THE HOMETOWN HEALTH 2018
IOWA RURAL & CRITICAL ACCESS HOSPITAL CONFERENCE
MARCH 14 & 15, 2018 * COURTYARD BY MARRIOTT DES MOINES/ANKENY

POPULATION HEALTH FORUM: ASSESSING YOUR HOSPITAL'S PREPAREDNESS

Funding through the "Rural Hospital Learning Opportunities Program" provided by the Iowa Department of Public Health and HomeTown Health through the HRSA Critical Access Hospital FLEX Grant 2017-2018, Iowa contract #5888CA04.

AGENDA

POPULATION HEALTH FORUM: ASSESSING YOUR HOSPITAL'S PREPAREDNESS

Time	Session	Presenter
4:15pm - 5:00pm	**Assessing Hospital Preparedness for Transitions to Care Management and Population Health** The purpose of the Population Health Forum is to provide training in Population Health preparedness, and the moderation of a forum that encourages participants to share ideas and views on population health in their region with other leaders. The audience will be asked to provide ideas and feedback through a moderated forum through the use of cell phone polling and a "forum" of sharing.	Dr. Angie Charlet - ICAHN
5:00pm - 6:00pm	**Population Health interactive Forum**	Jimmy Lewis - HomeTown Health, & Dr. Angie Charlet - ICAHN

RURAL HOSPITAL LEARNING OPPORTUNITY PROGRAM

The **Rural Hospital Learning Opportunities Program (RHLOP)** will support Iowa's CAHs in activities that will improve their financial and operational outcomes *and* the quality and patient safety due to policy implementation.

Goal of the Population Health Forum:
A forum for hospital stakeholders & hospital leadership:

- to provide details as to how a hospital can start to implement population health in their community.
- to hear where you are at with Population Health initiatives.

THE RURAL HOSPITAL LEARNING OPPORTUNITY PROGRAM

Angie Charlet, Director of Quality Services - Illinois Critical Access Hospital Network (ICAHN): *Angie Charlet is a Registered Nurse with over 20 years in the healthcare industry. She has a Bachelor's in Nursing, a Master's in Healthcare Management with a focus in performance improvement and her Doctorate Degree in Business Administration with a focus on Healthcare Management and Executive Leadership. She is certified in CPHQ, Certified in both Lean and Black Belt Six Sigma. She is employed by the Illinois Critical Access Hospital Network (ICAHN) as the Director of Quality and Education and also functions as the Quality Director and Compliance Officer for their new ACO; Illinois Rural Community Care Organization (IRCCO), which is currently implementing the Patient Centered Medical Home and Care Coordination as the foundation within the ACO. Angie provides training, education, mock surveys and resources to both critical access hospitals and RHCs. Her focus is around regulations, quality initiatives, PCMH implementation, care coordination and expanding the market share by creating a medical neighborhood. Her skill sets include demonstrated team building, network engagement, evidence-based practice, PCMH, Lean and Six Sigma along with Leadership Coaching to bring new initiatives/practice models.*

THE RURAL HOSPITAL LEARNING OPPORTUNITY PROGRAM

Jimmy Lewis, CEO - HomeTown Health, LLC: *Jimmy Lewis has roots in rural South Georgia where he was born in Cordele, Georgia. Having graduated high school in Cordele, he attended Middle Georgia College and then Auburn University. He received a Bachelor's Degree in Industrial Engineering from Auburn. Jimmy has held senior management positions in six fortune five hundred companies. He has been instrumental in passing key rural legislation and regulation for hospital based nursing homes, state merit, PPS and critical access hospitals. All of these have been key to the survival of rural hospitals and rural health care in Georgia. Under his leadership, HomeTown Health has grown to a Georgia-based virtual company where 60+ hospital members and 60 business partners cumulatively have over $800 million in sales. HomeTown Health activities range from the identification of best practice solutions, to education, collective purchasing, developing managed care strategies, reimbursement advocacy, as well as legislative representation. HomeTown Health's efforts have been very instrumental in saving many of Georgia's rural hospitals. Jimmy is married with two grown sons. He and his wife, June, live in Cumming, Georgia.*

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IOWA HTH BUSINESS PARTNERS

HomeTown Health employs a unique model with its Business Partner Program, which is a partnership model with a long term commitment, not sponsorship of a one-time event. We value our network partners who have a proven track record and offer best practice solutions. HTH Business Partners must be invested in the success of small or rural hospitals and understand the challenges they face. HomeTown Health management selects its Business Partners based on an aggressive due diligence process that includes reference checking, performance checking, customer satisfaction, and capability to perform and communicate well in rural settings.

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IOWA HTH BUSINESS PARTNERS

- Collect your "HomeTown Bucks" throughout the day from Business Partners at networking breaks and receptions
- During the Reception this evening, we'll have announce all of the prizes and open up the silent auction
- Use your "HomeTown Bucks" to bid on the prizes
- Bidding will end at the end of the reception and prizes will be distributed to the highest bidder starting

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EVALUATIONS

HOMETOWN HEALTH

2018 Lessons Learned from the Hospital Transformation Consortium

Thank you for joining us at the HomeTown Health 2018 Iowa Rural & Critical Access Hospital Conference. Your feedback is a valuable part of our continuing improvement process and contributes to our future event planning. Please share your opinions by marking in the applicable column below.

OVERALL CONFERENCE EXPERIENCE				
Please rate your overall satisfaction with the following:	Excellent	Good	Average	Below Average
Overall Satisfaction with Registration/Check-In				
Overall Satisfaction with One-on-One with Dale Gibson				
Overall Satisfaction with Evening Receptions				
Overall Satisfaction with Meals Provided				
Overall Satisfaction with Meeting Spaces				
Overall Satisfaction with Breaks/Networking Times				
Overall Satisfaction with HTH Staff Assistance				
PRESENTER FEEDBACK				
Wednesday, March 14, 2018				
Please rate speakers based on their presentation being applicable, engaging and informative.	Excellent	Good	Average	Below Average
Jennie Price – Conference Welcome				
Jimmy Lewis – Rural Hospital Transformation				
Bubba Joiner – Financial State of Iowa's Small Hospitals				
Angie Charlet – Technology & Population Health				
Tesa Schlatman – Project Report and the Future of Quality				
Jerian Custer – Project Report and the Future of CDI				
Bena Brewer – Project Report and the Future of Telehealth				
Kerry Dunning – The Financial Impact of Quality with SNFs, SWBs and RHCs				
Michele Madison – What's Coming for Small and Rural Hospitals				
Jennie Price – SHIP Grant Update and Planning Session				
Jennie Price and Kristy Thomson – Closing and Evaluations				
OVERALL CONFERENCE INSTRUCTIONAL VALUE				
Please rate your overall satisfaction with the following:	Excellent	Good	Average	Below Average
Learning Objectives Issues & Content Material Covered				
Usefulness of knowledge/skills acquired				
Instructor's knowledge of materials/topics				
Instructor's presentational skills				
Overall Event Rating				

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LIVE COLLABORATION & FEEDBACK

To participate in live polling, you must first join our session.
(If you already joined yesterday, you **do not** need to join again!)

Here's how:
Send a text message to the five digit number 22333.
In the body of the message, you'll type the keyword HTHIOWA.

You will get a confirmation message that you are now part of our session.

To vote, simply reply to that message with your response.

Note:
Standard text messaging rates apply, so it is likely free for you to participate (or up to twenty cents on some carriers if you do not have a text messaging plan.)
The service we are using is serious about privacy. We cannot see your phone numbers, and you will never receive follow-up messages outside this presentation.

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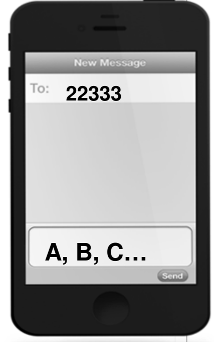
LIVE COLLABORATION & FEEDBACK

Let's test it out!
Multiple Choice:

To vote, simply reply to that message with your response (A,B,C)…



LEARNING OUTCOMES

By the end of this presentation, you should be able to:

- Describe how care management fits into Population Health
- Identify starting point for building a Population Health Strategic Plan
- Identify current community resources available for your Population Health Program

Assessing Hospital Preparedness for Transitions to Population Health

How do we make the transformation to population health successful in a rural hospital?

- Involves assessing and continually improving the way patient care is delivered at all levels
- Occurs when an organization rejects existing practice patterns that deliver inefficient or less effective results and embrace a common goal
- Involves shared commitment to patient safety, clinical outcomes and quality care
- Involved process redesign and information technology implementation
- Involves blending people, processes and technology
- Involves commitment across facilities, departments and clinical fields of expertise
- Involves developing new systems and roles and overcoming resistance to change
- Involves transitioning to provide wellness care AND illness care

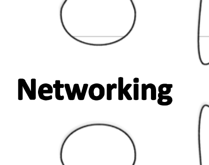
What is Population Health?

Population health management has been identified as a critical strategy for improving **value** in an era of reform.

It is a model of care management designed to enhance **coordination of care** and services for specific patient populations, such as Medicare patients or patients with chronic disease, and more actively **engage consumers** in improving and maintaining their health.

This model has the potential to significantly **reduce costs** for healthcare purchasers and consumers.

Population Health Forum



Poll Questions & Forum Topics

How many today are part of an ACO?

Yes
No
Considering for 2019

Defining Terminology Related to Population Health

Population Health
- Programs targeted to a defined population that use a variety of individual, organizational, and social interventions to improve health outcomes.

Accountable Care Organization (ACO)
- Groups of doctors, hospitals, and other health care providers who join together to provide coordinated, high quality care to well-defined populations of patients such as Medicare and commercial) patients.

Clinically Integrated Network
- A structured collaboration among physicians, hospitals, and other providers to improve the access, quality and efficiency of health care across broad geographies.

Public Health
- Aims to protect and improve the health of communities by promoting healthy lifestyles, conducting research for disease and injury prevention, and controlling infectious diseases

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8 Goals of the Population Health Program

- Keep population healthy
- Minimize need to ED visits; promote PCP-Patient Relationships
- Decreased need for hospitalization
- Reduce readmissions
- Reduce interventions, procedures, imaging, tests etc.
- Lower costs
- Improve quality and health outcomes
- Maintain and improve person’s health across the continuum of care

Population Health Forum

Poll Questions & Forum Topics

Our hospital has identified population health practices as part of our current Strategic Plan:

Yes
No
In process of review for 2018

Components for Success:

Population Health

A Leadership Team ready for Population Health….

- Is actively engaged in change management as part of transformation
- understands hospital transformation and population health management principles
- supports and takes responsibility to implement the strategic plan
- considering or interested in developing Clinically Integrated Networks (CIN) and advancing population health efforts in the community.
- has provided education on ACO concepts to governing board, physicians and others
- maintains both formal and informal means of communication and encourages new ideas and informal feedback

Components for Success:

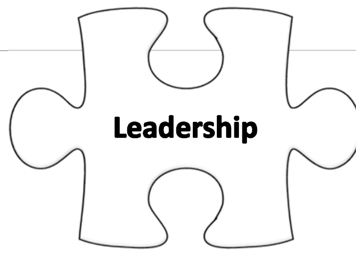
Population Health

A Governing Board ready for Population Health….

- is involved and supports hospital transformation and organizational change
- is actively involved in the development of its strategic plan
- understands and supports quality and performance improvement principles (board priority)
- participates in ongoing education and training on care coordination and transformation principles

Components for Success:

Population Health



A Leadership Team as whole has prepared the organization by….

- aligning its mission and vision with population health
- Promoting a culture that positively embraces population health and change implementing its Community Health Needs Assessment plan targeting the needs of its community and those we serve
- having a process to identify patients for population health management
- Having a strategic plan that includes initiatives to prepare for hospital transformation and population health management

Components for Success:

Population Health

A Financial team ready for Population Health…

- is actively engaged in hospital transformation
- financially supports care navigation programs – inpatient and outpatient
- has identified budget items required for care transitions and population health management for next fiscal year
- has tools to analyze service line value and return on investment
- financially supports population health management initiatives

Population Health Forum

Poll Questions & Forum Topics

Our greatest struggle with care management is:

a. **Understanding care transitions and HCAHPS scores**
b. **Managing patients through the health care network**
c. **Communication between providers of care**
d. **Implementing CCM/TCM processes**
e. **All the above**

Components for Success:

Population Health

A Hospital prepared for Population Health in Care Transitions…
- has a centralized scheduling program
- has a system for patient reminders/appointment changes
- has dedicated staff to provide community education programs
- offers wellness programs. (for employees, business partners, community
- has a plan to shift more patient services to the outpatient setting, which includes retraining staff
- has begun education to staff on care transitions and care management
- participates in readmissions and chronic disease management programs
- provides resources for clinical areas to incorporate evidence-based practice
- has a organization-wide customer service program
- has implemented Lean practices throughout the organization with staff engagement
- has incorporated performance/productivity based measures
- has initiated a chronic disease wellness program for employees and/or community
- Case managers and other have reviewed the Community Health Needs Assessment

Components for Success:

Population Health

A Hospital prepared for Population Health in Patient Care Management…
- has an inpatient case management program
- case manager is 'on call' for after-hours discharges and difficult patient care situations
- has an outpatient case management program
- has a discharge call-back program and includes Emergency room visits, D/C from nursing floors, Outpatient visits
- Nursing staff utilizes a discharge assessment tool to determine patient readiness for discharge
- Nursing and other health professionals incorporate evidence-based practices into the clinical setting and hospital policies and procedures
- Nursing has established bedside reporting program
- Nursing/case management includes patient and family in the care planning process
- Medical providers are part of the care management team
- Discharge program includes making appointments for follow-up visit with medical providers and/or therapy services as needed

Components for Success:

Population Health

A Hospital prepared for Population Health in Patient Care Management…

- Nursing/case management conducts at least weekly multidisciplinary care management meetings
- Hospital has established ongoing communications with area nursing homes, local health departments, referral centers, home health, hospice and other social services and behavioral health programs
- Hospital staff has established ongoing communication with primary care providers to ensure continuity of care and improvement in care and hospital services
- Hospital has a means to identify and monitor high-risk chronic disease patients and create a care plan based on needs and resources
- Hospital staff is engaged in care transition from one level of care to next
- Hospital has behavioral health resources readily available for inpatient and outpatient care needs

Components for Success:

Population Health

Wellness & Disease Management

Hospital has ated a population health management plan
Hos at least one outpatient chronic disease ma ent program (i.e. diabetes, congestive heart failur ity) If yes, please indicate in comments
Hos wellness education and r the community
Hosp education and screening in cooperation local medical primary care providers
Hospital has blished a community health education program, providing at least one program quarterly, and based on population health needs
Providers have a well-designed process in place for referral tracking and obtaining feedback from specialists
Hospital is actively engaged with local health department programs and initiatives
Medical providers actively support and refer to hospital's chronic disease management and community education programs

A Hospital prepared for Population Health in Disease Management…

- initiated a population health management plan for its employees
- established at least one outpatient chronic disease management program (i.e. diabetes, congestive heart failure, obesity)
- offers an annual wellness education and screening program for the community
- provides offsite education and screening in cooperation with local medical primary care providers
- has established a community health education program, providing at least one program quarterly, and based on population health needs
- Providers have a well-designed process in place for referral tracking and obtaining feedback from specialists
- actively engaged with local health department programs and initiatives
- Medical providers actively support and refer to hospital's chronic disease management and community education programs

Population Health Forum

Poll Questions & Forum Topics

We currently have wellness programs for staff?

Yes
No
Considering for 2018

Patient Engagement Ideas

- Track blood pressure, weight, blood glucose
- Exercise plan, physical accomplishments
- Seek employer engagement
  - Healthier employees = healthier population
- Employee wellness programs
- Employee wellness coaches
- Lunch n learn events/cooking events
- Community promotion/education
- Home visits
- School education: target younger obese population

Components for Success:

Population Health

A Hospital prepared for Population Health in Quality…

- has an active hospital-wide quality improvement program and reports findings to the board
- has established a program to measure readmission rates and actively monitor trends/improvement methods
- Medical providers report quality improvement measures, including practices and clinics
- participates in programs, such as Project RED,BOOST, pursuit of High Reliability Organization(HRO) or other programs
- Leadership rounds a minimum of once a week
- staff has embraced quality as part of the organization's culture and practice
- staff is aware of the quality measures and participates in data collection and improvement of care and service
- provides a transparent view of quality measures to the public – reports required measures to Hospital Compare
- Providers are monitoring PQRS quality metrics for improvement

Components for Success:

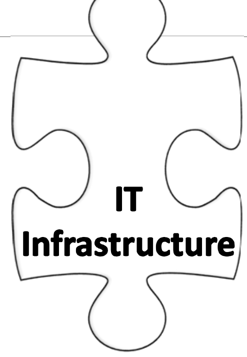
Population Health

A Physician team and Medical Providers ready for Population Health….

- are involved in hospital decision-making and are supportive of the hospital strategic plan
- participate in ongoing education and training on clinical integration and population health management
- are actively involved in quality Improvement
- are involved in hospital decision-making and are supportive of hospital's strategic plan
- understand Patient Centered Medical Home and have implemented concept
- support and incorporate evidence- based medicine in practice

Components for Success:

Population Health



A Hospital prepared for Population Health in IT Infrastructure and Data…

- Hospital has conducted a facility-wide analysis of internal improvements required for statistical data and informatics reporting through EMR
- Hospital has or will meet Meaningful Use Stage II by December 2017
- Clinic will meet Meaningful Use Stage I by 2017
- Hospital has IT connection to all departments, including physician practices, clinics and off-campus services, such as home health
- Hospital EMR connects to one or more physician practices or clinics for exchange of patient information
- Medical providers have the ability to share data electronically with other medical providers
- Hospital participates in a statewide, regional or system-wide health information exchange
- Hospital utilizes a clinical information specialist
- Hospital utilizes a discharge call management software program
- Hospital has initiated or plans to launch a patient portal within six months for its customers
- Hospital IT system provides for medical provider e-prescribing with pharmacies and others
- Hospital IT system has modules for population health management (trend and track data)

Population Health Forum

Poll Questions & Forum Topics

We use EHR data to drive change through:

a. **Quality of care outcomes**
b. **Understand our disease management**
c. **Determine readmissions (LACE)**
d. **None of the above**
e. **All of the above**

Identifying the Population(s)

- What patient data sets are available?
- What can your EHR query by diagnosis?
- Most at risk for disease progression
- Who are your high utilizers of care?
- Who are your frequent users in ED?
- Most at risk for hospitalization? Readmission?

Establish Criteria for Disease Registry

Asthma

- Age range? > 1 yr. old with at least (one of the following)
  - New diagnosis
  - Persistent rescue inhaler use
  - Needs education
  - > 2 ED visits in past 6 months
  - > 1 hospitalization as primary diagnosis in past 12 months
  - Considered risk population in community

Establish Criteria for Disease Registry

COPD or CHF

- Age range? > 18 yr. old with at least (one of the following)
  - New diagnosis
  - Medication management
  - Use of specialist for care
  - No office visit in past 6 months
  - Needs self management program
  - > 2 ED visits in past 3-4 months
  - > 1 hospitalization as primary diagnosis in past 6 months
  - Considered risk population in community

Thoughts

Questions to answer:

1. What factors affect a person's health? Community?
2. How should we assure care coordination across the continuum?
3. How do we engage individual's in their health and subsequently their care?
4. What types of staff and technologies do we need?
5. Are there community agencies that we need to partner with, and how do we begin those conversations?
6. Is creating an infrastructure important?
7. Are we using evidence-based protocols?
8. Are we using LACE to determine likelihood of readmission

Consider

- Patient Centered Medical Home Model of Care
- Team Based Care
- Motivational Interviewing Training
- Transition in Care Management
- Working with local nursing homes
- Managing discharges
- Determine quality metrics (MIPS)
- TeamSTEPPS for Office Setting
- High Reliability Organization Assessment
- CDSMP: Chronic Disease Self Management Program

Where We Started Quick Review

Six Specific Categories

- Governance and Leadership
- Operations
- Patient Care Management
- Population Health/Disease Management
- IT Infrastructure

Lesson Learned

- ✓ It may seem simple but change is hard
- ✓ Not everyone is engaged right from the start
- ✓ Ongoing communication is essential to success
- ✓ Ensure you have the right people at the table
- ✓ Understand current workflow before looking to improve

The Triple Aim

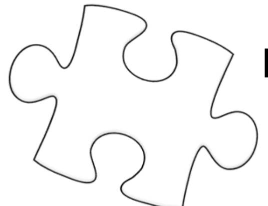
Better care for Individuals	Better health for Populations	Lower Cost

Population Health Forum

Moderators:

Jimmy Lewis, Chief Executive Officer - HomeTown Health, LLC.
Dr. Angie Charlet, Director of Quality Services - Illinois Critical Access Hospital Network (ICAHN)

Please share your hospital's experiences with Population Health!



Leadership & Governance with Population Health

Tell us about your hospital's experience:

What challenges, changes, planning, or success has your hospital leadership team had in **managing or leading** population health?

In collaborating with your community?

Finance & Operations: Population Health

Tell us about your hospital's experience:

What challenges, changes, planning, or success has your hospital had in budgeting for, planning for or managing the **financial** or **operational** aspects of population health?

Care Management & Population Health

Tell us about your hospital's experience:

What new initiatives or preparedness has your hospital started in the area of **care management**?
What have been your challenges or successes?

Wellness Programs & Chronic Disease Management

Tell us about your hospital's experience:

What has your hospital implemented for staff, the community or both, related to **Wellness or Disease Management program**?

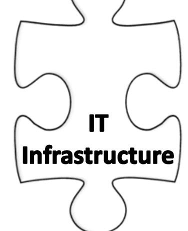
Where have you been successful?
What are your challenges?

Providers & Population Health

Tell us about your hospital's experience:

What has been your participation and response from your community **physicians**?

Where have you found challenges?
Where have you been successful?



IT Infrastructure & Use of Data for Population Health

Tell us about your hospital's experience:

What **technology** have you utilized for pop health; where have you been successful?

What has been your experience gathering and utilizing **data** to support pop health?

THE HOMETOWN HEALTH 2018

IOWA RURAL & CRITICAL ACCESS HOSPITAL CONFERENCE

MARCH 14 & 15, 2018 * COURTYARD BY MARRIOTT DES MOINES/ANKENY

6:00pm - 8:00pm **Opening Networking Reception & Silent Auction/Prizes**

Post-Reception **Optional Dinner/Entertainment with Business Partner Sponsors**

Day Two:
7:00am – 8:00am: Breakfast and Networking Reception