Blueprint for Community Health Improvement

Regional Commission on Community Health Improvement

Prepared by: Finger Lakes Health Systems Agency

July 2015

Improving community health requires increased collaboration and integration. Even as medical professionals find new ways of treating disease, data show that many of our most basic health problems are proving intractable or, in some instances, getting worse. Careful analysis by experts indicates that the current healthcare system – while very good at providing high quality acute care – is fragmented and ill-equipped to meet the complex needs of many non-acute patients, especially those with multiple chronic conditions. Developing systems to better serve those patients could help communities achieve breakthrough improvement in overall health, but doing so will require new strategies that move beyond the traditional health care system to integrate multiple aspects, agents and determinants of health.

> ***"We can no longer separate health from the community; the integration of medical and nonmedical determinants of health is essential to reach our goals for community health improvement."***
>
> ~Regional Commission on Community Health Improvement

To take on this challenge in the Finger Lakes region,[*] the Finger Lakes Health Systems Agency (FLHSA) convened the Regional Commission on Community Health Improvement (RCCHI) in late 2013. Over the last year and a half, the Commission engaged leaders from across the region to study and develop ideas for improving the integration of care and addressing the complex medical, behavioral and social needs of vulnerable community residents.

Composed of 30 regional leaders from human service and community-based organizations, public health, health care, government, education and business (*Appendix A*), the Commission met 13 times between November 2013 and June 2015. It endorsed overarching principles to guide its work (*Appendix B)* and convened three workgroups to explore key focus areas in response to its charter (*Appendix C*):

- Behavioral Health
- Prevention and Population Health
- Senior Health

Combined, these workgroups engaged an additional 120 community leaders and met 22 times to assess the current status of health and health care in the region; identify and reduce disparities in health care access and outcomes; develop consensus on communitywide goals; prioritize activities needed to attain those goals; and develop measures to track regional health.

[*] The nine-county Finger Lakes region comprises Chemung, Livingston, Monroe, Ontario, Schuyler, Seneca, Steuben, Wayne and Yates counties.

The following ***Blueprint for Community Health Improvement*** represents the culmination of the Commission's work. The plan's strength lies not only in its data-driven analysis and expert insights but also in the power of consensus. The *Blueprint* presents a set of recommendations – jointly developed and endorsed by diverse community leaders – that requires continued collaboration across key sectors.

The *Blueprint* begins with background information on health planning in the region and the role of the Finger Lakes Health Systems Agency in supporting that work. The core of the document presents a summary of the Commission's key recommendations by focus area:

- *Behavioral Health* – Eliminate behavioral and physical health silos to integrate care and increase access to behavioral health services.
- *Prevention and Population Health* – Improve population health through clinical and community prevention, with a particular focus on obesity and respiratory disease.
- *Senior Health* – Create an integrated, person-centered health care model across medical, social and behavioral care domains that is geriatric-informed.

Finally, the *Blueprint* highlights three cross-cutting issues that rose to the top of Commission and workgroup discussions – information sharing, financing and workforce development – and presents a set of communitywide measures that will be used to evaluate the region's collective progress toward improved health.

Health Planning and the Finger Lakes Health Systems Agency

The Finger Lakes region is recognized as a national model for collaborative health planning, one that has yielded the lowest per capita Medicare spending of any region in the United States.[1] This success stems from a long history of leadership and commitment that can be traced back to the 1960s, when Rochester pioneered the concept of community health planning. The most important catalyst for the region's achievement has been, and continues to be, *community collaboration*. Health systems, hospitals, insurers, county health departments, government agencies, human service- and community based-organizations, and the business community routinely put aside sometimes competing interests and work together to advance health and health care in the region.

At the center of the region's collaborative health planning efforts, the Finger Lakes Health Systems Agency provides an independent forum where diverse stakeholders can come together and work in partnership to document conditions, analyze needs and gaps, and develop community strategies and interventions to address concerns. The FLHSA maintains the region's most comprehensive source of health and health care data, performs regular analyses to inform health care capacity planning/development, and both convenes and participates in numerous multi-stakeholder coalitions, task forces and other health-related initiatives in the region. The

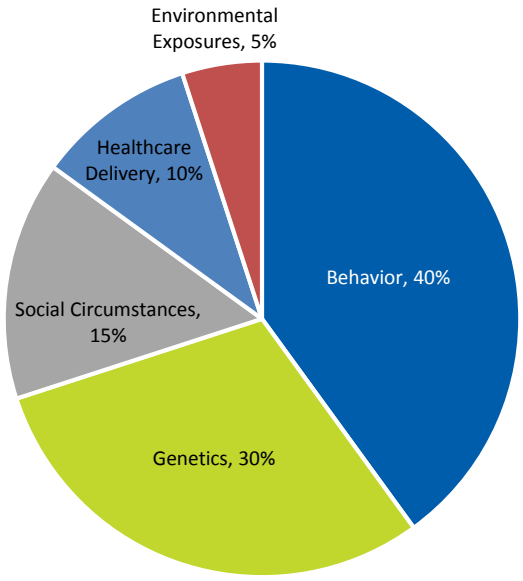
FLHSA Board of Directors chartered the formation of the Regional Commission on Community Health Improvement, as well as prior commissions whose work ultimately led to the RCCHI's formation, including the:

- *Community Health System 2020 Commission* (2008) to analyze health care infrastructure and recommend the best allocation of system resources.
- *Community Health 2020 Commission on System Performance* (2009) to collaboratively determine community investment goals to reduce preventable hospital admissions and avoidable emergency room visits and develop a sustainable plan for central Finger Lakes hospitals.
- *Sage Commission* (2010) to create a strategic vision and comprehensive long-range plan for elder care, aging services and senior (65+) health care needs.

Each one of the commissions above was instrumental in prioritizing goals, identifying challenges and developing thoughtful steps to address these concerns. Follow up monitoring by the FLHSA indicated that these commissions were successful in moving the needle toward their individual objectives, but improvement in overall community health fell short of identified goals.

Health is a complex issue, one that the health care delivery system has limited capacity to improve on its own (*Figure 1*).[2] As such, improving communitywide health will take a new approach, including efforts that go beyond medical solutions and are fully coordinated and integrated among diverse sectors and stakeholders. The FLHSA convened the Regional Commission on Community Health Improvement to address these broader dimensions of health and to continue the work of prior commissions and other community efforts. The Commission was also charged with enhancing communication, collaboration and integration within and across medical, social and behavioral realms to improve regional health overall.

Figure 1. Behavior, Genetics and Social Circumstance are Important Factors in Premature Mortality



Source: McGinnis et al. (2002).

RCCHI Recommendations

After reviewing extensive data regarding the health status of the region, the Commission identified three top priority areas on which to focus its work:

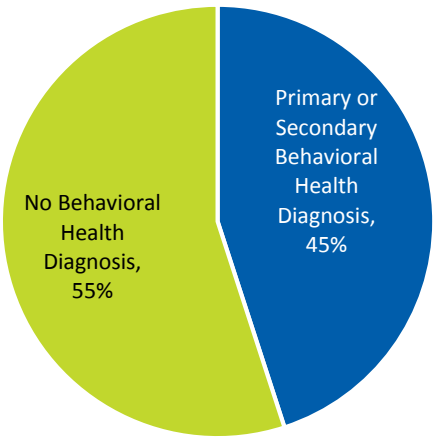
- Behavioral Health
- Prevention and Population Health
- Senior Health

In collaboration with its workgroups, the Commission adopted recommendations within each of the focus areas that reflect current research[†] and policy guidance on evidence-based practices and models. Wherever possible, the recommendations also seek to leverage significantly-related initiatives – such as the Delivery System Reform Incentive Payment (DSRIP) program introduced by New York State in April 2014 to redesign Medicaid. Several recommendations overlap focus areas, reflecting the cross-cutting need for financing, information sharing and health care workforce development.

Behavioral Health

Behavioral health refers to the often interrelated conditions of mental health and substance abuse disorders. A study of national health spending found that mental disorders were the most burdensome of all health conditions, costing nearly $150 billion per year,[3] and state data show that the Finger Lakes region has a higher prevalence of adults who self-reported experiencing poor mental health days (12 percent) than does New York State overall.[4] More troubling are the high rates of behavioral health conditions among Medicaid beneficiaries in the region, who experience a 40 percent higher rate of mental disease and disorder diagnosis and 14 percent higher substance use disorder diagnosis rate than the New York State Medicaid population overall.[5] Recent analysis by the FLHSA also revealed that behavioral health issues are associated with expensive inpatient and

Figure 2. Hospital Admissions with a Behavioral Health Diagnosis in the Finger Lakes Region, 2011



Data Source: NYSDOH SPARCS file (2011).

[†] Sources include Institute of Medicine and Agency for Healthcare Research and Quality reports and the Guide to Community Prevention Services. U.S. Department of Health and Human Services. Office of Disease Prevention and Health Promotion. *Healthy People 2020*. Washington, DC. Available at www.HealthyPeople.gov. Accessed January 15, 2015. New York State Department of Health. *Prevention Agenda 2013-2017*. Albany, NY. Available at www.health.ny.gov/prevention/prevention_agenda/2013-2017/. Accessed January 15, 2015.

emergency department hospital use in the region, particularly among Medicaid patients (*Figure 2).*[6] Data also rank suicide as the fifth leading cause of years of potential life lost for the greater Finger Lakes region.[7]

In recognition of the prevalence, cost and burden of behavioral health conditions, the RCCHI formed a workgroup of 45 local experts in mental health, substance abuse, physical health and primary care, social services, hospital systems and county planning agencies to discuss issues and identify priorities.

Central to the workgroup's discussions and recommendations is a call to increase access to behavioral health care and to better integrate physical health and behavioral health services. Currently, the Finger Lakes region has a shortage of behavioral health providers,[8] restricting access for people needing treatment. Additionally, physical and behavioral health care systems remain disconnected, operating separately and independently of one another and exacerbating the lack of access.

National research on behavioral health shortages and fragmented care systems indicates that more than 60 percent of adults with a diagnosable behavioral health disorder[9] and nearly 90 percent of people over the age of 12 with a substance use disorder[10] do not receive appropriate treatment. The workgroup's discussions and analysis suggest that similar unmet behavioral health needs exist in the Finger Lakes region and that these unmet needs impose significant health, social and financial costs on communities throughout the region.

> ***"Most of the time, all I really need is to talk to my therapist. But the system today doesn't provide that anymore…Preventive care has all been taken away. All that's left are emergency solutions, with expensive ambulance rides."***
>
> ~Behavioral health patient quoted in FLHSA *Community Needs Assessment*

Recommendations

Improve access to behavioral health care:

- Provide care management – similar to that provided under the Health Homes model in Medicaid – across all populations, regardless of payer.
- Expand the use of telepsychiatry and other forms of distance treatment and support.
- Develop and implement a regional social marketing strategy to reduce stigma around behavioral illness and raise awareness of available treatment and support resources.
- Increase the number and geographic availability of health care professionals to treat behavioral health conditions.
- Develop new and expand existing models of social support to avert crises, maintain stability and sustain recovery for individuals with behavioral illness.

- Improve access to supportive housing for people with a behavioral health diagnosis and increase the availability of affordable, safe, reliable and timely transportation to programs and services.

Address the lack of integration between physical and behavioral health:

- Integrate the current physical care and behavioral health care delivery systems, beginning with individual practice pilot programs.
- Create standards and protocols for the sharing of protected electronic health information between physical health, behavioral health and community service providers.
- Develop and implement communitywide guidelines regarding the integrated treatment of behavioral health and physical health conditions.
- 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:

- Leverage existing data sources (and explore the creation of new data sources to fill knowledge gaps) to evaluate the current state of behavioral health in the region.
- Conduct ongoing monitoring as a partnership among local governments and agencies with expertise in the areas of behavioral health to ensure that the unique assets and data resources are fully leveraged.

The Behavioral Health Integration Workgroup's full recommendations, as well as background data and information used to develop them, and a list of workgroup members are available online at http://ow.ly/PfQpm.

Prevention and Population Health

Unhealthy behaviors – such as tobacco use, poor diet and lack of physical activity – are the leading causes of preventable mortality in the United States and exert a greater effect on population health than genetics or any other single factor (*Figure 1, pg 4*).[11]

Historically, the U.S. health care system has operated as an episodic acute care system, focused more on *treating* disease than *preventing* it (or promoting overall health and wellness). This approach has led to worse population health outcomes and higher overall health expenses in the United States than most developed countries.[12] Health care reform efforts, both nationally and at the state level, have identified preventive care and population health as key to transforming the current system to achieve better results.

Acknowledging this insight, the RCCHI formed a workgroup with 35 community leaders from public health (including County Health Directors), business, insurers, hospitals, physician practices, academia and community groups to identify priority conditions for prevention efforts and strategic areas of focus to advance population health.

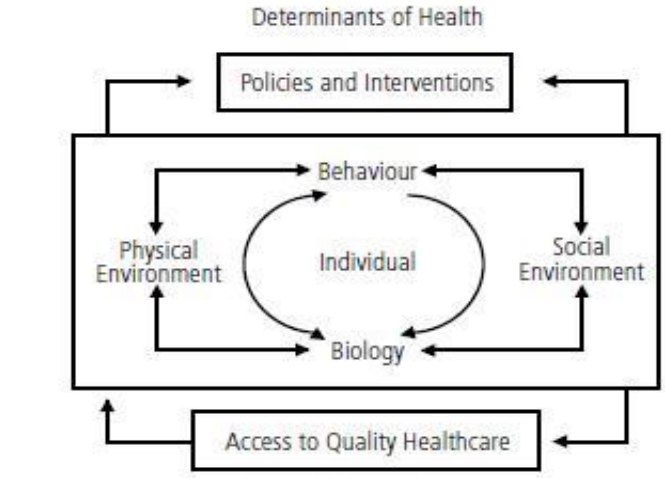
After reviewing all the County Health Improvement Plans and nonprofit hospital Community Service Plans in the region, as well as relevant national data and literature, the workgroup decided to focus on obesity and respiratory disease as the key conditions for local prevention efforts:

- Obesity is a national epidemic, one that has accounted for as much as 21 percent of overall annual medical spending ($190 billion).[13] Its impact is pervasive regionally as well, with the prevalence of adult obesity and overweight ranging from 56 percent in Ontario County to 72 percent in Wayne County.[14] Obesity and overweight are particularly high among minority groups, estimated to impact 75 percent of African-American adults in Monroe County.[15]

- While public health initiatives continue to reduce the overall population's exposure to tobacco, chronic respiratory diseases remain problematic in the region. On average, 17 percent of adults in the Finger Lakes smoke, and the prevalence of smoking among adults in the region with low socioeconomic status and educational attainment is significantly higher (28 percent).[16] Asthma is the third most prevalent chronic condition among Medicaid beneficiaries in the region[17] and causes more than 5,000 emergency department visits per year in local hospitals.[18]

One key challenge identified during workgroup discussions is the complexity of preventing chronic conditions like obesity and respiratory disease. The causes of these conditions are multifaceted, resulting from the dynamic interactions and interdependencies of environment, access, social norms and behavior (*Figure 3*). Preventing these conditions at the population level will require many environmental and institutional changes by multiple stakeholders across diverse sectors, settings and scales.

Figure 3. The Determinants of Health



Source: US Department of Health and Human Services (2000).

This complexity also makes it difficult to identify, implement and measure effective, evidenced-based initiatives to address these conditions. Few programs or policies have demonstrated significant results at the population level to date, and sustainable results may take many years to demonstrate. To succeed, initiatives will require sustained multi-sector commitment, long-term funding and intermediate measures to demonstrate incremental progress.

Recommendations

- Implement policies that promote healthy, active living across the life span by increasing healthy eating and physical activity, and reducing smoking and exposure to environmental triggers in diverse community settings; prioritize policies with a high strength of evidence,[19] a multi-jurisdiction commitment to advance within the region,[20] and broad population effect[21] (*Appendix D*).

- Recommend and support policies that better incentivize and meaningfully and consistently deliver preventive health care, such as adopting evidence-based clinical prevention guidelines, leveraging appropriate and available technology, and developing a regional standard of information-sharing in both clinical and community settings for comprehensive, real-time monitoring across care settings.

- Implement evidence-based programs that prevent or manage obesity and respiratory disease and the complications of these conditions for high-risk populations and life stages through education and behavior support; prioritize programs with a high strength of evidence,[22] a multi-jurisdiction commitment to advance within the region,[23] and demonstrated effect of sustained positive behavior change over time (*Appendix E*).

- Develop a diverse and culturally competent health care workforce that is team-based, cross-trained and highly skilled in preventive care, patient activation, population health management and wellness.

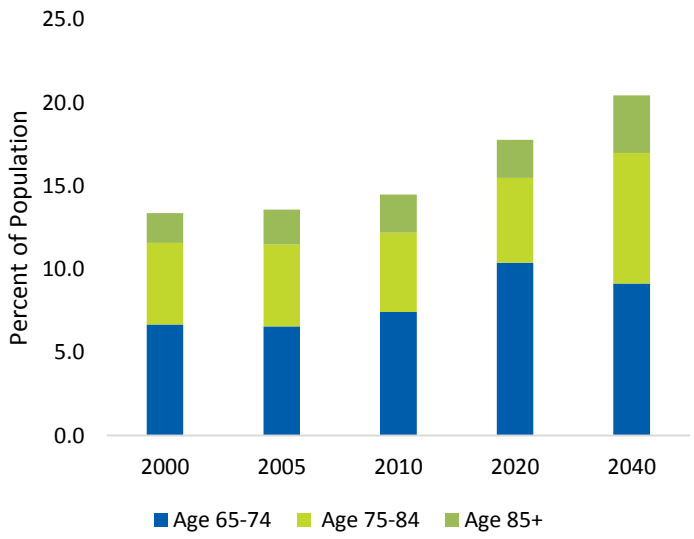
- Document and evaluate the outcomes, costs, challenges and lessons learned from key community prevention efforts, including population health behavior outcomes and health disparities.

The Prevention and Population Health Workgroup's full recommendations, as well as background data and information used to develop them, and a list of workgroup members are available online at http://ow.ly/PfQfY.

Senior Health

Adults age 65 and older are the fastest growing demographic nationally and in the Finger Lakes region.[24] Nationally, the older adult population is expected to increase by 30 million people between 2010 and 2030; regionally the senior population is projected to grow 38 percent from 2007 to 2025, at which point one in five people living in the region will be 65 or older (*Figure 4*).[25] At the same time, the ability of families to informally care for seniors is expected to decline due in part to smaller families, a higher percentage of women in the workforce and the geographic dispersion of family members. The ratio of caregivers to seniors is projected to decline from 6.6 to 1 in 2007 to 5.6 to 1 in 2025, a drop of more than 15 percent.[26] Meanwhile, the number of seniors living with a chronic condition is expected to double between 2000 and 2030.[27]

Figure 4. More than One in Five People In the Finger Lakes will be 65 or Older By 2040



Source: 1990-2005 U.S. Census Bureau, Population Estimates Program; 2010-2035 Cornell University, Program on Applied Demographics

These shifts will place tremendous burdens on the health care system and society at large unless steps are taken to address them. To respond to this concern, the Sage Commission was convened in 2010-2011 to create a strategic vision for elder care, aging services and senior health care in the region. To build on the work of Sage and connect it with the effort to improve preventive care and behavioral health integration in the region, the RCHHI formed a Senior Health Workgroup composed 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.

Sage Commission recommendations focused on creating a person-centered health system that could accommodate older adults' residential preferences and delay institutional care for as long as possible. Despite widespread community endorsement of the Sage Commission plan, the transformation to person-centered care has been slower than desired. The Regional Commission on Community Health Improvement's Senior Health Workgroup sought to understand the reasons behind this delay and identify actions to address barriers.

Discussion and analysis suggested that systems of medical care, social support and behavioral health are still highly fragmented and that the supply of home- and community-based services is insufficient to meet seniors' needs.[28] Additionally, discussions indicated that the supply of geriatric-informed health care providers (in both physical and behavioral health settings) is inadequate and that financing is a significant barrier for many seniors' ability to access essential, but nonmedical, health supports, especially those who are just above the Medicaid eligibility threshold.

In developing their recommendations, workgroup members envisioned an integrated, person-centered health care model that strengthens care within each domain – medical, social and behavioral – and integrates and coordinates across these areas. Their model places the individual elder at the center of care coordination (*Figure 5*).

Figure 5. Model of Integrated, Person-Centered Senior Care

Source: FLHSA (2015).

Recommendations

Improve integration across medical, social and behavioral care domains:

- Foster better integration within medical, social and behavioral care teams and improve coordination and relationship-building across care providers and settings to manage the complex medical and social needs of seniors.
- Expand Patient-Centered Medical Homes to include co-location of services, expand telehealth and partner with community-based organizations.
- Develop regional standards and protocols for real-time data entry and information sharing across medical care, behavioral health, and home- and community-based services.
- Implement a communitywide, integrated information technology solution to support population health management.
- Expand Rochester RHIO connectivity and services across medical care, behavioral health, long-term care and community settings.

Strengthen the health care workforce to better serve older adults with complex medical, behavioral and social needs:

- Build a skilled provider base of "hands-on" caregivers to address the health needs of the elder population.
- Coordinate with educational institutions to develop new curricula.
- Identify policy solutions to address workforce shortages.
- Determine the finances required to support training to develop a sustainable approach to the identification, development, recruitment and retention of the needed workforce.

Develop information sharing standards and processes to facilitate integrated care:

- Improve data management, sharing and transfer, including developing a regional information technology strategy to support data sharing and expanding RHIO adoption and participation.
- Commit to integrating information and addressing regulatory barriers to sharing protected behavioral health and substance abuse information, while ensuring client confidentiality and security of all health-related information.
- Create a data warehouse, including medical, social and behavioral data that facilitates regional health care analysis at the population level.

Address financing issues that currently prevent integrated care:

- Advocate for the expansion of Medicaid/Medicare coverage of nonmedical, long-term services and supports.
- Contract with managed care and other payers using a value-driven payment system that includes cost sharing and sliding scale contributions.

- Facilitate contracting between health systems, skilled nursing facilities, and long-term services and support agencies to deliver care.

The Senior Health Workgroup's full recommendations, as well as background data and information used to develop them, and a list of workgroup members are available online at http://ow.ly/PfQwx.

Cross-Cutting Issues

Recommendations common to all three RCCHI workgroups revealed three cross-cutting issues that are integral to improving regional community health: the need for information sharing, financing and health care workforce development.

Information Sharing

The recommendation to share information seamlessly across providers and systems (both medical and nonmedical) evolves from the recommendation for integrated and coordinated care, a recommendation shared by behavioral health and senior health workgroups. Information sharing – including anything from communication protocols to information technology – is critical to breaking down silos and supporting integration within and across domains of care, yet current mechanisms are too often intermittent and unreliable. In some instances, providers have low connectivity driven by restrictions in their funding sources or regulation, such as confidentiality laws. Other barriers include technical issues like the lack of interoperability among software or electronic health records systems that limit, or actively block, the free flow of information. Overcoming these challenges requires a collaborative approach across many stakeholders and is central to achieving coordinated and integrated care in the region.

Financing

Adequate, appropriate and sustainable financing is another key to achieving better coordinated and integrated care. Current health care financing mechanisms may not be aligned with an integrated approach, as providers are not always compensated for time spent coordinating care with one another or incentivized to provide care management for their patients. The shift from fee-for-service to value-based payments should provide opportunities to better align coordinated care and the financing mechanisms needed to support it.

Beyond the realm of health care delivery, funding is needed to develop and implement community-based policies and programs that make healthy choices easy and affordable. Such initiatives will require strong multi-sectoral partnerships as they may be costly to implement, difficult to measure, and likely to require sustainable funding and support over long time horizons to demonstrate results. To sustain meaningful levels of such initiatives in the region, partners should coordinate to leverage funding from multiple sources, including national, state

and local governments, the private sector and foundations. This report provides a foundation for collaborative grant applications and other advocacy efforts.

Workforce Development

Workforce concerns emerged so consistently across workgroups that the Commission held two meetings to assess the data and seek consensus on a strategy. The Commission reviewed the *Community Needs Assessment* recently completed by the FLHSA[29] which shows that health care workforce shortages are a burgeoning problem in the region. For example, the region consistently measures below the New York State average for the availability of behavioral health care workforce, despite having a higher prevalence of behavioral health conditions. And eight of the nine counties in the Finger Lakes region are listed as Health Professional Shortage Areas for all or a portion of their population.[30] Demographic trends and health care reform will exacerbate these shortages, placing additional demands on the system – in terms of both volume and complexity – as the senior population and number of individuals with complex, yet preventable, co-morbid conditions swells.

In addition to recruiting and retaining staff to close current workforce shortfalls, the Commission's focus on prevention and integrated care calls for the creation of such new positions as care managers who can help patients better prevent and manage complex chronic conditions. The group also recognized the need for new roles, responsibilities and workflows for existing staff transitioning to team-based care, changes that require careful definitions and the identification of the barriers presented by limitations on scope of license and certification requirements.

Several entities have committed to explore aspects of the region's health care workforce, including the Finger Lakes Performing Providing System, the Rochester Monroe Anti-Poverty Initiative and the Finger Lakes Regional Economic Development Council. In addition, the New York State Department of Health has launched a statewide workgroup to examine health care workforce regulations.

To ensure continuity and coordination, an overarching planning effort around workforce is needed. Broad collaboration is critical to avoid duplication, align health care workforce development efforts with emerging health needs, and maximize effective advocacy for the resources and flexibility our region needs.

As such, *the RCCHI recommends that the FLHSA develop a regional consortium to coordinate local and state efforts and design a comprehensive health care workforce plan for the Finger Lakes.*

RCCHI Community Health Measures

The RCCHI 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 (*Table 1, below*).

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

Macro in scope, the RCCHI Community Health Measures reflect the Institute of Medicine's (IOM) approach to assessing health and health care progress, where measures are selected to represent "key domains of influence – those areas with the greatest potential to have a positive effect on health and well-being."[31] The IOM approach further identified disparities in health status and health care as a pervasive issue and key aspect of determining true progress toward community health improvement. As such, the FLHSA has committed to reporting the RCCHI Community Health Measures in aggregate, as well as broken down by race/ethnicity, geographic region and socio-economic status – to the extent the data allow – to better understand where and how health disparities impact overall community health in the region.

The RCCHI Community Health Measures are designed to measure *overall health outcomes in the region*, rather than the impact of individual programs or initiatives recommended in the *Blueprint* (*see Appendix F*). It is the collective implementation of *Blueprint* recommended initiatives that is expected to improve our region's overall health. As such, improvement among the RCCHI Community Health Measures is expected to occur incrementally, over a long period of time, and as a result of sustained and coordinated efforts by the many diverse stakeholders who play a role in achieving their common goal.

Conclusion

The Finger Lakes region is in the midst of a period of fundamental change in health planning and health care delivery. Our region's decades-long commitment to collaborative health planning positions us well to take advantage of emerging opportunities in this time of change.

The *Blueprint for Community Health Improvement* provides an assessment of where we are now and consensus from dozens of community leaders about where we need to be and what we need to prioritize to get there. The *Blueprint* includes many ideas that can help our region move in the right direction by integrating behavioral health, preventing chronic disease and supporting residents' health as they age. The Commission's call for collaborative workforce development planning ensures that our region will develop, train, retain and grow the full range of professionals and skills needed to support its vision for coordinated, integrated care and community health improvement.

> ***"If you want to go fast, go alone. If you want to go far, go with others."***
>
> ~African proverb

Yet success in achieving the Commission's vision will require more: the sustained and coordinated efforts of many stakeholders – spanning diverse sectors and geographies throughout the region – to *implement and evolve* its recommendations. It is our hope that stakeholders will use the information contained in this *Blueprint* to take action – to identify partners, develop new programs, advocate for new policies and collaborate on new funding

applications. Throughout, FLSHA will track health outcomes and look to our partners for additional process measures to assess the community's progress.

Rather than an ending, we see the *Blueprint* as a new beginning – a roadmap to where we need to go with the power of consensus to help us get there.

Appendix A. RCCHI Commissioners

Stephen B. Ashley (Chair)
The Ashley Group
Chairman and CEO

Jose Acevedo, MD, MBA
Finger Lakes Health
President and CEO

Nancy Adams
Monroe County Medical Society
Executive Director

William Armbruster
AARP
Associate State Director

Karla Austen
MVP Heath Care
Executive VP Network Management

Marc Berliant, M.D.
URMC
Associate Chair for Clinical Affairs

Daan Braveman (Vice Chair)
Nazareth College
President

Jordon Brown
Lifetime Assistance, Inc.
Executive Vice President and COO

William G. Clark (Vice Chair)
Urban League of Rochester
President and CEO

Ann Marie Cook
Lifespan
President and CEO

Dianne Cooney-Miner, Ph.D., RN, CNS
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Dean, Wegmans School of Nursing

Robert Dobies
Rochester Regional Health System
Board Chair

The Honorable Craig Doran (Vice Chair)
Courts of Ontario County
Superior Court Judge

David T. Hannan, MD, MPA, FAAFP (Vice Chair)
Arcadia Family Practice PC
Wayne County Physicians Organization

Andrea J. Haradon
S2AY Rural Health Network
Coordinator/Human Service Development

Susan Holliday
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Byron Kennedy, MD, Ph.D., MPH
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Director

Robert K. Lambert, MD
Arnot Health
Executive Vice President

Robert R. Lebman
Huther Doyle
President and CEO

Marty Lustick, MD
Excellus BCBS
Senior Vice President, Corporate Medical Director

Patty Malgieri
Rochester City School District
Chief of Staff

Michael R. Nuccitelli
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Sandra A. Parker
Rochester Business Alliance
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Kathleen Parrinello
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Appendix B. RCCHI Principles

1. Measure and advance each dimension of the Triple Aim: providing better health for populations, better care, and appropriate lower per capita cost of care
2. Involve consumers of care as full participants in the Commission
3. Integrate prevention, public health to improve quality of life
4. Develop a mechanism for identifying persons in need, gaps in care and services, to address the barriers to access and care
5. Help to coordinate and integrate services in care, leveraging community strengths and innovations already underway
6. Identify redundancy and waste in order to reduce duplicative costs
7. Identify and focus initial attention on common themes among populations to efficiently prioritize activities
8. Model and build the business case for sustained funding from within the community, among current payers, from New York State and from the federal government

Appendix C. RCCHI Charter

Vision: Regional stakeholders will agree on community goals, measures and strategies that integrate and coordinate activities to meet the complex needs of individuals across the spectrum of their care.

Purpose: The Commission will provide the forum for stakeholders to:

1. Assess current status and develop consensus on community goals
2. Develop community measures focused on the elements of the Triple Aim that measure community health
3. Ensure transparency of community performance on those measures
4. Identify those activities needed to attain the community goals that are best addressed with community collaboration.

The Commission will convene stakeholders across the nine county region to:

- Develop communitywide metrics to measure and advance successful strategies for each dimension of the Triple Aim: providing better health for populations, better care and appropriate lower per capita cost of care.
- Involve consumers of care as integral members in the Commission's work.
- Identify and make recommendations to address disparities wherever they exist; socioeconomic, race or place.
- Develop a mechanism for identifying persons / populations in need, gaps in services needed and barriers to access necessary services.
- Develop and recommend strategies that will promote coordination between practitioners, families, health and human service providers, to promote and enhance care coordination; leveraging community strengths and innovations already underway.
- Model and build the business case for sustained funding from within the community, among current payers, from New York State and the federal government.

Appendix D. Evidence-Based Policies Consistent with Prevention and Population Health Workgroup Recommendations

Policy type	Potential Community Partners	Effect
Breast-feeding	Worksites Hospitals, health care Policymakers, government agencies	Increase healthy eating from infancy
Healthy food cafeteria/vending	Schools, early childhood, universities Businesses, worksites Hospitals, health care	Increase healthy eating by improving healthy choices and reducing unhealthy choices
Complete streets or active transportation promotion	Municipalities, government agencies Schools Worksites, universities	Increase physical activity by making it easier/safer to walk, bike, use transit
Physical activity/ recess or joint use	Schools, early childhood Universities	Increase physical activity by requiring students to be active and providing exercise space for community residents on school campuses/facilities
Smoke-free campus	Schools, early childhood Worksites, universities Municipalities, government agencies *(including public health departments)*	Prevent/reduce smoking

Appendix E. Evidence-Based Programs Consistent with Prevention and Population Health Workgroup Recommendations

Program	Target Population	Delivery Setting	Effect
Nurse Family Partnership (NFP)	First time mothers, infants/toddlers 0-2	In home	Reduced smoking and hypertension for mothers *(prevent pregnancy associated hypertension and tobacco abuse)* Improved health and nutrition for children *(prevent obesity)*
Diabetes Prevention Program (DPP)	Adults 45+ that are overweight or pre-diabetic	Worksites, faith, YMCAs/community centers	Lose weight to prevent or delay onset of type 2 diabetes *(prevent diabetes, manage obesity)*
Stanford Chronic Disease Self-Management (CDSM)	Adults with chronic conditions	Worksites, faith, YMCAs/community centers	Increased exercise, physician communication, general health *(manage obesity and respiratory disease)*
Tobacco Cessation Programs: -Proactive NYS Quitline -High intensity 1-1 counseling	Adult smokers	In home, by phone One-to-one counseling in community centers, FQHCs	Reduced smoking *(prevent and delay respiratory disease)*
Multi-Trigger Multi-Component Environmental Programs (e.g., Healthy Homes, Healthy Neighborhoods)	Families, particularly those with children with asthma	In-home	Reduce negative health consequences of asthma Reduce preventable ED visits

Appendix F. Alignment of RCCHI Blueprint Recommendations and Community Health Measures

RCCHI Blueprint Recommendation	RCCHI Community Health Measure	
	Primary	Secondary
Behavioral Health		
Improve access to behavioral health care.	BH1-BH4	PH1-PH2, PH4-PH5, PH7-PH9, PH11
Address the lack of integration between physical and mental health.	BH1-BH4	PH1-PH2,PH4-PH5, PH7-PH9, PH11
Provide ongoing measurement and monitoring of behavioral health services.		BH1-BH4
Prevention and Population Health		
Implement policies that promote healthy, active living across the life span.	PH1-PH9, PH11	
Recommend and support policies that better incentivize and deliver preventive health care.	PH1-PH9, PH11	
Implement evidenced-based programs to prevent or manage obesity/respiratory disease.	PH1-PH9, PH11	
Develop a diverse and culturally competent health care workforce.	PH1-PH9,PH11	BH1-BH4,SH1-SH3
Document and evaluate outcomes, costs and lessons of community prevention efforts.	PH1-PH11	BH1-BH4,SH1-SH3
Senior Health		
Improve integration across medical, social and behavior care domains.	SH1-SH3	PH4-PH5,PH7-PH9
Strengthen the health care workforce to better serve older adults with complex medical, behavior and social needs.	SH1-SH3	PH4-PH5,PH7-PH9
Develop information sharing standards and processes to facilitate integrated care.	SH1-SH3	PH4-PH5,PH7-PH9
Address financing issues that currently impede integrated care.	SH1-SH3	PH4-PH5,PH7-PH9

Key for RCCHI Community Health Measures

Behavioral Health:

BH-1 Screening rate for clinical depression (%)
BH-2 Emergency dept. visits w/BH diagnosis (primary or co-morbid) (%)
BH-3 30 day hospital readmits among those with a BH diagnosis (%)
BH-4 Follow-up visit (within 7 days) after hospitalization for mental illness (%)

Prevention and Population Health:

PH-1 Years (<65 yrs.) of potential life lost (years per 100,000)
PH-2 Low (<2,500 g) birth weight (rate per 1,000 births)
PH-3 Children w/recommended immunizations at 2 yrs. of age
PH-4 Cigarette smoking (% of adult population)
PH-5 Obesity (BMI=>30) among adults (% of adult population)
PH-6 Obesity (=>95th percentile) among children (% of population <18 yrs.)
PH-7 Hypertension control (HEDIS 2015) (% of registry)
PH-8 Diabetics with poor (> 9.0%) HbA1c control (% of "RHIO" diabetics)
PH-9 PQI 90 – Composite avoidable hospital admissions (rate per 100,000)
PH-10 High school graduation rate (%)
PH-11 Self-reported excellent/v. good/good general health status (% of adult population)

Senior Health:

SH-1 Emergency department visits among those 65+ (rate per 1,000 pop. 65+)
SH-2 Medicaid nursing home spend/home and community-based spending (%)
SH-3 Nursing home utilization days (rate per 1,000 persons aged 85+)

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