

NM HSI Summit, August 19, 2015
Health Care Committee Notes

Topic	Discussion	Next Steps/Follow-Up
Introductions	Pass around sign-in sheet and collect at end of session	
Discussion		
<p>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.</p> <p><i>~Ask each committee member to share:</i> </p>	<p>What was the 1 – 2 key “learning” or “take away” from your round table discussion?</p> <ul style="list-style-type: none"> • What meaning do some of these have for our committee—is it something that we need to address now? <p>How will the funding stream work to bring about these innovations?</p> <p>We need to understand how we will build the “architectural” structure that will address the community integration needs.</p> <p>The job of the Southwest Regional Health Council is to find out from the community what the needs are and bring this information back to state.</p> <p>Determine what the health councils will contribute; how is the system going to support the full spectrum of the data?</p> <p>We currently have data exchanges that are not interchangeable. For example, Gallup area is not integrated in sharing of information.</p> <p>There is concern about all the additional workers in the plan. How will additional worker training look and fit into the model (e.g., EMS extended duties)?</p> <p>Well-being coordinator, CHW, Care Coordinator etc., would it be better to talk about individual functions and specific certifications within these categories?</p> <p>Why don’t we utilize the CHWs we have in place rather than create another role? Will we use the CHWs to reach the outer, hard to reach populations?</p> <p>There is a need for clarity on school based health centers; what are the requirements to becoming certified [as a PCMH?]</p> <p>Quality measurements tend to measure the process rather than outcomes.</p> <p>Related to health outcomes, we are placing a lot on the health system to solve all problems of a community.</p>	

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What are our expectations of the system with regard toward playing this part in the health of the individual community; what are parameters of this [PCMH's/medical care's?] responsibility?

How can we reach a "Shared savings" goal among organizations and be able to keep organizations in business while keeping the larger goals in mind?

There is much concern regarding all the requirements and with a gap analysis within the community.

Regarding the PCMH model, should everything be centered into one spot? Each team may look different.

Funding should flow through medical home with reimbursement based on outcomes of the team, while keeping the goal in mind and not focusing on all the measures.

Should we be keeping a record of the social services accessed by different communities?

Catron county has only 6 hours of medical doctor availability each week.

For rural areas we need "boots on ground" with mobile units utilized. Meet individuals where they are; incorporate mobility.

Use the infrastructure of school. How can we incorporate school based medicine? More money toward health education?

Rural vs urban issues:

~ Rural has a consistent problem of finding adequate care and continuity of care.

~ Urban has a maze of providers that exist with coordination issues.

[An option to consider might be?] Websites devoted to real-time available appointments and their locations.

How about a phone app that alerts people to a doctor's availability and his/her whereabouts?

How do we incentivize the providers????? How do we keep people in rural areas?

For workforce there is a real issue with recruiting people to come and stay in New Mexico.

Ideas:

~ One possible remedy is to recruit kids from these towns and encourage entry into the health care profession. Perhaps incentivizing them to stick with this track by paying their way through school.

~ Legislation will be needed to be put in place.

~ Utilize School based health centers; they are only open part time which is not sufficient (often because of a lack of providers to serve full-time; this is the situation with school nurses also). This could possibly be a great place for career education.

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- ~ Need for training and to engage young people in health professions.
 - ~ Need for programs that teach the value in building resiliency and leadership.
 - ~ We need to remedy the glitches in the system that make it harder for professionals to enter the N.M. system.
 - ~ Take education to community. Not realistic for people to leave their pueblo for education.
 - ~ Nursing program is difficult to get into. Alamogordo and NMSU students are not meeting qualifications once they complete the various programs. Traveling nurses from other states are getting paid more than nurses from New Mexico.
 - ~ There exists a state wide based curriculum for nursing with 15 programs so students can do BSN (Bachelor of Science in Nursing) work at community colleges.
 - ~ Hard to find a job due to older nurses staying around.
 - ~ Doctors leave to get more pay elsewhere after residency.
 - ~ J1 visas are relied on for placement in small towns.
- Tax credits could be used to support these movements. [We should bring ?] New models working through FQHC.
- ~ Should telemedicine be a model where we offer reimbursements to manage offices?
 - ~ Perfect example is Medicare payment for physicians; a Formula is needed that comes up to tie physicians pay to quality incentives.
 - ~ It is being said that Congress is going to start pushing doctors to reduce readmission rates. Key issue is doctors will not be accountable to all metrics if they are a part of incentives.
 - ~ Look at bundled payments; El Centro is a model that has done this well.
 - ~ ACO with 5000 Medicare patients, so you have to spread risk. If you send high risk patients down the road, you'll have to find a way to pay.
 - ~ CMS [has?] seed money for FQHCs that own school based health centers if they are really intentional they can identify population and get to helping and educating risky populations early.
 - ~ Identify what policy changes are needed to help with what we want to accomplish. What are legislative barriers??? Does the Centennial Care Model have to change?
- ~ Care coordination is key at local level.
 - ~ What would we need to do to facilitate data sharing???
 - ~ Doctors [or databases] have to strip information before sharing. How to comply with this?
 - ~ State statutes limit this sharing.

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~ Medicaid patients need to be held accountable as well. Why is all the blame placed on Healthcare?

~ Does this change mean increased co-pays?

Patients are going to go to E.R. regardless.

Perhaps more Case management is needed.

Introduce a triage system that would allow residents access to medical advice from a RN as to whether or not their medical situation justifies an ER visit. The nurse could direct them to an urgent care or somewhere other than an emergency room.

When hospitals lose money they simply cut back on salaries.

Education is a good way to deal with information sharing.

Patients need to understand health care and rates. If we have to chart so much information, we do not have adequate time with the patient.

Other topics in the draft design from the round tables:

Engaging patients in their own health care

Need for a state database

Employee based intervention

Utilizing health equity as a foundation.

Looking at health over the lifetime

Share real time information

Standardized payments

Modified state wide standards

Shared savings model

Support 638's to also become 330's.

Collaborative care coordination establishes quality measures.

For practices it takes far too long to be credentialed by an MCO, 15 months and upward.

Aligning payment with specific health issues.

Data, resources and role recruiting; someone should have a designated role in the PCMH that is in charge of recruitment and sustainment.

Medicaid model. 2 person practice needs diff supports than a 5 person practice

Modified state model based on standards. When they reach national recognition, they will have additional reimbursement.

Increase reimbursement depending on what level or tier PCMHs were on. If they had more CHWs, they would get a higher rate-- that would be an incentive.

Value based tiering should be relevant to the complexity of population.

Can Medicaid Health Homes be aligned with the PCMH?

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A PCMH has a separate process to accreditation. Let's make PCMH concept modeled after the health homes. They are slightly different, however related.

Health Homes are tied to top tier group: SMI (Severe Mental Illness) and SED (Severely Emotionally Disturbed)—they're tied to two populations with no incentive for them to collaborate.

Regarding School based health, what level of integration is needed?

What are critical criteria that are not reflected in plan?

A well-defined payment model is essential to the project.

What does value based payment mean in practical terms?

Different incentives make a standardized approach of payment difficult.

How do we involve the uninsured in Medical Homes?

More work needs to be done in signing up patients with ACA's expanded care.

Some children have insurance but the insurance cannot be billed due to uncompensated care for confidential services.

Medicaid process needs to be completed and this step can't be without parent consent.

Young can consent themselves to services but can't get coverage due to inability to give out information without parent.

With regard to Community Centered Wellness Homes

Who pays the salary?

What are the roles within the model?

How do we get from patient centered to community centered?

How do we get patients to follow prescriptions for a walk in the park if there is no park?

Community centered ability to address trauma, housing, problems with asthma. Who are the developers of community wellness?

Who is leading these community efforts?

Health Leads will follow through with patient.

"Health Leads" vs. "CHW's," how are they different?

Maybe strengthen and broaden CHW's approach?

Health Homes are untied to PCMH. PCMH needs to have intentionality; there's a primary care need with a mental health component. How do we merge the two?

BH providers don't like asking about Primary Care.

How do we take care of Complex Chronic conditions?

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ROI's (Release of Information) needed to communicate and collaborate with primary care.

Health homes operate with a different payment system from PCMH; they use a PMPM that goes to HH. Decide what the care plan is determined from primary care.

School based health centers used to be alone and some are now involved with FQHC's. They receive more administrative support but are not incentivized and are still a fee for service model.

In school based model there is a lot of coordination between primary and BH that is not compensated. They still are being asked to support this process. Physicians do not have time for care coordination. Where is the time for physicians to do their jobs if they are being asked to do additional tasks?

We need a well-being coordinator that is the link between the providers and BH (Behavioral Health). A high level Coordinator or position to oversee care across the spectrum.

Practice team needs to coordinate to find out medications.

Treatment team is needed where all would meet to determine best practice approach for care of patient.

(Referral Coordinator, Nurse, Case Manager, Doctor)

How do we pay for a real integrated system of patient information tracking?

Some outcomes that should apply across the board?

In establishing quality within the system, what quality measures should we be reporting on?

Who's analyzing the data?

Small practice does not have resources for analysis.

A PCMH collaborative approach--would there be a single oversight body for this?