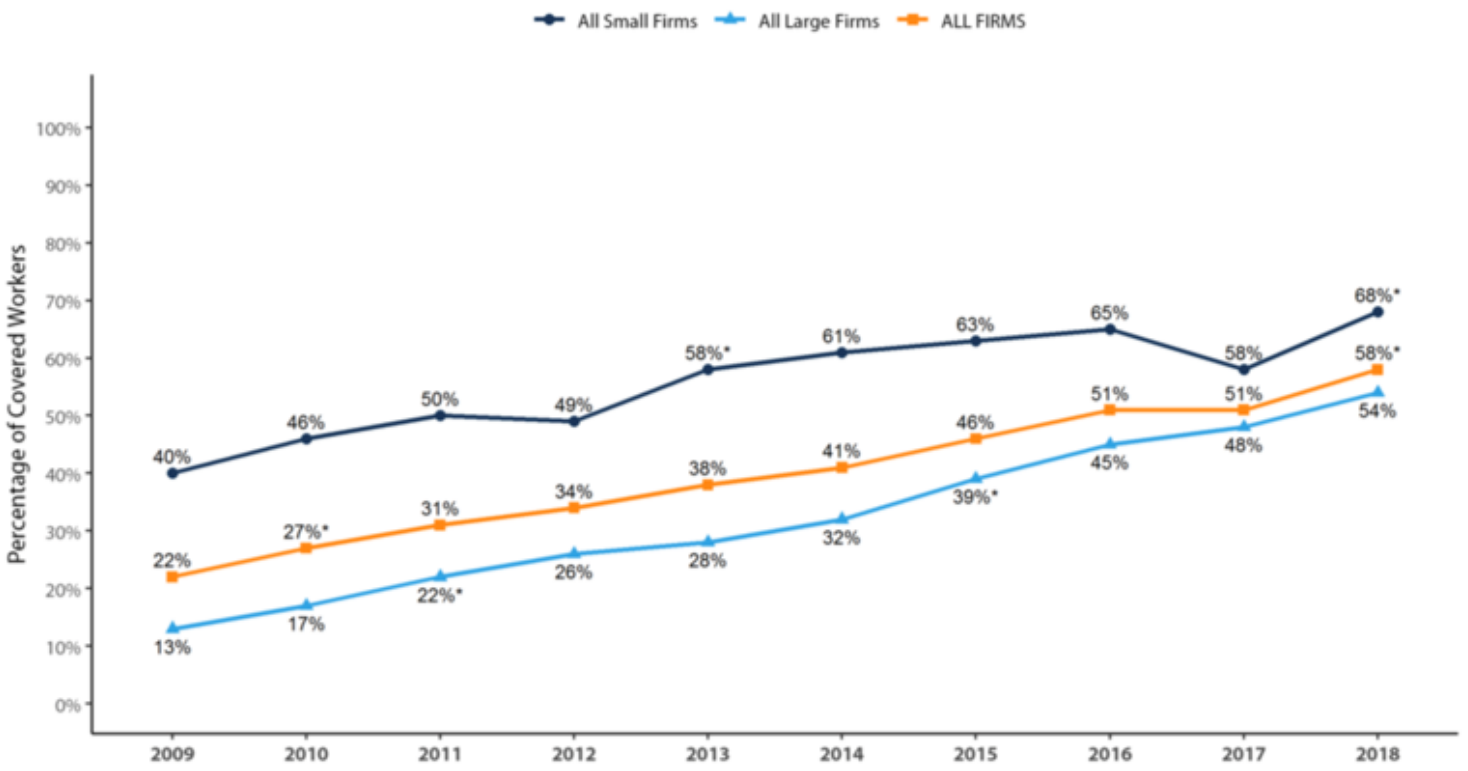
Employer Health Benefits

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

Medicare Margins Continue to Decline

Call to Action: Declining Medicare Margins

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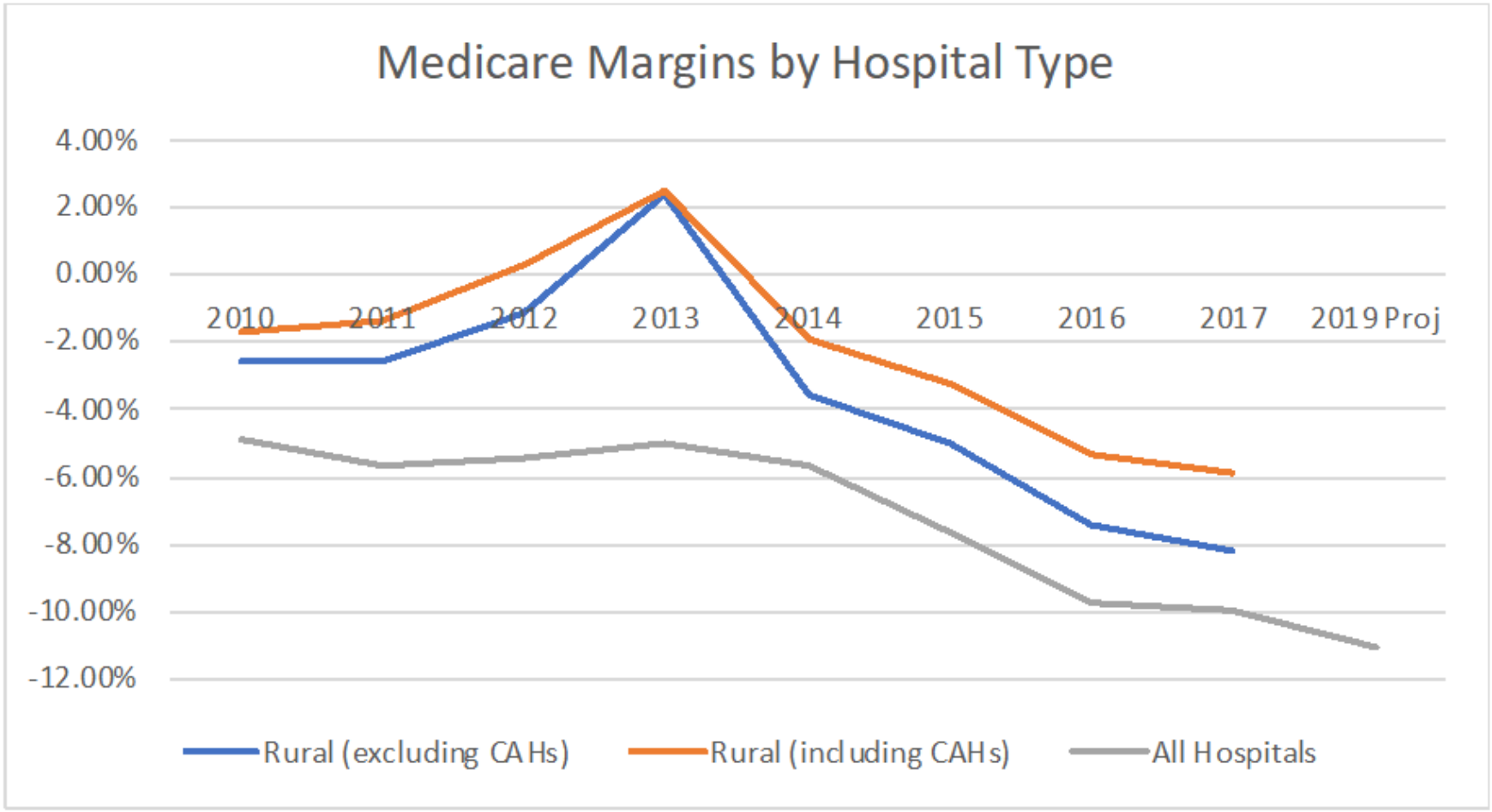

Source: MedPac Report to Congress, March 15, 2019

An Evolution in Thought and Practice

Phase 1

- ED "High Flyers"
- Chronic disease patients
- High utilizers

"The patient is driving up our costs."

Phase 2

- Analytics to ID patients and patterns
- Chronic care *management*
- Pt and physician engagement
- Behavioral health integration into primary care
- Some SDOH care

"Maybe we can do more to control costs."

Phase 3

- Care redesign
- Maximizing Medicare benefit options
- Increasing telehealth
- Challenging assumptions
- Innovations in care

"Maybe we need to redesign the way we deliver care."

Source: Teresa Wilson, ACO Coordinator, CMS, National Rural Health Association Annual Meeting, May 2019.

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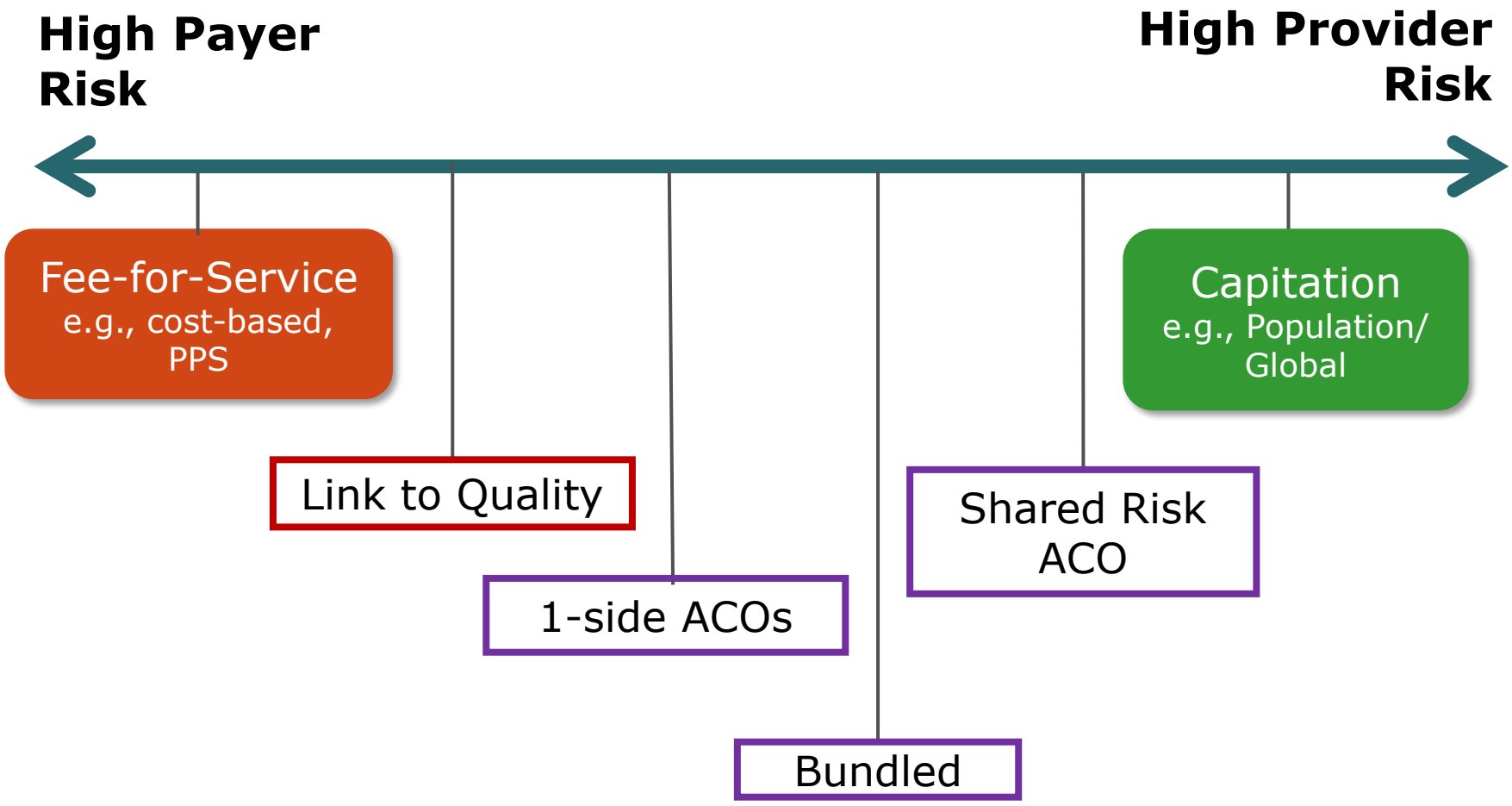
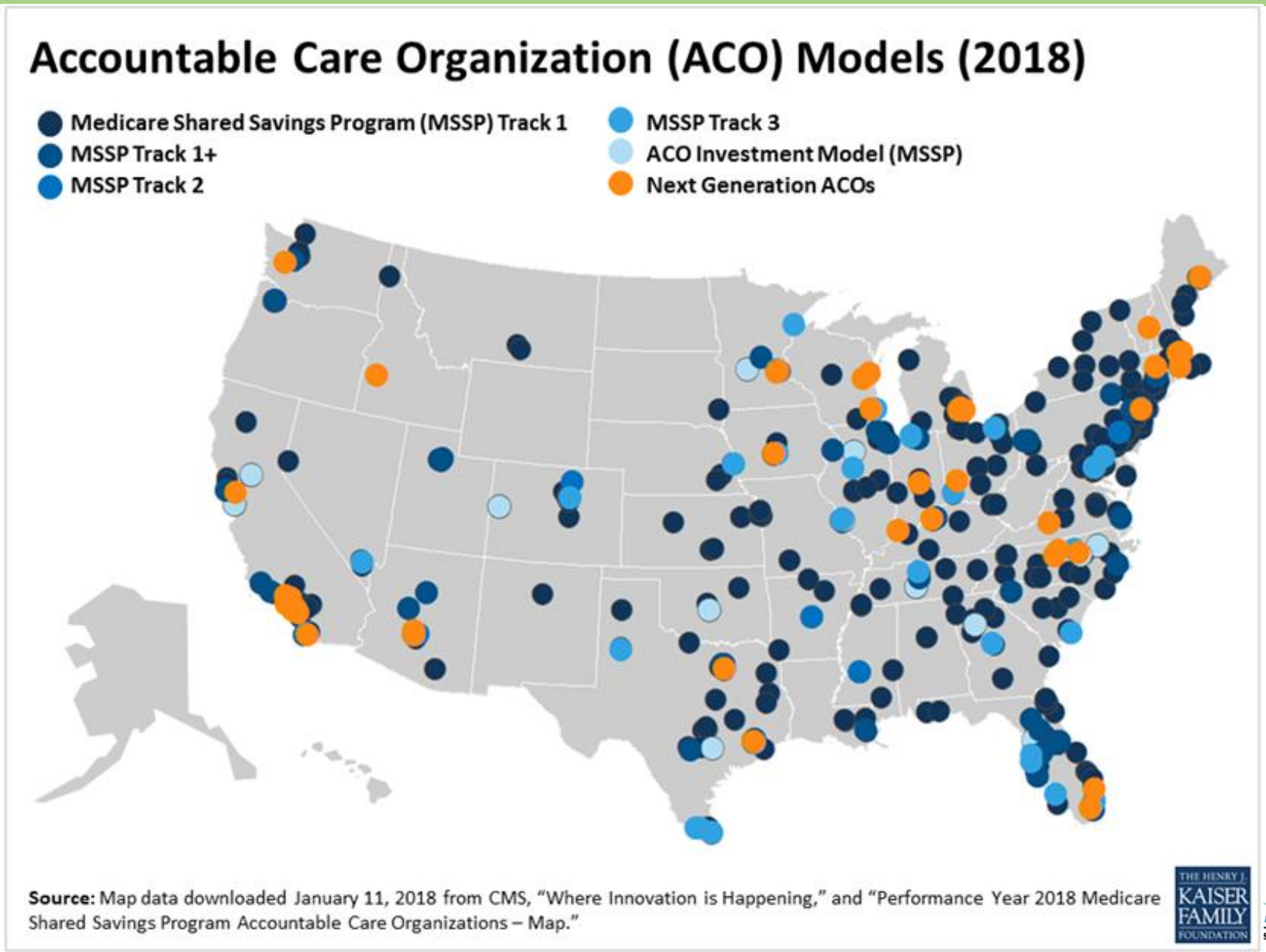
Payment Risk Continuum



ACO Spread - 2018



Players and Disrupters

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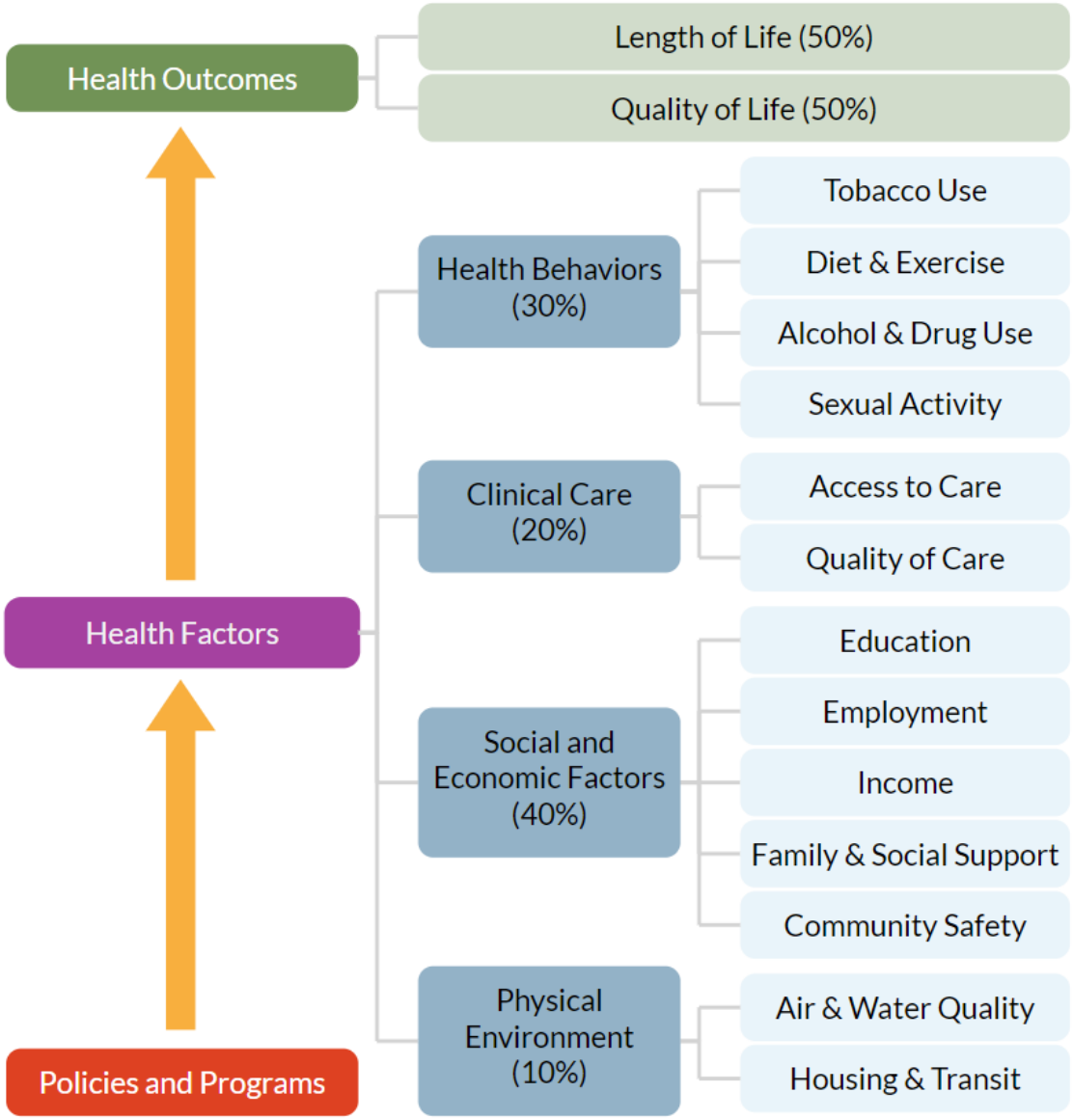
Population Health has Many Determinants



County Health Rankings model © 2014 UWPHI

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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.

Adapted from: World Health Organization (WHO) and Centers for Disease Control and Prevention (CDC)

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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

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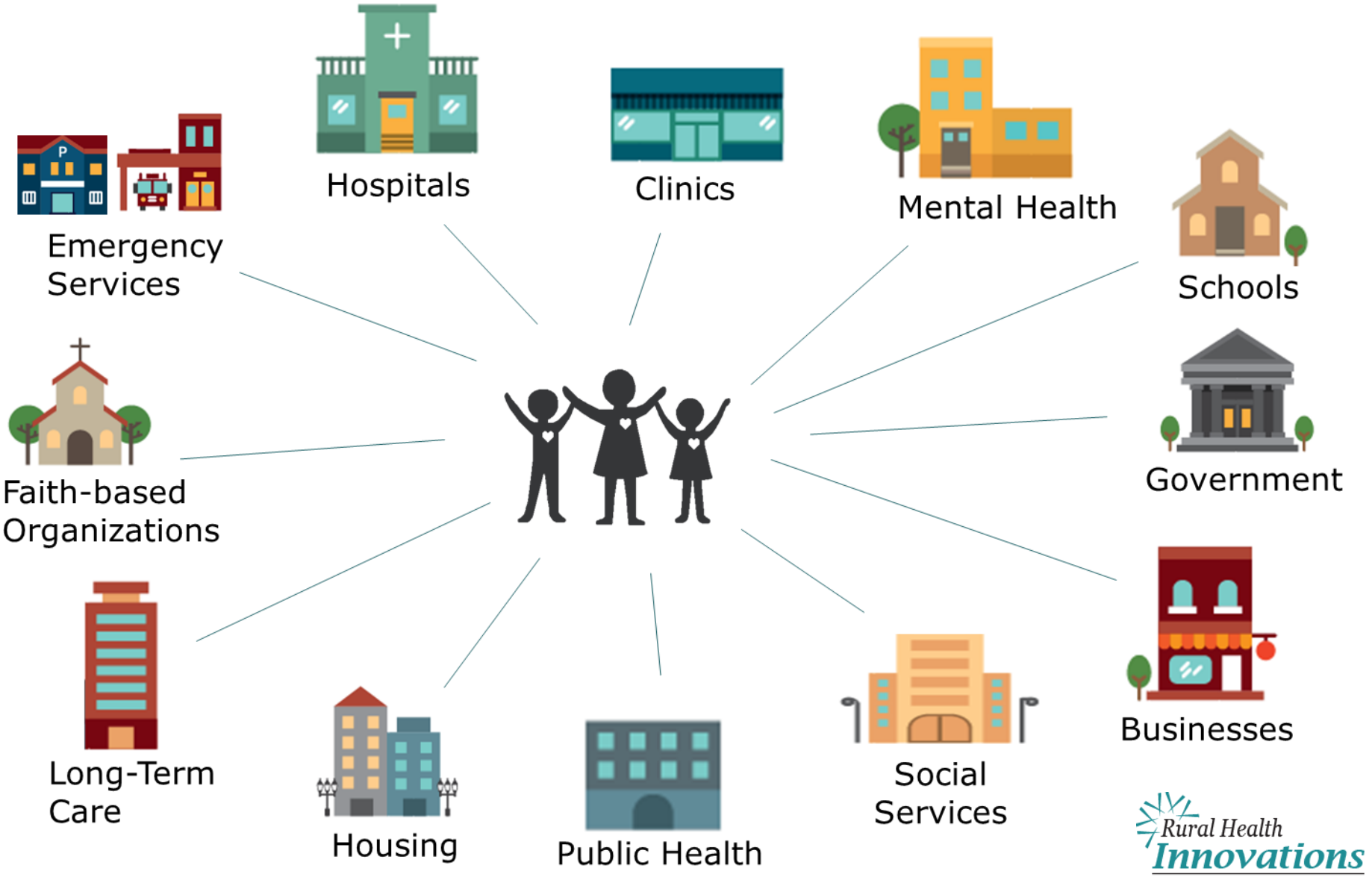
Health Equity

Health equity means that everyone has a fair and just opportunity to be as healthy as possible.

Source: What is health equity? And what difference does a definition make? Robert Wood Johnson Foundation, May 2017.

Population Health has Many Partners



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The Incentive

Figure 1. Six Foundational Concepts of Pathways to Population Health

Source: Pathways to Population Health: An Invitation to Health Care Change Agents, Institute for Healthcare Improvement, www.ihi.org/p2ph

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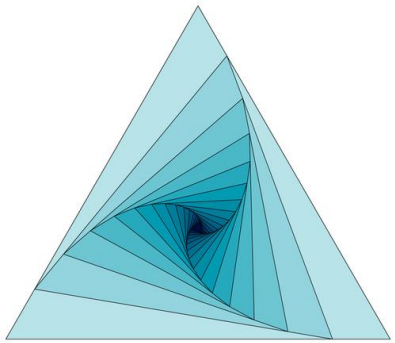
The Why

- **Move out of unsustainable health care system**
  - Moving through one that is developing unevenly
- **Drive down per capita cost**
  - Shared savings
  - Better cost controlling



- **Improve experience and outcomes of care**
  - Focus on quality and satisfaction
  - EHR, reporting
- **Create healthier communities**
  - Relevance
    - Rethink care management
    - Provider of choice

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How do we Realize Population Health

- Leadership and staff driven culture change
- Commitment of resources and strategy that align with organization mission and vision
- Evaluate current operations for wins and gaps
- Collaborate with partners for success
- Leverage partners' strengths and assets
- Ask why not? Why can't something be done a certain way? Innovate and address SDOH
- Use clearly defined strategies
- Focus on actionable items
- Seek measurable outcomes that can be monitored over time

ACO Top 10 Lessons Learned

1. Set up Care Coordination Programs
2. Perform Annual Wellness Visits
3. Provide Behavioral Health Support
4. Improve Hierarchical Conditioning Coding
5. Improve Quality Processes/Pre-Visit Planning
6. Provide care in physician-led teams
7. Expand use of telehealth and technology
8. Take care of health care providers
9. Manage patient information & analysis
10. Manage downstream costs of patient care

Source: National Rural Accountable Care Consortium

Opportunities

Workforce

Primary Care Capacity

Nurse-led Programs

Revenue Sources

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Expand Services Through Funded Workforce

- Build primary care capacity
- Nurse-led programs support an increase in primary care demand
- Fill care gaps and create more access for chronically ill
- Use data to inform processes (IT, thorough documentation)
- Increased revenue to support more population health staff

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

Build Primary Care Capacity

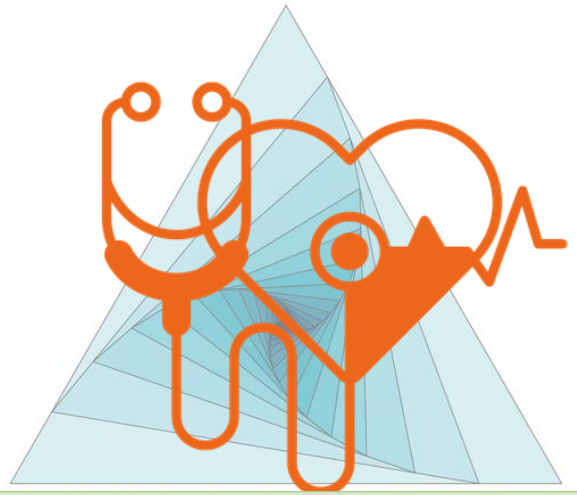
- Population health management requires one hour a year more in visits for every Medicare patient
- Care management creates the need for right time visits

150 annual Chronic Care Management (CCM) patient visits will pay for one nurse

- Wellness and prevention services build strong relationships with all patients, not just those with chronic conditions

Three Annual Wellness Visits a day will pay for one nurse

- Use pre-visit planning



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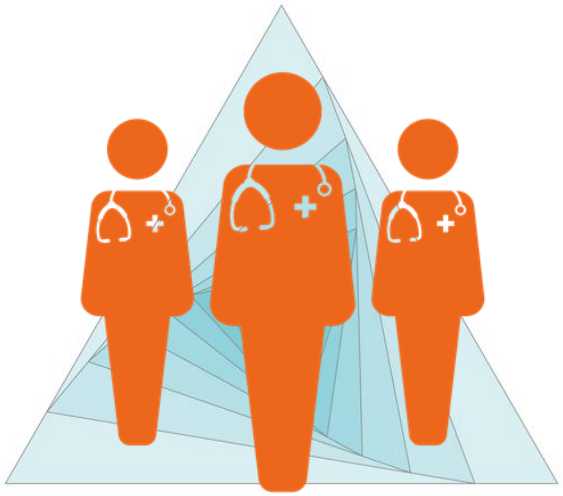
Nurse-led Programs Drive Primary Care Demand

- Meet patient needs, build relationships
- Use data to manage patient needs
- Support provider needs
- Patient receives right level of attention when they need it most
- Manage patient and disease through consistent evidence-based processes



- Better Care
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Population Health Revenue Opportunities

- Initial Preventative Physical Exam
- Annual Wellness Visit, Initial
- Annual Wellness Visit, Subsequent
- Preventative Health Screening
- Depression Screening
- Alcohol and Drug Screening
- Alcohol/substance abuse Assessment and Intervention
- Tobacco Use Counseling
- Advanced Care Planning

- Chronic Care Management
- Transition of Care Management
- Diabetes Self Management Education
- Diabetes Self Management Training
- Integrated Behavioral Health
- Remote Patient Monitoring
- Telehealth Originating Site Facility
- BMI Above Normal
- Behavioral Therapy for Obesity

Master Hierarchical Conditions Category Coding - webinar

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Rural is Well Positioned

- Rural has a foundation of primary care
- The basis for health care transformation is population health, prevention, and wellness

"Simply stated, the healthcare delivery systems of today will increasingly leverage the platform and resources that they have in place to become a hub for both health and healthcare in the future. There is a level of urgency to move quickly. Many feel that if they don't expand the role they play in both health and healthcare in their community, someone else will step in." - Becker's Hospital Review

The Destination…

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

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Complete the Post-Webinar Poll Question

What is your confidence in explaining the benefits of population health to others in your organization?

- Not confident
- Slightly confident
- Moderately confident
- Confident in my knowledge
- Extremely confident

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Complete the Poll Questions

On a scale from 1-5 (1 being not at all), I learned something from this webinar that I would like to implement in my hospital.

On a scale from 1-5 (1 being not at all), overall, I am satisfied with this webinar.

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Contact Information

Tracy Morton

Director of Population Health

(218) 216-7027

tmorton@ruralcenter.org

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