New Mexico ALLIANCE of Health Councils

Mobilizing Communities for Health

New Mexico Alliance of Health Councils
Health System Innovation (HSI)

Community Stakeholder Input Report

January 29, 2016

APPENDIX

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New Mexico Alliance of Health Councils
Health System Innovation: Community Stakeholder Engagement
APPENDIX 1: Community Input Sessions

Health Councils	Round 1*	Round 2	Round 3	Round 4	Other Activities
Northeast					
Colfax	May 12	Sept. 2	Sept. 29	October 19	
Guadalupe	May 14	Aug. 26	Sept. 21	Oct. 28	
Harding	May 14	Aug. 26	Sept. 22	Oct. 21	
Los Alamos	May 12	Sept. 11	September 3	Oct. 26	Survey
Mora	May 14	Aug. 31	Sept. 28	Oct. 28	
Rio Arriba	May 12	Sept. 9	Sept. 22	Oct. 20	
San Ildefonso Pueblo	May 12	Did not accept funding	Did not accept funding	Did not accept funding	
San Miguel	May 14	Aug. 26	Sept. 19	Oct. 29	
Santa Clara Pueblo	May 12	Did not accept funding	Did not accept funding	Did not accept funding	
Santa Fe	Did not participate in first round	Sept. 11	Sept. 29	Oct. 6	Survey: July & Aug.
Taos	May 12	Sept. 16	Sept. 29	Oct. 15	
Union	May 14	Sept. 18	September 25	October 20	Collected info.
Northwest/Metro					
Acoma Pueblo	May 28	Sept. 29	Sept. 29	Sept. 29	Surveys (combined 3 & 4 and joined Cibola)
Bernalillo	June 23	July 28	Aug. 25	Sept. 22	
Cibola	May 27	Sept. 9	Sept. 16	Sept. 29	Focus groups
Cochiti Pueblo	May 15	July 22	Aug. 17	Sept. 28	
McKinley	May 13	Aug. 12	Sept. 29	Sept. 29	Surveys (combined 3 & 4)
Sandoval	June 10	Sept. 8	Sept. 14	Oct. 9	9/8 Incl. Five Pueblos
San Juan	June 18	Aug. 20	Sept. 10	Sept. 17	
Tohajillee	June 1	Aug. 3	Sept. 8	Oct. 5	
Torrance	June 3	Aug. 5	Sept. 15	Oct. 22	

Valencia	June 3	July 1	Sept. 9	Oct. 7	
Southwest					
Catron	June 1	Aug. 21	Sept. 14	Oct. 4	
Dona Ana	June 24	Aug. 19	Sept. 29	Oct. 27	
Grant	June 22	Aug. 24	Sept. 21	Oct. 5	
Hidalgo	June 3	Aug. 24	Sept. 2	Oct. 7	
Luna	June 25	Aug. 25	Sept. 29	Oct. 22	
Otero	June 2	Aug. 13	Sept. 1	Oct. 6	
Sierra	June 17	Aug. 20, 21	Sept. 14	Oct. 28	
Socorro	June 18	Aug. 19	Sept. 17	Oct. 15	
Southeast					
Chaves	May 27	Aug. 7	Oct. 22	Oct. 22	
Curry	May 21	Sept. 3	Oct. 5	Nov. 4	Survey
De Baca	June 3	Sept. 8	Oct. 6	Oct. 6	Survey
Eddy	May 28	Sept. 8	N/A	N/A	Survey
Lea	May 26	Aug. 7	Sept. 30	Oct. 13	
Lincoln	June 2	Sept. 1	Oct. 8	Oct. 15	Survey
Quay	May 14	Aug. 13	Sept. 10	Nov. 2	Focus groups, interviews
Roosevelt	May 6	Aug. 7	Oct. 8	Oct. 8	
TOTALS:	28	36	35	35	134 sessions

*Orientation sessions in the Northeast Region were combined into two regional gatherings of health councils in Espanola and Las Vegas, NM, with all councils participating.

Additional Community Stakeholder Input/Information Sessions:

Espanola Input/Information Session (various health councils & communities)	May 12
Las Vegas Input/Information Session (various health councils & communities)	May 14
NM Assn. of Counties, Health Affiliate	June 18
Health Care for All Coalition	July 30
Con Alma Health Foundation, Community Advisory Committee	Oct. 2
Local Collaborative 16, Sandoval Co.	Oct. 9
Penasco/Picuris Pueblo	Oct. 28

New Mexico Alliance of Health Councils
Health System Innovation: Community Stakeholder Engagement
APPENDIX 2: HSI Data: Health Council Priorities

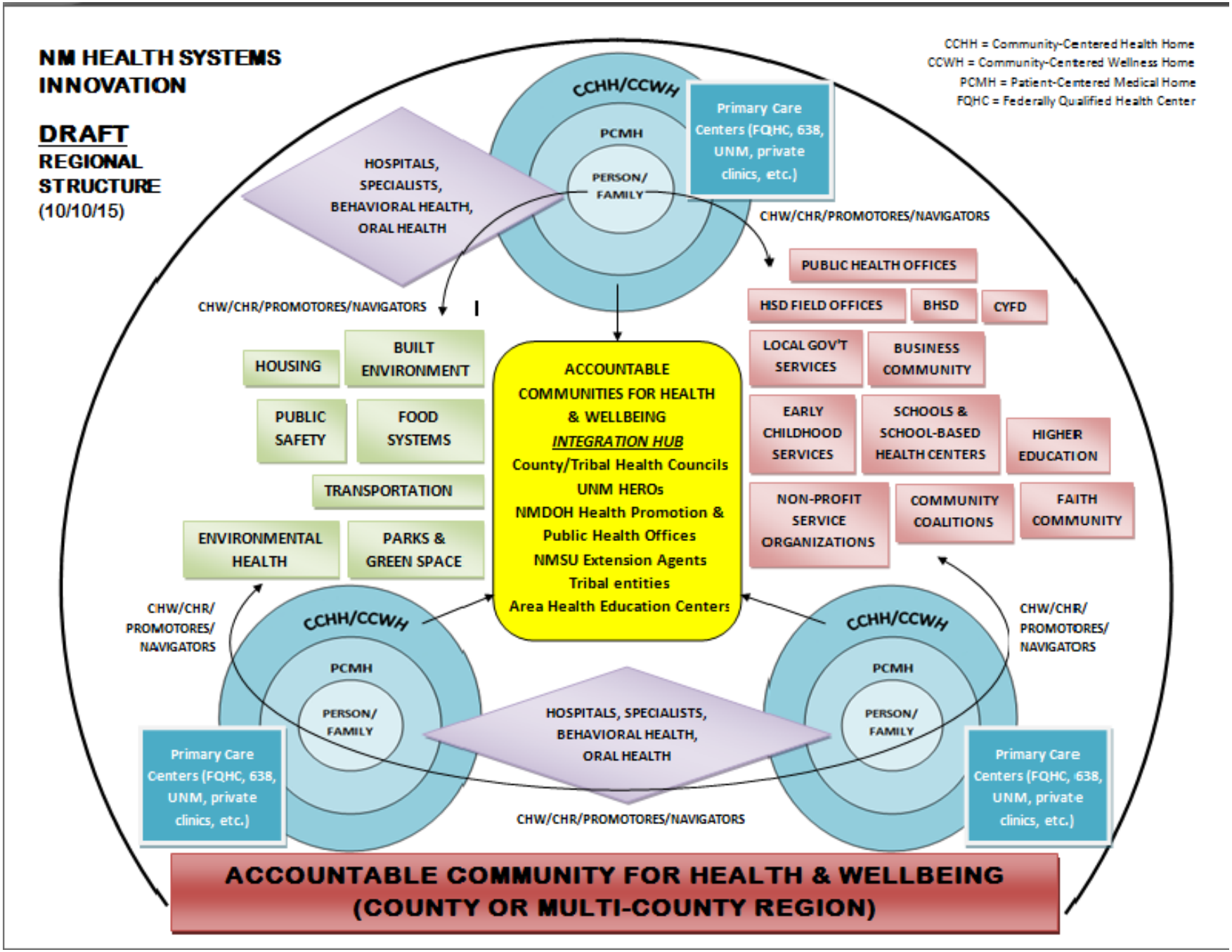
Health Councils	Access to Care	BH: Substance Abuse	BH: MH, Suicide Prev.	Healthy Food, Nutrition	Social Deter-minants	Chronic Disease Prev., Mgt.	Teen Pregnancy	Transport ation	Diabetes/ Obesity	Other
Northeast										
Colfax		x	x	x	x	x	x	x	x	Crime,
Guadalupe	x	x								ER use
Harding		x	x			x		x		EMS
Los Alamos		x	x		x					Elder/youth
Mora	x	x	x			x			x	
Rio Arriba		x		x						ER,Jail,youth
San Ildefonso *										
San Miguel							x		x	Interp./dom.violence
Santa Clara *										
Santa Fe	x	x	x	x		x				LBW,
Taos	x	x	x			x				
Union	x		x	x						Asst. Living
Northwest/Metro										
Acoma Pueblo	x	x	x					x	x	Funding
Bernalillo				x	x			x		Undoc.
Cibola	x	x	x	x		x				
Cochiti Pueblo	x									
McKinley	x				x			x		HIAP, data
Sandoval		x	x						x	Brst.feeding
San Juan	x	x		x				x		
Tohajillee				x	x					data
Torrance										HIAP
Valencia	x	x	x					x		Hospital
Southwest										
Catron	x	x	x	x	x					Home hlth.
Dona Ana										Prevention
Grant		x		x		x			x	
Hidalgo		x		x						Fam. Resil.
Luna		x	x		x		x	x	x	
Otero	x	x	x		x					Prevention
Sierra		x	x	x		x		x		

Socorro	x	x		x						Dialysis
Southeast										
Chaves	x	x	x		x	x			x	
Curry		x	x	x	x		x		x	
De Baca				x	x				x	
Eddy		x	x	x		x			x	
Lea		x				x	x			
Lincoln		x	x			x			x	Child abuse
Quay				x	x	x		x		Prevention
Roosevelt	x	x	x	x	x		x		x	
TOTALS:	**16**	**26**	**20**	**18**	**13**	**13**	**6**	**10**	**13**	
Per Cent:	**44%**	**72%**	**56%**	**50%**	**36%**	**36%**	**17%**	**28%**	**36%**	

*Did not participate

- Health Insurance/affordable care/education about options: Cibola, Cochiti, Guadalupe, San Juan, Santa Fe, Union, Luna, Otero, Sierra, Socorro **(10/28%)**
- Oral Health: To'hajiillee, Cibola, Cochiti, Rio Arriba, Union, Chaves, Quay **(7/19%)**
- Elderly/Senior falls: Sandoval, Taos, Los Alamos, Union, Chaves, Curry, Catron **(7/19%)**
- Interpersonal violence: Mora, San Miguel, Chaves (3)
- Data systems: Rio Arriba, To'haijillee, McKinley (3)
- MCH/early childhood, prenatal care: Taos, Santa Fe, Union, Quay, Roosevelt, Sierra **(6/17%)**
- Tobacco: Eddy, Lea, Lincoln (in pregnancy), Roosevelt **(4/11%)**
- Patient support system/CHWs: Quay
- Medicare reimbursement for home health & hospice: Catron
- Internet, affordable technology: Catron, Luna
- BH, Primary care integration: Dona Ana
- Urgent care, specialty care:

APPENDIX 3


NM HEALTH SYSTEMS INNOVATION
DRAFT
REGIONAL STRUCTURE
(10/10/15)
CCHH = Community-Centered Health Home
CCWH = Community-Centered Wellness Home
PCMH = Patient-Centered Medical Home
FQHC = Federally Qualified Health Center
CCHH/CCWH
PCMH
PERSON/ FAMILY
Primary Care Centers (FQHC, 638, UNM, private clinics, etc.)
HOSPITALS, SPECIALISTS, BEHAVIORAL HEALTH, ORAL HEALTH
CHW/CHR/PROMOTORES/NAVIGATORS
PUBLIC HEALTH OFFICES
HSD FIELD OFFICES
BHSD
CYFD
LOCAL GOV'T SERVICES
BUSINESS COMMUNITY
EARLY CHILDHOOD SERVICES
SCHOOLS & SCHOOL-BASED HEALTH CENTERS
HIGHER EDUCATION
NON-PROFIT SERVICE ORGANIZATIONS
COMMUNITY COALITIONS
FAITH COMMUNITY
HOUSING
BUILT ENVIRONMENT
PUBLIC SAFETY
FOOD SYSTEMS
TRANSPORTATION
ENVIRONMENTAL HEALTH
PARKS & GREEN SPACE
ACCOUNTABLE COMMUNITIES FOR HEALTH & WELLBEING
INTEGRATION HUB
County/Tribal Health Councils
UNM HEROs
NMDOH Health Promotion & Public Health Offices
NMSU Extension Agents
Tribal entities
Area Health Education Centers
CHW/CHR/ PROMOTORES/ NAVIGATORS
ACCOUNTABLE COMMUNITY FOR HEALTH & WELLBEING
(COUNTY OR MULTI-COUNTY REGION)

Health System Innovation:

APPENDIX 4: HSI Statewide Community Engagement Plan

August 7, 2015

Purpose

1. Improve the New Mexico Health System Innovation (HSI) design by engaging NM community members and local stakeholders in the planning process.
2. Provide community-generated ideas and perspectives on health and health care systems, including strengths, current strategies that are working, potential areas for improvement, and promising solutions.
3. Ensure community buy-in and effective implementation of HSI strategies and solutions developed.
4. Build upon and increase the capacity of New Mexico's community health councils as effective partners in community health improvement.

Key assumptions

This Community Engagement Plan represents a community-based process to work in parallel with the statewide Stakeholder Engagement process. Information gathered through the Community Engagement process will inform the work being done by the statewide Stakeholder Committees and the Health System Innovation Committee (steering committee), who will then present overall recommendations for approval by the Governor.

The recommendations and results of the HSI planning process will be of major benefit to the health of New Mexicans, *regardless of whether or not additional CMS funding will follow*. The county and tribal health councils, along with other community representatives, are expected to provide important information and perspectives that will supplement the statewide stakeholder engagement process and strengthen its recommendations.

The overriding question for the community engagement process is: ***How can the Triple Aim be achieved in New Mexico communities?*** This question is broken down further according to the Health System Innovation objectives, as stated in the Community Engagement Template following this Plan outline. Each of the Community Input Rounds will be structured around a series of research questions to guide discussions.

Community Engagement Process

The Community Engagement process is divided into four rounds. Community health councils may elect to conduct expanded health council meetings, town hall-type meetings, focus groups, surveys, sessions with other community groups, or other information-gathering strategies. Each round will build on the previous rounds, resulting in discussions of increasing depth and detail, and culminating in careful consideration of the draft HSI model design in Round 4. There may be some overlap from one round to the next, but the hope is that the concepts and information will be clarified and honed down as the process moves forward.

Round 1. HSI orientation sessions

This round has been completed, using a Power Point presentation developed by the DOH Office of Policy and Accountability, with input from DOH Health Promotion Teams and the NM Alliance of Health Councils. In some cases, the Community Engagement Template (June 2, 2015) was used as a discussion guide. All health councils participated in the orientation sessions. (The Santa Fe County Health Policy and Planning Commission participated in a regional orientation session, but elected not to seek DOH reimbursement.) Summaries of information from these sessions are being prepared and submitted to the NM Alliance of Health Councils.

Round 2. Community Input--Community engagement planning and community assessment

Questions:

1. *What are the major health-related needs in your community, and potential barriers to meeting those needs?*
2. *What is currently working in your community? What resources are there?*
3. *What are the top health priorities in your community?*
4. *What steps can be taken to improve health in your community?*

These sessions are currently under way in the NW/Metro regions, and are scheduled to begin in August in the other regions. The Community Engagement Plan Template (June 2, 2015) is being used.

Round 3. Community Input--Identifying innovative health system solutions for New Mexico

Questions:

1. *What approaches are currently working in your community?*
2. *What approaches are not working well in your community?*
3. *What would you like the HSI Committee and the Governor to know about health in your community"?*
4. *How does this information address the different assets/needs/disparities of various geographic areas and communities within each county or tribal area?*
5. *What role(s) do you see for the health councils in future health systems?*

For Round 3 Input Sessions, the Community Engagement Plan template will be used as a general guide, but focusing on the above questions, emphasizing geographic diversity and disparities *within* counties and tribal areas. This reflects a recognition that even within counties and tribal areas there can be widely different needs, resources, and conditions affecting health and health equity—for example, counties that have one or more principal population centers with concentrated resources, surrounded by rural and frontier areas. An overriding goal of this round is to identify effective and promising practices that are tailored to the unique situations of New Mexico communities.

Round 4: Community Input--Feedback on proposed statewide innovative model design

Questions:

1. *Is this model design appropriate for your community? Will it work?*
2. *What additional resources would be needed to make it work?*
3. *Do you foresee problems with any of the elements of this innovation model?*
4. *Based on your community's experience, are there changes in the model that you would recommend?*
5. *Is it clear who will be responsible and accountable for coordinating the implementation of this model?*

These are tentative questions that may be modified, following release of the proposed model design. Introduction of the model design to the health councils is likely to involve some description, interpretation, and education as a prelude to in-depth discussions and feedback. DOH Health Promotion Teams and the Alliance of Health Councils will develop a standard message to be used statewide as a basis for providing feedback on the proposed design.

Formats for all community input sessions may involve expanded health council meetings, surveys, consultations with other community groups, focus groups, and other strategies appropriate to each community.

New Mexico Health System Innovation
Design Phase
Draft Community Engagement Plan Template

Introduction

The New Mexico Health System Innovation (HSI) process is an initiative to re-design New Mexico's health and health care systems in order to achieve the triple aim of *(1) improving population health, (2) enhancing patient care, and (3) reducing health care costs*. The HSI Community Engagement Process is an opportunity for communities to provide input to policymakers and health system stakeholders about ways to improve the health of people and communities throughout New Mexico. The goal is to work with county and tribal health councils to ensure maximum input and engagement in the HIS planning process, in order to arrive at solutions that make sense for New Mexicans, and that build on existing strengths and resources of New Mexico communities. This template (in use by health councils since June 2015) is meant to serve as a guide in developing a local Community Engagement Plan.

1. *Who will be involved?*

Community Stakeholders: **Who will you engage?**	**Current:** **Sectors currently represented on the health council:**	**To be added:** **Additional sectors who should be involved:**
Examples: • Government • Health care providers • Education (schools, educational institutions) • Social services • Business representatives • Faith communities • Community members • Advocacy groups		

2. *How they will be involved?*

Strategies for engagement: **How will people be involved?**	**Community meetings**	**Other Strategies**
Examples: • Community input sessions (special events or expanded health council meetings) • Community forums/town hall gatherings • Focus groups • Attending meetings of other community organizations, coalitions, networks • Community surveys • Key informant interviews • Community outreach campaigns		

3. Community Assessment Input

Gathering this information will help to prepare your community for providing input into respond to ideas regarding the re-design of New Mexico's health and health care systems. This information may be drawn from the health council's previous community assessment work, and from ideas expressed in initial HSI orientation meetings. The table on the following page may provide a useful framework for organizing your thoughts and information.

Community Assessment Information:

How can the Triple Aims be achieved in your community?

AIMS & OBJECTIVES	Needs: *What are the major health-related needs in your community, and potential barriers to meeting those needs?*	Strengths and resources: *What is currently working in your community? What resources are there?*	Priorities: *What are the top health priorities in your community?*	Solutions and ideas: *What steps can be taken to improve health in your community?*
1. Improve Population Health: • Integration of population health, prevention, & primary care • Address social determinants of health • Create environments that offer healthy choices				
2. Enhance Patient Experience of Care: • Patient-centered care • Integration of primary care, behavioral health, & oral health • Chronic disease management • Access, health care workforce development				
3. Reduce Health Care Costs: • Reform payment systems • Increase health insurance coverage • Expand health information technology				

New Mexico Alliance of Health Councils
Health System Innovation: Community Stakeholder Engagement
APPENDIX 5: Round 4 Brief Data Summary

Health Councils	1. Will the model work?	2. Additional resources needed?	3. Foresee problems?	4. Changes necessary?	5. Clear who is responsible?
Northeast					
Colfax	No, not as written		Distance, cooperation w/ other agencies, funding	Person/family in center	Clear in revised model diagram (MMA)
Guadalupe	No. Need mandate for agency cooperation	Need a revised visual to present to community	Getting agencies to collaborate		Not clear. Has to be a joint effort in county
Harding	Not as presented; more resources needed	Resources are HC members & neighbors	Schematic elements are all services not available here	County needs Public Health presence	No. The model does not support our goals
Los Alamos	Maybe. Some services in the model are out of county	Need SBHC, case coordination network	Needs to be person-centered	Already several integrating hubs in LA	No. County will need to be responsible
Mora	No. Lack of communication	Change Federal poverty guidlines	Accountability, red tape.	Funds needed to support health care	No. Not clear
Penasco-Picuris Pueblo	No. Have limited govt. services. Need to work earlier with small communities	Need employment, vocational training, funding for FQHC, CHWs	Resources on diagram are not in the community; need data systems	Include alternative practitioners; water, communication systems, ranching, agriculture	No. Appears that CHWs & CHRs will have a lot of responsibility
Rio Arriba	Yes. Move the patient to the center of diagram	HCs should be funded & serve as the HUB; can't tie all funds to outcomes (de-incentivizes serving highest need people)	Funneling money through FQHCs will lose many outlying providers	Hub; use ACHW model; decouple CCMH from FQHC; enrollers can't refer pts. to a specific clinic	No. HC could be the HUB: policy, evaluation, distr. of bonuses, create health profile & assessment
San Ildefonso					
San Miguel	Yes. Model looks flexible	Need technology access; HC is resource; HUB will act as coordinator	Duplication of services, HIPPA		No. Who will be the lead coordinator?
Santa Clara					
Santa Fe	Unclear. SF would have to use a different model. Many issues need to be addressed. Need flexibility	Housing, IT compatibility, warm hand-offs, incentives for collaboration,	Doesn't include vulnerable populations; agency competition, funding needed for prevention	Prefer "accountable comm. of health>"home" Payers need to be central; more emphasis on behavioral health	No. A Healthcare Authority is needed; hospitals & govt. can take lead in coordination; use consortium
Taos	No, not without providers in the HUB and funding for the model	System is complex, need navigators, care coordinators	Need a chamber of commerce for health.	System is too complex & a radical departure. It isn't going to happen	No. DOH Health councils

			Difficult to start over. People are over extended		The State
Union	Maybe. No PCMH in our area. Need care coordination, BH services. County lacks basic resources	Need funding ($52.5K/yr.)		Use "coordinated"> "accountable". Define roles & resp. in HUB. Have State create one-stop model for field services	Yes. We can do it with funding.
Northwest/ Metro					
Acoma Pueblo					
Bernalillo	Yes. Clear that CHWs are link to pts.			Comm. coalitions part of HUB; higher ed. In model; need integration; make HUB responsibility clear	Yes.
Cibola					
Cochiti Pueblo					
McKinley					
Sandoval					
San Juan					
Tohajillee					
Torrance	Maybe—the question was not asked.	Transportation obstacles;	Have 2 PCMH clinics: PMS & First Choice are competitors transportation needs to be addressed	Re-write Medicaid rules to include same-day medications, change 72-hr. notification;	
Valencia	Maybe—the question was not asked.				
Southwest					
Catron	Yes. It will be a challenge	Have primary care clinic with oral & BH services; few resources, no hospital, social services or pharmacy, small Public Health presence	Will be a real challenge with lack of services and resources.		No.
Dona Ana	Yes. Needs to be marketed.	NCOs have resources. Have transportation resources, DOH, NMSU students; need funding, coordination	Model is hard to understand, abstract; hard to know action steps.	Model needs to be flexible, less complicated; ways to keep provider autonomy, but attractive to be involved.	No.

Grant	Yes—has possibilities. Are physicians willing to do this?	Community experienced in coming to the table; facilitators HC leadership; DOH Health Promotion, hospital	Payment model could be a problem	Include alternative pr.; organizations struggling with limited resources; can't absorb additional costs; coord. staff	Yes. Looks like primary care, partnership
Hidalgo	Yes. Some components in place. Unsure of role of EMS	Hidalgo Medical Svces., CHWs, EMS in place; need money, training, pharmacy, structure	Easy for client to slip through the cracks, get lost, not receive treatment (e.g., recent suicide victim)		No. Communities should have a voice in design & included in statewide decisions
Luna	Yes. We have a shortage of health professionals, poor internet connectivity	Have promotoras, good hospital, trouble recruiting doctors		Spend more time looking at rural, frontier areas, make plan to fit their needs	No. How will coordinators and health leads be funded?
Otero	Yes. Seems complex; simplified would be better	Have diabetes programs, BH local collaborative, clinics, walking trails; need money, admin. structure	Payment model could be a problem. PCMH & CCWH better in urban areas; private practices need to agree to participate	Bundling pmts. Better; need to incentivize hospital participation; need to change Medicaid non-reimbursement of same-day services	Yes and no.
Sierra	Yes.	Have many existing resources; need funded coordination; need svces. for women & children		Need drug treatment, transportation for seniors, women, & children	Yes. Health care providers responsible, with whole community involved
Socorro	Yes.	Have programs that work together; need funding, provider incentives, reduce duplication of services	DOH owning & implementing without funding & dialog. Model is idealized vision; health system barriers	Need clearer identification of who is on the team; need buy-in from community & providers	No. This plan is far from ready for implementation.
Southeast					
Chaves	Maybe. Info. is lacking from the draft. Chaves Co. has something similar, but resources are lacking.	Need more information. Where would the money come from	Non-competing clause for physicians is a problem. There is some duplication of services now.	Need evidence from other, similar, states	No.
Curry	Maybe. Have to see if it would meet needs of Medicaid & non-Medicaid populations	Need Telehealth resources. Do providers have the technology? Need necessary workforce.	How would current providers communicate? Need to establish roles. Could invade privacy. Are there enough resources?	Questions about provider roles and coordinator responsibilities. Who is paying the coordinator?	The State?

De Baca	Yes, it is working here. Transportation also needs to be addressed.	A community resource brochure, vision providers, CHWs, transportation for appts.	Funding for CHWs & resources. Lack of commitment from providers and/or community. Need standardized EHR system.	Use of credit card type medical record to facilitate communication among providers	No.
Eddy		Smaller communities don't have all the resources	Funding, building, coordinating, leadership issues. Is it per county?	Need Telemedicine, mobile unit, utilize technology	Too much responsibility for one agency. Need qualified staff for PCMH to be successful.
Lea	Yes. How will it be funded?				
Lincoln	Yes.	Get community input. Mental health, medical insurance cooperation. Transportation, dental, vision, more EMS & public health	Who will fund it? Lack of provider resources. Who is the coordinator?	Look to surrounding agencies. Physical therapy. More education, target priorities.	No. Not clear. Responsibility & accountability not clear.
Quay	No. This one size fits all model will not work in Quay County. Resources are limited. Will take time to see positive results, at least 5 years.There are concerns: patient education, pt. Literacy, expense, needs of rural areas (healthy food, housing)	Not enough financial resources to pay for the model; patients are nervous; Public Health vacancies; providers & administrators do not see how reimbursement systems can support the cost.	There is a serious mistrust in Eastern NM of the state. Resources are not available. Medical personnel (including RNs) are scarce in rural areas. Costs of the model; lack of comm. understanding; confidentiality issues. Concerns about abuse of the system. Public Health lacks personnel to cover additional duties. Lack of communication among coordinators. How will coordinators help people who can't afford healthy food & housing?	Need CHWs, Telehealth for it to work; insurance systems must support all of this. Need to develop workforce locally <u>now.</u> Include alternative therapies. Focus on prevention with pt. Incentives. Need dental and specialty care.	No. Lots of confusion about responsibilities. Concern about who will oversee this system. Need clarification of roles.
Roosevelt					

APPENDIX 6

New Mexico Alliance of Health Councils
Brief description of Health System Innovation (HSI) initiative and Health Equity implications

(DISCUSSION DRAFT)

Background. New Mexico is one of 34 states that have received funding from the Centers for Medicare and Medicaid Services to re-design the state's health and health care systems. The goals of this initiative are to integrate health care and population health systems, and to achieve the Triple Aim: Improve the patient health care experience, improve population health, and reduce health care costs. New Mexico has undertaken an extensive, statewide planning and stakeholder engagement process, which included working with and through the state's 38 county and tribal health councils to gather community input as part of developing a model design. The community input process consisted of multiple community meetings over a five-month period (four meetings for each participating health council), with discussions focusing on addressing a number of open-ended questions regarding community health needs and solutions for addressing those needs.

Model design. The proposed model design is still being developed, but it is likely to include a focus on the Community-Centered Health Home (CCHH) model, as articulated by the Prevention Institute. This model is to some extent an enhanced version of the Patient Centered Medical Home (PCMH), an approach that has been widely adopted through the U.S., resulting in PCHM provider certification through several national accrediting agencies.

The Community-Centered Health Home approach in New Mexico will likely include further integration of population health and primary care, with a reconfiguring of current resources at the regional and local community levels, with relationships that are structured to ensure effective coordination and collaboration of key players. Those key players will include community health centers (Federally Qualified Health Centers), of which roughly 70 currently have PCMH certification; county and tribal health councils; community health workers/promotores (currently numbering approximately 1,000); a dozen Health Extension Resource Offices (HEROs) through the University of New Mexico Office of Community Health; Area Health Education Centers; hospitals and hospital systems; and local and regional offices of the NM Department of Health; and others. The ultimate goal will be a system that uses resources efficiently and effectively through increased coordination and integration and reduced duplication; that addresses systems-level changes; and that moves the entire health system "upstream" to address social determinants of health in New Mexico.

Implications for health equity. There are a number of objectives in the proposed HSI model design that should have impacts on health equity:

- Increased health insurance enrollments, building on the state's Medicaid expansion and operational improvements in the New Mexico Health insurance Exchange.

- Improved access to primary care, behavioral health, oral health, and specialty care in all areas of New Mexico, especially in underserved areas with high-risk populations, including rural and frontier regions, tribal lands, and the border area.
- Increased attention to environmental factors in health—not only the built environment, but also pollution and toxic waste. The Community-Centered Health Home model should incorporate addressing social and environmental determinants of health as part of team-based and community-oriented health care.
- Increased emphasis on preventive health. The model design is likely to include changing the roles of public health offices, with reduced clinical responsibilities (shifted to CCHH/PCMH centers), and increased attention to prevention initiatives.
- Use of community health workers/promotores in many different contexts, in order to ensure culturally sensitive services and providers that are responsive to community needs and constraints.
- Payment reforms, including use of outcomes-based reimbursement systems backed up interoperable data management systems, leading to more cost-effective (and less expensive) health care services for low-income, high-risk populations.

Community Responses Related to the ACA: Participants in the HSI community input process expressed a number of concerns regarding the ACA. The largest number of negative comments focused on lack of health insurance and coverage issues (80); NM Health Insurance Exchange issues (38); provider reimbursement issues (30); the need for assistance in navigating the insurance system (28); and Medicaid/Medicare-related issues (36).

ACA-supported prevention initiatives in New Mexico. The ACA Prevention Fund was created to support innovative prevention and population initiatives in the states, although the Fund has faced periodic funding cuts since its creation. New Mexico received two Community Transformation Grants (CTG)—one for Bernalillo County and one to cover fourteen communities elsewhere in the state with high rates of obesity, diabetes, tobacco use, and other indicators of need. The planned five-year grants were terminated prematurely as a result of federal budget cuts, but the NM Dept. of Health has continued to support the programs in the fourteen communities outside of Bernalillo County—presumably extending the impacts of the original CTG funding.

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