MINUTES OF THE

SANTA FE COUNTY

HEALTH POLICY & PLANNING COMMISSION

SPECIAL MEETING

October 6, 2015

Santa Fe, New Mexico

I. This special meeting of the Santa Fe County Health Policy & Planning Commission (HPPC) was called to order by Chair Judith Williams at approximately 9:08 a.m. on the above-cited date at the Southwest Conference Room at Christus St. Vincent Hospital, Santa Fe, NM.

II. The following members were present:

Members Present:
Judith Williams, Chair
John Abrams
Vivian Heye
Bonnie Keene
Don Reece
Kim Straus
Anna Voltura

Member(s) Absent:
Carolyn Roberts [excused]
AnnaMaria Cardinalli
Reena Szczepanski

County Staff Present:
Patricia Boies, Director, Health Services Division
Kyra Ochoa, Health Services Staff
Kati Schwartz, Mobile Health Van Nurse
Jennifer Romero, Teen Court Program Manager

Others Present:
Sylvia Barela, Associate Director, Santa Fe Recovery Center
Jim Breland, Director of Clinics and Support Services, Presbyterian Medical Group
Yolanda Briscoe, Director, Santa Fe Recovery Center
Kristin Carmichael, Director, Community Health, CHRISTUS St. Vincent
Dave Delgado, President, SVH Support
Christine DeLucas
Julian Duran, Community Services Support Specialist, Blue Cross Blue Shield
Leslie Dye, CEO, Santa Fe Indian Hospital
Carolyn Earnest
Ramona Flores-Lopez, Fiscal Services Manager, PMS
Katherine Freeman, CEO, United Way of Santa Fe County

Paul Haidle, Field Representative, Senator Martin Heinrich
Ron Hale, Coordinator, New Mexico Alliance of Health Councils
Gaile Herling, Adelante Program, Santa Fe Public Schools
Jay Jolly, CEO, La Familia Medical Center
Wendy Johnson, Medical Director, La Familia Medical Center
Joe Jordan-Berenis, Director, Interfaith Community Shelter
Cathy Kinney, former member, Health Policy and Planning Commission
Paige Leigh Kitson, Case Manager, Interfaith Community Shelter
Janette Lee, Great Start Family Support Program Manager, United Way
Bernie Lieving, Community and Policy Advocate, Southwest CARE Center
Shelley Mann-Lev, Director, Santa Fe Prevention Alliance, Santa Fe Public Schools
Susan Mayes, New Mexico Association of Counties
Andres Mercado, Paramedic, City of Santa Fe Fire Department
Mike Mestas, Fire Captain, Santa Fe County Fire Department
Mary Kay Pera
Sue Perry, Wellness Coordinator, Human Resources, City of Santa Fe
Maria Jose Rodriguez Cadiz, Executive Director, Solace Crisis Treatment Center
Trip Rothschild, Board Chair, La Familia Medical Center
Ramona Scholder
Dan Sleavin, Chief Financial Officer, SVH Support
Tom Starke, Santa Fe Behavioral Health Alliance
Amanda Valdez-Androlewicz
Deborah Walker, Executive Director, NM Nurses Association

NM Department of Health:
Kelly Gallagher, Community Health Epidemiologist, Health Promotion Program
Susan Gonzales, Director, Northeast Region
Christine Hollis, NM Health System Innovation Coordinator
Amy Sandoval, Health Promotion Program Manager, Northeast Region
Tres Schnell, Director, Office of Policy and Accountability
Desiree Valdez, Health Promotion Specialist, Northeast Region
Rachel Wexler, Health Promotion Coordinator, Northeast Region
Amy Wilson, Chief Nurse

Introductions

Roll was called and showed a quorum of HPPC members. Those present introduced themselves.

HPPC Chair Judith Williams welcomed the participants to the special meeting designed to gather input for the State Department of Health on the draft Health Systems Innovation Design. She explained this initiative was created by the Affordable Care Act (ACA) and administered by the Centers for Medicare and Medicaid Services Innovation Center. The initiative is intended to support states in the design and testing of innovative health delivery and payment model that reduce spending, enhance quality of care and improve population health.

Chair Williams said New Mexico received a $1.9 million planning grant in January and the design is due January 2016. If approved the state will get substantial additional funds to test the model. She introduced the Director of the Office of Policy and Accountability at DOH, Tres Schnell, MSW.

Health Systems Innovation Design – Draft Presentation by the New Mexico Department of Health

Ms. Schnell said they are looking at patient centered medical homes and social determinants of health. She believed this was the level at which most could be accomplished to influence the public health system positively. She clarified that the process they are engaged in is a design process to get input from local and state stakeholders, hospital associations, the Office of the Superintendent of Insurance, payer groups, and food banks. They have enlisted the aid of 38 health councils around the state and she commended the health promotion teams. She emphasized there is no guaranteed funding to support the design. The next step will be to apply for funding to test the design. Thus far states have been granted between $35 million to $120 million. Since there is no dedicated money they are seeking other funding.

They are looking at ways to innovate the health system to focus on improving population health. They are looking at a person-centered approach, paying more attention to the social determinants of health. In a community centered approach they intend to invite the healthcare system to come upstream and join in health promotion and prevention. She acknowledged the behavioral health system is very broken. Additionally, there is a workforce shortage. They are aiming at an integrated health system over the continuum of healthy communities all the way to end of life – hospitals, primary care, federally qualified health centers – and at promoting patient or person-centered care. This will be inclusive of public health, behavioral health, oral health, and primary care.

Ms. Schnell said a healthy community needs access to the continuum of the health system. The model of a community-centered well being home includes a patient-centered medical home approach, which is team based with community health workers or EMTs engaging with caregivers to ensure healthy behaviors continue once someone leaves the system. Accountable care organizations such as hospitals will work closely with providers to ensure the whole person approach.

She recognized the challenges that some people have related to the social determinants of health – transportation, employment, access to education and health literacy. She said they need to look at what is currently in the state that can be built on, such as the 70 certified medical homes now in the state. She mentioned initiatives regarding community EMS. Ms. Schnell showed a chart with the person/family in center, surrounded community health and tribal health councils, 54 local public health offices that can be transformed into hubs of community wellbeing. The ACA recommends transferring clinical services into the healthcare environment. Community-centered wellbeing homes are at the core of the model.

Turning to guiding principles, she mentioned the whole person approach, primary prevention, and how to promote wellbeing; smoke-free housing units and walking trails as examples. Health equity and access are essential which entail a "no wrong door" approach. The

payment model has to support the model design and is based on healthy outcomes rather than fee for service to incentivize payers to reimburse on the basis of outcomes. Metrics to be examined are population-based. The three key metrics they have chosen are obesity, diabetes and tobacco use, all major contributors to chronic disease. They are also looking at access to behavioral health services, and substance misuse. Consultation and collaboration are essential elements for system innovation; there has to be stakeholder and consumer input at every stage.

Ms. Schnell reviewed 12 key strategies, one of which is to establish and define criteria for community-centered wellbeing. The hubs need a set of descriptors. Washington State and Vermont have model of accountable communities which could help inform what a community-centered wellbeing home looks like in New Mexico. She recognized that some communities in the state are under-resourced and they are looking at a technical assistance center to help practices transform to become more person-centered. There is a need for a value-based, bundled payment model. Centennial Care has several models throughout the state. Metrics need to be standardized. Policies and regulations are being examined.

Other strategies include transforming and growing the workforce through such measures as community EMTs, residency programs and grow-your-own strategies. There has to be an effort to build technology capabilities that foster communication. Currently there is no functional health information exchange in the country. Additionally, partnership and governance have to be established.

Ms. Schnell said they have engaged over 1,000 people in stakeholder conversations and she is optimistic about progress.

Questions:

What kind of incentives would there be for payment models and how would that be rolled out? Ms. Schnell stated Blue Cross/Blue Shield is currently in a pilot program that is still fee-for-service, but with patient evaluation and positive outcomes, with a per-person-per-month approach with follow-ups.

How would this work in rural areas? Ms. Schnell mentioned a regional approach, mobile services, and public health offices. "It takes a lot of cooperation." Ms. Wexler said she has been getting input from the rural areas and they are trying to bring in creative approaches and trade-offs.

What about the Spanish-speaking population? Ms. Schnell recognized there is a tendency for the immigrant community to fall through the cracks. They are doing medical Spanish trainings within and outside the Department to support health equity. However, some are not eligible for coverage.

Is there any example in the United States where progress is being made without payment reform? Ms. Schnell said there was not; payment reform is key. She reiterated that there are several pilot programs in the state involving payment reform.

Are there areas in New Mexico for social impact investing? Ms. Schnell said they are working on that issue with an economist to look at return on investment. She mentioned the food bank as a possible example as an innovative approach.

Given the prevalence of state-level organizations where most of the money is in the care system rather than in public health, how have the conversations with the MCOs, etc., gone? Ms. Schnell said that is a challenge and that's where policies come in. With accountability and criteria that have to be met there are opportunities to make it work, although she admitted it would not be easy.

Does the model request changes in Medicare and Medicaid payments? Ms. Schnell indicated the ACA in creating the Center for Innovation is offering various types of waivers for different payment models. They understand the need for changes in areas like behavioral health. She noted 60 percent of the population is covered by private pay, including state employees, and Medicaid. A wellness center has been opened for state employees and there are negotiations underway to be more inclusive of wellness practices.

Are there specific plans for transforming the workforce, given that 2/3 of UNM graduates leave the state? Ms. Schnell directed the participants to the health innovation website where there is more information on tele-health, residencies, and incentives such as loan repayment. She mentioned Project Echo wherein retired physicians do remote consultations on specialties. Ms. Wexler added the model also looks at other sorts of providers such as community para-medicine and community health workers. It's all part of reimagining what the healthcare system will look like in the future. Ms. Schnell spoke of advanced training for nurses and other health workers to create bridges and allow care providers to practice to the full extent of their license. There was a discussion regarding reimbursement for health teams.

If there is an emphasis on paying for outcomes will providers be incentivized to "cherry-pick" their population and avoid the chronically ill, the homeless, etc.? Saying they were cognizant of that challenge, Ms. Schnell noted they will be meeting with the Superintendent of Insurance to talk about people in the high-risk pool as well as the immigrant population. It's essential to work out how to engage with that population in terms of preventive care and healthcare.

Given the fact that one in four deaths in New Mexico is related to alcohol or drugs, why is that not one of the key metrics? Ms. Schnell said the strategic plan includes substance misuse and alcohol-related death among the top nine priority indicators and it recognizes the importance. CMS has dictated the top three priority indicators because of chronic disease, so it comes from their directives. However, DOH is passionate about those factors along with suicide, interpersonal violence, elder falls, etc.

A discussion ensued regarding "substance misuse" and "use disorders". Ms. Schnell said CMS priorities include both as well as DWI, opioids, binge drinking, chronic alcoholism, etc.

Where do economic development and social determinants fit into the plan? Ms. Schnell said they believe the plan will contribute to economic stability through a greater workforce and payment systems that support more workers, as well as reduced health costs and healthier communities in

general. However, economic development per se goes beyond the purview of the study. Ms. Wexler pointed to the grow-your-own model as contributing to economic development.

[The session recessed for a ten minute break at 10:20, followed by separate small group discussions from 10:30 to 11:30.]

Ms. Wexler asked that input be on paper so it can be fed into the design process. She asked that the question on additional resources include creative things beyond merely money. She also asked the groups to add to or modify the Community-Centered Wellbeing Home diagram. Ms. Hollis noted that rural areas are going to differ from areas with more resources. Most areas have tribal or community health councils and cooperative extension offices. It is envisioned these will play a role.

[The remarks are collated from all of the groups by topic.]

1. Is this model design appropriate for your community? Will it work?

- Lots of questions remain; a key to the diagram would have been helpful
- A behavioral health component seems to be missing
- Santa Fe would have to have a different model
- Is this practical?
- Role of the community health worker is unclear
- Where do lessons learned from elsewhere fit in and why is it believed this could work now
- Buy-in is critical
- Model might be imposed at any event
- Until poverty, housing and unemployment are addressed this is only a band-aid
- There are good elements, but implementation plan unclear and needs the provider voice to ensure implementation strategies can be effective
- All state agencies need to be onboard
- Payment issues need to be fleshed out
- Given the size of the project model it should be phased
- What is meant by "community"? Success depends on definition
- Could this design make the system worse?
- Process needs to be community-driven given variety in state
- One system that has to fit everywhere could water it down
- Is there sufficient flexibility? Could there be a menu of models?
- Model seems complicated; might be a hard sell

2. What additional resources would be needed to make it work?

- Safe and affordable housing are important
- IT compatibility among providers and access to broadband
- Standardized health screenings
- "Warm hand-offs" between players

- Structure and policy in place in order to utilize resources in a coordinated fashion
- An incentive for collaboration
- Enhance communication in general
- Build on elements that are working now
- Standardize measures across state
- Responsibility of insurance providers need to be fleshed out
- Pilots on smaller scale to see what works
- Model could work for 90% of population and leave the high utilizers, who use a greater portion of resources are left behind
- Bring in sociologists, anthropologists, and marketing experts since this represents a cultural shift

3. Do you foresee problems with any of the elements of this innovation model?

- Doesn't seem to include most vulnerable populations: illicit drug users, undocumented, the homeless, and a large aging population with different medical needs
- "Accountable community of health" preferred to "home"
- Responsibility, coordination and financial models were not included in model
- Incentives that encourage cherry-picking are to be avoided
- Funding needed for transportation, prevention and wellness care
- How will risk pools be established?
- All elements need to be fleshed out
- Financial incentives need to be in place
- More community feedback needed to ensure cultural sensitivity
- Balkanization and competition among agencies and political organizations
- Providers are feeling disenfranchised
- Legal provisions, HIPAA, could impede collaboration
- Needs to be brought to human level; model should be tested by examples
- Health literacy could be an issue

4. Based on your community's experience, are there changes in the model that you would recommend?

- Payers need to be front and center; they need to be on the same page with fostering change
- Unclear what Medicaid would pay for
- Outreach needed to inform public what is available
- Include mobile community care, with options for chemotherapy, dialysis, etc
- Prison, military and VA should be included
- More emphasis on behavioral health and its integration into primary care
- Eliminate barriers and obstacles that inhibit care, such as limitations on payment critical to case management
- More needs to be in central role besides "person/family"; significant providers and caregivers should be in middle, not the fringes

- More emphasis on prevention
- A menu of models

5. Is it clear who will be responsible and accountable for coordinating the implementation of this model?

- There was consensus that the answer to this question is no
- A healthcare authority involving existing agencies must be brought together
- Funding should be tied to metrics of population health
- Hospitals and government agencies could take the lead in coordination and facilitation
- Leadership could be assumed by a consortium
- Could agencies be merged? Could bureaucracy be streamlined?

Ms. Wexler said she will take the information and pass it along to Ron Hale who is gathering input from all over the state through meetings with stakeholders, tribal councils, focus groups and health councils. After that it will go to the steering committee. The final model will be presented December 15th in Albuquerque.

Adjournment

This meeting was declared adjourned at approximately 12:10 p.m.

Approved by:

Judith Williams, Chair
Health Policy & Planning Commission

Respectfully submitted by:
Debbie Doyle, Wordswork

COUNTY OF SANTA FE)
STATE OF NEW MEXICO) ss
I Hereby Certify That This Instrument Was Filed for Record On The 10TH Day Of November, 2015 at 11:11:42 AM
And Was Duly Recorded as Instrument # 1779334
Of The Records Of Santa Fe County
Witness My Hand And Seal Of Office
Geraldine Salazar
County Clerk, Santa Fe, NM
Deputy

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