

Recommendations

The North Country Health Systems Redesign Commission (NCHSRDC) has based its recommendations on the framework and priorities of the State Health Innovation Plan (SHIP), which is New York State's roadmap for achieving the Triple Aim.

Transformation of the North Country Health Systems into a collaborative and integrated model of high value health care requires an initial investment to achieve significant savings as a byproduct. We applaud the efforts of the Cuomo Administration to secure \$8 billion in federal support as part of the NYS waiver demonstration. The NCHSRC unanimously recommends that distribution of this funding be based on a safety net definition that reflects the reality of providing care to all vulnerable populations in our region. That means any formula must address the challenges to provider stability that result from a high overall public payor mix. It should also reflect vulnerability associated with geographic isolation and the attendant access problems for populations in need.

For each priority of the SHIP, the NCHSRC has the following recommendations and thoughts:

Improving Access and Integrating Care

1. Primary Care

- Endorse care delivery models that include enhanced care management and care coordination approaches such as the Advanced Primary Care (APC) and Health Homes models.
- Endorse the SHIP's health care workforce priorities:
 - a) Increasing the recruitment and retention of a primary care workforce throughout the State, including expansion of the Doctors Across New York (DANY) program;
 - b) Updating and aligning standards and educational programs for all types of health care workers with the APC model, particularly training in care coordination, multidisciplinary teamwork, and necessary administrative and business skills;
 - c) Identifying regulatory reform needed for primary care-related workforce flexibility opportunities by putting in place the infrastructure to test and evaluate workforce models of care and their implications for professionals to work closer to the top of their licenses;
 - d) Assuring adequate education and training throughout the State and developing more robust working data, analytics and planning capacity.
 - e) Advancing regulatory reform so that advanced nurses and care managers and other types of health care professionals can deliver a wider scope of primary care services.
- Suggest the State provide primary care providers access to capital investments funds that would address their needs and risks, and provide financing for restructuring that is aligned with integration.
- Authorize the Commissioner of Health to allow collaborative projects in the North Country to proceed without extensive Certificate of Need (CON) review.
- Expand the Medical Home model, which applies in Long Term Care as well as primary care settings.

- Urge Department of Financial Services to support the expanded participation in Medical Homes by all insurers active in the North Country.
- Facilitate expansion of primary care across the region into appropriate community settings including schools and places of employment.
- The NYS Department of Health should continue data analysis to identify gaps in primary care as evidenced by factors such as avoidable Emergency Department visits.

2. Behavioral Health

- Integrate primary care and behavioral health services through regulatory and financial reform to promote value-based models that are supportive of the SHIP. While the movement to managed care is expected to achieve integration, the Commission recommends financial incentives to embed primary care and behavioral health services into the health care continuum across the region.
- Enhance collaboration among primary care providers and behavioral health providers to co-locate screening, assessment and brief outpatient treatment services to improve integrated person-centered care.
- Improve access and availability of prevention and wellness services in primary care settings through partnerships with local prevention organizations (behavioral health agencies, Healthy Heart networks, etc.).
- Reform payment for services to include care provided by non-clinical social workers and other licensed mental health professionals.
- Explore alternative pathways to the licensing of mental health professionals.
- Support providers in attaining assistance to possess a viable health IT structure.
- Support efforts to increase supportive housing.
- Establish a multi-agency team to identify regulatory barriers to integrate health and behavior health services to achieve the goals of the SHIP.

3. Long Term Care

- Explore conversion of skilled nursing facilities (SNFs) into a new design known as Skilled Care Campuses (SCCs). An SCC could be a group of virtual expanded services provided by the current SNF that would support a reduction in SNF bed capacity, and reuse the existing SNF space and infrastructure to support adults needing other services. Services might include outpatient therapy, assisted living, social day care, supportive housing with meals and activities.
 - a) Establish with funding support as needed, one or more SCC pilots to explore and evaluate the concept and to connect it to primary care, emergency care and behavioral health.
 - b) Allow SNFs to reduce certified bed numbers while allowing the remaining space to carry 100% of the capital cost burden. Create incentives for some form of senior housing to be developed either in the spaces no longer used as SNF beds or in new construction in close proximity to the SNF.
 - c) Grant outpatient therapy licenses to the SNF associated with the SCC, so their therapy departments can support post- discharge rehabilitation.

- d) Allow certified nursing assistant staff employed by the SNF to serve other individuals receiving services through the SCC without additional certification or provide a streamlined path for dual certification.
 - e) Enable licensed professional staff of the SNF to support the residents, perhaps with a consulting certified home health aide available.
 - f) In conjunction with other organizations, allow SNFs to be involved in defining the priority admission list to the housing to facilitate appropriate discharges from the SNF.
 - g) Integrate silos of care management, so primary care managers (e.g. Medical Home Model) and long-term care managers are working in a coordinated manner.
 - h) Consider funding for housing on the SCC sites or other free standing locations from House NY program or MRT Supportive Housing program.
- Develop initiatives such as consumer-directed care models that support families and recognize that informal caregiving provides most of the long-term services and supports in the North Country.
 - Change the financial paradigm of Medicaid to pay for a broad set of supportive services, with incentives to keep to an irreducible minimum the number of people in expensive skilled beds, but with enough funding to keep essential rural facilities viable.
 - a) Vital Access Provider (VAP) funding may provide bridge funding to a reformed landscape, but sustainability may require an Essential Community Health Network (ECHN) designation or another program. For example, the Commission supports the VAP funding of the Blue Line Group. If an ECHN program goes into effect, the Blue Line Group should be evaluated for such support.
 - Support the expansion of assisted living particularly for low-income individuals throughout the region. Consider easing any applicable equity contribution requirements and/or providing access to grant funding.
 - Request Department of Health to carefully evaluate and consider for implementation the recommendations that are made on or about September 30, 2014, as a result of the grant, “A Roadmap to a Rational, Sustainable and Replicable System of LTC Services in the Eastern Adirondacks,” which is being conducted by the Foundation for Long Term Care and LeadingAge New York and funded by the NYS Health Foundation.
 - Promote the expansion of managed long-term care in the North Country.
 - Give small providers assistance to attain a viable health IT structure.
 - We recommend strengthening home care, in three areas:
 - a) Expand the use of the consumer-directed home care model;
 - b) Foster development of para-professional resources (home health aide, personal care assistants).
 - c) Increase Medicaid reimbursement rates in the North Country to support the recruitment and retention of the para-professional workforce in Home Health Care
 - d) Expand access to telehealth by first ensuring access to the internet in the region, and then through investment in remote monitoring telehealth equipment.
 - Increase access to palliative care programs for persons with serious, advanced illness and those at the end of life to ensure care end of life planning needs are understood, addressed, and met, which will in turn reduce the need for hospital care in these situations.

4. Hospitals

- Encourage all hospitals to engage in collaborative efforts to integrate services across the spectrum of medical and health services, with the waiver focused on reducing unnecessary and preventable hospital utilization.

5. Regional Planning

- Create Regional Health Improvement Collaboratives (RHICs) to promote regional leadership and a population-based approach to health system resource evaluation and development.
- RHICs should facilitate regional planning for care delivery to connect with the greater health of the community. They can achieve this by building linkages across primary care, hospitals, behavioral health, EMS long-term care providers, local health departments, occupational health, offices of the aging and a variety of community stakeholders.
- RHICs should:
 - a) Support the promotion, success and sustainability of the APC model, including the provision of technical assistance to local providers, as part of their mandate.
 - b) Receive timely and regular data sets to monitor population health outcomes and have the freedom to be flexible and innovative.
 - c) Identify opportunities for collaboration, integration, and consolidation that will maintain or improve access and quality, and financial viability; promote integrated care; facilitate discussions between local providers and payers regarding joint transition to value-based payments; require mandatory involvement with local planning and engage regional economic council; and co-locate screening and assessment.
 - d) Support funding to conduct sub-area analyses in specific regions such as St. Lawrence, and Hamilton counties to assess the potential for either a single unified system or optional arrangements with other providers.
 - e) Establish a joint committee of the two RHICs to coordinate efforts where appropriate, as well as to facilitate the sharing of information and data. The committee should meet once a year or more often to bridge the planning between the proposed two RHICs in the North Country.
 - f) Meet with the regional economic councils at least once a year to coordinate the economic development priorities with economic development policies.

6. Workforce

- Develop Graduate Medical Education (GME) programs to train medical graduates with financial incentives for service in the Adirondacks. The Commission urges financial support for an expansion of family medicine residency programs.
- Adapt medical school curriculum to align and train health care providers at all skill levels to outcome focused care and team based, coordinated care. We support integrating Advanced Care models into educational programs.
- Urge the Legislature to commit to a diverse and strong primary care workforce by safeguarding and expanding programs like Primary Care Service Corps (PCSC) and DANY which advance the recruitment and retention of primary care providers.

- Provide Doctors Across New York State with annual, consistent funding and with the North Country designated as a targeted area.
- Align State rules with more current federal direction with respect to standing orders and practice protocols.
- NYS should allow for house calls by Article 28-employed physicians and physician extenders, and provide reimbursement for services provided to chronically ill/home bound patients, including expanding telehealth reimbursement.
- Strengthen post acute services, via agreements to cross train and share staff across the continuum of care depending on where the need is greatest.
- Dedicate financial support to retrain health care workers based upon a movement from inpatient based to community based services.
- Align certified nursing aide (CNA) and home care aide training, and allow stackable credentials in order to meet needs in multiple venues.
- Aim for all health care providers to operate at the top of their license.
- Establish additional loan repayment incentives for physicians, and mid-level practitioners in the North Country.
- Work with State Education Department to recognize national licensure and reciprocity with other state to speed up access to providers and Canadian provinces.

7. Telehealth

- Expand telehealth throughout the region, and support efforts to:
 - a) License and credential telehealth providers (including development of policies relating to interstate practice of telehealth)
 - b) Develop policy that encourages and/or requires all payers to support telehealth reimbursement.
 - c) Allow multiple provider specialties to participate
 - d) Address technical transmission efforts
 - e) Expand existing Medicaid telehealth reimbursement policy to include Article 31 clinics, Article 36 Certified Home Health Agencies, SNFs, private practices, and federally qualified health centers (FQHCs) as eligible hub or spoke sites, regardless of opting in or out of ambulatory patient groups.
 - f) Develop a rural New York State Telemedicine Resource Center in the North Country.
 - g) Expand existing Medicaid reimbursement policy on eligible providers to include:
 - Clinical psychologists
 - Certified diabetes educators
 - Physician specialists, including psychiatrists
 - Certified diabetes educators
 - Certified asthma educators
 - Psychiatric nurse practitioners
 - Dentists
 - Genetic counselors
 - Mental health clinicians
 - Physical therapists for the purpose of supervision of physical therapist assist supervision

8. Emergency Medical Services (EMS)

- Integrate the EMS system into the coordination of health care in the North Country.
- Improve communications systems and technology to allow for better consultations with physician medical control.
- Explore ways to incentivize potential work force, improve working/volunteering conditions and salaries.
- Explore reimbursement options to improve stability of pre-hospital care and inter-facility transportation, including that provided by air-ambulance.
- Implement alternative models of community-based care, including the community para-medicine model that leverages the Emergency Medical System for home visits and preventive care.
- Support legislative proposal allowing volunteer fire departments to bill for EMS services rendered.

Financial Rewards for Value

- Coordinate the State's investments in capital restructuring with the deployment of Delivery System Reform Incentive Payment (DSRIP) funds, and emphasize the need to direct these investments towards:
 - a) Collaborative efforts that involve multiple stakeholders and partnerships.
 - b) Entities providing services to populations in geographically isolated communities that are essential to the region;
 - c) Ensuring that the definition of a "safety net provider" does not focus solely on Medicaid, but rather on all public payors. The North Country has a lower Medicaid proportion and the providers play a unique role in ensuring access for underserved and isolated populations;
 - d) Services that provide timely, high-quality care to all, consistent with patient-centered, population health-based, care models that aim for greater integration, over applications from single organizations.
- Create a new funding category to address sustainability called Essential Community Health Network (ECHN) for providers that are essential and financially distressed due to their engagement in transformation.
 - a) Facilities may be hospitals, nursing homes or some other entity that is a safety net provider, given their isolation and/or population served. They are also committed to transformation initiatives called for by the Medicaid Redesign Team or SHIP.
 - b) A collapse of these institutions will jeopardize the particular initiative with which they are engaged, such as medical home expansion, but the financial distress may undercut other critical services supported by the traditional inpatient and outpatient base.
- Implement a North Country Medicaid rate adjustment, with review after three years, when the impact of managed long-term care and the above changes are evaluated.
- Examine Medicaid policies and programs for VAPs to ensure they:
 - a) Provide financial support while facilities transition to new models of care.
 - b) Identify and reduce incentives that contradict a value approach to reimbursement, such as policies that encourage overuse of expensive skilled beds.

- Support the Governor’s proposal to double the appropriation allocated for the VAP program in FY 2014-15.
- Expand the Health Facility Restructuring Program to FQHCs, in order to allow DOH to work with select providers to access interest-free loan programs to sustain essential services.
- Embrace various payment reform initiatives that may include: global budgets for essential providers, a variety of bundling initiatives across the spectrum of care providers, ACO-like shared savings models, etc.
- Call upon DFS to establish mechanisms that incentivize the participation in Medical Homes by all insurers active in the North Country region.
- Expand application of the Certificate of Public Advantage (COPA) to allow clinically integrated providers, who demonstrate value enhancement, to negotiate collectively with private insurers, as since their efforts to improve value in Medicaid and Medicare will benefit other insurers.
- Explore ways to expand intermediate levels of care (e.g., partial hospitalization, crisis respite services or observation programs) to reduce unnecessary hospitalizations and ED visits.

Transparency and Consumer Engagement

- Encourage the input of consumers and patients to gauge satisfaction with health care resources in the North Country. This includes the extent to which cost and quality are transparent and incorporated into consumer decision-making and commensurate with state and federal reforms.
- Create a subgroup to implement a communications plan that highlights the key points in the recommendations.
- Create a subgroup to identify and develop regulatory modifications that are necessary to assist providers at implementing the recommendations from this report.
- RHICs should engage and include consumer representatives on the councils.

Measurement/Evaluation

- Use the SHIP principle of developing a standardized, statewide approach to measure and evaluate the quality and efficiency of care delivery.
- Use measurement and evaluation to provide common standards and performance metrics by which to track and evaluate the progress of health system sustainability, performance and transformation within the North Country.
- Encourage the establishment of a statewide “common scorecard” to produce meaningful population and regional data in order to inform regional health assessment and planning efforts.

Promote Population Health

- Use public health initiatives to address population health.
- Support the State’s Prevention Agenda.
- Encourage physician-based best practices for population health.
- Align DSRIP with community health improvement plans and community health plans.

Conclusion

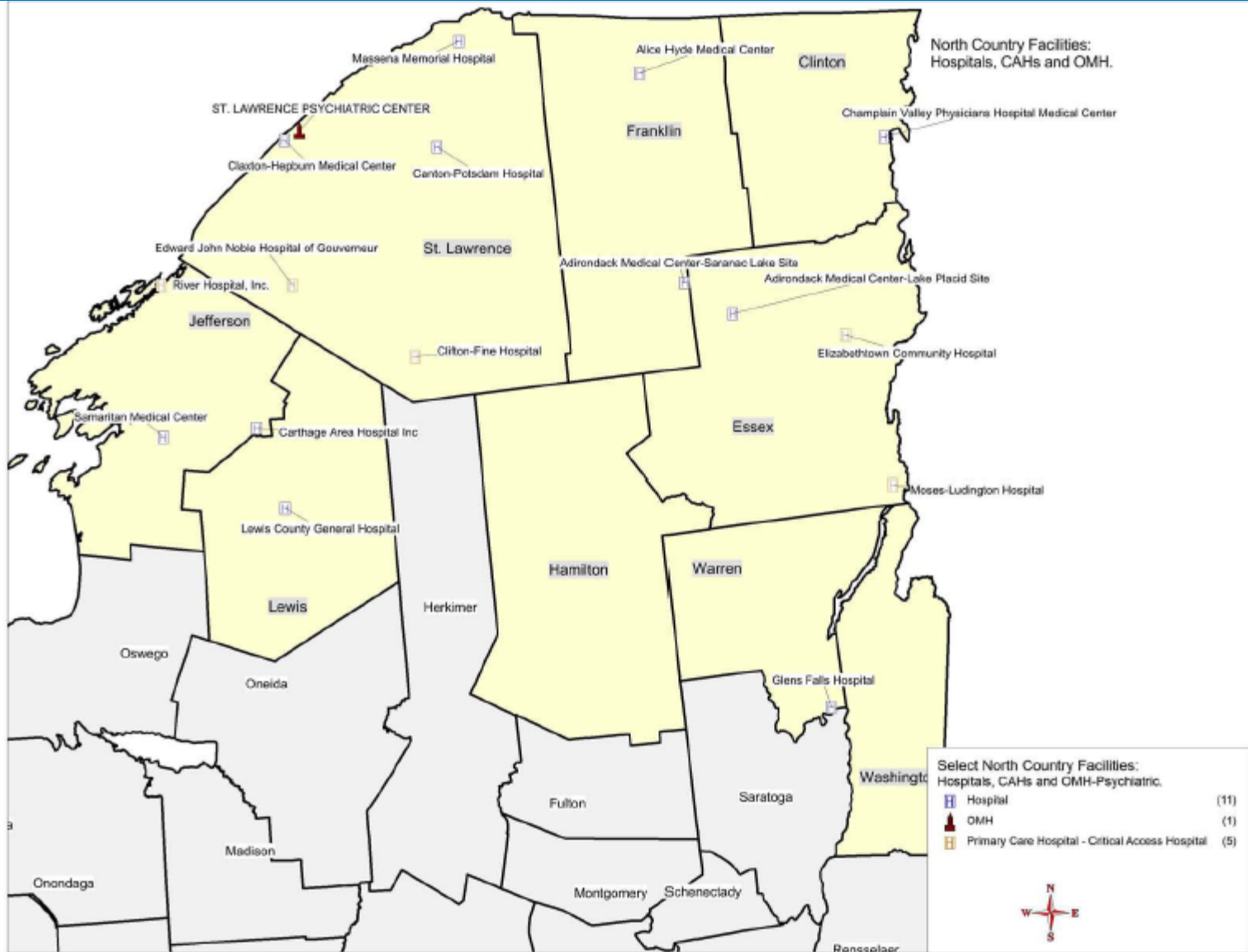
The challenges involved in delivering health care throughout the North Country can no longer be ignored or delayed. Multiple trends have converged to create a precarious situation in the region's health care delivery system. Rising rates of chronic disease, a growing dearth of health care workers, transportation challenges, and the fiscal difficulties confronting the region's health care facilities are making it increasingly difficult for the residents in this region to access quality health care and for providers to remain financially viable. Compounding the problems are the region's high rates of poverty, the vast geographic size and the pressure from reforms in the health care delivery system.

It has become incumbent upon all stakeholders in the region to adjust the way they do business in order to rebuild a viable system, so that residents in the North Country can access high quality health care, be it acute services, preventive care, or inpatient care. The recommendations laid out in this report are designed to help move in that direction and stabilize the health care delivery system in the North Country. They have been carefully constructed to satisfy the demands of the State Health Innovation Plan, which is the roadmap for achieving the Triple Aim – better patient care, improved population health and reduced costs – while also taking into account government reforms, financial restraints and the reality of the region's demographics and geography.

Achieving any significant change will require the region's health care providers to adjust the way they do business. It calls upon them to restructure, collaborate and integrate in order to develop new models of care that are better able to adapt to an evolving payment system while meeting the goals of the Triple Aim. Pursuing these recommendations will take years and require significant effort by providers, patients and community entities alike.

No doubt, we live in times of great turmoil in the health care industry, and the North Country is no exception. Issues of access, quality and cost continue to impact communities throughout New York State as well as the rest of the country. The recommendations in this report address all of these concerns and have been carefully designed with a patient-centered focus. We believe that they will result in a stronger, more stable and viable health care system, and that the lessons learned here will be worthy of consideration in other communities facing similar struggles.

Figure 2.1 North Country Facilities – Hospitals, CAHs and OMH



Source: Department of Health, New York State

Figure 2.2 North Country facilities – Residential healthcare facilities and long term health care programs

