Topic	Discussion	Next Steps/Follow-Up
Introductions	Pass around sign-in sheet and collect at end of session	
	Discussion	
A goal of this meeting is to refine and/or add to the recommendations we have already made to the HSI design. Given your discussion in the mixed Round Tables, we may want to "dig a little deeper" into some of the issues that fall within our committee charge and/or our recommendations. *~Ask each committee member to share*:	What was the 1 – 2 key "learning" or "take away" from your round table discussion? • What meaning do some of these have for our committee—is it something that we need to address now? A. A few tribal-related concerns mentioned: about HIS integration with tribal nations; there is distrust related to government structure and history of HIS. Tribal nations often cannot attract physicians and when they do they leave pretty quickly; one reason may be because they're in an isolated area. The broader issue is integration among government entities. This can apply to the Veterans Admin also. B. An overall reaction to the design was that we should draw on what we do well and uniquely in NM rather than "inventing positions" like health leads or a well-being coordinator. It's unclear about how supervision would be done and whether the roles of EMTs and CHWs would be duplicated. Who is going to pay for these people? C. Counties can be seen as existing entities that can align health care delivery and public health as a locus to address health determinants. The county is a stable location, and has staff, funding, etc. GRT money and indigent funding is only available in Santa Fe. Let's amp up what we have to see how we can do the integration. D. The payment systems are flexible enough. There needs to be some blending of those three tiers to make sure they're appropriate for the community and local level planning. When reframing primary health care, we include dental, mental and community health. E. A role for city or county officials was not described. Looking at providers, etc. We need to look at government and elected official roles. F. All the terms we use like health care. CHWs roles can be redefined. G. There's a lack of a population health focus and addressing social health determinants. [The design] was more on health care, with little on population health. There were many references to patients and Centennial Care. H. We tried to figure out the well-being home concept and felt it was redundant to what other organizations are doing in using a wraparound care approach. The need for health councils or others or somebody in a region is to figure out what is needed. They would provide accountability, oversight responsibility and report to the state level. Some things would have to be mandatory. A region couldn't say we're not dealing with diabetes but that if the State mandated it they wouldn't have a choice.	

	I. This was one concern raised by the health councils. When they do their county health assessments, councils select their priorities, and often these done match the HSI grant priorities (obesity, tobacco, diabetes). They felt it was prescriptive. There can be different ways to assign priorities. J. More focused on Medicaid and people who receive care from clinics in rural areas and not the ordinary insured patient who just goes to a doctor. It seemed very government oriented. K. Shannon clarified that the plan should address all payer sources. The key role of employers because they have a definite incentive because they're involved with private agencies. (unclear) L. Public employees could be a good pilot group.	
Committee tasks and approach to complete Committee work given the timeframe and deliverables: *August*— ***Does the current version of the HSI design adequately incorporate the recommendations made by and the work done by this committee? If not, please list what needs to be incorporated and provide as part of the summary question (below) responses***.	M. The design does not yet address a "backbone" organization. It doesn't address accountability for the implementation authority. N. Volunteers were not mentioned in the proposal. That has been eroded over time. Volunteers come from different backgrounds. There's a whole area of volunteering. Maybe a better way of incentivizing and funding can be available. [Volunteers?] could support community health. You wouldn't have to recreate the workforce but looking at the scope of practice/role and resources. Could there be a career ladder for high school students interested in being a paramedic, CHW, etc.? O. The medical neighborhood model is used by several SIM State Models. Something we can look at. P. There's nothing on detention centers and how they house the mentally ill. Needs to be mentioned. Q. The design needs more alignment. Public health is more than population health. Redistribution of savings. R. Workforce preparedness. What do we have now? Using the paraprofessionals. Some groups may be already working on recruiting and retaining where we have shortages. Roswell is looking at those issues but the whole problem is keeping these people. What is the incentive to keep them there? Every part of the state is dealing with that. S. We had a large section of tribal members and they have different issues in terms of dealing with rural and IHS problems. We have such a diverse need. There's a lot of talk about exchanging information and HIS won't exchange information. We deal with that all the time. It's going to take a lot of effort. Systems aren't designed to exchange information so freely. T. The focus should not be only on Medicaid and medically insured folks. We see lots of insured patients. Community health centers are not just a safety net. We see everybody. U. Electronic health records and interoperability were a main topic of discussion. A specific concern regarding EHRs is that many EHR products can't be readily or affordably modified to align well with preferred work	

	flow in a particular clinic/practice setting. Modifications to work flow are an important component of health systems change to support integration or referral to key public health services, such as tobacco cessation and disease self-management services. If practices can't afford to modify EHRs to be more "user friendly", this is a barrier to community-clinical linkage services. V. There are a lot of things we can do to help the systems get better. W. An issue not addressed is the absence of long-term care and how costly and important that is. X. There needs to be some sort of consumer driving force. Not sure if we have that. Y. There was some mention of incentives that could be used to reward communities. Some states have provided rewards through summer camps or toolkits that a community could choose. Safer sidewalks, etc. Z. Within our existing system how do we standardize certain systems of data outcomes, credentialing and care coordination? Right now we have so many different systems with no standardized approach to these services and care types. Each MCO has its own way of doing things, which makes it difficult for people providing and getting care. AA. It's about the payment. It's like if we could follow a dollar bill through the SIM process then we could make it make sense. Who gets the money? Where does it come from? Describe it from the dollar bill's view. BB. How do we allow for local flexibility, while also still finding a way to align public health and health care delivery? How do we have consistency in terms of whose providing care or services--by volunteer fire departments, with a nurse, church, etc. CC. We can't forget about those who don't qualify for insurance but will be going in for services. Ex: Undocumented, working poor, incarcerated individuals.	
Next steps for the Committee		
Report Out Preparation		
Identify at least 4 key recommendations for the HSI model design in your committee's area of responsibility. These will be reported out. 15 minutes	• Public health as primary prevention. • Concerns of superimposing new structure like on CHWs. • Tertiary care for mental health. SAMHSA generated. They need to be part of model. To not have them mentioned is a deficit. • Backbone structure. Local representation important. • Health councils to be partners at the table; they should not be the authority at the local level.	

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