

New Hampshire Citizens Health Initiative



Annual Summary 2010

NH CITIZENS HEALTH INITIATIVE

A MULTI-STAKEHOLDER COLLABORATIVE EFFORT

OVERVIEW OF REPORT CONTENT

This year's report includes a: 1) brief historical overview of The Initiative, 2) description of our current pillar projects, and 3) additional activities undertaken by the Initiative. We have also attached reports/publications completed in the past year by the Initiative including: 1) *A Strategic Plan for Integrating the Work of NH's Public Health and Medical Care Systems* 2) *Advocates for Healthy Youth Coalition Integration Case Study*, and 3) *Accountable Care – The Overarching Vehicle for Rehabilitating Health Care – A New Hampshire Perspective Issue Brief*.

Initiative meetings and activities are documented regularly on our website (www.citizenshealthinitiative.org). We encourage interest and involvement.

BACKGROUND

The NH Citizens Health Initiative was borne out of recommendations from the NH Endowment for Health Pillar Project. The Pillar Project recognized that high quality, cost-effective care could not be realized without specific intent, focused effort and a well-defined health care framework. The Pillar Project further acknowledged the requirement that the effort must be sustained if the goals were to be achieved.

From its inception, the NH Citizens Health Initiative (Initiative) has functioned as a collaborative organization with diverse financial and advisory support from foundations, educational institutions, government sources and insurers. It has engaged leadership from health care stakeholders as well as the general public, to determine its structure and focus, and on an ongoing basis, its work streams.

Each of the Initiative's work streams, or Pillars, are chaired by an industry leader and facilitated by staffing obtained through the Institute for Health Policy and Practice at the University of New Hampshire.

New Hampshire's Governor John Lynch convened the first meeting of the Initiative. Over its history, the Initiative has obtained financial support from:

- Endowment for Health
- Local Government Center Trust
- New Hampshire Charitable Foundation
- The University of New Hampshire
- HNH foundation
- WellPoint Foundation
- NH Department of Health and Human Services
- Harvard Pilgrim Health Care Foundation
- NH Department of Insurance
- MVP Health Care
- Norwin S. and Elizabeth N. Bean Foundation
- Dartmouth-Hitchcock Medical Center

The Initiative is led by a Chair and Director, has an executive committee in the form of Founders & Funders, and exists as an initiative, under no formal corporate or not-for-profit structure, but rather is organized under the Institute for Health Policy and Practice, advancing its good work through the collaborative efforts of its myriad of stakeholders.

INITIATIVE VISION & GOALS

Over the next decade, New Hampshire will take a ‘health first’ approach so that all citizens will benefit from proven approaches that improve health and prevent disease. When care is needed, it will be delivered according to the highest quality standards and it will be provided in an efficient, measurable, and scientifically sound manner to help individuals sustain or improve health. The organization and financing of care will occur in a logically constructed and understandable system.

Our long term goal is to create and sustain a public dialogue that will measurably improve the “systems” that finance and provide health care in New Hampshire in order to accomplish two fundamental objectives:

- Assure a healthy population; and
- Create an effective system of care.

PILLAR PROJECTS

HEALTH PROMOTION DISEASE PREVENTION

The charge of the Health Promotion and Disease Prevention (HPDP) effort within the Initiative is to facilitate implementation of evidence based public health practices to decrease the leading causes of illness and death among New Hampshire citizens (tobacco use, physical activity and nutrition, and unhealthy alcohol use). This is accomplished through convening experts, engagement across our projects, a strategic focus at the community level, and sharing results with legislators and the general public. Current work is focused on facilitating the successful adoption at the organizational, community, and state level of strategies to integrate the work of NH’s health care and public health systems. To this end, a statewide plan has been developed, A Strategic Plan for Integrating the Work of New Hampshire’s Public Health and Medical Care Systems. See Appendix A for more information about 2010 HPDP accomplishments and proposed objectives for 2011.

MEDICAL HOME

The Initiative convened the NH Multi-Stakeholder Medical Home Pilot in January 2008 to value, prescribe and reward primary medical care that is tightly coordinated and of superior quality and efficiency. The pilot is a collaboration of the four major health insurance carriers, Anthem Blue Cross Blue Shield NH, Cigna Health Care, and Harvard Pilgrim Health Care and MVP Healthcare. The pilot sites include nine primary care practices with nearly 100 clinicians, 39,000 commercially insured members and more than 130,000 unique patient visits per year. Per member per month payments by the commercial carriers to the sites began effective June 2009. See Appendix B for more information about 2010 Medical Home Pillar accomplishments and proposed activities for 2011.

PAYMENT REFORM

The Payment Reform Pillar is comprised of leadership from the State Department of Insurance and Department of Health and Human Services, insurance carriers, NH Hospital Association, behavioral health centers, hospitals, primary and specialty care clinicians and the NH Medical Society. The intent of this Pillar is to reform the health care payment system to align goals and incentives across disciplines and sites of care, across employers, carriers and providers of care, and to do so in a way that

improves quality, outcomes and efficiency. The Pillar launched an Accountable Care Organization (ACO) Project in 2010 with five integrated health care systems that are focused on slowing the rate of increase in health care costs while concurrently improving patient outcomes. The Project is a five-year initiative, the first year of which is focused on defining the global budget and shared savings payment structure, data needs and entities, form and content of a learning collaborative and communications strategy and plan. See Appendix C for more information about 2010 Payment Reform Pillar accomplishments and future activities.

OTHER ACTIVITIES

NH PURCHASERS GROUP ON HEALTH (NHPGH)

The NH Purchasers Group on Health (www.nhpgh.org), a purchasers group comprised of the four largest public purchasers in the state, representing 120,000 members, was facilitated by Initiative staff at its founding three years ago. Since that time it has become a self-supporting entity with staffing contracted through the Institute for Health Policy. In 2010, it continued its efforts at improving transparency in health care to drive changes in the organization and process of health care and improve quality and cost. NHPGH continued production of the NHPGH Hospital Cost and Quality Scorecard (www.nhpghscorecard.org); promoted use of the NH Health Cost web site (www.nhhealthcost.org), benchmarked data from its members on cost, quality, and preventive services; and advanced its Vision for Health through direct conversations with hospital systems around the state. In 2011, NHPGH will continue its 2010 activities and extend its conversation on cost, quality and appropriate use of health care services through the creation of a video and social media campaign.

OCTOBER 25TH STAKEHOLDER MEETING

As a part of its planning efforts, the Initiative hosted a three hour facilitated discussion with a broad group of NH stakeholders to discern health policy issues that might benefit from further discussion and exploration in the future. Over three dozen stakeholders representing hospitals, providers, public health, consumers, business, and the insurance perspectives participated in this conversation. The group discussed a range of different topics affecting NH's evolving health care system and the health of its citizens. At the end of this discussion, group consensus discerned the following as the top three priority areas for NH:

1. NH State Health Plan: Stakeholders voiced the need for a state health plan that articulates vision, goals, and priorities in a manner that business, healthcare industry, and consumers can utilize and understand.
2. Transparency: Because of the Initiative's role as a trusted third party and consumer ombudsman, stakeholders expressed their interest in having it function as a champion for health care system transparency.
3. Affordable Care Act (ACA)/System Reform "Translator": Stakeholders voiced their support for the Initiative helping audiences, such as consumers and small business, be more fully aware of the impact of ACA.

A detailed summary of the Oct. 25th meeting is available in Appendix D.

Based on the outcomes of the Oct. 25th stakeholders meeting, the Founders and Funder have decided to investigate whether and how the Initiative could play a constructive role in establishing a State Health Plan. Examples of some of these key questions include:

- What do we mean by a State Health Plan?
- Who are the critical stakeholders that should and must play a role in the development and support of such a plan?
- What are the most successful examples of similar efforts by other states?
- If such an effort were to be taken on, what are the requirements for leadership, support, production, and adoption for a successful effort?
- Finally what if any role should the Initiative play in an endeavor of this type?

APPENDICES

- A. Health Promotion/Disease Prevention Pillar Summary
- B. NH Multi-Stakeholder Medical Home Pilot /Medical Home Pillar Summary
- C. Payment Reform Pillar/Accountable Care Organization Summary
- D. October 25th Citizens Health Initiative Stakeholder Retreat Summary

ATTACHMENTS

Click on links below for attachments:

- 1. State Strategic Plan for Linking NH's Public Health and Medical Care Systems
- 2. Advocates for Healthy Youth Coalition Integration Case Study
- 3. Accountable Care – The Overarching Vehicle for Rehabilitating Health Care – A New Hampshire Perspective
- 4. Previous Citizen Health Initiative Legislative Reports

APPENDIX A

HEALTH PROMOTION/DISEASE PREVENTION PILLAR SUMMARY

2010 Accomplishments

For its 2010 work, the Health Promotion Disease Prevention Pillar Group (HPDPPG) selected the following two priorities:

1. Developing a state plan/strategy for fostering increased integration activity in NH
2. Identifying and facilitating the connection between groups engaged in similar integration efforts.

In late August 2010, a *“Strategic Plan for Integrating the Work of NH’s Public Health and Medical Care Systems”* was completed. Plan promotion efforts conducted in 2009 included:

- Providing a link to the plan on the Citizens Health Initiative Website
- Two conference presentations/panels (NH Public Health Forum, New England Rural Health Roundtable) about the Plan
- A statewide press release
- Submission and acceptance of an abstract in collaboration with Cheshire Medical Center/Dartmouth-Hitchcock Keene to provide a seminar about the use of integration strategies to promote community health at the Association for Community Health Improvement meeting in March 2011.

With respect to identifying and facilitating connections between groups engaged in similar efforts, in 2010, the HPDPPG: 1) developed recommendations included in the strategic plan for linking integration efforts in the state and 2) conducted and summarized a case study review of the Advocates for Healthy Youth (AFHY) Coalition in Keene to garner lessons learned about how to rally medicine, public health and other community stakeholders to address an identified health priority. The AFHY case study is available on the Citizens Health Initiative website.

2011 Proposed Objectives

Building on accomplishments from 2010, the HPDPPG plans to focus on the following three objectives for 2011.

1. Increase awareness statewide about the “Strategic Plan for Integrating NewHampshire’s Public Health and Medical Care Systems”
2. Discern feasible approaches to incorporate integration strategies that address one or more of NH’s health behavior priorities (unhealthy eating, sedentary lifestyle, tobacco use, and unhealthy alcohol use) into the NH Citizens Health Initiative’s Accountable Care Organization (ACO) Pilot.
3. Develop tools and strategies to promote awareness about integration and facilitate the linking of medicine, public health, and other community stakeholders to address NH’s health behavior priorities.

APPENDIX B

NH MULTI-STAKEHOLDER MEDICAL HOME PILOT /MEDICAL HOME PILLAR SUMMARY

The New Hampshire Citizens Health Initiative Multi-Stakeholder Medical Home Pilot represents a collaboration among The Initiative (NHCHI) medical home workgroup, the Center for Medical Home Improvement and the four private New Hampshire Health Plans: Harvard Pilgrim Health Care, CIGNA, Anthem, and MVP Healthcare. The goal of the pilot is to value, prescribe and reward medical care that is tightly coordinated and of superior quality and efficiency.

Planning for the project began in January of 2008, with sites selected in December 2008. Payment by the commercial payers to the pilot sites for the two year pilot commenced in July 2009 for the PMPM payment period of 06/01/2009 through 12/31/2009.

The practices recognized as patient-centered medical homes receive per member per month compensation for the time and work physicians and their staff spend to provide comprehensive and coordinated services. This approach is distinctly different from the current system which solely pays for procedures and treatment of individual diseases.

The nine (9) pilot sites selected for the project represent the full spectrum of practice types and sizes, including a residency program, with geographic distribution that covers nearly the entire state, in both urban and rural settings. The practices selected provide services for more than 39,000 commercially insured members, and 130,000 unique patient visits per year, or greater than 10% of the state population.

Each site was required to achieve, minimally, Level 1 Patient-Centered Medical Home Recognition by NCQA in order to participate and was required to fully implement Medical Home practices and submit to NCQA for recognition by May 1, 2009.

By December 2010, all 9 sites in the pilot are recognized at Level 3, the highest level of recognition by NCQA.

In 2011, the pilot sites will continue collaborating in the following areas:

- Motivational interviewing, with a focus on hard to reach patients with chronic disease;
- Spreading the processes of Medical Homes across teams of clinical and administrative staff;
- Meaningful Use in the Medical Home;
- Quality measurement and improvement.

Highlights of the NH Patient-Centered Medical Home sites include:

- 100% of the sites have an electronic medical record in place.
- 100% of the sites are actively using ePrescribing.
- Nearly all sites electronically import hospital, radiology and laboratory data directly into the medical record, helping to avoid duplicate testing and visits.
- 7 out of the 9 sites have implemented an electronic care plan.
- Nearly all sites use standing orders that allow treatment for common conditions such as urinary tract infections, pharyngitis or diabetes that help to prevent unnecessary visits and improve overall access to care.
- 100% of the sites actively survey patients on satisfaction.
- 1/3 of the sites report assessing provider satisfaction.
- Most of the sites have invested 100 to 200 hours of clinical staff time for the purposes of obtaining NCQA Patient Centered Medical Home recognition, after already meeting a high threshold of patient-centeredness.
- 5 sites make use of a daily team huddle to coordinate the plans for the day and prospectively address any patient needs.
- Some specific examples of successes include:
 - **Lamprey Medical Center** transformed their Newmarket practice to a Medical Home. They extended all services to all members, regardless of insurance carrier or status, and, in fact, the practice has a rate of uninsured patients of 21%.

- Their medical home site in Newmarket provided acute care access to a patient's primary care team within 24 hours 90% of the time, as compared to their other sites which were only able to do so 70 to 80% of the time.
- 97% of all the diabetics in their Medical Home had HbA1c tests within 12 months.
- 100% of patients with hypertension had blood pressures taken within 12 months.
- The practice rate for pap smear screening increased from 68% to 78%.
- **Derry Medical Center**, through the course of the program:
 - Implemented monthly diabetes education classes for patients.
 - Decreased or maintained HbA1c values of less than 8.0% in 84% of patients.
 - Implemented a health reminder system resulting in identifying and successfully providing annual physical services to 2500 patients who were overdue for their annual check-up.
 - Added behavioral health services 5 days per week.

The success of the pilot will be evaluated through a rigorous, multi-state design. It will include qualitative, quantitative and satisfaction measures, assessing impacts on utilization, both appropriate and inappropriate, cost and, most importantly, quality. The evaluation will rely on claims data from the NH Comprehensive Health Information System (CHIS), an all payer claims database, as well as direct medical chart data.

About Patient Centered Medical Homes

The patient-centered medical home concept re-centers health care on the patient's needs and priorities by providing primary, preventive, and chronic condition care that is personalized for each patient. It emphasizes the use of care coordination and

health information technology, including electronic health records, to help prevent and manage chronic disease. It also features consumer conveniences such as same-

day scheduling and secure e-mail communications. The medical home strengthens the patient-physician relationship by allowing the doctor and team of health professionals to spend more time with each patient and to develop and follow through on an individualized plan of care.

Medical homes have been shown to improve health outcomes, reduce costs and improve patient, family, physician and staff satisfaction.

APPENDIX C

PAYMENT REFORM PILLAR/ACCOUNTABLE CARE ORGANIZATION SUMMARY

In New Hampshire, we are uniquely positioned to design and implement a reimbursement system that values, prescribes and rewards medical care that is tightly coordinated and of superior quality and efficiency. In August 2010, the NH Citizen's Health Initiative (The Initiative), which is staffed by the NH Institute for Health Policy and Practice (IHPP), launched a statewide, five-year Accountable Care Organization (ACO) pilot project in an effort to achieve the level of cost and quality performance of the top five "low cost, high quality" states. The project encompasses the commercial insurance market and includes five delivery systems statewide. It is aligned with the State of NH's efforts to provide affordable and accessible health care for the citizens of NH. This ACO pilot project builds on a long-term relationship between The Initiative and several organizations including, but not limited to, the NH Department of Health and Human Services, The NH Department of Insurance, the NH Medical Society, the NH Hospital Association, and the four private commercial carriers (Anthem Blue Cross Blue Shield of NH, CIGNA HealthCare, Harvard Pilgrim Health Care and MVP Health Care). The participating delivery systems represent a total population of greater than 400,000 individuals of the total 1.3 million NH citizens and 700 of the 3,900 practicing clinicians in the state. The pilot systems were selected through a competitive application process.

The New Hampshire Accountable Care Organization (ACO) Pilot Outline

1. The pilot is a collaboration of five delivery systems which include: 6 hospitals, 60 primary care sites, 3 home health agencies, 5 hospice agencies, 40 behavioral health providers, 7 community health centers, as well as independent and employed regional clinicians.
2. The ACOs in the pilot assume responsibility for a cross-carrier global budget and a clearly defined scope of services for the population in its region. Responsibility includes management of health care services utilization, performance within a global budget, and management of outcomes.
3. The ACOs involved in the pilot will participate in a formal learning collaborative, where they will be responsible for reporting progress towards explicit pilot goals, improving overall and process-specific performance, sharing best practices, and participating in the development and publication of a sharable tool-kit.
4. Pilot leadership, in conjunction with contracted expertise, will develop risk adjustment methodologies for the global budgets, and will participate in defining the manner and methods by which any savings are distributed across the entities within an ACO.
5. The project is facilitated through The Initiative, which serves as a convening white-space. It is aided by an advisory committee comprised of health care system, insurance carrier, business, consumer, State policy, and professional society representatives.
6. technical support will be provided to the pilot participants to link the pilot delivery systems to national best performers and to assist in the translation of other lessons learned. This support includes, but is not limited to, Six Sigma and lean processes, risk adjustment, contracting, population health design, legal guidance, risk adjustment and HIE.
7. The Initiative and the NH Purchasers Group on Health will facilitate ACO pilot and community-level consumer engagement strategy and implementation, including messaging, benefit design evaluation, focus groups and program and communications design recommendations.
8. All data about the pilot, including quality, cost, and efficiency outcomes with benchmarks will be reported transparently, and with adherence to HIPPA privacy regulations.

Proposed Payment Activities

(a) Data Design and Analysis. Paramount to provider systems functioning as ACOs is the availability of cross-carrier data for the purposes of reporting and measurement to support ACO operations, efforts in performance improvement, changes to clinical process design, and to affect patient and stakeholder engagement. The NH ACO pilot will leverage cross-carrier data available through NH's All-Payer Claims Data (APCD) system, known as the NH Comprehensive Healthcare Information System (NH CHIS). This data will be used for the purposes of supporting the ACO's by the independent data entity.

NH CHIS currently includes commercial claims and Medicaid data. IHPP is working with NH DHHS to include Medicare data, as well. With that, NH CHIS will include an accounting of the overwhelming majority of the public and private health care services and expenditures in the State of NH.

To date, in NH, claims data has been used extensively to better inform consumers about health care cost and health cost variation (NH Department of Insurance Market Basket Analysis and HealthCost Database - www.nhhealthcost.org), and to better understand the distribution of health insurance coverage (Office of Medicaid Business and Policy in NH Department of Health and Human Services – www.nhchis.org) and to inform health policy. Additionally, employers, in the form of the NH Purchasers Group on Health (www.nhpgh.org), a coalition of large public employers in NH representing more than 120,000 covered members, have used claims data for comparative benchmarks in cost, utilization and prevalence of chronic conditions in order to improve health and develop appropriate cost containment measures. Claims data has also been used in projects such as IHPP's work within the Center for Disease Control and Prevention Assessment Initiative grant. In this, IHPP is augmenting its health web query system (Health WRQS) with the addition of a claims data-based web query module to produce estimates for the population with claims for a particular condition or disease and care indicators for conditions in user-defined geographic areas.

The exact ways that APCD data can be used to support ACO development are not entirely clear, but are likely to be a key data source in developing global budgets, understanding patterns of care across payers for the ACO pilot areas, and creating benchmarks for utilizations and quality that are key components to measuring the success of the ACO project.

While APCD data is highly valuable as currently configured, it is not likely to address the full breadth of clinical and operational needs of the ACO Pilot. For example, APCD systems do not include the uninsured population, premium information, back-end settlements, or clinical outcome information. Therefore, it is predicted that there will be a need to obtain additional identifiable claims and ultimately medical records and registry data in order to determine how and where health care dollars are being spent. *The ACO Pilot needs to identify those data gaps and determine sources to fill them.*

(b) Development of Metrics and Benchmarks. The pilot will leverage standardized sets of quality and use of service measures for diabetes, CVD, blood pressure, CHF, COPD, and preventive health. It will further incorporate episode of care measures for chronic disease, preference sensitive and supply sensitive services, and will evaluate performance in areas of ambulatory sensitive care and patient safety. Finally, it will evaluate standard sets of rates of health care use for emergency services, pharmacy, radiology, laboratory testing, admissions and readmissions. To extend the reach and effect of measurement, the clinical and administrative leadership *will develop new data models and algorithms* to allow for comparative evaluation of care, cost, and outcomes at both the system level and statewide level. Clinical leaders will establish standards of care and recommendations *within episodes* and the pilot will in turn use those definitions to measure performance for providers both inside of and outside of the pilot.

(c) Development of Global Budgets. The pilot will use cross-carrier claims data to develop risk-adjusted global budgets for which the systems will be accountable. Historical experience, a clearly defined set of services, historical trend, and mutually established future trend targets will be used for the purposes of establishing expected future performance. These targets will be set and reported against transparently, and will be set not only for systems inside of the pilot, but will also be established for comparative purposes to systems outside of the pilot.

(d) Project and system level reporting. Clinical, financial, and operational teams from the systems, carriers, and employer groups within the project will work collaboratively to establish a set of reports that will aid them, respectively, in managing within the budget and to the mutually defined performance standards.

PROJECT GOALS & OBJECTIVES – DATA DESIGN, TRANSFORMATION, AND SHARED LEARNING

Data Design and Transformation

This project seeks to augment the current efforts underway with the NH ACO Pilot, with a specific focus on the data needs for the project. It is clear to all involved that a centralized, independent repository for health care data and a set of operational reporting systems that leverage that data are essentially to the success of each ACO. Whereas IHPP is a public education and research institution actively engaged in practical and policy related work, all of its work is in the public domain; it can serve as that independent entity. The three over-arching data design and transformation goals encompass the development of metrics and benchmarks, the development of global budgets, and project and system level reporting as previously discussed.

Shared Learning

A vital part of the success of our statewide ACO Pilot and other ACOs development will be the ability to provide national technical assistance and knowledge transfer through formal regional and national learning collaborative, and sharing of best practices. The intent is to be able to replicate the data/outcomes theory, models and algorithms used in other states actively involved in ACO development. In particular, NH's neighboring state of Maine is also a nationwide leader in payment reform through their work on Medical Home and ACO, among other projects (including work funded by the RWJ Aligning Forces in Quality). A formal learning collaborative will allow us to further utilize knowledge gained, processes/models developed, and technologies built through the ACO Pilot project.

As NH and ME are non-competitive partners in learning, both states also participate in broader collaborative efforts with VT, CT, MA, RI, MN, CO and PA through their Multi-Payer Medical Home Pilots. ME and NH additionally currently share processes and intellectual resources whenever possible, and plan on partnering on future regional and national projects and grant applications in the area of payment reform.

The lessons learned from this work will be appropriate for national evaluation and national ACO integration. The planned openness of the NH ACO Pilot is purposeful so that the lessons learned and tangible intellectual property can be widely shared. This understanding of health care expenditure patterns and the performance of the health care system, via quality and access metrics, is vital to develop data-driven health reform efforts resulting in impacts (including improved access to care, reduced costs, and improved quality) that can be effectively measured and reproduced regionally and nationally. As such, the NH ACO project will make its metrics, algorithms, and processes available to other states and health systems that are developing ACO models.

Importantly, the use of APCD data to drive ACO development could be of particular interest to other states. There are fourteen states that currently have (or are implementing) APCDs and another five states that show strong interest in APCDs. Staff members of IHPP and The Initiative are leaders and managers of the All-Payer Claims Database Council (www.apcdouncil.org) and have served as consultants to multiple states engaged in developing all-payer claims databases. NH has an existing mechanism to reach other states with APCD data to share how data can be leveraged to support ACO development.

ACO PILOT PROJECT TIMELINE

Foundation Setting – 2010 Completed Goals

- Process Announced - February 2010
- Applications Solicited - February 2010
- Presentations - April 2010
- Pilot Sites Selected - April 2010
- Funding Determined by - May 2010
- ACO Pilot Kick-Off - August 2010
- ACO Foundation Activities – Fall 2010

Inception – 1 Year

- Define Technical, Analytic and Operational Requirements
- Identify and Solve for Legal and Regulatory Barriers
- Clarify Pilot Parameters
- Identify Risk Adjustment Methodology
- Establish Risk Adjusted Budgets
- Define Shared Savings & Incentive Payment Methodology
- Define Savings & Incentive Distribution Schedule
- Define Independent Data Organization
- Test Readiness of Pilot Participants
- Define Consumer Engagement
- Define & Pursue Medicare Engagement Strategy 1
- Define and Formalize Payment

Transformation – 3 Years

- Implement Care Processes
- Participate in Learning Collaborative
- Implement Independent Data Organization
- Engage Consumers
- Report on Progress
- Perform & Adjust New Payments and Payment Systems
- Rapid PDSA Cycles

Evaluation and Assessment – 1 Year

- Plan for Transition of Pilot – Expand or Retract
 - If Expand:
 - Determine Payment Transition for Current Pilot Participants
 - Determine Expansion Plan
 - If Retract:
 - Determine & Implement Plan
 - Formal Communication and Publication of Results
 - Translation of Methods and Results Including Creation of a Tool-Kit

APPENDIX D

CITIZENS HEALTH INITIATIVE STAKEHOLDER RETREAT SUMMARY

AUDUBON SOCIETY – OCTOBER 25, 2010

The following represents a distillation of a three hour facilitated discussion with diverse stakeholders of the Citizens Health Initiative regarding major health policy issues for CHI Founders and Funders consideration for FY12.

MAJOR DISCUSSION THEMES

- Behavioral Medicine/Primary Care integration
- End of Life Care
- Wellness and Personal Accountability
- Outcome Measurement and Evidence Based Care
- Transparency Champion
- NH State Health Plan
- Governance of Public Health Care Trusts
- Affordable Care Act (ACA)
- Workforce Development and Geographic parity
- Outcome measurement and Evidence Based Practice

Behavioral Health/Primary Care

This subject which arose originally at a discussion at a Founders and Funders meeting received little attention with the larger group. It did not seem to resonate as a CHI discussion topic for the near term in the summary priority cards submitted at the end of the session.

End of Life Care

The conversation detoured towards chronic care management, workforce development, and person centered planning. Questions also arose regarding the ACA and how this issue will be embedded in ACO pilots. This issue did not seem to resonate as a CHI priority for the near term in the summary priority cards submitted at the end of the session.

Wellness and Personal Accountability

Discussion revolved around the role of “consumer” and how ACO’s will influence person centered planning, the active participation of consumers, and the social determinants of health (nutrition, transportation, housing, disability, etc.) Questions again were raised regarding the ACA and how ACO’s will embrace this issue. This topic did not resonate as a CHI priority on the priority cards.

Outcome Measurement and Evidence Based Care

Questions were raised about definitions, uniform data management and reporting, and who controls the dialogue. This did not resonate as a CHI priority on the cards.

Transparency Champion

Transparency dominated many aspects of the dialogue; communication to small business, education to general public about healthcare reform, NH State Health Plan, navigating the health system, culture change, defining essential information sets, dissemination, reflective learning, shared decision making were all directly or indirectly linked to the conversation about transparency. Participant suggested there is no reliable and unbiased convener of the conversation and that both government and

health related business were not trusted entities in this dialogue. CHI as the trusted third party and consumer ombudsman was mentioned as a potential role by some. This conversation did resonate strongly as a CHI priority for consideration in the cards submitted.

NH State Health Plan

Last plan was documented in 1998 (to be disseminated to all attendees). Need for State to articulate vision, goals, and priorities in a manner that business, healthcare industry, and consumers can utilize and understand. Plan needed to be seen as an effort owned by a broad set of stakeholders, not just State Government, Providers, etc. Priority cards seemed to indicate that CHI should potentially play (perhaps with others) a convening role.

Governance of Public Healthcare Trusts

This topic generated interesting dialogue including the role of physician leadership. The topic did not resonate as a CHI priority among the cards.

Affordable Care Act

Most of the discussion regarding ACA revolved around it's role affecting other noted subjects discussed during the retreat. ACO pilots in NH are viewed as vehicles that can influence transparency, person centered planning, workforce development, end of life care, yet ACA/ACO did not resonate as a CHI priority moving forward, with the exception of helping audiences such as consumers and small business be more fully aware of the impact.

Workforce Development and Geographic Parity

The need for need skill sets for existing professionals, new care giver capacity, influx of newly covered lives, and geographic capacity were briefly discussed. Seen as a critical problem, but unclear how CHI could or should play a role going forward.

Outcome Measurement and Evidenced Base Practice

This area was referenced as an area of interest and infused in the conversation about Transparency and ACOs. Issues of data design, dissemination, and knowledge translation underlay the discussion. No resonance as a CHI priority in the priority cards.

Summary of Participant Rankings

The data found on the anonymous ranking cards used to conclude the retreat clustered around three main topic areas:

1. NH State Health Plan
2. Transparency
3. ACA/System Reform "Translator"

The Funders and Founders plan to review these items, and potentially some of the others on the list at their next meeting.