FEDERAL HEALTH CARE REFORM IN NYS
A POPULATION HEALTH PERSPECTIVE

Jo Ivey Boufford, MD
Ruth Finkelstein, ScD
Ana Garcia, MPA

June 2012
ACKNOWLEDGEMENTS

Support for this work was provided by the New York State Health Foundation (NYSHealth). The mission of NYSHealth is to expand health insurance coverage, increase access to high-quality health care services, and improve public and community health. The views presented here are those of the authors and not necessarily those of the New York State Health Foundation or its directors, officers, or staff.
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EXECUTIVE SUMMARY

Though its primary focus is access to medical care through insurance reforms, the Patient Protection and Affordable Care Act (ACA) is remarkable for giving long-delayed attention to the ways both the medical care system and public health system can work together to achieve improved population health outcomes. Title IV of the Act, Prevention of Chronic Disease and Improving Public Health, and numerous other provisions aim to reverse the historic emphasis in the U.S. on personal medical care by directing the federal government to fund and give other infrastructure support to disease-prevention and public health initiatives. These innovative provisions can potentially provide new energy to the significant state-level health reform work that has been under way in New York over the last decade to reduce health system costs and improve efficiencies. They could also provide the foundation for new and reinvigorated public health-health system partnerships needed to make headway on New York’s persistent population health challenges and disparities. This report identifies opportunities that build on both the ACA and New York’s ongoing efforts with a particular eye toward disease prevention and promoting good health for more New Yorkers, especially those who currently suffer from poor health.

The recommendations in this report were generated following a detailed review of the ACA and consultation with numerous stakeholders, including representatives of New York State agencies and county and city health departments. To arrive at our recommendations, we first identified opportunities for which there was a consensus concerning the potential to improve population health. We then eliminated issues where other groups had already recommended implementation priorities; where significant legislation had already been drafted; where no implementation is anticipated in New York in the near future; or where action seemed less feasible (e.g. those that would require significant new, additional public resource investments). We then also sought key opportunities to make significant improvements to the state’s public health infrastructure within the constraints of the current fiscal environment and to build on ongoing reforms and investments.

The recommendations that have emerged are a set of strategic opportunities to increase the synergy between New York’s medical care and public health systems and generate an enhanced, better-integrated health care system oriented toward population health improvement. We offer three sets of recommendations that address the public health infrastructure (data collection, availability, and analysis; public health workforce; and local community health action) and two sets that concern the health care delivery system (Medicaid health homes, and hospital community benefit). In addition, to enable New York to effectively address the recommendations within these areas, we recognized that a level of collaboration is required that exceeds the capacity or authority of existing mechanisms, particularly with respect to the consideration of population health priorities in the investment of public resources by non-health sectors (such as transportation, agriculture, parks, housing, and economic development strategies). There is currently no mechanism to support this kind of cross-agency collaboration. Accordingly, as context for our subsequent recommendations, we also developed a set of overarching recommendations.

These recommendations build upon ongoing reform and planning efforts, in particular by maximizing the potential of the new collaborations forming through New York’s statewide health improvement plan—the Prevention Agenda. NYS is poised to transform its public health enterprise for the better. By focusing on population health imperatives, and with ACA implementation as a catalyst, New York can realize a new vision for its health system that reduces incidence of chronic disease, eliminates health disparities, and improves the health of all New Yorkers.
OVERARCHING RECOMMENDATIONS

- In the development of the new Prevention Agenda, the New York State Department of Health (DOH) should develop specific population health improvement targets and action plans that incorporate the efforts of state agencies across sectors and non-governmental organizations. This would include efforts ranging from the potential contributions of the state Medicaid program and the new health insurance exchange, to the contributions economic development, transportation, housing, education, and other sectors can make to health improvement.

- DOH should align priorities in the new Prevention Agenda with those in the National Prevention Strategy, with an eye toward becoming more competitive for federal funding.

- The Executive Branch should undertake a review of all available public health funds to assess 1) the potential for combining pools, and 2) where state resources could be made more effective in addressing health disparities.

- Using the National Prevention, Health Promotion and Public Health Council as a model, and consistent with Governor Cuomo’s call for greater government efficiency, the executive branch and legislature should name an intergovernmental group to advance a Health in all Policies approach across state agencies, with the goals of:
  - Reducing duplication of efforts and potentially blending categorical funding streams across agencies to achieve agreed health goals.
  - Achieving the greatest possible integration and coordination of policies and financial incentives across current programs and state agencies providing personal health care and public health programs. Targeted programs can be myopic (sometimes an unintended consequence of categorical funding). For example, long-term care programs may overlook primary care needs of people with developmental disabilities; tobacco cessation programs might neglect referrals for nutritional counseling (overeating is a common side-effect of nicotine withdrawal).
  - Leveraging investments currently being made by many sectors (e.g. labor, education, corrections, agriculture, transportation, etc.) for improved population health outcomes. NYS should fully embrace a Health in All Policies approach.

DATA RECOMMENDATIONS

- Develop uniform data standards across all state, county, and city health programs, prioritizing implementation of the ACA’s new data collection standards and requiring all state and state-funded health agencies to obtain and report the same set of demographic data to characterize service recipients.
  - Convene multi-sector partners to enhance consistency of data collection related to program outcomes across non-health agencies and non-governmental stakeholders.
Support community education on the value of accurate self-reports of demographic data.

Consistent with the Medicaid Redesign Team’s recommendation to prioritize the collection of ACA-compliant demographic data, require that all state reports of health or epidemiological information disclose whether an analysis of health disparities was possible, if it was conducted, and what findings are available.

Require entities to submit ACA-compliant data and consider implementing institutional consequences for non-submission (e.g., consider this as a factor in Certificate of Need and quality reviews).

- Develop capacities for the analysis and application of the data collected as a result of the ACA’s new data collection standards.
  - Provide DOH and Local Health Department (LHD) staff training and equipment so that available data can be utilized appropriately.
  - Incorporate analytic capability from academic and other organizations into the design and development of analyses.
  - Create a New York State health observatory, working with third parties to integrate clinical and population health information and clarify issues for policymakers.
  - Require state agencies to make publicly available all existing population health-related data, preferably online, and in user-friendly formats (consistent with privacy and consumer protection laws).

Workforce Recommendations

- DOH should support LHDs to assess what competencies they will require to take advantage of changes in the health care system and develop a plan to achieve them. In particular, DOH should collaborate with LHDs to define their optimal roles in multi-sectoral public health collaborations, particularly with respect to hospitals and health homes. The revision of the State’s Prevention Agenda and New York’s local and state health department accreditation processes should support such efforts and use accreditation board measures and standards to document changes in the need for clinical safety net services and an increased emphasis on population health priorities.

- DOH, in collaboration with Public Health Training Centers and NYS schools and programs in public health, should ensure that the training envisioned to support the changes outlined in the ACA are available to the existing public health workforce and that needed competencies are built into education and training of the future workforce, especially those competencies needed to serve remaining uninsured and underinsured populations, primarily adolescents and immigrants.

- DOH should provide training for governmental public health leadership to address the new data analysis, data translation, and strategic planning needs of the state that will be needed in the State’s waiver application and to respond to conditions generated as a result of the ACA. Public health leaders must also receive training in the skills needed to enable multisector engagement and collaboration, and policy change.
EXECUTIVE SUMMARY

- NYS foundations should consider developing programs to support strengthening of the public health workforce.

Local Community Health Action

- NYS elected and administration officials should prioritize legislative and other policy recommendations emerging from the CTGs as they will be community-identified priorities that have the further endorsement of local health officials and evidence-based support from the CDC. Annual briefings for Albany legislators on CTG findings may be appropriate.

- The NYS Congressional delegation should work to assure that funding for 2013 and future years of the CTG are 1) preserved and 2) free from restrictions prohibiting policy actions that are a priority for disease prevention in NYS.

- NYS investment in both data systems and enhancing public health workforce capacity to analyze data and develop and implement policy changes should be made with an eye toward positioning local community partnerships to compete more effectively for CTGs and other federal community development funds. Specifically, LHDs and partners will need grantwriting skills.

Medicaid Health Homes Recommendations

- Ensure that primary and secondary prevention interventions are among the range of services for which health homes are reimbursed and held accountable (for direct provision or through referral).

- Encourage health homes to include LHD representatives in their interdisciplinary provider teams and to shape their governance and service delivery strategies.

- Develop methods to identify preventable conditions among health home populations and target these with evidence-based interventions. For example, establish referral linkages between health homes, LHDs, and community-based smoking cessation and exercise programs.

- Ensure that health home HIT systems conform to State data standards, including EHRs, incorporate population health indicators and that a routine analysis of health outcome disparities is conducted to identify and specifically target interventions to patients, or groups of patients, with poor outcomes.

- Ensure that health home data systems have the capacity to aggregate patient data (including, but not limited to population health indicators) and make data available for health planning purposes.

- Evaluate health home performance both for patients who remain and who drop out of care.

- Ensure that health homes are involved in the development and implementation of community health plans, including any structural or environmental interventions.

- Ensure that public health information about community health needs and resources is disseminated to health homes.

Community Benefit Recommendations

- New York should develop standards for the provision of community benefits
by hospitals in exchange for tax exemption. The standards should clearly define the community-based prevention activities that are eligible to be considered for the community benefit requirement; insure that this includes broad stakeholder consultation in the health assessment process in the identification, design and implementation of community-level interventions; and that there are clear mechanism for enforcement of the standards.

- New York should permit hospitals to utilize LHD Community Health Assessments in their Community Service Plans.
- New York should formally and permanently align the reporting cycles and timelines for both LHD Community Health Assessments and hospital Community Service Plans.

EXECUTIVE SUMMARY
INTRODUCTION

The Patient Protection and Affordable Care Act (ACA) represents the most momentous change in the U.S. health care system in half a century, since the creation of Medicaid and Medicare in 1965. Though its primary focus is access to medical care through insurance reforms, the ACA also emphasizes population health improvement and includes many disease prevention and health promotion provisions. While the medical care system focuses on diseases, and medical care focuses on the treatment of individuals, population health interventions seek to shape the health outcomes observed among large groups of people. Most of the responsibility for improving population health has traditionally fallen on government, especially public health agencies at the federal, state, and local level.

The ACA is remarkable for giving long-delayed attention to the ways both the medical care system and public health system can work together to achieve improved population health outcomes. It is estimated that only 5% of current national health spending goes toward supporting prevention and public health.¹ Title IV of the Act, Prevention of Chronic Disease and Improving Public Health, and numerous other provisions aim to address the historic imbalance in U.S. spending on personal medical care by directing the federal government to fund and give other infrastructure support to disease-prevention and public health initiatives. These innovative provisions can potentially provide new energy to the significant state-level health reform work that has been under way in New York over the last decade to reduce health system costs and improve quality and efficiency. They can also provide the foundation for new and reinvigorated public health-medical care system partnerships needed to make headway on New York’s persistent population health challenges and health disparities. This report identifies opportunities that build on both the ACA and New York’s ongoing efforts with a particular eye toward disease prevention and promoting good health for more New Yorkers, especially those who currently suffer the poorest health.
BACKGROUND

THE NEED FOR A POPULATION HEALTH APPROACH – UNITED STATES

The need for the population health approach evident in the ACA could not be more obvious both nationally and in New York. In 2010, health care expenses in the U.S. exceeded $2.6 trillion. According to the World Health Organization, these expenditures, both per capita and as a percentage of GDP (17%), exceed those of any other nation. This spending includes substantial investments in research and specialty medical care – resulting in what is arguably the world’s most technologically sophisticated personal health care system and its richest biomedical enterprise – but the U.S. population lags significantly behind other developed countries on multiple health indicators (for example, ranking 43rd in infant mortality and 34th in life expectancy).

Along with falling short relative to other systems, our system also fails to adequately support all Americans. There are significant disparities in health outcomes across geographic areas of the United States, and among certain racial and ethnic minorities, with a disproportionate burden of disease falling on poor communities. These disparities have little to no biological or genetic basis. While the majority (50%) of preventable deaths can be associated with risk behaviors such as smoking, alcohol use, lack of exercise, poor diet, or other substance abuse, these risks are exacerbated by the conditions prevalent in our communities which limit the health choices individuals can make. These conditions include factors like income, education, employment, workplace safety, social isolation, housing, and food insecurity. Known as social determinants, they reflect the conditions in which people are “born, grow, live, work, and age.”

It is impossible to adequately address these important influences on health outcomes by working solely within either the health care or public health systems. Population health improvement requires the public health system’s efforts at primary prevention, which seek to prevent disease or injury in the first place by reducing risks (e.g. via workplace safety, health education, immunizations, safe water, tobacco cessation interventions); and it requires the clinical system’s secondary prevention, which seeks to detect diseases before they become apparent or symptomatic and prevent them from becoming more serious, and to prevent transmission of communicable diseases (e.g. mammography; hypertension screening; STD testing). And as noted above, there is also work to be carried out jointly and with other sectors to address the determinants of health such as employment opportunities, educational attainment, housing, safe communities and access to healthy foods. Recently, support has increased in the U.S. for a “health in all policies” approach that emphasizes improved health and reduced health disparities as shared goals across health and non-health agencies in the public sector. The benefits of working in this manner are supported by a growing body of research: for example, an analysis by Trust for America’s Health concluded that investing $10 per person per year in proven community-based programs to prevent diseases could save more than $16 billion in all-payer health care expenditures nationally and $1.3 billion in New York State within 5 years.

1. The prevention literature also includes the notion of tertiary prevention, which seeks to mitigate the effects of complicated, long-term health problems such as diabetes, heart disease, cancer or chronic musculoskeletal pain, with management strategies that prevent further deterioration and maximize quality of life (e.g., insulin treatment for diabetes, chronic pain management).
THE NEED FOR A POPULATION HEALTH APPROACH – NEW YORK

New York has a large, sophisticated, and costly medical care system that features significant numbers of highly specialized teaching hospitals and a still predominantly fee-for-service medical care system. The system has been under significant scrutiny for the past several years with the goal of “right-sizing” its inpatient capacity and controlling costs. To that end, New York has multiple ongoing reform processes, including implementation of the Berger Commission findings, the Cuomo administration’s Medicaid Redesign Team, the Department of Health’s Prevention Agenda, and New York City’s Take Care New York campaign. These efforts are relatively recent, and New York still reports some of the poorest health indicators in the country. The Commonwealth Fund State Scorecard on Health System Performance ranks New York last among 50 states in avoidable hospital use and costs, 22nd in the provision of preventive care, and 17th on healthy lives (a measure that combines several indicators of the degree to which a state’s residents enjoy long and healthy lives).10

Like other states in the US, New York’s population also exhibits troubling disparities in health status for key health indicators. For example, premature death rates are 200% higher among African Americans and Hispanics, and 50% higher among Asian Americans, than among white New Yorkers. Among all racial and ethnic groups, African American New Yorkers have the highest rates of diabetes and are more likely to die from breast cancer, diabetes (dying twice as frequently as whites), prostate cancer, colorectal cancer, HIV/AIDS, asthma, and heart disease. African Americans also suffer from the highest rates of maternal mortality, low birth weight, and infant death. Among high school students and children, Hispanics suffer the highest rates of obesity, and Hispanic adults die 46% more frequently from diabetes than whites. New York also experiences striking geographic health disparities. The national Project MATCH County Health Rankings show significant disparities in health outcomes among New York Counties (for example, 17% of adult residents of Greene County and 25% of adult residents of the Bronx report fair to poor health, compared to only eight percent of residents of Ontario County). New York City is also notable for its profound variations from one neighborhood to the next.

SUPPORT FOR POPULATION HEALTH IN THE ACA

The ACA supports population health improvement through a variety of approaches, including the provision of health insurance coverage, new models of care, investment in community-based prevention and the public health workforce, and new community health policies. Below is an overview of the major areas of intervention.

INSURANCE BENEFITS

The ACA requires coverage by insurance plans without cost-sharing for certain clinical preventive and wellness services, including screening for breast, cervical, and colorectal cancer; HIV testing; alcohol-misuse counseling; depression screening; and immunizations (§2713). It also calls for the creation of an Essential Health Benefits Package, which sets minimum standards for health plans offered in individual and small group markets. The package must include diagnostic and treatment services to identify and manage chronic diseases, treatment of mental health or substance abuse disorders, preventive maternity and newborn care, and (for young people) vision or oral care (§1302). Beginning in 2014, consumers shopping for individual and small group insurance will be able to compare plans through the state-level insurance exchanges created by the ACA. The ACA gives states the option to establish one or more state or regional exchanges, partner with the federal government to run the exchange, or to merge with other state exchanges.
If a state chooses not to create an exchange, the federal government will set up the exchange(s) in the state. States that create their own exchanges have the opportunity to include mechanisms to coordinate the provision of essential health benefits through both public and private insurance.

The ACA mandates preventive services for newly eligible Medicaid beneficiaries. For those eligible prior to ACA implementation, states are incentivized to provide preventive services with enhanced reimbursement rates (§4106). Grants are available to states who provide incentives to Medicaid enrollees who adopt and maintain healthy behaviors (§4108). Under the Medicaid Incentives for the Prevention of Chronic Disease program, New York State received one of ten awards and will pilot programs in Western New York and NYC focusing on smoking cessation, lowering high blood pressure, and managing and preventing diabetes.

MODELS OF CARE

The new Center for Medicare and Medicaid Innovation created through the ACA is sponsoring pilots and cooperative agreements that aim to improve population health through higher quality clinical care services, with an emphasis on encouraging healthy behaviors. For example, University Emergency Medical Services, a practice plan affiliated with the Department of Emergency Medicine at the University at Buffalo, is receiving an award to deploy community health workers in emergency departments (EDs) to identify high-risk patients and link them to primary care, social and health services, education, and health coaching.

In addition, through the CMMI and as part of the new Medicare Shared Savings Program, the ACA establishes Accountable Care Organizations (ACOs). ACOs are groups of doctors, hospitals, and other health care providers who agree to assume responsibility for care for a defined group of patients, with reimbursements linked to quality metrics and reductions in the overall cost of care under a shared savings model (§3022). Montefiore Medical Center in the Bronx is among the 32 “Pioneer ACOs” created to date. CMMI estimates that approximately 23,000 traditional Medicare beneficiaries in the Bronx will be eligible for care coordination services from the Montefiore ACO. If Montefiore meets certain quality standards and reduces costs over a three-year period, it will share a percentage of the savings it generates for Medicare.

To improve care for Medicaid-covered individuals with multiple chronic conditions, states are authorized to develop health homes (see also discussion below, p. 33), for which a temporary 90% federal match rate (FMAP) is provided. Health homes are required to track avoidable hospital readmissions and utilize health information technology to coordinate care (§2703). To coordinate disease prevention and integrate medical care and community preventive and health promotion services at health homes and other primary care settings, grants are authorized to establish Community Health Teams (§3502), though the provision has yet to be funded. The Act also reauthorized Patient Navigator demonstration programs, designed to help patients overcome barriers to care, particularly from among populations suffering health disparities (§3510).

COMMUNITY-BASED PREVENTION

One of the most significant constructs of the ACA is the new Prevention and Public Health Fund, with an annual appropriation that began at $500 million in fiscal year 2010 and increases to $2 billion in fiscal year 2015 and beyond (§4002). The Fund awarded $500 million in FY10 and $750 million in FY11 to states and communities to boost prevention and public health efforts, improve health, and enhance health care quality. Much of the FY10 money went to restore earlier budget cuts to public health programs; however, and somewhat controversially, more than half went to support the next generation of primary health care professionals (as opposed to community
programming). FY11 funds were dedicated to four critical priorities: community prevention ($298 million), clinical prevention ($182 million), public health infrastructure and training ($137 million), and research and tracking ($133 million). New York has received awards totaling more than $62 million from the Prevention and Public Health Fund, including just over $26 million in FY11.

Through the ACA, the CDC is authorized to award new competitive Community Transformation Grants for state and local governments and community-based organizations for the implementation, evaluation, and dissemination of evidence-based programs to reduce the rates of chronic conditions, improve prevention, reduce disparities, and decrease rates of disease (§4201). These grants provide an important opportunity to strengthen the capacity of local health departments and to create multisector partnerships and coalitions to address the root causes of chronic conditions. In the first round of CTG grants, CDC provided $103 million to 61 communities, including NYC DOHMH, which was awarded $8.4 million, and the University of Rochester Medical Center, which was awarded $730,000. Their programs promote tobacco-free living, healthy eating and active living, clinical preventive services, and healthy and safe environments. These are discussed in further detail on page 30.

In May 2011, a new CTG Small Communities Program was announced. CDC expects to make 25 to 50 competitive grant awards with successful applicants announced in September 2012. The awards are one-time funding with a two year project period. 

WORKFORCE

Several ACA provisions are designed to augment the medical and public health workforces, though to date, few public health programs have received appropriations. State Health Care Workforce Development Grants were funded to analyze the labor market and identify resources to recruit and retain workers. In New York, two Public Health Training Centers each received $650,000 (see p. 28) and the NYS Department of Labor was awarded $150,000. While a new National Health Care Workforce Commission was authorized to analyze future needs (§5101), no appropriations have been made to date to fund its work.

INFORMATION TECHNOLOGY

ACA Section 4302 imposes new uniform data collection standards across all population surveys conducted by HHS (including state Medicaid plans). Section 4302 also requires analysis of the newly-acquired information for the purpose of detecting and monitoring trends in health disparities. These provisions support the creation and evaluation of population health interventions.

POLICIES

There are two major community-oriented health policy changes enacted through ACA. A menu-labeling provision requires the disclosure of specified nutrient information for food sold in certain chain restaurants and vending machines (§4205), a concept already implemented in New York City and for which statewide legislation has been drafted. Secondly, Section 9007 outlines new requirements for charitable hospitals seeking tax exemption. They are now mandated to complete an annual community health needs assessment, which must include input from persons representing community interests, including public health experts. (See also the discussion at p. 37.)

In addition to these two specific policies, the ACA breaks new ground for the implementation of a “health in all policies” approach at the federal level. It creates a National Prevention, Health Promotion and Public Health Council to “provide coordination and leadership at the Federal level,
and among all executive departments and agencies, with respect to prevention, wellness, and health promotion practices, the public health system, and integrative health care in the United States. The Council, composed of the heads of 17 federal agencies (including, the Secretary of Agriculture; the Secretary of Labor; the Secretary of Transportation; and the Administrator of the Environmental Protection Agency) and chaired by the Surgeon General, is charged with developing the National Prevention Strategy, which offers a vision, goals, recommendations, and action items that individuals and public, private, and non-profit organizations can use to reduce preventable death, disease, and disability in the United States.
AIMS AND METHODS

We began with a detailed review of ACA provisions to determine which had the capacity to positively impact the clinical prevention, community prevention, and public health infrastructure of New York. We also consulted peer-reviewed and grey literature to deepen our understanding of the potential for the Act’s provisions to support prevention either directly or indirectly, and to identify future opportunities and challenges. Sources reviewed included materials from national organization such as Trust for America’s Health, the Institute of Medicine, the Henry J. Kaiser Family Foundation, the Council of State Governments, the National Association of County and City Health Officers (NACCHO), and the Robert Wood Johnson Foundation, as well as federal agencies, including the Department of Health and Human Services Health Resources and Services Administration (HRSA), Centers for Disease Control and Prevention (CDC), Office of Minority Health, and SAMHSA-HRSA Center for Integrated Health Solutions.

To understand the history and status of health care reform efforts in New York, we reviewed materials from state agencies including the Departments of Health (DOH), Department of Corrections and Community Supervision (DOCCS), Department of Labor (DOL), Office of Alcoholism and Substance Abuse Services (OASAS), Office of Mental Health (OMH), and Office of Persons with Developmental Disabilities (OPWDD). Lastly, we obtained written information from organizations representing provider groups including the New York State Association of County Health Officers (NYSACHO) and the New York State Conference of Local Mental Hygiene Directors, which was invaluable in providing a statewide picture.

Following our literature review, we interviewed stakeholders to obtain additional background information and narrow our proposed areas of focus. We interviewed representatives of state agencies, county and city health departments, the Public Health Training Centers, and NYSACHO. Following interviews, we synthesized and summarized the considerable information gleaned; the comments and suggestions we received reflected both the creativity of the public health workforce, as well as the diversity of challenges New York faces in implementing the ACA.

To arrive at our key recommendations, we first identified opportunities for which there was a consensus concerning the potential to improve population health. We then eliminated issues where other groups had already recommended implementation priorities (e.g. defining and implementing the ACA’s clinical preventive services provisions and essential benefits packages); where significant legislation had already been drafted (e.g. health insurance exchanges, although the proposed legislation was ultimately supplanted by an executive order); where no implementation is anticipated in New York in the near future (e.g. additional ACOs do not seem to be forthcoming); or where action seemed less feasible (e.g. those that would require significant new, additional public resource investments). We then also sought key opportunities to make significant improvements to the state’s public health infrastructure within the constraints of the current fiscal environment and to build on ongoing reforms and investments.

The recommendations that have emerged are a set of strategic opportunities to increase the synergy between New York’s medical care and public health systems and generate an enhanced, better-integrated health care system oriented toward population health improvement. It has been noted that the health care system has only recently begun to grapple with population health goals. We hope with these examples to illustrate the potential created by the ACA to rethink the balance between the two systems throughout the continuum between public health and clinical care.

2. Numerous groups have conducted analyses related to ACA implementation, the results of which include the following reports: Taconic Health Information Network and Community (THINC). Building ACOs and Outcome Based Contracting in the Commercial Market: Provider and Payor Perspectives (October 2011) • Bachrach D, Belfort R, Bernstein W, Ingargiola S. Considerations for the
THE HEALTH SYSTEM REFORM CONTEXT IN NEW YORK STATE

For purposes of this report, the health system consists of the medical care delivery system (which includes clinical care providers of all types as well as payers) and the governmental public health agencies that, working with a broad base of community partners, constitute the public health system. Governments have the ultimate responsibility for “assuring the conditions” in which people can be as healthy as they can be. In New York, as elsewhere in the United States public health responsibilities are largely the domain of key state and local public health and other agencies, though state functions are somewhat fragmented among several parallel units, including the Department of Health (DOH), Office of Mental Health, Office of People with Developmental Disabilities, Office for the Aging, and Office of Alcoholism and Substance Abuse Services. Because of its size, its frequently independent (and sometimes larger) funding streams, and the 8.24 million people (42% of the NYS population) it serves, the NYC Department of Health and Mental Hygiene exerts vastly disproportionate influence among its counterparts in 57 counties, and at times seems more of a counterpart to the NYS DOH and its sister state agencies. Stakeholders we interviewed frequently noted the need for better communication and coordination between the two “powerhouse” agencies.

HEALTH CARE SYSTEM REFORM

Over the past decade there have been numerous calls for the overhaul of New York’s health care system. Mirroring national concerns, escalating health care costs, system inefficiencies, patient safety, and inadequate service quality led New York to establish in 2005 the Commission on Health Care Facilities in the 21st Century (the so-called “Berger Commission,” after its Chairman, Stephen Berger). This legislatively mandated non-partisan panel undertook an independent review of NYS health care capacity and resources. It generated recommendations that would lead to the reconfiguration of 48 (25%) of New York hospitals, ultimately closing nine hospitals (eliminating 4200 acute care beds) and eight nursing homes (eliminating 2900 beds). The Commission’s review focused on inpatient capacity.

PUBLIC HEALTH PLANNING

Since the 1990’s, New York’s local health departments (LHDs) have been required to conduct quadrennial Community Health Assessments (CHAs) that conduct epidemiologic and other studies to describe community health needs, and identify health care and other community resources. CHAs must identify target populations at increased risk of poor health outcomes and assess the role of the larger community environment. CHAs must also identify areas where better information is needed, especially related to health disparities, quality of health care, and the
 occurrence and severity of disabilities. DOH describes CHAs as the basis for local public health planning.

In 2008, DOH released 18 Local Health Planning Initiative grants to non-profit organizations, academic institutions, and LHDs under the Health Care Efficiency and Affordability Law for New Yorkers (HEAL NY) Phase 9, to reinvigorate local health and health care planning. In 2011, DOH awarded two additional grants. Both sets of grants supported efforts to assess community health needs and priorities; barriers to appropriate care; the availability, affordability, and quality of care; and strengths and weaknesses of the public health and health care delivery systems. Grantees developed recommendations concerning the alignment of resources with community health needs. Where successful, these grants brought together health plans, providers, consumers, and employers, to consider community needs, thus providing a springboard for more integrated health planning in a particular region or community.

THE PREVENTION AGENDA

Also in 2008, anticipating federal health care reform, DOH undertook a Statewide Health Improvement Plan called the Prevention Agenda for the Healthiest State, which established ten statewide public health priorities. For each priority, the Prevention Agenda set goals and defined performance indicators, including the elimination of racial, ethnic, and socioeconomic health disparities. Significantly, it also called upon LHDs and area hospitals to collaboratively identify two or three of these priorities, and then work with community providers, insurers, community based organizations and others to address them. Each LHD was required to reference Prevention Agenda activities in its CHA and Municipal Public Health Services Plan for the period 2010-2013. New York State also requires hospitals to submit a triennial Community Service Plan (CSP) in which they must describe their operational commitment to meet community needs. LHDs and hospitals were encouraged to coordinate their efforts in addressing issues on the Prevention Agenda relevant to their community.

RECENT INITIATIVES: THE PUBLIC HEALTH AND HEALTH PLANNING COUNCIL AND MEDICAID REDESIGN TEAM

Since his election in 2010, Governor Andrew Cuomo has prioritized streamlining of government bureaucracy. In 2010, the State Hospital Review and Planning Council (responsible for approving

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3. The priorities are: 1) Access to Quality Health Care; 2) Chronic Disease; 3) Community Preparedness; 4) Healthy Environment; 5) Healthy Mothers, Healthy Babies, Healthy Children; 6) Infectious Disease; 7) Mental Health and Substance Abuse; 8) Physical Activity and Nutrition; 9) Tobacco Use; and 10) Unintentional Injury.

4. It should be noted that in addition to the Prevention Agenda, several programs within the DOH Office of Public Health develop issue-specific strategic plans, including: Division of Chronic Disease and Injury Prevention Strategic Plan 2010 – 2013; Viral Hepatitis Strategic Plan 2010 – 2015; Oral Health Plan 2005 (Currently being updated); NYS Cancer Control Plan, for which a new plan for 2012 – 2016 is near completion; and the AIDS Institute Strategic Plan 2008-2011, currently being updated for 2012-2015. Furthermore, outside of DOH, in 2008, a statewide Mental Hygiene Planning Committee developed an integrated local services planning process for three state agencies: the Office of Mental Health, the Office of Alcoholism and Substance Abuse Services, and the Office for People with Developmental Disabilities. This multi-stakeholder planning process is designed to encourage local units to address cross-system issues that affect people with co-occurring disorders, and requires an annual local services plan to be approved by local community service boards. These plans, in turn, are used to develop five-year statewide comprehensive plans under the auspices of each agency.
new and changes to existing health facilities) was consolidated with the Public Health Council (statutorily authorized to consider preservation and improvement of public health) to constitute a new body: the Public Health and Health Planning Council. Its membership comprises public health representatives, health care providers, and individuals with expertise in the clinical and administrative aspects of health care delivery, issues affecting health care consumers, health planning, health care financing and reimbursement, health care regulation and compliance, and public health practice. The Council’s Public Health Committee is charged with addressing statewide governmental public health infrastructure and interagency collaborations to support a “health in all policies” approach. The Health Planning Committee advises the Council on need-methodologies, health facility plans, and emerging health care issues, and has undertaken a review the Certificate of Need (CON) process, which governs the establishment, construction, renovation, and major medical equipment acquisitions of health care facilities.

In 2011, a new reform process was implemented through the NYS Medicaid Redesign Team (MRT). It was tasked by Governor Cuomo to reduce costs and increase quality and efficiency in the Medicaid program. In its first phase, the MRT Team developed a package of proposals for immediate cost-savings that were subsequently built into the Governor’s FY12 Medicaid budget, introducing several structural reforms designed to expand Medicaid managed care and amend benefits, reimbursements and eligibility determinations, and to lay the foundation for federal health care reform. In its second phase, the MRT identified opportunities for longer-terms savings and other reforms through a series of work groups (including work groups on population health priorities, such as health disparities and supportive housing) that convened a broad array of stakeholders. Some of these work group recommendations were also included in the Governor’s 2012 Budget, while some will inform an upcoming application to CMS for permission to implement a broad package of reforms.

PUBLIC HEALTH ACCREDITATION

In 2011, New York began the process of obtaining accreditation for its public health system, with the aim of improving the quality of public health services. Accreditation, a formal process governed by the independent Public Health Accreditation Board, whereby health departments are evaluated on the extent to which they meet a series of standards related to the ten Essential Public Health Services defined by CDC to provide the framework for the National Public Health Performance Standards Program. For accreditation purposes, mental health, substance abuse, primary care, human, and social services (including domestic violence), are not considered core public health services, but New York aims to encourage collaboration across these sectors. The accreditation standards and measures fall within 12 domains, among which are included key health planning functions: Domain 1 - Conduct and disseminate assessments focused on population health status and public health issues facing the community; Domain 4 - Engage with the community to identify and address health problems; and Domain 5 - Develop public health policies and plans.

Under the auspices of the Public Health and Health Planning Council’s Public Health Committee, an ad hoc Leadership Committee was convened to work with DOH to oversee the development of a new Prevention Agenda for 2013-2017, New York’s next five year statewide health improvement plan. The committee has reviewed progress to date on the Prevention Agenda, examined the current health status of New York State’s population; and is proposing new priorities and strategies to achieve priority health issues in the upcoming period. Significantly, among its five goals are to: 1) Advance a “Health in All Policies” approach in New York State that addresses the broader determinants of health by increasing awareness and action for health outside the
THE HEALTH SYSTEM REFORM CONTEXT IN NEW YORK STATE

traditional health sector; and 2) Create and strengthen sustainable public-private and multi-sector partnerships that align policies and investments with public health improvement goals at all levels.\textsuperscript{xv}

In the context of “modernizing” the Certificate of Need (CON) process, the Public Health and Health Planning Council has also begun to address anew the question of statewide health planning:

A consensus appears to be building around the importance of bringing together diverse stakeholders to address the issues affecting our health care delivery systems and community health. Population health, the financial stability and quality of health care providers and the cost of health care are all inter-related and critical not just to providers, health plans and consumers, but also to businesses, local governments, civic organizations, and the education system.\textsuperscript{xvi}

As this discussion illustrates, even before the ACA, NYS had made significant progress in reforming its health care system, and reforms continue apace. Now, building upon previous efforts, in particular by maximizing the potential of new collaborations that have formed through the Prevention Agenda and other planning initiatives described above, NYS is poised to transform its public health enterprise. By focusing on population health imperatives, and with ACA implementation as a catalyst, New York can truly move toward its desired “health in all policies” approach.
RECOMMENDATIONS FOR NEW YORK STATE

In this section, we discuss five potent opportunities to take advantage of ongoing ACA implementation requirements to bolster population health priorities. Three are related to the public health infrastructure (data collection, availability, and analysis; workforce; and local community health action) and two concern the health care delivery system (Medicaid health homes, hospital community benefit). We note, however, that for New York to effectively address the recommendations within these areas, a level of collaboration is required that exceeds the capacity or authority of existing mechanisms, particularly with respect to the consideration of population health priorities in the investment of public resources by non-health sectors (such as transportation, agriculture, parks, housing, and economic development strategies). There is currently no mechanism to support this kind of coordinated and sustained cross-agency collaboration. Accordingly, as context for our subsequent recommendations, we offer these overarching recommendations:

• In the development of the new Prevention Agenda, DOH should develop specific population health improvement targets and action plans that incorporate the efforts of state agencies across government and non-governmental organizations. This would include efforts ranging from the potential contributions of the state Medicaid program and the new health insurance exchange, to the contributions economic development, transportation, housing, education, and other sectors can make to health improvement.

• DOH should align priorities in the new Prevention Agenda with those in the National Prevention Strategy, with an eye toward becoming more competitive for federal funding.

• The Executive Branch should undertake a review of all available public health funds to assess 1) the potential for combining pools, and 2) where state resources could be made more effective in addressing health disparities.

• Using the National Prevention, Health Promotion and Public Health Council as a model, and consistent with Governor Cuomo’s call for greater government efficiency, the executive branch and legislature should name an intergovernmental group to advance a Health in all Policies approach across state agencies, with the goals of:
  ▶ Reducing duplication of efforts and potentially blending categorical funding streams across agencies to achieve agreed health goals.
  ▶ Achieving the greatest possible integration and coordination of policies and financial incentives across current programs and state agencies providing personal health care and public health programs. Targeted programs can be myopic (sometimes an unintended consequence of categorical funding). For example, long-term care programs may overlook primary care needs of people with developmental disabilities; tobacco cessation programs might neglect referrals for nutritional counseling (overeating is a common side-effect of nicotine withdrawal).
  ▶ Leveraging investments currently being made by many sectors (e.g. labor, education, corrections, agriculture, transportation, etc.) for improved population health outcomes. NYS should fully embrace a Health in All Policies approach.
PUBLIC HEALTH INFRASTRUCTURE: DATA COLLECTION, AVAILABILITY AND ANALYSIS

BACKGROUND

Health Information Technology (HIT) offers three key opportunities to improve population health: 1) individual patient data can be gathered in the context of patient-level medical care through EHR or disease registries and aggregated to inform public health planning; 2) population data gathered by public health agencies at the national, state, local levels can be used to target prevention interventions in a geographic community; and 3) population data can be used to inform clinical practice for appropriate sub-populations of patients or an individual patient. Realizing these goals, however, requires that data and data systems are uniform, interoperable and consistent within and across medical care and public health systems; that data networks accommodate their secure and reliable transmission; and that medical care providers, payers and public health officials have the resources and skills to collect, analyze, and integrate findings from the data.

Already, HIT is essential for public health surveillance and response, health status and disease monitoring (i.e. environmental risk factors, trends in chronic conditions and risk factors, monitoring disease virulence and emergence of new pathogenic agents or microbial resistance), population based health care access and quality improvement (i.e. care coordination, chronic disease management, clinical practice guidelines), population-based research, and health education. To reach its full potential with respect to population health, however, HIT implementation must achieve the efficient flow of meaningful data between and among providers, researchers, consumers, and public health officials. As noted in one analysis, there is a need for a ‘systems within systems’ approach to allow integration of the existing clinical care and government public health perspectives for measuring total population health, the determinants of health, and health improvement activities. The National Prevention and Health Promotion Strategy developed through the ACA calls for increased access to HIT and integrated data systems to implement prevention strategies and respond to public health threats, noting that “Linked data systems and metrics for a wide range of sectors and partners (e.g., health care, public health, emergency response, environmental, justice, transportation, labor, worker safety and housing) can support decision making. Integrating key data systems can also help streamline eligibility requirements and expedite enrollment to facilitate access to health and social services.”

To date, there has been substantial investment in HIT across multiple domains, including both government and private sectors, with particular emphasis on the development and implementation of EHR and disease registries, computerized provider order entry (CPOE), and clinical decision support (CDS) systems in the context of primary and specialty medical practices. The American Recovery and Reinvestment Act of 2009 (ARRA) authorized new federal HIT initiatives and incentives to induce EHR uptake among physicians and hospitals, and importantly, the development of a nationwide technology infrastructure to facilitate the use of electronic health information. Included among the ARRA incentives are payments for the “meaningful use” of EHR technology in the context of Medicare and Medicaid practices. The definition of “meaningful use” is being developed in phases through an intensive consultative process.

5. Stage 1 criteria define the collection of coded health information, tracking of key clinical conditions, communicating data for the purposes of care coordination, and reporting quality measures and public health information. Criteria are based on core (required) and menu (optional) objectives and performance measures. To demonstrate meaningful use and receive incentive payments, providers must submit clinical quality measures using certified EHR technology, which is designed to reduce the administrative reporting burden. Stage 2 criteria will include disease management, clinical decision support, medication
The ACA includes many HIT provisions, with initiatives to expand the HIT workforce and to establish standards and operating rules to simplify administration and ease reimbursement, as well as multiple provisions designed to improve health care quality, including many new requirements to enhance data quality. Importantly, the ACA Section 4302 imposes new uniform data collection standards across all population surveys conducted by HHS (including state Medicaid plans), and the department has issued new minimum standards pertaining to race, ethnicity, sex, primary language, English proficiency (optional) and disability that apply to all surveys that collect person-level data. Section 4302 also requires analysis of the newly-acquired information for the purpose of detecting and monitoring trends in health disparities.

NEW YORK STATE

New York State has aggressively pursued the evolution of HIT strategies for several years. The DOH Office of Health Information Technology Transformation coordinates HIT programs and policies across public and private health care sectors in support of DOH health care reform initiatives, including the administration of four rounds of competitive HEAL (Health Care Efficiency and Affordability Law for New Yorkers) Capital Grants, one objective of which is the implementation of a 21st Century health information infrastructure to support the delivery of high quality care.

One area of substantial investment has been electronic health records (EHRs). In partnership with the New York eHealth Collaborative, NYS is developing policies and standards, assisting health care providers make the transition from paper-based to EHR, and creating an electronic network to connect providers statewide. The Statewide Health Information Network for New York (SHIN-NY) will connect private practices, nursing homes, clinics, and hospitals to Regional Health Information Organizations (RHIOs). RHIOs are not-for-profit organizations responsible for governing the health information exchange and quality and population health reporting for the purpose of improving health and care in that community. Previous HEAL NY Health IT grant awards totaled $52.9 million in Phase 1, $105.7 million in Phase 5, and $100 million in Phase 10. In its most recent round, HEAL NY Phase 17 grants totaling $109 million were awarded to community-based health information technology (IT) projects focused on the Patient Centered Medical Home model using interoperable EHRs linked through SHIN-NY.

In line with 14 other states, and with support from funding authorized through the ACA, NYS DOH is creating an “All-Payer, All-Claims Database” (APD) that collects data from all payers for care in all settings. The APD will be used to examine the impact of reimbursement methodologies, public health interventions, and health care resources on utilization, quality, outcomes, and costs, and will eventually become a repository for clinical data extracted from EHRs as well. When fully implemented, New York’s APD will expand upon the existing Statewide Planning and Research Cooperative System (SPARCS), which currently provides data on hospital inpatient discharges, ambulatory surgery center and emergency room visits. There are also plans to connect the APD to DOH’s METRIX Project (Maximizing Essential Tools for Research Innovation and eXcellence), a website that facilitates access to datasets for management, patient access to health information, transitions in care, quality measurement and research, and bi-directional communication with public health agencies; Stage 3 will focus on quality, safety and efficiency; high priority national conditions; patient self management tools; and population health outcomes.

6. HHS also plans in 2013 to issue data collection standards pertaining to gay/lesbian/transgender individuals.
RECOMMENDATIONS FOR NEW YORK STATE

researchers, providers, and community-based organizations.7

With respect to demographic data, NYS conducts multiple population surveys, though at present
the state does not uniformly collect data elements in a manner that complies with new ACA
requirements. For example, the NYS Behavioral Risk Factor Surveillance Survey defines disability
differently than does the ACA (although presumably, as a CDC sponsored study, the protocol
will be revised). DOH does produce the biennial Minority Health Surveillance Report, which
examines 49 health indicators, 27 related to health outcomes such as disease and mortality rates,
14 of which measure behavioral/risk factors and eight that correspond to access to health care.
Trend data are reported for 24 of the indicators. Other routine surveys include the Student Weight
Status Category Reporting System, the New York Adult Tobacco Survey, and the NYS Healthy
Neighborhoods Program.

NEW YORK CITY

New York City, with leadership from the Department of Health and Mental Hygiene (DOHMH),
has also invested substantially in EHRs. The Primary Care Information Project (PCIP), which
seeks to improve population health through HIT and data exchange, supports the adoption and
use of prevention-oriented EHRs among primary care providers in underserved communities.
To date, PCIP has assisted 1,800 providers to adopt EHRs designed under contract by
eClinicalWorks, and it is now the largest community-based EHR program in the country. The
PCIP oversees the NYC Regional Electronic Adoption Center for Health (NYC REACH), the
mission of which is to assist providers in adopting technology and methods that measurably
improve the health of New Yorkers. NYC REACH has a team of experts for all stages of EHR
adoption, implementation, and use.

As an important example of the potential for integrating clinical and public health data, the
eClinicalWorks EHR was designed to incorporate ten population health indicators derived
from Take Care New York (TCNY), NYC’s health policy agenda.8 Providers can review their
entire population and identify and track patients with chronic conditions or who require
outreach or targeted interventions, using TCNY population health tools including a clinical
decision support function, a comprehensive order set, a quality measure report function,
and an enhanced registry function. An innovative program based on this functionality is the
eHearts program, which rewards providers who achieve excellent heart health using EHR-
generated clinical quality outcomes. Participating practices transmit to DOHMH prevention-
oriented TCNY quality measures and are rewarded based on their performance on a core
set of quality measures in cardiovascular health. Participants also receive customized
practice-level reports to help them track their progress and improve care. Quality Reports
summarize provider and practice-level achievement (and areas for improvement) as well
as comparisons to benchmarks. Randomly selected participants receive financial incentives
to evaluate the impact of the program on health outcomes, based on goals achieved for
each patient. Incentives are larger for high-risk, Medicaid or uninsured patients with a co-

7. The METRIX data sets currently include: Behavioral Risk Factor Surveillance System; Cancer Mapping; Healthy
Neighborhoods Program; New York Adult Tobacco Survey; New York National Comparison Adult Tobacco Survey; and Nursing
Home Weekly Bed Census.

8. NYC’s Take Care New York is distinct, though in parts overlapping with the NYS Prevention Agenda. The TCNY priorities are:
having a regular doctor; being tobacco free; having a healthy heart; knowing HIV status; getting help for depression; treating
substance abuse; getting cancer screenings; getting immunized; maintaining a healthy home; and having a healthy baby.
morbidity diagnosis.9

PCIP has also pioneered data-sharing strategies among EHR equipped providers. For example, in partnership with three of four NYC Regional Health Information Organizations (RHIOs), eClinicalWorks facilitates the bi-directional exchange of clinical information among health care organizations in order to reduce medical errors and redundant tests, and to improve care coordination for patients who move through various health care settings in NYC. In addition to sharing patient histories with other providers, a practice can retrieve from eClinicalWorks EHRs consolidated patient health histories that include clinical data from multiple data sources in the region (e.g. hospital, home health care agencies, and labs).

The DOHMH has also been at the forefront of making available to the public key health related datasets. DOHMH maintains multiple surveys of population health data. The NYC Community Health Survey (CHS), modeled on the BRFSS, provides robust data on the health of New York City residents, including neighborhood, borough, and citywide estimates on a broad range of chronic diseases and behavioral risk factors. The survey is intended to influence health program decisions, increase the understanding of the relationship between health behavior and health status, and to support health policy positions. EpiQuery is a web-based portal that provides access to these and other health datasets from a variety of sources, offering prevalence estimates with confidence intervals, rates over time, bar charts and neighborhood maps, etc. Modules include surveys (including the CHS, as well as the Health and Nutrition Examination Survey, Youth Risk Behavior Survey, World Trade Center Health Registry), Surveillance (Communicable Disease, Sexually Transmitted Diseases), Administrative (Vital Statistics, including Birth Data, Death/Mortality Data), and Population (NYC Estimates, US Census).

OPPORTUNITIES AND CHALLENGES

With the increased attention to HIT associated with ACA implementation, NYS has several opportunities to maximize the potential for system upgrades and innovations to benefit population health, the most important of which are: 1) enhancing data collection to ensure consistency and uniformity of demographic variables collected by the State and City with ACA standards and to include population health indicators; 2) improving the general accessibility of population health data for planning and analysis and use by communities; 3) developing greater capacity to analyze data to improve population health outcomes; and 4) creating bi-directional data flows between clinical providers and public health officials (i.e. exchanging clinical and population-level data.) In particular, if thoughtfully implemented, the ACA’s uniform data collection standards afford NYS the opportunity to better understand the sub-populations (whether defined geographically or demographically) most affected by disparities in health.

9. Another innovative example is in place at The Institute for Family Health (IFH), one of the largest community health centers in NYS. IFH created EHR-based registries for diabetes and congestive health failure, conditions for which, though serious, the risk for complications can be mitigated with appropriate interventions. Primary care providers use registries to make sure patients are getting the best care, while outreach staff use them to remind patients of screenings or follow-up visits. IFH developed a customized scoring system to rank patients according to their risk for diabetes, based upon a longitudinal analysis of EHR-documented factors. For example, when EHR data showed that patients of color were at higher risk for complications from diabetes, IFH designed a comprehensive diabetes care model to help patients achieve good control of their diabetes. The Institute’s risk-based outreach initiatives began with a pilot to increase screening for colon cancer among patients at increased risk – the pilot demonstrated higher screening completion rates among patients with higher risk scores who were targeted for enhanced outreach.
outcomes. As noted in the National Prevention Strategy: “Improving the standardization of population data, especially for race/ethnicity, age, gender, religion, socioeconomic status, primary language, disability status, sexual orientation and gender identity, and geographic location, will improve our ability to identify and target efforts to address health disparities.”

Indeed, the Medicaid Redesign Team’s Health Disparities Workgroup (see p. 17) cited implementation of the ACA data-collection requirements as critical to addressing inequities in the health care system and improving the health of all New Yorkers. The Work Group recommended that HHS data requirements be implemented across all data-collection efforts regardless of payer – including not only HHS programs such as Medicare and Medicaid, but all other public data collection programs as well, such as SPARCS, the New York e-Health Collaborative, and the all-payer database currently under development. Based upon the prevalence of institutionalized individuals in NYS, who are known to suffer high rates of chronic, preventable disease (and who are not among the explicit beneficiaries of the increased coverage provided through the ACA), such requirements should also apply to state institutions, including prisons, mental hospitals, and long-term care facilities. Such consistency across settings would allow for a fuller picture of disease burden and increased accountability for progress among all populations.

Ensuring consistency with new ACA requirements and improving the value of data for population planning purposes will require collecting new, or more detailed information from individuals about, potentially, their specific race/ethnicity, country of birth, language proficiency, disabilities, and/or sexual orientation. Stakeholders noted that challenges may arise owing to patient concerns about confidentiality and disclosure, however, which may in turn require special efforts to mitigate. In some instances, because of stigma associated with certain vulnerable populations, patients may be reluctant to self-identify (e.g. gay men or lesbians who are not out to their employer or health care provider; immigrants who fear ethnicity data will enhance their risk for deportation) or simply do not so self-identify (e.g. seniors who are simply “slowing down,” as opposed to having a disability). Training workers in multiple settings to collect these new, sometimes nuanced data will also present a challenge.

In addition to capturing the demographic characteristics of populations of concern, there is an unprecedented opportunity, insofar as the ACA is driving substantial activities to develop and implement EHRs at the practice level, to incorporate population health indicators within EHR systems – e.g. known determinants of health, particularly those that relate to risk for chronic disease or disease progression, like tobacco and alcohol use, exercise, diet, and environmental exposures. Such data would be of enormous benefit at the public health level in terms of understanding the prevalence and incidence of chronic diseases and their determinants. But these data could also be used at the practice level to identify patients who need reminders for preventive care or tests, who are overdue for care or not meeting management goals, who have failed to receive follow-up after being sent reminders, or who might benefit from discussion of risk reduction. The federal Agency for Healthcare Research and Quality coined the term Practice-Based Population Health to refer to “an approach to care that uses information on a group (“population”) of patients within a primary care practice or group of practices (“practice-based”) to improve the care and clinical outcomes of patients within that practice.”

Of course, collecting and ensuring the quality of data is just a first step. To maximize their utility, population health datasets must be widely and easily available to researchers, consumers, and

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10. At a recent meeting of the Public Health and Health Planning Council it was discussed that some health system registrars refrain from asking questions about race or ethnicity because they believe the questions to be illegal.
RECOMMENDATIONS FOR NEW YORK STATE

Policy makers. Both NYS and NYC have demonstrated a commitment to releasing public data via systems such as Metrix and EpiQuery. While Metrix, the newer of the two programs, is a good start, much further progress will be needed to fulfill the project’s stated goals: to increase government transparency, help to identify high priority areas where analytics can support New York State’s health reform strategy; create a streamlined process to make NYS DOH data assets available for innovation, economic development, and research; expand policy analysis and research; and contribute to the scientific evidence base with the hope of improving health outcomes. As a more mature system, EpiQuery already has greater capacity. Both will be useful not only to population health planners, but in monitoring implementation of the statewide Prevention Agenda (see p. 16).

Data analysis, much of it complex, will be required to design initiatives to increase service quality, improve service coordination and reduce duplication, identify gaps, monitor disease prevalence, and monitor compliance with state and federal mandates. Across stakeholder interviews, our informants expressed concern that the existing state and local health department workforce lacks sufficient expertise to use data to inform public health decision-making. Enhancing public health workforce competencies, particularly at the city and county level, will also be important (see the Workforce Section below, p. 26). Support for research, one of the essential public health functions, will also be critical.

It may be preferable for analysis to occur through an independent third party. In England, a system of nine Public Health Observatories (out of 12 in the United Kingdom) produces information, data and intelligence on people’s health and health care for practitioners, policy makers and the wider community. These independent organizations work together on an agreed national workplan, and are designed to be a single gateway to a vast range of high-quality and trustworthy public health intelligence, expertise and support. These data are central to both local and national government health policy and decision-making. Importantly, the PHOs monitor and forecast trends in health status and disease, show how health inequalities are being tackled locally and regionally, and assess the effects of health and health care interventions to help give policymakers scientific evidence and data to reduce inequalities in access and outcomes.

Regardless of how the analyses are performed, a goal for the future should be to define mechanisms for financial incentives and conditions for regulatory approvals that support the achievement of certain targets identified through the enhanced data sets. As it prepares its waiver application and reviews its CON and hospital community benefits programs (see p. 24), the State also has an opportunity to drive health care system investments towards the achievement of those same targets.

RECOMMENDATIONS

• Develop uniform data standards across all state, county, and city health programs, prioritizing implementation of the ACA’s new data collection standards and requiring all state and state-funded health agencies to obtain and report the same set of demographic data to characterize service recipients.
  ▶ Convene multi-sector partners to enhance consistency of data collection related to program outcomes across non-health agencies and non-governmental stakeholders.
  ▶ Support community education on the value of accurate self-reports of demographic data.
RECOMMENDATIONS FOR NEW YORK STATE

- Consistent with the Medicaid Redesign Team’s recommendation to prioritize the collection of ACA-compliant demographic data, require that all state reports of health or epidemiological information disclose whether an analysis of health disparities was possible, if it was conducted, and what findings are available.

- Require entities to submit ACA-compliant data and consider implementing institutional consequences for non-submission (e.g., consider this as a factor in Certificate of Need and quality reviews).

- Develop capacities for the analysis and application of the data collected as a result of the ACA’s new data collection standards.

- Provide DOH and LHD staff training and equipment so that available data can be utilized appropriately.

- Incorporate analytic capability from academic and other organizations into the design and development of analyses.

- Create a New York State health observatory, working with third parties to integrate clinical and population health information and clarify issues for policymakers.

- Require state agencies to make publicly available all existing population health-related data, preferably online, and in user-friendly formats (consistent with privacy and consumer protection laws).

PUBLIC HEALTH INFRASTRUCTURE: WORKFORCE

BACKGROUND

The public health workforce is largely the domain of government. HHS estimates that 85% of the public health workforce is employed by government, including local health departments, state and territorial agencies, and federal agencies. The public health workforce includes health educators, administrators, physicians, nurses, epidemiologists, first responders, food inspectors, laboratory scientists, and environmental health specialists, among others. While the public health workforce’s focus on population health distinguishes it from the clinical health care workforce, which treats individual patients in clinical settings, there is some overlap between the two sectors. Many health departments, for example, are sites for clinical “safety-net” services, including childhood immunizations, family planning and reproductive health services, STD screening, etc., for the un- or under-insured. The provision of such safety-net services, however, has also been the source of some tension within the public health sector, with some officials arguing that such services should properly fall within the domain of the clinical care system.

Recently, there have been calls for public health workers to place a greater emphasis on addressing the social determinants of health through data analysis, the development and implementation of structural and policy interventions, and collaboration with non-health partners. For example, recent declines in tobacco use are associated not only with smoking cessation interventions traditionally offered by health departments, but also with multiple overlapping structural interventions, including the Clean Indoor Air Act and increased taxes (which led to higher retail prices). Similar examples include efforts to reduce the availability of high-calorie snacks and beverages in schools, or to increase the availability of walkable communities. The National Prevention Strategy created through the ACA endorses this multi-sectoral approach,
identifying “Partners in Prevention” as state, tribal, local and territorial governments; businesses; health care; education; community and faith based organizations. But such an approach demands new competencies on the part of LHDs to work across sectors and disciplines, as structural interventions require collaboration among public health and other government and non-governmental sectors, including business as well as elected officials.

Once the ACA’s insurance provisions are implemented, which is anticipated to increase the number of individuals with access to care, the Institute of Medicine recently urged health departments to transition their core competencies, away from providing clinical care and toward population health services, noting that exceptions would apply to those populations who remain un- or under-insured. Addressing the communities most likely to remain uninsured (recent immigrants and all undocumented people) may require LHDs to develop new or greater cultural competencies and language proficiency.

As the demands on public health departments have changed and expanded, however, resources have diminished, sometimes dramatically, especially in the last 3-4 years. A recent analysis by Trust for America’s Health showed that 40 states decreased their public health budgets in fiscal year 2011. In July 2011, nearly half of LHDs reported reduced budgets, which is in addition to 44 percent that reported lower budgets in November 2010. More than 50 percent of LHDs nationally expect cuts to their budgets in the upcoming fiscal year. Since 2008, more than 52,200 state and local public health jobs have been lost, representing loss of 17% of the state and territorial public health workforce and 22% of the local public health workforce. In 2011 alone, 57% of LHDs reduced or eliminated programs, including population-based primary prevention services, a larger percentage than in any 12-month period since the recession began in 2008.

NEW YORK STATE

Reductions in public health spending have reduced New York’s public health workforce. In a national survey of local health departments, 65% of New York LHDs reported losing staff in 2011, and another 29% reported cutting staff hours. Interestingly, our informants suggest that in some instances, cuts are already premised on the assumption that LHDs will experience sharply decreased demands for personal preventive services upon ACA implementation – a calculation which, in the absence of any strategic analysis of workforce needs, may be problematic. Some counties have divested themselves of directly providing personal preventive services. Our informants reported that Erie County, for example, closed its family planning and WIC clinics; both were taken over by private agencies. Oneida County is outsourcing its public health programs. A “graying” workforce may compound the problems, as many LHDs do not replace personnel as they retire due to county hiring freezes. Stakeholders noted in confidence that in some instances, cash-strapped counties in NYS have even declined to accept funds for new public health hires, out of fear of assuming future liabilities for retirement and benefit costs.

11. To reflect the scope of responsibilities undertaken by modern public health organizations, CDC’s National Public Health Performance Standards Program defined ten essential public health services: 1) Monitor health status to identify community health problems; 2) Diagnose and investigate health problems and health hazards in the community; 3) Inform, educate, and empower people about health issues; 4) Mobilize community partnerships to identify and solve health problems; 5) Develop policies and plans that support individual and community health efforts; 6) Enforce laws and regulations that protect health and ensure safety; 7) Link people to needed personal health services and assure the provision of health care when otherwise unavailable; 8) Assure a competent public health and personal health care workforce; 9) Evaluate effectiveness, accessibility, and quality of personal and population-based health services; and, 10) Research for new insights and innovative solutions to health problems.
The ACA contains multiple provisions to enhance the supply and training of the health care workforce, but it places substantially more emphasis on the clinical as compared to the public health care workforce. Provisions designed to augment the public health workforce include loan repayment programs, training grants and fellowships, and a new Public Health Sciences Track to award degrees that emphasize team-based service, public health, epidemiology, and emergency preparedness. New grant programs to enhance laboratory capacity and promote community health workers were also authorized. There are also provisions for new initiatives to study the health care workforce.

Unfortunately, only some of the critical provisions have received funding to date and of the $320 million that was spent in FY10 to enhance the health workforce, $227 million was directed toward the clinical primary care workforce. Moreover, as noted above, the Prevention and Public Health Fund that underwrites these investments remains controversial and has come under sustained efforts in Congress to redirect or eliminate it. The APHA notes that near-term prospects for full funding of the ACA’s workforce provisions are dim.

One area which has been funded to New York’s benefit is the Public Health Training Centers. New York now has two such centers: the Empire State PHTC is a partnership between the University at Albany School of Public Health and the University at Buffalo School of Public Health and Health Professions; the New York City-Long Island-Lower Tri-County Public Health Training Center is a collaborative project of the Columbia University Mailman School of Public Health and the State University of New York, Stony Brook’s Graduate Program in Public Health, in collaboration with the NYSDOH, NYC DOHMH, and five county health departments (Suffolk, Nassau, Westchester, Rockland and Putnam). Both centers have undertaken needs assessments to delineate the training needs of the public health workforce. Though no data are yet available from New York City-Long Island-Lower Tri-County Public Health Training Center, preliminary results from the Empire State PHTC suggest that greatest training needs among LHDs include financial planning and management, data analysis and assessment, and policy development and program planning. Training Center staff also expressed concerns about the sustainability of funding, particularly in light of reductions (and threat of future reductions) in the Prevention and Public Health Fund.

OPPORTUNITIES AND CHALLENGES

ACA implementation portends a potentially substantial realignment of responsibilities at every step along the health system continuum, and as such represents an important opportunity to embed population health imperatives at every point, from public health to clinical care. Implementation of the ACA is likely to exert substantial pressures on the existing public health workforce in five key ways – each of which represents an opportunity to re-tool workforce competencies at the local level:

1. Changes in the Safety Net Population. With some 1.2 million New Yorkers gaining insurance coverage, there will be a decreased need for some safety-net prevention services currently provided by LHDs, such as immunizations and reproductive health services. While the overall demand for such services may diminish, however, service delivery needs for those who remain uninsured (an estimated 1.4 to 1.8 million New Yorkers, including some 400,000 undocumented and uninsured immigrants) are likely to become more complex, demanding a greater level of cultural competency and language proficiency among LHD workers. In addition to immigrants, another key population will be adolescents seeking reproductive health services outside of the context of their family provider.
2. Community Health Teams. For health homes targeting populations with chronic diseases (see discussion at p. 33), the ACA authorizes a federal grant program to support Community Health Teams to help coordinate care and provide access to a range of services, including preventive care. Teams must comprise an interdisciplinary, inter-professional group of health care providers, including existing state and community-based resources to coordinate disease prevention and chronic disease management, representing a significant opportunity for intersectoral collaboration. To maximize the efficiency of such teams, it will be particularly important to leverage existing LHD capacity to conduct outreach and health education and to avoid duplicating efforts – it will be essential for local LHDs to exert leadership in this process. (See also the discussion of Community Benefit at p. 36)

3. Data Analysis and Health Program Planning. As discussed above (see p. 20), the availability of enhanced datasets offers to opportunity for much more sophisticated analysis, for which some responsibility is likely to fall on LHDs. But as previously noted, our stakeholders repeatedly expressed the concern that LHDs may lack appropriate skills and will require support to remediate this capacity.

4. Policy development to support innovation. In recent years, recognizing the importance of structural interventions, CDC has encouraged health departments to develop and implement “policy, systems, and environmental” initiatives in addition to pursuing traditional public health programs. With its emphasis on prevention and community health, several ACA grant programs (including Community Transformation Grants) offer additional opportunities for LHDs to pursue innovative policy interventions, though such innovations are likely to require new analysis and development capacity. As previously noted, our informants expressed repeated concerns that LHDs currently lack the necessary capacities to effectively engage in multi-sector policy change.

5. Partnerships with non-public health entities. To deliver the essential components of public health will require collaboration across sectors – not only with other health-related community based organizations and medical care providers, but with governmental and non-governmental organizations in a wide range of sectors including transportation; land-use and urban planning; parks and recreation; housing etc. It will be essential for LHDs to develop the leadership skills to develop and sustain these partnerships.

RECOMMENDATIONS

- DOH should support LHDs to assess what competencies they will require to take advantage of changes in the health care system and develop a plan to achieve them. In particular, DOH should collaborate with LHDs to define their optimal roles in multisector public health collaborations, particularly with respect to hospitals and health homes. The revision of the State’s Prevention Agenda and New York’s local and state health department accreditation processes should support such efforts and use accreditation board measures and standards to document changes in the need for clinical safety net services and an increased emphasis on population health priorities.

- DOH, in collaboration with Public Health Training Centers and NYS schools and programs in public health, should ensure that the training envisioned to support the changes outlined in the ACA are available to the existing public health workforce and that needed competencies are built into education and training of the future
workforce, especially those competencies needed to serve remaining uninsured and underinsured populations, primarily adolescents and immigrants.

- DOH should provide training for governmental public health leadership to address the new data analysis, data translation, and strategic planning needs of the state that will be needed in the State’s waiver application and to respond to conditions generated as a result of the ACA. Public health leaders must also receive training in the skills needed to enable multisector engagement and collaboration, and policy change.

- NYS foundations should consider developing programs to support strengthening of the public health workforce.

PUBLIC HEALTH INFRASTRUCTURE: LOCAL COMMUNITY HEALTH ACTION

BACKGROUND

The Prevention and Public Health Fund Community Transformation Grants (CTGs) are designed to support community-level efforts to address injury and disease. These efforts are mirrored and potentially reinforced by other federal efforts to address community conditions (e.g. the National Prevention Strategy; the Sustainable Community programs through the federal Department of Housing and Urban Development, Environmental Protection Agency, and Department of Transportation; and the Department of Education Promise Neighborhoods). Such initiatives provide significant opportunities for local communities to develop and implement multi-sector community infrastructure efforts.

CTGs support community-level efforts to prevent chronic diseases such as heart disease, cancer, stroke, and diabetes. Administered by CDC, CTG funds are intended to tackle the root causes of poor health by promoting healthy lifestyles, especially among population groups experiencing the greatest burden of chronic disease, to improve health, reduce health disparities, and control health care spending. CTGs are awarded to state and local agencies, tribes and territories, or non-profit organizations, with at least 20 percent of grant funds directed to rural areas; grantees serve “communities” comprising large counties, states without their large counties, entire states, tribes or territories. To date, CDC has awarded approximately $103 million through 61 grants in 36 states.

CTG initiatives are required to incorporate goals from Healthy People 2020 within their program plans and strategies (i.e. reduce death and disability due to tobacco use by 5%; reduce the rate of obesity through nutrition and physical activity interventions by 5%; and reduce death/disability due to heart disease and stroke by 5%) and to demonstrate how community-level interventions lead to: 1) reductions in weight; 2) increases in proper nutrition; 3) increases in physical activity; 4) reductions in tobacco use; and 5) improvements in emotional well-being and overall mental health. By breaking out of the usual categorical funding paradigm, which critics argue has balkanized the public health system, thereby reducing its effectiveness, CTGs were widely heralded for their potential to transform the current disease-by-disease prevention approach to one which is more comprehensive, innovative, and cross-cutting. Properly implemented, they have the potential to create sustainable conditions that promote health across the life span, prevent the development of secondary conditions, promote safety by preventing injuries and violence, and encourage overall healthier and more resilient communities.

The NYS DOH submitted an unsuccessful application for a CTG but two CTGs have been awarded in the state. The University of Rochester Medical Center (in collaboration with the Monroe County Department of Public Health and community partners) was awarded
$730,000 (renewable for five years) to develop Health Engagement and Action for Rochester’s Transformation (HEART), a comprehensive initiative to improve the health of Monroe County residents by creating a community environment that supports healthy behaviors. HEART will combine interventions across the county in four key venues (community, worksites, health care and schools), with targeted initiatives in the city’s Crescent district, a particularly impoverished area. HEART also will focus on the county’s unusually large deaf population. HEART strategies include increasing access to healthy food in inner city communities, increasing access to the Diabetes Prevention Program, crime prevention through environmental design training, and increasing smoke-free places. To help worksites implement evidence-based policy and environmental changes to improve employee health, HEART will develop a Worksite Health Index and Recognition program. Its health care system strategies include offering intensive behavioral counseling in health centers and baby-friendly prenatal care. In schools, the Rochester City School District and the Rochester School for the Deaf will implement Coordinated School Health Plans, blueprints for creating healthy school environments. The URMC Department of Community and Preventive Medicine will perform a comprehensive evaluation in concert with the CDC.

The second New York awardee, the NYC DOHMH, received $8.39 million, renewable for five years, which it will use to enhance its Take Care New York (TCNY) programs with a series of policy, environmental, programmatic and infrastructure interventions. A CTG Leadership Team, called the Partnership for a Healthier NYC, will comprise leaders from government, faith-based organizations, business, labor, health, and community coalitions. Activities to promote tobacco-free living will include tax law enforcement, environmental changes in retail settings, anti-tobacco public education campaigns, and smoke-free housing standards. Active Living-Healthy Eating activities will include environmental changes, healthier food procurement standards in public and private settings, the National Salt Reduction Initiative, the Baby-Friendly Hospital Initiative, and training teachers in the Move to Improve curriculum. Clinical preventive services will include enhancing DOHMH’s Primary Care Information Project (PCIP, see also p. 22) to provide clinicians with enhanced patient information and enhancing PCIP’s data “hub” to support health analysis; brief interventions to help clinicians address excessive drinking; and improving the capacity of the health care community to provide smoking cessation interventions. To promote a Health and Safe Physical Environment, DOHMH will expand the “Play Streets” program; adopt Active Design Guidelines; strengthen infrastructure interventions restricting alcohol access at/near colleges; facilitate enforcement of laws restricting the sale of alcohol to youth; and conduct an educational campaign to raise awareness of alcohol laws.

OPPORTUNITIES AND CHALLENGES

New York’s two CTGs represent an especially important and strategic investment, both because of their innovative approach and the potential for two important metropolitan areas to make meaningful use of the funds. That said, CTG goals are extremely ambitious, with both policy and service delivery intervention requirements, the results of which will be measured against population-based health outcomes. Moreover, the potential for success may be impeded in several ways. At the federal level, the Prevention and Public Health Fund has come under sustained attack, with lawmakers proposing to redirect funds for various purposes. In February 2012, the Middle Class Tax Relief and Job Creation Act, cuts the fund’s spending in FY13 by 33 percent or $5 billion over 10 years. Were cuts to lead to a reduction in CTG funding, it would represent a damaging reversal and waste resources already invested. Furthermore, programmatic goals to reduce consumption of tobacco, alcohol, and low-nutrition foods have been made substantially more challenging by new Congressional restrictions. While not focused specifically on CTGs, the 2012 appropriations bill that funds the CTGs (and other CDC and DHHS programs)
prohibits grant recipients from conducting any activity to: “advocate or promote any proposed, pending or future Federal, State or local tax increase, or any proposed, pending, or future requirement or restriction on any legal consumer product, including its sale or marketing, including but not limited to the advocacy or promotion of gun control.” Insofar as the restriction would seem to prohibit campaigns targeting high-sugar beverages or high-fat foods, it may pose substantial challenges for the food policy goals in New York City and Rochester. Finally, it may be difficult to scale up innovations developed in communities to a state level. It will be important to find ways to leverage community innovations to promote statewide reforms.

RECOMMENDATIONS

- NYS elected and administration officials should prioritize legislative and other policy recommendations emerging from the CTGs as they will be community-identified priorities that have the further endorsement of local health officials and evidence-based support from the CDC. Annual briefings for Albany legislators on CTG findings may be appropriate.

- The NYS Congressional delegation should work to assure that funding for 2013 and future years of the CTG are 1) preserved and 2) free from restrictions prohibiting policy actions that are a priority for disease prevention in NYS.

- NYS’ investment in both data systems and enhancing public health workforce capacity to analyze data and develop and implement policy changes should be made with an eye toward positioning local community partnerships to compete more effectively for CTGs and other federal community development funds. Specifically, LHDs and partners will need grantwriting skills.
BACKGROUND

Fragmented and disjointed care, particularly for those with multiple or serious chronic conditions, is among the many challenges posed by the current health care system. The patient-centered medical home is a model designed with a “whole person” orientation to meet the large majority of a patients’ physical and mental health care needs, including prevention and wellness, acute care, and chronic care. Medical homes are typically physician-led, but coordinate care across the health care system, including specialty care, hospitals, home health care, and community services and supports, utilizing a (sometimes virtual) team of care providers that also include advanced practice nurses, physician assistants, nurses, pharmacists, nutritionists, social workers, educators, and care coordinators. A key aspect of the medical home model is accessibility -- shorter waiting times for urgent needs, enhanced in-person hours, around-the-clock telephone or electronic access, and alternative methods of communication such as email and telephone care. Medical homes feature requirements for “meaningful use” of electronic health records to support systems of quality improvement, performance evaluation, and population health management, and to share quality and safety data publicly to contribute to system-level improvement. The National Committee for Quality Assurance and a number of other professional associations have established voluntary standards for medical homes.

The ACA expanded upon the medical home model with the authorization of Medicaid health homes (with a temporary 90% federal match rate as an incentive for states to adopt) by building additional linkages and enhancing coordination and integration of medical and behavioral health care. To qualify, Medicaid recipients must have at least two chronic conditions, including asthma, diabetes, heart disease, obesity, mental condition, or substance abuse disorder; one chronic condition and be at risk for another; or one serious and persistent mental health condition. Health home services that are eligible for the 90% federal match include: comprehensive care management; care coordination and health promotion, comprehensive transitional care from inpatient to other settings, including appropriate follow-up; individual and family support; referral to community and social support services, if relevant; and the use of health information technology (HIT) to link services.

NEW YORK

In 2008, DOH developed the Chronic Illness Demonstration Project (CIDP) to improve health outcomes and reduce costs for chronically ill Medicaid beneficiaries with complex needs, whom the department estimated to constitute 21% of beneficiaries who incurred 76% of overall Medicaid costs. DOH used a predictive algorithm to identify potential patients at high risk for medical, substance abuse, or psychiatric hospitalization in the next 12 months – during which time such patients would be expected to incur $47,500 in medical expenses. Six teams were chosen to participate: the Institute for Community Living, NYC Health & Hospitals Corporation, Optum Health, Federation Employment & Guidance Services, Hudson Health Plan, and the University of Buffalo, Family Medicine. Based on the patient-centered medical home model, CIDP’s received a monthly fee to assess and coordinate participant care and were required to have an integrated network of medical, mental health and substance abuse providers, as well as linkages with community-based social service providers. The three-year projects were designed to share risk and savings in years two and three, and entities that successfully reduced costs and improved health outcomes were eligible to receive additional funding from a $6 million incentive pool. CIDP was considered a “learning collaborative,” and the experiences of providers informed the subsequent development of the health homes model in NYS.
Subsequently, the Medicaid Redesign Team recommended implementation of Medicaid health homes for enrollees with chronic conditions. To take into account current service delivery structures of patients who will qualify, the state divided the population into four mutually exclusive groups for patients: 1) with mental health or substance abuse disorders; 2) with other chronic medical conditions; 3) with need of long term care; and 4) with those who are disabled. The program will be implemented in three waves, with patient groups one and two in the first wave, group three in the second wave, and group four in the third wave.

Health home providers will be accountable for reducing avoidable health care costs, specifically preventable hospital admissions/readmissions and avoidable emergency room visits, and improving patient outcomes. In developing health home requirements, NYS solicited input from experienced community, medical, behavioral, and social services providers. As a result, and in acknowledgment of the services already provided in the community, health homes will be required to develop strong community connections to meet the complex needs of enrollees.

The first wave of applications for health homes (targeting patients with mental health or substance abuse disorders, or other chronic medical conditions) is being processed in three phases, divided by county. DOH received 61 applications to serve the ten counties in the first phase, and conditionally approved 12. Forty-two applications were received for the second phase, comprising an additional 13 counties, and 16 were conditionally approved. Approvals for the third phase, comprising the remaining 39 counties, are tentatively scheduled to be announced in July 2012.

Negotiations with providers continue as DOH evolves regulations and standards for current and future patient groups. A Health Homes Learning Collaborative is also being launched in 2012 to share best practices in design and implementation, guide ongoing implementation efforts, and inform state policy decisions.

**OPPORTUNITIES AND CHALLENGES**

To realize the full potential of this innovative new care delivery model, health homes will need to fully incorporate prevention and health promotion interventions within the range of clinical and social services they provide; and collect, analyze and report population health data to identify disparities in health outcomes. As such, there are two broad opportunities to maximize the potential for Medicaid health homes to benefit population health: 1) ensure that health home protocols and quality measures include prevention services, and that health homes are accountable both for the prevention and health promotion needs of their clients as well as their medical and/or mental health care; and 2) assure that health homes are working effectively with the broader community of population health stakeholders in broader efforts to improve community health. This might also involve including LHDs in the governance structure of the health home as partners in community health assessments and action plans.

DOH has developed provider standards for health homes serving first wave enrollees with behavioral health and/or chronic medical conditions. Among the myriad requirements, standards call for health homes to have in place procedures to develop a patient-centered care plan for each individual; coordinate the provision of services through a dedicated care manager; and, importantly, monitor patients’ needs, including prevention, wellness, medical, specialist and behavioral health treatment, care transitions, and social and community services; promote evidence based wellness and prevention by linking enrollees with resources for smoking.

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12. The 10 counties were: Bronx, Clinton, Kings (Brooklyn), Essex, Franklin, Hamilton, Nassau, Schenectady, Warren, and Washington.
cessation, diabetes, asthma, hypertension, and self help recovery resources; and identify available community-based resources and actively manage appropriate referrals, access, engagement, follow-up and coordination of services. As DOH continues to refine standards by which health homes operate, it will be important to provide greater specificity regarding the delivery of primary and secondary prevention and population interventions, and to involve LHDs in the collaborative networks that will be required to implement such interventions.

DOH standards also require health home providers to demonstrate how they will develop and implement systems to utilize an EHR system that qualifies under Meaningful Use provisions; support the use of evidence-based clinical decision making tools, consensus guidelines, and best practices to achieve optimal outcomes and cost avoidance. As DOH refines and finalizes standards to govern data systems, it will be important to define what primary and secondary prevention and population health measures are to be incorporated within health home HIT systems, including EHRs.

DOH HIT standards will also require health homes to utilize health information exchange systems to access and share data through RHIOs via the SHIN-NY, not only to ensure portability of patient health records, and thus coordination and continuity of care, but also to permit population-based data analysis. Here, too, DOH should ensure that providers have the capacity to aggregate, transmit to and receive from LHDs appropriate data for health planning purposes, including but not limited to population health measures and to develop methods to share this information with LHDs and receive population health information from them.

Health homes have the potential to provide a wealth of population health data that can be used for community health planning. By linking and comparing aggregate patient data from health homes with population-based community health data, for example, it may be possible to identify and mitigate through structural interventions community or environmental factors that contribute to preventable conditions. Clinical/epidemiological analyses can identify problem “clusters” – a classic example is a “cluster” of asthma-related hospitalizations linked to specific housing stock in a community. Conversely, there is also an opportunity to ensure that data linkages are bi-directional – i.e. that population health data are available to health homes to assist them in identifying individuals with preventable conditions among their patient population and providing them with evidence-based prevention interventions, including referrals to community based resources that help them address risk factors like smoking, diet, and exercise. Finally, health home providers will be responsible for sharing data and reporting quality measures that will be used by DOH and CMS to evaluate the model. Here, too, DOH must specifically define and enforce the quality indicators relating to prevention and population health that will be used to evaluate health home performance and accountability. (DOH already has the capacity to analyze and provide health homes with claims, acuity, and demographic data about patient populations.)

One important consideration for appropriately evaluating the health home model will be to require the capture of information for all patients who encounter the system (i.e. those who are “ever touched” by the system) to maximize outreach to these individuals to engage them in ongoing care if possible; it will be especially important to identify characteristics and determinants for high-needs patients who drop out of care or cannot be engaged. Another important consideration will be to determine whether sub-populations within a health home census are especially vulnerable and may require a different services mix or delivery model to achieve desired outcomes. Subpopulations that may warrant such an analysis include re-entering prisoners, active substance users, and non-English speaking patients.

With the health home model there is a real opportunity to integrate individual and community
health – i.e. to merge efforts to provide care to individual patients with efforts to prevent illness and injury in the first place, not only at the individual but at the community level, and to identify and mitigate disparities in health outcomes. Achieving such integration will require not only that health homes analyze and respond to community-level data and in turn provide data to the community (both described above) but that they also participate in the planning and execution of a community-level prevention and health promotion agenda. DOH could create incentives and/or expectations that health homes participate in the ongoing efforts of the Prevention Agenda at the community level to develop community health plans, as well as the design and implementation of structural interventions (i.e. bike paths or walking paths, public transit, toxic waste remediation, pest control). Such efforts are not unknown: in one example, Kaiser Permanente, in an effort to improve community health by increasing access to fresh and wholesome food, has installed farmers’ markets at 37 of its hospitals in 7 states.

RECOMMENDATIONS

• Ensure that primary and secondary prevention interventions are among the range of services for which health homes are reimbursed and held accountable (for direct provision or through referral).

• Encourage health homes to include LHD representatives in their interdisciplinary provider teams and to shape their governance and service delivery strategies.

• Develop methods to identify preventable conditions among health home populations and target these with evidence-based interventions. For example, establish referral linkages between health homes, LHDs, and community-based smoking cessation and exercise programs.

• Ensure that health home HIT systems conform to State data standards, including EHRs, incorporate population health indicators and that a routine analysis of health outcome disparities is conducted to identify and specifically target interventions to patients, or groups of patients, with poor outcomes.

• Ensure that health home data systems have the capacity to aggregate patient data (including, but not limited to population health indicators) and make data available for health planning purposes.

• Evaluate health home performance both for patients who remain and who drop out of care.

• Ensure that health homes are involved in the development and implementation of community health plans, including any structural or environmental interventions.

• Ensure that public health information about community health needs and resources is disseminated to health homes.

HEALTH CARE DELIVERY SYSTEM: COMMUNITY BENEFIT

BACKGROUND

The provision of charity care has long been required by the IRS in exchange for tax benefits received by non-profit hospitals. With the advent of Medicaid and Medicare in 1965, which were anticipated to sharply reduce the numbers of patients in need of uncompensated care, the IRS shifted the activities required to qualify for tax exemption to include “community benefit,” including public health initiatives and health promotion. In recent decades, the adequacy of
community benefit provided by hospitals in exchange for tax benefits has come under increasing scrutiny in Congress, and the IRS recently required hospitals, beginning in 2009, to report substantially more detail on schedule H of their Form 990, the annual return filed by all non-profits.

The new schedule H requirements were based on the Catholic Health Association’s community benefit reporting standards, which include the number of persons receiving uncompensated care and the value of that care as a percentage of operating expenses. Along with charity care and other items that can be included (for example, some research and graduate medical education expenses) to count towards meeting their community benefit obligation, schedule H now gives hospitals the opportunity to report: 1) community health service programs at cost; and 2) community building activities. While the level of information required by schedule H is substantially greater than earlier versions, neither the form nor subsequent IRS guidance has defined either the amount of community benefit hospitals must provide, nor what defines certain types of community benefit.

ACA PROVISIONS RELATED TO COMMUNITY BENEFIT

Because most hospitals (including New York hospitals) have long construed the provision of uncompensated care to largely fulfill their obligation to provide community benefit, and insofar as the ACA is anticipated to sharply reduce the number of persons seeking uncompensated care, the Act sets forth new requirements for hospitals to maintain their tax-exempt status. Hospitals will be required to 1) collaborate with local stakeholders in assessing community health needs and take actions to address needs identified; and 2) implement financial aid and billing practices that protect consumers. Hospitals are required to conduct a Community Health Needs Assessment every three years, and in doing so, solicit input from persons who represent the broad interests of their catchment area. While the act defines neither the process nor the final product, nor does it offer guidance about how to prioritize identified needs, it does require that the results and an implementation plan are reported to the IRS, along with audited financial statements – though the IRS has yet to finalize regulations governing such reports.

NEW YORK

In the absence of federal specificity, many states have undertaken to define and regulate community benefit – including New York, which has for many years required voluntary not-for-profit hospitals annually to submit a Community Service Plan (CSP) to DOH. (Public hospitals are exempt from this requirement.) DOH also requires hospitals to disseminate the CSP to the public, including pertinent financial data to demonstrate its current and future commitment to public health programs and financial assistance. Hospitals are required in their CSP to assess community needs, and in so doing to consult community stakeholders to determine what benefits are needed, but the nature of this consultation has been undefined, and ultimately it was left to hospitals to determine what constituted the community benefit they provided. As is the case nationally, for most New York hospitals, the provision of uncompensated care has constituted its primary component.

As previously discussed, DOH requires LHDs to conduct Community Health Assessments (CHAs) that describe community health by presenting epidemiologic and other studies, and describing community health needs, health care and community resources and develop plans for action on selected health problems. DOH describes CHAs as the basis for local public health planning.

With its 2008 Prevention Agenda for the Healthiest State, one goal of which was to integrate
traditional medical services with public health interventions, DOH linked these two processes by asking LHDs and hospitals to collaborate with other community partners to identify two or three priority areas on which to focus their efforts. Reinforcing the LHDs role as convener of stakeholders to improve the health of their community and giving hospitals an equally important role as co-convener, these collaborations were to include health care providers and insurers; community-based organizations; businesses, labor and work sites; schools, colleges and universities; government; industry; and the media. In 2010, DOH required hospitals to update their CSPs to explain the collaborative process undertaken, list its overall goals, and describe the strategies they will use to address selected Prevention Agenda priorities. A recent assessment of the planning process determined that while local hospitals and LHDs did collaborate to identify health problems, most lacked the expertise and resources to move into further into implementation and evaluation.

OPPORTUNITIES AND CHALLENGES

The extent to which the federal government will provide guidance related to community benefit remains to be seen, though there is some evidence that a significant revision may be planned for 2015. Many states, including New York as described above, have policies addressing community benefit, some of which may inform the future promulgation of federal regulations. But the ACA’s promise to reduce the need for uncompensated care provides a unique opportunity to capture and redirect these resources to improve community health. Moreover, the ACA provides a strong impetus for states to clarify their expectations and New York should seize the opportunity to do so and, perhaps, influence the guidance that will be forthcoming form the IRS.

The current process to update the New York State Prevention Agenda provides an ideal vehicle to clarify priorities for hospitals and LHDs in this process. The NYS Public Health and Health Planning Council’s Planning Committee has discussed community benefit in the context of its ongoing review of the Certificate of Need process, while the Public Health Committee has established an ad hoc Committee to develop the next five year Prevention Agenda for the period 2013-2017 and the issue of community needs assessment is slated to be an important part of this process. In the end, DOH should ensure that the expectations and processes for hospitals to assess community health needs and collaborate with community stakeholders are more fully described, and that communities realize maximum population health benefit from this important resource. One important step will be to formally and permanently coordinate the LHD CHA and hospital CSP processes (i.e. reconciling their time frames and allowing hospitals to use LHD CHAs as the needs assessment portion of the CSPs).

RECOMMENDATIONS

• New York should develop standards for the provision of community benefits by hospitals in exchange for tax exemption. The standards should clearly define the community-based prevention activities that are eligible to be considered for the community benefit requirement; insure that this includes broad stakeholder consultation in the health assessment process in the identification, design and implementation of community-level interventions; and that there are clear mechanism for enforcement of the standards.

• New York should permit hospitals to utilize LHD Community Health Assessments in their Community Service Plans.

• New York should formally and permanently align the reporting cycles and timelines for both LHD Community Health Assessments and hospital Community Service Plans.
CONCLUSION

In New York, the Affordable Care Act’s prevention and population health provisions will provide multiple opportunities to enhance the public health system and to improve its integration with the medical care system. But beyond these provisions, as illustrated by the examples above, New York will have countless opportunities to embed population health priorities within the implementation of the Act’s many other provisions. For example, the structure and functioning of an insurance exchange is beyond the scope of this report, but structuring the exchange to act as active purchaser that has both carrots and sticks to reward improvements in population health would be consistent with New York’s history of actively regulating insurers and would further the recommendations in this report. With determination, New York can realize a new vision for health that reduces the incidence of chronic disease, eliminates health disparities, and improves the population’s health by working in partnership with communities, families, and individuals to identify health needs and support collective and individual action to prevent illness, protect and promote health, and achieve greater individual and community well-being.
REFERENCES


REFERENCES


xxxi Consolidated Appropriations Act (HR2055). 112th Congress of the United States. §503(c).