Regional Commission on Community Health Improvement

Executive Summary Workgroup Recommendations

Prevention and Population Health:

The partners: The Prevention and Population Health Workgroup was made up of 35 community leaders from public health sectors, including county health directors and representatives from businesses, insurers, hospitals, physician practices, academia and community groups.

The problem: Obesity accounts for as much as 21 percent of overall annual medical spending in the nation, and rates of people who are overweight or obese locally range from 50 to 75 percent, depending on geography and ethnicity.

Though smoking rates have dropped, chronic respiratory disease is still a problem in the region; 17 percent of adults in the Finger Lakes smoke, and smoking rates are 28 percent among poorer and less educated adults in the region. Asthma is prevalent among Medicaid beneficiaries and causes more than 5,000 emergency department visits each year in local hospitals.

Recommendation highlights:

- **Implement policies that increase healthy eating and physical activity and reduce smoking and exposure to environmental triggers of asthma**. These policies should promote breastfeeding, healthy food in cafeterias and vending machines, complete streets/active transportation, physical activity/recess, community use of institutional exercise facilities, and smoke-free schools, worksites, municipalities and government agencies.
- **Create incentives to deliver preventive health care.** Adopt evidence-based clinical prevention guidelines and use technology to share information in clinical and community settings to enable real-time monitoring.
- **Prioritize and implement evidence-based programs that target obesity and respiratory disease**. Such programs include the Nurse-Family Partnership, Diabetes Prevention Program, the Stanford Chronic Disease Self-Management, telephone and in-person tobacco cessation programs, and Healthy Homes and Healthy Neighborhoods programs.
- **Develop and train medical professionals** who are diverse, culturally competent and skilled in preventive care.
- **Document and evaluate outcomes, costs, challenges and lessons learned** by tracking community health measures.

Senior Health:

The partners: The RCCHI Senior Health Workgroup was made up of 40 community experts from hospitals and health systems, long-term care and aging services, consumer representatives, primary care and social service providers, public health and higher education.

The problem: Shifting demographics have created a need for increased focus on seniors living with a chronic condition; this population is expected to double between 2000 and 2030. At the same time, the number of caregivers is projected to drop by more than 15 percent over the next 10 years. Unless steps are taken to address these shifts, they will place tremendous burdens on the health care system and society at large.

A communitywide transition to patient-centered care and accommodation of seniors' wishes to live at home as long as possible has been slower than anticipated.

Recommendation highlights:

- **Integrate medical, social and behavioral care teams.** To do this, expand Patient-Centered Medical Homes, develop regional standards and protocols for real-time data entry and information sharing and implement a communitywide integrated information technology and expand Rochester RHIO connectivity and services.
- **Strengthen the health care workforce to serve older adults** by building a skilled base of hands-on caregivers. Coordinate educational institutions to develop new curricula, identify policies to address workforce shortages and determine finances required to train and retain a skilled workforce.
- **Share information better to enable the integration of care**, such as via a data warehouse and secure data sharing.
- **Advocate for the expansion of Medicaid/Medicare coverage of nonmedical, long-term services and supports.** Contract with managed care or other payers using a value-driven payment system that shares costs and incorporates sliding scale contributions, and simplify contracting between health systems, skilled nursing facilities, and long-term services and support agencies to deliver care.

Behavioral Health:

The partners: The RCCHI behavioral health workgroup brought together 45 local experts in mental health, substance abuse, physical health, primary care, social services, hospital systems and county planning agencies.

The problem: Behavioral health is a term that refers to the often interrelated conditions of mental health and substance abuse disorders. Behavioral health issues are associated with 45 percent of hospital admissions in the Finger Lakes region.

In the Finger Lakes region, there is a higher prevalence of adults who self-report experiencing poor mental health days than in the state overall. Medicaid beneficiaries in the region experience a 40 percent higher rate of mental disease and disorder diagnosis and a 14 percent higher substance use disorder diagnosis rate than the state Medicaid population overall.

The Finger Lakes region has a shortage of behavioral health providers, and that shortage restricts access for people needing treatment. Also, physical and behavioral health care systems are disconnected, which exacerbates the lack of access. Unmet behavioral health needs impose significant health, social and financial costs on communities throughout the region.

Recommendation highlights:

- **Improve access to behavioral health care by providing care management,** expanding the use of telepsychiatry, developing a regional social marketing strategy to reduce stigma around behavioral illness and raise awareness of treatment and support resources, increase the number and geographic availability of behavioral health care professionals, develop and expand models of social support to avert crises, maintain stability and sustain recovery for individuals with behavioral illness and improve access to supportive housing and transportation options for people with a behavioral health diagnosis.
- **Integrate physical and behavioral health care delivery systems** beginning with pilot programs in individual practices, create standards and protocols for sharing protected electronic health information between providers, develop and implement communitywide guidelines regarding the integrated treatment of behavioral health and physical health conditions and conduct formal community trainings and in-services for behavioral health and primary care providers to increase knowledge of the respective systems' cultures, practices and available resources.
- **Provide ongoing measurement and monitoring of behavioral health services** by using existing and new data sources. Partner with local governments and agencies skilled in behavioral health to ensure all assets and data resources are fully utilized.

Community Health Measures:

The commission adopted a set of communitywide measures that the FLHSA has committed to track over time to gauge the region's collective progress toward improved community health. The measures span all recommendation areas and include obesity, hypertension control, depression screening rates, high school graduation rates, emergency department visits and readmissions. They represent areas with the greatest potential to have a positive influence on health and well-being. Reflecting the importance of addressing disparities in health status and health care, the FLHSA will report the Community Health Measures in aggregate as well as by race/ethnicity, geographic region and socio-economic status – to the extent the data allow – to better understand where and how disparities impact overall community health in the region.

Cross-cutting issues:

Information sharing: The commission called for integrating and coordinating care through seamless, confidential and secure information sharing**.** Barriers to information-sharing among medical and nonmedical providers and systems include low connectivity due to funding sources, such regulations as confidentiality laws, and lack of interoperability among software or electronic records systems. A collaborative approach is needed to overcome these barriers.

Financing: Current fee-for-service health care financing may not lend itself to care coordination and care management, so shifting to value-based payments should incorporate a compensation model for coordinated care. Non-medical policies and programs that support healthy choices should be supported by long-term funding, and by partnerships across public, private and nonprofit sectors.

Workforce: To address health care workforce shortages in the region, the RCCHI recommends that FLHSA develop a regional consortium to coordinate local and state workforce development efforts and design a targeted health care workforce plan for the Finger Lakes.

Table 1. RCCHI Community Health Measures

RCCHI Measure	Triple Aim Dimension	IOM Core Measure?	*Can Track Disparities?*			Current Value (Reg. Avg.)[4]	Target (Sage/NYPA/ HP2020/DSRIP)
			R/E[1]	SES[2]	Geo.[3]		
Behavioral Health							
PHQ9 Depression Screening rate (or avg. community score)	Patient Experience	x	x	x	x	*TBD*	-
ED visits w/ behav. health diagnosis, primary or comorbid (% of all ED visits)	Cost/Patient Exp.		x	x	x	18.8%	-
30 day hospital re-admits among those with a behav. health diagnoses (%)	Cost/Patient Exp.		x	x	x	*TBD*	-
7 day outpatient mental health follow-up visit after inpatient discharge (%)	Patient Experience					46.8%	74.2%
Prevention and Population Health							
Years of potential life lost (YPLL) (<65 years)	Population Health	x	x	x	x	5,850	-
Low(<2500 g) birth weight (rate per 1,000 births)	Population Health		x	x	x	59.8	31.2
Children w/recommended immunizations as of 2 yrs. of age (%)	Population Health	x	x	x	x	*TBD*	88.4%
Cigarette smoking -Adults (%)	Population Health	x			x	19.6%	12.0%
Obesity -Adults (%)	Population Health	x			x	27.0%	-
Obesity -Children (%)	Population Health	x			x	17.6%	14.5%
Hypertension control (%)	Population Health	x	x	x	x	78.0%	73.3%
Type II diabetes control (%)	Population Health	x	x	x	x	*TBD*	76.8%
Prevention quality indicator (PQI) 90 (Composite)	Population Health	x	x	x	x	833.7	0
High school graduation rate (%)	Population Health	x	x	x	x	80.0%	82.4%
Self-reported excellent/very good/good general health status (%)	Population Health	x	x	x	x	83.9%	-
Senior Health							
Emergency department visits among those 65+ (rate per 1,000)	Cost/Patient Exp.		x	x	x	553.6	-
Medicaid nursing home/home- and community-based services spending (%)	Cost/Patient Exp.					*TBD*	130%
Nursing home utilization days (per 1,000 persons aged 85+)	Cost/Patient Exp.					*TBD*	-

Key:

Measure RHIO dependent, not yet available

Medicaid Only

Category notes:

1 - Race/ethnicity

2 - Socioeconomic status

3 - Geographical

4 - Current values are nine-county regional averages