Population Health Initiatives in Maryland

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Defining “Population Health”

• According to the IOM Roundtable on Population Health Improvement, “the health outcomes of a group of individuals, including the distribution of such outcomes within the group”

• According to the Public Health Agency of Canada, “an approach to health that aims to improve the health of the entire population and reduce health inequities among population groups”

• According to Kindig and Stoddart, “a concept defined as the health outcomes of a group of individuals, including the distribution of such outcomes within the group”

• According to Dunn and Hayes, “measured by health status indicators and as influenced by social, economic, and physical environments, personal health practices, individual capacity and coping skills, human biology, early childhood development, and health services”

• According to Young, “a conceptual framework for thinking about why some populations are healthier than others,” as well as the policy development, research agenda, resource allocation that flows from it
Hallmarks of Population Health

• Seen as the sum of individual parts or a cross-sectional perspective
• Requires consideration of a broader array of the determinants of health than is typical in public health
• Recognizes that responsibility for population health outcomes is shared but that accountability is varied

Stoto, M (2013). Population Health in the Affordable Care Act Era
Population Health

Present Day in Affordable Care Act Era

• Health care reform addresses population health by aiming to:
  – Expand insurance coverage by improving access to the health care delivery system
  – Improve quality of care
  – Enhance prevention and health promotion measures within the health care delivery system
  – Promote community and population-based activities

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State Health Improvement Process

• To catalyze and integrate efforts of:
  – Public Health
  – Hospitals
  – Community Groups and Providers
  – Patient Centered Medical Homes
  – Accountable Care Organizations
  – Health Benefits Exchange

• Goal: Improve population health and reduce health disparities
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Local Health Improvement Coalitions

- All SHIP indicators are provided to 20 local health improvement coalitions (LHICs) spanning the entire state
- LHICs provide a framework for accountability and continual progress
- They bring together a wide array of population-health focused community leaders to use data to identify community’s priority health needs and develop local health improvement action plans to address needs
- As a part of the Community Integrated Medical Home, Maryland will enhance data resources to support LHICS, as well as primary care and Community Health Hubs (CHHs), to support joint planning locally
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*Local Health Improvement Coalitions*

- In 2012, LHICs prioritized these areas:
  - Obesity (16)
  - Behavioral health (9)
  - Access to health care (9)
  - Smoking cessation (9)

- SHIP provides LHICs with:
  - County-level profiles annually
  - List of tools and resources designated to assist the general public, health planners, and providers
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*State Innovation Models (SIM)*

SIM Round 1 – “Model Design”

- Released by Center for Medicare & Medicaid Innovation (CMMI) at CMS
- Purpose: Develop, implement, and test new health care payment and service delivery models at the state-level
- Maryland received “Model Design” award
  - $2.37 million
  - Planning grant to develop “Community-Integrated Medical Home”
  - Opportunity to apply for “Model Testing” award for up to $60 million to fund implementation over a 4 year period.
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Community-Integrated Medical Home

Community Health Team
- Local Health Departments
- Community Organizations
- Social Services
- Hospitals
- Other providers

Primary Care Team
- Primary Care Physicians
- Nurse Practitioners
- Allied Health Professionals
- Community Pharmacists

Shared data

Care Manager
Community Team Leader & Community Health Workers
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*Regional Community Health Hubs*

- CHHs will be established in MD to deploy community wrap around interventions for defined target populations – “hot spotting”

- CHHs entities may include: *Local Health Departments, Hospital, LHIC, 501c3 community-based organization, or a collaborative partnership.*

- **Responsibilities:**
  - Deploy hot spotting intervention
  - Oversight/management of staff
  - Ensure fidelity to intervention model
  - Quality assurance and quality improvement
  - Data monitoring /tracking/reporting
  - Participate in HUB learning system to share data and improve processes
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*State Innovation Models*

SIM Round 2 – “Model Test”
- Released by CMMI at CMS
- Purpose: Provide financial and technical support to implement fully developed proposals for successful statewide transformation
- Focus:
  - Improving population health
  - Transforming health care delivery systems
  - Decreasing per capita total health care spending
- Timeframe:
  - 10/31/14 – Anticipated announcement date
  - 1/1/15 through 12/31/15 – Pre-implementation ramp up period
  - 1/1/16 through 12/31/18 – Anticipated period of performance
Opportunities