**Health System Innovation**
**June 17, 2015 Summit**
**Alignment and Integration Committee**

**Attendance (New People—added to the contact list):**

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| Nicole Taylor | Doris Caimi | Ruth Burkhart | Susan Wilger |
| Arturo Gonzales | Dick Mason | Daryl Smith | Kathleen Schuster |
| Eileen Goode | Nick Estes | James Gillson | Robert Horowitz |
| Bryce Pittenger | Sam McBride | Rashad Mahmood | Kyra Ochoa |
| Susan Baum | Chris Novak | | |

| Topic | Discussion | Next Steps/Follow-Up |
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| Introductions | (see above) New professional categories present: ABQ City Council, dental hygienist, nurse therapist, Santo Christo Health Partnership, Health Councils, Health Action advocate, UNM Hospital Board member, community-based mental health agency, CYFD-Juvenile Justice, Gallup family physician, media, Santa Fe community services. | |
| **Discussion Questions** | | |
| Principles the A&I Committee agreed on in past meetings | 1. The HSI model in NM has to be community-centered.<br>2. Collective action by different involved groups is needed to accomplish this model's goals.<br>3. HSI requires a change in vision, mission and funding | |
| If NM was designing a totally new health system (the old one disappeared), how would it be designed? How would we get to this envisioned integrated system? | • What would be the charge of the County Health Councils (CHC), which currently fight to get funding, in this new design? CHCs' original charge is to do primary assessment of county data, planning & providing strategic guidance to communities.<br>• If the new system is community-centered, we should beware of past designs, like the behavioral health system oversight group, which did not work well without community representation.<br>• A <u>state-level "backbone" entity</u> (as well as ones at the community levels) is needed to provide oversight as an umbrella group. Currently, health care has a fractured oversight structure. (We need to be careful in how it's set up, so an entity is seen to be apolitical.)<br>▪ Health Councils are not yet strong enough to handle this type of responsibility, overseeing multiple, complex systems.<br>▪ NM's SAMHSA-funded Systems of Care grant created communities of stakeholders that provide wraparound services, with CYFD-related community Boards—which might be a resource in developing the backbone group.<br>• The HSI should have <u>a consistent payment structure</u>—one payment model for the state as a whole.<br>• <u>Information sharing</u> is important and could be based on the Native American systems' cultural expectations that providers share information on the patient. This is more than just a "data-sharing" process; the providers also need to have "buy-in" to do this.<br>▪ This info-sharing concept must be flexible, to accommodate the model in different geographies with low levels of resources, health care staff, infrastructure development. Technical assistance will be needed on information-sharing to less-resourced communities.<br>• Health (care) providers must <u>be educated/trained differently</u>—that is, in a more integrated manner to better understand what other professionals/para-professionals contribute (especially home visitors, EMTs, public health nurses, CHWs), where they reach patients, and the like for working better as health teams. | There is a list of services that a CCMH or PCMH should provide from the Vermont SIM project. |

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| What are opportunities and gaps that you see? | • We need to know how indigent patients will be handled by PCMHs? How would this be paid for?<br>• We should consider the CYFD's early childhood efforts in setting & overseeing quality standards (1-5 STAR grades) and levels for child care institutions?<br>• Project ECHO is one model we should consider for the training of health professionals from different geographies, fields, professional levels, and others together.<br>• Though a community-centered well-being model (CCWM) will probably be easier to implement in smaller communities, capacity to handle patients and community members is an issue. The new model must be fluid and flexible enough to handle this issue; currently, all systems (socio-economic supports, medical system) are basically rigid ones.<br>▪ A key question: how to build fluidity into this new system?<br>• Another key question is <u>how will we pay for those services</u> (public health and social supports<u>) not usually paid for</u>, but which will run the risk of "drowning" under increased consumer demand in a community-centered well-being model (CCWM). | |
| What would an integrated and/or aligned model look like? | • This committee must still address how to <u>integrate behavioral and physical health care</u>. One possible method to use would be a short, standardized assessment with guidelines for standard, short-term treatment. This would not be used for long-term, intensive treatment needs. Three community-centered behavioral health models couild be considered: (a) the Certified Community Behavioral Health Centers (CCBHC) model; (b) the Medicaid-supported Health Homes model—both of which are intended for severe or serious mental health/substance abuse issues. The third model is the SAMHSA-funded System of Care model—which is community-based, but not necessarily for those with severe mental health illness. The first two models do not address prevention as much, though they include peer support programs and employee assistance. It was noted <u>that the new health system should be more focused on prevention</u>, rather than on the chronic care system. Others noted that the system should include primary, secondary, and tertiary levels of prevention.<br>• It was asked whether a goal of this HSI would be that every New Mexican have a medical home—even though it could not be expected that every person would get their medical home at the same time.<br>• One principle of a community-centered well-being home model would be that it have <u>multiple entry points</u> for those needing care or other services. Thus, a community member might enter from the PCMH or clinical service, or from another service, such as SNAP, WIC, or transport.<br>▪ If community members access the CCWM from different entry points, it would be helpful for providers at each entry point to have a standardized assessment form with core questions to guide them in referring people to the right services. This might include a "navigator" position to help people through the maze of services. Should such a person be used, this would require training in not only what other services provide, but how all different systems (transport, social, financial, medical) are linked.<br>▪ Or, there could be a standard intake form with a common set of questions at each access point, and a way or technology to make automatic referrals based on the answers given. This would be difficult in communities with limited resources. It also requires that every provider or agency involved in the CCWM system be committed and able to follow-up on those patients/people.<br>▪ Once a person has accessed the system, how do we ensure follow-up with patients later and long-term to be sure they're doing OK? This also goes to the issue of sharing information on patients—an action made easier if the patients trust their providers. | Daryl Smith noted Cuba as an example of such a system. He has sent an article; Chris Hollis forwarded it to the committee members for review.<br><br>One suggestion for this intake process was to use motivational interviewing. |

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| | ▪ Example: in South Valley, ABQ, First Choice uses the WellRx survey—the questions being asked during the taking of patient vital signs.<br>▪ Example: Pathways, as its services go beyond health care to handling housing problems and the like. (Question: how is Pathways funded?) | Check the WellRx survey. |
| How could we scale-up this new system to the state level? | • Different organizations provide different certifications; this is not a sustainable or efficient method. We should pick one certifying organization to administer the PCMH status of applicants.<br>• Since there will be different CCWH "systems" in different parts of NM—and because patients will sometimes be referred to providers outside their communities—good data and information sharing processes are necessary<br>• Physicians need to know what/where resources are in the community.<br>• How do we fund/pay for social services that will be facing increased demand for their help with the CCWH model? There needs to be a revenue source for this, as currently, all the money goes to health care.<br>• This should be a wellness promotion model in which doctors are charged with influencing population health outcomes. Thus, if they improve population health measures, like low birthweight, by referring patients to home visiting programs, etc., they're compensated. This is why we need a mix of clinical and population health outcomes as measures of success.<br>• To implement this system, we need to identify networks of providers—medical, social, economic, public health, etc. We need to identify who's in the network, who gets paid for what, and how do we fund networks to improve health outcomes. Network members might be paid to provide a service that's attached to outcomes. For the state, we need a system with linkages of networks (like Medical Neighborhoods?). There must be access to good data for accountability. One option for funding might be to look at how hospitals' community benefit funds are used.<br>• At the state level, there's a need for a "backbone" or management entity. There are negative examples like the ACO, the Healthcare Authority, the Behavioral Health Collaborative. But the committee felt an "oversight" entity (board/committee/group) of some kind is needed to help coordinate services, oversee regional networks and data, check how funds are spent, allocate resources, data, planning clinic development, etc.<br>o This entity is also needed because currently agencies do what they're tasked to do and tend to protect their turf—rather than act in an aligned or integrated way. | The Office of the Superintendent of Insurance is working on identification of resources in communities, so is Share NM. We need more info.<br><br>Check on Idaho's medical neighborhood model. |
| What are our next steps? | • Consider in more detail what a "health authority" type of backbone entity should look like and whether each community could have its own entity<br>• Consider in more detail what a fluid "wellness" or "healthy home" for integrated care (that includes a PCMH) would be<br>• Explore further the concepts of "no wrong door for access" and a standard intake form—as well as how to ensure follow-up action in networks<br>• Explore further the concept of information-sharing and a culture of sharing (how to provide technical assistance, etc.)<br>• Further define "networks"—who's a part, what health services, who's already paid and who needs to be paid, the redirection of funding streams, etc. Look at how the system "incentivizes" everyone effectively to take part. | |
| What information exchange (questions for and/or information do we want to share) do you want with other committees? | • HIS Committee—how will we integrate all the data from different EMRs, and how can providers send the data back in a useful way (so the information is transferable to other users)?<br>• Payment Models Committee—how can we pay for the integrated training of providers? How can we pay for "healthy homes" and networks of providers?<br>• Workforce Development—how do we plan to address integrated training of providers?<br>• | |

| Report Out Preparation (15 minutes total) | | |
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| What 4 recommendations is your committee making for the model design to be provided to the steering committee? *These will be in the report out.* | • There should be a statewide (and possibly also at the regional or local level) "backbone" entity/structure that is apolitical, with the capacity to oversee design implementation and funding distribution, distribute revenues, communicate with other SIM states, etc. This entity should be explored in detail to identify an appropriate one for NM; potential models to consider include the Idaho model, an ACO++, amplified health councils, etc.<br>• The community-centered well-being home/model (CCWH) should be built upon "networks" of medical care, public health, socio-economic, and community service providers. In order to be effective, we must determine who is currently getting paid to provide services (and network) and those (social services/non-profits) who do not, and what/how revenue can be generated and allocated to pay for this.<br>• The elements/components of a "wellness" or "well-being" home [like a medical home] should be explored and identified. Potential models to explore include the Native American 638 health care model.<br>• Throughout the CCWH network, there is no "wrong door" in terms of access—people can enter through a PCMH, traditional clinic, public health program, etc. For this to work well, and address social determinants, there should be a common in-take form and working system of follow-up.<br>• The CCWH must be built upon an effective system and culture of information-sharing—not just in terms of data sharing, but also in a personal, culturally-competent sense of connecting/linking with other providers and case sharing. | |