



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

COMMUNITY STAKEHOLDER INPUT REPORT

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TABLE OF CONTENTS

	<u>Page</u>
A. BACKGROUND.....	1
B. THE HSI COMMUNITY ENGAGEMENT PROCESS IN NEW MEXICO.....	1
Overall Structure.....	3
C. HSI COMMUNITY ENGAGEMENT RESULTS.....	6
Round 1: HSI Orientation.....	6
Round 2: Community health needs and current resources.....	6
Round 3: Community health strategies, resources, and barriers.....	13
Round 4: Community feedback on outline of draft HSI Model Design.....	21
D. COMMUNITY ENGAGEMENT THEMES AND RECOMMENDATIONS.....	26
The HSI context.....	26
The Model Design.....	27
Factors critical to the success of the Model Design.....	27
Final comments.....	30

A. BACKGROUND

New Mexico's Health System Innovation (NM HSI) design planning process included a structured community engagement process to obtain substantive input and participation from community members throughout New Mexico. This process was in addition to the statewide Stakeholder engagement process and its series of Stakeholder Summits. The Community Stakeholder Engagement process was meant to supplement the statewide stakeholder deliberations with local, and in many cases non-professional, input from the community level. The assumption was that such a grassroots engagement process would not only improve the quality of the state's model design, but it would also ensure community buy-in, leading to potentially more effective implementation of HSI strategies and initiatives.

The goal of the Community Stakeholder Engagement process was to obtain community input about pressing health needs and resources; strategies and community-based approaches to improve population health and which could inform the development and implementation of New Mexico's HSI model design; and provide feedback from communities in response to the proposed model design.

New Mexico's community health councils

The principal vehicle for organizing and obtaining community input has been the state's system of county and tribal health councils, working with the support of the New Mexico Alliance of Health Councils. The New Mexico Legislature established the health councils in 1991 as a system to ensure local, community-based health assessment, planning, and coordination. New Mexico is one of a handful of states that has a relatively centralized public health system, with the county and tribal health councils performing functions analogous to those of county health boards in other states. Representation on the health councils includes community volunteers, health care providers, public schools, social service programs, health advocates, elected officials, business and faith community representatives, and others. Currently there are active health councils in 33 counties and 5 tribal communities. A few of the health councils have paid coordinators, but most function as all-volunteer, community-based coalitions.

The New Mexico Alliance of Health Councils is a statewide organization established in 2010 to support the work of the councils and to serve as a unified voice for the statewide network. A major role of the Alliance is to facilitate communication and coordination with the NM Department of Health and other state agencies.

B. THE HSI COMMUNITY ENGAGEMENT PROCESS IN NEW MEXICO

Overall structure. The New Mexico Alliance of Health Councils (NMAHC) was contracted by the NM Department of Health (DOH) to assist the HSI process by developing a Community Engagement Plan; developing and sustaining community engagement practices, including technical assistance to ensure participation from diverse stakeholders—especially those facing

health disparities; and compiling, organizing, aggregating and summarizing the information gathered through community input sessions under the auspices of the county and tribal health councils. The Alliance of Health Councils worked closely with the New Mexico Department of Health's Regional Health Promotion Teams (HPT) to develop the overall Community Engagement Plan, and to encourage health councils to take part in the community engagement process in their regions. The NMDOH divides the state into the following regions: Northeast, Northwest/Metro, Southeast, and Southwest. NMDOH Health Promotion Team members were often responsible for facilitating the local community input sessions and for summarizing the results of these sessions, sending those results to the NM Alliance of Health Councils for statewide compilation and analysis. Participation by health councils varied by Community Engagement Rounds; see Appendix for a summary of participation levels.

Most county and tribal health councils participated in all four rounds of community input sessions, for which they each received a stipend of \$5,000 to cover expenses related to organizing and hosting the community engagement sessions. Two tribal health councils (Santa Clara and San Ildefonso Pueblos) elected not to continue beyond the orientation sessions. Some other health councils did not submit discussion summary reports for later sessions (mostly in Round 4). (For a complete listing of the community engagement sessions, please see Appendix 1, NMAHC Community Engagement Sessions Summary.) The purpose of each round was outlined in the Community Engagement Plan that was developed by the NM Alliance of Health Councils, with active involvement in the planning by NMDOH Regional Health Promotion Managers and Public Health Division staff. (The Community Engagement Plan is included in Appendix 5 with this Report.) Each round was built around several organizing questions, as follows:

Round 1: Orientation to the Health System Innovation process

1. *Who will be involved in your community engagement process (which community sectors)?*
2. *How will they be involved (e.g., through community meetings, surveys, focus groups)?*

Round 2: Identifying community health needs and resources

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?*

Round 3: Identifying innovative health system solutions for New Mexico

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?*

Round 4: Providing feedback on the proposed HSI Model Design

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?*

The NM HSI Triple Aim served as an organizing framework for much of the community discussions:

1. Improving population health
2. Improving the patient experience of care
3. Reducing health care costs

Engagement activities. A total of 134 community meetings and public forums were held throughout New Mexico, in communities ranging from the Albuquerque, Santa Fe, and Las Cruces metropolitan areas to remote rural, frontier, tribal, and border regions. Most of the community input sessions were built around the timing of regular monthly public meetings of the health councils, often with additional community members and groups invited to join in the discussions. Input sessions and related activities are listed below:

- 38 health councils participated in the initial HSI orientation sessions. (Two tribal health councils, representing the Pueblos of San Ildefonso and Santa Clara, elected not to continue with the subsequent sessions, because they did not feel they could devote the time and attention to the project that would have been required.)
- 36 health councils reported conducting multiple **community input sessions**. In most cases, these sessions consisted of an orientation session and three input sessions. The input sessions were usually scheduled as regular health council meetings or expanded council meetings--i.e., with additional invited guests representing other community sectors.
- 8 health councils reported conducting **community surveys**.
- 2 health councils reported conducting **focus groups**.
- One health council reported **attending meetings** of other community organizations, coalitions, and a Board of County Commissioners meeting.
- One health council reported conducting **key informant interviews**.
- One health council reported conducting **information-gathering sessions** with key community leaders and entities.

In addition, HSI orientation/input sessions were conducted with several statewide coalitions and organizations representing community stakeholder groups:

- NM Health Care for All Coalition/Health Action New Mexico

- Con Alma Health Foundation, Community Advisory Committee
- New Mexico Association of Counties, Health Affiliate

Results of these sessions are summarized later in this report. All in all, the process involved over 1,000 New Mexico residents from diverse community sectors and geographic areas.

Limitations. It is important to keep in mind that this was a *participatory community engagement process*, and not a research project or formal needs assessment. The purpose was to engage community members in a discussion regarding the design of health and health care systems, much like the parallel planning process undertaken in the statewide Stakeholder Summits and on-going special workgroup meetings. The information gathered was qualitative, but health council and HPT facilitators and the NMAHC worked to quantify categories of responses, along with presenting representative quotes supportive of the overall responses

At the state level, it had been assumed that the development of an HSI “model” design would occur more quickly than it actually did, given the involvement of so many different stakeholders in the overall state design process. It was also difficult to present the draft model of system change, as it developed, in a simple manner to be easily understood by many community participants. This created a timing issue in the community input sessions, which were scheduled to address certain topics and questions at each meeting. Quite often the health council-coordinated community engagement facilitators did not receive, in a timely manner, sufficient information—or a “complete” model of system change (given the many adaptations taking place as input from stakeholders was continuously processed)—to best handle discussions or inform those participating. Despite this, the community engagement sessions were facilitated for the most part by NMDOH Regional Health Promotion staff and health council coordinators, using the best information and skills they had to get the most useful insights from their community participants.

For this reason, community engagement formats and facilitation styles varied from region to region and community to community. In addition, the information gathered at the community level and provided to the NMAHC also varied widely in terms of its specificity and completeness. Most summaries of information gathered and submitted were presented in bullet points, with little in the way of explanatory narrative. Many reports lacked important information, such as who was in attendance, or even the dates of sessions (although the meetings were documented within NMDOH in order to ensure cost reimbursement payments from the Dept. of Health). The input sessions and other activities were focused on answering specific sets of questions, but often the most recent design status and information coming from the state summit sessions were less detailed and clear than was needed to enable participants to directly address the discussion questions or even the Triple Aim elements.

Community sectors involved. The NM HSI community input sessions included both current members of county and tribal health councils and invited guests. A wide diversity of community sectors and entities were represented—including, but not limited to those listed in the following table:

Community Sectors Represented in HSI Process

Health	Community	Other	Government
<ul style="list-style-type: none"> • Health care provider groups • School-based health centers • Behavioral health & substance abuse treatment programs • Hospitals • Managed care organizations (MCOs) • Pharmacies • Health Insight New Mexico • KUNM Public Health Program • March of Dimes • Early Childhood Accountability Partnership • Place Matters Teams • DOH Health Promotion Teams • NM Community Data Collaborative (NMDOH) • NM Health Connections • NM Primary Care Assn. • UNM Health Sciences Center • Physicians Association • Hospital board of trustees • Local Behavioral Health Collaboratives 	<ul style="list-style-type: none"> • Social services agencies • Child advocates • Early childhood programs • Senior programs • Native American groups • Faith communities • Youth providers • Community groups (e.g., Centro Savila, March of Dimes, youth groups, civic groups) • Major employers (e.g., Los Alamos National Laboratory) • Breastfeeding groups • NM Suicide Prevention Line • NM Crisis & Access Line • First Born Program 	<ul style="list-style-type: none"> • DWI Councils • Residents of remote communities in rural counties • Chambers of Commerce • Foster Grandparents/RSVP • Colleges & universities (UNM, NMSU Extension, ENMU) • Advocacy groups, beyond children • Veterans • Mining (business) • Immigrants • Homeless • Incarcerated 	<ul style="list-style-type: none"> • Local government officials (e.g., county commissions, city govt.) • Tribal administration leaders (from Acoma Pueblo, Cochiti Pueblo, To'hajjilee, and the Navajo Nation—under 6 in all) • Law enforcement • District Attorney's Offices • Adult literacy programs • Fire departments • Military officials • Magistrate judges • U.S. Senator's office (Sen. Heinrich) • Workforce Solutions

C. HSI COMMUNITY ENGAGEMENT RESULTS

Round 1: HSI Orientation

An initial Power Point presentation, developed jointly by the NM Department of Health (Office of Policy & Accountability and the Regional Health Promotion Teams) and the NM Alliance of Health Councils, was presented to community meetings organized by the county and tribal health councils. In the Northeast Region, these informational sessions were presented to a combination of health councils together; different county health council members had the option of attending one of two meetings, in Española or in Las Vegas, NM. These initial meetings varied somewhat by region. Most included a presentation followed by interactive discussions that focused on two questions:

1. *Who will be involved in your community engagement process (which community sectors)?*
2. *How will they be involved (e.g., through community meetings, surveys, focus groups)?*

These meetings, like all future HSI Community Engagement sessions, were facilitated by NMDOH Regional Health Promotion staff, with assistance from health council coordinators and/or community volunteers. A few of these sessions also included some of the Round 2 questions, such as, *“How can the Triple Aim be achieved in your community?”* These initial orientation sessions were helpful, since they indicated a need for clarification of some of the terms used, an example being how to distinguish “population health” from clinically-based health care. Some participants also expressed concern over the CMS focus on diabetes, obesity, and tobacco use; while these are priority areas for many health councils, others are concerned with behavioral health, especially in those counties that have some of the highest rates of alcohol and drug-related deaths in the nation. Consensus was reached that the focus on diabetes, obesity, and tobacco use does not preclude continued work on other, equally urgent, priorities.

Round 2: Community health needs and current resources

Organizing 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?*

Answers to these questions were categorized according to which of the Triple Aims each response best related to: *Improving population health, improving patient experience of care, and reducing health care costs.* Below is a summary of the principal themes, based on frequency of comments identifying health needs and barriers to access.

1. **What are the major health-related needs in your community, and potential barriers to meeting those needs?**

a. Population Health:

- **Transportation:** Comments related to the lack of adequate transportation systems—for general travel, for travel to medical and pharmaceutical providers, and everyday transportation for the elderly.
- **Behavioral health:** Many New Mexico communities have high rates of drug and alcohol-related deaths, youth suicides, binge drinking, and interpersonal violence, and the community comments reflected the need to address these indicators. There is a need for prevention, brief intervention, and community-based prevention and treatment programs to address these problems.
- **Coordination of Community services:** These comments referred to the need for better coordination among agencies, service providers, and service systems.
- **Food systems and obesity:** Obesity was frequently cited as a major issue facing communities, along with a lack of access to healthy food, and food insecurity.
- **Teen pregnancy:** Teen pregnancy rates in New Mexico are generally falling, but this is still seen as a major health issue.
- **Rural health:** Issues related to rural health ran through much of the HSI community conversations; roughly 30 out of 33 New Mexico counties are primarily rural (with the exception of Bernalillo, Santa Fe, and parts of Doña Ana and San Juan Counties). Issues cited related to rural population health included aging populations, food deserts, and access to health care services within reasonable distances.

b. Patient Experience of Care

- **Access to basic health care:** Comments focused on provider shortages in primary care, urgent care, specialty care, and women’s health. One commenter from an extremely rural county (population under 700) said they had three resident nurses, but no doctors, police, or local EMS.
- **Access to behavioral health services:** Almost all community sessions mentioned the need for additional mental health, substance abuse treatment, inpatient and intensive outpatient services, and detox centers. One said, “Severe access issues have eclipsed integration of primary care and behavioral health,” referring to the widespread perception that New Mexico’s 2013 suspension of Medicaid funds to contracted behavioral health providers over allegations of fraud resulted in interruptions of services and continued provider instability.
- **Access to oral health services:** Comments mentioned the lack of dentists that accept Medicaid, and long waits for dental appointments.
- **Rural health:** This is a subset of the larger issue of access to services, but it is one that was mentioned frequently by community respondents in rural and frontier areas. Specific issues mentioned included lack of transportation and distance to services, health workforce shortages, a shortage of diabetes educators, and lack of patient support for chronic disease management.

- **Tribal health:** Some tribal representatives complained about inadequate hospital services for their members and difficulties in recruiting and retaining providers. Others mentioned the need for a tribal health information sharing system.
- **Coordination issues:** The need for coordination and integration among service providers was mentioned frequently in both Rounds 2, 3 and 4 discussions. One participant said that communication between providers was inhibited by the lack of a health information exchange system. In one county just outside Albuquerque, community people said that inter-agency referrals and collaboration occurred more smoothly when those agencies were talking with one another, either at the local level or at the state level. Funding for care coordination was also mentioned as a need.

c. Reducing Health Care Costs

- **Health insurance issues:** In spite of the ACA, there were complaints about difficulties in obtaining affordable health insurance—because of high premiums, the high cost of insurance through employers, and difficulties navigating the NM Health Insurance Exchange. Someone said that “Folks here miss the state insurance plan, because it was more affordable than the ACA plans,” a reference to New Mexico’s State Coverage Insurance for low-income NM residents that was dropped when the ACA was implemented.
- **Managed care organizations:** Comments alluded to problems with claims being processed by MCOs, and overly restrictive Medicaid billing codes for children’s services.

2. What is currently working in your community? What resources are there?

a. Population health

Community groups listed a wealth of local activities and resources related to population health, prevention, and community support systems:

- Health fairs: Awareness of services, low-cost screenings, lab tests, etc.
- Mobile mammography units
- Opportunities for physical activities
- Services provided at senior centers
- Regional transportation systems
- Healthy Here (REACH-funded grant in Bernalillo Co.)
- Healthy Kids/Healthy Communities
- Farmers’ markets
- Walking programs
- MyCD classes
- Community health workers
- Early childhood program
- Home visiting programs
- Prevention coalitions (teen pregnancy, substance abuse, etc.)

b. Patient Experience of Care

Resources mentioned frequently that related to this category included:

- **EMS services:** Community EMS services have been mentioned in a number of the HSI community input sessions as a resource whose use could be expanded in rural areas to help address behavioral health emergencies, provide information and referrals to treatment, and enhance the role of EMS workers by providing community health worker training or training in information and referral techniques
- **Residency programs:** Provide nursing, medical assistant, physician residency programs to encourage practice in rural areas: An example given was a cross-disciplinary residency program in Doña Ana County
- **Task forces to address health professional shortages:** One such task force was mentioned in Roswell, although no information was given regarding the results of their work.
- **Telehealth services** were mentioned (in Rounds 2, 3, and 4 of the community input sessions) as a valuable resource for providing patient contact with, or training for primary care providers from specialty care, psychiatry, medical nutrition therapy, and other health care services not currently found in rural areas.
- **Certified Patient-Centered Medical Homes** were mentioned as an existing resource (with approximately 70 PCMH centers now certified in New Mexico).
- **Integrated care:** The First Choice Community Healthcare clinic in Albuquerque's South Valley neighborhood was mentioned as an effective example of a clinic that integrates primary care, behavioral health, oral health, and community-based education, wellness, and patient support programs, which makes it easier for patients to get all needed care or services at one time. Other examples of this innovation are the Sandoval County Health Commons and the Rio Arriba County Health Commons facilities.
- **School-based health centers** were mentioned frequently in Rounds 2, 3, and 4 of the HSI community input sessions as an effective means of providing primary health care and prevention services to children and youth, and (in some cases) to other community members as well.

c. Reducing Health Care Costs

There were very few resources cited in relation to the reduction of costs of health care. Among those stated were:

- Telehealth in rural areas
- Increased insurance coverage through Medicaid expansion and the ACA
- Community health workers: New Mexico has close to 1,000 community health workers employed in a variety of contexts, and the state is actively supporting CHWs through newly-established certification and training programs.

3. What are the top health priorities in your community?

As part of the community engagement process, the health councils, together with other participating community members, were asked to list their current priorities with respect to improving health in their communities. This was not a new question for the 38 county and

tribal health councils; for the past 20 years, all of them have done community health assessments and then selected two or more health-related priorities around which to organize much of their work. Among those established priorities, the top ones to be addressed included:

- Access to care (including provider recruitment, retention, workforce, and transportation issues)
- Mental health and substance abuse
- Teen pregnancy prevention
- Obesity & diabetes
- Interpersonal violence
- Youth suicide prevention

In recent years, the health councils have continued to work on these priority areas, but they have brought to the work a greater awareness of focusing their efforts on improving community environments, social determinants of health, and implementing systems-level changes.

The HSI community input sessions were different from the more formal and deliberative health council processes of selecting priorities in previous years—priorities that were explicitly described in the health councils' Community Health improvement Plans, and that served as a basis for receiving DOH funding. These HSI community engagement discussion sessions, on the other hand, provided an opportunity to revisit previous priority discussions in a slightly different context—more like community brainstorming sessions, in contrast to the more focused deliberations that result in the formal selection of a council's priorities to guide its work with the NM Department of Health. The HSI brainstorming-like sessions yielded long lists of priorities for some communities (as many as two dozen), indicating that facilitators did not ask them to make forced choices or rankings of priorities.

Taken as a whole, the priorities of health councils yielded some interesting information. The table below summarizes the priorities most frequently mentioned by the 36 participating health councils:

Community Health Priorities	Number of Council-hosted community engagement sessions	Percentage of Council-hosted community engagement sessions
BH: Substance abuse	26	72%
BH: Mental health	20	56%
Healthy food, nutrition	18	50%
Access to health care	16	44%
Social determinants	13	36%
Chronic disease prevention & mgmt..	13	36%
Diabetes & obesity	13	36%
Transportation	10	28%
Health insurance/affordable care	10	28%
Oral health	7	19%
Elderly/aging/senior falls	7	19%
MCH/prenatal care/early childhood	6	17%
Teen pregnancy	6	17%

(For a detailed breakdown of priorities by health councils, see *Health Council Priorities Summary* in the Appendix to this Report.)

What is striking is that the findings from the HSI community engagement sessions show behavioral health (substance abuse and mental health/suicide prevention) as top-level priorities, followed by access to healthy foods and access to health care. Social determinants of health in communities (primarily unemployment and poverty, which have negative impacts on health) were also commonly mentioned priorities. A number of other priorities brought up by community members, but in lower percentages, included:

- Difficulty in physician recruitment & retention in rural areas and small cities
- Making improvements to Medicaid and managed care: streamlining billing processes, providing better training for claims administrators
- Improving data systems: integrated systems for multiple providers, outcome-based evaluation data
- Generating greater consumer participation in health planning
- Patient education
- Improved information dissemination through resource guides, radio outreach, etc.
- Medicare & MCO reimbursement for home health and hospice, in order to provide services locally
- Improved access to services for veterans
- Improved access to domestic violence services

4. What steps can be taken to improve health in your community?

This was another brainstorming question, meant to stimulate collective thinking that would lead into subsequent discussions of innovative approaches to community health and health care. Participants offered a wide variety of suggested steps, based on experience in their communities and elsewhere. Suggested steps are presented below, organized by the appropriate elements of the Triple Aim, to indicate the breadth and diversity of the community discussions regarding this question. (Headings in bold indicate items with multiple mentions.)

Population Health	Patient Experience of Care	Reduce Health Care Costs
<p>Improve Community health planning:</p> <ul style="list-style-type: none"> • Create Community Resource Guides (<i>Note: print & on-line resource directories were produced by health councils when they were fully funded</i>) • Involve community & elected officials in health councils • Encourage funders to fund collective impact work • Promote health in all policies • Engage the community in health planning, including telehealth to do so • “We need a central hub to keep track of what’s going on” • Increased funding, more grantwriters <p>Other suggestions:</p> <ul style="list-style-type: none"> • Strengthen regional transportation systems • Rural health fairs: Provide information, services, immunizations, health insurance enrollment • Seniors: Provide home risk assessments, wrap-around discharge planning for home-based seniors • Poverty: Create revolving lending program for rent, expand school free lunch programs to summer • Behavioral health: Expand number of providers covered under County Health Care Assistance Programs to serve patients • Use CHWs for prevention, health 	<ul style="list-style-type: none"> • Expand funding/policies for school-based health centers to serve non-student populations and to operate during summers • Expand and increase reimbursements for telehealth options, • Use salaried EMTs with behavioral health qualifications • Increase use of mobile units: crisis teams, veterans’ services • Convene local task forces to address health professional shortages • Create more Health Commons • Expand Food Policy Councils • Early Childhood Steering Committees • Implement programs to change prescribing behavior of providers (e.g., Santa Fe Opiate Safe) • “Keep doctors happy!” 	<ul style="list-style-type: none"> • Provide more information & outreach for ACA enrollment (including involving the business community, health council involvement) • Provide education regarding reimbursement procedures for consumers and providers • Greater coordination among agencies • Establish a single payer system • Provide more input to and oversight of MCOs operating in rural areas • Increase outreach to those eligible for Centennial Care • Establish a usable data system • Use mill levy to provide health care for undocumented immigrants

<p>promotion, home health visits</p> <ul style="list-style-type: none"> • Strengthen Head Start parent education (e.g., UNM CHILE Project) • Involve law enforcement in underage drinking problem • Increase funding for community exercise equipment • Look at Washington State Plan, “My success is your success” culture • Teen pregnancy prevention: Look at Colorado & Pennsylvania • Increase access to MyCD program 		
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Round 3: Community health strategies, resources, and barriers

Organizing 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?*

A goal of the Round 3 portion of the community input process was to provide community representatives an opportunity to identify strategies currently being used to address the state’s health needs. Respondents identified strategies that were seen as effective, as well as those characterized as not effective or as needing improvement. An assumption underlying this round of questioning is that community members and consumers of services can offer different perspectives on “what works” and what doesn’t work, based on perceptions and reasons that may not always be obvious to service providers and policymakers.

This round of Community Input discussions was by far the most difficult to compile and summarize. Many of the comments recorded did not specifically address the questions asked, and there was a great deal of overlap among the responses. Certain aspects of the state’s health systems were named both as assets and deficits. For example, hospitals were cited as significant assets to communities, but others said that the nearest hospital was too far away (distance to the hospital being the deficit). Providers were mentioned as excellent (assets), but there were also many mentions of provider shortages (deficits). For these reasons, this section of the Report has not been organized by responses to the questions asked, but rather by themes that emerged overall.

The reports from community discussion sessions also varied widely with respect to content, format, and specificity. In retrospect, the organizing questions for Round 3 tended to gain

somewhat repetitive responses, both during this one session, and with respect to responses gained from the questions asked in Round 2. Question #3 was designed to elicit responses that may not have fit neatly with expected answers to any of the other questions. Question #4 was meant to elicit comments about health and economic disparities within counties—recognizing that virtually every New Mexico county has a major population center surrounded by very rural (and often under-served) areas. However, there were almost no direct responses to this question—perhaps because people did not fully understand its meaning.

In all, 1,729 responses were tabulated from 35 Round 3 community input sessions. These were entered into spreadsheets, categorized and coded to identify frequency patterns. This helped give a rough measure of the relative importance or perceived level of urgency of response groupings. Within categories, responses were classified as Assets (has a positive impact, works well or is a support in the community), Deficits (considered a need or is lacking in the community, has a negative influence, or is a population in need), or neutral. Coding categories were generated by the content of responses as well as by the discussion questions. Some comments were coded in more than one category, making the calculations of percentages difficult. While the data are unwieldy, they are potentially useful for the communities themselves (from their own discussion reports) in identifying issues to address as they put the HSI design model to work in their geographic areas. The following table summarizes numbers of responses by coding categories:

Community Stakeholder Input Sessions: Overall Summary of Coded Responses

Coding Category	Total Responses	Assets (Working well)	Deficits (Needs/Lacking)
1. Health services	273	100	149
2. Social Determinants/Misc.	203	50	122
3. Access & Transportation	168	20	134
4. Education & Health	192	78	76
5. Behavioral Health	118	34	82
6. Providers	110	19	78
7. Substance Abuse	76	22	51
8. Coalitions, Collaboration	70	21	15
9. Food & Nutrition	70	30	36
10. Children	63	38	25
11. Funding	58	4	37
12. Seniors	53	15	31
13. Pregnancy & Parenting	48	21	22
14. Culture, Diversity	34	15	4
15. Technology	31	5	12
16. Rural Issues	31	0	22
17. Tribal concerns	27	6	14
18. Insurance/Payments	23	16	6
19. Diabetes	20	11	7
20. Obesity	13	3	7
21. Homelessness	12	5	7

22.	Veterans	10	5	5
23.	Incarcerated individuals	8	1	6

Notes on the table:

* The numbers in the Assets and Deficits columns do not always add up to the Total Number of Responses in their row because those responses coded as “Neutral” were not included in this table.

Please see the section below headed **Highlights of Round 3 Community Stakeholder Input Data for further clarification of the data in this table.

Note: In addition, there were a total of 268 comments regarding the roles of the health councils in response to question #5. The question regarding health councils did not ask for an assessment of their effectiveness, but rather for feedback regarding the appropriate roles of the health councils as the health system changed. As a result, the responses to this question were not framed in terms of assets and deficits and are discussed in a following section.

Highlights of Round 3 Community Stakeholder Input Data

a. Assets: What is currently working?

Health Care Services: There were numerous comments about the state’s community health centers (*Federally Qualified Health Centers*), which were generally seen as important community assets that provide high quality, affordable health care. Respondents generally had positive things to say about the quality of care provided by community health centers. A typical comment was one from DeBaca County, who called their health center “a vital part of our small rural community.” Others receiving praise were clinics in Hidalgo, Doña Ana, and Mora Counties. *Hospitals* in Taos, San Miguel, McKinley, Grant, and Union Counties were also singled out as providing high-quality services. *School-based health centers* received frequent mentions as providing access to high-quality services. With regard to chronic disease management, there were multiple comments regarding “excellent *diabetes education and self-management* classes.” *Other services* cited as approaches currently working include dental clinics, the Nurse Family Partnership home visiting program, PACT (Program of Assertive Care and Treatment), *Pathways* programs for care coordination, the use of promotoras or *community health workers*, and the *MyCD program* for chronic disease management. The New Mexico Department of Health *Public Health Offices* received positive feedback. The *Nurse Family Partnership* home visiting program was also mentioned as an asset.

Behavioral health: Substance abuse continues to be cited as a major health need in New Mexico communities. Assets mentioned—including programs people felt helped improve health-- include NMDOH’s *needle exchange program, detox programs, DWI Planning Councils*, substance abuse treatment services provided through FQHCs, and education/prevention services provided by *school-based health centers*. With regard to mental health, assets mentioned included *community-based counseling centers, FQHCs, school-based health centers, private behavioral health providers, home visiting programs*, and a *Mobile Crisis Response Team* in Santa Fe County.

Access issues and transportation: Many participants cited assets designed to improve transportation and access to health care services: *Expanded hours and locations of services; mobile health vans (4 mentions); transportation provided by service providers and senior centers to health care; telehealth service use in rural areas; and use of smartphones in prenatal care and chronic disease management.*

Pregnancy & parenting: Assets listed included: *Public Health Office-provided programs in family planning, STDs, communicable diseases; parenting programs; Families First care coordination; WIC programs; First Born programs; early childhood programs; breast and cervical program services; and educational programs.*

Senior programs: Assets included: *senior centers which provide recreation, fitness, meals, transportation, health screenings, and other services; Los Alamos Retired & Senior Organization & Home Instead Inc., which facilitate workshops to local organizations about becoming dementia-friendly, and providing home-based services for older and frail adults.*

Coordination and collaboration: Many respondents mentioned that *coordination of services is a key asset.* In smaller communities, this occurs with the building of inter-agency and personal relationships. Respondents mentioned the importance of positive working relationships among schools, police, and community agencies, often facilitated through the health councils.

Food and nutrition: There appears to be a comparatively large proportion of strong assets to address nutritional concerns in New Mexico. Assets mentioned included *food pantries, free summer food programs in schools, senior programs, ICAN, community gardens (some with FQHCs), farmers markets, faith communities, and the Kitchen Creations program in Socorro.*

Health insurance coverage: Several people mentioned the *positive impacts of the ACA* in New Mexico communities—both in terms of increasing insurance coverage and enabling health centers to hire additional providers and increase services.

Health education: This was a fairly large area of concern for respondents, with roughly equal numbers of positive and negative comments. Assets included: *health fairs, as a means to increase health awareness and spread knowledge about available services and resources; educational programs, such as cooking classes, gardening, parenting, health promotion, better sleeping, trauma, use of prescription drugs, and other areas; and the health councils, providing policy updates, resource information, and education.*

Social determinants of health: Respondents mentioned several programs that address certain negative social determinants of health as assets in their communities. Examples included programs such as: *Health Care for the Homeless, a police/Self-Help program using debit cards to put people into emergency housing, and a small program called Immediate Action that provides food and social interaction.* Another asset mentioned was the recent passage of legislation allowing *Medicaid benefits for incarcerated individuals.*

b. Deficits: What is currently not working?

Health care services: More people mentioned “deficits” or needs in health care services than those who listed health care services as assets. Most of these dealt with the fact that health care services were inadequate or largely unavailable—rather than that the quality of their services was unappreciated. Many communities basically said they needed more health care services of all kinds. Some said that providers are simply too far away (e.g., “Getting health care in Curry County is difficult without traveling 100+ miles.”) Harding County community members said they need a full-time public health nurse, and Hidalgo County needs a pharmacy. Physicians in some areas are overbooked, with long wait times, according to respondents. There were also calls for increased access to specialty care, urgent care, and pharmacy services.

Access & Transportation: Of the 168 comments related to services, most comments described the negative aspects of access barriers; 85 of these related to general barriers (including geography and distance), and 40 specifically mentioned difficulties with transportation. Transportation was a major area of concern, mentioned by respondents in both rural and urban settings.

Behavioral health and substance abuse: At least 193 responses reflected widespread interest in and concern about the urgency of addressing these issues. Some 54 respondents mentioned the need for additional behavioral health services, with another 41 citing the need for substance abuse services. Barriers to access include social stigma, funding cuts, limited services through Core Service Agencies, reductions in county Health Care Assistance funds, the Medicaid behavioral health shakeup in the state, and workforce instability. Specific needs expressed included: substance use prevention and education; detox facilities (in Rio Arriba, Mora, and Otero Counties); facilities for treatment, transitional living, rehab, and halfway houses.

Social determinants of health: In compiling the community stakeholder input data, a collection of comments concerning social determinants of health (SDOH) emerged, even though the community input questions were not framed in these terms. New Mexico continues to face enormous challenges of poverty, high unemployment, low salaries, and resource-poor rural areas. As one person put it, “We’re a great place to visit but a difficult place to raise a family.”

Food and nutrition: Community members noted the need for access to healthy and affordable foods, with six counties mentioned as food deserts or lacking in grocery stores. A Native American participant stated, “Health is the last priority to improve [in] the Native community; instead, the government has loaded us with fatty sugar and carbohydrates.”

Rural & provider issues: Most of New Mexico is rural geography, with only seven counties (Bernalillo, Sandoval, Torrance, Valencia, Santa Fe, Doña Ana, and San Juan) classified as metropolitan by the U.S. Census Bureau. Even these counties have areas that are rural by

almost any measure, as are the state's tribal areas. The HSI community input discussions affirmed the neglect that many rural residents feel with respect to the allocation of state resources; some respondents said that they feel under-represented in political discourse (Harding & McKinley Counties). Here are few comments from other rural areas:

"We are the forgotten frontier with the greatest need." (Catron Co.)

" [What] the residents of Colfax County would like the HSI Steering Committee and the governor to know about our community is that we are a very rural area in critical need of healthcare services such as primary care, dental, behavioral health, emergency, and public health services."

"The Governor and NM DOH need to clearly understand that they have a responsibility to not only the majority population in the middle of the state, but especially to rural areas that have incredible challenges maintaining good health and accessing appropriate healthcare services." (Quay Co.)

"I would ask the governor to take a drive around Tucumcari and just look at what is going on here." (Quay Co.)

It is unclear how the Patient Centered Well-Being Home concept will be applied in rural areas (Rio Arriba Co.)

"Always remember that rural needs are different and more complex than urban needs." (Grant Co.)

There were a number of comments about workforce issues, and about the need to develop creative incentive programs to attract and retain health care providers in rural areas, including developing educational and training opportunities for rural residents, since "home-grown" providers are more likely to remain in their communities than those recruited from outside the area.

Specific health issues and populations: There were 285 responses related to addressing categorical health areas and populations (diabetes, obesity, pregnancy and parenting, seniors, homeless, veterans, children, and incarcerated individuals). There were many calls for education and prevention programs related to teen pregnancy prevention programs (in six counties), and in rural areas for WIC personnel, Families First programs, obstetricians, and an increased public health presence. The lack of children's services and early childhood programs continue to be an area of concern.

Obesity: Several participants mentioned obesity as a "huge" issue, and 70 people referred to food and nutrition resources and issues. Prescription trails (community trails identified in brochures to be used by health care providers in recommending exercise to patients) were mentioned as an asset in fighting obesity, along with food pantries, summer food programs in

schools, senior programs, and other community initiatives. Many communities (including tribal areas) are located in food deserts, with limited access to healthy and affordable foods (cited in six counties). Hunger is described as widespread.

Health insurance and the ACA: An additional sorting of the data was done by comments referring to the Affordable Care Act, insurance coverage, costs of health care, Medicare & Medicaid, and reimbursement issues. Negative comments focused on New Mexico Health insurance Exchange issues (38); lack of health insurance, affordability, and coverage issues (80); provider reimbursement issues (30); the need for assistance in navigating the insurance system (28); and Medicaid/Medicare-related issues (36).

c. Recommendations Emerging from Community Engagement Sessions

Health care services: School-based health centers were cited frequently as valued community assets, with funding increases recommended. Senior programs were frequently cited as assets, with increased support for them needed in some rural areas. Many respondents recommended increasing funding and hours of service of school-based health centers, including after-school hours. With regard to incarcerated individuals, a recommendation was to “consider the jails as part of the health care system.”

Behavioral health: There were calls for increasing the availability of behavioral health service providers. Recommendations included establishing new detox and treatment facilities and enabling mid-level providers to provide and monitor Suboxone (medication-assisted treatment for opioid addiction). Multiple community participants mentioned problems created by the 2013 suspension by the state of Medicaid funding for behavioral health providers, and the subsequent service interruptions and provider instability. There were calls for increased funding of behavioral health services in seven areas (McKinley, Taos, Cibola, Grant, Santa Fe, and Lincoln Counties, and Acoma Pueblo).

Diabetes and chronic disease management: Diabetes education and self-management classes were spoken of positively, although diabetes educators are needed in some rural areas. One respondent suggested, “We should learn more from our friends and neighbors at the pueblos who are doing innovative public health initiatives like having community public health nurses, multigenerational fitness classes, and mobile diabetes trainings.”

Food and nutrition: Several suggestions were given: Offer Medicaid payment for meals-on-wheels services to Medicaid clients; keep locally-grown produce available to local residents (Luna County); do not ask SNAP recipients to do a work program in rural areas where there are no jobs.

Access and transportation: Recommendations included strengthening regional transportation systems; increasing Medicaid agency reimbursement for transportation; expanding the use of Telehealth services, with adequate funding and provisions to ensure patient satisfaction and confidentiality.

Coordination, collaboration, and integration: These were themes that ran through most of the community input sessions, citing inadequate coordination and communications among health providers and social service agencies, and the need for smooth transitions between services (such as active referrals and “warm hand-offs”) and for sharing of innovations and resources. Inter-agency coordination at the state level was also seen as important: “When state agencies are working together at the state level, things work better at the local community level.”

Social determinants of health: Many respondents said that any proposed health system innovation model must address social determinants of health, including quality of life issues, educational systems, and environmental infrastructure needs (e.g., water, sewer, housing, transportation)—all of which have profound implications for individual and population health.

Health insurance, the ACA, and CHW reimbursement: There were calls for improving outreach and health insurance enrollment efforts, and further streamlining the New Mexico Health Insurance Exchange (NMHIX) enrollment process. One respondent suggested “Consider new reimbursement for CHWs [using] codes related to insurance counseling and enrollment assistance, and for case management/patient navigation (see Oregon’s evidence-based Pathways Program)”

d. Role of the Health Councils

Current roles of the Health Councils: This question brought up a large number of comments (268 recorded), mostly in the form of descriptions of current activities, suggestions for new activities, and other recommendations. The current functions of the state’s 38 county and tribal health councils most frequently cited by participants were: leadership (31); education (31); networking and collaboration, including convening and connecting stakeholders (23); planning and assessment (18); coordinating services, including avoiding duplication and filling gaps; and sharing resources (18). Other functions mentioned were developing resource directories and databases, and identifying issues that would not otherwise come to light.

Recommendations and Suggestions made by communities for future roles of the health councils in a transformed health system: Many participants talked about the importance of supporting the state’s health council system as part of any health system redesign, noting that health councils could assume greater responsibility for ensuring accountability, integration of services, developing resource information, and acting as a clearinghouse for innovative models. One participant went so far as to say, “You cannot have a Community Medical Home without health councils to provide community education and build community collaboration.” A number of participants referred to health councils as local community hubs for assessment, planning, coordination, education, and accountability. Other recommended roles included assisting in review of medication and health care costs; assisting agencies in signing people up for Medicaid and helping to publicize changes in enrollment periods; serving as a clearinghouse for innovative models; assisting in making policy regarding limiting the number of liquor licenses, zoning smoke shops, and ensuring that local halfway and treatment houses maintain

quality assurance. One respondent recommended putting an option in health council contracts to help implement the HSI model and to mentor other health councils.

Round 4: Community feedback on outline of draft HSI 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?*

Although 35 health councils were listed as having completed this round, there were only 28 session summaries received from Department of Health facilitators. Part of the reason may be that a number of health councils combined Rounds 3 and 4, and yet the information summaries by and large only reflected Round 3 questions. As a result, the information in some regions was not as complete or consistent as it could have been.

As was the case in the other input rounds, there was great variety in responses, again reflecting the geographic, cultural and demographic diversity of the participating communities. There were also some difficulties resulting from timing. The State's HSI design process was still under way when some of the Round 4 community engagement sessions were being held, and a draft conceptual model—in visual format—had not been fully agreed-upon by stakeholders. As a result, many of the community engagement facilitators used different ways of presenting and describing the model with their groups. In general, they used means they felt would best suit their communities in terms of getting the input needed. Even though the discussion methods varied somewhat, the input gained from participating communities was still useful.

For example, DOH staff in the Northeast Region developed, and health council-generated community engagement sessions participated in, an innovative conceptual mapping exercise. Using a draft visual/graphic of the potential HSI model in a community setting (see Appendix) community participants identified elements of the model that might already be in place in their respective communities. They also used the draft graphic model to identify elements lacking (where gaps in resources exist) in their areas, and what it might take in their community to implement the model. This turned out to be a useful process—one that could serve as the groundwork for later implementation of the model at the local level.

Answers to the five questions in this community engagement round are summarized on the following pages. (For more detailed results, see Appendix 4: Round 4 Brief Data Summary.)

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

Fourteen health council community participants (50% of all those responding) answered with an unequivocal “yes”. There were seven “maybe” answers and seven “no” answers. The “no” answers generally had to do not so much with the merits of the model, but rather wondering if they had the capacity or the resources to implement it in their communities. Some of the “no” answers were because the model would have to be changed in specific ways. Santa Fe County participants said that they would have to use a different model. Participants in two counties said they would have to change the schematic representation of the model, putting the patient at the center of the diagram (as it was in earlier versions). Some of the “maybe” answers were also contingent on making changes, or simply because they felt they needed more information. All of them seemed to have considered the feasibility of the model thoughtfully, and all seemed open to moving further with it.

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

Community engagement participants answered this question in two ways, listing resources they already had, and resources they would need to implement the model. Answers varied widely. Resources already in place included the health councils (that can serve as the core of an integrating HUB), community health centers with PCMH certification, existing programs and services, and community organizations that were accustomed to working together. Resources needed included Telehealth capabilities, more health and social service providers, CHWs, coordinators, transportation resources, and of course, funding.

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

A potential problem mentioned more than once was the difficulty in getting agencies to collaborate with one another. Other problems noted were with elements of the draft model design diagram—things that needed to be added or changed. Some said that the model was confusing and difficult to understand. Rio Arriba County predicted problems with funneling money through FQHCs, which could result in losing many providers in outlying areas. Others worried about HIPAA and confidentiality and privacy concerns, with the sharing of patient health information among a network of agencies. Others felt that community resources were already spread too thin for them to be able to undertake anything of this magnitude and complexity. Two health council-generated sessions mentioned vacancies among Public Health personnel in some parts of the state, making it difficult for regional DOH employees to take on more tasks.

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

Recommended changes to the draft model in many cases related to the potential problems, or to resources needed for implementation. Several people mentioned the challenges of funding, coordination, and sorting out roles and responsibilities of the hub and the coordinators. Again,

participants in Rio Arriba County thought that the Community Centered Health Home model, as they understood it, should be de-coupled from an FQHC, since enrollers can't refer patients to a specific clinic. Santa Fe County session participants said that they preferred the term, "Accountable Communities of Health," rather than using the word, "home". A Taos County community member simply said, "the system is too complex and a radical departure. It isn't going to happen." Another council asked for evidence from other states regarding the feasibility and likely success of the model.

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

There were only four engagement sessions sponsored by the health councils that answered this in the affirmative. Some participants did not answer the question. Most admitted to some confusion and lack of clarity about who or which entity would be responsible and accountable for coordinating implementation of the draft model. Some thought that the State would be responsible, while others thought it would be communities, providers, or partnerships. Santa Fe County respondents said that a Healthcare Authority is needed, with hospitals and government taking a lead in coordination or consortium development.

Most participants in the health council sessions did not answer this question directly. Of the councils reporting back on the community discussions, 7 said *yes* and 5 said *no*. Most participants avoided a yes/no answer and instead responded with comments. A number said that the draft model was abstract and difficult to understand, and they asked for more information, and for something simpler and more easily described. One group asked for evidence from other states that such a model was likely to succeed in transforming the state's health systems and improving health outcomes for its residents.

Additional Community Input & Linkages

An informational session was held by the NMAHC in June 18, 2015, with the New Mexico Association of Counties, Health Affiliate. Community input sessions were also held by the NMAHC with the Health Care for All Coalition, and the Con Alma Health Foundation's Community Advisory Committee. In addition, the New Mexico Alliance of Health Councils served as a link between the New Mexico Health System Innovation and the Con Alma Foundation's ACA Implementation Monitoring Project.

1. Con Alma Health Foundation Community Advisory Committee, October 2, 2015

The Con Alma Health Foundation is New Mexico's only foundation dedicated solely to health. Its Community Advisory Committee provides advice to the foundation's Board of Trustees and is made up of 15 representatives from communities across New Mexico. At its October 2, 2015 meeting (which included Con Alma staff), Ron Hale, Executive Director of the New Mexico Alliance of Health Councils, gave a presentation on the Health System Innovation planning to date and stakeholder input process, and then led a discussion to obtain input and feedback

from the group. The principal points raised (some echoing those considered in the Summit and stakeholder meetings) in the discussion included the following.

a. Important issues and concerns that participants felt should be addressed:

- Rural health (needs to be reflected in the graphic schematic of the draft HSI model)
- Built environment: e.g., proliferation of fast food outlets that provide low-quality jobs and less healthy food
- Workforce issues, including quality and quantity of credentialing
- Importance of health data: What kinds of data will be needed, and how will data be shared? There needs to be a central location for NM health data.
- Patient portals: “No wrong door” for the NM Health Insurance Exchange and other portals into the health care system. Some noted that doctors are starting to implement patient portals for patients to be able to look up their health history and get lab tests etc., but that sharing of information between doctors is still difficult.
- Community health workers: Should be paid to help patients utilize different ways to gain access to the health care system
- Integration of primary care and public health: Full integration will depend on developing intentional ways to work together; simply co-locating services without structuring relationships will not guarantee full integration and collaboration.
- Competition: Concerns about completion between for-profit and non-profit entities in a system that should be based on collaboration and effective use of scarce resources
- Continuity of care: Difficulties with having to change providers as insurance plans and insurance providers change
- Hiring of nurses by MCOs: MCOs hire nurses to work as case coordinators at comparatively high salaries, reducing the pool of nurses who can provide direct services in line with their clinical training.
- Payment systems: Concerns about health outcomes: Are people getting better?

b. Groups that should be involved in the HSI planning process:

1. NM Public Education Department (School-based health centers are represented; health educators should also be at the table)
2. NM Aging & Long-Term Services Dept. (represented on the HSI Steering Committee)
3. NM Environment Dept. (Environmental rules and regulations impact our health.)
4. NM Dept. of Transportation (DOH and Con Alma have both been represented in the DOT planning process)
5. NM Dept. of Corrections (major providers of health care; criminal justice, community services, jails are all important to this process)
6. Local Collaboratives (including the Local Collaborative Alliance New Mexico)

2. Health Care for All Coalition: July 29, 2015

Ron Hale, Executive Director of the New Mexico Alliance of Health Councils, gave a presentation on the Health System Innovation planning and stakeholder input process, and then led a discussion to obtain input and feedback from HCFA Coalition members. There were twelve people in attendance, representing a variety of organizations. Also participating was former New Mexico State Senator Dede Feldman. The following points were made by participants in the input discussion:

- An assessment or report card is needed on how the health system is working.
- Someone needs to do an inventory of innovative practices in New Mexico, focusing on organizations, programs, and grants received.
- How is innovation defined? One definition was offered: “Innovation is meeting a health care need in a new way that saves money and reaches more people.”
- New Mexico needs a systematic dissemination of innovations.
- We need to function as a “team of teams” (to use a term coined by General McChrystal, former commander of U.S./NATO forces in Afghanistan).
- The NM Human Services Department (HSD) needs to be accountable for the Managed Care Organizations (MCOs), state agencies, and the entire payment system.
- Groups that appear to be missing from the process: Veterans Administration, Indian Health Service, organized dentistry. [Note: The Indian Health Service was involved in the HSI planning process, and the VA had been invited.]
- The new system needs to be run with full transparency, including contract management. It probably needs to be run by an independent entity.
- Coordination and integration are of paramount importance.
- Need to look at the cost-effectiveness of every intervention or innovation.
- Innovations need to be sustainable.
- Tribes do not trust the State. IHS representation is not the same as tribal representation.
- One-third of New Mexico residents are on Medicaid: Anything we do to improve Medicaid programs and outcomes will have major impacts on the health system.
- Integration and interoperability: For example, Presbyterian Healthcare Services home health care does not communicate with doctors or the PHS hospital.
- A key assumption is that many of the HSI recommendations can be implemented without additional funding.

3. Con Alma Foundation ACA Implementation Monitoring Project

The ACA Monitoring Project is a two-year project supported by the W.K. Kellogg Foundation and focuses on the health equity implications of the ACA implementation in New Mexico. As part of that project, NMAHC has functioned as a liaison with the HSI planning process, providing monthly HSI reports to the Con Alma ACA Project Team, which includes Con Alma staff and a University of New Mexico research team headed by Dr. Lisa Cacari-Stone. NMAHC separated out HSI community input data related to ACA implementation in New Mexico, citing 161 references to ACA-related concerns (described elsewhere in this Report). NMAHC staff wrote a brief draft report on the health equity implications of HSI process to date (See Appendix to this Report).

D. THEMES AND RECOMMENDATIONS BASED ON COMMUNITY ENGAGEMENT DISCUSSIONS

The following themes and recommendations are drawn from discussion sessions throughout Rounds 2, 3, and 4 of the Community Stakeholder Engagement process. In most cases, the statements are based on frequency of comments reported in community discussion sessions hosted by county and tribal health councils. Another criterion for inclusion here is the relevance of comments to the HSI framework and draft model design. The discussions did not always lend themselves neatly to quantification, as would be the case in a more formal, and more rigorously controlled, needs assessment process. This Community Engagement process can be thought of as providing locally-based, community input that was in addition to the series of state-level Stakeholder Summit meetings that occurred simultaneously. Both the statewide Stakeholder Summits and the local Community Engagement sessions were part of an inclusive HSI planning process, in which stakeholders from all parts of New Mexico and from many walks of life had the opportunity to participate in the re-design of the state's health and health care systems.

The HSI context

1. **Community members' comments indicate that New Mexico continues to experience seemingly intractable challenges to the health of its citizens.** Chief among these is poverty, with all its attendant ills: food insecurity, inadequate housing, low educational attainment—and above all, poor health and lower life expectancy. This was reflected in the discussions of community needs in Round 2, with frequent references in Round 3 as well.
2. **Community members indicate that New Mexico faces a continuing crisis in behavioral health.** Participants in the county and tribal health council discussions demonstrated their concern in the Round 2 discussions, when the priority named most frequently was substance abuse, selected by 72% of the respondents, followed by mental health at 56 percent. Behavioral health also scored high in the Round 3 discussions of pressing health issues.
3. **Access to basic health care services is a top priority for New Mexico communities.** Access to health care and related social services was the top-scoring issue raised in Round 3 of the Community Input sessions—encompassing primary care, specialty care, behavioral health, oral health, urgent care, and nearby hospital services. Access to care is a major challenge in a largely rural and resource-poor state like New Mexico.
4. **There is growing awareness that access to healthy food is now seen as a necessity for good health.** Access to healthy foods was named as a priority by half of those participating in health council discussions. Food issues were raised throughout the Community Input discussions, particularly in the context of “food deserts” in rural, frontier, and tribal communities, as well as in lower-income neighborhoods in the state's urban centers.

5. **New Mexico communities are willing to work together to create more effective and equitable community health systems.** The fact that an estimated 1,000 people (mostly volunteers) participated in the HSI Community Input process over six months is in itself remarkable. The HSI process was able to build momentum toward developing appropriate solutions to health challenges in New Mexico communities.

The Model Design

6. **The proposed draft Model Design can serve as an appropriate framework for re-designing New Mexico’s health and health care systems.** Participating communities gave their cautious approval to the draft model design, with 50% agreeing that the design would work in its current draft form. A quarter of the community groups said essentially that the model could work if changes were made in the draft model presented to them, or in the ways in which that draft model was presented. Another quarter recommended changes to the Model Design before they could give it their final approval.
7. **The Model Design needs to be flexible.** A number of community participants underscored the cultural and geographic diversity of New Mexico when they said that every community is different, and that the design should reflect and accommodate those differences. Key players in each community—government, providers, hospitals, health councils, health advocates, faith communities, and others—need to be at the table to develop appropriate structures, strategies, and solutions.
8. **The HSI Model Design needs to be straightforward and easy to understand and describe.** This is no small task, given the complexity of the health care system and the complicated processes of community engagement, dialogue, and collaboration. Community representatives in the HSI process pointed out that clear communication of the design is essential to obtaining buy-in from physicians, local governments, and all the other key players in communities.

Factors critical to the success of the Model Design

9. **The role of the Integration hub, as portrayed in the draft model, needs to be clear.** At the community level, the regional “Integration hub” (see the graphic in appendix to this Report—one of many draft diagrams used to describe the Model Design) was seen as critical to successful implementation. Community discussion participants said that the hub’s composition, roles, and responsibilities must be clearly delineated. Many thought that the county and tribal health councils should serve as the core entity of the hubs, with adequate representation from providers, community organizations, local government, hospitals, and others. The hub could serve as the backbone of a local collective impact model. The view of some participants was that the hub could be responsible and accountable for coordination of services, identification of gaps and duplication of services, monitoring and tracking of outcomes, and possibly overseeing financial incentives to reward positive health outcomes.

10. **Community coordination needs to be defined and described in detail.** A few participants in the engagement process said that the local coordination functions were too complex and broad in scope to be the responsibility of a single organizational entity, and they recommended using a public-private partnership. Some noted that success of the coordination function will depend on adequate funding, information technology, and facilitated inter-agency communication. Some participants noted that a number of entities employ care coordinators—MCOs, outcomes-based Pathways programs, and community health centers. Several participants felt that these coordinators need to work together, and their services need to be reimbursable from both public and third-party payers, in order to make any design work well.
11. **Statewide governance and coordination also need to be clearly defined.** Most community members said they did not understand who would be responsible and accountable for implementing the draft HSI Model Design, as presented, at either the state or community levels. Community members suggested and discussed some potential governance models, including establishing a Healthcare Authority, or using the current HSI planning structure, coordinated and staffed by the NM Department of Health and the NM Human Services Department.
12. **Many support the concept of co-location of services as a core element of the draft Model Design.** Many participants supported the notion of “one-stop” services (including primary care, public health offices, educational programs, and social services), currently exemplified in health commons facilities—for example, in Rio Arriba and Sandoval Counties and in Albuquerque’s South Valley. However, it was pointed out by a staff member of one such facility that inter-agency collaboration does not just happen; the collaboration needs to be intentional, structured, and rewarded—otherwise, old patterns of competition and functional isolation (working in silos) can persist.
13. **A number of participants noted that the success of the HSI model will depend on adequate funding of community infrastructure.** Numerous community member comments emphasized the importance of adequate funding to support coordination, integration, and staffing. New Mexico has many innovative models and practices already in place. These include community health councils, extensive use of community health workers, care coordinators working for managed care organizations, the University of New Mexico’s Health Extension Resource Offices, the Area Health Education Centers, and approximately 70 community health centers that are certified as Patient Centered Medical Homes. Making all of this work together will require careful planning, structured ways to coordinate, collaborate, and communicate, and dedicated staffing and funding. Members of health councils in rural areas (Union County, for example), said that their resources are already worn thin and will need to be augmented.
14. **Community members feel workforce development is critical to improving access to services.** Workforce shortages were identified throughout the HSI community engagement

process as a major barrier to successful implementation of the model. There were calls for increased incentives to be offered to healthcare professionals to attract them to rural areas, as well as programs to recruit and train local residents, who are more likely to remain in their home communities than those brought in from outside. People cited the need to expand public health staff throughout the state to perform more “upstream” functions (addressing the root causes of disease and poor health), and to expand the use of community health workers or promotoras (approximately 1,000 working in the state) in health care and social service settings. In any case, many respondents felt there were current shortages and high turnover rates of health care providers, and this clearly affects how they view any proposed model design.

15. **Outreach and education are considered essential.** A number of community members felt that successful implementation of the model will depend on widespread understanding of how it is intended to work, requiring education of patients, providers, payers, administrators, government officials, and the private sector. Some participants suggested using Wikipedia-style websites, local resource directories (traditionally a function of the health councils), community meetings, and other approaches to “get the word out” and promote acceptance of the model
16. **Community members feel success of the model will depend on community buy-in.** Ten responding community groups cited the need to have buy-in from providers and others, in order to make the proposed system work as intended. Providers, payers, and others need to perceive tangible benefits to themselves and to the system as a whole. There need to be incentives to encourage effective coordination and sharing of resources.
17. **Many participants indicated that data sharing is critical.** This was seen by many as critical to the success of New Mexico’s HSI Model Design, including sharing of electronic health records (which should be standardized), transmitting prescription information, and possibly using a credit card-type medical record card for each patient, with medical records encrypted. Some respondents also raised potential problems of HIPAA violations and privacy and confidentiality issues.
18. **Transportation needs to be part of the model.** Geographic distance and lack of affordable public transportation were often cited as barriers to access to services and to effective model implementation. Some areas have established effective rural transportation systems and could share information about the approach to see if it can serve as model for other areas. Some respondents urged system planners to include rural transportation as a key element of the HSI Model Design—including non-Medicaid medical transportation and the re-writing of Medicaid rules to facilitate greater access to medical appointments. They saw this as fitting into the “regional” aspect of the model.
19. **Rural areas have special needs.** Rural areas in New Mexico face particular challenges that will have an impact on implementing the HSI design. Respondents from rural areas traditionally feel that their needs are neglected in favor of more populous regions (a

sentiment expressed more than once in this HSI engagement process). Some respondents noted that Internet service is spotty and slow in many areas, which would hamper electronic data sharing among health care providers. Many communities are classified as food deserts, with limited access to fresh and healthy food. In developing Community-Centered Health Homes, respondents suggested being flexible in defining “community”, since some communities are lacking in basic health resources, and others straddle county and even state boundaries. One group suggested establishing a Rural/Frontier Workgroup to guide future HSI activities.

Final Comments

The Community Stakeholder Engagement process in New Mexico was an enormously complex undertaking, completed in what seemed at many points to be an impossible timeframe. Nevertheless, it yielded a wealth of data that can inform the conceptualization, planning, and implementation of a re-design of the state’s health and health care systems. This summary of findings cannot begin to do justice to the richness of detail and sense of urgency that characterized the vast majority of the community input discussions. It is hoped that the summaries of these community discussions can be further used in the development of regional health and health care systems as part of the HSI model design.

Each time communities are asked for input, expectations are raised concerning the acknowledgement and actual use of the data provided by community members in influencing public policy. Such requests for input are often greeted with skepticism from community members, rooted in past experiences and the fear that their opinions and insights will be ignored.

The positive response and active participation in the community engagement process was gratifying, with roughly 130 community meetings, surveys and focus groups, and intense, hard work on the part of regional Public Health staff, health council coordinators and members, community facilitators, and many others. This community engagement process could not have been accomplished without the enormous effort, skill, and dedication of everyone involved. Maintaining and building on this momentum and participation will go a long way toward ensuring success of the Health System Innovation in New Mexico.

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