

**NM Health System Innovation**  
Population Health Committee Notes, Stakeholder Summit III  
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**Report Outs from Workgroups:**

Prenatal-Age 24 group: One issue brought up was gestational diabetes. Teenagers have certain different needs from other population groups. Prevention, early intervention, and early support are needed. One recommendation is to acknowledge social determinants of health and their impact.

Age 25-59 group: Noted some social determinants of health that need to be addressed, including poverty, unemployment, housing, stress, food, education, poor access to health care, insurance coverage, culture barriers & beliefs, education, transportation, violence, economic environment, immigration.

Age 60+ group: Acknowledged the need to normalize language in this group. Epidemiologists need more data for this age group; the workgroup could see what is lacking. One recommendation was to ensure older people, who can suffer from food insecurity, have access to healthy foods.

**SCENARIOS DISCUSSION**

To have committee members focus on how to integrate public health and clinical services (as in PCMHs), in regions of New Mexico that have different levels of resources, small workgroups worked on different scenarios. Each table picked a population card (Native Americans, those with diabetes), a location card and health outcome card, and was asked to design a community centered wellness (health) home.

**TABLE 1 Scenario**

Population: family below poverty level; Health outcome: Decrease tobacco use; Location: rural area with limited resources

Make use of school based health centers (SBHCs), school health services and advisory councils. Make sure to get community input on any initiatives. EMTs are Points of Contact for the community. Senior centers, if available, can be sources for prevention information and activity. Use hotlines, like the TUPAC Quit line. Pharmacies could expand the services they offer. Communities can use libraries, churches, rural HCPs for outreach and information-sharing, as well as organizations like the American Heart Assn, American Cancer Society, Diabetes Society. Given this situation, there's a need to emphasize community-based education (like Family First), home visiting, tele-health capacities. Providers could be trained in motivational interviewing. Increase access to tele-medicine, and encourage patients/persons to use My CD and/or Quit lines for tobacco cessation. The incentives to change will vary because incentives tend to be best when personal in nature.

Potential sources of funding would be through grants, such as from BCBS, RWJF.

**TABLE 2 Scenario:** Population: middle class workers; Health outcome: reducing diabetes. Medical home nearby. Location: urban community.

Collaborate with employers to help broaden wellness programs for employees. For example, make sure employees get gym time. Collaborate with MCOs, SBHCs and broaden their scope, and think about providing services after hours. Make sure local government is focusing on the impact of the built environment. Make sure there are translators and interpreters for patients and community-based programs.

Services to include for healthy communities: community gardens, screen for diabetes, access to nutritionally-good, fresh foods, as from farmers markets, and nutritional education—as in preparing healthy meals. Use media, PSAs to promote these initiatives. Promote healthy community meals. Provide screenings. Make internet free to the community. Increase mobile services.

Have an organizational home for services and do provider outreach. Make sure initiatives are sustainable. Build employee wellness into insurance contracts with employers where employers get money for encouraging and supporting employee wellness. One incentive might be for employees to pitch in 10% and after, start billing annually to continue.

**TABLE 3 Scenario:** Population: undocumented population; Health outcome: decrease obesity; Location: rural area with limited resources.

The sky is the limit. Barriers are language access, and lack of access to appropriate medical care. It's important to address policy and system/structural barriers, such as oppression and patriarchy. Build this into RFPs as an expectation. Make DOH buildings more inviting – make them culturally relevant, let the community teach DOH how to make Public Health Offices (or other buildings—like clinics or hospitals) welcoming and relevant—perhaps in how to turn it in to a community cooperative. Provide education on cultural competency to providers and community members to eliminate fear and suspicion. Community wellness centers should not look like hospitals or government buildings. Determine how to run the centers at no cost to the community. Make sure it is accessible, affordable, that community members don't have to pay to use it. Ways to pay for services should include a cash system exchange. Transportation support is needed. Look into use of food trucks that should come at least one time per week; consider the Mo-grow program. Use mobile technology, and reimburse for transportation.

**TABLE 4 Scenario:** Population: undocumented families; Health outcome: reduce diabetes; Location: frontier, closest PCMH is more than 10 miles away.

The needs of undocumented and citizen families are not that different. Harding County, as an example, has about 700 people, and its population is decreasing. There are no services, but there are resources, including SBHCs with part-time staff, health fairs, senior center, and volunteer fire department. This is a place for a community health organizing model. Have a community coordinator in each community (half to full-time), paid, whose job it is to help find resources and organize the community toward better health. A first step in this type of situation is to inventory resources, then engage the community and find on-going funding. Examples of things that are working: HEROS, CHC Coordinators, ECHO programs and tele-health. We need to expand and broaden these models for other communities.

## **RECOMMENDATIONS:**

- Require accountability for cultural competency. To move in this direction:
  - Develop/adapt guidelines for cultural competency in health care/wellness and apply them to every facet of SIM/NMHSI.
  - Develop indicators and measures to ensure that cultural competency goals are continuously met.
- Ensure that, in addition to Health and Health Care, the other social determinants of health are considered and integrated into SIM/NMHSI work. Broadly, these are: Education, Neighborhood & Built Environment, Social and Community Context, and Economic Stability.  
(<http://www.healthypeople.gov/2020/topics-objectives/topic/social-determinants-health>)
- Develop and deploy a mechanism of accountability to ensure that all levels of government involvement in SIM/NMHSI truly represent the will of the people.
- Ensure that Community Wellness initiatives are self-sustaining; that they do not rely exclusively or mainly on external funding.
- Expand and broaden successful models already in place. Mobile services is an example. HERO (<http://hsc.unm.edu/community/heros.shtml>) ECHO (<http://echo.unm.edu/>) are two more examples.
- In each community where needed, hire .5 or 1 FTE Community Health Coordinator who helps the community organize itself toward better health.
- Adopt Ohio definition of population health, if it is aligned with CMS/SIM definition of population health. “Population health is the distribution of health outcomes across a geographically-defined group which result from the interaction between individual biology and behaviors; the social, familial, cultural, economic and physical environments that support or hinder wellbeing; and the effectiveness of the public health and healthcare systems.”  
([http://www.healthpolicyohio.org/wp-content/uploads/2014/11/WhatIsPopHealth\\_PolicyBrief.pdf](http://www.healthpolicyohio.org/wp-content/uploads/2014/11/WhatIsPopHealth_PolicyBrief.pdf))