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

2014 – 2015
Hospital Global Budgets

2016 – 2018
Financial Alignment

2019 and Beyond
Total Cost of Care

SHIP and LHICs

Formal Partnerships & Infrastructure

Sustainable Population Health Models

ALL-PAYER MODEL

POPULATION HEALTH
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

Patient-Designated Provider (PDP)

Coordinating Entity

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

PDP embeds or requests unembedded CM resources based on PT need

Patien-Designated Provider (PDP)

Traditional PCPs
- Specialists
- Behavioral Health Providers
- SNF Providers
- Ambulatory Care Providers
- LTSS Providers
- Chronic HH Providers

Population Health Mgmt/HIT

CM

xx% CM Funds

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

Medicare + Medicaid + Commercial Care Coordination Payments

Quality Payments at Risk (MACRA qualifying)

Visit/Non-Visit-based Payments

xx% CM Funds

Person-Centered Home (PCH)
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

- Care coordination
- Disease management
- Information sharing
- Clinical integration
- Patient safety initiatives

↓ Admissions
↓ Readmissions
↓ HAIs

Addressing health determinants

Health Care
Population Health Management

Public Health
Population Health Improvement

Potentially Avoidable Utilization

Time →
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 31st
    • Primary Care Model Concept Paper
    • State Population Health Plan