Population Health Initiatives in Maryland

Regional Forum on Hospital-Community Partnerships
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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 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

Population Health and Delivery System Reform

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- **State Health Improvement Process and Local Health Improvement Coalitions** provide measurement framework and infrastructure to support collective community action to improve population health.
- **State Innovation Model** would establish new care management/ community health infrastructure through **Community Health Hubs**

State Health Improvement Process

- A framework for accountability, local action, and public engagement to advance the health of Maryland residents.
- Goal is to enable communities to identify critical health needs and implement evidence-based strategies for change while measuring success through a common platform.

- 41 measures to track population health across five domains:
  - Health Beginnings
  - Healthy Living
  - Healthy Communities
  - Access to Care
  - Quality Preventive Care

Local Health Improvement Coalitions

- 20 coalitions across the state that identify priority health needs, develop local action plans, and monitor progress.
- Fosters shared accountability for continual population health improvement.
- Diverse group of community leaders representing local health departments, hospitals, primary care providers, behavioral health providers, community based organizations, and other key health stakeholders.
- Most common priority areas in 2014 Action Plans:
  - Obesity (16)
  - Behavioral health (9)
  - Access to health care (9)
  - Smoking cessation (9)

2014 SHIP Report Card

- Reduce infant deaths
- Reduce the teen birth rate
- Increase the % of pregnancies starting care in the 1st trimester
- Increase the % of adults who are at a healthy weight
- Reduce the % of children who are considered obese
- Reduce the % of youths using any kind of tobacco product
- Decrease the rate of alcohol-impaired driving fatalities
- Reduce new HIV infections among adults and adolescents
- Reduce domestic violence
- Reduce the number of unhealthy air days
- Increase the number of affordable housing options
- Increase the % of adolescents receiving an annual wellness checkup
- Increase the % of individuals receiving dental care
- Reduce deaths from heart disease
- Reduce the overall cancer death rate
- Reduce the number of hospitalizations related to Alzheimer's disease

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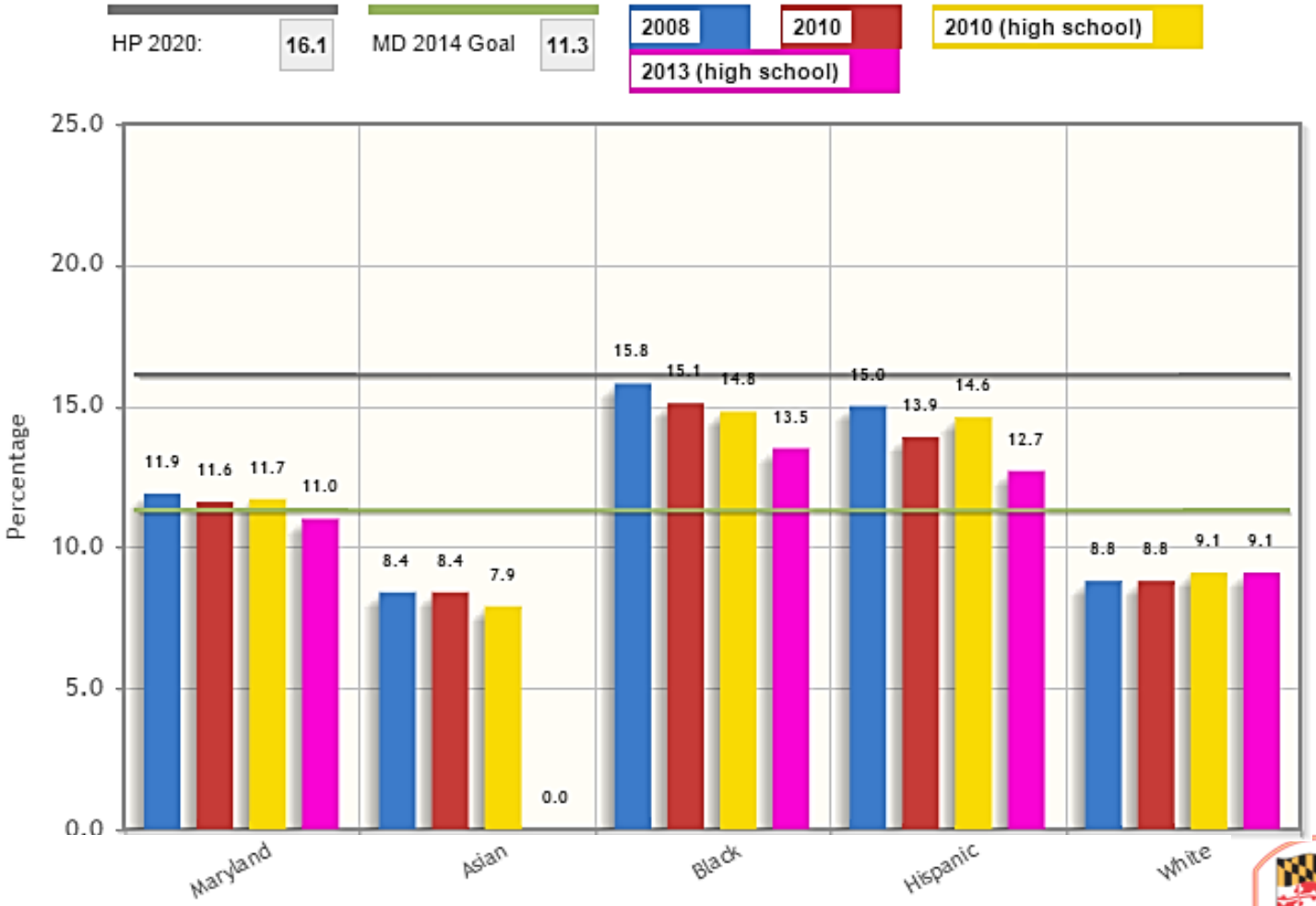
Child & Adolescent Obesity



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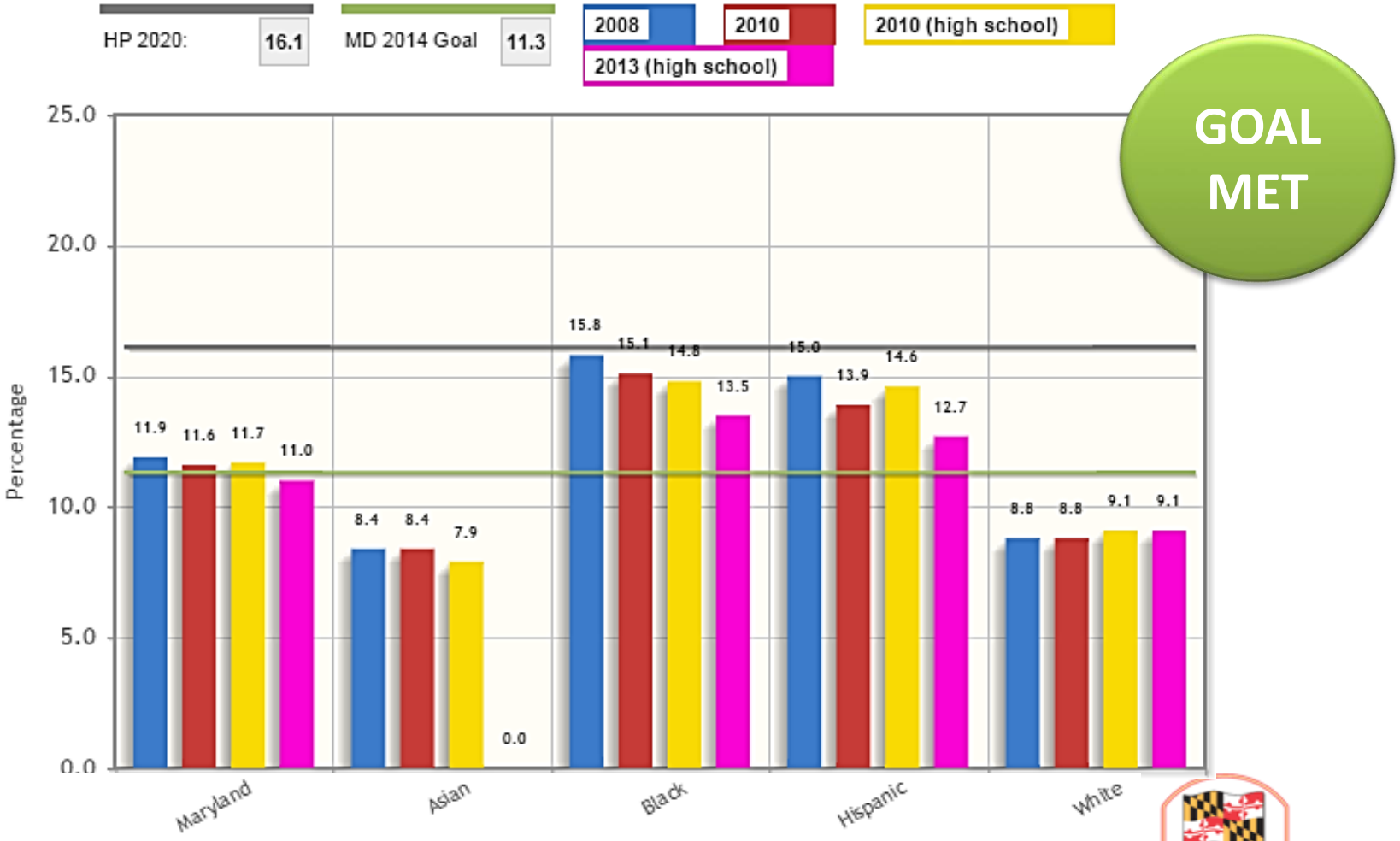

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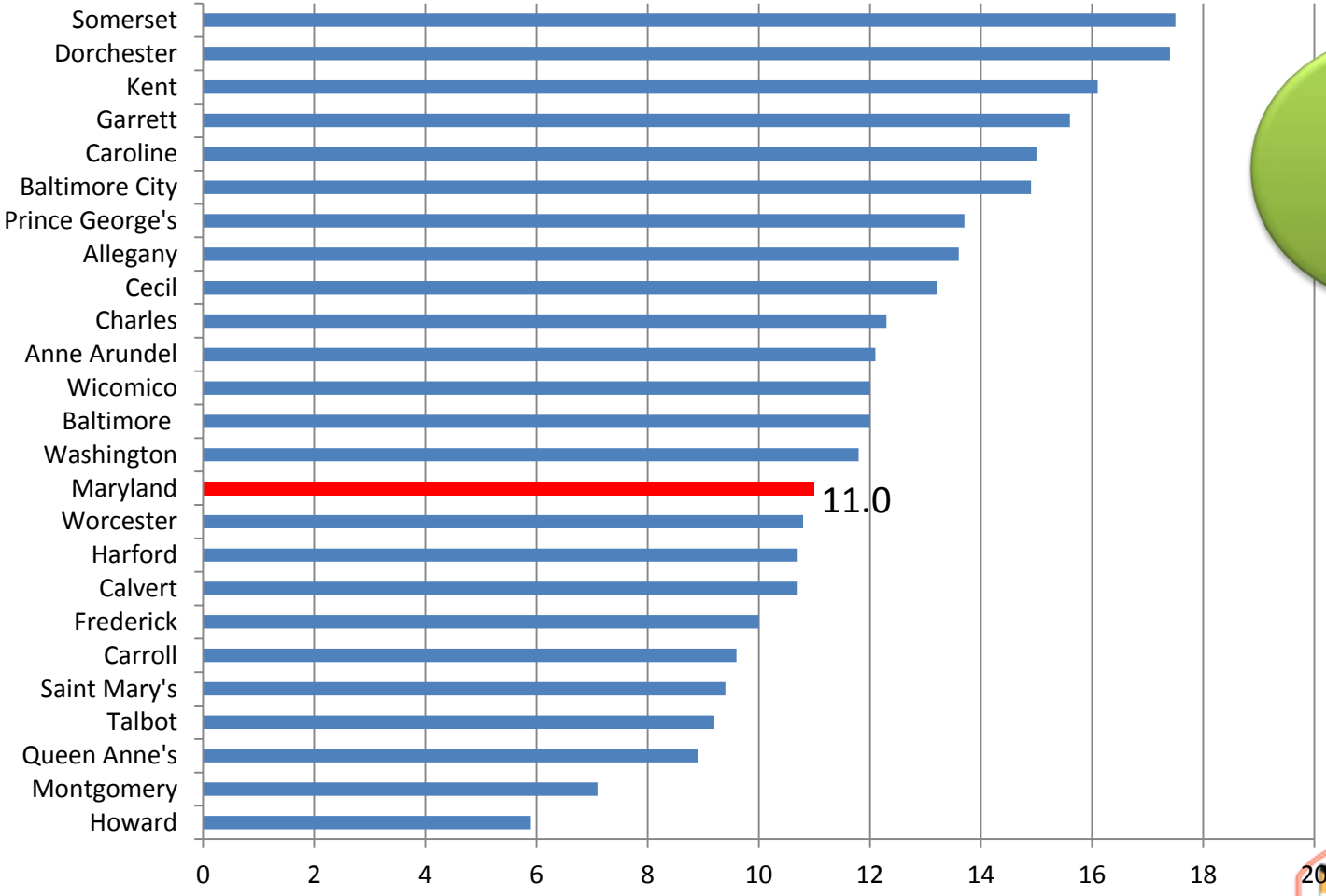

GOAL MET

Percent of High School Students that are Obese, 2013

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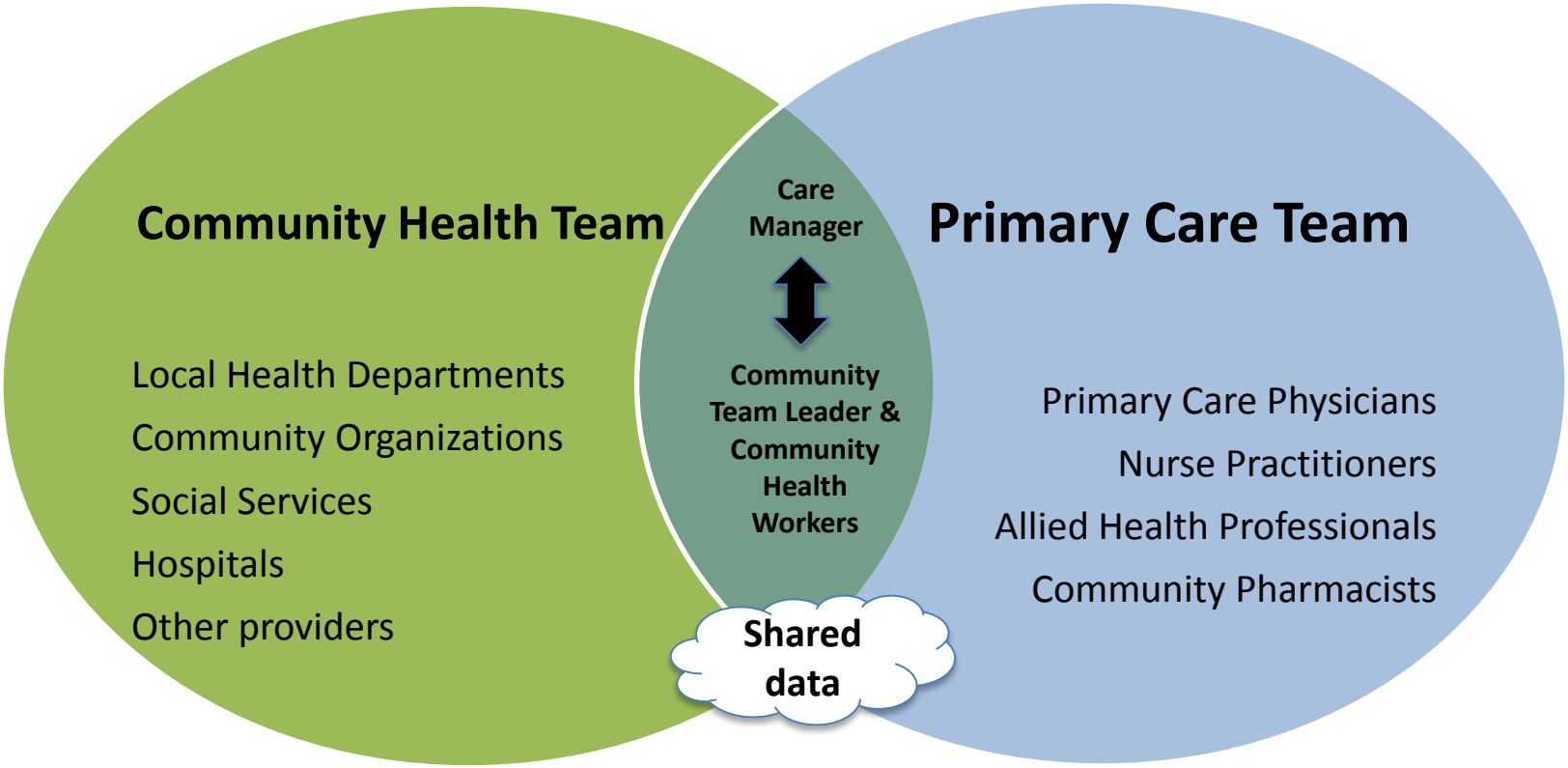
State Innovation Model



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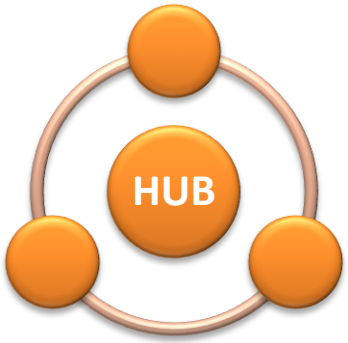
Community Health Hubs

- CHHs would be established to deploy community wrap around interventions for defined target populations – "hot spotting"
- Mutually beneficial to range of providers and payers at-risk.
- CHHs entities may include: Local health departments, hospitals, LHICs, 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



SIM Funding

- **Round 1 – Model Design**
  - Planning grant, 2013-2014
- **Round 2 – Model Test**
  - 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 – Original award announcement date… still waiting.
    - 1/1/15 through 12/31/15 – Pre-implementation ramp up period
    - 1/1/16 through 12/31/18 – Anticipated period of performance

Future State of SHIP & LHICs

- **Setting New SHIP Target Goals**
  - SHIP target goals for improvement expire in 2014.
  - DHMH is reviewing data and setting new timeline and goals.
  - Some measures are likely to be removed or modified; new measures possible.

- **LHIC Evolution with Delivery Reform**
  - With incentives aligned for population health improvement, DHMH sees LHICs as necessary infrastructure for establishing coordinated community action to support waiver and other delivery reforms.
  - Currently considering ways to give LHICs enhanced capacity to help meet targets under new delivery models.
    - ➢ Multiple funding sources will be needed to sustain current work and increase capacity.

Funding to Support Population Health

- **State Innovation Model**
  - Still awaiting a decision on SIM funding. Potentially would include funding for population health at local level. Stay tuned.

- **State Funding**
  - CHRC has released new funding opportunity focused on enhanced LHIC capacity.
  - Potential additional funding. Stay tuned.

- **Hospital Community Benefits**
  - DHMH strongly encourages the use of community benefits dollars to support population health interventions through the LHICs.

Q&A

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