



*Central New Hampshire
Health Partnership*

Accountable Care Organization *Fact Sheet*

- The Central New Hampshire Health Partnership came together in the fall of 2008 to improve the health and well being of central New Hampshire communities, serving approximately 27,000 residents, by collaborating to optimize prevention, access and coordination of health care delivery.
- As a community based rural health network, the CNHHP's founding members include:
 - Communities For Alcohol and Drug Free Youth (CADY)
 - Community Action Program
 - Genesis Behavioral health
 - Mid-State Health Center
 - Newfound Area Nursing Association (NANA)
 - Pemi-Baker Home Health and Hospice/Aquatic & Wellness center
 - Plymouth Pediatrics
 - Plymouth Regional Clinic
 - Speare Memorial Hospital
 - Whole Village Family Resource Center
- The goals of the CNHHP are:
 - Work to be a community resource for proactive, collaborative planning of systems and services that improves access and enhance the well being of all area residents including those who are uninsured, underinsured or exhibit a high level of health care needs.
 - Design initiatives to be sustainable, effective and efficient.
 - Involve the community in setting short and long term goals for the public health delivery system and monitoring its effectiveness over time.
 - Base all planning and development decisions on reliable, agreed upon information and on evidence-base practices.
 - Improve capacity for disease prevention, health promotion and protection.
- The CHNHP Leadership Team:
 - Michelle McEwen, Chair, President/CEO of Speare Memorial Hospital
 - Sharon Beaty, Vice Chair, CEO of Mid-State Health Center
 - Patricia Wentworth, Finance Chair, Executive Director of NANA
 - Chandra L. Engelbert, Secretary, Executive Director of Pemi-Baker Home Health
- The Accountable Care Organization Project (ACO) is a five year project whereby local health systems are organized and designated an ACO to take responsibility for the overall health of the population in their community, with a particular focus on quality, timely access and affordability.
- The ACO assumes the primary accountability for a populations healthcare:
 - Through a multi-stakeholder, multi-carrier design;
 - By focusing more on outcomes and providing the right care at the right time;
 - Taking time to collaborate with colleagues and other treating providers on treatment plans and alternatives;
 - Plan for care in a formalized, long-term way;
 - Communicate with patients to provide individualized care using methods that make sense for the situation and the needs of the patient;
 - Focus on being more efficient in delivering services, decreasing waste, improving communication and streamlining processes.

- The CNHHP's focus for collaboration on the Accountable Care Organization Project will be the management of adult patients with Diabetes, Congestive Heart Failure and Chronic Obstructive Pulmonary Disease (COPD).
- Why these clinical focus areas? We wanted to begin this pilot with the management of a patient population where the majority of their care can be delivered in this area. Due to our rural nature and overall population, we don't have the wide array of specialists you would find in a more urban setting. We do see the need to expand our efforts to involve the entire population of the greater Plymouth area, but narrowed our initial focus to identify and develop best practices for our service area.
- Our ACO proposes to use the Medical Home model of care as our foundation to facilitate effective, efficient care delivery that improves care quality and contains/decreases care costs. The Medical Home model maintains a patient-centered view of care, and clinical decisions take into account the preferences, education, and culture of individuals and families. Patients are fully engaged in all aspects of their care from prevention and health promotion, to acute and chronic area activities requiring assistance from one or many health practitioners.