Ross County:
The “WOW” of Building Partnerships to Improve Rural Population Health

Ohio Rural Health Conference
August 27, 2018
Learning Objectives

After this presentation, attendees will:

✓ Understand the value of building community partnerships to navigate and succeed in the development of Medicaid Wellness.

✓ Recognize opportunities for population health partnerships within rural communities.

✓ Identify sources of data that are available to support a collaborative plan.
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Ross County Medicaid Wellness Partnership with ODH Medical Director Dr. Clint Koenig
Ross County Medicaid Wellness Partnership

Our Vision

To transform the healthcare experience through a culture of caring, quality, safety, service, innovation and excellence.
A Snapshot of Ross County

Ross County

688.5 sq. miles
(2nd largest county by size in state)

Medicaid Population: 23,894

Ross County | Ohio
---|---
Population (2010 Census) | 78,064 | 11,536,504
% Population by Age
Under 5 years: | 5.5% | 6.2%
5-17 years: | 16.5% | 18.2%
18-24 years: | 8.0% | 8.7%
25-44 years: | 26.2% | 25.0%
45-64 years: | 29.1% | 27.7%
65 years or older: | 14.8% | 14.1%

https://development.ohio.gov/files/research/P1007.pdf
https://development.ohio.gov/files/research/C1072.pdf
History of the Ross County Partnership

Previous collaboration

• Organizations are members of the **Partners for a Healthier Ross County** which develops and oversees implementation of the **Ross County Health Improvement Plan**.

• **Hopewell and Adena** collaborate with the **Ross County Health District** on numerous community outreach initiatives.

• **Hopewell and Adena** working with the **CliniSync HIE** to exchange data electronically.

Triggers for Medicaid project

• **Hopewell and Adena** both accepted into the Ohio Medicaid CPC program in 2016; Medicaid patients attributed to each organization for care.

• As part of Medicaid CPC, providers are responsible for patients’ Medicaid quality & utilization rates of both inpatient and emergency department services.

• Both **Hopewell and Adena** showed high utilization rates of the emergency department for Medicaid populations.

• **Ross County Health District** exploring ways to provide additional population health services.
Creating the Team

➢ Made use of existing contacts to raise possibility of collaboration; informal network used to identify correct people.

First Meeting
- Defined and analyzed the data

Second Meeting
- Identified areas of concentration and current resources.
- Contacted other parties that needed to be involved.

Third Meeting
- Selected focus areas
- Team members migrated to areas of project concentration

➢ As meetings progressed, a more formal process was established to analyze the problem of access to care and identify potential solutions through monthly action plans and reporting.
Analyzing the Issues

Project divided into five areas of concentration:

- Emergency Department Utilization
- Access to Healthcare
- Behavioral Health Concerns
- Public Education (e.g., health services, sites of care, insurance, and chronic care; identification of pathways to distribute information)
- Community tools and personnel to create more intensive model for care management
Using Data to Tell the Story

Identifying Sources of Data

To Support a Collaborative Medicaid Wellness Plan
Using Data to Shape Decisions

**Sources of data: Understanding the problem**

- Data provided by both Medicare and Medicaid payers by individual patient on emergency visits and hospitalization.

- **Ross County Health District Soil & Water** used mapping program to Geozone locations of Medicaid populations. **Goal:** Determine access issues.

- **Adena** provided analysis on emergency department visits using several different metrics:
  - ✓ Age
  - ✓ Diagnosis
  - ✓ Time of day, day of week
  - ✓ Patient risk factors (e.g., heart failure, diabetes, asthma, depression, stroke, BH issues)
  - ✓ # of visits that can be listed as avoidable visits based on diagnosis
Team development of data

Team mapped provider locations in Ross County:

✓ Location of service (i.e., address or provider; location of hospital)

✓ Type of service (i.e., pediatric, primary care, behavioral health, urgent care, emergency)

✓ Pediatric age of patient in emergency room vs. time of day
Data Mapping for Access Analysis

Medicaid Participant Distribution with 3+ ED Visits

*Using data to define the issue:* Adults with 3+ ED visits considered non-emergency versus their physical location to determine where clinical care may be lacking.
Data Mapping

Pediatric Use of ED vs. Time of Day

Peds ED Utilizations – All Facilities
Advantages of a Community Partnership
Identified need: Clinical services needed in the eastern part of the county with more open hours and no advance scheduling. Special emphasis on childhood needs.

• FT Medicaid Wellness Navigator hired

Funding/resources:

• Grants: Desirable but can be slow, cumbersome, and limited in focus
• Internal: Pool resources and arrive at a plan to maximize impact
  ▪ Facility: Chillicothe City School District
  ▪ Capital: Adena Health System and Hopewell
  ▪ Manpower: Adena Graduate Medical Education/Hopewell FQHC
  ▪ Patient education and outreach: Ross County Health District

Solution: Ross County Partnership opted to go with an internal solution, with everyone contributing resources.
Working Toward a Solution

Advantages of Community Approach:
Enables participants to:

• React more quickly to fill needs
• Tailor the project to meet the community’s unique situation
• Develop a solution that fulfills the partners’ business needs AND the community aims

Anticipated Outcome:

• Plan: New Medicaid clinic will open in eastern Ross County: 1st Quarter 2019
• Clinic to be housed in facility being used for other family & children services
Recognizing Opportunities for Population Health Partnerships

Within Rural Communities
Public Health Delivery in Ohio’s 21st Century

Most of a HD’s Work is “Above the Line”

- Assessment (Surveillance, Epidemiology, & Laboratory Capacity)
- All Hazards Preparedness/Response
- Policy Development/Support
- Communications
- Community Partnership Development
- Organizational Competencies (Leadership/Governance, Health Equity, Accountability/Performance Management, QI; IT; HR; Financial Management; Legal)

Programs/Activities Specific to an HD and/or Community Needs

- Communicable Disease Control
- Chronic Disease & Injury Prevention
- Environmental Health
- Maternal, Child & Family Health
- Access to and Linkage w/Clinical Care

Foundational Public Health Services

- Communicable Disease Control
- Chronic Disease & Injury Prevention
- Environmental Health
- Maternal, Child & Family Health
- Access to and Linkage w/Clinical Care

Foundational Capabilities
Collaborative efforts in progress:

- Case Management Certification
- Community Health Workers
- National Accreditation through the Public Health Accreditation Board (PHAB)
LESSONS LEARNED
Key Takeaways

Establish bi-directional community clinic partnerships.

Analyze. Analyze. Analyze your data – but be watchful of “analysis paralysis.”

Stratify data for super utilizers to customize level of intervention.

Address most preventable non-clinical drivers of inappropriate utilization.

Determine and target manageable entry points to establish locations.

Augment staffing models to include non-clinical roles.

Hone risk stratification methodology with social health determinants.

Recruit patients to Pop Health programs through navigation/service coordinators’ alignment.

Execute the plan.

Review and adjust the plan as needed.
This project is a process, not a point in time.

2018: Planning
- Understand the data
- Develop the plan

2019: Momentum
- Begin implementation
- Look for concrete results
- Review & analyze, make adjustments

2020: Innovation
- Build on a successful structure
- Consider new ways of solving problems
Pathway to Innovation

Determine behavioral health needs and staffing.

Develop strategy for use of Ross County Health District, to coordinate outreach to potential patient population in eastern Chillicothe.

Develop a communications program aimed at both advertising the new site of service at Mt. Logan and educating patients to important health basics.

Provide outreach to Chillicothe and Ross County schools to maximize contacts with families and make use of facilities to provide some clinical services.

Analyze and develop plan to more closely integrate categories of professionals not currently engaged in the project (e.g., EMT responders through the fire department).

Implement Notify with providers through the CliniSync HIE to provide alerts when their patients are seen in either the inpatient or ED setting.
“Coming together is a beginning; keeping together is progress; working together is success.”

--Henry Ford
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