Summary of the 2008 - 2013 Consumer Leadership Conference Series

Including Findings of the *"Healing Spirits of Kilauea"*

December 4-6, 2013 ~ Hilo, Hawaii

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Background

On December 4-6, 2013, Bay Clinic, Inc. of Hilo, Hawaii hosted the "Healing Spirits of Kilauea" consumer leadership conference at the Kilauea Army Rest Camp located in the town of Volcano on the Big Island of Hawaii. The conference was the last in a series of six leadership conferences over six years that focused on engaging Federally Qualified Health Centers (FQHC) consumers in the development of healthcare policy in the current healthcare transformation environment. The six conferences are listed below.

Journey to an Island Healthcare Home
December 1-3, 2008 ~ Ko Olina, Hawaii
Hosted by Waianae Coast Comprehensive Health Center

***The Rising Stars of Healthcare Reform (Consumer Board Members*)**
August 23-25, 2010 ~ Imiloa Astronomy Center
Hosted by Bay Clinic, Inc.

The Mission: Consumer Leadership in Healthcare Transformation
August 25-26, 2011 ~ San Ysidro, California
Hosted by San Ysidro Health Center

The Journey Continues: Consumer Leadership in Healthcare Transformation – Finding the Value & Sharing the Savings
March 19, 2012 ~ Washington, D.C.
(Conducted as a component of AAPCHO's 25th Anniversary Leadership Conference)

Journey Back to Your Island Healthcare Home
November 28-30, 2012 ~ Ko Olina, Hawaii
Hosted by Waianae Coast Comprehensive Health Center

Healing Spirits of Kilauea
December 4-6, 2013 ~ Volcano, Hawaii
Hosted by Bay Clinic, Inc.

The 2008 Consumer Leadership Conference was organized as a response to the early initiatives in "pay for performance" and the desire by a founding group of health center leaders to engage consumers from low-income communities in this process. At the time of the first conference in December 2008, the NCQA healthcare home standards were newly formulated and rather narrow in focus when applied to the high-poverty, underserved populations served by community health centers. The "Healing Spirits of Kilauea" conference held in Volcano, Hawaii in December 2013 concluded this series.

This report is intended to identify key findings that evolved over time and were adopted by FQHC consumer attendees during their consumer caucuses. Key findings carried over from previous conferences are also identified in this report as "Reaffirmation of Previous Conference Findings" along with new findings made by Volcano conference attendees.

Mahalo **("Thank you")**

First and foremost, we wish to recognize the late Senator Daniel K. Inouye, who was responsible for launching the federal funding for these conferences. Senator Inouye spent his nearly fifty years in the Senate advocating for community health centers and supporting their vital role in meeting the needs of the medically underserved. He will always be greatly missed.

We wish to acknowledge the founding community health centers; Asian Health Services, Bay Clinic, Inc., Northeast Medical Services, and Waianae Coast Comprehensive Health Center. Their board members and staff saw the need for leadership conferences that would engage consumers from low income communities in "pay for performance" and other healthcare transformation initiatives.

Support and sponsorship was also provided over the years by several organizations including the National Association of Community Health Centers (NACHC), the Association of Asian Pacific Community Health Organizations (AAPCHO), the Hawaii Primary Care Association, AlohaCare and UnitedHealthcare.

The conferences were fortunate to attract accomplished keynote speakers and panelists who generously shared their knowledge, experience and insights. The list includes representatives from a wide range of healthcare organizations including community health centers, national nonprofit organizations, private industry and government.

Featured Speakers *(partial list)*
Ashish Abraham, MD – President and Co-Founder, Altruista Health
Melinda Abrams, MS – Assistant Vice President, The Commonwealth Fund
Bill Hagan, Chief Growth Officer – UnitedHealth Group (*Former President, UnitedHealthcare West Region & Senior VP National Clinic Operations, Community and State)*
Calvin C. J. Sia, MD, FAAP – Retired Pediatrician and Clinical Professor of Pediatrics at University of Hawaii School of Medicine *(Considered the "grandfather" of the medical home concept of care.)*
Douglas Jutte, MD – Assistant Adjunct Professor - Division of Community Health and Human Development, School of Public Health, University of California, Berkeley
Herb Schultz, Regional Director, Office of Governmental Affairs, U.S. Department of Health and Human Services
Joe Gallegos – Regional Coordinator, NACHC
Kauila Clark – Chair of the National Association of Community Health Services (2011-2013) 2nd Vice Chair – Waianae Coast Comprehensive Health Center Board of Directors
Karen DeSalvo, MD, MPH, MSc – Current Acting Assistant Secretary for Health and National Coordinator for Health Information Technology, U.S. Department of Health and Human Services *(Former City of New Orleans Health Commissioner and Senior Health Policy Advisor and Associate Dean – Tulane University Medical School)*
Marcie Zakheim – Partner, Feldesman Tucker Leifer Fidell
Robert Tagalicod – Director, Office of E-Health Standards – Centers for Medicare and Medicaid Services (CMS)
Todd Gilmore, PhD – Professor, University of California at San Diego / Director, Masters of Advanced Studies, Leadership in Health Care Organizations, Acting Chief - Division of Health Policy
Sarah Scholle, DrPH, MPH – Assistant Vice President for Research and Analysis, National Committee for Quality Assurance (NCQA)
Tom Tsang, MD, MPH – Medical Director, Meaningful Use Division, Office of Provider Adoption Support, Office of the National Coordinator for Health Information Technology

Featured Panelists *(partial list)*		
Anita Monoian	Past Chair	NACHC
Anthony R. Guerrero, Jr.	Board Chair	Waianae Coast Comprehensive Health Center *(Retired First Hawaiian Bank Vice Chair)*
Ben Pettus	CEO	Koʻolauloa Community Health and Wellness Center
C. Glenn Dudas, MD	Medical Director	Bay Clinic, Inc.
Christina Lee, MD	Medical Director	Waimanalo Health Center
Christine Sakuda	CEO (former)	Hawaii Health Information Exchange
David Goodman, MD	Chief Medical Officer	First Vitals Health and Wellness
Denise Esper	Chief Revenue Officer	Lone Star Circle of Care
Dew-Anne langcaon	Co-founder and CEO	Hoʻokele Health
Ed Martinez	CEO	San Ysidro Health Center
Ed Phippen	Consultant	Robert Wood Johnson Foundation
Emmanuel Kintu	Board Chair	Hawaii Primary Care Association
Fred Fortin, MD	Senior Vice President	HMSA
Gary Cloud	Assistant Provost, Associate Dean for Financial Resources	A.T. Still University
Gervean Williams	Director	NACHC Community Health Center Finance and Operations, Training / Technical Assistance Dept.
Harold Wallace	CEO	Bay Clinic, Inc.
Heather Law	Research Association	AAPCHO
Hiroshi Nakano	Board President	International Community Health Services
James W. Hunt, Jr.	President and CEO	Massachusetts League of Community Health Centers
Jeff Caballero	Executive Director	AAPCHO
John McComas	CEO	AlohaCare
John Williams	Chief Information Officer	Waianae Coast Comprehensive Health Center
Joyce O'Brien	Executive Vice President	Waianae Coast Comprehensive Health Center
Julie Bodën Schmidt	Associate Vice President	NACHC – Training & Technical Assistance Dept.
Ken Welch	CEO	MediSense
Lyndsey A. Tyra	VP of Corporate Services	Lone Star Circle of Care
Mary Oneha	CEO	Waimanalo Health Center
Mike Schnake	Partner, Consultant	BKD, LLP
Mike Wurtsmith	Chair	NACHC Consumer Committee
Nolan Namba	Director of Strategic and Business Development	AlohaCare
Pamela Byrnes	Senior Consultant	John Snow, Inc. (former Director of Health Center Growth and Development Program
Rachel Wolfe	Transitions of Care Program Mgr.	Salud Family Health Centers
Richard Bettini	CEO	Waianae Coast Comprehensive Health Center
Richard Taffe	Executive Director	West Hawaii Community Health Center
Robert Hirokawa	CEO	Hawaii Primary Care Association
Rosy Chang-Weir	Director of Research	AAPCHO
Roy LaCroix	CEO	PTSA of Washington
Samir Patel, MD	HIT Developer	Kaiser Permanente
Sherry Hirota	CEO	Asian Health Services
Stephen Bradley, MD	Medical Director	Waianae Coast Comprehensive Health Center
Susan Hunt	CEO	Hamakua Health Center
Vija Sehgal, MD	Chief Quality Officer	Waianae Coast Comprehensive Health Center
Warren Wong, MD	Geriatrician and Consultant	Kaiser Medicare Transformation Team
Winston F. Wong, MD	Medical Director	Kaiser Permanente
William Shanks	CEO	Hawaii Patient Accounting Services

The success and value of these conferences is directly related to the hundreds of dedicated community health center consumer board members and staff who attended them over the years. Their commitment to the vision of creating a healthcare home for themselves, their families and neighbors is an example of the power that a dedicated consumer board has to make real change. That commitment clearly does not end with this conference series and will only grow stronger. The following is a list of the health centers represented at the conferences:

Name	Location
Adams County Health Center	Council, ID
Asian Health Services	Oakland, CA
Asian Human Services Family Health Center	Chicago, IL
Bay Clinic	Hilo, HI
Community Health Centers Inc.	Oklahoma City, OK
Community Health Centers of the Central Coast	Nipomo, CA
Community Health of Central Washington	Yakima, WA
Delaware Valley Community Health Center	Philadelphia, PA
East Boston Neighborhood Health Center	East Boston, MA
Golden Valley Health Centers	Merced, CA
Hamakua Health Center	Hamakua, HI
International Community Health Services	Seattle, WA
Kalihi-Palama Health Center	Honolulu, HI
Koolauloa Community Health and Wellness Center	Hauula, HI
La Maestra Community Health Centers	San Diego, CA
Lanai Community Health Center	Lanai City, HI
Lone Star Circle of Care	Georgetown, TX
Madison County Community Health Center, Inc.	Anderson, IN
Molokai Community Health Center	Kaunakakai, HI
North East Medical Services	San Francisco, CA
Open Door Family Medical Centers, Inc.	Ossining, NY
Pacific Islander Health Partnership	Huntington Beach, CA
Peninsula Community Health Services of Alaska	Soldotna, AK
PTSO of Washington	Seattle, WA
Salud Family Health Centers	Fort Lupton, CO
South Cove Community Health Center	Boston, MA
Tri-City Health Center	Fremont, CA
Wahiawa Center for Community Health	Wahiawa, HI
Waianae Coast Comprehensive Health Center	Waianae, HI
Waikiki Health Center	Waikiki, HI
Waimanalo Health Center	Waimanalo, HI
West Hawaii Community Health Center	Kailua-Kona, HI

The Healing Spirits of Kilauea

The December 2013 conference was limited to 100 participants and was intended to build on the findings of the November 28 – 30, 2012 "Journey Back to Your Island Healthcare Home" held in Ko Olina, Hawaii. Participants included both consumers and healthcare professionals and represented 13 community health centers, the Hawaii Primary Care Association, AAPCHO and several health plans. Attendees were asked to respond to the specific recommendations of the 2012 report (available online at www.aharo.net) and to discuss concepts that would further the potential of health centers to succeed under payment reform and the emerging healthcare home environment.

The conference agenda (Appendix A) was divided into technical assistance related to the roles and responsibilities of FQHC board members, keynote presenters focusing on key healthcare transformation issues, and breakout sessions intended to engage health centers in policy development. Keynote speakers and areas of expertise included the following:

Value Based Community Development
Dr. Doug Jutte, Assistant Adjunct Professor, Division of Community Health & Human Development, School of Public Health, University of California, Berkeley

The Important Role of Consumers in Healthcare Transformation
Kauila Clark, 2nd Vice Chair, Waianae Coast Comprehensive Health Center and outgoing Chair of the National Association of Community Health Centers

Risk Adjustment
Todd Gilmer, Professor of Health Economics, Division of Health Policy, Department of Family and Preventive Medicine, University of California - San Diego

Health Care Reform: Challenges and Opportunities for Community Health Centers
Ignatius Bau, Health Policy Consultant

(Brief biographies for these and other speakers are provided in Appendix B.)

Breakout Group Reports

The series of conferences used consumer-driven games and breakout sessions to define supplemental standards that were not emphasized in national models but were relevant to healthcare homes in medically underserved communities. These supplemental standards were identified as cultural proficiency, community engagement, and job creation/economic development.

The 360° evaluation of health plans scoring concept was also developed and concepts of shared savings and virtual accountable care organizations (ACOs) were discussed. These concepts became the foundation for the AHARO Payment Reform Model (www.AHARO.net) which is now a part of several Medicaid managed care contracts in Hawaii.

The task for attendees of the "Healing Spirits of Kilauea" conference was to produce the framework for this final report on the series through the following four breakout groups.

Group #1: Supplemental Healthcare Home Standards

Healthcare homes, like beachfront homes, are not all created equal and…

…the most reliable predictor of population health is the zip code lived in.

Group #1 - Reaffirmation of Previous Conference Findings

Group #1 reaffirmed the supplemental standards that healthcare homes located in Medically Underserved Areas (MUAs) should aspire to attain. Previous leadership conferences had established the following four areas for which standards need to be formally adopted that relate to proficiencies valued by healthcare homes in high-poverty communities:

Care Enabling	***Cultural Proficiency***	***Community Involvement***	***Workforce & Economic Development***
Patients of healthcare homes in medically underserved areas often face access barriers that exceed those in less challenged communities. There must be standards for evaluating the effectiveness of reducing access barriers.	Healthcare homes in low-income communities often serve a cultural subset of the population. There must be standards for measuring the effectiveness of health-care homes in addressing cultural norms.	There must be standards for the level of community engagement healthcare homes afford their consumers and the level to which they engage a network of agencies within their community.	As healthcare homes in high-poverty communities are often one of the largest employers, they must be accountable to the community they are active in, creating job opportunities and providing job training for its service area residents.

Supplemental Healthcare Home Standards scoring templates were developed for each of these four areas that provide an effective means of measuring a healthcare home's level of accomplishment (see www.AHARO.net). The following lists the measurement criteria for each area.

Care Enabling Services	
The practice evaluates patients' abilities to receive services and has systems in place to overcome potential access barriers through the following:	
1.	Assesses on an ongoing basis the self-reported and actual access barriers experienced by patients in the PCMH.
2.	Has appropriate programs, staffing, and resources to provide these care enabling services.
3.	Offers patients the eight basic enabling services identified by AAPCHO and NACHC.
4.	Codes and tracks these enabling services on charge tags or electronic records.
5.	Measures the impact of enabling services on performance metrics.
6.	Develops and utilizes enabling protocols on electronic health record templates.
7.	Has an established patient and family feedback system for appropriateness, effectiveness and improvement of care enabling services

Cultural Proficiency	
The practice addresses the cultural background of consumers in its policies, procedures and practices through the following:	
1.	Assesses the diversity of consumers and trains staff, providers, and others about the diversity.
2.	Has a panel of cultural advisors engaged in developing and evaluating cultural practices.
3.	Has an established plan for cultural sensitivity training and professional development for staff.
4.	Providers follow culturally specific protocols based on patient background and demographics.
5.	Buildings and facilities that reflect the patient population's culture and background (e.g. male family planning clinic design to make men feel welcome).
6.	Provides and/or promotes complementary and/or alternative healing practices in alignment with primary and preventive health services.

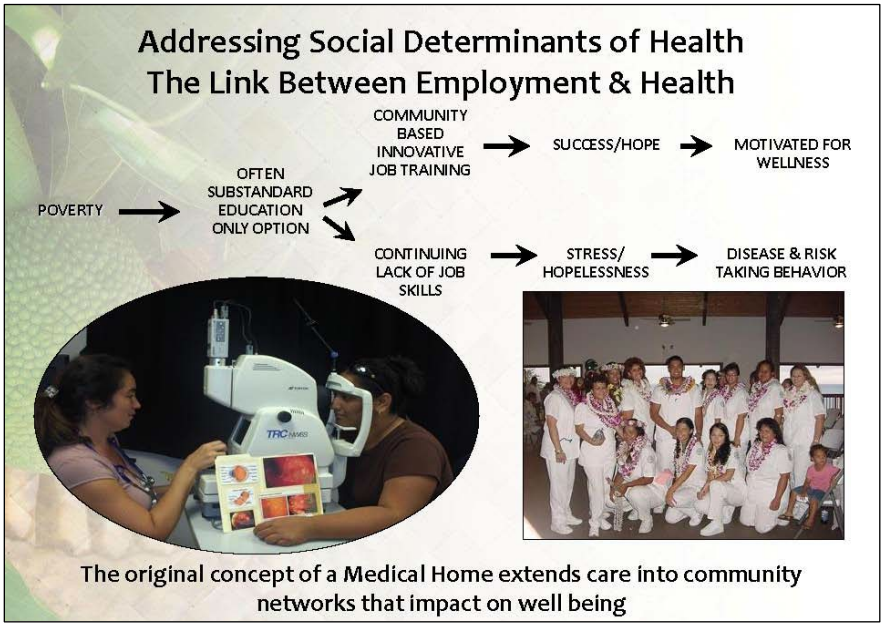
Community Involvement	
The practice is an integrated part of the community, encouraging participation and elevating the level of health education and organization through the following:	
1.	Has a panel of patients or Consumer Board that reviews and approves an annual plan that identifies health care needs and disparities within the community; establishes an action plan to address these issues.
2.	Reviews adequate data to measure performance to promote access, quality, cost effectiveness and makes recommendations for consideration.
3.	Has a systematic process in place to measure patient satisfaction and performs any remedial actions deemed necessary.
4.	Has a volunteer program that involves community members and various activities to promote a healthier community.
5.	Conducts outreach with community participation through health fairs, etc.
6.	Engages in Community Based Participatory Research with patients trained as the investigator (PI).
7.	Has patients sitting on internal committees, (for example, Quality Improvement Committee or Cultural Competency Committee.)

Workforce and Economic Development	
The practice is a center of economic opportunity for the community through the following:	
1.	Has a protocol in place to refer unemployed patients to job training activities within the service area.
2.	Offers an "on the job" training program for workers to improve job competencies that are aligned with healthcare transformation needs.
3.	Has a plan in place to promote a continuum of job training activities for service area residents that ranges from entry level careers to professional education with preparatory or "pipeline" services identified.
4.	Offers programs to support staff development activities, e.g. tuition reimbursement, flexible scheduling, job-sharing, telecommuting, and other training programs.
5.	Programs to attract workers from other industries with transferable skills to work at a healthcare home.
6.	Programs to share labor resources with other healthcare homes as needed.
7.	Acts as a training site for at least 3 different health care disciplines, ex. medical assistants, nurses, nurse practitioners, physician's assistants, social workers, medical students, psychology interns, or medical or dental residents.

The following pages include recommendations from conference attendees dating back 5-10 years. While considerable time has passed, some of these findings continue to be relevant and serve as the foundation for a continued dialogue.

Group #1 - New Conclusions/Recommendations from Volcano Attendees

1. Payment reform can be a catalyst for economic development in our communities. Shared savings and economic development as a standard for an MUA healthcare home can be factors.
2. To best understand what a community needs, conduct a community needs assessment that includes focus groups comprised of community organizations and consumers.
3. As a component of the healthcare home, build institutional partnerships within your community, including relationships with schools.
4. To address cultural issues, we must better understand cultural issues such as language and values that affect access to care. Communications is the key in culturally diverse areas. Word-of-mouth (referred to as "the coconut wireless" in Hawaii) plays a very important role in the communication process.
5. Healthcare homes in high poverty communities need to identify and foster homegrown leadership early on so their skills can be developed. Careers education should begin no later than kindergarten level and continue lifelong. Including career education for mothers participating in pre-natal counseling should be considered.
6. Community integration should include partnerships with employers and developers that may want to invest in a wellness environment and community economic development (as described by Dr. Jutte in his presentation, "Purpose Built Communities"). Workforce development fairs and job counseling should be brought to health center sites.
7. Case management for behavioral health services and integration of behavioral health into primary care is essential. Care coordination should include a link to behavioral health.
8. Health centers should use Affordable Care Act (ACA) outreach opportunities to identify additional consumer needs and help to coordinate those services.



Group #2: Community Applications of Health Information Technology

Group #2 - Reaffirmation of Previous Conference Findings

1. Care coordination and health information technology (HIT) must be developed by each community health center as key functions necessary under health information technology.

2. Every health center should develop an HIT/care coordination work plan and determine what scope of this functionality will be performed directly by the health center, by a network, or by a health care payer.

3. Databases administered by health centers can play an essential role in identifying preventable costs in health care and proving the value health centers provide in addressing those costs.

4. The most significant health care costs are associated with hospitalizations. Thus preventable costs need to address preventing hospitalizations, reducing length of stay and preventing re-hospitalizations. Health centers need to take the initiative to co-manage hospital care transitions by hiring appropriate care coordinating staff who are involved in discharge planning to the community outpatient setting. Best practices templates need to include advance health care directives.

5. Inappropriate emergency room (ER) visits must be identified and monitored. The key to decrease inappropriate ER visits lies with improving access to primary care services. Hospital-based ER services and perhaps even hospital admissions could be reduced if primary care providers extended their hours into the late evenings, weekends and holidays. Health centers need to be incentivized to develop after-hour acute care services. Nurse advice lines could provide information to patients to prevent them from seeking high cost emergency room care. Electronic-based visits should also be explored.

6. Immediate, accurate data exchange between hospitals and community health centers is fundamental in the reduction of preventable costs. Community health centers ought to initiate the development of direct relationships with hospitals, not waiting for health plans to facilitate the process.

7. Patients with behavioral health needs as well as those with chronic pain diagnoses are key population groups served by community health centers. Their needs must be appropriately addressed through an integrated approach in order to avoid inappropriate emergency room utilization. Community based pain management services must be developed and supported.

8. Patient navigators, health educators and wellness coaches are key personnel in reducing preventable costs. Lifestyle education and community-based campaigns to address chronic disease prevention needs to be supported through extended healthcare homes. Patients can be empowered to play an active role in their own health care with home-based technology.

9. Health plans have to support investments in HIT and care coordination at the community health center and patient centered healthcare home level.

10. Medications, radiology and laboratory diagnostic services are another significant health care cost driver. Data exchange can be used to avoid duplication in these services between hospitals, emergency rooms, specialists and primary care providers. The use of clinical pharmacists for patient education in medication adherence and medication reconciliation could be incentivized. The utilization of 'lock-down' restricted recipient programs to avoid narcotic abuse would also curb costs.

11. To effectively address preventable costs associated with highly complex patients, community health centers must develop new strategies for integrating behavioral health and primary care services. Improved methods for diagnosing the Serious Mentally Ill (SMI) populations and the assignment of these patients to the appropriate level of care need to be developed.

12. Models of care coordination should be: a) available directly through those community health centers that choose to offer these services; b) offered by care coordinators employed directly by these health centers; and c) supported by health care plans.

13. Care coordination and related services ought to be provided through one set of community-based care coordinators. Duplication of effort including having care coordinators from all health plans at a single site must be avoided.

14. State Health Exchanges, including the Hawaii Health Connector, need to provide information on the level of care coordination services and means of delivery of such services offered by competing health plans.

15. Board of directors of community health centers should be regularly updated on the status of care coordination at the facilities they oversee. Board member advocacy for care coordination services is fundamental.

16. Standardized templates should be developed for care coordination in cooperation with hospitals that specify responsibilities and procedures assigned to each group.

17. Care coordination should be provided within a cultural context. Translation services must be provided. Patient satisfaction needs to be measured in this area.

18. A major emphasis must be placed on transitions of care from hospital to the community setting.

19. Health Information Technology should be considered an essential component of healthcare transformation for every community health center. An HIT plan needs to be developed by each health center and presented to their boards.

20. Key components of an HIT plan for health centers must include practice management, electronic health records, patient and care management systems, data exchange software, a patient portal and predictive analytics identifying families with potential preventable costs.

21. Customized HIT systems that some health centers should consider include backend patient navigation software, patient engagement and utilization software, public and private kiosks to engage patients and patient information on encrypted devices.

22. Data exchange should occur at the point of care and be linked to care coordination programs at the health center level.

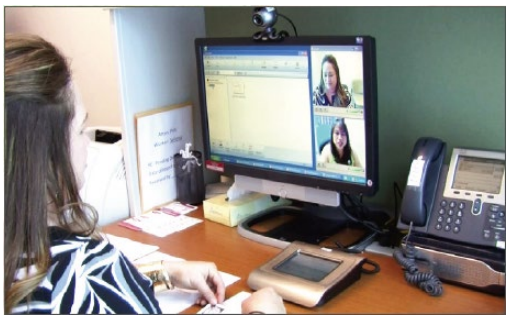
23. Risk adjustment systems identifying medical complexity and social determinants need to be improved and adopted throughout the delivery system in order to make performance based incentives fair.

24. Health center-owned management services organizations could be developed to help health centers develop self-sufficient HIT capability.

25. HIT system development should be based on collaboration; however when health center networks have advanced HIT capabilities, their efforts should be built upon by state HIT system developers in order to avoid duplication.

New Healthcare Technology will lead to the measurement of the relative value healthcare providers offer payers and patients.

(Reimbursement will then be associated with this measured value.)



Key Questions:
Will we be fairly valued?
Who picks the measures?
Who shares the savings?

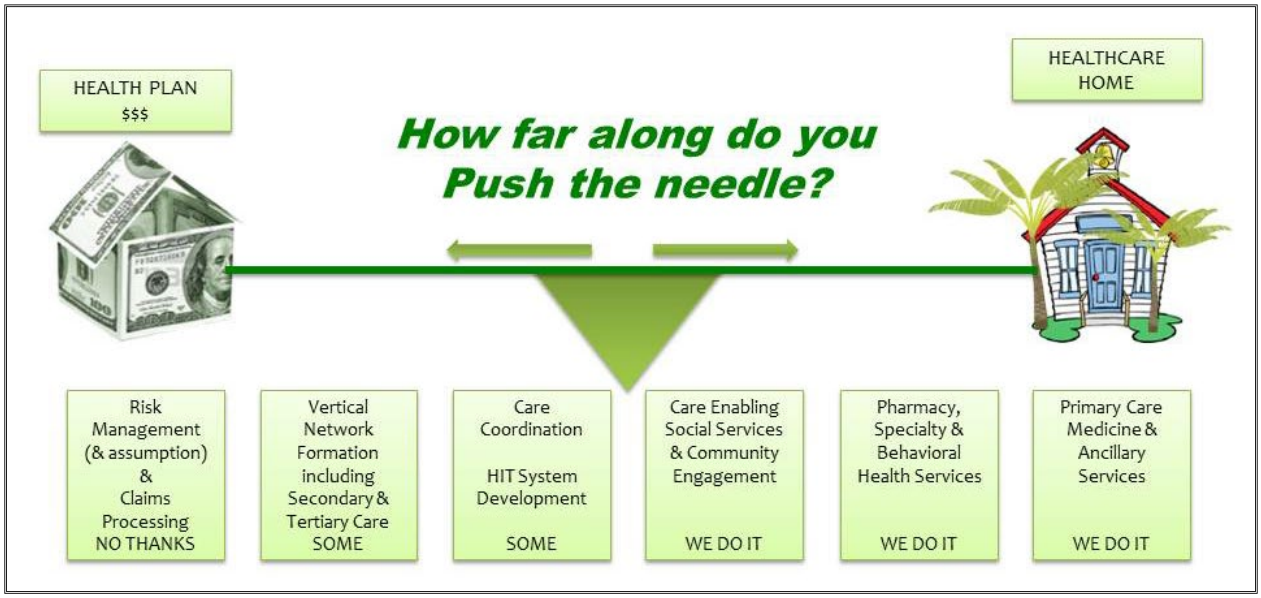
<u>Group #2 - New Conclusions/Recommendations from Volcano Attendees</u>

1. Health information technology should evolve to be able to track social determinants of health so these conditions can be incorporated into risk adjustment and care coordination.

2. Developing HIT capability is a potential community economic development issue and provides an opportunity to train our youth to aspire to a career in the HIT workforce.

3. Another way for health centers to address social determinants of health is by working with new funding structures such as community banks, the Federal Reserve, and tax credit programs.

Breakout Group 3: Building Partnerships with Payers and Hospitals



Group #3 - Reaffirmation of Previous Conference Findings

1. Performance-based healthcare should be a 360 degree evaluation process where the performance of payers is measured and factored into aligned incentives.

2. Performance data needs to be shared with FQHC governing boards with true meaningful engagement of community and community leaders.

3. The incentives provided by the state to health plans (currently HEDIS-type measures) need to be restructured to align incentives effectively in order to fairly value the performance of health centers.

4. The role of state insurance commissioners needs to be reconsidered with some oversight on the fairness of performance metrics related to health plans. In some states elected insurance commissioners have produced more responsive results.

5. New performance incentives that flow from healthcare home to health plan need to be negotiated including data capability, claims processing capability and specialty network performance. The format for current evaluation of health plans adopted by one health center network is posted at www.AHARO.net as Appendix C of the AHARO Payment Reform Model.

6. Efforts should be made to reduce the coding inconsistencies between plans. More clarity needs to be provided in how future ICD-10 coding will be accomplished.

7. The effectiveness of plan-coordinated behavioral health services needs to be more clearly monitored. Specific plan capabilities in addressing problems of substance abuse and pain management need to be measured.

8. Plan risk pools need to be more transparent and shared with healthcare home partners. Co-management of risk pools should be undertaken by community health centers seeking to enter this arrangement.

9. There is a need to embed value-added services into healthcare homes such as engaging community, cultural proficiency, workforce and job training, and care enabling services. Plans that deliver these services should be incentivized by the state.

10. Shared savings models such as the one developed by the Accountable Healthcare Alliance of Rural Oahu (see www.AHARO.net) should be facilitated as a part of accountable care organization development.

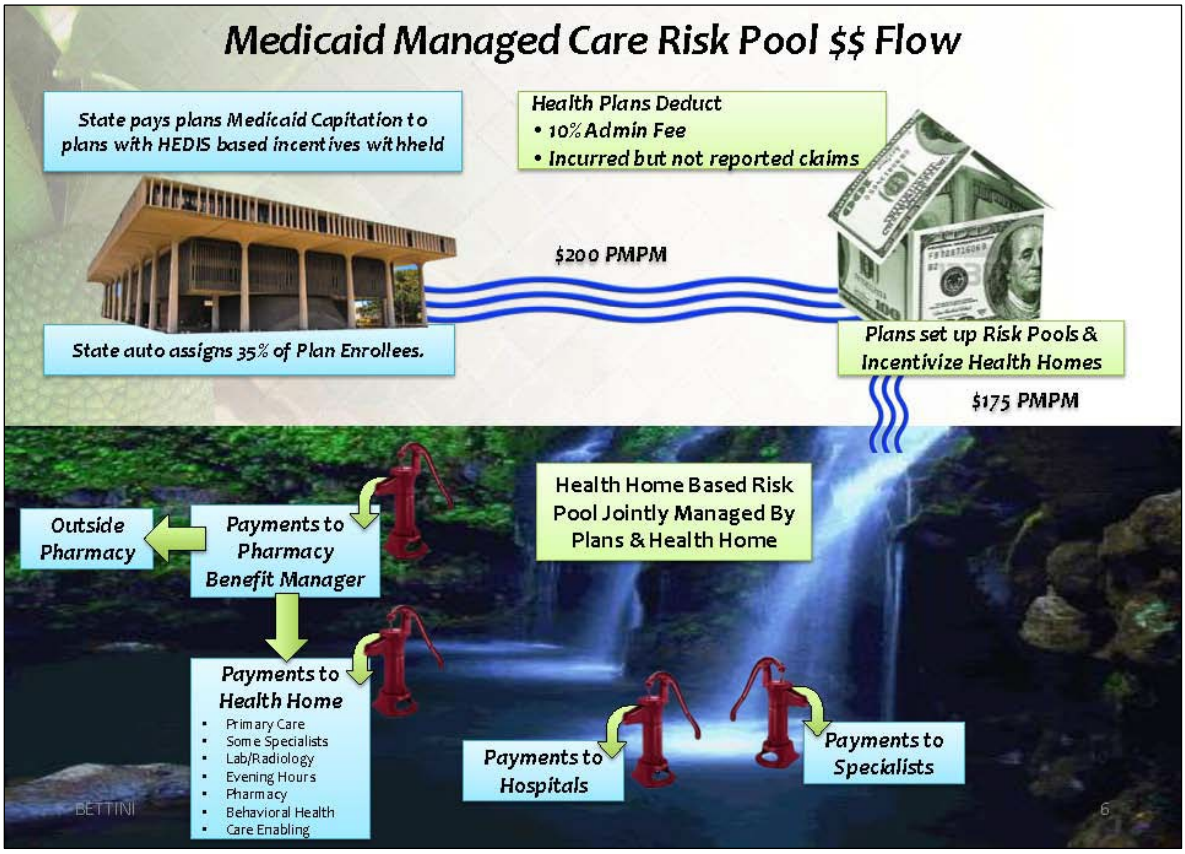
Group #3 - New Conclusions/Recommendations from Volcano Attendees

1. We need to avoid redundancy in the community and build on existing health center services and capability.

2. Health center providers need quick access to care management information from both the health payer and health center HIT systems.

3. Health center boards should engage in a process where they actively evaluate the relative capability each health plan contributes to producing value in their community. Once this has been accomplished, they can identify for their communities those plans that produce the greatest value for addressing identified community needs.

4. Processes required by individual health plans need to be integrated at the community level to avoid duplication of effort.



Group 4: Community Advocacy Issues

Group #4 - Reaffirmation of Previous Conference Findings

1. Consumer health center boards should be partners in developing healthcare policy and not only advocates of policies developed by others.

2. A strong consumer governing board along with an alliance of such boards is critical to the continuing success of health centers.

3. As the health center movement has become broader in scope, there is an increasing danger that the consumer component of the movement will be marginalized.

4. HEDIS evaluation measures are not effective in describing the value produced by health centers in addressing preventable costs or the quality of their services, particularly those for Aged, Blind and Disabled patients. New performance metrics need to be developed.

5. FQHC care enabling services need to be clearly defined in state Medicaid bid documents and contracts with health plans. With the Aged, Blind and Disabled patients, care enabling services are extremely important in producing a positive care outcome.

6. Eligibility requirements must be aligned with patient needs and with identified high risk populations.

7. Medicaid healthcare home provisions need to allow the reimbursement of separate service coordination fees by health plans.

8. The gap group between 133% and 200% of the federal poverty level is an important group in healthcare transformation. A decision on a benefit package for this population should be established only after an analysis of their needs is reviewed. In Hawaii, this gap group shares many of the same economic and care enabling needs of the poverty level population.

9. The Prospective Payment System (PPS) must be employed for patients in the gap group categories as many of them seek the full set of services provided by community health centers.

10. Health centers and the Hawaii Primary Care Association should present data-supported justification for the service delivery needs and payment system utilized for the gap group.

11. Incentives need to be built into the Hawaii delivery system that support addressing preventable costs in healthcare. Incentives must be fair and aligned correctly along the entire continuum of the healthcare delivery system.

12. Risk adjustment between the State of Hawaii and health plans needs to be discussed transparently and in depth. State adjustment of health plans with high risk patients including those with behavioral conditions and those with early onset of chronic disease is essential. Social determinants of health including census tract-based risk adjustment should also be considered.

13. It should be recognized that health centers are the entry point into the Medicaid QUEST plan for many high risk/high cost patients and for patients that migrate between uninsured status and Medicaid coverage.

14. HEDIS measures are not an accurate means to determine the effectiveness of a health plan in addressing poverty level patients. An alternative to HEDIS needs to be explored such as those developed in the "360° Health Plan Evaluation Templates" (posted at www.AHARO.net).

15. The auto assignment of QUEST patients to health plans needs to be reconsidered. It should be noted that at least one third of QUEST patients are auto assigned and this is a huge incentive to health plans. Value-added services offered by health plans should be important criteria in determining auto assignment. This may include supplemental healthcare home payments and levels of reinvestment back into the communities they serve.

16. Consumers need to be more actively educated and engaged in the current state planning efforts towards healthcare transformation. Currently there is only token engagement and no effective process of community-based education.

17. In Hawaii, Native Hawaiians experience a much earlier onset of chronic disease than the overall Medicaid population yet there is no chronic disease risk adjustment for health plans serving Native Hawaiians. At a minimum this must be addressed through some form of chronic disease adjustment. This adjustment should flow through to the service level.

Group #4 - New Conclusions/Recommendations from Volcano Attendees

1. There is a need to develop a statewide consumer council.
2. Hawaii consumers need to be more active on the NACHC consumer committee. In order to take on leadership roles, both the health center and the consumer as an individual must be members of NACHC.
3. Hawaii's Consumer Council model should be promoted in other states.
4. Ongoing funding support should be secured for consumer councils in Hawaii and other states.
5. Consumers need to advocate for risk adjustments that take into account social determinants of health.
6. Once provided with additional information (through briefing sessions and workshops), consumer board members will be better positioned to support the AHARO payment reform model (see www.AHARO.net).

Consumer Caucus Report

The consumer caucus of attendees met on the final day of the conference and reached the following conclusions:

1. Adopted the recommendations of individual breakout sessions detailed in the previous sections of this report.
2. Reaffirmed that there is a need to strengthen the role of consumers in the FQHC movement, recognizing that consumer governance is fundamental to the community health center model and essential to its continued success.
3. Affirms that health center consumers should be engaged not only in *advocating* health policy, but also actively engaged in the *development* of such health policy.
4. The consumer caucus also reached consensus to establish the Community Health Council HI (CHCHI), an association of community health center board members. Its purpose is "to empower the consumer voice by unifying and strengthening community health center leadership." The caucus agreed to find funding support and seek cooperation from the Hawaii Primary Care Association.

Summary/Conclusion

This series of consumer-designed leadership conferences closes with this report. These conferences have been provided at little or no cost to participants. The payment reform model that was produced by this series of conferences is now operational in the state of Hawaii. Multiple health plans are participating, including national for-profit plans. This has led to a shift in payment methodology that now realizes 30% of reimbursement is designed to come from performance and gain sharing. The model builds in a contribution to community economic development if preventable costs are addressed by participating health centers.

Increasing consumer engagement, facilitating community service integration, and more precisely measuring the levels of community involvement and governance in medically underserved healthcare homes remains a challenge. To this end the Hawaii consumer caucus will be firmly established. They will seek to work through the NACHC consumer board committee and will offer collaboration to similarly minded organizations in other states.

This series of consumer leadership conferences led to the creation of AHARO Hawaii, a clinically integrated network of community health centers placing a high value on community engagement in healthcare reform.

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"When we first looked at the concept of the medical home we thought in terms of patients' physical and social development. The proposition was built around accessible primary care that was community-based, close to home. We talked about family partnerships, coordinated care, culturally effective care, comprehensive care, and training (providers) with compassion."

Dr. Calvin Sia
(Early pioneer of the medical home concept.)
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