NYS PHHPC Health Planning and Public Health Committees

Report - September 2020

Shaping the Future Health System in NYS: Lessons from COVID

On August 12, the Health Planning and Public Health Committees of the NYS PHHPC convened two panels of primary care providers (consisting of FQHCs and other models of primary care practice) and a third panel of local health departments and county executives to hear their experience in responding to the COVID pandemic. The goal was to identify lessons for preparing for future health care crises and for shaping the future health system in NYS.

An additional session was held on the 19th for three innovative patient-oriented integrated health systems (two provider systems and a health plan and affiliated physician practice) to review the development of their programs along with the enablers and barriers to success.

Although each panel represented a distinct perspective, they all shared similar concerns and recommendations, which are outlined below. Panel participants are listed in Attachment I. Details can be found in session transcripts.

OVERALL PANEL RECOMMENDATIONS

- Inclusion of primary care and local health departments when key decisions are made about planning for future emergency response and system redesign
- Consistent and sustained financing policy , strategy and mechanisms that promotes "managed care"-- i.e., a capitated approach that includes value based payments to incentivize and reward integrated , cost effective, patient centered care across all providers in the health care system
- A clear, consistent primary care strategy, led by DOH senior leadership in a collaborative working relationship with primary care systems and providers
- A significant investment in the public health infrastructure at all levels, including need for upfront funding for emergency response
- Continued efforts to strengthen collaborative planning; utilize the Governor's Executive Order to assure health across all policies and age-friendly NY among state agencies; and promote collaborative planning with relevant community /local government partners to assure an effective and sustainable emergency response and a longer-term focus on social determinants of health in system redesign.
- Regulatory and administrative simplification to reduce unnecessary burden on providers.
- Support for regulatory and financing changes to more effectively utilize telehealth.
- Investment in innovative and affordable efforts to build workforce capacity.

I. Need for an intergovernmental and cross-sector approach to harness the health system's full capacity

A. State policymakers are too often unaware of the needs of the populations served, the services provided and the capabilities of the primary care sector as well as the capacity and authority of local health departments (LHDs) as parts of local government (counties and cities). Both of these components of the health care system are undervalued in planning and policy making.

- LHDs and county governments need to be more engaged in statewide planning and decision making for emergency response
- Within health care, policy and planning should include participation by and coordination across all components of the health care system - primary care, public health agencies, acute care, and long-term care .

B. Local intergovernmental cooperation has been very important in responding effectively to COVIDat the vounty level - i.e., environment, social services; area offices on aging; mental health, education, criminal justice; police; public works.

- At the State level, human service departments – DOH, OMH, OASAS and OPWDD – need to develop a more formal and intentional coordination on relevant cross-department concerns.
- Need to explore how best to use Governor's Executive Order for Health Across All Policies and Age Friendly New York State to not ony mobilize across agencies and sectors at state level but also link to and support local efforts in emergency planning and future health system design.

C. Specific COVID experience

PPE, Screening and Testing

- The well-established experience of local health departments in screening, testing, contact tracing and data management was not tapped in the design of local strategies.
- One hospital system reported that 80% of COVID cases in their system were managed outside of the hospital, yet primary care and local health departments were the last to get PPE, reagents, tests, etc. and were unable to utilize their local lab capacity.
- LHDs are not in a position to expend significant dollars in hopes of reimbursement. Emergencies like COVID require upfront funds to fully utilze the local capacity.
- In the planning process, the respective roles and contributions of primary care and LHDs need to be clarified for both outbreaks and normal times.

Communications

- While LHDs were appreciative of the regular communications from NYSDOH, suggestions were made to strengthen communication management for future emergency responses.

- The key messages to the public were largely hospital related; in the future, messages advising patients to contact their primary care providers could have avoided disruptions in ongoing care for non-COVID related services
- Communications systems should recognize local expertise and consider the importance of LHDs and PCPs as trusted sources of information for local communities, especially the most vunerable; local health departments need to be advised before NYSDOH gives out messages to the pubic so questions from local communities can be answered.
- Need better multilingual communication/materials
- COVID-related conflicting information from federal, state and local governments needs to be reconciled to avoid inconsistencies and misinformation;

Shared Learning Opportunities

- Consider some centralized vehicle to coordinate real time sharing of clinical problems and learnings among clinicians and across providers during emergencies;
- Share clinical innovations, e.g., Northwell learned to set up "hospitals at home" with telehealth, and nurse visits. Of 300 participants, only two needed hospitalization
- Compile best practices from primary care and innovative responses from all sectors in this emergency for future use
- Share innovative models across the systems for community engagement: deep and extensive community links are critical to the success of integrated systems and their ability to act on broad determinants of health for their patients and, for plans, for their members

II. Addressing Disparities as a Priority

Racial and economic disparities—many based on patterns of structural racism--became all too evident during COVID. The critical importance of addressing social determinants of health (SDOH) to improve community conditions became clear: housing, education, jobs, food, and environment. Local health departments and primary care practices play a special role in community partnerships and have the community's trust, especially in vulnerable and poor communities.

- Mobiize state efforts aross departments and encourage leadership in policy setting, funding design and capacity strategies that focus on impacting SDOH
- Prioritize identification of the services, organizations and systems (health and other sectors) serving disadvantaged and vulnerable communities around the state and make them a priority in planning and investment for future emergencies and shaping the future health care system.
- Need explicit plan of action to tackle structural racism in health care delivery and across the public health system.

III. Financing System needs to transition away from fee-for-service to enable incentives for system integration

COVID highlighted the urgent need to move toward system wide capitated/managed care financing with a value-based payment incentive model to provide adequate funding for primary care and public health to sustain and expand system integration. Data on savings and performance from some systems does exist (Maimonides) and other examples need to be documented and tracked .

Primary Care

- IPAs do not now qualify for the relief funds that hospitals are eligible to receive yet require up-front funding to prepare for future emergencies
- The impending shift of 340(b) revenue from FQHCs to DOH (estimated to be ~$100M) requires a new strategy for maintaining adequate support funding for safety net

Public Health

- Tax caps create funding challenges for local government in general; emergencies such as COVID create serious budget shortfalls.
- The historic national failure to invest in PH infrastructure is magnified during COVID. At the state level, upfront funding and flexibility of investment to prepare the local health department to respond to emergencies is critically important.

Integrated Systems

Better integrated care achieves improved health outcomes and can save money. Capitated managed care financing has incentivized collaboration within systems but concerns were expressed about "anti-trust" constraints that currently hinder cross-system collaboration.

Deep organized partnerships with the community and community based organizations are critical to cost effective and high quality care; managed care financing is the only way to build these partnerships into improved system performance.

IV. Administrative Simplification

- All providers, especially those in primary care, are extremely burdened by multiple data-use agreements and reporting requirements imposed by payers. DOH should partner with DFS to coordinate and standardize reporting requirements among payers and providers with the goal of a single data use agreement across all payers.
- Credentialing is another high cost burden for primary care. DOH should coordinate a standardized and centralized effort to establish requirements and process for credentialing of clinician eligibility for reimbursement.
- New approaches to care require accelerated regulatory approvals to enable the capture of federal and private funds and that depend on the experience and expertise of local providers.

V. Telehealth/telemedicine

IT is now an access and equity issue. Lack of broad band access and lack of devices impede the delivery of care.

- Maintain regulatory relaxation and more appropriate reimbursement for telehealth and telemedicine services regardless of site.
- Need clarity/parity on medical and behavioral health reimbursement that recognizes capacity for telephone vs. visual visit and for provision regardless of site; continue reimbursement changes implemented in COVID.
- Expand types of providers that can be qualified to use and be compensated for this technology.
- Lack of adequate behavioral health services and specialty care and other services in communities could be addressed through organized telehealth networks.
- NYS needs a process to assure broad band access for routine and emergency availability which could include establishing/identifying community sites to provide access to individuals without service and/or equipment needed, eg. libraries, pharmacies, senior centers, banks.
- Need statewide strategy to train patients and workforce in the use of IT.

VI. Workforce

Aging of public health and primary care workforce together with retirements and practice closures after COVID will exacerbate weaknesses and gaps in both sectors with a critical shortage of certain categories of providers/clinicians

- Need support/ attention to public health, primary care and education partnerships to set up links with local community colleges for career ladders;
- The long-standing problem of NY's strict scope of practice regulations limit local use of non-traditional providers such as community health workers and home health aides in developing more effective, affordable and responsive local systems of care. DOH needs to be more of an advocate with the State Education Department to amend these regulations

VII. Conclusions

- The panel members expressed their thanks for being invited to provide their perspective. All participants collectively felt that the voice of the health care and public health community – outside of hospitals – was missing in the state's response to COVID.
- The overarching request of panelists is to have more involvement in the strategy and decisions made at the state level and to be recognized and valued as integral parts of keeping New Yorkers safe and healthy.

The joint Public Health and Health Planning Committees intend to hold more listening sessions to both educate ourselves and our colleagues and to set our priority agendas for the future. We appreciate the extensive participation of Council members in these sessions and the support of the staff in making them happen smoothly.

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