Northern New Hampshire AHEC
North Country Health Consortium
Board of Directors Meeting Minutes
March 9, 2012

Present: Sharon Beaty, Roxie Severance, Charlie White, Tony Poekert, Ed Shanshala, Adele Woods, Elaine Bussey, Jane MacKay, Nancy Bishop, Margo Sullivan
Absent: Gail Clark, Rob Darling, Alisa Druzba, Russell Keene, Jim Michalik, Rosemary Orgren, Lucille Tremblay
Staff: Nancy Frank, Debra Simmons
Guests: Lizann Peyton, Bob Fink

Consent Agenda

Consent agenda included February 10, 2012 board meeting minutes, January 2012 financials, and the Finance Committee recommendation to accept FY 2011 audit.
Charlie White made a motion to accept the consent agenda, Sharon Beaty seconded; motion passed.

Grant Update

TK Foundation: grant opportunity to expand health career pipeline programs to high school students. Adele Woods made a motion to move forward with the proposal, Tony Poekert seconded the motion; motion passed.

North Country ACO Update

Sharon Beaty explained that CMS is asking for lots of additional information so there is guarded optimism among the ACO participants. It's anticipated that awards will be announced by March 16th.

Other Business

Ed Shanshala has submitted a grant to Covidien for "bricks and mortar" to build a fixed dental site. It is a matching grant and Ed has secured funding from Cottage Hospital and Littleton Regional Hospital.

Board Attendance-2011-2012

Directors	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Roxie Severance	√	√	Ab	Ab	√	√	√	√	√	√	√	√
Tony Poekert	Ab	√	√	√	Ab	√	√	√	√	Ab	√	√
Charlie White	Ab	√	Ab	Ab	√	√	√	Ab	Ab	√	Ab	√
Jane MacKay	n/a	n/a	n/a	n/a	n/a	n/a	n/a	Ab	Ab	√	√	√
Ed Shanshala	Ab	Ab	Ab	Ab	√	√	Ab	√	√	√	√	√
Sharon Beaty	Ab	√	Ab	Ab	√	√	√	Ab	Ab	√	√	√
Nancy Bishop	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	√	√	√	√
Elaine Bussey	n/a	n/a	n/a	n/a	n/a	n/a	n/a	√	√	√	√	√
Gail Clark	Ab	Ab	Ab	Ab	Ab	Ab	Ab	Ab	Ab	Ab	Ab	Ab
Rob Darling	n/a	n/a	n/a	n/a	n/a	n/a	n/a	√	√	Ab	√	Ab
Alisa Druzba	√	Ab	Ab	Ab	√	Ab	√	Ab	Ab	√	√	Ab
Russell Keene	Ab	Ab	Ab	Ab	Ab	Ab	Ab	Ab	Ab	Ab	Ab	Ab
James Michalik	√	√	√	√	√	Ab	Ab	Ab	Ab	Ab	Ab	Ab
Rosemary Orgren	n/a	n/a	n/a	n/a	n/a	n/a	n/a	Ab	√	Ab	Ab	Ab
Margo Sullivan	Ab	√	√	√	Ab	√	√	Ab	√	√	√	√
Lucille Tremblay	√	√	Ab	Ab	Ab	Ab	Ab	Ab	Ab	Ab	Ab	Ab
Adele Woods	√	Ab	√	√	√	√	√	√	√	√	√	√

Northern New Hampshire AHEC
North Country Health Consortium
Strategic Planning Retreat
March 9, 2012

Present: Roxie Severance, Tony Poekert, Sharon Beaty, Charlie White, Ed Shanshala, Adele Woods, Elaine Bussey, Jane MacKay, Nancy Bishop, Margo Sullivan, Bob Fink.
Staff: Nancy Frank, Amy Holmes, Bob Thompson, Debra Simmons, April Allin
Facilitator: Lizann Peyton

Retreat Hopes and Goals:

- Take stock of where we are now, and create a vision where we can drive change – not one that is reactive
- Establish 3-5 priorities that are realistic, time-bound, and attainable
- Define the value proposition – what we add that makes Consortium membership compelling to current and potential members
- Prioritize which external partnerships to put energy into now
- Support Nancy, without micromanaging – and be clear about what micromanaging is
- Keep the focus today on needs of the board – an environment where staff feel welcomed to speak up and bring realities into the discussion, but where operational details (e.g. organizational structure) for internal staff discussion
- New board members and staff be part of the discussion
- Clarify the Molar Express burden and how to deal with it
- Clarify the expectations and role of members when interfacing with the Consortium
- Get through the agenda, don't get side-tracked, focus on the whole

SUMMARY OF FIVE-YEAR GOALS

Vision: A strong coalition that doesn't just watch, react, and adapt to change – but can drive the shift ourselves – and where we can't do it alone, join with others.

1. **Re-engage hospital CEOs to participate regularly in the Board:** One-on-one outreach, satisfying, value-added meeting experiences, address their emerging pressure points, and convey the value of being at the table to shape direction.

2. **Continue Molar Express while evaluating its sustainability and program alternatives:** Continue the program as a hygiene model, talk to funders about their responsibility for operating support, seek other creative funding, and explore the possibility of re-directing our efforts away from direct service and toward advocacy, convening, and public health/culture change. Create a responsible phase-out strategy if necessary.

3. **Increase our messaging about value-added strategies:** Prioritize target audiences, craft a clear message about our value added, build messaging tools and capacity, and do a systematic assessment of member perceptions and satisfaction.

4. **Anticipate the needs of a rapidly aging population (the "silver tsunami"):** Look ahead at changing needs and health costs as the North Country's population moves into the over-65 and over-85 range, cultivate a skilled health workforce as the younger population declines, and partner with others outside the region also preparing for the aging demographic.

5. **Advocacy:** Bring the rural voice to statewide groups, and educate each of our members about how to advocate for rural needs in their own networks and contacts with policy-makers

6. **Build our organization capacity:** Build financial sustainability and revenue diversification, explore marketable fee-for-service management and health education and contracts, assess staffing needs and organization structure to adapt to growth, centralize fund development, reach out to human service organizations as members, develop a clear membership structure and expectations, and keep clear board roles separate from the organization "hats" we wear, and separate from micromanaging staff.

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RETREAT DISCUSSION AND DETAILS OF 5-YEAR GOALS

Taking stock: A lot of big changes in recent years

- *A lot of leadership change, with impact on our capacity:* A new executive director, all four directors will have turned over. We have an opportunity to move forward with a new look, create a new Board-Executive Director relationship and relationship with outsiders, repair real or perceived damage in the community, with more access and availability to individual organizations and their leaders.
- *Board expansion:* A shift from founding members to a more open group and access to the network, but loss of hospital participation.
- *Moved the office amidst a lot of other work:* More expensive, more "back in Littleton."
- *Instability of state and federal budgets:* Concern about NCHC financial sustainability when a grant ends, future bundling of state contracts and state efforts to consolidate: Makes it hard to plan, risk that the funding tail wags the dog. Important to stay on track with our mission and have the board drive policy consistent with community needs, not funding trends; keep our focus on multi-generational needs and disparities.
- *Molar Express:* Got and then lost a full-time dentist
- *AHEC framework:* Where does it go, what are our obligations, what is the educational value we can deliver

Future Trends:

How can we look at change as a crisis or opportunity: the importance of flexibility and willingness to look at different things, e.g. ACO.

Health care:

- Hard to predict the future of health care – e.g. how will ACOs look in 5 years
- Shift from a medical/health care model to public health and prevention
- Paying for documented outcomes, not procedures
- A shift from patients as passive receptacles to a customer-driven system and patient accountability for their health
- Expectations about transparency re: costs and outcomes
- Fewer CEOs – health companies go out of business because new reimbursement structures demand efficiency

Demographics and the economy:

- A dramatic increase in the percentage of residents over 65 – up to 40% of the population -- and drop in younger residents – implications for rising health care costs, transportation problems, drop in tax revenues, fewer workers and caregivers to support the elderly
- Widening of the haves/have-not's chasm with worsening realities for poorer people – transportation, less safety net
- State-to-state migration will decrease – people are afraid, worried about their finances, a house is a liability, less able to move

Climate changes:

- Loss of some industries/jobs (ski, sugaring, timber), increase in others (longer growing season, summer tourism, golf and water sports industry); more time for outdoor exercise
- Need for career flexibility and adaptability

Technology:

- Stem cell advances can solve more health problems.
- Renewable energy advances
- Ability to work remotely allows people to have new and more adaptable career opportunities, live anywhere, emphasize lifestyle and be willing to accept less income

Cultural changes:

- A coming generation interested in shared resources (cars, homes)
- Multigenerational homes

VISION

A strong coalition that doesn't just watch, react, and adapt to change – but can drive the shift ourselves – and where we can't do it alone, join with others.

FIVE YEAR GOALS

1. Re-engage hospital CEOs to participate regularly in the Board

- Engage them through 1-on-1 outreach, and recognize that time is needed to build trust and relationships
- Make meeting experiences good – comfort, food, meaningful meeting content, peer relationships, learning, value I take back to my own agency, my meaningful contribution to shaping the system
- Meet their evolving pressure points and opportunities (e.g. ACO and reimbursement changes)
- Messaging: sell our existing value (e.g. collaborative needs assessment data) and the value of being at the table

2. Continue Molar Express while evaluating its sustainability and program alternatives:

- Continue the program for now
- Continue to evaluate its sustainability in 2012, while also talking to funders about their role in jeopardizing the sustainability of this model
- Continue with the mobile hygiene model: it is reaching break-even sustainability this year, with the decision not to re-hire a dentist and become just a hygiene model for school-aged children. Celebrate the good we are able to do and accept the limits on who we can reach (geography, age, service needs). Continue to evaluate its sustainability in 2012 and continue it until/if Ed or someone else has a program in place
- Change the foundation funding model: Talk to funders about how their funding approach limits the sustainability – they gave generous 3-5 year demonstration funding, but no ongoing operating support. Test whether they might be receptive to contributing toward operating costs
- Shift our oral health work to align with our public health mindset: drop direct service, advocate for the big picture of severe unmet oral health needs in the region, and take a public health approach to creating a generational culture change (e.g. toothpaste in public restrooms, dental mints in restaurants)
- Look for other potential funding sources – school and town budgets, employment readiness programs "4 front teeth"
- Consider a responsible, staged phase-out of Molar Express, especially if Medicaid eliminates payment for child dental care. Craft a careful strategy for addressing the expectations of children served, funders, and the public – a communications strategy that clearly explains how funding decisions contribute to the closure, why the model was a good experiment and why it's OK to close if not sustainable, how else NCHC will pursue oral health advocacy. Be sure to guard NCHC's reputation with funders and the public.

Other discussion:

- We have already made the shift to a hygiene/prevention model, by not re-hiring a dentist
- Should NCHC be in the business of direct service or could our role instead be helping other entities do it? Yet we don't want to stop doing a service that's becoming financially sustainable and is meeting a critical need, even if there are limits.

- There's a huge need in the region – but we can't sustain it all, and it's taken a big financial toll on our organization. Other needs are still unmet – distance and transportation to get to the "hub" practice.
- Could we have a bigger impact on oral health if we shifted Molar Express time, energy, money, and staff focus and used it instead for aggressive advocacy for oral health?
- How would we approach Molar Express is we stick to our core mission of leading innovative collaborations and convenings (as we do with other programs) to improve the oral health status of the region?
- Ramp up our messaging strategies – public and funder outcry, partner conversations, media, consistent message, leverage members

3. Increase our messaging about value-added strategies

- Prioritize target audiences – hospitals, town meetings/city councils, small businesses/chambers of commerce, Mobile Express funders & public
- Build our messaging capacity: tools, processes, staff time, dedicated focus
- Develop our consistent and compelling message: our value-added membership benefits, our impact on health status and on the organizations that do this work
- Communicate regional overview as our added-value:
    - Expertise
    - Research
    - Grant-writing/bringing large grants to the region
    - Advocacy
    - Planning
    - Convening
    - Be seen as the go-to place for health planning and convening
- Do a systematic assessment of member satisfaction and perception of added value

4. Anticipate the needs of a rapidly aging population (the "silver tsunami"):

- Anticipate communities' changing health needs and costs
    - Subsets of needs: 65-85, over-85, elders in deep poverty
- Decline in younger workforce – opportunities to develop a skilled health workforce
- Technology and social media opportunities
- Get to the pre-65 year olds early
- New partners outside the region also trying to prepare for the aging tsunami – advocacy, funding, program model, and collaboration opportunities

5. Advocacy – Strategies to be discussed further

- Bring the rural voice to statewide groups
- Educate each of our members about how to advocate for rural needs in their own networks and contacts with policy-makers

6. Build our organization capacity:

A. Financial sustainability and revenue diversification:

- Anticipate and adapt to a climate of volatile federal and state funding decisions

- Explore the marketability of management fee-for-service model: ACT contracting with the Consortium for management and accounting services. May be an opportunity to develop it as a larger service for other organizations, and an earned income stream
- Revenue diversification opportunities = schools? towns? Hospitals that want to cut back on expensive emergency department utilization?
- Explore the marketability of health education fee-for-service: AHEC educational services, patient education, technology provides webinar and distance learning opportunities (live and recorded). We have content expertise in our membership and can leverage our reputation as the expert go-to organization – share revenue opportunity with members – we have the internal capacity to produce technology-based educational products

B. Management structure

- Assess staffing needs and structure
- Assess the overall management model, given the complexity of this organization's funding model
- Adapt to growth and changing external trends (aging population, funding streams, economy, technology advances)
- Develop a strong, centralized system and strategic plan for fund development to maximize opportunities and reduce fragmentation of efforts

C. Membership structure

- Reach out to human service organizations as members. The value we can add: – they care deeply about their constituencies' unmet needs and health is a critical part of that; they can learn a lot about the complexities of the health system and why it does and doesn't work. The value they can add to us:, they can enrich our board discussion, bring their gifts and talents and expertise, and bring a louder advocacy voice, in settings beyond our own networks
- Develop a clearer and more effective membership structure:
    - General/community membership: No expectations or formal role, basically a statement of their support. They get: for a minimal fee (e.g. $25) they get a newsletter and information about an issue they care about. The Consortium gets: ability to publicly claim a large number of people backing what we do. If we also want to be able to rally them, we will need to find ways to build sustained engagement with them so they will be willing to step up to our appeal (e.g. advocacy). Membership could be automatic if they sign up for an event – goes into our database, we send them more invitations and build ongoing engagement with them. Consortium members can distribute their information/appeals to our list.
    - Put on a "wow" annual event, high profile speaker with a big public audience to hold him/her accountable
    - Board membership
    - Have organizational members" corporate members? build on existing advisory committees?
    - Look at the impact of membership discounts if we grow

D. Board roles and expectations:

- Be sensitive to the boundary between board vs. management purview
- Be sensitive to the dual hats we wear – "my Consortium hat" and "my agency hat" – articulate it in discussion