MARYLAND
Department of Health

Population Health Summit: Innovation under the Maryland Model

Overview and Key Takeaways

On December 4, 2018, the Maryland Department of Health (MDH) hosted a one-day meeting entitled *Population Health Summit: Innovation under the Maryland Model*. The goals of the meeting were the following:

- Educate Marylanders about the Maryland Total Cost of Care (TCOC) Model
- Develop stakeholder buy-in on population health components of the Maryland TCOC Model
- Identify key partnerships and stakeholder roles for successful implementation.

Over 350 stakeholders attending the meeting, representing various private and public sectors. Stakeholders included those representing federal, state, and local government, health care providers and health systems (including primary care, behavioral health care, and pediatrics), human and social services (including housing development and food insecurity), advocacy organizations, academia, as well as employers. The following is an overview of the key takeaways and remarks from each of the day's sessions.

Remarks

Keynote – Call to Action: "Better Health through Better Partnerships"

- The TCOC Model provides a framework to transition the state's health care system into a "system of health" that improves the health and quality of life of all Marylanders, while boosting the state's economy.
- The key aspects of the model include engaging hospital and provider systems in improving population health, boosting the primary care system in the state, and prioritizing the health of the state by addressing leading-edge indicators that play a larger role in the health of the population, starting with diabetes.
- Maryland has the opportunity to disrupt how health care is provided in this country by launching a TCOC model that focuses on improving the health status of the population by addressing social determinants and other factors related to health.
- Participants are encouraged to identify their role in helping their communities focus on "upstream" innovations and partnering with non-traditional entities, such as law enforcement and faith-based leaders.

Plenary Sessions

Social Determinants of Health, Population Health Innovations, and Total Population Health Approaches:

- Population health improvement relies on examining interventions that are "upstream" that can affect health outcomes, including social class, gender, education level, income, etc. The right balance of upstream and downstream efforts is needed to improve population health.
- Health and education is a reciprocal relationship—addressing health in schools can have significant impact on the health status of children and later on as adults.
- Recognizing how to create a bridge between the public and private health care sectors is necessary to get individuals access to services and resources for social needs.

- A focus on behavioral health is a key component for cost containment.
- Hiring staff who are mission driven is a critical component to successful implementation. This should include a multidisciplinary team that incorporates a team-based approach and includes case or care managers or coordinators, access to telehealth/telemedicine, integrated primary care, behavioral health, and pharmacy, and access to quantitative and qualitative health care data.
- Developing a community health strategy requires aligning interests and mandates across agencies/systems. One way to do this is conducting bi-annual health assessment survey with agencies or other hospital systems to identify priority areas, shared goals, and shared incentives.
- People are looking for success stories, and the Maryland model really sets an example for the rest of the nation. Health is holistic.
- Social Determinacy Spectrum – find your place in one more pillars (four pillars in system)
    - Screening – evidence based clinical devices (Insurance/Provider pays)
    - In-House Social Services – clinical help onsite where screenings are conducted. (Insurance/Provider pay).
    - Community Based Social Services – programs and services outside the health care system (Government pays).
    - Changes to Laws, Policies, Regulations – community-wide conditions; working across sectors (Government pays).
- There is tremendous opportunity for providers to advocate for policy changes to improve health that may have a longer return on investment horizon.

Breakout Sessions – Common Themes

- **Partnerships between and across sectors is vital to ensuring success in the Maryland TCOC Model**
    - "Non-traditional" partners, such as those in law enforcement, corrections, housing development, social welfare, and faith-based/community leaders, should be engaged when developing population health strategies.
    - Patient voices should be considered and at the heart of population health management. Identifying a communication/dissemination strategy to engage consumers and relying on consumer feedback is a priority.
    - Ensuring alignment and identifying shared goals and priorities between organizations and agencies is a first step in a successful partnership.

  A focus on achieving health equity and reducing health disparities is a core tenet of population health – There is a clear need to ensure that strategies take on a "health equity" lens when being developed and implemented.
- **A comprehensive workforce strategy should focus on training providers to deliver care in a transformed health care system**
    - Providers should deliver care that is patient-centered and culturally-and-linguistically appropriate and should be trained to work in a multidisciplinary, team-based setting.
    - Care teams should include care coordinators/managers, providers such as community health workers and social workers, as well as the patient themselves.
    - Reimbursement for care coordination and other "non-clinical" services continues to be a challenge and should be addressed
- **Access to timely and accurate data and data interoperability is necessary to address needs across the continuum of care -** Public policy and/or developing memorandums of understandings, common consent forms, etc. have the potential to break down barriers to sharing patient data across providers and between clinical and non-clinical systems.