



# **New York State Community Health and Wellness Framework**

Joint Meeting of the Hoc Committee to Lead the Prevention  
Agenda and the Public Health Committee of the Public Health and  
Health Planning Council

**Paul Francis, Deputy Secretary for Health and Human Services,  
New York State**

November 17, 2016

# Defining “Community Health and Wellness”

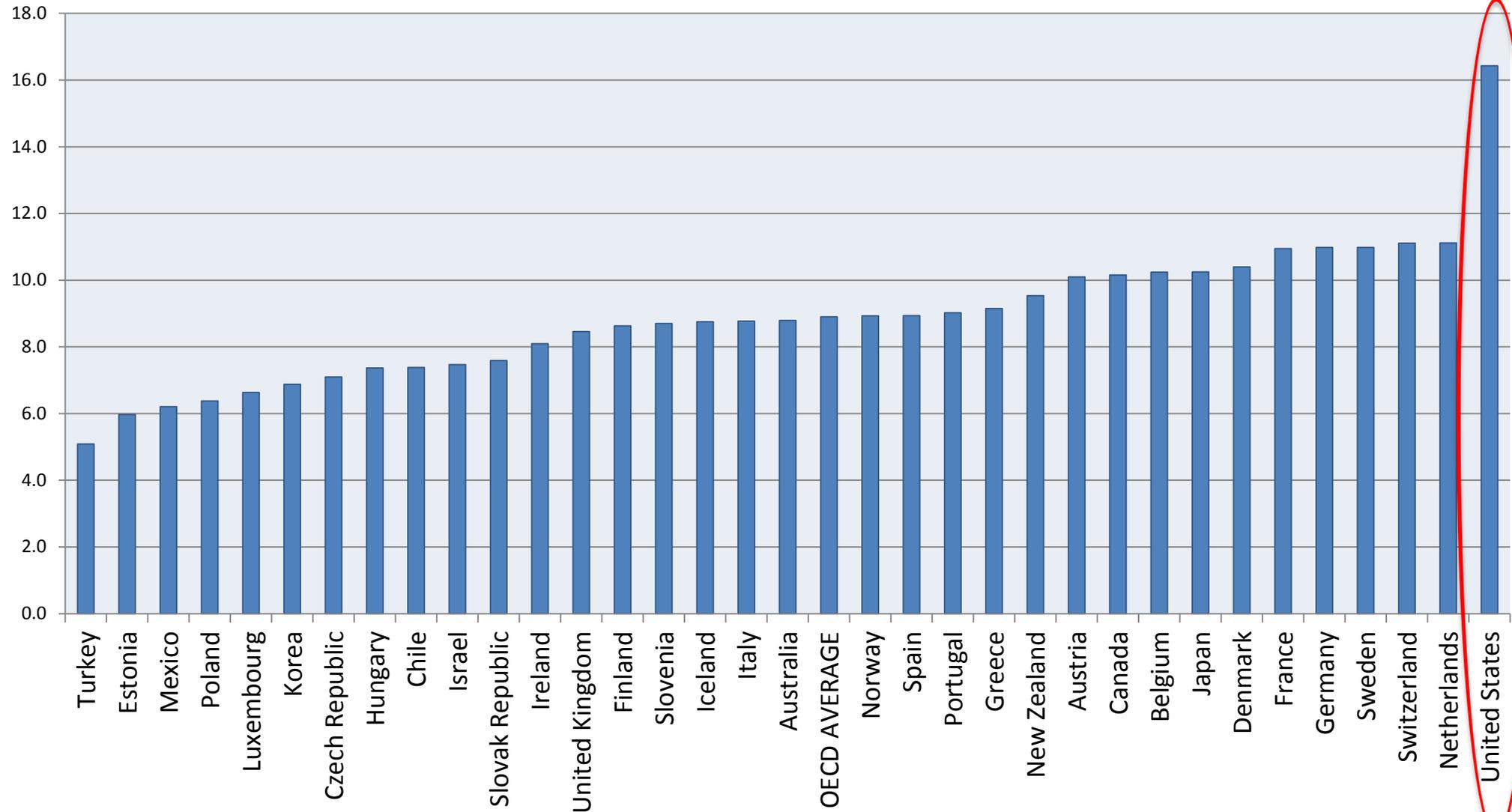
- There is a convergence of public health and clinical strategies in our health and health care reform efforts including DSRIP, Primary Care Reform and the Prevention Agenda
- Addressing Social Determinants of Health is a common denominator
- Two useful frameworks:
  - Primary, Secondary And Tertiary Prevention
  - “Three Buckets Of Prevention”

# The Health Impact Pyramid

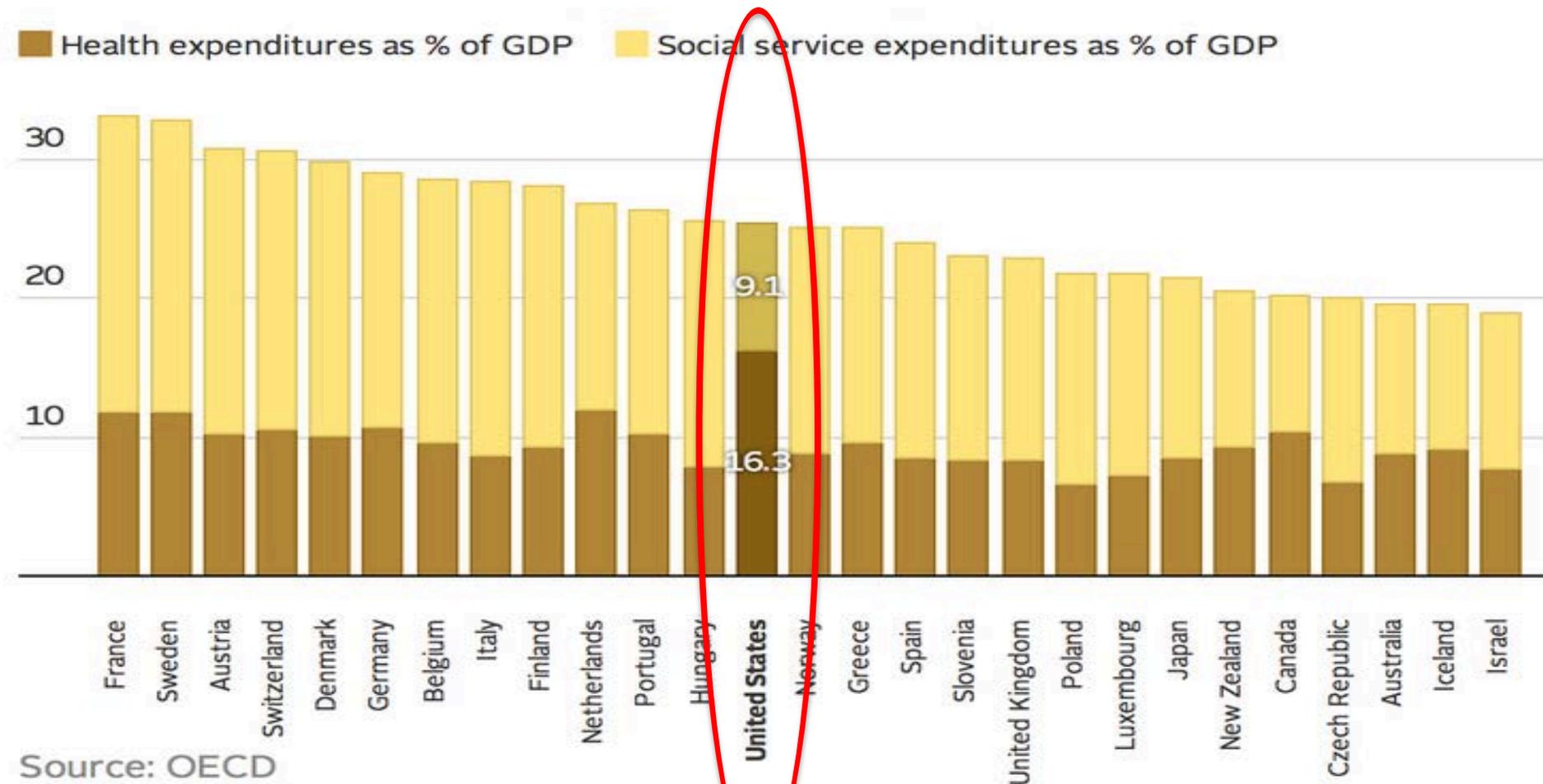


The Health Impact Pyramid, April 2010, Vol 100, No. 4, American Journal of Public Health. This pyramid is adapted from Thomas Frieden, MD, MPH presentation at the Weight of the Nation conference, Washington D.C., July 27, 2009

# Healthcare Spending As % of GDP (OECD Countries)



## Healthcare And Social Service Spending As % of GDP



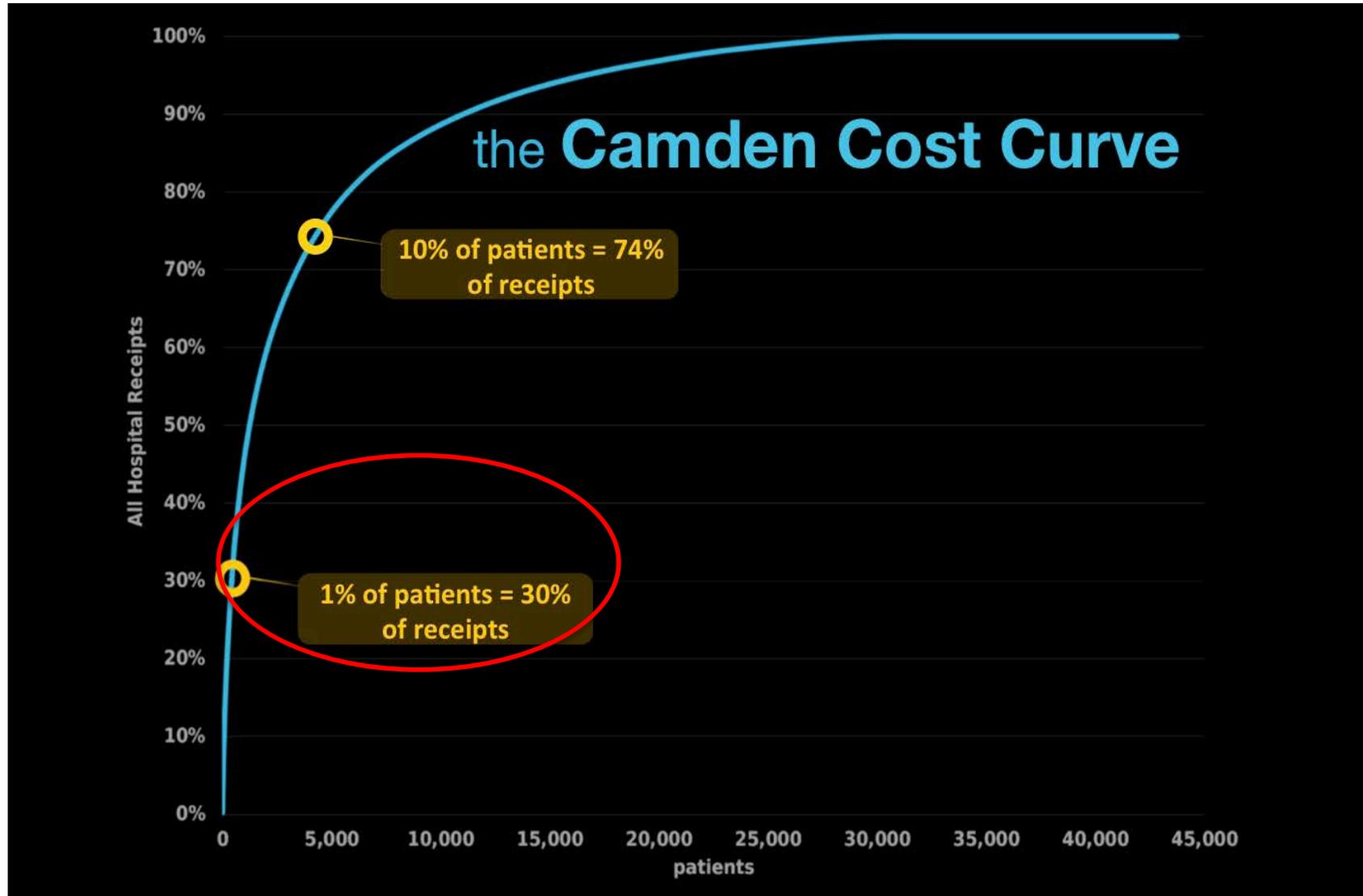
# Framework # 1: Three Tiers Of Prevention

**Primary prevention**

**Secondary prevention**

**Tertiary prevention**

# Camden Hospital Cost Curve

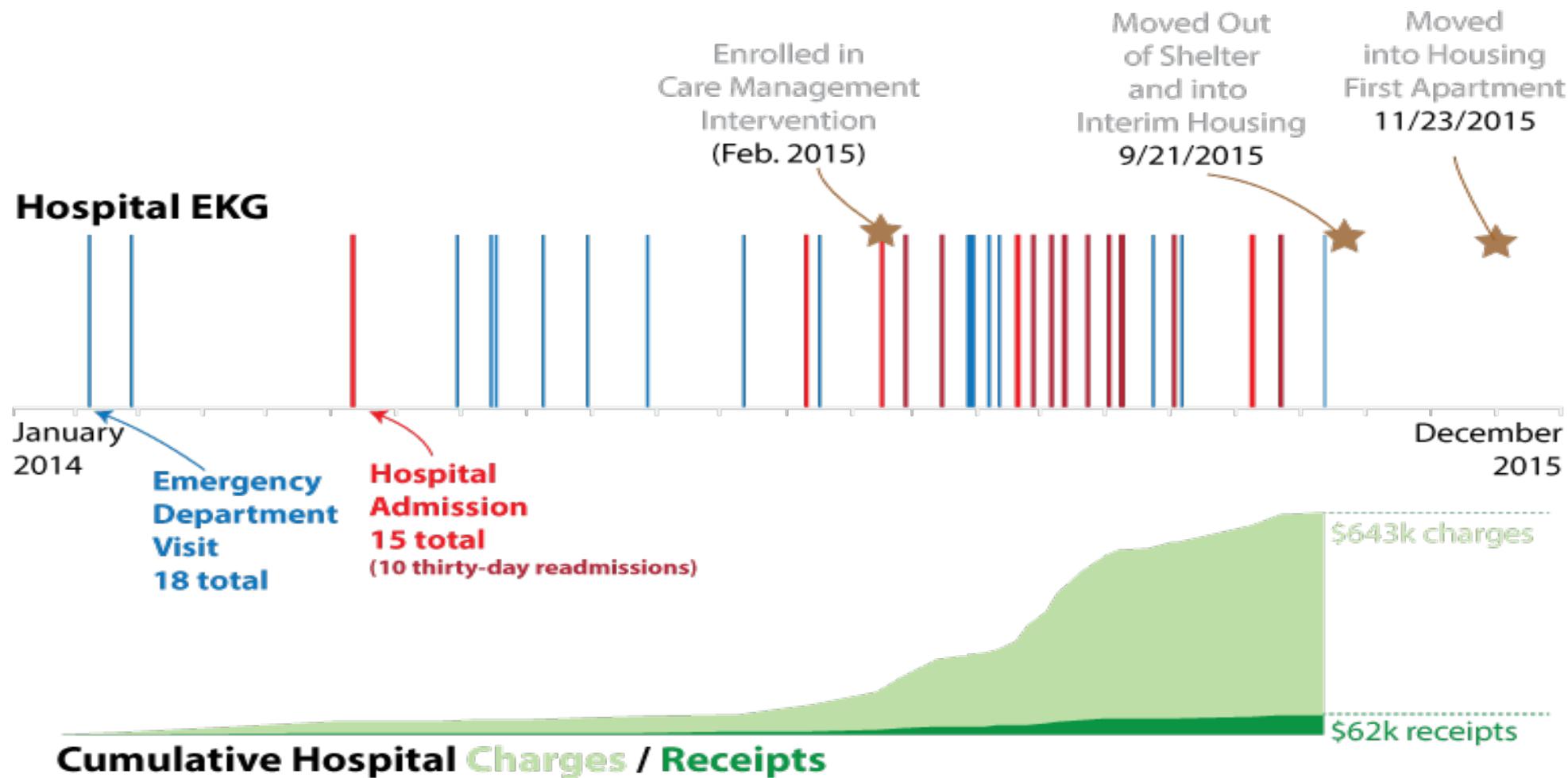


# Meet Peter

- 51-year old African American male
- COPD exacerbation, Acute Asthma Exacerbation, Hypertension
- Generalized Anxiety Disorder, Major Depressive Disorder
- Homeless (1+ year in shelter)
- Limited income (~\$200/month)
- History of incarceration



# Peter's Hospital Utilization



# DSRIP's MAX Series Focuses On People Like Peter

| <b>Super-utilizers:</b><br>Meeting patient needs in Primary Care                                   | <b>Integrating Behavioral Health and Primary Care services</b>                             | <b>Primary Care access optimization</b>                                  | <b>High Risk Populations:</b><br>Patient Engagement and Preventative Care |
|--|--|--|---|
| <b>Reduce avoidable hospital use by 25% over 5 years (better care, better health, lower costs)</b> |  |  |   |
| Care system redesign to better meet complex and high-cost patient needs                            | Ensure care coordination to improve outcomes for patients with Behavioral Health diagnoses | Building an effective Primary Care system to avoid use of secondary care | Prevent high risk patients from becoming super-utilizers                  |
| October 2015   | January 2016   | February 2016  | March 2016  |

# MAX Series In Action

## └ NewYork-Presbyterian └ Queens

- Brightpoint Health serves a predominately homeless patient population with almost half of their patients presenting from nearby shelters.
- Through the MAX Program, Brightpoint Health has created an integrated care team including Health Homes as an active member to better connect and engage with their patient population directly in the shelter.

# Permanent Supportive Housing Is Targeted At People Like Peter

- New construction of 94 units of mixed-income housing, including 14 units up to 130% AMI.
- **31 units reserved for individuals with serious mental illness with incomes below 40% AMI.**



*Developer: Bronx Pro*

*Service Provider: SUS*

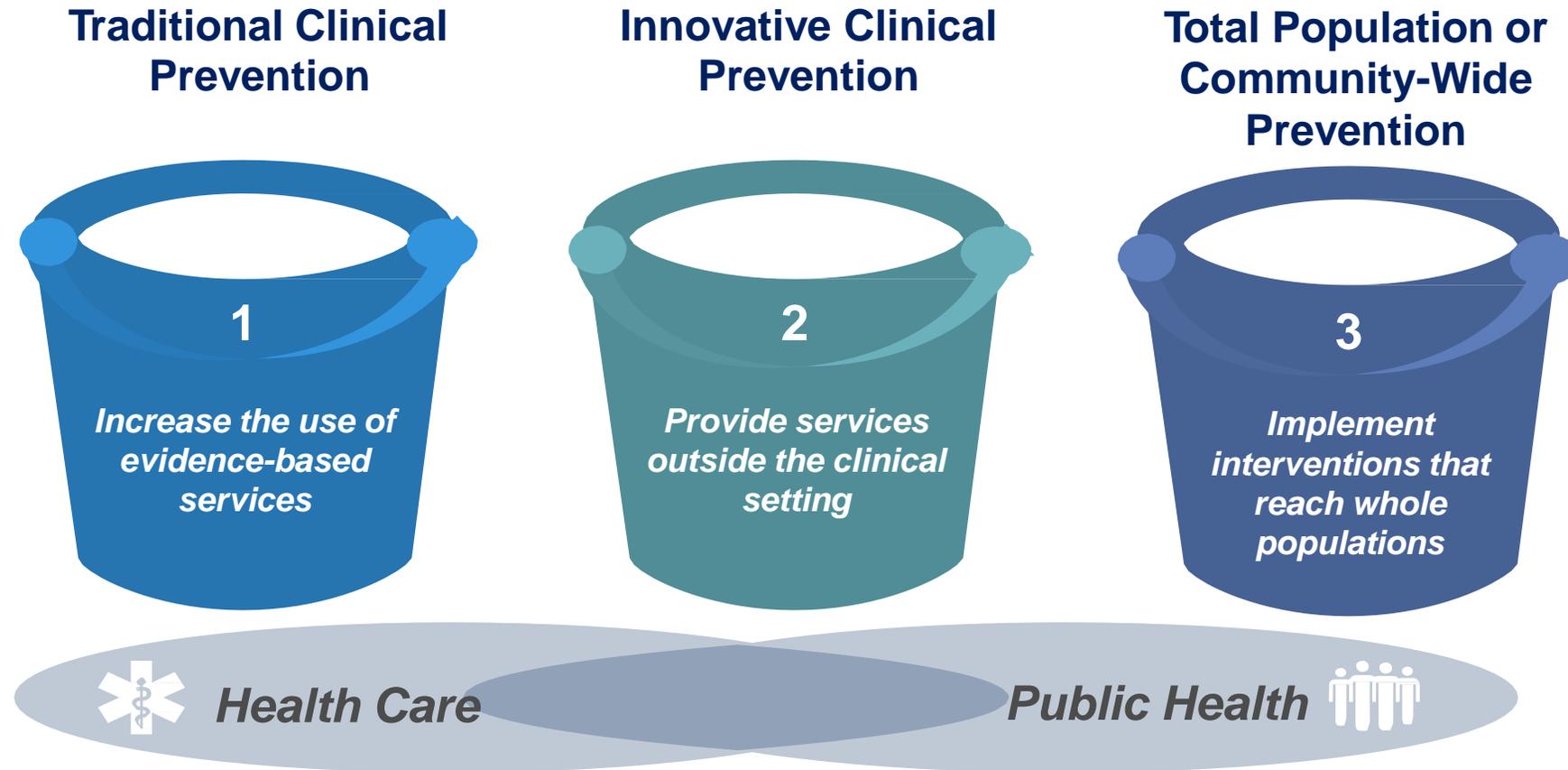
*Location: Bronx*

*TDC: \$47 million*



**Homes and  
Community Renewal**

# Framework # 2: Three Buckets of Prevention



Auerbach J., The 3 Buckets of Prevention. *Journal of Public Health Management and Practice* 2016.

# Practice Transformation Focuses On Bucket #1

“Practice transformation” as we use the term refers to an advanced primary care model that facilitates more integrated and coordinated care for patients coupled with payment approaches that support and reward high-value care.

**The state has articulated a statewide delivery system objective that by 2020 80% of the population will receive primary care setting with the following characteristics:**

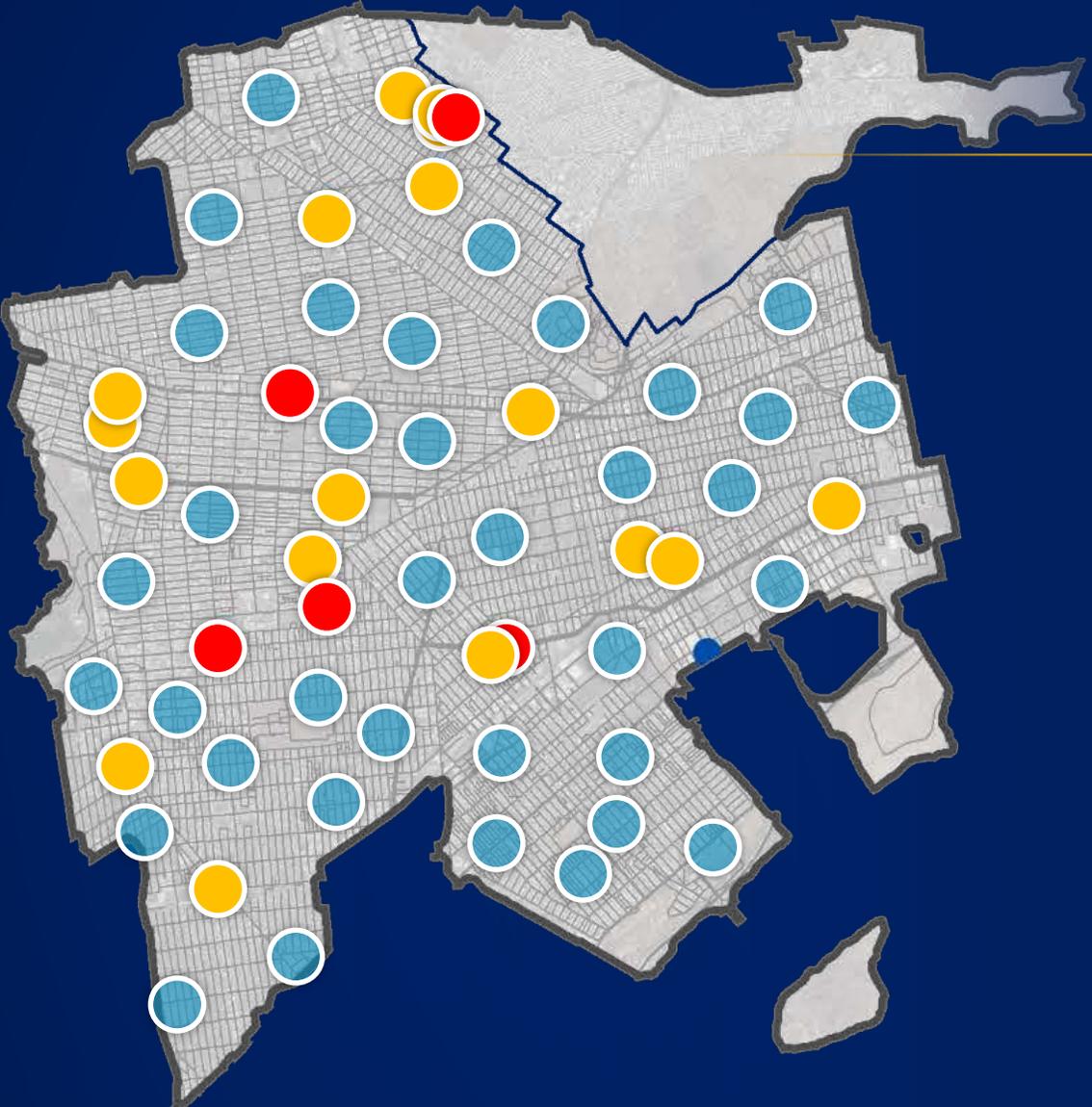
- A systematic approach to primary care based prevention services, care coordination and care management for high risk patients, use of quality metrics for improvement, integration of behavioral health services and population health management
- A payment environment in which primary care is supported by alternative payment models across a critical mass of payers that recognize primary care providers for advanced services (including non-visit or procedure based interventions) and rewards them for improved performance.



# Sufficient Ambulatory and Primary Care is Necessary for Bucket # 1



# Future State in Central and Northeastern Brooklyn

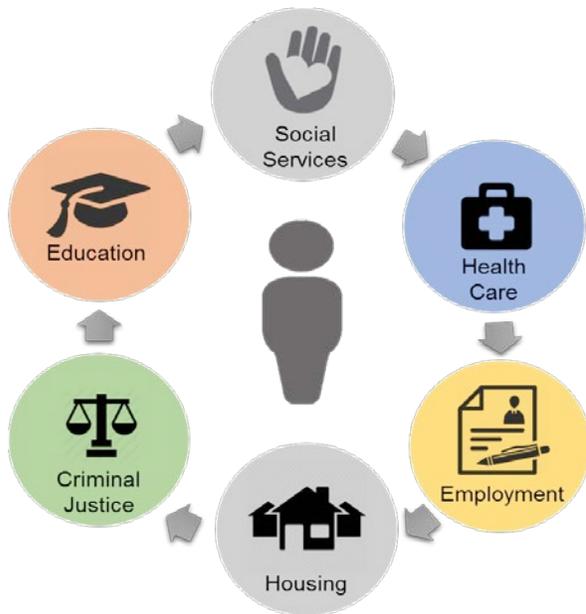


● 5 hospitals

● 16 ambulatory care sites

● 36 new ambulatory/primary care sites

# DSRIP Promotes Innovative Clinical Prevention



**“DSRIP is challenging normative models, leveraging what we know and boldly exploring what we don’t, to redefine the healthcare delivery system.”**

## Innovative Clinical Prevention



# BPHC PPS - CBO Engagement

**air**.nyc

Asthma home-based services

- 15 years experience
- Community health workers
- Know the Bronx
- Speak the languages
- Strong track record



- Diabetes Self-Management Program (Stanford model)
- Lower Extremity Amputation Prevention Program (LEAP)
- Paid training for 20 coaches = individuals recruited from community
- Classes for 600-800 students from community **hot spots**

request  
**for**  
proposal

CBO-driven

- Process & Criteria
- Content & Curriculum

Community-based BH and social services targeted for funding in DY2:

- **Cultural Competency Training**
- **Critical Time Intervention**
- **Behavioral Health “Call to Action”**
- **Community Health Literacy**



# DSRIP Leads To Value Based Payment

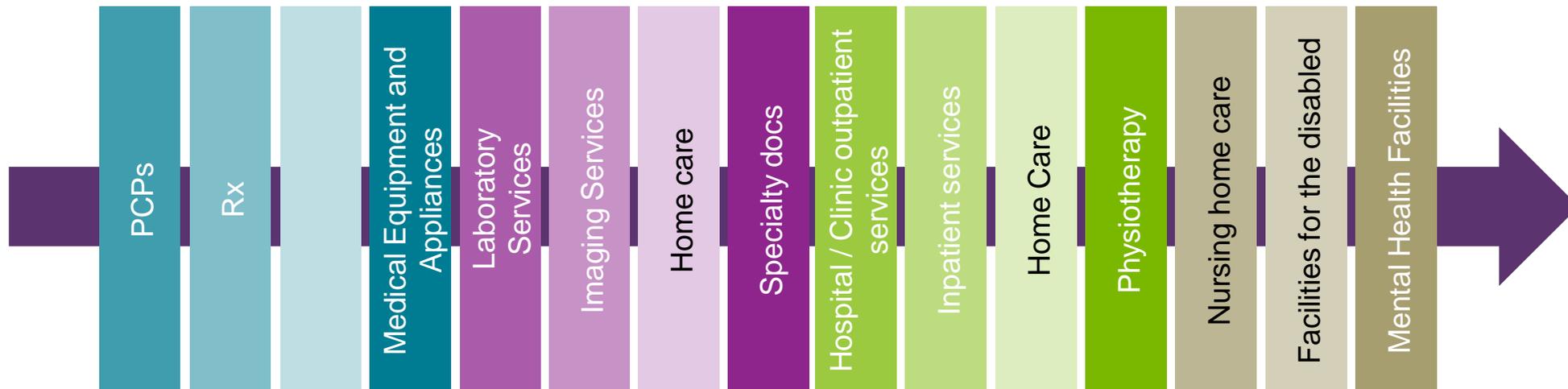
- Transformation of the delivery system can only become and remain successful when the payment system is transformed as well
- Many of NYS system's problems (fragmentation, high re-admission rates) are rooted in how the State pays for services
  - Fee-for-Service (FFS) pays for inputs rather than outcome; an avoidable readmission is rewarded more than a successful transition to integrated home care
  - Current payment systems do not adequately incentivize prevention, coordination, or integration

Financial and regulatory incentives drive...

a delivery system which realizes...

cost efficiency and quality outcomes: **value**

# The Old World: Fee for Service; Each in its Own Silo



- There is no incentive for coordination or integration *across* the continuum of care
- Much Value is destroyed along the way:
  - Quality of patient care & patient experience
  - Avoidable costs due to lack of coordination, rework, including avoidable hospital use
  - Avoidable complications, *also* leading to avoidable hospital use

## Current Public Health Programs Potentially Could Be Financed Through the Reimbursement System

### Examples

- Chronic Disease Management
- Home Blood Pressure Monitors
- Quality improvement learning collaboratives
- In-Home Based Asthma Services
- Environmental In-home assessments and interventions
- Comprehensive medically-indicated orthodontia
- Family Planning
- Patient navigation for young adults with sickle-cell anemia
- Universal Home Visits
- Peer Delivered Services

# Creating Wellness

## Bon Secours Community Hospital – Port Jervis, NY

*Through community partnerships, peer support programs and innovative initiatives, the Medical Village in Port Jervis will go beyond the boundaries of the brick and mortar of an acute care hospital. Some of the initiatives already underway in our virtual village as construction commences include:*

- Partnering with a well established Federally Qualified Health Center (FQHC) to provide primary care and dental care
- Nutrition information and coaching on healthy purchasing practices offered by ShopRite Super Market, in partnership with Cornell Cooperative Extension. Dieticians will be available to evaluate patients' homes and provide counseling on food selection and preparation.
- Maternal health and wellness services for high risk women of reproductive age offered by the Maternal-Infant Services Network.
- Smoking cessation and diabetes education and counseling programs.
- A warming station for the homeless that includes primary care and behavioral health services.
- Project Discovery, a special education service that includes Speech and Language therapy, Occupational therapy, Physical therapy, Counseling and Special Education to special needs preschoolers.

# To Be Most Effective, Three Buckets of Prevention Need to Be Connected

With funding from the SIM grant, NYS is investing a total of \$1 million in five locally based projects that bring together health care, public health and community organizations to address community health improvement goals by implementing an aligned set of strategies within all three buckets: prevention within the health care setting, health care services connected with community resources and policy and systems changes that address prevention in the community.

Grantees will be implementing a spectrum of coordinated and linked prevention activities that focus on one of the five issues associated with the Prevent Chronic Disease priority area of the Prevention Agenda.

# Community-Wide Prevention Probably Still Requires the Traditional Public Health Funding Model

**This includes things like:**

- *Healthy Eating*
- *Physical Activity*

**Community-Wide Prevention**



*“In 1960, Americans spent nearly three times as much on food as they did on healthcare...”*

*Today, Americans spend twice as much on healthcare as they do on food”*

## Increase Access to Healthy Foods

1. Encourage “urban farming” on school, hospital and vacant land
2. Implement healthy food procurement strategies in hospitals and State institutions
3. Expand supplemental SNAP benefits for healthy foods
4. Launch a DOH/DAM prescribed meals program pilot to distribute healthy foods to the homes of patients recently discharged from the hospital.

# Building Healthy Communities: Brownsville



Photo: Project EATS

## Buying Farm Fresh Food

Shop for fresh produce in your neighborhood farmers markets, Youthmarkets, Fresh Food Boxes, and farms. Farmers markets sell fresh produce directly from local and regional farmers. Youthmarkets are urban farm stands operated by neighborhood youth and supplied by farmers. Fresh Food Boxes operate like buying clubs: customers pay one week in advance to receive a selection of locally grown, fresh produce for less than retail prices.

Keep your eye out for free, interactive, bilingual nutrition education, cooking demos and food tastings for adults and children at select farmers markets. With hands-on activities, classes encourage children to eat more fresh fruits and vegetables. Explore new produce, taste featured recipes and receive a \$2 Health Bucks coupon. Health Bucks coupons are redeemable for fresh fruit and vegetables at most NYC farmers markets, Youthmarkets, and Fresh Food Box sites. If you use SNAP, you will receive a \$2 coupon for every \$5 you spend on fruits and vegetables.

### Resources:

Mayor's Office of Food Policy: [www.nyc.gov/foodpolicy](http://www.nyc.gov/foodpolicy)  
 GrowNYC: [www.grownyc.org](http://www.grownyc.org)  
 Project EATS: [www.projecteats.org](http://www.projecteats.org)  
 Isabahlia Ladies of Elegance Foundation: [www.isabahlialoefinc.org](http://www.isabahlialoefinc.org)



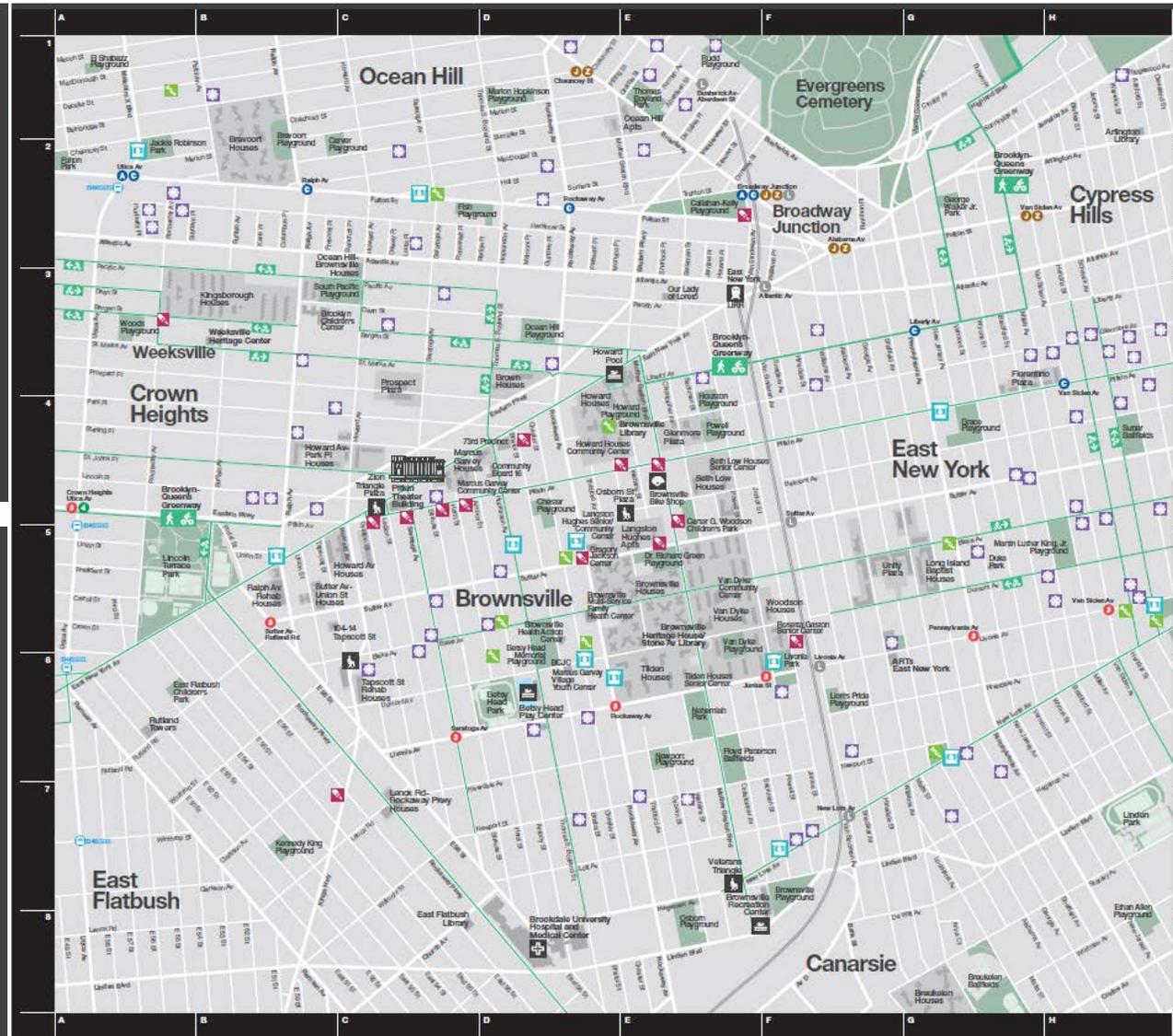
Photo: Daniel Avila, NYC Parks

## Brownsville Recreation Center

The recreation center first opened in 1953 as the Brownsville Boys' Club and was gifted to the City of New York the following year. Today, the Brownsville Recreation Center has programs for members of all ages, ranging from swimming lessons in the indoor pool to table tennis, martial arts, and Oldtimers basketball. Or dust off your roller skates - Brownsville Recreation Center hosts Friday Night Roller Skating in the gym. Stop by and show off your dance moves.

**Brownsville Recreation Center**  
 Year-Round, M-F 7:30AM-10PM, Sat & Sun 8AM-5PM

**Roller Skating**  
 Fridays, 5PM-8PM



# DSRIP PPS Initiatives To Address Food Insecurity



- St. Luke's Cornwall Hospital identified that food insecurity is a pressing issue faced by large number of their high utilizer patient population.
- As a result of the MAX program, the Action Team has began collaborating with a local food agency to install a food pantry in the hospital.
- Now providing healthy food to food insecure patients and reducing unnecessary utilization of the emergency department.

# Expand Opportunities for Recreation and Active Living

- Explore the use of State facilities for a design competition to support recreational activity
- Expand affordable physical activity programs, such as the Diabetes Self-Management Program
- Implement principles of active design in new housing and NYCHA renovations

# DSRIP PPS's Are Working With CBO's To Address Community-Wide Prevention

## Example: Refuah Community Health Center

Contracted with a Haitian Community Center to address the diabetic disparities experienced in their community by:

- Providing transportation, with linguistically accessible dispatch, to and from medical appointments
- **Offering Zumba exercise classes at the community center**
- Holding educational sessions on diabetes prevention and evidence-based Stanford Diabetes Self-Management Programs (DSMP) in Creole

Plans to replicate this model in Spanish, Hindi, and Chinese-speaking target communities

# Designing for Health - Community Visioning Sessions



## DESIGN YOUR HEALTHY NEIGHBORHOOD

**1. DESIGN YOUR SUPERMARKET**

What food would be sold there?

What would make a supermarket feel more welcoming to you? What are the challenges supermarkets face?

Who would work there, and what would they be paid?

HELLO,  
My name is

What would the prices be?

WHAT ELSE?

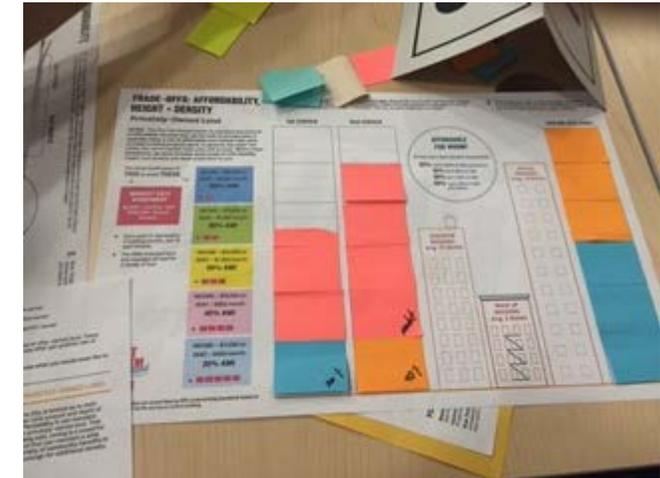
**2. DESIGN YOUR TOWN SQUARE**

A. What is most important to you in a healthy public space?

B. How can it serve all the different populations in the community?

C. What are the activities that would bring you there?

| FOOD | FAMILAR LOCAL BUSINESSES | RECREATION OPPORTUNITIES | ARTS & CULTURE | SHOPPING | WHAT ELSE? |
|------|--------------------------|--------------------------|----------------|----------|------------|
|      |                          |                          |                |          |            |



# Health in All Policies Approach

## Economic Development

- **Improve access and availability of healthy foods, opportunities for physical activity, and improved built environment (e.g., smart growth, mixed use, “green”)**

## Healthy Eating

- **Adopt healthy food procurement policies in hospitals and other institutions**
- **Adopt healthy food and beverage procurement policies in all State agencies, including healthy vending machine policies**
- **Increase options and incentives for using government-sponsored programs** such as federally funded Health Bucks and Child and Adult Care Food Program **to purchase healthy foods**

## Active Living

- **Promote Complete Streets** policies, plans and practices and monitor implementation
- **Promote shared space** agreements and joint use agreements **to increase areas designated for public recreation, particularly in low-income communities**

## Built Environment

- **Improve home environment:**
  - Incorporate 'Healthy Homes' education and inspections into other non-health opportunity points, e.g., building inspections, NYSERDA weatherization programs.
  - Offer incentives for compliance with and enforcement of existing housing and building code in high-risk housing.
- **Optimize indoor air quality** by developing and promoting codes to promote indoor environment
- **Target fall risk in public housing** by reducing slip and fall hazards in common areas of residences and public buildings

## Injuries, Violence and Occupational Health

- **Reduce violence by targeting prevention programs** particularly to highest-risk populations
- **Increase school based and community programs** in violence prevention and conflict resolution such as SOS, Cure Violence or CEASEFIRE or Summer Night Lights.

# CONCLUSION