Senate Memorial 44 - Initial Meeting to Create a Task Force to Recommend Revisions to the Maternal Child Health Care Act of 1991, as amended in 2007
Hyatt Regency, Albuquerque, NM
April 3, 2018

Summary from the Minutes

Meeting objectives: Come to consensus about the goals of the memorial and the goals of what we want to accomplish over the six months, including a time table. We should also include guiding principles in this process.

Objectives of the Memorial (language from the Memorial):

1. Analyze the work of the county and tribal health councils in relation to the Maternal and Child Health Plan Act, as amended in 2007.
2. Recommend steps to strengthen the structure, effectiveness and sustainability of county and tribal health councils in identifying and addressing the health needs of New Mexico communities.

Guiding principles:

1. An overall goal is to increase the effectiveness of New Mexico's health councils and the health council system as a whole, including effective structures, support systems, and relationships with state/local/tribal governments.
2. Self determination (and the need for flexibility)
3. Balancing unity and diversity
4. Utilizing collaborative approaches
5. Community-centered focus/approach
6. Honoring relationships with other community councils/ creating networks
7. Do this work in the interest of all people and with a health equity lens.

Overarching objectives of the Task Force:

1. Create functional guidelines/criteria for defining what a health councils is and does, including standards and best practices.
    a. What are the primary operational functions of health councils?"
    b. "What can you do as a health council that no other entity in your community can do?
    c. Create criteria for what constitutes a health council and what the basic functions and standards are, possibly with a tiered system of capacity levels.
2. Support a goal of having a paid, well-trained coordinator for every health council.
3. Restore funding and provide a stable funding structure for health councils.
4. Work towards ways to integrate the work of health councils into county/tribal government planning and implementation of policies.

Items to be included in report:

1. Health Councils' original purpose as backbone and conveners for communities
2. Include all counties and recognized tribal communities in New Mexico as potential sites for health councils
3. Recognition of NMAHC as a central organization representing and supporting the health councils

4. Summary of the history of the health council system to provide context
5. Recognition of what has worked, and has not worked; explanation and suggestions for improving the MCH Plan Act language and supporting regulations
6. Funding is necessary to revive the goals of the legislation

Things to remember:

1. Don't be bound by the language in the memorial - the important thing is the recommendation that we produce, not that we address every point raised in the memorial.
2. While using "health equity" and "health in all policies" lenses in internal Task Force work, we need to be be careful to not politicize language in the recommendation .

Resources:

1. DOH's Community Health Improvement Toolbox and other tools/supports
2. NM Public Health Institute training and support services
3. The 2006 - 20011 Evaluation of the Health Council System in NM, led by Victoria Sanchez
4. UNM
5. The NM Alliance of Health Councils

Alliance's Role (current and expanded): Funding; Capacity-building, and Policy

1. Increased training, mentoring etc. for health councils
2. Provide opportunities for peer mentoring, collaboration and networking
3. Writing white papers
4. Increase funding and opportunities for health councils
5. Advocate at the policy level for funding and legislation that affects the work of the health councils
6. Create partnerships with other organizations/coalition building
7. Provide a unified voice for the health councils
8. Increase awareness of the function of health councils and the work that they do
9. Facilitate the relationship between state agencies and health councils as a whole
10. Help to identify the unique role of health councils and look for ways to avoid duplication of services from a systemic standpoint
11. Create a system of metrics that health councils can use to measure effectiveness

Task Force Sub-committees:

History (Tom)
Criteria for health councils
Researching/tracking of health council models
(More)

Process/Tasks:

1. Create an inventory of various models of current health council organization. (We have this but need to update this information.)
2. Look at the systems that support the health councils, such as training new health council coordinators and providing training on how to do assessments.
3. Create a history of health councils, including funding, and other relevant factors to give a context to this report. It should also include lessons learned.
4. Define the role of the Alliance and position it at the center of this work.

5. Define the roles of health councils in relation to multiple state agencies, in part to minimize duplication of services but also to ensure that all voices are at the table.
6. Identify people/organizations to be on the Task Force, including tribal representatives for all tribal areas (not just those that currently have health councils).
7. Contact the people who are working on Senate Memorial 108 to create an Indian Health Care Task Force and see if we can work collaboratively.
8. Contact the people involved with the Frontier Health Task Force (Susan Wilger) to work collaboratively.
9. Define common ways to measure things that health councils do/achieve.
10. Contact DOH and request an officially designated person to work on the Task Force.
11. Finalize internship for the project.

Desired Task Force Composition (representing both the working group and others who will be invited to give input):

State:

CYFD
HSD
DOT
DOH
Juvenile Justice

Other collaborators:

UNM - Victoria Sanchez
Art Kaufman
College of Population Health - Karen Armitage
NMSU - Dr. Sue Forster-Cox, and Dr. Holly Mata (internship being developed)
NMPHA
J. Paul Taylor - Kim Straus
NM Association of Counties
Tribal representation
Association of Local Collaboratives (Patricia Gallegos)
ALTS
Indian Healthcare Task Force (SM108)
Additional Task Forces as necessary – DWI, JJ, LBHC
Health Equity Partnership
First Nations ABQ

Criteria for inclusion in the Task Force: Members of the Task Force need to have an understanding of health councils, and represent distinct areas of each sector. Members also need to be able to contribute time consistently to the project through September (monthly meetings, in person or on Zoom), committee work and other work as necessary, including reviewing the final report.

Meetings/Logistics:

- Monthly meetings of the Task Force on the First Tuesday of the month at 1:00pm in person and on Zoom
- Sub-committees will meet in between monthly meetings – times, dates and locations TBD

- We will start a list serve, Dropbox and a menu item on the NMAHC website for sharing information.

Timeline:

April
- ✦ Finalize Task Force membership and identify others who will give input (create a recruitment committee). (NMAHC Staff with input from all)
- ✦ Request DOH to assign someone as an official representative. (NMAHC Staff)
- ✦ Contact the people who are working on Senate Memorial 108 to create an Indian Health Care Task Force and see if we can work collaboratively. (NMAHC Staff)
- ✦ Contact the people involved with the Frontier Health Task Force (Susan Wilger) to work collaboratively. (NMAHC Staff)
- ✦ Set up internship and organize student participation (NMAHC Staff)

May
- ✦ May 1, 1:00-2:30pm Task Force Meeting, Bernalillo County Community Health Council offices, 228 Adams Street SE, Albuquerque, NM 87108
- ✦ Committee meetings and reports

June
- ✦ June 5, 1:00-2:30pm Task Force Meeting, Location TBD
- ✦ Committee meetings and reports

July
- ✦ July 3, 1:00-2:30pm Task Force Meeting, Location TBD
- ✦ Committee meetings and reports

August
- ✦ August 7, 1:00-2:30pm Task Force Meeting, Location TBD
- ✦ Committee meetings and reports
- ✦ August 15 First draft of report done
- ✦ August 16-23 Revisions to report
- ✦ August 30 Second draft of report done
- ✦ August 31- Sept 7 Revision/proofreading of report

September
- ✦ September 7, 1:00-2:30pm Task Force Meeting, Location TBD
- ✦ Sept 14 Final draft of report done
- ✦ Sept 17 Design/typesetting of report
- ✦ Sept 20-24 Printing report
- ✦ Sept 25 Report Delivered to LHHSC

October
- ✦ The final report is due October 1, 2018

Minutes of the Initial Task Force Meeting April 3, 2018

Present, in alphabetical order: Zachary Coffman, Anthony Cook, Chris DeBolt, Cynthia Estrada, Co-Chair Ron Hale, Helen Henry, Christa Hernadez, Alisha Herrick, Athena Huckaby, Christopher Hudson, Cari Lemon, Dick Mason, Jimmy Masters, Marsha McMurray-Avila, Jerry Montoya, Jackie Muncy, Lauren Reichelt, Terrie Rodriguez, Amy Sandoval, Melissa Sayegh, Tom Scharmen, Maureen Schmittle, Kim Straus, Co-Chair Susie Trujillo, Sharz Weeks

Many thanks to all who contributed to this meeting. Where possible, we have added the names of the people who contributed the comments and ideas to this process. Since these minutes were done from a recording, we were not able to attribute all of the comments and we apologize for any errors and omissions.

Ron Hale (Co-Chair) opened the meeting by asking for introductions (see attached sheet for contact information).

Ron started by saying that he felt that the objectives for the meeting were to come to consensus about the goals of the memorial and the goals of what we want to accomplish over the six months, including a time table. Someone added that we should also include some principles in this process. Someone else commented on needing some history/background.

Comment that there are different structures for health councils, which needs to be recognized, so that any recommendations would take this into consideration. There is a principle of self-determination at work here, and a need for flexibility and the ability to recognize what works in their community or tribe and create an organization that addresses those needs.

We have to recognize what didn't work in the past, part of that being the fact that everyone is all over the map in terms of how they function. This is a drawback when approaching legislators.

One of the overall principles should be effectiveness and creating effective structures. There was a comment on the fact that when health councils stopped being part of a county structure, and did their own thing, this cut down on effectiveness.

Shared values, shared vision, shared ways of measuring things.

We have rural, frontier, urban areas and everything in between, but we can look at the end goals as our common objective rather than how we each get there. We need to figure out what we are currently doing that is working or not working.

We need to create a balance between these two approaches (unity and diversity), especially in regard to approaching policy makers. We won't be effective if we try to dictate how things should be done.

Ron: Two principles that are proposed - self-determination (and a need for flexibility) and an effective working relationship with a unit of local government (county, state and tribal).

Another principle that was proposed is that there be collaboration and that the focus is community-centered.

Jerry commented that when he would go out and do CHIP trainings, he would ask, "What is the primary operational function of the council?" and he would often get as many answers as there were people in the room. So asking "What is the primary operational function of each council?" could be a guiding principle could help in achieving the goal of effectiveness. He referenced the MCH pyramid, which has the operational function at the bottom of the pyramid, with higher goals that could be achieved. This is a measure of effectiveness. So we would need to have a common understanding of what is the primary operational function as defined by each health council.

Ron said that a variation of that is to ask is "What can you do as a health council that no other entity in your community can do? And often that's determined by who is around the table.

Maslow's hierarchy of councils :)

Begin with the end in mind.

Dick: Don't be bound by the language in the memorial - the import thing is the recommendation that we produce, not that we address every point raised in the memorial.

The statement of purpose from the Memorial is to "ANALYZE THE WORK OF THE COUNTY AND TRIBAL HEALTH COUNCILS IN RELATION TO THE MATERNAL AND CHILD HEALTH PLAN ACT, AS AMENDED IN 2007, AND TO RECOMMEND STEPS TO STRENGTHEN THE STRUCTURE, EFFECTIVENESS AND SUSTAINABILITY OF COUNTY AND TRIBAL HEALTH COUNCILS IN IDENTIFYING AND ADDRESSING THE HEALTH NEEDS OF NEW MEXICO COMMUNITIES.

People agreed that this is a clear goal and that this is the most important part of the Memorial.

Timeline: We're committed to submitting a report to the Health and Human Services Committee by October 1, 2018 (6 months). Dick says that we could possibly move the presentation to early November, depending on the schedule for the LHHS Committee. But October might be better for us because of getting endorsements, so we should stick with our October deadline.

One of our tasks is to look at the health council models and how they work. Another task is to look at the systems that supports the health councils such as training new health council coordinators and providing training on how to do assessments.

Jerry Montoya reminded people of the Community Health Improvement Toolbox which has powerpoint presentations and many other things can help with training and building capacity, including things like core competencies for health council coordinators including costs associated with running a health council at this level.

Question: Does part of this process include giving more "teeth" to the Alliance? Can the Alliance take on more of the role of coordinating training, etc? Having a toolbox is wonderful, but having interactive working sessions where members of health councils can be together and really work through issues that

they are challenged strengthens capacity in a larger way.

Susie commented that the Alliance should play the role that the state MCH organization used to play, coordinating trainings, putting together a white paper, etc. Ron mentioned that the level of funding that was in place for training and technical assistance for the MCH Councils was over $100,000/year. Susie commented that it all boils down to money and if you don't have the money, you need to do things differently - partnerships with counties, which could look different in each circumstance, etc. but this is what needs to be explored. Gathering political influence through this partnerships will help set health councils apart and give more weight to bringing in state funding. so funding needs to be a priority, and we need to create a strategy to build the political alliances that will make this happen.

Marsha spoke to one of the reasons why the Alliance was created, which was so that the health councils could speak with a unified voice. Ron commented that the "three legs of the stool" (of the Alliance) were 1) funding; 2) capacity-building; and 3 policy.

Jerry Montoya commented that historically, DOH has been responsible for funding the health councils and his feeling is that this has been a mistake, either because the Department has controlled how things were done or because of lack of funds, or because of lack of buy-in and cooperation from other state agencies en though the health assessments are valuable to these organizations. We have to create more of an understanding of the role and services that health councils provide, especially health assessments. The Alliance can play a big role in this by aggregating funding from other agencies. (I'm not sure if that's exactly what he meant.) Ron - the health councils are an identifiable means of communication between the state and the communities.

There have been problems over the years where people have worked against each and against this happening.

There are other collaboratives and we need to figure out how to work with these organizations and figure out how not to duplicate services.

Alisha Herrick - The NM Public Health Institute provides resources in the form of convenings, policy work, trainings, etc. These services are provided free of charge.

Dick pointed out that a priority is to have well-trained coordinators in every health council. This comes down to having the funding.

Jerry - Having criteria for what constitutes a health council and what the basic functions and standards are is important. This is the same as the need for core competencies. We can define different levels of functioning for health council so that they can grow and build capacity. This approach is more goal-driven, and health councils can begin to help each other learn how to reach goals in the stages of building capacity. Some of this is in the study that Victoria Sanchez did (Ron - an evaluation that UNM and DOH done in 2006-2011 called An Evaluation of the Health Council System in NM.) This study showed very clearly what health councils could achieve - influencing policy, developing (not implementing) programs, and bringing in financial and other resources. (Ron can send out this evaluation.)

We need to show the next governor that health councils are functioning in a way that demonstrates

these core competencies and that we can measure the results of this.

The minimum cost of running a health council exhibiting core competencies (including a paid coordinator) was estimated by the NM Dept. of Health at $75,000/year in the early 2000's.

There is so much work that has already been done that we can draw on.

Susie - There is a need to be able to demonstrate the value of the work that is being done by health councils so that their counties will recognize and accept this work and adopt it into their planning. Everybody needs to be on the same page. Health councils don't want counties telling them what to do, but there needs to be a relationship. Crucial NMAOC relationship to this effort and HCs need to demonstrate value to counties ie; standard assessment,etc. in order for counties to support, ask for $, etc. for HC efforts.

Health councils are the voice of the community. Health councils can function as health advisory boards which can serve as an umbrella for other groups to feed into their recommendations.

Some health councils function under the auspices of the county - the county approves the membership of the council. Because of this structure and other current structures of health councils, these organization would probably not fit under the original definition of a health council.

Marsha noted that when the Bernalillo health council was previously housed in the county, and heath council staff were county employees. They did not have the freedom, flexibility or authority that they now have as a separate 501(c)(3) organization. The county now comes to them as a resource and voice of authority.

Susie - Part of the study should be to identify the organizational models of the current health councils.

Ron - Summary:

- We have a lot of resources that have already been created which are available to guide us. There are also organizations that can support this work, including the NM Public Health Institute, DOH, UNM, the Alliance and others.

- Needs:
  - An inventory of various models of current health council organization. (We have this but need to update this information.) Susie volunteered to head this committee, the only identified one at this point.
  - Define/refine criteria for defining what a health councils is and does, which includes standards.
  - Define the role of the Alliance and position it at the center of this work.
  - Define the roles of health council in relation to multiple state agencies, in part to minimize duplication of services but also to ensure that all voices are at the table

- Principles:
  - Self-determination
  - Effective/significant relationships with local/tribal government
  - Honoring relationships with other community councils/ creating networks

- This work is done in the interest of all people/ with an equity lens.
- We are effective.

Chris brought up the list of original regulations supporting the MCH Plan Act legislation that no longer are applicable.

We need to be aware of buzz words like "equity."

We are missing tribal representation at this table and we should be considering all of the tribal areas, not just the ones who have recognized health councils.

Evolution of the health councils from 1991 as maternal child health councils to comprehensive health councils. For a while there were both. The current legislation does not reflect the current reality of health councils.

There was a question about whether doing this study and proposing changes would bring opposition to what is currently in place. It was felt that the risk is low and that it would possibly stimulate discussion among legislators and we need to be a part of that discussion. Dick feels that the LHHSC is favorably disposed towards any changes we might suggest. There is strong support for health councils with this legislature.

Someone (Tom?) mentioned the early history (1995) which involved the Healthy Communities Program.

Part of our report should show this historical background, including all of the relevant factors, to provide context. It should also include lessons learned.

Ron - We need to have an effective relationship between the health councils and state government which includes all agencies. We also need to find a way to make it more difficult for the state to cut funding.

The MCH Association made it difficult to cut the funding.

The need for strong advocacy is a good argument for strengthening the Alliance, Public Health Institute and other organizations.

Task Force Composition:

State:

CYFD
HSD
DOT
DOH
Juvenile Justice

Other collaboratives:

We can include organizations' input into the plan who are not specifically on the Task Force.

We want to have people on the Task Force who have an understanding of health councils, so we can focus on the work and not spend time educating people.

We need people with a systems approach and not just programmatic approaches.

We need to make sure there is tribal representation on the Task Force.

Dick - There is currently a memorial (SM 108) creating an Indian Health Care Task Force to work with the Dept of Indian Affairs. This is an opportunity to work collaboratively.

Tesque Pueblo is a new tribal community that is part of the Northeast region. There is another group that was also mentioned.

Christopher asked how we envision involving the Navajo Nation?

Marsha suggested that they ask the keynote speaker at the conference and ask him who would be a good person to contact. There were other names mentioned - Mark Freedland, others (hard to hear)

Ron mentioned contacting the J. Paul Taylor Task Force. (Kim Strauss is on the JPT Task Force, and he as agreed to continue to serve on the SM44 Task Force.) We should also coordinate with the Frontier Health Task Force (Susan Wilger).

The DOH Secretary's office is looking for people to participating in the Task Force.

Dick - feels strongly that it would be good to have someone from DOH who is officially designated.

Jerry commented on DOH's approach to finding someone to be on the Task Force - they are asking for people to submit names, have people get approval etc. which is a departure from how it has happening in the past.

Ron suggested that the Alliance write a letter to DOH requesting someone be appointed, suggesting names and welcoming someone from the Secretary's office.

Ron brought up UNM as an institution that should be represented on the SM44 Task Force. Ron suggested Victoria Sanchez and Art Kaufman, as well as Karen Armitage, representing the College of Population Health.

Chris - We will have an intern for this project.There will be one MHH student from NMSU and medical students from the Burrell College of Osteopathy.

Other possible Task Force members:

NMSU - Sue Forster-Cox and Holly Mata, or ?

UNM Dr. Shannon ?

NMPHA - check with Courtney Fitzgerald and Jessica Reno

Association of Counties

Is there a Native American Advocacy Organization?

Maybe we can find someone who is also on the Indian Health Care Task Force - we should talk with the Indian Affairs Department.

Look at tribal local collaboratives for someone who could participate.

Someone from the Association of Local Collaboratives (Patricia Gallegos).

Con Alma was invited, but they are not able to participate in something that involves legislation.

Time table:
We now have a Zoom account.
Meet monthly with other committee meetings
Location - Could meet at DOH or Bernalillo County offices (and on Zoom), or the Association of Counties
First meeting at Bernalillo County offices
There needs to be a set membership for the Task Force.
By next meeting, we will have contacted other potential members.
We need a recruitment committee.
Set up a Dropbox for document sharing and organize folders and documents (Helen)
First Tuesday of the month in the afternoon at 1:00pm. at 228 Adams Street SE, Albuquerque
Terrie will send out a reminder.
Sub-committees:

- History (Tom)
- Criteria committee
- Researching/tracking of health council models
- Create the rest of the committees at the next meeting

Chris Hudson will reach out to people at Zuni and the Navajo Nation.
Start a list serve.
Draft a letter for the DOH Secretary (Ron)
Write “official” Task Force involvement letters to members. (Terrie)
We need to quantify how much time is needed for serving on the Task Force.