

**Health System Innovation  
June 17, 2015 Summit  
Tribal Committee**

**Attendance:**

Valerie Quintana, Presbyterian REACH	Travis Renville, Presbyterian HP	Aiko Allen, NM Department of Health Tribal Liaison	
Trish Moore, Presbyterian REACH	Ervin Chavez, San Juan Regional Medical Center	Priscilla Caverly, NM Human Services Department, Tribal Liaison	
Shandiin Wood, NM Department of Health, Office of Tribal Liaison	David Antle, Pueblo of Isleta, Health Center	Marangellie Trujillo, NM Department of Health, Office of Policy and Accountability	
Joyce Naseyowma-Chalan, UNM Sandoval Regional Medical Center	Theresa Belanger, NM Human Services Department (in another committee during summit)		
Barbara Alvarez, NM Human Services Department, Tribal Liaison	Amy Armistad, UNM Project ECHO		
Julia Platero, Blue Cross Blue Shield New Mexico	Lucia Lopez, NM Indian Affairs Department		

Topic	Discussion	Next Steps/Follow-Up
Introductions (Name, Position, and Organization)	<p>Introductions</p> <p>Observation: A participant suggested that we must have assurance from CMS that the state will be held accountable for integrating tribal stakeholder group recommendations into the SIM design model.</p>	<p>Lessons learned: Suggest that the stakeholder group follow the same process used by HSD in healthcare reform, Affordable Health Care, Native American workgroup.</p> <p>Stay together rather than separate into different groups for committee work. Can hear questions from other workgroup and respond to them.</p> <p>Decision: The workgroup will have a roundtable between summits in order to address key questions.</p>
<b>Discussion Questions (60 minutes total)</b>		

<p>Describe the integrated care and wellness approach as you understand it.</p> <p>15 minutes</p>	<p>From a tribal perspective, we are including physical, social, spiritual, behavioral aspects to describe wellness. Wellness is also about working together and sharing information.</p> <p>Do you have an integrated health system in your community?</p> <ul style="list-style-type: none"> <li>- Yes: IHS (for Native Americans) in the following ways: <ol style="list-style-type: none"> <li>1. IHS is a comprehensive system. Example: dental exam and what is included.</li> <li>2. IHS has best example“ of a one-stop shop”: physical, dental, vision care, etc.. Some clinics (Gallup Medical Center) have traditional healers.</li> <li>3. Holistic care (mind, body, and spirit); they (IHS) have incorporated traditional healing (both are represented: the female and male medicine people)</li> <li>4. The system (IHS)-- is created to deal with disease not well-being.</li> </ol> </li> <li>- Would turn the question (#2) on its head and look more broadly at what is included in health. An integrated system would also include social service programs, senior service centers, tribal court systems, veterans, school-based systems (BIE), tribal nutrition programs, CHRs, Head Start (to name some).</li> <li>- A major barrier to integrating all the different organizations mentioned above is HIPAA violations and concern for informal sharing of information in small/rural towns where everyone knows everyone.</li> </ul> <p>What about behavioral health?</p> <ul style="list-style-type: none"> <li>- Not integrated with healthcare usually (or slower to happen) due to a lack of resources in terms of clinicians and facilities.</li> <li>- It is a broken system (in total). Example: Tribal courts are sending people to jail and they aren't aware of their treatment from behavioral health professionals</li> </ul> <p>How about urban AI/AN?</p> <p>Yes: the urban population faces gaps and lack of resources, especially for behavioral health.</p> <ol style="list-style-type: none"> <li>1. First Nations Health Source—clinic in Albuquerque has a similar healthcare delivery model as the IHS one stop shop. They have also recently started a homeless outreach program.</li> <li>2. Due to FQHC status, there's a perception that native clients are served last. FQHCs must serve everybody.</li> </ol>	<p>Comment: We need to assess vocabulary from a cultural context. Can we find a common ground in what we are talking about? Example: For native people, we think in terms of “well being” rather than wellness. Well-being means living life to its fullest. Prefer this term. The healthcare system (IHS) separates well-being out into healthcare. Also, we need to give consideration to historical trauma.</p> <p>Also, in terms of disparities (sounds like despair) use “inequities”.</p>
<p>What are current differences in health care delivery models for Native Americans among tribal-run (638)</p>	<p>638 and IHS differences:</p> <ul style="list-style-type: none"> <li>- Possibility of creating a collaboration will be a barrier because they operate differently (resentment is manifested when tribes take over healthcare for their community)</li> </ul>	

<p>health services, IHS, and those accessing NM public health clinics and urban, off-reservation services?</p> <p>a. What are differences between these models and the integrated care and wellness model we'd need to address?</p> <p>b. What are any opportunities that exist to move toward the desired integrated care and wellness model? (What about ways it encompasses tribal values, traditions? Any gaps here?)</p> <p>15 minutes</p>	<ul style="list-style-type: none"> <li>- Disconnect among tribal programs. Challenge of integration of services in IHS. Example: when we get to tribal 638, CHRs don't work cooperatively with IHS or 638 tribes; people work in silos (e.g. EMS)</li> <li>- Challenge: IHS is bound to what is developed in its budget formulation as IHS is a collection of 12 regions.</li> <li>- IHS and tribal sector don't share information.</li> <li>- Public health and IHS sees things differently.             <ol style="list-style-type: none"> <li>1. When tribes go 638, there is a bit more control. 638 is more agile and can restructure priorities when needed.</li> <li>2. 638 facilities are supported by leveraging resources to pay for things supported by 638 facilities.</li> <li>3. Can operate very well and integrate behavioral health (examples: Alamo and Ramah)</li> <li>4. Ramah and Alamo also great examples of successfully combining school and healthcare delivery. Also for behavioral health integration.</li> </ol> </li> <li>- Private sector and IHS challenge: don't share information because of HIPAA compliance.</li> <li>- IHS you see any physician; in the private sector you tend to see the same medical provider.</li> <li>- Purchased Referred Care (aka Contract Health Services) dollars. If all the PRC money has been used, you don't have access to services unless you have Medicaid.</li> <li>- Private sector is dealing with the big challenge of the ER.</li> <li>- In addition, dealing with the disagreement on who is ultimately responsible for medical services rendered when IHS refers a patient to a private hospital.</li> </ul> <p>2a. What are differences between these models and the integrated care and wellness model we'd need to address?</p> <ul style="list-style-type: none"> <li>- Data sharing is crucial for developing tribal programs and it needs to be bi-directional: give back to tribes when requesting data (e.g. immunization reporting-tribes can't get data but they are required to provide data)</li> <li>- Wifi in pueblos an issue (lack of connectivity).</li> <li>- IHS and VA need to be involved in these conversation (very important)</li> <li>- Inter-governmental agreements or inter-agency agreements can help with the information sharing (Example: PED did it with student scoring among schools. MOU developed with</li> </ul>	<p>638 can be out on their "own island" depending on shares, etc. Tribes like Fond du lac (Wisconsin) great example of taking entire shares and not piecemeal.</p> <p>Care team: how do we get CHR's in the picture? What will it take to develop this partnership?</p> <p>Will need to address Quality measures. Have lots of different measurement systems: GPRA, RPMS, NCQA.</p> <ol style="list-style-type: none"> <li>1. Suggestion to prioritize improvement areas (i.e. standardize measures from NCQA, RPMS, GPRA, Baldrige)</li> <li>2. Identify data elements that are being collected under each</li> </ol>
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	<p>tribes and pueblos. Data was compiled and sent back to tribes. No one could share data outside tribes. PED not allowed to grade schools. Schools interpreted data and self-graded.</p> <ul style="list-style-type: none"> <li>- Example: Look at Networks of Care. HSD. Integrates IHS, VA. Has behavioral health—holistic approach.</li> </ul> <p>2b. What are any opportunities that exist to move toward the desired integrated care and wellness model? (What about ways it encompasses tribal values, traditions? Any gaps here?)</p> <ul style="list-style-type: none"> <li>- Scarce resources faced--helps us to come together and create a model like this.</li> <li>- Care coordination (MCOs). (I/T/Us may call this case management). As all MCOs have different ones, opportunity to have standardization of these assessments. Question: Do health assessments work in Indian country?</li> <li>- Payment structures—have agreements.</li> <li>- Opportunity: we have lack of contractual agreements in terms of an identified gap—access to healthcare providers, hospitals, etc.</li> <li>- Potential: we have 77,000 fee for service AIs. Potential if they sign up with MCO.</li> <li>- Request for rate adjustment for Medicaid in order to attract Primary care providers.</li> <li>- Adjustment in HIPAA language important—policy clarification statewide. Could improve data sharing.</li> <li>- Model/example for integration of traditional healers. Look at Navajo Nation (cultural aspects of healthcare delivery system). Navajo Nation has been successful in integrating payment for traditional healers.</li> </ul>	<p>systems so commonalities can be found</p> <ol style="list-style-type: none"> <li>3. Identify measures that are important for Native Americans</li> <li>4. Inequity (disparity) measures</li> </ol>
<p>What are implications if this integrated approach moves forward based off what you learned today? 15 minutes</p>	<ul style="list-style-type: none"> <li>- More data-sharing and communication.</li> <li>- Short term initial cost would be high in order to ensure the long-term cost is low (ROI).</li> <li>- Health status improvement #</li> <li>- Increase providers and care coordinators.</li> <li>- New systems and processing (who is taking on what responsibilities).</li> <li>- Utilization of tele-health. IHS has equipment everywhere.</li> <li>- Costs of medicines keep rising. Without integrated system, a lot of medications stored at home. People shop many locations. Young populations combine these medicines—drug abuse.</li> </ul>	

	<p>Opportunity and example: Pharmacy point of sale (narcotics prescriptions) is an example that shows integrated care model and benefits of integrated information between state and IHS.</p> <p>Can see if same narcotic script has been used at another dispensing site in multiple systems (e.g., CVS can see if VA or IHS has already filled given script).</p>	
<p>What is an/what are some example(s) of geographic areas and/or populations facing disparities (tribal, rural) in New Mexico where we can apply the integrated care and wellness model? What are your reasons for suggesting this/these examples? <b>15 minutes</b></p>	<ul style="list-style-type: none"> <li>- Distances between healthcare facilities.</li> <li>- Big Navajo area: to get access is a major issue to which tele-health could address.</li> <li>- Tele-health could be problematic for pueblos and tribes that don't have adequate access to internet connectivity.</li> <li>- Start with (single) disease-based case management (i.e., diabetes) in order to demonstrate integration of care rather than many at the same time.</li> <li>- System of care integration would eliminate duplication of medical services.</li> <li>- Geography</li> </ul>	
<b>Committee Updates (45 minutes total)</b>		
<p>Tribal Committee members who attended other committee meetings return to the Tribal Committee to present key learnings from their other meetings.</p>	<p>David Antle (brief report-out on Alignment Group where he participates)</p> <ul style="list-style-type: none"> <li>- Integrated when working well.</li> <li>- Qualities in FQHC setting.</li> <li>- Bigger challenge when governance is spread out; we have governments that work with public sector.</li> <li>- Territoriality between state and feds.</li> </ul>	
<p>Participants determine a time to meet between June 17th and July 15th to further the work from the summits.</p>	<p>The workgroup decided to meet at a roundtable discussion between each summit. Logistics to be worked out.</p>	
<b>Report Out Preparation (15 minutes total)</b>		
<p>Select are the 4 key points from the discussion to share with the whole Summit groups. <b>15 minutes</b></p>	<ul style="list-style-type: none"> <li>- Incorporate a better understanding of key terms from a cultural perspective (e.g., inequities in lieu of disparities; wellbeing in lieu of wellness)</li> <li>- Our tribal systems include ITUs (IHS, Tribal, Urban) and to some degree there is integrated care but gaps exist.</li> </ul>	

- Differences: A 638 can address local issues vs. IHS's one size fits all approach that is constrained by budget formulation. 638 is more agile and can restructure priorities when needed. Some 638s have reached integration (Alamo, Ramah, Isleta)
- Differences between model:
  1. Data sharing (one direction) and territorial. Shift to bi-directional.
  2. Internet connectivity a concern.
  3. Quality measures (different metrics-point of issue).
- Commonalities:
  1. Seek Intergovernmental agreement and interagency agreements to help data sharing.
- Opportunities
  1. Care coordination (standardization).
  2. Scarce resources as driver for working together.
  3. Access to healthcare providers (lack of contractual agreement helpful).
  4. Reimbursement rate adjustment for Medicaid.
  5. Adjust HIPAA language statewide.
- Implications:
  1. Short-term increase cost to ensure long-term lower cost (ROI).
  2. Health status improvement.
  3. More data sharing and communication
  4. Utilization of tele-health
  5. Increase providers and care coordination
  6. Replicate Pharmacy POS model