

HEAL 9 GRANTEE SUMMARIES AS OF SEPTEMBER 2011

- 1. Allegany/Western Steuben Rural Health Network (AWSRHN):** HEAL 9 funding allowed for the development of an integrated health plan that contributes to improving the health status of Allegany County's population. Utilizing the Mobilizing Action through Planning and Partnerships framework, our vision is *to collaboratively build the infrastructure and capacity of our local healthcare delivery system to make Allegany County the healthiest community in New York State*. Quantitative and qualitative data gathering and analysis presented the following priorities: Chronic Disease-Prevention, Secondary Prevention, Medical Management, Self-Management; Health Professional Shortage- Recruitment, Retention and Training; Behavioral Health-Primary Care Integration; Caregiver Support, Education and Empowerment; Medication Reconciliation; Volunteerism for the Greater Good; and Coordinated, Consistent Health Messaging.

As a result, the following initiatives have been implemented to address key issues: Development and launch of an evolutionary approach to a living, sustainable Community Health Assessment entitled Allegany County Network of Care for Healthy Communities. This website will benefit all sectors of the local health system; including professionals, consumers and caregivers. The project also developed the Allegany County Caregiver Coalition; establishment of the Allegany County Volunteer Coordinators' Collaborative Community-Wide Patient Safety Council, Medication Reconciliation Initiative, Allegany County Fall Prevention Collaborative, Chronic Disease Self-Management Initiative including Stanford University Living Healthy Program and PEARLS Geriatric Depression Initiative; and Murray Hospitality House in Belmont, New York, allowing for healthcare professional student housing.

- 2. Catskill Hudson Area Health Education Center Inc.(Catskill Hudson AHEC):** This grantee has created a community-specific healthcare provider recruitment and retention program, known as HealthMatch. Catskill Hudson AHEC continues as an in-kind consultant to the community of Ellenville/Wawarsing to assist in the completion of this project as well as continue in the recruitment of additional providers to this area of the state. The organization is moving forward to replicate the HealthMatch project in other communities across their 11-county region and is working with the NYS AHEC System to license the HealthMatch service to become a statewide provider recruitment initiative.
- 3. Center for Health Workforce Studies:** The Center for Health Workforce Studies, in collaboration with the Community Health Care Association of New York State is conducting a comprehensive primary care assessment of New York City. Using a small area analysis, 317 primary care rational services areas (RSAs) were developed statewide as part of this project based on commuting patterns of patients to their primary care provider. Insurance data from various sources that includes both the zip code of the patient and the primary care provider were used to analyze patient commuting patterns. Primary care capacity in each RSA was assessed using current health professional shortage area (HPSA) designation rules and the proposed 2008 guidelines using population. Community meetings to gain local input on conditions that may affect primary care access and thus the configuration of RSAs have been held in various regions of the state. Re-licensure surveys were developed for midwives, nurse practitioners, and physician assistants to assist in understanding their contribution to primary care, and data collection from these surveys started in the spring of 2011.

Preliminary findings indicate that more current and more comprehensive data are needed to reflect current access to providers across the state. The approach did not adequately address commuting into and out of the larger cities for care or cross-state commuting for care, which may impact access to care for many high need communities and populations. Additional analysis of Medicaid managed care beneficiary utilization is also needed. Next steps include continuing local meetings and analyzing commuting patterns by individual insurance status (Medicaid, Medicare, Commercial, and Uninsured).

- 4. Chautauqua County Health Network (CCHN):** The Chautauqua Local Community Health Planning project is focused on three key objectives which include: development of a health status report, creation of a primary care vision statement, and an assessment of immediate and future long term health care needs.

Long Term Care: As part of the HEAL process, Chautauqua applied for and was awarded a HRSA Office of Rural Health Policy Network Planning (ORHP) grant for long term care. A gap analysis was completed and strategic planning is underway. Three priorities that have emerged include: case management and referral services; subsidized/affordable home and community based services for frail elderly; and residential services for geriatric mental health and developmentally disabled. Transitions of care and discharge planning will be a focus of program implementation. Review of health information exchange technology, as well as root-cause analyses and cost modeling are in preparation to apply for ORHP implementation funds, as well as CMS *Partnerships with Patients* (3026) reimbursements.

Primary Care: Three key accomplishments to date: a New Access Point application was submitted to HRSA in December to create *The Chautauqua Center* (TCC) as an FQHC in Dunkirk. Significant effort has been put into developing the structure including: Board recruitment, by-laws, lease agreements, policies, and staffing contracts. A CON application has been prepared; a Physician Assessment Report was completed and has been distributed throughout the county to stakeholders with recommendations for community action to enhance recruitment and retention; and an existing CCHN Committee has been re-purposed to focus on addressing the current and future needs of primary care providers. It is comprised of payers and PCP office managers; common issues have been identified for discussion and action. A consultant will begin evaluating the extent to which this project met its goals.

- 5. Chenango Health Network (CHN):** This grantee is the lead organization and facilitator for local health care planning activities in Chenango County. Over the past two years CHN used *Mobilizing for Action through Planning and Partnerships* (MAPP), a community-driven strategic planning tool for improving community health.

The planning activities focused on three New York State Prevention Agenda items: Access to Quality Health Care Services; Chronic Disease and Cancer; Mental Health and Substance Abuse. CHN is working with group members on community health projects specific to DOH's Prevention Agenda as a direct result of this project. Projects which are either in the developmental or implementation stages include chronic disease prevention through environmental change; satellite mental health clinics; and medication therapy management.

CHN and planning group members supported the value and importance of a county-specific GIS planning tool, however, implementation has had to be postponed due to the need for additional

technical assistance in order to develop, implement and maintain the GIS tool. The local health planning group has started to consider key elements of *Healthy People 2020*, integrating *Healthy People 2020* into local activities including adopting a similar vision statement. The group has opted to continue meeting and working together beyond the HEAL9 grant period. CHN will continue to convene meetings and facilitate discussions through grant support from NYS Office Rural Health. A final report of the project will be produced and available in September 2011.

- 6. Columbia County Community Healthcare Consortium Inc.:** This grant is intended to improve preventive and primary care in Columbia and Greene counties by data collection and analysis, an assessment of access to preventive and primary care services, and the input of stakeholders.

The Consortium : (1) convened a Task Force on Preventive and Primary Care; (2) developed and completed a report -- *A Vision for Better Health: Improving Preventive & Primary Care in Columbia and Greene Counties*, a 21-page document describing a vision with goals for better health and a more effective, well-funded preventive/primary care system in the two counties; (3) completed another document entitled, " How Far...How Close," which reflects extensive data collection to measure the gap between the goals enumerated in the "Vision" document referenced above and county residents' current health status/healthy lifestyles; (4) identified four top priorities after reviewing the "How Far...How Close" document (cardiovascular disease, obesity, tobacco use, and behavioral health [mental health, substance and alcohol abuse]), which reflect some of the most costly medical conditions and unhealthy lifestyles; and (5) developed preliminary recommendations on these priority areas to close the gap between the Vision and residents' current status.

During the fall and early winter (2010-11), the recommendations were subjected to an extensive public process to ensure that they reflect local concerns, creativity, and support. This process sought public comments on the recommendations and included multiple points of input – two advisory groups; a scientific survey of 1,200 households; surveys of businesses, local officials and health care providers; six focus groups (2 consumer, 2 chambers of commerce, 2 primary care physician groups); and a media awareness campaign that publicized the draft recommendations and encouraged people to submit comments via the Consortium's web site.

The grantee gathered all the comments on recommendations and presented them to the Task Force. After reviewing the comments, the Task Force decided on 36 recommendations. Given the fiscal constraints facing government and the private sector, the members also attached priorities to those recommendations with fiscal implications that they thought should be implemented first. The final report was submitted to the State DOH in April 2011 and is available on our web site.

- 7. Community Health Care Association of New York State (CHCANYS):** CHCANYS, in collaboration with the Center for Health Workforce Studies, is conducting a comprehensive primary care assessment of upstate New York, including the following New York State regions: Western, Finger Lakes, Central, Southern Tier, Northern, Hudson Valley, and Long Island. Using a small area analysis, 317 primary care rational services areas (RSAs) were developed statewide as part of this project based on commuting patterns of patients to their primary care provider. Insurance data from various sources that includes both the zip code of the patient and the primary care provider were used to analyze patient commuting patterns. Primary care capacity in each RSA was assessed using current health professional shortage area (HPSA) designation rules and the proposed 2008 guidelines using population. Community meetings to gain local input on conditions that may affect primary care access and thus the configuration of RSAs have been held in regions around the state. Re-licensure

surveys were developed for midwives, nurse practitioners, and physician assistants to assist in understanding their contribution to primary care, and data collection from these surveys started in the spring of 2011.

Preliminary findings indicate that more current and more comprehensive data are needed to reflect current access to providers across the state. The approach did not adequately address commuting into and out of the larger cities for care or cross-state commuting for care, which may impact access to care for many high need communities and populations. Additional analysis of Medicaid managed care beneficiary utilization is also needed. Next steps include continuing local meetings and analyzing commuting patterns by individual insurance status (Medicaid, Medicare, Commercial, and Uninsured).

- 8. Finger Lakes Health System Agency (FLHSA):** FLHSA continues to promulgate replicable model of community health care planning through the work of The 2020 Performance Commission (2020 PC); a multi-stakeholder collaborative working to reduce preventable hospitalizations (PQI related hospitalizations), divert sub-optimal emergency department visits, strengthen the system of regional hospitals, and the SAGE Commission focused on developing a person-centered integrated health care service system for older adults.

During this period, FLHSA and its partners have begun pursuing a three-pronged strategy aimed at reducing PQI readmissions and improving chronic disease care which includes: 1. Implementing 4 community hospital discharge standards among the 6 Finger Lakes regions; 2. Embedding care managers in primary care offices; and 3. Implementing community-based patient coaching by implementing a formal, community-wide Care Transitions ProgramSM that will engage 5 hospitals, 3 home care agencies and 3 community-based care giving organizations and agencies.

Accomplishments include: Convening an implementation work group that serves as a regional learning collaborative for discharge planners working to implement the community standards; selecting 9 practices to participate in the 2-year Care Manager pilot in which two of the selected sites are city-based community health centers that also provide care to disparate populations; and negotiating agreement with local insurers to reimburse for embedded care management. FLHSA continues to make progress in collecting outpatient healthcare data from the major private insurers in the Finger Lakes region (Excellus BlueCross BlueShield and MVP Healthcare) to develop a community healthcare claims database.

- 9. Fort Drum Regional Health Planning Organization:** This grantee developed a business and implementation plan for an innovative and replicable Emergency medical Services (EMS) system to align fragmented and unsustainable pre-hospital emergency medical care resources under a single high-functioning, county-wide cooperative system and eliminate unnecessary or duplicative services. The grantee completed a Community EMS Cooperative preliminary feasibility analysis; provider interviews to obtain feedback on issues identified in the feasibility analysis; and contracted a web vendor to keep all stakeholders, media, and the public informed of the progress. The grantee has also received the final plan from a sub-contractor and worked with EMS agencies, county and village officials, and EMS committee members to secure municipal resolutions and submit a NYS Department of State Implementation Grant to implement the plan for consolidated services.
- 10. Healthy Capital District Initiative:** Healthy Capital District Initiative (HCDI) has brought together a diverse group of organizations in the Capital District to focus on reducing sub-optimal emergency

department (ED) use; including area hospitals, physician groups, federally qualified health centers, employers, consumers, elected representatives, and other health providers. Participants enabled and helped interpret research on primary care treatable ED use in the Capital Region. Three lines of research were completed: individual decision-making (over 700 ED patients surveyed), structural characteristics of the provision of health services (gap analysis of 45 provider interviews), and utilization patterns (2008 SPARCS data for the region).

Findings brought to light that nearly half of ED visits were for primary care treatable conditions; pain and convenience were the most commonly cited motivation for emergency care; 1/3 of ED patients surveyed did not have a Primary Care Provider (PCP); 1/7 could not see their PCP because they hadn't completed a well-care visit; ED utilization patterns were more similar than not across payer types; and ED use was highest in lower income and neighborhoods more proximate to ED's. Workgroups were developed to address improving access to primary and preventive care, consumer education and communication between EDs and PCPs. An educational campaign and initiatives to engage public health insurance applicants with a PCP are under way. Additional initiatives were piloted or are still under development with collaborators in the region.

- 11. Jefferson County Public Health Service:** Jefferson County Public Health Service (JCPHS) has developed a regional consortium of all 4 hospitals, providers and the 2 local health departments in Jefferson and Lewis Counties. The consortia has updated health data and assessed rural health challenges, including primary care capacity and access to care, identified community health priorities, and is addressing infrastructure and health system improvements in Jefferson and Lewis Counties. Key informant interview surveys were developed and health insurance providers, seniors, and businesses from a variety of industries were surveyed; barriers to care have been examined as a result of survey, and data was ranked based on need. The project has held the following symposiums: "Continuum of Care for our Elderly," which delineated the unique characteristics of the rural community as applied to the senior population; "Delivering Care through Telemedicine in 2010," which was for medical providers to learn about telemedicine to increase rural access to care; and an intensive network training to North Country Telemedicine Project members.

From the data collected and analyzed and from these symposiums, the project is addressing the region's top three NYS-DOH Prevention Agenda priorities: Nutrition and Physical Activity, Access to Care, and Chronic Disease. In order to address all three priorities the project has developed the following work plan goals and associated interventions: (1) Raise public awareness about the risk factors and complications of diabetes and the role that a healthy lifestyle, screening and diagnosis, education, treatment and support services play in controlling the disease; and (2) Ensure that all Jefferson and Lewis County residents diagnosed with diabetes have access to quality services, equipment and supplies. From this ground work JCPHS has developed a diabetes coalition to address and work on these goals. The overall regional consortium will be sustained through the Fort Drum Regional Health Planning Organizations Quality Committee which has blended with the HEAL NY Phase 9 group.

- 12. New York and Presbyterian Hospital:** This grantee's HEAL 9 project aims to develop and implement a model of community health assessment and planning that can enhance the State's ambulatory CON process. The model will focus on health disparities, delivery system capacity to address public health priorities, access to primary care, and over-use of emergency departments. It will include a standard data set for an ambulatory Certificate of Need (CON) planning process within the Northern

Manhattan/Western Bronx selected planning area, including: Washington Heights/Inwood, Central Harlem and Riverdale/Kingsbridge.

The grantee has collected all pre-intervention data including a demographic profile of the Northern Manhattan/Western Bronx residents and conducted focus groups with two primary groups: community residents and independent community physicians. Some of the preliminary findings concluded that: 1. Patients who are more familiar with the healthcare system tend to use all aspects of the system such as the ER when sick and tend to follow up with their primary care physicians; 2. Older, female patients with several co-morbidities were most likely to report the name of their primary care physicians; 3. Patients who knew their primary care physicians names were less likely to die, more likely to return to the ER and more likely to be hospitalized.

The final project report will include the data presented in this preliminary report along with conclusions drawn from each of the data collection initiatives. The final report will also make recommendations regarding the current community need in the Northern Manhattan/ Western Bronx communities and draw conclusions about data collection strategies that will inform the NYS Certificate of Need Process.

- 13. North Shore – LIJ Health System:** The grantee is sponsoring the creation of the Long Island Center for Health Policy Studies (LICHPS) in order to collect, analyze and disseminate healthcare information and data to formulate sustainable and cost effective strategies to meet identified community healthcare needs. The grantee convened an Advisory Council composed of over 70 community stakeholders, including consumers, business leaders, providers, and county officials.

Key findings from data presentations to the Advisory Council included Long Island's Preventable Quality Indicators trends from 1997 to 2007 (Diabetes up 158%, Cardiac Related down 21%) and actual/projected data on Long Island's growing senior population (projecting an increase of 85% in Nassau and 178% in Suffolk between 1980 and 2035). The Council suggested an exploration of common priorities based on the community health assessments conducted by the Nassau and Suffolk County's Department of Health. Both counties and all the hospitals are collaborating towards achieving two common Prevention Agenda goals: Tobacco Use - Prevention and Cessation, and Unintentional Injury- Prevention of falls among those aged 65+.

LICHPS developed a web site (www.lihealthpolicy.com) to function as a centralized location for the collection, storage, and dissemination of health information from all valid and reliable sources. The web site is used to communicate any findings or policy recommendations from the data to the general public and local government.

LICHPS completed a Small Area Analysis study of 2008 hospitalizations of Long Islanders using the Agency for Healthcare Research and Quality clinical classifications software, developed a 45-item senior needs survey which was reviewed and finalized by the Advisory Council's Senior Needs Subcommittee, and developed a Long Island Health Atlas which highlights vulnerable communities on Long Island who experience a complex interaction of social, economic, environmental, and biological influences which result in lower health status. The analysis results, as well as the survey and Atlas can be found on the LICHPS website.

- 14. P2 Collaborative of Western New York:** The Western New York Community Health Planning Institute (WNYCHPI), through the P² Collaborative of Western New York, commenced its community

health planning work with initiating development of an organizational and data analysis infrastructure seeking to address inappropriate emergency room use and inappropriate hospital admissions/readmissions. The grantee is currently working with the FLHSA to support both the emergency room (ER) and hospital admission areas of focus. At the same time, P² is in discussion with local health plans to use the aggregated health plan claims data base supporting more robust data analytics across the continuum of care.

In building a community health planning capacity two opportunities arose to strengthen the health planning relationship with local organizations. The Community Medicaid Collaborative, with seed funding from the four regional health plans in WNY and the Community Health Foundation of Western and Central New York, received additional funding May 2011 through the Robert Wood Johnson *Aligning Forces for Quality* grant to focus on addressing the needs of the Medicaid population through opportunities for enhanced care coordination and integration with community based organizations. The second opportunity presented itself in March 2011 when SNAPCAP, a local collaborative of safety-net providers reached out to P² to access the data repository and analytical capabilities developed under the HEAL9 grant. We have assisted this group in analyzing primary care needs and access in their catchment areas with next steps to include understanding how to implement interventions to effect change. WNYCHPI continues to develop web capability for communications and has initiated planning efforts to support a sustainable business model.

15. The Research Foundation of the State University of New York (SUNY Downstate Medical Center):

The grantee is developing a comprehensive community health planning process with diverse stakeholders to articulate the vision for health care in Central and Northern Brooklyn; study emergency department use; collect data as it pertains to high rates of ambulatory care sensitive hospital admissions; and develop information reservoir that can be updated and used in the future. Over thirty partners including all the major insurers, School of Public Health, Central and northern Brooklyn Hospitals, community-based organizations, behavioral health agencies, 1199 and the NYCDOH are among the members of our coalition. Three new members have joined the Coalition: HealthPlus, Novartis Pharmaceutical, and the Brooklyn Center for Health Disparities. The Community Advisory Board has been appointed and active in the Coalition.

The Coalition meets regularly at Brooklyn Borough Hall and is active in development and implementation of the project studies. To date, the block by block canvassing of Central and Northern Brooklyn neighborhoods for the comprehensive health resources inventory has been completed and the data has been compiled into the GIS system along with other pertinent information for the needs assessment. An Emergency Department utilization study has been completed in each of the participating hospitals. More than 10,000 patients were surveyed, as well as ED staff. Proprietary claims information for the primary care service analysis and ACS analysis has been received from five health plans. The Coalition is currently analyzing and reviewing preliminary survey results and drafting recommendations to the NYSDOH.

16. Rockland County Department of Health: (as of August 2010) The grantee developed a comprehensive assessment of health care needs in a seven-county region focusing on access to care, chronic disease prevention and control, maternal and child health, and make recommendations for the alignment of resources with those needs. To facilitate identification and monitoring of priorities, the project has developed and implemented a Regional Performance Monitoring Tool (RPMT). The RPMT was successfully used to collect input from 6,911 consumers across the region. Data has been incorporated into the 2010-2013 Community Health Assessments.

Analysis and reports of the survey data continues to be provided in the seven counties by the New York Medical College. Further input was garnered through the use of consumer and provider focus groups as key stakeholders in this health systems approach to planning. Two regional HEAL 9 Summits were held with health leaders from the seven counties of the Lower Hudson Valley in attendance focusing on the need for regional planning and the New York State Prevention Agenda. Recommendations based on the summits and data have been prepared and plans for a sustainable planning coalition are in process.

- 17. United Hospital Fund (UHF):** UHF conducted an analysis of ED use, with a focus on neighborhood variation and frequent users, with HEAL 9 support; and with foundation support is conducting community research into reasons for frequent use of EDs.

An analysis of SPARCS ED and inpatient data examined patterns of ED utilization in New York City by UHF neighborhood, age, diagnosis, insurance coverage, race/ethnicity, gender, time of day and day of week of visit, and other variables. Special attention was focused on frequent users to determine drivers of utilization. In-depth interviews with families in Medicaid managed care that have multiple members with frequent emergency department (ED) use in the south Bronx and southwest Brooklyn were conducted to better understand their care-seeking behavior and to test their responsiveness to a range of messages promoting appropriate ED use.

UHF's partners in this work have been Health Plus PHSP, Lutheran Medical Center, and Lincoln Medical and Mental Health Center. Recommendations concerning more refined analyses of ED use and messaging for consumers will be developed and disseminated through journal articles and conference presentations.

- 18. Village Care:** With funding from New York State's HEAL NY Local Health Planning Projects, a coalition of 17 health providers, aging service providers, and other key players came together to understand the health of older adults residing in downtown Manhattan. The goal was to make recommendations which will improve the health and well-being of older adults living in the lower Manhattan communities, such that the need for long-term nursing home placement can be reduced. The project began with comprehensive fact-finding and analysis on senior demographics, risk factors, needs, emergency room visits, and hospitalization trends, along with a cataloguing of health and wellness resources available in the area. From this, the grantee developed the following logic model: The top "actionable" health problems among seniors in Downtown Manhattan are heart disease, falls and mental health. (Actionable means that much hospitalization and disability resulting from these issues can be prevented effectively.) These actionable health problems can be addressed effectively, especially with four key services: 1) primary care medical homes; 2) geriatric-specific mental health treatment; 3) vision assistance; and 4) physical therapy or exercise. For the vast majority of Downtown's seniors, payment is not a barrier to utilization. Instead, the major barriers to utilizing the key preventive services are ignorance and complex psychological barriers like fear and shame.

The second phase of the project then researched interventions, policies and delivery models that could first appropriately identify at-risk seniors, and then successfully link them to primary and preventive services, taking account of their area's multi-culturalism. They identified 11 potential improvements, and then operated a three-month pilot of Health Navigators. As a result, the grantee has put forward five recommendations that should simultaneously improve health, "bend the Medicaid cost curve," and establish a sustainable senior wellness infrastructure in downtown

Manhattan. Their chief recommendations include: 1) implement a centralized pool of Health Navigators covering census tracts of high vulnerability, targeting seniors who have been treated and released from emergency rooms more than once, and those who have not seen a primary care physician in more than a year; 2) implement financial rewards that encourage primary care providers to partner with aging network agencies, to create Patient Centered Medical Homes that provide care coordination and linkage to needed services without the addition of new resources; and 3) Expedite efforts to increase reimbursement for home-based mental health and substance abuse services.

HEAL NY Phase 19 Grantees:

Central New York Health Systems Agency: The Central New York Health Systems Agency was awarded a \$950,000 HEAL NY Phase 19 grant to create a robust and sustainable community health planning capacity and to implement 3 studies. Their major objectives are to: execute a formal collaboration between themselves and the Health Advancement Collaborative of Central New York; create the infrastructure necessary to support data aggregation and analysis, timely and focused reports and dissemination of findings; and completion of 3 studies related to unnecessary emergency room use, long term care demand and supply, and a broader community needs assessment.

Adirondack Health Institute: This project seeks to transform the Upper Hudson Primary Care Consortium (UHPCC) into the Adirondack Health Institute (AHI) as the vehicle for regional collaboration in the development and implementation of high quality, low cost community health services. AHI will focus on areas of public health and community planning, clinical data warehouse development, informatics research, the continued stabilization and development of comprehensive primary care services, including continuing medical education, and the ongoing support and development of integrated support programs. Projects include strategic planning and regional collaboration to stabilize and enhance primary care services; assess area health needs and capacity; identify areas for Medically Underserved area (MUA) development; and develop new corporate affiliations among providers.