

Population Health Planning Guide

State Example

Setting State Priorities and Strategies under SIM

Vision for improving population health	2
A State health needs assessment and priority setting.....	3
A-1 Leveraging the State Health Improvement Plan.....	3
A-2 Determining areas of high burden and cost	4
B Existing capacity and efforts aimed at population health	5
B-1 Activities and capacity to be leveraged	5
B-2 Population health strategies and activities under SIM.....	6
B-3 Additional opportunities under SIM	7
C Roadmap to improve population health.....	8
C-1 Traditional clinical approaches	8
C-2 Innovative patient-centered care and/or community linkages	9
C-3 Community-wide strategies.....	9
D [Table] Population health strategies.....	10

Sustained Vision for Improving Population Health

Develop an Integrated Strategy across Payment, Delivery, and Population Health Domains

Improving population health is one of three SIM focus areas (the other two being transforming delivery systems and decreasing per capita spending)—but these focus areas should be aligned components of an integrated strategy, rather than conceptualized as three separate activities. The true potential of SIM is in uniting these three areas of focus under a single set of activities in order to meaningfully address them in an integrated way.

By specifically focusing on improving population health in the context of payment and delivery reform, the SIM program aims to identify unique opportunities to advance population health as part of overall health system transformation efforts, and maximize the impact of various state and local activities on population health, quality of care and health care costs through better alignment and coordination.

As states refine strategic goals, CMS and CDC can provide assistance to help understand the best routes to maximize integrated efforts. Tobacco, obesity and diabetes are great examples of issues that states might want to address—but state goal-setting should be informed first and foremost by a data-based assessment of capacities and needs, and should be aligned in support of a unified SIM strategy that leverages the states' existing initiatives and infrastructure whenever possible. These goals (and associated metrics) should be focused around system transformations that can have the most impact on the health and health care for the preponderance of a population in a state.

The core guiding principles underlying improvement of population health under SIM also recognize that:

1. No two states are alike; SIM aims to achieve measurable improvements for the preponderance of a state's population by adopting interventions that are evidence-based, feasible, sustainable and reflect each state's unique needs and contextual factors.
2. The population health goals and metrics should complement, fully align with and leverage states' existing priorities, strategies, infrastructure and capacity, and avoid duplicating existing efforts.

This document is intended to serve as a planning guide to inform state goal-setting by providing a summary of existing state health improvement plans and other state initiatives, identifying burden and cost information for prevalent and costly conditions, and highlighting current SIM efforts that could directly relate to or inform future population health strategies.

The following sections provide an example of a strategy-setting document for one state, as developed in partnership with the Centers for Disease Control and Prevention and CMMI. The information contained does not necessarily reflect an up to date and/or comprehensive plan.

Population Health Planning Guide

A State health needs assessment and priority setting

A-1 Leveraging the State Health Improvement Plan

[The State Health Improvement Plan \(SHIP\)](#) is designed to improve the health of all state residents. SIM year 2 operational plans states: “The State Health Improvement Plan (SHIP) is the cornerstone for our population health plan.” The State Health Improvement Plan is based on part of data from the 2012 State Health Assessment and goals set in our state Healthy People 2020 document. It focuses on six health priorities, with goals, objectives, and strategies for achieving measurable success over the next three years.

The first four priorities are subject-specific:

- Immunizations – Goal: Increase immunization rates by an average of 10% by June 2017
 - Increase routine childhood vaccinations
 - Increase routine adolescent vaccinations
 - Increase human papillomavirus (HPV) vaccinations
 - Increase school-based access to influenza vaccinations
 - Promote standard practices for tetanus, diphtheria, and pertussis (Tdap) vaccinations among obstetric providers
 - Increase pneumococcal vaccinations among seniors
- Obesity - Goal: Reduce adult obesity by 5% and youth obesity by 10% by June 2017
 - Reduce consumption of sugar-sweetened beverages
 - Increase consumption of fruits and vegetables
 - Increase adult physical activity during leisure time
 - Increase youth physical activity
 - Increase infant breastfeeding
- Substance Abuse and Mental Health – Goal: Reduce substance abuse and improve mental health by 5% by June 2017
 - Increase developmental screening of children birth to three years of age
 - Promote drug-prescribing protocols in health care settings
 - Increase Screening, Brief Intervention, Referral and Treatment (SBIRT) services
 - Increase depression and substance abuse screening in health homes
 - Increase adoption of evidence-based suicide prevention, screening and assessment in health care and school settings
 - Increase access to substance abuse and mental health services via primary care providers

- Tobacco Use - Goal: Reduce adult and adolescent tobacco use by 5% by June 2017
 - Increase access to and use of state tobacco treatment programs:
 - Under Objective 1 (Treatment) in SHIP:
 - Promote Partnership for a Tobacco-Free (PTF) clinical outreach sessions to increase brief tobacco interventions in clinical settings.
 - Promote PTF basic skills training to increase brief tobacco interventions in clinical settings.
 - Promote Intensive Tobacco Cessation training.
 - Increase number of smoke-free environments
 - Reduce exposure to indoor tobacco smoke in homes
 - Increase partnerships with organizations serving vulnerable populations to promote or increase awareness of tobacco treatment, prevention, and control resources.
 - Increase youth involvement in anti-tobacco initiatives

The remaining two priorities are focused on public health infrastructure:

- Inform, Educate and Empower the Public (Essential Public Health Service # 3) - Goal: Increase the state's capacity to inform, educate and empower people about health issues by June 2017
 - Implement a system for distributing public health messages
 - Increase use of plain language best practices
- Mobilize Community Partnerships (Essential Public Health Service # 4) - Goal: Increase the state's capacity to mobilize community partnerships and action to identify and solve health problems by June 2017
 - Increase community engagement in public health activities
 - Increase awareness of the value of public health
 -

A-2 Determining areas of high burden and cost

[Additional work underway]

Some areas of potential assistance include:

- IAP—BCN
- Superutilizer resources from SIM
- Camden Coalition case studies

B Existing capacity and efforts aimed at population health

B-1 Activities and capacity to be leveraged

The State's Shared Health Needs Assessment & Planning Process (SHNAPP) Project

SHNAPP is a framework and approach for a shared health needs assessment (SHNA) that addresses community benefit reporting needs of hospitals, supports state and local public health accreditation efforts, and provides valuable population health assessment data for a wide variety of organizations concerned with the health of the state's communities and citizens. It reemphasizes all of the priorities reflected in the SHIP and also includes indicators related to those and other issues.

Indicator Domains within the 2016 Shared Health Needs Assessment (SHNA)

161 Indicators included in SHNA

Demographics [5]	Chronic Disease
SES measures [7]	• Cardiovascular Health [10]
General Health Status [4]	• Respiratory [7]
Mortality [4]	• Cancer [19]
Access [5]	• Diabetes [10]
Oral Health [3]	Infectious Disease [8]
Maternal and Child Health	• Immunization [6]
• Reproductive Health [5]	• STD/HIV [6]
• Children with Special Needs [1]	Occupational Health [2]
Injury	Emergency Preparedness [1]
• Intentional Injury [9]	Substance Abuse [14]
• Unintentional Injury [7]	Mental Health [8]
Health Care Quality [2]	Tobacco Use [4]
Environmental Health [4]	Physical Activity, Nutrition, & Weight [10]

For a list of all indicators, contact the SHNAPP Project Director.

B-2 Population health strategies and activities under SIM

Improved Diabetes Care

The state has identified diabetes care and prevention as a core metric for SIM as part of their self-evaluation efforts.

The state is piloting the National Diabetes Prevention Program (NDPP) with specific focus around the issue of sustainability of the initiative under current and emerging payment arrangements.

A year 2 goal of NDPP is to have at least one ACO plan, design and implement a primary/secondary prevention strategy for T2DM. PCMH will test NDPP where ACOs will utilize a pre-diabetes algorithm (developed by the State) and then spread the model to at least one other ACO. Development of a sustainability plan will be part of this effort.

In addition, the Delivery System Reform Subcommittee and Payment Reform Subcommittee have both provided opportunities to present and engage in discussion related to NDPP.

For NDPP, the state will work with individual employers to assist them in evaluating a NDPP plan design as part of a population health strategy. Employers are asking their payers to conduct cost benefit analysis and ROI for NDPP as part of offered health plans. Each Payer who attends the November NDPP Forum will have action steps on payment design.

Accountable Communities Initiative

Through an **Accountable Communities Initiative**, the Department will engage in shared savings arrangements with provider organizations that commit to coordinating the care of all patients who rely on those organizations as their point of access to health care services. Accountable Communities that demonstrate cost savings and meet quality performance benchmarks will share in savings generated under the model.

There are four Accountable Communities participating in the first round of the initiative. An estimated 50,000 Medicaid members will be attributed through these Accountable Communities in 2014. An additional 25,000 members, while not directly attributed, receive some of their care through these Accountable Communities and will also benefit from improved systems of care coordination. In total, almost 30% of the state's Medicaid population will benefit from the Accountable Communities Initiative in this first round.

Accountable Communities will result in improvements such as:

- Reductions in inpatient readmissions
- Less non-emergent Emergency Department use
- More effective use of Electronic Medical Records and real-time data through the State's Health Information Exchange
- Increased investment in care management for members with chronic conditions, and
- Increased emphasis on preventive care

Community Health Worker (CHW) pilot

The CHW Initiative has a dual focus of capacity-building under the CHW pilot projects while simultaneously working on the systems-building /sustainability efforts through the convening of a statewide CHW Stakeholder Group. This system work includes informing development of alternative payment models under SIM and completing the foundational work that would be necessary for a third party payer to consider reimbursing for CHW services. The Delivery System Reform Subcommittee and Payment Reform Subcommittee have both provided opportunities to present and engage in discussion related to CHW.

Definitions, core-competencies and scope of work have all been developed to date by the Stakeholder Group. During year 2, recommendations for standardized training of CHWs and reviewing models of certification and/or registry of CHWs will be completed.

The goal of the CHW pilots is to identify best practices, as well as facilitators and barriers to the team work required in order to support the use of CHWs more broadly. The work of both the pilots and the CHW Stakeholder Group will enhance effective and more widespread use of CHWs.

B-3 Additional opportunities under SIM

- CDC TA team meets with State SIM Management Team and Commissioner's Office Representatives on a monthly basis to discuss practical opportunities to better coordinate public health programs with primary care objectives (e.g., WIC, Public Health Nursing, Breast and Cervical Health, Children w. Special Health Needs).
- Discuss viability of aligning annual MCH priorities to contribute toward achievement of the Triple Aim goals – reduced health care costs, advanced population health, and improved patient experience of care.

C Roadmap to improve population health

The State's current activities summarized above provide a terrific platform from which to leverage and integrate health care system strategies (as are being developed in the SIM section above) and broader public health goals and efforts (as summarized in the SHIP section above) to improve the health of the preponderance of the state's population.

This section provides items for further discussion in order to develop a roadmap to improve population health in coordination with delivery system and payment transformation efforts. The strategies and approaches are categorized by the three "buckets" of traditional clinical, innovative clinical (often with community linkages), and broad community-wide approaches. A table version is also provided.

C-1 Traditional clinical approaches

- Disease-specific
 - Tobacco: Indicator - NQF 28 at health care system level
 - Build on SHIP stated priority to address tobacco use by leveraging health care system approaches such as incorporating NQF0028 in value-based purchasing, reducing barriers to accessing effective cessation therapies, and implementing QI strategies such as CDS, e-referral, etc.
 - Diabetes: Indicator - Obesity screening and counseling in health care settings, quality of diabetes care measures like NQF 59 or diabetes composite.
 - Building capacity, infrastructure and training for providers to identify and refer patients to DPP programs that are being implemented in the state.
 - Enabling pre-diabetes screening and referrals through value-based purchasing, QI strategies such as Clinical Decision Support (CDS) and e-referrals.
 - Improving quality of care for patients with diabetes through QI improvement strategies and incentives as part of the value-based purchasing.
- General approaches
 - Quality improvement efforts aligned with Million Hearts campaign.

C-2 Innovative patient-centered care and/or community linkages

- Disease-specific
 - Tobacco: Indicator - Develop measure based on specific strategy. i.e. Quitline capacity or referral rates, etc.
 - Opportunities include building Quitline capacity in response to increased uptake of tobacco screening and cessation services in clinical settings (bucket 1: Traditional clinical approaches).
 - Leverage Shared Health Needs Assessment (SHNA) approaches to compliment the increased uptake of clinical preventive services.
 - Diabetes: Develop appropriate measures (i.e., Number of people served in DPP)
 - Building capacity to provide DPP services that meet population health needs.
 - Enabling infrastructure necessary to receive referrals and provide feedback to providers.
 - Exploring Diabetes Self-management Education (DSME) Chronic Disease Self-Management Education, etc. under the SHNA (tentative)
- General approaches
 - Role of community health workers in CCTs: The current list of core and optional services does not include upstream strategies, although the CHW function is explicitly included in the Medicaid Waiver for CCT.
 - Linkage to Healthy Living, Healthy Development as part of the broader ACH models, targeted home-based interventions, bi-lateral referrals and information exchange.
 - Support the care management reporting initiative through state-wide HIT efforts and link the registries to the aforementioned efforts (ACH, Healthy Living, etc.).

C-3 Community-wide strategies

- Disease-specific
 - Tobacco: Indicator - BRFSS tobacco use prevalence at state level.
 - Address gaps identified through the prevention status reports <http://www.cdc.gov/psr/tobacco/2013/me-tobacco.pdf>
 - Align CDC and other federally funded programs aimed at addressing tobacco use with SIM efforts.
 - Diabetes: Indicator - Prevalence of obesity
 - Address gaps identified through the prevention status reports <http://www.cdc.gov/psr/summaryreports/2013/psrstatesummary-me.pdf>, <http://www.cdc.gov/psr/errata.html>, <http://www.cdc.gov/psr/heartandstroke/2013/me-hds.pdf>,
- General approaches
 - Leverage the Population Health Measures with the Community Transformation Grant (CTG) initiative and support availability/delivery of recommended interventions.
 - Inform, Educate and Empower the Public: Increase capacity to inform, educate and empower people about health issues by June 2017.
 - Mobilize Community Partnerships: Increase capacity to mobilize community partnerships and action to identify and solve health problems by June 2017.
 - Increase capacity to mobilize community partnerships and action to identify and solve health problems by June 2017.

D [Table] Population health strategies

Level of impact	Priority area	Proposed Approach/Strategy	Proposed Indicator	Funding Mechanism
Traditional clinical care	Tobacco	<ul style="list-style-type: none"> Build on SHIP stated priority to address tobacco use by leveraging health care system approaches such as incorporating NQF0028 in value-based purchasing, reducing barriers to accessing effective cessation therapies, and implementing QI strategies such as CDS, e-referral, etc. 	NQF 28 at health care system level	
Traditional clinical care	Diabetes	<ul style="list-style-type: none"> Building capacity, infrastructure and training for providers to identify and refer patients to DPP programs that are being implemented throughout the state. Enabling pre-diabetes screening and referrals through value-based purchasing, QI strategies such as CDS and e-referrals. Improving quality of care for patients with diabetes through QI improvement strategies and incentives as part of the value-based purchasing. 	Obesity screening and counseling in health care settings, quality of diabetes care measures like NQF 59 or diabetes composite.	
Traditional clinical care	General	<ul style="list-style-type: none"> Quality improvement efforts aligned with Million Hearts campaign. 	<i>TBD</i>	
Innovative clinical care and/or community linkages	Tobacco	<ul style="list-style-type: none"> Opportunities include building Quitline capacity in response to increased uptake of tobacco screening and cessation services in clinical settings (bucket 1). Leverage Shared Health Needs Assessment (SHNA) approaches to compliment the 	Develop measure based on specific strategy. i.e. Quitline capacity or referral rates, etc.	

Attachment 3. Pop Health Planning Guide: Setting State Priorities and Determining Strategies
(State example)

Level of impact	Priority area	Proposed Approach/Strategy	Proposed Indicator	Funding Mechanism
		increased uptake of clinical preventive services.		
Innovative clinical care and/or community linkages	Diabetes	<ul style="list-style-type: none"> • Building capacity to provide DPP services that meet population health needs. • Enabling infrastructure necessary to receive referrals and provide feedback to providers. • Exploring DSME, etc. under the SHNA(tentative) 	Develop appropriate measures, i.e.: Number of people served in DPP	
Innovative clinical care and/or community linkages	General	<ul style="list-style-type: none"> • Role of community health workers in CCTs: The current list of core and optional services does not include upstream strategies, although the CHW function is explicitly included in the Medicaid Waiver for CCT. • Linkage to Healthy Living, Healthy Development as part of the broader ACH models. Targeted home-based interventions, bi-lateral referrals and information exchange. • Support the Care management reporting initiative through state-wide HIT efforts and link the registries to the aforementioned efforts (ACH, Healthy Living, etc.). 	TBD	
Community-wide strategies	Tobacco	<ul style="list-style-type: none"> • Address gaps identified through the prevention status reports http://www.cdc.gov/psr/tobacco/2013/me-tobacco.pdf • Align CDC and other federally funded programs aimed at addressing tobacco use with SIM efforts 	BRFSS tobacco use prevalence at state level.	
Community-wide	Diabetes	<ul style="list-style-type: none"> • Address gaps identified through the prevention status reports 	Prevalence of obesity	

Attachment 3. Pop Health Planning Guide: Setting State Priorities and Determining Strategies
(State example)

Level of impact	Priority area	Proposed Approach/Strategy	Proposed Indicator	Funding Mechanism
strategies		http://www.cdc.gov/psr/summaryreports/2013/psrstatesummary-me.pdf , http://www.cdc.gov/psr/errata.html , http://www.cdc.gov/psr/heartandstroke/2013/me-hds.pdf ,		
Community-wide strategies	General	<ul style="list-style-type: none"> • Leverage the Population Health Measures with CTG initiative and support availability/delivery of recommended interventions. • Inform, Educate and Empower the Public: Increase the State’s capacity to inform, educate and empower people about health issues by June 2017. • Mobilize Community Partnerships: Increase capacity to mobilize community partnerships and action to identify and solve health problems by June 2017. 	<i>TBD</i>	