



2009 YEAR END SUMMARY

NH CITIZENS HEALTH INITIATIVE

A MULTI-STAKEHOLDER COLLABORATIVE EFFORT

This year's report provides: A brief historical overview of The Initiative, a summary of 2009's Pillar Project Activity, and an overview of the 2010 Pillar Projects. We have also provided as attachments the following documents: A summary of the Multi-Payer Medical Home Pilot; An outline of the work that we are undertaking for our Payment Reform Pillar; The most current draft of our work plan for the Health Promotion and Disease Prevention Pillar; and finally a copy of our 2008 transmittal letter.

The meetings that we hold and the work that we do is tracked on a regular basis at our website at www.citizenshealthinitiative.org and 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
- New Hampshire Charitable Foundation
- HNH foundation
- NH Department of Health and Human Services
- NH Department of Insurance
- Norwin S. and Elizabeth N. Bean Foundation
- Local Government Center Trust
- The University of New Hampshire
- WellPoint Foundation
- Harvard Pilgrim Health Care Foundation
- MVP Health Care
- 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.

2009 PILLARS

Each of the Pillars and their associated projects are developed based on recommendations from the advisory group and the broader health care community.

TRANSPARENCY

With a goal of sustaining a public dialogue to shape the health and health care system of this state, the Initiative led the charge to provide accurate information about the structure, behavior, outcomes, quality, and financing of the current system. As such, the Initiative independently and through partnerships published or collaborated on a series of reports including the NH Health Care Dashboard, NH Department of Insurance Acute Care Hospital Analysis, Patient Migration Analysis and New Hampshire & Maine Adverse Drug Events. While formerly a Pillar project with its own set of projects, moving forward in 2010 the Initiative will approach each project it engages in with the fundamental principles of transparency.

HEALTH INFORMATION TECHNOLOGY & EXCHANGE

The direct benefits of Health Information Technology (HIT) and Health Information Exchange (HIE) include: improved patient safety and health care quality, enhanced public health, health care cost reduction, access to care, and consumer engagement and empowerment. Pillar Project work in the domain of HIT/HIE includes the advancement of Electronic Prescribing in the State, resulting in a 660% increase in ePrescribers between January 2008 and August 2009. It additionally includes the development of an HIT/HIE Strategic Plan, delivered to Governor Lynch in January 2009 per Executive Order. Work against the HIT/HIE Strategic Plan is now being led by the NH Department of Health and Human Services.

2009–2010 PILLARS

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. This includes tobacco use, physical activity and nutrition, and unhealthy alcohol use. 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. 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.

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, Harvard Pilgrim Health Care and MVP Healthcare and NH Medicaid. The pilot sites include 9 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.

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 Payment Reform Model chosen is an Accountable Care Organization (ACO) Model, with statewide and ACO-specific global budget targets. The Model relies heavily on developing and leveraging a trusted, independent data entity that integrates all-payer claims with clinical records, for the purpose of transparently reporting against operations and to compare effectiveness of treatments, processes and protocols. The Pillar will define a set of multi-stakeholder, cross-carrier pilots by early 2010, for implementation by the end of 2010.

OTHER ACTIVITIES

RESEARCH AND ACTION PARTNERS

The Research and Action Partners is a group of stakeholders invested in restructuring the current healthcare delivery system in New Hampshire. Some members fulfill that role through data analysis and report dissemination. Other members use reports to advocate for public policy reform. Members meet bi-monthly to discuss their work in an effort to increase communication and collaboration as well as to raise awareness of projects taking place locally, regionally, and nationally. Meetings also aid in identifying gaps in research. The shared goal of the Research and Action Partners is to see actualized healthcare reform shaped through thoughtful and provocative discussion by informed and empowered New Hampshire citizens.

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 2009, it released the first consumer hospital report card for New Hampshire and its Vision for Health. NHPGH has benchmarked data from its members on cost, quality, and



preventive services. Its goals are to improve in each aforementioned area, jointly purchase services, and advocate for employers.

REGIONAL ALL PAYER HEALTHCARE INFORMATION COUNCIL (RAPHIC)

The Regional All-Payer Healthcare Information Council (www.raphic.org) was initially convened by Initiative and UNH staff. Its role is to promote all payer claims databases regionally and nationally and to promote standards for data collection, data dissemination, reporting, applications, and metadata. This work continues with support from the Institute for Health Policy.

Appendices

- A. **Potential Future Direction for the Health Promotion/Disease Prevention (HPDP) Workgroup**
- B. **NH Multi-Stakeholder Medical Home Pilot January 2010**
- C. **Payment Reform Pillar Accountable Care Organization Blueprint Proposal**
- D. **2008 Letter of Transmittal**

Appendix A

Potential Future Direction for the Health Promotion/Disease Prevention (HPDP) Workgroup

To measurably improve the health of a population requires the expertise, skills, and services of both the public health and medical care systems. In the past century, life expectancy in the U.S. has increased by 30 years due to the efforts of the public health and medical care systems. Unfortunately, much of this work has been completed with public health and medical care operating on two parallel tracks and competing for resources. As recognized by Institute of Medicine, to make a significant leap in optimizing population health, the activities of NH's public health and personal care systems must be wed. As such, the HPDPPG focused its year 2009 work on initiating a process to enhance current "bridge building" efforts in NH as well as catalyze new ones. The process led to the development of this work plan for 2010.

Proposed Mission:

To improve the health of people residing in NH by 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 work towards this mission, we seek to address the below questions:

1. Who are the system stakeholders that should be involved in a community initiative to integrate the work of the public health and healthcare sectors?
2. How do we effectively engage identified stakeholders in a community initiative to integrate the public health and health care sectors?
3. How do we effectively identify opportunities to integrate the work of the public health and healthcare sector within a community?
4. What criteria should be used to evaluate whether an integration activity is "successful"?
5. How do we sustain these integration changes?

Proposed Objectives

1. *Enhance/support the capacity of HPDP group members and others to act as agents of change in their organizations and community with respect to integrating the work of the public health and health care systems in NH.*
 - a. This objective seeks to address this group's desire to "set up a way of communicating best practices of integration."
 - b. In most cases, facilitates creation of a near-term concrete project deliverable/product.

2. *Develop a state level plan that outlines and prioritizes: a) the critical strategies necessary to catalyze and sustain the integration of the work of NH's health care and public health sectors and b) for each strategy a set of next steps.*
 - a. In essence, this objective seeks to answer the five questions identified from our previous meeting.
 - b. Having this plan will help to: 1) support existing organizational and community level activities to promote integration (like the ones illustrated at previous meetings) AND 2) initiate a comprehensive, coordinated, and deliberate state level strategy to support integration at the state system level and at the organization and community level.
 - c. The plan facilitates the ability to go after funding since it provides a cogent blueprint to support a state-wide shift toward integration.
3. *Assist with (as appropriate), identify, and incorporate lessons learned from local efforts within NH to promote the integration of the work of the public health and healthcare sectors.*
 - a. Activities under this objective seek to support Keene as a "lab" setting for integration work as well as simultaneously support other NH communities.
 - b. Activities and findings from the two previous objectives are incorporated.

Potential "Menu" of Activity Options for Each Objective

Objectives	Potential Activities
1. Enhance/Support the capacity of HPDP group members and others to act as agents of change in their organizations and community with respect to integrating the work of public health and health care sector in NH.	1. Incorporate into meetings, time for members to discuss integration activities/issues they are facing in their community or organization 2. Incorporate into meetings, time for members to bring up tools/resources/articles regarding integration 3. Create and distribute an email of tools and articles related to integration efforts 4. Create an interactive web-based medium to discuss integration activities/problem-solving 5. Develop a website describing what integration is and why it is important as well as tools, articles, and examples of integration from NH and elsewhere 6. Hold webinars or other types of training/education opportunities to facilitate awareness about the what and why's for integration 7. Develop a speaker's bureau on various topics related to integration 8. Create some sort of marketing piece (You-tube video, etc) to explain what integration is 9.

Objectives	Potential Activities
<p>2. Develop a state level plan that outlines and prioritizes: a) the critical strategies necessary to catalyst and sustain the integration of the work of the NH’s health care and public health sectors and b) for each strategy articulates a set of next steps.</p>	<p>1. Develop a written document that includes:</p> <ul style="list-style-type: none"> a. Answers to the five “future” questions b. Prioritized list of critical strategies c. For each strategy, a list of next steps is identified d. Identification of the five most critical and grant-fundable strategies to support integration efforts statewide <p>2. Research other state-wide, regional, or national efforts to promote integration and if they do exist develop a plan similar to what they did and do it in NH</p>
<p>3. Assist with (as appropriate) and identify lessons learned from local efforts within NH to promote the integration of the work of the public health and healthcare sectors.</p>	<p><i>Keene Laboratory</i> Discuss with Keene options for supporting them as a lab site for integration. Options could include:</p> <ul style="list-style-type: none"> 1. Acting as a sounding board for ideas being strategized by Keene 2. Being a pilot site for strategies identified under Objective 2 3. Offering tools that may help them with implementing an integration activity 4. Forwarding grant opportunities that may support their integration work <p><i>Supporting other local efforts</i></p> <ul style="list-style-type: none"> 5. Identifying and facilitating the connection between groups engaged in similar integration efforts 6. Communicating grant opportunities that could support integration-type projects or funders that are particularly interested in these project types 7. Developing briefs on integration efforts in NH and communicating them out statewide (through marketing channels developed in Obj. 1?) 8. Holding an annual or biannual summit featuring case studies/lessons learned from NH-focused integration efforts 9. Many activities from Obj 1 would also help to achieve Obj. 3 as well

Appendix B



NH Multi-Stakeholder Medical Home Pilot January 2010

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 Health Care as well as NH Medicaid. 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 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 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 the National Committee for Quality Assurance (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 January of 2010, 9 sites submitted for recognition, with seven sites recognized at Level 3 and two sites recognized at Level 1.

The pilot sites are:

Practice Name	City/Town
Ammonoosuc Community Health Services	Littleton, Whitefield, Franconia, Warren and Woodsville
Cheshire Medical Center Dartmouth Hitchcock Keene	Keene
Concord Hospital Family Health Center	Concord
Derry Medical Center	Derry

Elliot Family Medicine at Bedford Commons
Lamprey Health Care
Life Long Care
Mid-State Health Center
Westside Healthcare

Bedford
Newmarket
New London
Plymouth, Bristol
Franklin

The NH Multi-Stakeholder Medical Home Pilot Project further has:

- Been selected by the National Governor's Association Center for Best Practices to present on Multi-Stakeholder Medical Home development at their Medical Home Summit.
- Been selected by the National Association of State Health Plans as one of the Medicaid Medical Home pilots to receive resources and support from the Commonwealth Fund, the Center for Health System Change and CMS.
- Been engaged by our NH Purchasers Group on Health, representing 120,000 members in the state with solid geographic diversity and representation across all the participating carriers.
- Prompted a legislative rule requiring the inclusion of a Medical Home for the NH HealthFirst population, the first mandated small group benefit plan.

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.
- All of the sites have standing quality improvement meetings to review their program results.

The success of the pilot will be evaluated through a rigorous, multi-state design in partnership with Maine. 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 JANUARY 2010

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. Our ability to affect change is unique as we are comprised of stakeholders representing private and public payers, clinicians, delivery systems, state government and private citizens, and we have established positive precedents for advancing policy and programs through our work for and as the NH Citizens Health Initiative.

We will re-architect the payment system in New Hampshire to:

- Align payment, goals and incentives across the systems of care: primary, specialty, behavioral, ancillary and hospital;
- Align goals and incentives across employers, payers and systems of care;
- Address the unsustainable rate of growth in healthcare expenditures;
- Reward explicitly defined quality care;
- Reward excellence in the delivery of evidence-based clinical practices;
- Incent the use health information technology;
- Recognize administrative best practices and lean processes; and
- Serve as a model of transparency.

We propose the following pilot of reformed payment systems, to be launched with all of the major insurance carriers in New Hampshire (Anthem Blue Cross Blue Shield, CIGNA Health Care, Harvard Pilgrim Health Care, MVP Health Care) and NH Medicaid. The payment models piloted include Accountable Care Organizations, Global Budgeting and Episodes of Care:

PROPOSED PAYMENT MODEL:

ACCOUNTABLE CARE ORGANIZATION (GLOBAL BUDGET WITH SHARED SAVINGS)

A reformed payment system will be defined by a statewide and a set of community-level budget targets based on the current medical, behavioral health and pharmacy claims experience with a provision for moderate increases to account for inflation. Any savings incurred would be shared within the Accountable Care Organization, insurance carriers and, ultimately, the premium holders.

HIGH-LEVEL DEFINING CHARACTERISTICS

1. Accountable Care Organization (ACO) global budgets will be developed based on current experience.

2. Budgets will include the full range of services including inpatient, outpatient, therapies, pharmacy, behavioral health, etc. and organizations becoming ACO's will be responsible for managing the entire budget.
3. To be effective, payments and policy should span public and private carriers (Medicare, Medicaid, Commercial) and address the areas of the uninsured and uncompensated care.
4. ACO budgets will be driven by experience of care data, using attribution algorithms that take primary care providers and define the members for an area based on volume thresholds of services with those primary care providers. All other providers servicing those members will then fall within the organization.
5. Organizations functioning as an ACO will be required to create a formalized legal structure for owned, non-owned and contracted entities within the ACO.
6. The ACO will further have a governance structure that provides for the rationalization of payment and distribution of bonuses and gain sharing.
7. The organizations will be required to administer distribution of savings, and possible other, funds across affected provider entities.
8. Carrier contracts may remain in force and, if so, there will be a settlement back to the budget on a periodic basis.
9. An independent entity will be created and/or contracted with to provide cross-carrier and cross-provider analysis and budget development (see Independent Data Organization for further details).
10. The organizations will be required to work with the entity to obtain episode of care data for their community and for the data of other communities to use in benchmarking and management within the budget.
11. The independent entity will further provide data to the carriers on the budgets and episodes of care.
12. Episodes of care will be common statewide, with a common set of definitions for each episode.
13. Episode of care data will serve as a management tool to be used by the Accountable Organizations to compare and monitor cost, quality and models of best practices per each episode of care.

PROPOSED PILOT DESIGN:

There will be a competitive process for "application" to pilot. The pilot will be managed by a steering committee and will be facilitated with ongoing technical support provided to the participants. The technical support will be provided within the context of a formal learning collaborative for the purposes of continuous improvement and best practice translation.

The timeline and outline of the pilot is as follows:

- a. Process Announced February 2010
- b. Applications Solicited February 2010
- c. Presentations March 2010
- d. Pilot Sites Selected March 2010
- e. Funding Determined by March 2010
- f. Implementation Begins April 2010
- g. Pilot Runs for 5 Years in Stages:
 - i. Inception – 1 Year
 1. Define Technical, Analytic and Operational Requirements
 2. Identify and Solve for Legal and Regulatory Barriers
 3. Clarify Pilot Parameters
 4. Identify Risk Adjustment Methodology
 5. Establish Risk Adjusted Budgets
 6. Define Shared Savings & Incentive Payment Methodology
 7. Define Savings & Incentive Distribution Schedule
 8. Define Independent Data Organization
 9. Test Readiness of Pilot Participants
 10. Define Consumer Engagement
 11. Define & Pursue Medicare Engagement Strategy
 12. Define and Formalize Payment
 - ii. Transformation – 3 Years
 1. Implement Care Processes
 2. Participate in Learning Collaborative
 3. Implement Independent Data Organization
 4. Engage Consumers
 5. Report on Progress
 6. Perform & Adjust New Payments and Payment Systems
 7. Rapid PDSA Cycles
 - iii. Evaluation and Assessment – 1 Year
 1. Plan for Transition of Pilot – Expand or Retract
 - a. If Expand:
 - i. Determine Payment Transition for Current Pilot Participants
 - ii. Determine Expansion Plan
 - b. If Retract – Determine & Implement Plan
 2. Formal Communication and Publication of Results
 3. Translation of Methods and Results Including Creation of a Tool-Kit

INDEPENDENT DATA ORGANIZATION

As a supportive mechanism for the development and oversight of the Payment Reform Pilot, an Independent Data Organization will be created as follows:

GOALS

- Conduct transparent research that compares clinical outcomes, effectiveness and appropriateness of items, services and procedures that are used to prevent, diagnose or treat conditions or disorders¹;
- Provide accurate, unbiased, evidence-based information to inform treatment decisions²;
- Provide service and episode-level utilization and financial information to determine efficiency of care within and across providers and systems/Accountable Care Organizations (ACO);
- Publish ACO-level utilization and financial statistics on preference and supply-sensitive care;
- Produce statewide, regional and ACO-level summary total budget and detail type of service financial data;
- Delivery operational quality and efficiency of care reporting;
- Conduct research and produce operational reporting that is longitudinal and spans all public and private carriers and includes the uninsured.

Proposed PLAN

To develop an independent analytic organization that:

1. Leverages the all-payer, Medicaid and Medicare data sets and methodological and technical experience of the NH Institute for Health Policy and Practice, The Dartmouth Institute and other research entities.
2. Supports payment reform and system transformation.
3. Provides a predictive modeling vehicle for commercial members aging into the Medicare population.
4. Produces comparative effectiveness research that advises evidence-based-medicine protocols.
5. Conducts ongoing research and policy analysis.

¹*Text of the Recovery Act Related to Comparative Effectiveness Funding.* March 2009.

[http:// www.dhhs.gov/recovery/programs/cer/recoveryacttext.htm](http://www.dhhs.gov/recovery/programs/cer/recoveryacttext.htm)

²*Better Health Through Information – Comparative Effectiveness Research Will Help Deliver Better Medical Care.* Center for American Progress. Accessed October 2009.

http://www.americanprogress.org/issues/2009/09/cer_brief.html

Appendix D

2008 letter of Transmittal

Sent to:

Sylvia Larsen: President of the NH Senate

Margaret W. Hassan: Chair of Senate Commerce, Labor and Consumer Protection Committee

Kathleen Sgambati: Chair of Senate Health and Human Services Committee

Terie Norelli: Speaker of the House of Representatives

Tara Reardon: Chair of House Commerce Committee

Cindy Rosenwald: Chair of House Health, Human Services and Elderly Affairs Committee

December 16, 2008

From: Citizens Health Initiative Executive Committee

Re: Senate Bill 450

In accordance with Senate Bill 450, the New Hampshire Citizens Health Initiative is required to provide an annual summary to the general court each year. Our report to you is enclosed. In addition to our summary, the Executive Committee of the Citizens Health Initiative offers to the Legislature six overarching areas for policy consideration. These recommendations are based upon a review of the Initiative's activities to date, preparation of our upcoming 2009 efforts, a review and assessment of the work of other policy and research organizations, and an examination of the study areas the Legislature has undertaken in regard to health and health care. Our six areas for policy consideration are central to our goal of a health and health care system that assures a healthy population and creates an effective system of care.

Legislative Recommendations

Recommendation One: Financial Transparency

The Executive Committee recommends that the Legislature consider shaping legislation that would allow the Department of Health and Human Services and the Department of Insurance to recommend the nature and extent of data needed in order to support transparency of our health care system. The data needs to be of the highest validity, consistently measurable, and actionable by policy makers and healthcare system stakeholders. Such data collected and reported shall also meet the standards of patient privacy and confidentiality.

The Initiative's goal is to shape our system through an active and public dialogue. No meaningful dialogue can take place without access to timely, accurate, robust and full information regarding the system of care and the health of our population. We have seen an increase in the type and the quality of the information that is available for this work. Included in that work is:

1. The many reports on the finance and structure of the health care system published by the New Hampshire Center for Public Policy Studies.
2. The Reports and Information provided by the Department of Insurance at their web site based on their analysis of Supplemental Reports by New Hampshire insurance carriers, as well as reports derived from the Comprehensive Health Information System's all payer claims data.

3. Studies generated by the Initiative that reveal: patient geographic movement to receive care within and outside their local health region (December 2008), hospital costs incurred as a result of adverse drug events (January 2009), as well as other gathered material available through our website at www.steppingupnh.org.
4. Recent reports undertaken by Nancy Kane from Harvard, on behalf of the Department of Health and Human Services, that examined the financial health and condition of our Hospitals and Community Health Centers.

In spite of the multitude of healthcare system transparency efforts to date, there is still a great deal of information that is needed if our state is to attempt to shape a healthcare system that uses resources wisely. As an example, there is a great deal of knowledge about the \$3.1B that comprises the hospital share of our \$8.4B annual health care spending, but very little is known about the \$2.1B comprising physician services, the \$990M comprising prescription drugs, and other sectors.

Recommendation Two: System Financial Stability

The Executive Committee recommends that the Legislature consider comprehensive legislation that is directed at System Financial Stability and Balance. While the major institutional providers of care are by and large not for profit and the state is the entity that grants that status, we do not as a state consider how the system made up of those not for profits can be balanced in a way that strengthens the system as a whole rather than individual parts. The Legislature should consider charging the Attorney General, the Department of Health and Human Services and the Department of Insurance to study and recommend action that would help support and sustain a strong and balanced state-wide system.

It is the view of the Executive Committee that the system of care that we provide to our citizens must be viewed from a statewide perspective. Currently, as we review the accessibility to certain services (child psychiatry, dermatology, and obstetric care) there are significant geographic variances in availability. In addition, through work that has been done by the University of New Hampshire, the New Hampshire Hospital Association, and by the Kane Group we can see that the financial strength of our southern tier hospitals is far greater than the northern tier, and our Community Health Centers are very fragile. This financial imbalance affects the ability to recruit and retain professionals at all levels, as well as to acquire the type of technology that can help improve administrative efficiencies and healthcare quality.

Recommendation Three: State Plans and Priorities

The Executive Committee recommends that the Legislature consider comprehensive legislation that is directed at establishing a STRATEGIC PLAN FOR NH HEALTH CARE that sets clear expectations and priorities for the shape of New Hampshire's health and health care system. The Legislature should consider charging the Department of Health and Human Services and the Department of Insurance to review the work of other regional and similar size states that have undertaken this task and recommend a path toward such a plan that would assure effectiveness as well as continuation over the long term.

This State has on numerous occasions, most recently in May 1998, undertaken efforts to create a comprehensive State Health Plan, or in the absence of said plan, a methodology to establish clear guidelines for system change. There is an old saying that "If you don't know where you are going any path will get you there" and it is the observation of the Executive Committee that we do not as a state have a

clear and common path to a healthy population with a rational system of care. While we believe that the Initiative and many others have taken significant, effective, and constructive steps toward a better system The Initiative believes there is much left to do. For example, ePrescribing and the use of Electronic Medical Records and Health Information Technology and Exchange would greatly improve the efficiency, quality, and effectiveness of care. The acquisition of some of this technology is expensive. Yet as a state, this acquisition has not been made a priority even though the state has approved nearly a \$1B of capital expansion projects in the last decade via the Certificate of Need process. Further, while Certificate of Need is required to replace certain expensive medical equipment and acquire new medical services, providers are able to terminate services viewed as unprofitable without a public dialogue, which may still be needed.

Recommendation Four: Reimbursement Reform

The Executive Committee recommends that the Legislature consider the establishment of an intensive review of innovative and promising reimbursement changes that will focus on rewarding and expanding primary and preventive care, best practices, and coordinated care. The Legislature and the Executive Branch should examine areas where Medicare is modifying its program (to reward ePrescribing and Medical Home) and have DHHS pursue those same modifications within the Medicaid program, and Department of Administrative Services for the State Employee and Retiree Health Benefit Program. Further the NH Department of Insurance should explore how similar modifications may be encouraged to occur in commercial plans offerings.

Our current healthcare system is driven almost exclusively by fee-for-service contractual arrangements. This results in businesses and public purchasers to reimburse for tests, visits, procedures, and prescriptions versus health and wellness. What employers and public purchasers truly want for their employees or clients are improved health, better outcomes, return to work, productivity, informed consumers, efficiency, and safety. In addition, New Hampshire faces a critical shortage of primary care providers and services, yet these are the services that we pay the least for in our system. Similar research by Elliott Fischer, MD and his colleagues at Dartmouth show that we pay a great deal for highly specialized services that often do not prove themselves to be cost effective.

A number of promising pilot projects are taking place in the country and in our state that are beginning to examine new models of care that promote primary care and reward quality and outcomes rather than volume of work. These include:

1. The Dartmouth - CIGNA Medical Home Pilot
2. The Dartmouth – CMS Physician Group Practice Demonstration Project
3. The NH Multi-Stakeholder Medical Home Pilot
4. Medicaid Medical Home Pilot
5. Benefit Structure work done by NHID in the HealthFirst Product

Recommendation Five: Primary Care

The executive committee recommends that the legislature support the expansion of the state's nursing education and training capacity at both the associate and baccalaureate levels. This could include the expansion of state nursing education programs to the university systems at the Plymouth and Keene campuses, as well as expanding the advanced nurse practitioner programs that could help to address pressing primary care health service needs within the state.

The Executive Committee reiterates the importance of our report to the Legislature of March 2008 on Primary Care and the crisis this state faces in regard to this critical function of our healthcare system. The Workforce Committee of the NH Legislature created by HB 1615 has been presented with the primary care workforce needs, reviewed the report and recommendations, and will bring back their recommendations to the Legislature on the need to increase funding for the state loan repayment program and the recruitment center as well as expand the program through a public-private partnership. At the same time, there is a pressing need to expand our capacity to educate and train our N.H. nursing workforce. At the present time there is an unmet demand for an expanded state nursing workforce. There is a ample supply of qualified nursing candidates, but a significant limitation in out state's capacity to educate and train them.

Recommendation Six: Health Information Technology and Exchange

The Executive Committee recommends that the Legislature provide a mechanism for funding the following activities: support within the NH Department of Health and Human Services to provide a convening function of healthcare stakeholders to ensure that the recommendations of the report to the Governor are implemented; a bi-annual survey and assessment process of HIT and HIE technology deployment with an associated gap analysis; development of a Resource Center to assist the healthcare community with the purchase and implement technology, develop and manage a revolving loan fund mechanism, develop and manage a grants program, leverage Federal dollars for technology deployment, and provide education and consulting outreach. The Legislature should examine how its purchasing activities for Medicaid and the State Employee Health Plan may be used to further the advancement of HIT and HIE activities in the state. This may also involve Federal matching or grant funding. The Legislature should examine opportunities for enabling legislation to support HIT and HIE.

The acquisition and deployment of Health Information Technology (HIT) and Health Information Exchange (HIE) throughout the healthcare system in New Hampshire offers a unique opportunity to make substantial progress in improving the health of our citizens. The direct benefits include: improved patient safety and healthcare quality, enhanced public health, healthcare cost reduction, access to care, and consumer engagement and empowerment. It is vitally important that the State of New Hampshire have a strategic vision for both the implementation of information technology and a system of connectivity that will provide for the free exchange of information among providers throughout the state. HIT and HIE is a core pillar of our healthcare system.

The HIT and HIE Working Group will deliver its final report to Governor Lynch on January 1, 2009. This report will be posted to www.stepsingupnh.org. The Executive Committee recognizes the importance of HIT and HIE as a core pillar of our healthcare system.



Finally, the Executive Committee provides assurance to the Legislature, that through the new structure of the Initiative moving forward, we stand ready to work with the Legislature, the Executive Branch, and all of the healthcare system stakeholders who share the Initiative's goals of a healthy population and an effective system of care.