

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

Attendance:

SallyAnne Wait, HSD			
Jerry Montoya, NMDOH, PHD			
Chris Novak, MD, NMDOH			
Susan Wilger, HMS, Center for Health Innovation			
(not all names listed)			

Topic	Discussion	Next Steps/Follow-Up
<p>Introductions (Name, Position, and Organization) & Insights from the morning presentations (as it relates to committee's charge) 20 minutes</p>	<p><i>"The linkage of programs and activities to promote overall efficiency and effectiveness, and achieve gains in population health" (IOM)</i></p> <p>The Institute of Medicine (IOM) definition of "integration" (above) is that in order to achieve the Triple Aim, population (public) health, behavioral health, oral health and primary care need to be aligned. Linkage among services is key to success. The morning's presentations highlighted important examples of integrated, patient-centered activities ongoing statewide. The charge of the state Alignment and Integration Committee is to identify "an integrated person-centered model in which public health, behavioral, and oral health initiatives are actively supported by healthcare providers [PCMH and other service models] and PCMH, and PCMH and other integrated care and wellness service models are integrated into public health, oral and behavioral health initiatives."</p> <p>There was concurrence that resources for system change are required, including technical assistance, and assessments of what integration already is in place, and by whom; identification of the organizations who have and have not the capacity to engage in integration; identification of the "system" or "model" that can embrace all entities; and the importance of the social determinants of health and environment in the design model. Public health needs to align its messages with those of other providers and vice versa. The key to achievement of the Triple Aim is prevention, which, along with public health, has been under resourced for decades.</p> <p>Without policies at the federal and State level, support of a "prevention culture" will not be realized. All participants from the individual and local level on up need to share and articulate a shared advocacy for prevention that includes personal responsibility for health. The "me" to "we" mentality is not happening. In general, the healthcare workforce, including public health, leans toward self-preservation and displays reluctance to change. Models of care are not as important as the wellness and wholeness of the community. The question is – "What type of system can engage all sectors which</p>	

	<p>are competitive by nature, to move from where they are now to a more collaborative approach?”</p> <p>It is critical to learn what the other Committees are discussing in terms of integration concepts and strategies. There are multiple “looks” of integration across the State and the Nation. In general, community health centers are further along, due to the federal Health and Human Services (HHS) mandate to Federally Qualified Health Centers (FQHC) to integrate and co-locate services and attain Patient Centered Medical Home (PCMH) certification. For services that are provided by multiple entities, such as family planning, currently available from NMDOH and the State’s FQHCs, it is necessary to obtain data to determine gaps and areas of overlap or duplication. The term, “community health center,” is broad in focus to encompass a location where all health and living needs may not be directly provided, but will be, at least, identified for a client. “FQHC” is a federal designation, and organizations so named qualify for enhanced reimbursement from Medicare and Medicaid, as well as other benefits, must serve an underserved area or population, offer a sliding fee scale, provide comprehensive services, have an ongoing quality assurance program, and a governing board of directors.</p> <p>Some points made: that co-location is not integration—it takes education and understanding to learn how to coordinate within and among disciplines not your own; we need to find ways to overcome the territorialism of different professional groups and provide a culture of team building.</p>	
--	---	--

Discussion Questions (80-90 minutes total)

<p>Describe an integrated system (PH, BH, CH, OH) that would better serve individuals, families, and communities and which would benefit entities delivering the services? 30 minutes</p>	<p>In New Mexico, multiple and varied stages of integration may only be realized due to the particular requirements and capacities of each community. Each community must be engaged to create their microcosm of a vision based on what that particular community needs and their priorities for attainment, while still focusing on the triple aim. In frontier and rural areas, for example, transportation (to healthcare) may be the top priority of need, and options of van service/biking trails might be on their list. The community vision, regardless of its location, requires participation of all resource leaders who represent housing, transportation, schools, business, law enforcement, government officials, food banks, etc., in addition to those from healthcare. There may not be one model that fits all areas of the state.</p> <p>The Indian Health Service (IHS) and FQHC (and NMDOH) systems are public with all services with some level of integration under one management. For private providers, integration is more challenging. In the case of IHS, prevention is a theme throughout the system but not promoted as a tenet of its service policy. It is a failure of leadership not considering all possibilities. There are many gaps between the state health and federal systems; for example, IHS does not report data into the State system. How would integration appear among the state and IHS systems?</p>	
--	--	--

	<p>There needs to be sharing of goals and work plans. Public health needs to be asking other partners about what they need from public health and vice versa. A Health in All Policies (HiAP) approach should be employed in policy development. Collective impact needs to occur among all partners. This is accomplished via a common agenda that includes a shared vision for change with common understanding of problems and joint approaches to resolutions; shared measurement with common data elements and measures will ensure alignment and accountability; mutually reinforcing activities where participant activities are different yet still coordinated through a mutual plan of action; continuous communication that is open and consistent to build trust, affirm mutual objectives and value common motivation, an understanding of what is expected of each member and what they expect in return from others and, a backbone support organization which would be a neutral, separate organization with staff and coalition management skills to manage the initiative and coordinate participating organizations.</p> <p>The backbone organization should be an apolitical health council or advisory board whose decisions and policy input would be evidence-based on the science of health, and not driven by political motive. Policy development would be informed by ongoing community input. The “form” of the model must follow the “function,” in that it clears the path for professionals to work within their own capacity as an integral part of bringing about success for the community vision.</p> <p>Transformational leadership is required to engage in team building resulting in shared acknowledgement of enabling persons to work at the top of their professions and providing a healthcare environment where one can receive “access to the care you need, when and where you need it.”</p> <p>The current fee-for-service reimbursement structure is a barrier to achieving the best outcome for patients. Empowered consumers would force transformation, however, It is difficult to influence increased responsibility for personal health. There needs to be incentives for consumers and for all participating entities. <u>The clinical and business (payment) models need to coincide and support each other.</u></p>	
<p>What are critical factors for the success of an integrated system? What are the roles of each of the following groups in assuring that success?</p> <ul style="list-style-type: none"> •public health •behavioral health •oral health 	<ul style="list-style-type: none"> • Integration of the clinical and business (payment) models was reaffirmed as critical to the success of integration. • Acknowledgement and understanding of the roles along the spectrum of healthcare providers is also key to providing an environment that will permit integration of services. • Appreciation and rewards for improved outcomes need to be provided to everyone involved, especially the patient. • Policy decisions need to be based on the science of health and guided by an apolitical, impartial body which provides technical assistance to partners, ensures accountability of all participants, encourages an environment and framework that 	

<p>•health/medical care 30 minutes</p>	<p>permits integration, and, develops a strengthened community that can accept and act upon challenges, as well as take ownership of its health outcomes. All participants must adhere to and honor the principles of collective impact.</p> <ul style="list-style-type: none"> • Quality indicators, cost model for delivering services, and incentives for healthy outcomes should be consistent with the NM Health System Innovation plan, and shared across all components within the community model. • Critical to success is abandoning the mind set of doing what always has been done and to look at true innovation. 	
<p>What is an/what are some example(s) of geographic areas and/or populations facing disparities (tribal, rural) in New Mexico where we can apply the integrated care and wellness model? What are your reasons for suggesting this/these examples? 30 minutes</p>	<p>There are various types of disparities, driven by community need. The issue of disparities requires a separate discussion. [This question was deferred due to the shortness of allocated time]</p>	
<p>Report Out Preparation (15 minutes total)</p>		
<p>Select are the 4 key points from the discussion to share with the whole Summit groups. 15 minutes</p>	<ol style="list-style-type: none"> 1. A shared vision of integration that includes individual (health consumer) and community input. 2. Shared, standardized measurements among providers and payers. 3. Commitment to Health in All Policies in system development 4. A “backbone” agency that can promulgate and engender a culture of prevention. 5. Adherence to the principle of “form follows function.” 6. Alignment of the clinical and business (payment) models. 	