The North Country Health Systems Redesign Commission
Summary of Recommendations

The NCHSRC has based its recommendations on the framework and priorities of the State Health Innovation Plan, which is New York State's roadmap for achieving the Triple Aim. For each priority of the SHIP, the NCHSRC has the following recommendations and thoughts:

Transformation of the NCHS 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 reflect provider vulnerability associated with a high overall public payor mix. It should also reflect vulnerability associated with geographic isolation and the attendant access problems for populations in need.

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 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 program;

(b) Updating standards and educational programs for all types of health care workers to reflect the needs of delivering the APC model, particularly training in care coordination, multidisciplinary teamwork, and necessary administrative and business skills;
(c) Identifying potential 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.

- Suggest the State provide primary care providers access to capital investments funds that would assess their needs and risks, and provide financing for restructuring.
- Allow for expeditious handling of collaborative activity by increasing flexibility for the Commissioner of Health to allow transformational type activities to proceed outside or prior to any extensive CON review, and to allow for greater regulatory flexibility during crisis .
- Expand the Medical Home model now being implemented in the Adirondack Medical Center's nursing homes. DFS should support the expanded participation in Medical Homes by all insurers active in the North Country.
- Require regulatory reform so that advanced nurses and care managers and other types of health care professionals can deliver more aspects of primary care.
- Expand primary care in Jefferson and St. Lawrence counties, based on 2012 data for avoidable ED visits. The Department should reevaluate this issue once 2013 data becomes available.

2. Behavioral Health

- Integrate primary care and behavioral health services. While the movement to managed care is expected to achieve integration, the Commission recommends financial incentives to embed primary care into clinical services 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.) for coordinated transition.
- Reform payment for services to include care provided by non-clinical social workers (MSWs).

3. Long-term Care

- 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 all those small, deeply rural facilities viable.

    (a) VAP funding may provide bridge funding to a reformed landscape, but sustainability may require an ECHN 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.

- Request DOH to carefully evaluate and consider for implementation the recommendations that are made 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. The final report will be made by September 30, 2014.

- Convert skilled nursing facilities into a new design known as virtual Skilled Care Campuses (SCCs). An SCC would be a virtual group of expanded services provided by the current SNFs that would support a reduction in SNF bed capacity, and reuse the existing SNF space and infrastructure to support adults needing services in multiple ways. Services might include outpatient therapy, social day care, supportive housing with meals and activities using SNF infrastructure.
- Merge the silos of care management, so primary care managers (e.g. Medical Home Model) and long term care managers are working in a coordinated manner.
- Allow impacted 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.
- Grant patient therapy licenses to the new form of senior housing proposed above, so their therapy departments can support post- discharge rehabilitation.
- Allow certified nurse aide staff employed by the SNF to serve without additional certification or provide a streamlined path for dual certification.
- Enable licensed professional staff of the SNF to support the residents, perhaps with a consulting CHHA available.
- Allow SNFs to have full control of defining the priority admission list to the housing.
- 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.
- Align the incentives of medical management with those of social support and long-term care management. To this end, if existing programs such as the Long Term Home Health Care Program are fulfilling this function, the

State should consider re-evaluating its initiative to mandate enrollment in Medicaid managed care for this population**.**

- 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 (HHA, PCA); and;
    (c) Affordably address the needs of the non-Medicaid population, increase rates for Medicaid population.

4. Regional Planning

- Create Regional Health Improvement Collaboratives (RHICs) to promote regional leadership and a population-based approach to health system resource evaluation.
- Adopt a framework in which care delivery is interconnected with the greater health of the community and linkages are built between primary care, hospitals, long-term care providers, local health departments, and a variety of community stakeholders to ensure a truly integrated approach to identifying and addressing local health challenges. RHICs should:
    (a) Support the promotion, success and sustainability of the Advanced Primary Care 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; and co-locate screening and assessment.
    (d) Support funding to conduct a sub area analysis of St. Lawrence County to assess the potential for either a single unified system or optional arrangements with other providers.

5. Workforce

- Develop 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 programs like PCSC and DANY which advance the recruitment and retention of primary care providers.
- Provide Doctors Across New York State with annual, consistent funding.
- 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 provide reimbursement for services provided to chronically ill/home bound patients, including expanding telemedicine 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
- Combine the CNA and home care training in order to create a rural health aide to meet needs in multiple venues.
- Aim for all health care providers to operate at the top of their license.
- Establish loan repayment incentives.
- Invest in a Family Medicine Residency Program for the North Country,

6. Telehealth

- Expand telehealth throughout the region, and support pilot 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 telemedicine reimbursement policy to include Article 31 clinics, SNFs, private practices, and 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.

(h) Expand existing Medicaid reimbursement policy on eligible providers to include:

- Psychologists
- Social workers
- Psychiatric nurse practitioners
- Physician extenders (NPs & PAs)

7. Emergency Medicine

- Integrate the EMS system into the streamlining of health care in the North Country.
- Improve communications systems and technology to allow for better consultations with physician medical control.
- Incentivize potential work force, improve working/volunteering conditions, and offer better paying jobs and work environments.
- Improve reimbursement rates for prehospital 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.

Financial Rewards for Value

1. Coordinate the State's investments in capital restructuring with the deployment of DSRIP funds, and emphasize the need to direct these investments towards:

- Entities providing services to populations in geographically isolated communities that are essential to the region;
- 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 that providers in the in ensuring access for underserved and isolated populations;
- 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.

2. Create a new funding category to address sustainability called Essential Community Health Network (ECHN) for providers that are financially distressed due to their engagement in transformation.

- 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 in the MRT or SHIP.
- 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.

3. Examine Medicaid policies and programs for Vital Access Providers to ensure they:

- Provide financial support while facilities transition to new models of care.

- Identify and reduce incentives that contradict a value approach to reimbursement, such as policies that encourage overuse of expensive skilled beds.

4. Support the Governor's proposal to double the appropriation allocated for the VAP program in FY 2014-15.

5. Expand the Health Facility Restructuring Program to FQHCs, in order to allow the Department of Health to work with select providers to access interest-free loan programs to sustain essential services.

6. Demonstrate 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, et al.

7. Encourage Department of Financial Services to establish mechanisms that support the participation in Medical Homes by all insurers active in the Adirondack region.

8. Expand application for the Certificate of Public Advantage to allow clinically integrated providers, who demonstrate value enhancement, to negotiate collectively with private insurers, as their efforts to improve value in Medicaid and Medicare will benefit other insurers.

9. Encourage the State to invest in efforts to expand intermediate levels of care (e.g., partial hospitalization or observation programs) to reduce unnecessary hospitalizations and ED visits.

Transparency and Consumer Engagement

1. Support state and regional programs that promote the transparency of quality, utilization and cost measurement across the health care system.

2. 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.

Measurement/Evaluation

1. Use the SHIP principle of developing a standardized, statewide approach to measure and evaluate the quality and efficiency of care delivery.

2. 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.

3. 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

1. Endorse diabetes prevention programs in the North Country such as the Department's Diabetes Prevention and Management Toolkit for health care providers.

2. Support the Department's anti-tobacco use goals to prevent initiation of tobacco use by New York youth and young adults, especially among low socioeconomic status (SES) populations; promote tobacco use cessation, especially among low SES populations and those with poor mental health; and eliminate exposure to secondhand smoke.