

# Planning for Population Health/Population Health Transformation

Developing a Long-Term Vision for  
Population Health Improvement in Maryland  
Presentation to Local Health Roundtable

September 14, 2016



# VISION FOR MARYLAND HEALTH SYSTEM

Care Delivery  
and Financing



All Payer

Coordinated  
Continuum of Care

Value-Based

Competitive

Population



Focus on Needs  
of the Community

Address  
Social Needs

Achieve  
Health Equity

Patient



Surrounded by a  
Support Team

Engaged and  
Health Literate



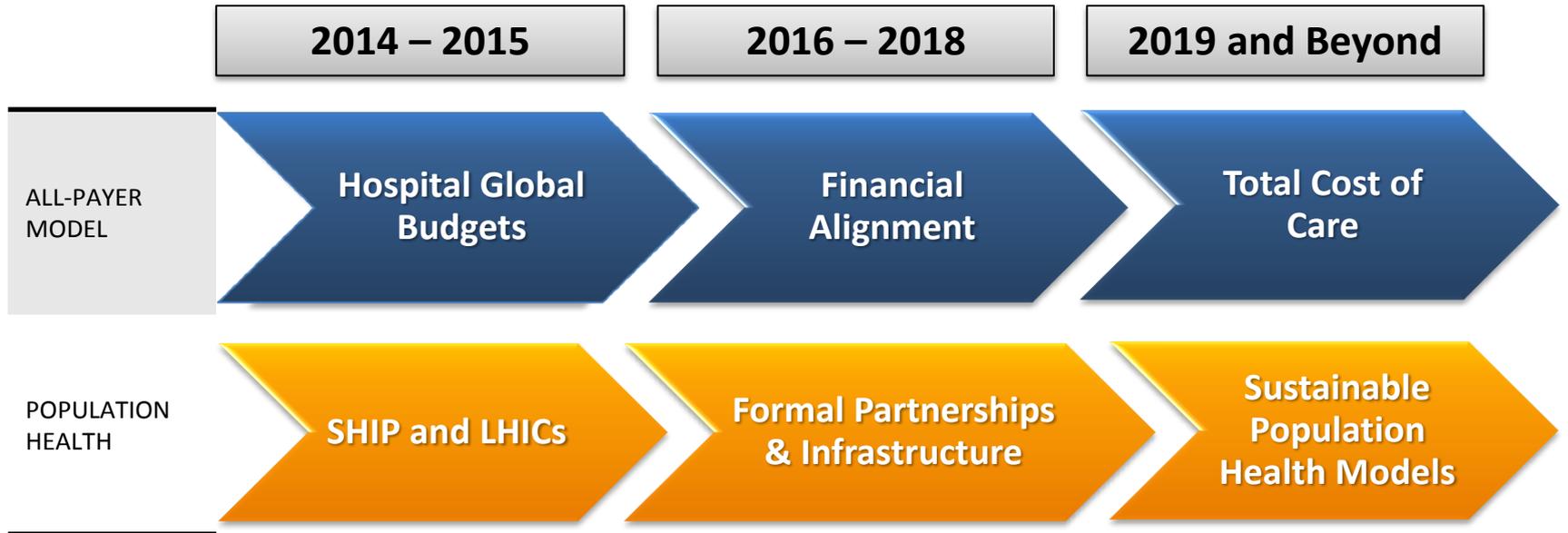
# Population Health Vision for Maryland

The State of Maryland envisions a system that functions as a fully integrated system of health for the individual regardless of the resident's location or complexity. The Maryland health care system will focus beyond the clinical space to address all factors that determine health. To improve health outcomes and equity, providers of care will engage and partner with community-based organizations, support services, and organizations functioning outside the traditional health care system, enabling a fully coordinated system that fosters both management of disease and addresses the underlying determinants of health.

# Priorities for the State

- Near-term focus:
  - Bolster All Payer Model including population health management initiatives
  - Develop a Customized State Primary Care Model
- Longer-term effort:
  - State Population Health Improvement Plan
    - How do we improve health outcomes and health equity for all Marylanders?
    - How do we make sustainable investments in health improvement that reinforces the All Payer Model goals?
    - How can we catalyze this work today, knowing this is a long-term effort?

# TRANSFORMATION PROGRESSION



# PRIMARY CARE MODEL

# Guiding Principles

- Broad-based provider participation design- Patient Designated Provider
- Aligned with the Triple Aim- Quality, Cost and Experience of Care
- Enhanced population health management functions
- All-payer capable in alignment with Phase 2 of waiver
- Care Management as a necessary element
- Regional Care Coordination Resources
- Person and Family Centered base of care
- Aligned and consistent set of quality/outcome metrics
- Efficient data exchange and robust, connected tools for providers
- Financial and non-financial incentives to encourage practice transformation
- Quality and cost transparency for providers and patients

# Maryland Primary Care Model

**Hospital Chronic Care Initiative (CCIP)**  
 High Risk Patients, Rising Risk Patients  
 PQI Bonuses

**Coordinating Entity**

**Care Management Resources & Infrastructure**  
 Administrator (State Level)  
 CRISP  
 Resource Manager (Regional)

**Medicare + Medicaid + Commercial**  
 Care Coordination Payments

PDP embeds or requests unembedded CM resources based on PT need

**PATIENT (PT)**

**Patient-Designated Provider (PDP)**  
 Person-Centered Home (PCH)

Quality Payments at Risk (MACRA qualifying)

Visit/Non-Visit-based Payments

**Population Health Mgmt/HIT**

**Traditional PCPs**

Specialists  
 Behavioral Health Providers  
 SNF Providers  
 Ambulatory Care Providers  
 LTSS Providers  
 Chronic HH Providers

xx% CM Funds

xx% CM Funds

UPDATE

# POPULATION HEALTH PLAN

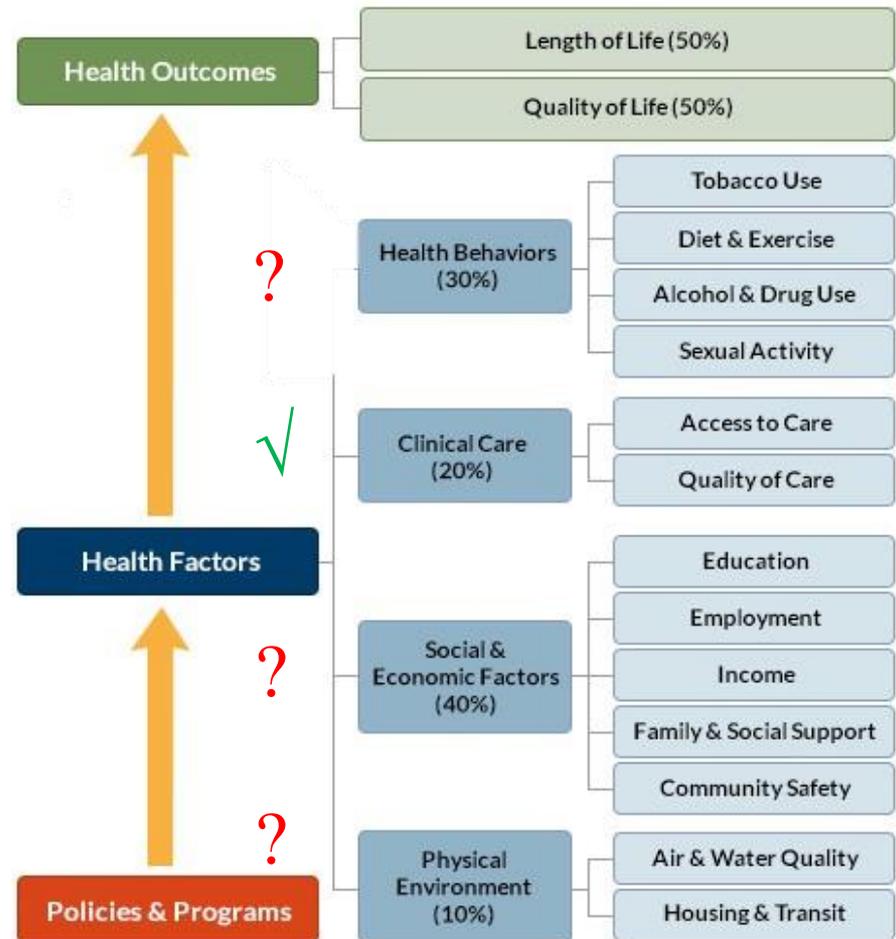
# PURPOSE OF PLAN

- Plan is a required deliverable to CMS under SIM Round Two Design Grant
- Plan will serve as a **roadmap** to guide future state priorities, investments, and programming in population health
- Outline sustainable mechanisms to invest in strategies and interventions that improve health outcomes over the long-term
- Intended for state/local government and private sector collaboration.
- Inform the best use and coordination of resources at state, regional, and local level to optimize investments

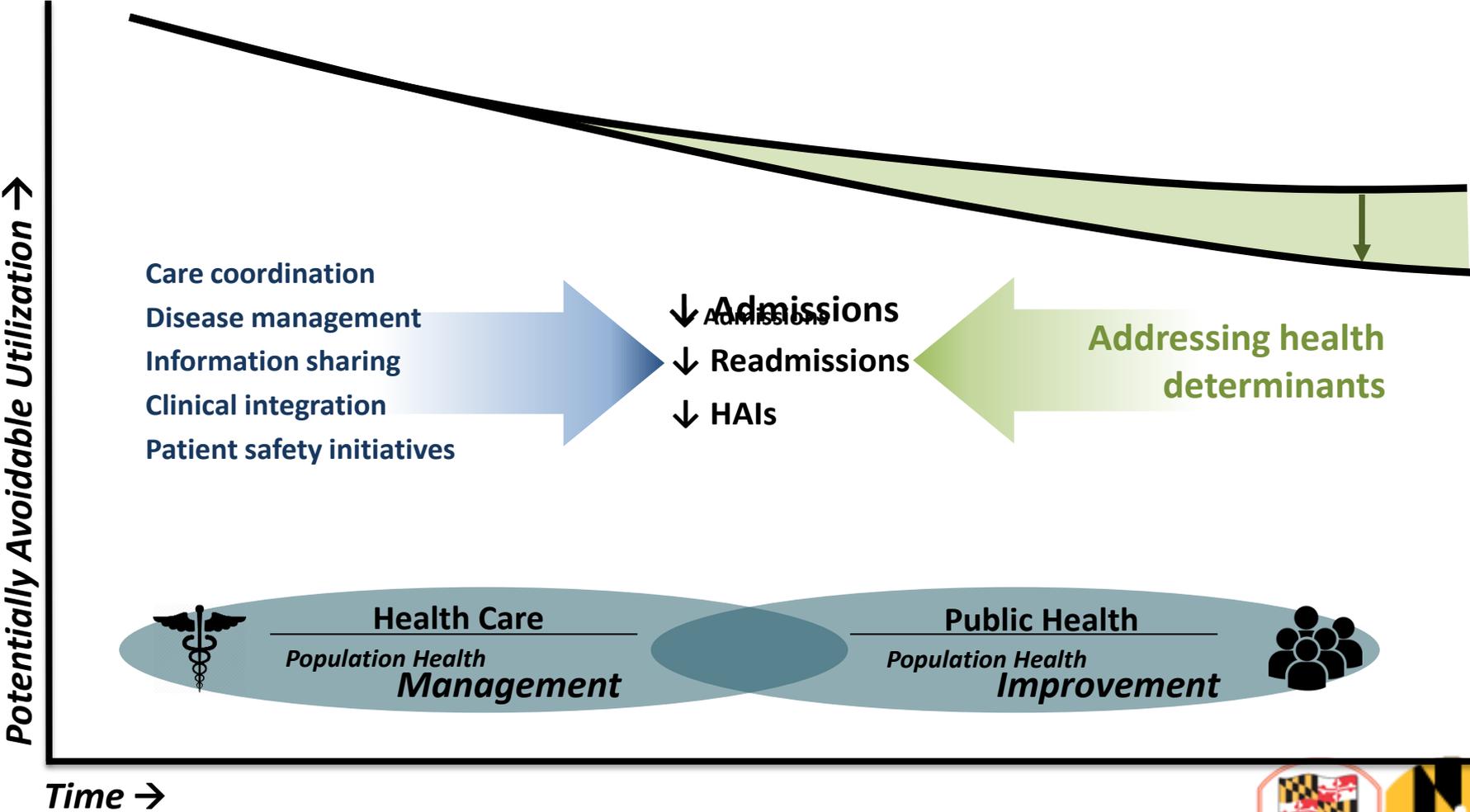


# REFINING POPULATION HEALTH

- Population health is both:
  - the health outcomes of a group of individuals, and
  - the distribution of such outcomes within the group
- Improving population health requires both:
  - clinical management of individuals in the group, and
  - addressing underlying determinants of health status across the group



# DESIRE FOR MANAGEMENT AND IMPROVEMENT ESPECIALLY IN HIGH UTILIZERS, COMPLEX NEEDS



# Goals of the Plan

The overall goals for the Population Health Improvement Plan are the following:

- Improve health status of Marylanders
- Achieve health equity across communities
- Promote ongoing healthy lifestyle and healthy behavior at the individual level, the neighborhood level and the Statewide policy level
- Establish sustainable financing for health improvement initiatives

# Stakeholder Engagement Process

## April Summit:

- Reviewed data on health status across state
- Learned about promising interventions and approaches
- Discussed priorities for Maryland moving forward
- Post-Summit Survey on priorities, interventions, financing, and governance

## Fall Review Period:

- Review/Comments of Draft Plan and Comments
- Additional LHO Roundtable Discussions

# Current and Future Steps

- Current
  - Developing Draft Plan that outlines a framework of priorities, strategies, funding options, and target measures to support these goals
    - Based on initial stakeholder input and existing priorities
- Fall 2016
  - Additional stakeholder engagement to refine Plan
  - Integrate Plan with Primary Care Model and Model Progression Plan to create opportunity for sustainable implementation
  - Submit harmonized concepts to CMMI by Dec 31<sup>st</sup>
    - Primary Care Model Concept Paper
    - State Population Health Plan