

NM HSI Summit, September 16, 2015
Health Care Committee

Topic	Discussion	Next Steps/ Follow-Up
Introductions	Pass around sign-in sheet and collect at end of session	
Discussion		
	<p>A goal is to review the specific design content related to the work done by and recommendations made by <u>your</u> committee and workgroups. Review and refer specifically to slide(s) numbered: 4, 10-11, 21-23, 28-29, 31-32 and others.</p> <p>The emphasis, at this point, is to refine and/or clarify input and recommendations already made, rather than to provide more recommendations. We hope the questions below help guide you.</p>	
<p>#1: Does the current version of the HSI design adequately incorporate the recommendations made by and the work done by this committee?</p> <p>If not, please describe what needs refining or changing.</p>	<p>~#4 PCMH and CCWH seem to be a merging concept. The actual goal is integration with a statewide expansion of PCMH that ends with a community wellness model. Where do Community Health Councils fit?</p> <p>~#13 BH continues to be missing from the overall picture and appears to still remain in a separate silo... "It speaks volumes that we continue to talk about BH as a separate silo."</p> <ul style="list-style-type: none"> - School districts are missing. - SBIRT (Screening, Brief Intervention, and Referral to Treatment) is a model that we talk a lot about. It requires primary care physicians to understand more in the area of BH. Because more physicians are prescribing psychotropic drugs, they should understand and be trained on more BH issues. - Reimburse adequately for <u>all</u> Behavioral Health services. - Reevaluate Medicaid Fee schedule. - New codes are needed in order to bill for CHW services. - Limit the cumbersome regulations around CCSS (Comprehensive Community Support Services). - Case Management should not have constraints and excessive regulations. - Care coordination is a case management function. - Change Centennial Care contract to add case management. - Care Coordinators should work in clinics to serve all MCOs and be out in the communities. Look to first Choice and Hidalgo as models for care coordination. - Care coordinators credentialed by all MCO's - Have adequate PCMH reimbursement so as to be able to pay CHW's employed by PCMH. 	<p>Wellness home/Network – how do we certify this or do we certify?</p> <p>CCWN- who within the community is doing the analysis to determine the community's social determinants?</p> <p>Who would work on the policy piece and help with finding funding</p> <p>Evaluate whether a SED (Severely emotionally disturbed) diagnosis is needed in order to qualify for BH services?</p>

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	<ul style="list-style-type: none"> - Better define the scope of work for a CHW. We don't want CHWs making medical recommendations. <p>~ #10, Bullet 2</p> <ul style="list-style-type: none"> - In place of CCWH (Community Centered Wellness Home), let's define it as a Community Centered Well-being Network so as not to confuse the public. This is not a concept; rather it is a model and social determinants are a component of the CCWN (Network) <p>- Wording- Not "explore" but "implement".</p> <ul style="list-style-type: none"> - Uniform should not be too uniform due to different size practices. - Define parameters of TA center. - PCMH workgroup will work on learning how to measure and improve quality of care and implement best practices. - Utilize someone from HEDIS unit that would be able to go out and provide the technical support; a guide that will offer that support and put that in front of a small practice. - It was stated that the Primary Care Association does this service for FQHC's. - Health Insight will do that because of Medicaid funding opportunity. - A collaborative approach that represents what everyone is doing is needed here. <p>~ Bullet 3.</p> <p>Independent Providers that are not part of Medicaid funding are not included and should be.</p> <p>~ #11, Number 9.</p> <ul style="list-style-type: none"> - Address social determinants. - Add case management within organizations. - Tribal should not be treated separately. However, take into consideration; they are not subjected to same regulations. - Once again, we did not talk about BH. Needs to be address everywhere. <p>~ #21</p> <ul style="list-style-type: none"> - CCWN alignment - Social services to address social determinants of care. - Add correctional facilities and emergency responders to the plan. - HSD and BHSD sit separately from health and this is a problem - Strengthen the fragile BH system that exists in New Mexico. Fund those with expertise and adequate knowledge to run BH successfully in New Mexico. 	<p>Evaluate the effectiveness of the MCO Care Coordination Staff because much of their time is spent sitting in cubicles calling members.</p> <p>Is it too excessive to require RN to be a care coordinator; is this the best use of a limited resource?</p> <p>Let's obtain wide spread knowledge around what exactly CHWs are doing.</p>
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	<ul style="list-style-type: none"> - BH needs additional investment and sustainability. - Substance Abuse needs to be a focus. It would be useful to know roughly what % of people are self-medicating. -FYI, there are CYFD funds for BH services and law enforcement also has funds for BH services. - Community politics –silo - Geography- silo. - Have a LISW (Licensed independent social worker) and psychologist in all hospitals. -Fund BH providers at the school level. - Reevaluate our state’s licensing and reciprocity laws. For example, one out-of-state LISW was not eligible for New Mexico licensure due to the order in which she attained her certifications. ~ #22, Bullet 3 - Just because you want to be a FQHC doesn’t mean you will be funded. - Note: HRSA pays for technical assistance for any entity wanting to be an FQHC. - Number 3 should be removed. The NM Primary Care Association already performs this function (FQHC technical assistance) and has assisted some tribal clinics already. 	
<p>#2: Are there any components or factors that have <u>not</u> been considered or reflected in the design that are important to <u>your committee’s specific area of expertise or interest</u>? If so, what are they? (Again, refer to slide(s) numbered 4, 10-11, 21-23, 28-29, 31-32 and others)</p>	<p>~ #23, Bullet 3</p> <ul style="list-style-type: none"> - SBIRT has no federal funding. Brief intervention is not covered. - FQHC’s were funded to do SBIRT which was imbedded in places that had no BH. - NM does not reimburse for these codes. Medicaid has codes but they have not been turned on. -OSAH and hospital indigent care provide some behavioral health services but the services are not part their fee schedule. - Min set of standards....PCMH like standards. - Establish a body to define the measures. TA center - Measurement set is determined at the state level (I.e., CMS measures, HEDIS measures, NCQA measures). - Need a pediatrician think about measures for all - Change strategy 3 to say “Will adopt minimum PCMH practice standards set.” - Need to report on a minimum set of measurements. - Number 3 doesn’t belong on strategy 3 because it is an actual measure. Say, “BH Care”. 	<p>Establish the needed measures.</p>

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Report Out

What are the key points from your discussion that you want to share with the rest of the Summit participants?

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