



# **Working to Achieve the Triple Aim: New York State Health Reform Activities to Promote Integration of Primary Care and Behavioral Health and Action by Primary Care and Public Health to Address Broad Determinants of Health**

Report on the Joint Meetings of the Health Planning and Public Health Committees  
to the Public Health and Health Planning Council

December 8, 2016

# Objectives of the Joint Committee Project

- Provide an overview of New York State initiatives that seek to facilitate the integration of primary care and behavioral health services and promote local collaboration of primary care providers, public health leaders and other stakeholders to act on broad determinants of health in their communities
- Document the progress of these initiatives
- Identify recommendations for PHHPC to make to the Department of Health (DOH), in collaboration with the Office of Mental Health (OMH) and the Office of Alcoholism and Substance Abuse Services (OASAS), to support implementation of these initiatives

# Joint Committee Discussions

- At the July 21, 2016 meeting, State agency staff brought Committee members up to date on the status of key State initiatives including the Prevention Agenda, Delivery Reform System Incentive Payment (DSRIP) Program, the State Health Innovation Plan (SHIP)/State Innovation Model (SIM), the Integrated Outpatient Services regulations and the Collaborative Care Model
- The Committees reviewed their goals, how progress is being measured, challenges identified and strategies for addressing those challenges
- The September 23, 2016 meeting brought together organizations working on integrating primary and behavioral health care, as well as those who are addressing social and broader determinants of health in their primary care practices, to share successes and identify barriers to further progress

# Primary Care and Behavioral Health Integration: Themes

# Primary Care and Behavioral Health Integration

- The need to integrate and align action on physical and behavioral health is reflected in the focus on mental health and substance use disorder priorities in the Prevention Agenda, implementation of behavioral health integration projects by all PPS as part of DSRIIP, and use of core measures related to behavioral health in the SIM APC model
- Various other state efforts support integration such as those focused on prevention (e.g., OMH programs focused on the prevention of psychiatric morbidity in children, screening for maternal depression and new mechanisms for addressing opioid abuse) or seek to facilitate delivery of supportive services in the community (such as OASAS state plan amendment for rehabilitation services)
- Organizations which are engaged in transformational activities and are committed to addressing the co-occurring physical and behavioral health needs of individuals are looking for opportunities to refine and expand their ability to improve the overall coordination and accessibility of care

# Current Challenges to Integration

- Guidance on billing, further alignment of reimbursement and payment models and improved access to data, including data on quality, would better promote integration in various settings
- Support for information sharing, including guidance on shared records in dually licensed sites given varying federal requirements for record keeping, would further support the provision of integrated care
- Agency guidance on shared space arrangements will help support integration of care but additional flexibility related to federally designated facilities should be pursued
- Efforts to promote a workforce that supports ongoing system transformation and the provision of integrated services could include attention to interdisciplinary training for health care workers, training in the collaborative care model and the use of community health workers

# Action by Primary Care to Address Broad Determinants of Health: Themes

# Addressing Broad Determinants of Health

- Population health depends not only on clinical care, but on the social determinants that affect the health of individuals as well as the broader determinants of health that affect the health of the communities in which these individuals live
- A number of efforts to support better integration of provision of social and community services (program eligibility determination, supportive housing, healthy food access, etc.) for individuals are often referred to as action on “social determinants of health”
- The state’s Value Based Purchasing (VBP) efforts recognize that implementing VBP and meeting DSRIP goals necessitate addressing social determinants of health for individual patients in conjunction with community-based organizations (CBOs)
- CBOs can help support evidence-based prevention models (e.g., New York City’s program to help primary care providers identify pre-diabetic patients and refer them to courses on making lifestyle changes), particularly by making assistance available in the communities where people live

# Addressing Broad Determinants of Health (cont.)

- The provision of services to connect patients to these evidence-based models outside the clinical setting should be financed through the reimbursement system, which would free up scarce public health dollars to invest in community wide prevention that focuses on the broad determinants of health
- Action on individual social determinants are important but there is also a need for action to address broader determinants of community health conditions
- Primary care practices can also be important participants in addressing the broader determinants of health that impact the health of their patients by leveraging the work of CBOs, local health departments and other organizations and joining Prevention Agenda coalitions locally (as required in APC)

# Addressing Broad Determinants of Health (cont.)

- The Prevention Agenda 2013-2018 incorporates considerations of these broader determinants of health such as transportation, housing, economic development, public safety and availability of health foods through its focus on improving conditions in communities that affect health and health status and reducing health disparities for racial, ethnic, disability, socioeconomic and other groups
- Building and maintaining community partnerships with a broad range of partners, including non-traditional partners such as business and economic development organizations, is at the core of the Prevention Agenda's local multi-stakeholder coalitions led by hospitals and local health departments and to which many community health centers and some multispecialty groups belong
- The coalitions identify local health priorities and develop collaborative plans to act on them together

# Addressing Broad Determinants of Health (cont.)

- The State has supported efforts for better alignment of action to advance community based prevention to “improve population health” in all elements of the reforms, but additional financial resources are needed to invest in evidence-based interventions to address broader conditions in the community (while opportunities are increasing to finance social supports for individuals through the reimbursement system, incorporation of evidence based actions and interventions related to these broader determinants of health into payment models should also be increased)
- To help identify and address health outcomes, population health analytics that rely on real time data – including public health data – should be shared widely, particularly for small geographic areas like neighborhoods and communities in addition to counties and regions

# Addressing Broad Determinants of Health (cont.)

- Aggregate data from the All Payer Database and electronic health records should be made available for planning and addressing determinants of health
- Changes to the public health and health care workforce consistent with ongoing transformative efforts are needed and require attention to licensure and scope of practice issues, as well as support for incentives to increase the number of primary care practitioners in underserved areas and strengthen the skills of all workers

# Recommendations

# Continue Collaborative Efforts

- PHHPC recognizes and is encouraged by the high level of cooperation between DOH, OMH and OASAS in incorporating principles related to integrated care and social determinants in their policies and programs, especially at the community level
- PHHPC takes note of new community partnerships supported by the State's health reform efforts, such as DSRIP Performing Provider Systems (PPS) and Population Health Improvement Programs (PHIPs), which play a role in addressing social determinants of individual patients
- *PHHPC recommends that DOH, working with OMH and OASAS, continue promoting partnerships that include a broad range of community stakeholders (including health care providers, local health departments, rural health networks and non-traditional partners such as business and economic development organizations) to address the determinants of health of individual patients and communities*

# Facilitate Shared Space

- PHHPC appreciates the guidance issued by DOH, OMH and OASAS to providers interested in sharing the same licensed space as a means of facilitating the coordination of services and integration of behavioral and primary care
- *PHHPC recommends that the agencies should issue additional guidance on information sharing to address questions related to the sharing of records in dually licensed sites given varying federal requirements for record keeping*
- *PHHPC recommends that DOH continue working with the Center for Medicare and Medicaid Services to pursue additional flexibility for federally designated providers (for example, the CMS requirement preventing FQHCs from sharing physical space with other entities during the same time)*

# Explore Opportunities to Expand Access to Data

- PHHPC heard from entities who are making use of real time population health data to help identify needs and evaluate the outcome of interventions designed to meet individual and community health needs
- *PHHPC recommends that DOH, OMH and OASAS seek additional opportunities to make more population health data available to providers and other entities participating in community partnerships aligned with health care reform efforts*
- *PHHPC recommends that efforts to increase access to data should focus on making data available in real time and include data for small geographic areas like neighborhoods and communities in addition to counties and regions*

# Support a Workforce Aligned with Transformation

- PHHPC has observed that achievement of goals related to integrating physical and behavioral care and addressing social and other determinants of health depends upon efforts to help expand the ability of the workforce to support ongoing system transformation and includes attention to interdisciplinary training for health care workers, training in the collaborative care model and the use of community health workers
- PHHPC recognizes and supports the work of the SHIP/DSRIP Workforce Workgroup, which reports to the Health Innovation Council under the SHIP/SIM and has taken an active role in bringing stakeholders to identify and implement ways to promote such a workforce
- PHHPC encourages the WWG to explore the roles that non-traditional providers can play in advancing individual and community health goals

# Expand and Align Telehealth Opportunities

- PHHPC embraces telehealth as an important means of addressing access issues, particularly in underserved areas
- *PHHPC recommends that DOH should consider options for expansion of the Telehealth Parity Law, which requires commercial insurers and the Medicaid program to provide reimbursement for services delivered via telehealth if those services would have been covered if delivered in person*
- *PHHPC recommends that DOH, OMH and OASAS continue working to align regulations issued by each agency to promote consistency and help promote the use of telehealth in addressing access issues*

# Explore Reimbursement Changes

- PHHPC notes that reimbursement plays an important role in providing opportunities for providers to integrate behavioral and physical health care or incorporate services for individuals in primary care that address social determinants
- *PHHPC recommends that DOH look for opportunities to promote conduct that supports these ideals (for example, using reimbursement to incentivize the use of telehealth to address access issues)*
- *PHHPC recommends that DOH should pursue additional opportunities to incorporate the recognition that implementing VBP and meeting DSRIIP goals necessitate addressing social determinants of health in conjunction with community-based organizations*
- *PHHPC recommends that reimbursement for social support services that connect patients to evidence-based programs that address their social determinants of health outside the clinical setting, freeing up resources for community-wide prevention activities focusing on the broad determinants of health*