



**Bernalillo County  
Healthcare Task Force  
Recommendations  
October 2014**

# Table of Contents

<b>EXECUTIVE SUMMARY: Principles &amp; Recommendations</b> .....	3
<b>BACKGROUND</b> .....	6
<b>TASK FORCE PROCESS</b> .....	6
<b>KEY ISSUES</b> .....	6
<b>HISTORIC OPPORTUNITY</b> .....	7
<b>COUNTY HEALTHCARE GOALS &amp; RECOMMENDATIONS</b> .....	9
<b>Goal #1: Assure Healthcare Coverage for All County Residents</b> .....	9
<b>Goal #2: Meet Native American Healthcare Obligations</b> .....	12
<b>Goal #3: Increase Availability of Behavioral Health Services</b> .....	13
<b>Goal #4: Build an Integrated System of Primary Care and Navigation Support</b> .....	14
<b>Goal #5: Provide Continuity of Care for Incarcerated People</b> .....	16
<b>Goal #6: Increase County Oversight and Accountability for Mill Levy Funds</b> .....	17
<b>APPENDICES</b> .....	20
<b>Appendix 1: Healthcare Task Force Members and Meeting Topics</b> .....	20
<b>Appendix 2: Safety Net Models from Other States</b> .....	21
<b>Appendix 3: Exchange Premium Assistance Programs</b> .....	28
<b>Appendix 4: Public Participation Model</b> .....	30
<b>Appendix 5: Pathways Navigator Program Description</b> .....	31
<b>Appendix 6: Templates for Reporting and Evaluation</b> .....	33
<b>Appendix 7: Potential County Sources for Leveraging Healthcare Funding</b> .....	36
<b>Appendix 8: Summary of Public Comments</b> .....	37
<b>Appendix 9: Listening Session: People Incarcerated at MDC</b> .....	51
<b>Appendix 10: Listening Session—Native Americans</b> .....	54
<b>Appendix 11: Website Comments</b> .....	57
<b>Appendix 12: Glossary of Acronyms</b> .....	67

# Bernalillo County Task Force Recommendations for Health System Planning and Renegotiation of UNM Hospital Lease

October 2014

## EXECUTIVE SUMMARY: Principles & Recommendations

Bernalillo County *can* achieve a well-designed system of care. This is essential for a more healthy and vibrant community, public safety, and the financial well-being of all residents.

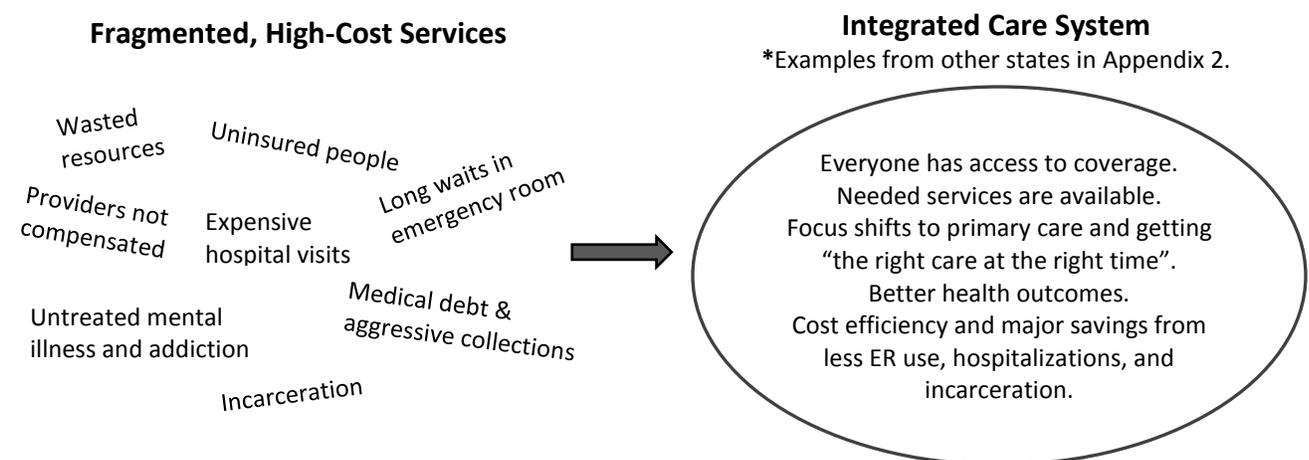
### PRINCIPLES

**#1: County Stewardship of Public Funds:** The County must provide leadership in setting health priorities, and oversight and accountability for public funds given to UNM Hospital. The lease negotiation is an opportunity to drive positive changes in the healthcare system—allocating resources wisely to save costs and achieve better health outcomes.

**#2: Access to Healthcare:** Everyone in the county must have coverage or an alternative through the safety net. This is critical for reducing uncompensated care costs for all hospitals and healthcare providers, and improving the public health, safety and financial well-being for families.

**#3: Critical Services for a Healthier and Safer Community:** Bernalillo County must expand the availability of primary care services and behavioral health services. People should not have to wait several months to obtain care. Incarceration has skyrocketed in part because treatment and support for mental illness and addiction is not widely available in the community.

**#4: System of Care with Navigation Support:** Bernalillo County and UNMH should work as partners to create a more collaborative health system that ensures comprehensive medical and mental health services for all county residents. The County can draw upon models from other states to achieve an integrated system of care. Key components include using navigators and incentives to move people away from using the emergency room and into primary care settings. **This will save costs!**



## RECOMMENDATIONS

### Goal 1: Assure Healthcare Coverage for All County Residents

- 1.1. UNMH must provide a safety net program for uninsured and low-income residents that includes comprehensive medical services, behavioral health services, and navigation support.
- 1.2. Ensure that all UNMH financial assistance programs have simple rules based on County residence and financial need.
- 1.3. Help County residents get healthcare coverage through the Exchange and Medicaid, including Native Americans, by assisting with both premiums and other out-of-pockets expenses, such as copays.
- 1.4. Stop UNMH from pursuing collections against low-income patients.

### Goal 2: Meet Native American Healthcare Obligations

- 2.1 Ensure that the Lease Agreement, as amended, honors the responsibilities to Native Americans as outlined in the original contract.
- 2.2 Define a process for Native American representation: a) during lease negotiations and b) for continued monitoring and evaluation of UNM Hospital's compliance with its obligations to Native Americans.
- 2.3 Require UNMH to have written policies affirming its obligations, including its process for identifying Native Americans, billing for services, and providing priority access and culturally competent care.
- 2.4 Ensure that individual Native American patients are not charged for hospital services, or sent to collections, whether or not they live in the county.
- 2.5 Require the Native American Health Office to have adequate staff to help ensure obligations are met.

### Goal 3: Increase Availability of Behavioral Health Services

- 3.1 Expand behavioral health funding and services through UNM Hospital.
- 3.2 Cover behavioral health services through the UNM Care program or its successor.
- 3.3 Seek to reduce incarceration and recidivism of residents by working with others to provide enhanced and freestanding crisis/triage services to community residents with mental illness and/or substance use disorders.
- 3.4 Require UNMH to devise and report annually to the County measures of treatment outcomes for depression, schizophrenia, and alcohol and opiate addiction.

### Goal 4: Build an Integrated System of Primary Care and Navigation Support

- 4.1 Expand community-based outreach and navigation support in the health system through the Pathways Program and other community programs.
- 4.2 Require all indigent care patients currently on UNMH's roster to be assigned a nationally recognized patient centered medical or health home.
- 4.3 Reduce ER utilization through a) triage programs, b) setting up expanded evening and weekend hours in safety net primary care centers, and c) navigation support to access these services instead of Emergency Departments.

### **Goal 5: Provide Continuity of Care for Incarcerated People**

- 5.1 Expand oversight of medical services at MDC, to include mental health, behavioral health and substance abuse services.
- 5.2 Provide coordination and transition from MDC health services to community-based services—pre-release, assessment, planned re-entry, and service handoffs—for persons being released to ensure that existing health problems are not the cause of the inmate’s return to the MDC.
- 5.3 Work with the Courts and others to oversee operations of programs that offer treatment as an alternative to incarceration achieve effective assessment, referral, and treatment, especially for behavioral health, substance use, and chronic diseases.
- 5.4 Work with Probation and Parole to oversee that persons outside of incarceration have effective assessment, referral and treatment.

### **Goal 6: Increase County Oversight and Accountability for Mill Levy Funds**

- 6.1 Require UNMH to provide an annual plan and budget for use of the mill levy funds, as specified by the County, that advances the County’s defined priorities.
- 6.2 Establish or designate an entity for the County to: 1) administer and monitor mill levy funds; 2) engage in safety net planning and evaluation; 3) contract with other providers to fill gaps and test innovative models.
- 6.3 Create a defined system of health planning and accountability for mill levy funds that measures health outcomes.
- 6.4 Establish a public participation process, including the creation of a community health board.

## **BACKGROUND**

Bernalillo County adopted a resolution this year to improve access to healthcare for all its residents by renegotiating the County's Lease Agreement with the University of New Mexico (UNM) on the operation of UNM Hospital (UNMH). In doing so, the County reaffirmed its vital community, legal and fiscal responsibilities. The County is a steward of public mill levy funds distributed to UNMH each year, and must ensure accountability over the use of taxpayer dollars.

## **TASK FORCE PROCESS**

The County Commission formed a Healthcare Task Force to provide recommendations for the County's negotiations with UNM. The Task Force convened 18 times between May and October 2014, and held 7 public outreach meetings in June and July. Two Task Force meetings were convened as listening sessions with, respectively, Native Americans and homeless individuals who have been incarcerated; and the Task Force also heard presentations by urban Indians representatives, the Metropolitan Detention Center (MDC) supportive housing project, and a community campaign for health access. The Task Force also consulted with UNMH and the All Pueblo Council of Governors. (See Appendix 1 for Task Force members and meeting topics).

## **KEY ISSUES**

UNM Hospital is a vital institution in the community that receives about \$90 million of County mill levy funds each year for its operations and maintenance. As a teaching institution, the Hospital regularly brings highly skilled and experienced physicians to the state, and it has developed a number of nationally ranked programs. The Hospital is the only Level 1 trauma center in New Mexico.

Importantly, UNMH is entrusted to provide safety net services for uninsured and indigent patients, and has provided financial assistance to over 25,000 county residents annually. Fundamental changes are occurring in the healthcare landscape that will benefit county residents. Revenues will expand for UNMH as more patients no longer need its indigent care programs and instead obtain coverage through Medicaid.

Yet crucial gaps in the healthcare system have emerged, with damaging health and financial repercussions for the entire community. Several concerns were repeatedly raised in public comments:

- **Native Americans are not receiving healthcare required by prior contractual agreements.**
- **Many people who are uninsured still do not have coverage even after the Affordable Care Act because of affordability barriers, hardships, and other circumstances.**
- **UNMH intends to change the UNM Care program to no longer provide financial assistance for the uninsured, creating serious concerns about access and shifting of uncompensated care costs to other hospitals and providers.**
- **Thousands of UNMH patients are in medical debt totaling over \$100 million each year.**
- **The behavioral health system in the county has deteriorated and become inaccessible, creating a cycle of untreated mental illness and addiction, homelessness and incarceration.**
- **There is inadequate continuity of care for people discharged from Metropolitan Detention Center (MDC).**
- **Patients too often must seek care in the emergency room rather than primary care settings.**
- **There is little oversight to ensure that public dollars are resulting in better health outcomes.**

- **Awareness that unmet health care contributes to higher costs for emergency services, public safety, criminal justice and incarceration, property loss, and lost productivity.**

## **HISTORIC OPPORTUNITY**

The present assumption about the mill levy has been that it offsets UNMH’s costs in providing care for eligible indigent County residents who use the Hospital or use the Hospital’s selected contractors. This falls short in terms of embracing what is possible.

Bernalillo County has a historic opportunity to fix and strengthen the healthcare system for all its residents. By leveraging the mill levy with the expansion of Medicaid and with the availability of federally subsidized insurance, the County is for the first time in a position to ensure all county residents receive high quality and cost effective care. Resources can be allocated wisely to ensure a stronger healthcare infrastructure that benefits all patients and healthcare providers. Low income residents, in particular, can be reached and served in ways that previously have not been possible. The opportunities include:

- Maximizing enrollment into available coverage programs—because every resident having health care coverage makes good health care sense and good business sense.
- Adopting innovative and proven models for financial assistance programs—to help more people obtain insurance or other healthcare coverage.
- Focusing more on prevention and primary care services—to reduce the need for expensive care later, and to reduce emergency room overcrowding.
- Building stronger partnerships with community-based providers—to provide more continuous, patient-centered care, and a more welcoming healthcare environment, while allowing each provider to focus on its strengths.
- Expanding treatment of behavioral health, drug dependency disorders and chronic diseases for persons who are incarcerated, in drug and mental health courts, and in the community on probation and parole.
- Creating incentives for reinvesting cost savings from prevention and community-based programs, including supportive, wraparound services—which can build a more sustainable and accountable healthcare system, and a stronger community.

**Case Example:** A case study provides clear examples of how such a system could work:

*TJ is a 41 year old male with a chronic back pain due to an injury on-the-job as a roofer. As a result, he became unemployed, was periodically homeless and suffered from depression. He began drinking to help his depression. After several emergency room visits, he was eventually referred to a medical home where he sought help for his chronic back pain from his primary care physician who referred TJ to a behaviorist to treat his depression and alcohol use and a patient navigator to assist him with his emergency needs to find housing. After twenty-four weeks of physical therapy and counseling services, TJ became more physically able, stopped drinking, began working part-time at a local restaurant, and was feeling less depressed. His patient navigator helped him enroll him in GED courses to obtain his high school diploma and permanent housing. TJ has plans to obtain his associates degree in accounting.*

The County's indigent community experiences the most complex health care needs with costly and, often, chronic health conditions. When a serious behavioral health issue is added their health care cost increases along with their risk for acute episodic care. Creating an integrated system of care brings

together medical, behavioral health, and social management and care strategies that can enable, empower and encourage vulnerable county residents to obtain better care—especially when they receive help to navigate the complexities of the health care system. True opportunities for fewer missed appointments, reduced emergency room and inpatient visits, decreased correctional facility recidivism rates, better adherence to care, improved quality of life, and lower health care costs can happen. This systematic approach provides an immense opportunity for the County to work in collaborative partnership with UNMH to provide high quality care while saving costs.

# COUNTY HEALTHCARE GOALS & RECOMMENDATIONS

## Goal #1: Assure Healthcare Coverage for All County Residents

**Context:** UNMH is entrusted to provide safety net services for low-income and uninsured patients, and receives substantial local funds, federal funding and tax exemptions to do so. The “UNM Care” program for uninsured Bernalillo county residents has in the past served about 25,000 people annually. As a financial assistance program that resembles healthcare coverage, the program is critical for:

- ✓ Better health by ensuring individuals can access a comprehensive array of services.
- ✓ Financial well-being of county residents by avoiding medical debt.
- ✓ Reducing uncompensated care costs for other healthcare providers.

However, there have been persistent gaps with devastating health and financial results. The program has not been large enough to serve the 120,000 uninsured residents in the county. Thousands of patients at UNMH are sent to collections for over \$100 million of debt each year. Only \$2 million of these bills were actually collected. Patients have been forced to seek care elsewhere (including the emergency rooms of other hospitals) and have become victim to financial ruin and even bankruptcy.

UNMH plans to stop providing safety net services for the uninsured in the near future. The Hospital has made several public announcements about its proposal to convert UNM Care into a program that solely serves people who already have insurance. Yet, despite implementation of the Affordable Care Act, less than half of all uninsured New Mexicans have obtained coverage, largely due to enrollment barriers, affordability concerns, hardships and other special circumstances.

Reaching ***all residents*** requires redirecting how the mill levy is to be used—from an offset of costs for charity care to being one critical component of a more comprehensive, integrated system of care. And it requires a commitment to building partnerships in order to seek out, accept, and serve residents on the basis of income and need.

A continued safety net program, supported by mill levy funds, will be critical for filling gaps in coverage. Examples of beneficiaries who could benefit from using the mill levy to fill gaps:

- Low wage workers who cannot afford insurance in the Exchange without further help with monthly premium costs;
- Low income residents who are administratively excluded from coverage options;
- Vulnerable populations at high risk while awaiting coverage (including the recently incarcerated, persons discharged from MATS, homeless individuals, and people with mental illness and/or in need of treatment for substance use);
- Older adults not eligible for either Medicare or Medicaid but unable to afford insurance or payments for medical care especially for chronic conditions;
- Others who remain “underinsured” and whose inability to afford deductibles and copayments keeps them from seeking needed care;
- Residents who need healthcare that is not covered by their insurance, but is necessary for successful medical intervention (such as selected wrap-around services);
- Native Americans, eligible under the 1952 agreement, who do not buy insurance because the federal government should provide health care – a responsibility not met by a chronically underfunded Indian Health Service; and

- People facing “hardships” or temporary gaps in coverage, for example due to being evicted or to medical expenses they could not pay in the last 24 months, or for many other reasons.

Under the law, many of these individuals and other groups are not required to get insurance in recognition of the unique circumstances of each population.<sup>1</sup> The law anticipates that a safety net of services is still necessary, as evidenced by options for states to adopt “Basic Health Plans” to bridge affordability gaps and stronger requirements for nonprofit hospitals to provide community benefits.

## **Recommendations:**

**1.1 UNMH must provide a safety net program for uninsured and low-income residents that includes comprehensive medical services, behavioral health services, and navigation support.** UNM Hospital must fulfill the county’s obligation to ensure healthcare services for indigent patients, and continue to provide the UNM Care program (or a similar full financial assistance program) for uninsured residents. Model programs across the country are structured similarly to UNM Care, but they additionally provide health homes for every patient and navigation support to ensure that patients seek and obtain primary care. See Appendix 2 for model programs. If UNMH is unable to provide adequate primary care, behavioral health, health homes, case management and navigation support, these services should be contracted out to other providers in the area. UNMH should not be allowed to make changes to its charity care programs without approval by the county and/or entity designated by the county that includes meaningful community stakeholder representation.

**1.2 Ensure that all UNMH financial assistance programs have simple rules based on County residence and financial need.** Most counties and other hospital systems in New Mexico have simple rules for financial assistance and indigent care programs that are based on having residence in the county, being low-income, and not being eligible for Medicaid. Other states use similar rules to provide coverage universally to both uninsured and insured county residents that fall below a certain income level. (See Appendix 2 for chart of model programs). UNMH should adopt these simple rules for financial assistance for all low-income patients, whether or not they are insured, who fall below 400% of the poverty level (the standard used for subsidized Exchange coverage). In addition, the verification standards to prove residency or income should be no more restrictive than that of the state Medicaid program. Currently, UNM Care appears out of sync with its unduly restrictive eligibility rules—for example, excluding people who are offered employer coverage even if it is unaffordable, or lawful immigrants who are temporary visa holders (making the UNMH rules even more restrictive than Medicaid). The rules are also complex, creating confusion and administrative burden. An inclusive policy, particularly when coupled with navigation support, has the potential to improve health, reduce uncompensated care costs for all providers in the health system and guard against aggressive tactics that leave people in financial debt.

**1.3 Help county residents get healthcare coverage through the Exchange and Medicaid, including Native Americans, by assisting with both premiums and other out-of-pocket costs such as copays.** UNMH helps individuals get coverage through Medicaid and the Exchange. However, UNMH must:

- Train UNMH financial assistance staff on Medicaid and Exchange enrollment processes. There is a public perception that staff do not understand the eligibility rules well and may be

---

<sup>1</sup> Affordable Care Act § 1501, codified at I.R.C. § 5000A(d) and (e). Exempt groups include Native Americans, certain “non-resident” immigrants (including students, temporary workers, deferred action youth, etc.), anyone granted a “hardship” exemption, people under the tax filing threshold, people with certain religious exemptions, and others.

providing inaccurate information to patients that deter them from applying for coverage, for example, by asking for unnecessary documents. All financial services staff, including Medicaid specialists, should be trained by an agency with expertise on the program rules.<sup>2</sup>

- Offer “premium assistance programs” to help low-income working families (including Native Americans) buy insurance through the Exchange, as well as help with out-of-pocket costs such as copays and deductibles. (See Appendix 3 for more information on premium assistance programs.) UNMH should continue to provide help to reduce the copayments and deductibles for low-income patients who have insurance. However, the Hospital should also help pay for premiums so that uninsured patients can access coverage. Costs have been cited as the number one reason why people are not getting insurance even after healthcare reform. Even with federal financial help, low-income families cannot afford coverage.

Premium assistance programs ensure more people have coverage while allowing them to take advantage of federal subsidies available. UNMH would likely save funds by helping people buy insurance on the Exchange (thereby maximizing federal subsidies) rather than face uncompensated care costs or uncollectible bills from patients who are uninsured or underinsured with plans that have expensive co-pays and deductibles. The program is especially beneficial for Native American patients because the federal government pays for all cost-sharing expenses for Native Americans with incomes under 300% of the poverty level, so long as the premium is paid to obtain a plan (which usually ranges from \$0 to \$50).

If UNMH provides such Exchange premium assistance programs, eligible patients should be expected to participate in them and would not be eligible for charity care. However, there must be exceptions for people who are not required to get insurance under the Affordable Care Act, for example, due to hardship.

If the Hospital does not provide assistance with premiums, then everyone who has not obtained coverage through the Exchange should be eligible for full financial assistance. These programs do not provide any “disincentive” to getting insurance, given that most people cannot afford the coverage anyway and are facing major tax penalties and/or health conditions that already provide incentives to get insurance if possible.

**1.4 Stop UNMH from pursuing collections against low-income patients.** Over \$100 million of bills are sent to collections each year, but little effort is being made to connect patients with financial assistance or investigate accounts for potential eligibility for financial assistance programs or even simple billing errors. The Hospital can and should audit all claims that are currently in collections to determine the income level of the patient and reasons for why financial assistance was not used. Assigning patient navigators to all of these patients would improve patient education and access of financial assistance resources. Additionally, processes should be implemented to insure that future claims are audited before they are sent to collections to determine the income level of the patient/accuracy of the claim and insure that his/her current financial situation does not warrant financial assistance. The collections efforts and financial assistance policies should be consistent across all payer categories (i.e., insurance should not be a barrier to financial assistance as it relates to patient liabilities). Native Americans should not be charged for their bills and therefore should never be sent to collections (as described below in Recommendation 2.4).

---

<sup>2</sup> For example, the NM Center on Law and Poverty is an expert on Medicaid eligibility and enrollment processes and has provided trainings to ISD supervisors and personnel, Exchange guides, social service workers, hospitals and other providers.

## Goal #2: Meet Native American Healthcare Obligations

**Context:** Bernalillo County and UNMH have the shared responsibility for delivering high quality health care to Native Americans that reside within the county. This shared responsibility has deep-seated historical origins that resulted in the creation of UNMH in 1952. The Hospital was initially established on 5.3 acres of BIA-controlled federal land that was given to Bernalillo County and so named as the Bernalillo County Indian Hospital, whose sole mission was to serve Native Americans in Bernalillo County. Subsequent amendments restated the hospital's original intent of providing comprehensive medical care to all Native Americans.

A prevailing concern, however, exists that the primary intent of the original contract has been greatly diminished and even altered in subsequent contracts and agreements. To date, UNMH admits to breaches in its contract and it has been unable to provide the agreed-upon full services treatment to Native Americans. Bernalillo County and UNMH have a joint responsibility to comply with the original contract for providing health care to all Native Americans in Bernalillo County at no cost in perpetuity in all subsequent contracts and agreements. The following are recommendations to address gaps in the health care obligations for Native Americans in Bernalillo County and uphold the historical commitment from UNMH and the County to ensure the provision of care to this population. Both entities must prioritize the delivery of accessible and high quality health care to this population.

### **Recommendations:**

**2.1 Ensure the Lease Agreement, as amended, honors the responsibilities to Native Americans as outlined in the original contract.** Ensure the language in the Lease and other documents explicitly includes providing care and treatment to all Native Americans in Bernalillo County and not just Native Americans from New Mexico's tribes who live in the County.

**2.2 Define a process for Native American representation: a) during lease negotiations; and b) for continued monitoring and evaluation of UNM Hospital's compliance with its obligations to Native Americans.** The All Pueblo Council of Governors (formerly the All Indian Pueblo Council) provides critical representation and advocacy for New Mexico's 19 Pueblos, and must be regularly consulted on the provisions and the monitoring of the Lease Agreement and MOU. Also important are the representation and advocacy from the Navajo Nation, Mescalero Apaches, Jicarilla Apaches and urban Indians from other tribes.

One option would be to create a Community Advisory Council that is representative of Bernalillo County's Native American population and is inclusive of urban Indians and Pueblo Indians to safeguard and monitor UNMH's adherence to its contractual agreement. This Council would serve in an advisory capacity to UNMH to make recommendations for addressing access to and quality of care needs, and for identifying appropriate measurable outcomes. By working together, UNMH and the Council can ensure the contractual obligations are met and that Native Americans in Bernalillo County receive accessible quality health services at no cost.

**2.3 Require UNMH to have written policies affirming its obligations, including its process for identifying Native Americans, billing for services, and providing priority access and culturally competent care.** This includes, but is not limited to a) assuring that behavioral health services are available to Native Americans; and b) educating UNMH providers and staff about the importance of

cultural competency to increase their understanding and sensitivity when providing care to Native Americans.

**2.4 Ensure that Native Americans are not charged for hospital services, or sent to collections, whether or not they live in the county.** Costs for Native American healthcare were intended to be paid by the Federal government, and the Hospital should rigorously pursue payment from IHS, based on federal agreements under the 1952 contract with Bernalillo County (not the eligibility rules for “Contract Health Services” as the Hospital currently does – these rules do not supersede or replace the 1952 agreement). If Native Americans are expected to enroll in the UNM Care program, they should be able to do so regardless of their tribal affiliation (whether in-state or out-of-state) while residing in Bernalillo County. If necessary, designate a portion of mill levy funds to pay for health services, including health insurance premiums for health plans through the Exchange, for Native Americans. Additionally, the financial assistance policies of UNMH should formally reflect that Native Americans are intended to have their care covered with no patient liability (pursuant to the previously referenced agreements) and, therefore, are exempt from the “consistency of collection efforts” requirements set forth in Section 1.4 of this document.

**2.5 Require the Native American Health Office to have adequate staff to help ensure UNMH obligations are met** and to be effective in meeting the needs of Native Americans seeking health services at UNMH.

---

### **Goal #3: Increase Availability of Behavioral Health Services**

**Context:** New Mexico’s behavioral health care system has deteriorated massively over the past fifteen years.<sup>3</sup> Meanwhile, Albuquerque inpatient mental health care has been largely relegated to serving incarcerated persons at the Metropolitan Detention Center. MDC has had to absorb and care for increasing numbers of untreated persons with mental illness, addictions, and other behavior disorders, and the community has witnessed a rash of police shootings of mentally ill individuals. Mental disorders comprise the largest single reason for indigent residents seeking care at UNMH, and the third largest area of costs for charity care is for psychiatry services, and psychiatry services is the second highest medical area in which patients reported need for financial assistance.<sup>4</sup> What’s more, many research studies have demonstrated that behavioral health is closely correlated with overall wellness, several of these studies finding that at least half of all primary healthcare visits involve one or more related behavioral health disorders. While UNMH has the capacity to provide excellent behavioral health care to mentally ill and alcohol and drug addicted individuals, access to these services is becoming increasingly hard to get as needs increase and providers in the community, including UNMH, decrease.

The expansion of Medicaid provides a major opportunity to supplement the resources needed to provide medical and behavioral health services to many county residents previously dependent on UNM Care or indigent and in situations where pathways into care is either not evident or being used. Also, additional incentives are possible from reinvesting cost savings from prevention and community-based programs, including supportive, wraparound services.

---

<sup>3</sup> See “Back to the Future: New Mexico Returns to the Early Days of Medicaid Managed Care. Psychiatric Services. [ps.psychiatryonline.org](http://ps.psychiatryonline.org); August 2014, Vol 65, No 8)

<sup>4</sup> UNMH report to Bernalillo County Commissioners (March 31, 2014).

## **Recommendations:**

**3.1 Expand behavioral health funding and services through UNM Hospital.** The current level of 12% of mill levy is insufficient, reflected in unduly long wait times for appointments—patients are being told they cannot be seen for 3-6 months for certain types of care. Expansion of current effort and services must be a priority. In addition to specialty services for persons with serious mental illness, UNMH must assure that behavioral health and substance abuse treatment assessment and services are integrated within primary care (as in the model required under Centennial Care). Specifically, UNMH should:

- Increase the availability of the full continuum of behavioral health care, including psychiatric services to residents, by recruiting and providing additional psychiatrists along with appropriate mid-level providers to the UNMH staff. The level of funding and staffing should be adequate to ensure that patients in crisis can be seen within 48 hours, and all patients can be seen within 30 days on a standard basis.
- Expand access to UNMH’s substance abuse treatment services, including detox and Suboxone services, by increasing enrollment in these programs by 10% per year, and through increased compliance/continuance in these programs.

**3.2 Cover behavioral health services through the UNM Care program or its successor.** Ensure that UNM Care in its continuing operation includes coverage for behavioral health care, particularly for those individuals who do not qualify for Medicaid or the Health Insurance Exchange. This will be provided through direct UNMH services and in partnership with community entities so as to increase availability of behavioral health services.

**3.3 Seek to reduce incarceration and recidivism of residents by working with others to provide enhanced and freestanding crisis/triage services to community residents with mental illness and/or substance use disorders.** While not all residents who struggle with behavioral health disorders will or do experience incarceration, a disproportionate number of those with few resources spend time in the Metropolitan Detention Center (MDC). A coordinated effort across the County Department of Substance Abuse Programs (DSAP), MDC, UNMH, other behavioral health centers, and other appropriate community-based providers will prevent and reduce crisis for this population, as well as for the larger population of residents with behavioral health needs.

**3.4 Require UNMH to devise and report annually to the County measures of treatment outcomes for depression, schizophrenia, and alcohol and opiate addiction.** Such measures and reports will include data on symptom reduction, wait times for behavioral healthcare appointments, treatment compliance, life adjustment of patients, and estimates on persons needing treatment who are not being treated; and on captured savings from reduced census at MDC and provision of preventive services. Bernalillo County will provide rewards and incentives (to be determined) to UNMH and partners for effective/efficient services.

---

## **Goal #4: Build an Integrated System of Primary Care and Navigation Support**

**Context:** For many users of UNMH, the healthcare system does not focus on public health, or on primary, secondary and tertiary prevention: Helping residents stay healthy and preventing the escalation of chronic conditions means that the health of the community can improve and that the impact of mill levy funding is maximized.

Integrated care systems are proven to save costs over time. (See Appendix 2 for model safety net programs and citations to the research.) Anticipating and proactively linking patients with appropriate preventive services ensures that the system leverages its funding appropriately, without wasting funding on Emergency Department use where primary care could better address the need.

Patients, specifically indigent patients, need assistance to access financial assistance, maneuver the health system, use services appropriately, and link with available social supports (housing, food and transportation) in the county that help them maintain their health. Without such assistance, the system incurs higher costs and patients receive sub-optimal care. UNMH must function as a part of a broad system of care that includes outreach, social services, and, collectively, a comprehensive scope of services.

## **Recommendations:**

- 4.1 Expand community-based outreach and assistance navigation support in the health system through the Pathways Program and other community programs.** Assist residents in navigating the medical and social service system by increasing the current availability of Pathways services and similar navigator and community health worker programs—to make better use of coordinated care and system navigation approaches, including social services (e.g., housing, transportation, job training) and partnerships with other community services and agencies. This includes encouraging UNMH to purchase/contract for services it is not able to provide. Increase funding for the Pathways Program, which has demonstrated effectiveness in navigating the UNMH system and in providing supportive services. The Pathways model and other models need to be coordinated with other agencies such as Albuquerque Health Care for the Homeless that are also doing outreach.
- 4.2 Require all indigent care patients currently on UNMH’s roster to be assigned a nationally recognized patient centered medical or health home.** UNMH should assess the number of uninsured indigents who a) have more than one admission to hospital and/or the Emergency Department and b) use Pathways or in-house navigators—and offer to connect these patients with a medical home at a UNM primary care site, or contract with a willing partner in the community—rather than waiting for them to come in during a health care crisis. The medical home would be responsible for case management, tracking referrals to specialists, and providing patient health education, among other duties.
- 4.3 Reduce emergency room utilization through a) triage programs, b) setting up expanded evening and weekend hours in safety net primary care centers, and c) navigation support to access these services instead of Emergency Departments<sup>5</sup>.** Have UNMH evaluate and submit a report to the County on the option of either creating its own Urgent Care or expanded hour primary care services connected to the Emergency Department or contracting with community-based safety-net partners who have the facility to add evening and weekend clinic hours subsidized through mill levy funds. These community partners should be contracted to link patients seen for walk-in care with a primary care medical home and take the steps necessary to prevent future (avoidable) Emergency Department visits. If UNM chooses to build its own Urgent Care, it should also link patients with its PCMH network. Navigators should be located in the Emergency Department to work with the triage nurse to link non-emergency patients with appropriate urgent care including providing transportation to an alternate site.

---

<sup>5</sup> According to an NIH study, an average bill for an ER visit costs 40% more than an average month’s rent<sup>5</sup>. In the meantime, the patient’s underlying cause for the visit has never been appropriately managed and sorted.

## **Goal #5: Provide Continuity of Care for Incarcerated People**

**Context:** The cycle of drug use, crime, incarceration, release, drug use and recidivism among people incarcerated at MDC is broadly acknowledged, as are the associations of mental illness and homelessness with cycles of incarceration. Approximately 70% of inmates have some identifiable drug use disorder. Likewise, a large proportion has diagnosable mental health disorders. Many have both.

A number of problems with health services have been reported. Some of them include

- Treatment services are insufficient in both of scope or intensity/frequency.
- The present contract at MDC for assessment and clinical care has high per capita cost.
- There is little or no connection of care within MDC with follow-up care after release—in effect, MDC acts in isolation from the community, rather than as a part of the community.
- The period immediately following release is a time of missed opportunity to connect with follow-up medical and behavioral health care or contact with social services.
- Treatment services for persons under Probation and Parole and in the Community Custody Program are haphazard.

UNMH’s Fast Track pilot program—using a caseworker to connect high-risk persons with mental illness with follow-up care—is an example of what could be replicated on a large scale, pending an evaluation of the program and its outcomes. Also, the Metro Court and District Court have provisions for using alternatives for incarceration via Drug Court that have been shown to be associated with reduced recidivism. These services could be paid for by Medicaid but presently are not.

*Note:* Similarly to Recommendation 3.3, the Task Force acknowledges that not all people who are incarcerated at MDC will be in need of behavioral health services. However, it is well-documented that the need within the jailed population is large and disproportionate to the greater community. Therefore, the following recommendations repeat an emphasis on the need for continuous, integrated and comprehensive behavioral health care for the population that experiences incarceration at MDC, and many times cycles between the jail and indigent services when released or between periods of incarceration.

### **Recommendations:**

**5.1 Expand oversight of medical services at MDC, to include mental health, behavioral health and substance abuse services.** The County should contract for a range of services at MDC. These could include the following:

- Quality control oversight of clinical contract services at MDC including the appropriateness of the provision of behavioral health, substance abuse and other clinical services at MDC
- An analysis of the reasons for recidivism and recommended strategies for reducing these rates to a lower level that is acceptable to the County and sustainable by the MDC (or jointly through UNMH and MDC), through use of mill levy or other funds. (Please see Appendix 7 for other potential County funding sources.)

**5.2 Provide coordination and transition from MDC health services to community-based services—pre-release, assessment, planned re-entry, and service handoffs—for persons being released to ensure that existing health problems are not the cause of the inmate’s return to the MDC.**

- Provide assessment and arrangement for continuity of clinical care, behavioral health, and substance abuse treatment services and for social support services upon release. Provide services to all assessed as having serious behavioral health issues, drug dependency, and other chronic diseases, whether or not the person is enrolled in Medicaid.
- Assure that eligible persons are enrolled in Medicaid so that it is in effect in either MDC or the community-based service provider, or becomes effective upon release from MDC.

**5.3 Work with the Courts and others to oversee operations of programs that offer treatment as an alternative to incarceration achieve effective assessment, referral, and treatment, especially for behavioral health, substance use, and chronic diseases.** This envisions an expansion of the drug courts and mental health court in terms of numbers of persons served, breadth of services, engagement with community resources, and more effective application for Medicaid funding.

**5.4 Work with Probation and Parole to oversee that persons outside of incarceration have effective assessment, referral and treatment** for behavioral health disorders, substance abuse, and other chronic diseases. This should include persons released from NM Corrections Department and well as MDC and the Courts, and should be applied to the Community Custody Program.

---

**Goal #6: Increase County Oversight and Accountability for Mill Levy Funds**

**Context:** UNM Hospital receives over \$90 million of Bernalillo County mill levy funds each year and is expected to be fully transparent and accountable to the County and its residents for their use. UNMH does provide regular reports; however, these focus on allocation of funds to various activities, without an assessment of public health outcomes. Public comments to the Task Force repeatedly recommended more oversight and reporting is required by the Hospital to show how mill levy funds are being used to actually benefit the County. The Hospital appears to be making important decisions unilaterally about the County’s health system, without input from the County or community.

The County must take a more active role in the oversight process and leverage mill levy funds for better cost-effectiveness and outcomes. Currently, mill levy funds are mostly used for general operations and maintenance of the Hospital, as per the lease.<sup>6</sup> The funds are a sizeable portion of the Hospital’s budget, amounting to 12% of revenues in FY13.<sup>7</sup> When reporting upon mill levy funds, UNMH shows an allocation of the funds to every part of the Hospital’s operational budget – salaries, equipment, supplies, services, etc.<sup>8</sup>

However, the mill levy also helps fund the Hospital’s safety net services, with specific expectations attached: The Lease and other agreements require UNMH to fulfill obligations to Native Americans, provide medically necessary care to indigent patients, and use mill levy funds for mental health services.

---

<sup>6</sup> See Bernalillo County and UNM Hospital, Lease Agreement, 1999, at Sec. I(L) and I(N).

<sup>7</sup> UNM Hospital, Bernalillo County Commissioner Reports, at 15, March 2014.

<sup>8</sup> Id. at 16-18.

In recent years, the County has (already) responded to requests from UNMH and the community for additional funding to meet these needs. For example,

- The mill levy was raised to 6.5 mills in 2000 because the prior amount of 4.8 mills was “insufficient to pay all the costs delivered by the Hospital and Mental Health Center to medically indigent residents”.<sup>9</sup>
- At least 12% of mill levy funds must be allocated for the Mental Health Center and associated behavioral health and substance use treatment services.<sup>10</sup> In 2013, these expenditures were about \$12 million.<sup>11</sup>
- Approximately \$800,000 of mill levy funding is dedicated to the Pathways navigator program.
- In recent years, the Hospital appears to have spent more on charity care for Bernalillo County residents (about \$140 million) than it received from mill levy funds (about \$90 million).<sup>12</sup> UNMH also reported nearly \$50 million in “uncompensated costs” for uninsured patients – a portion of which was offset by about \$35 million of federal “DSH” funds to help with the costs of uninsured and low-income patients.<sup>13</sup>

As indicated in the recommendations above, there is a clear and growing need to expand the safety net, simplify administrative procedures, create a more coordinated system of healthcare, and make a genuine effort to reach out to all people in the county. Yet the Hospital has not provided clear information about the future of its safety net programs or the impact of the Affordable Care Act on its finances. This has created uncertainty and serious concern that the healthcare needs of county residents may go unmet. Commentators at public input meetings noted that tens of thousands of county residents are not being served by UNM Hospital and will continue to need a safety net of services even after healthcare reform. The County must step in to ensure that all county residents are able to access healthcare and benefit from a robust system of healthcare services.

## **Recommendations:**

**6.1 Require UNMH to provide an annual plan and budget for use of mill levy funds, as specified by the County, that advances the County’s defined health priorities.** UNMH should provide a budget to Bernalillo County that lays out how it proposes to use mill levy funds consistent with the County’s health priorities and with the contract elements agreed to in the lease negotiation process. Monthly reports to the County will demonstrate how UNMH is supporting the County’s plans and health outcome metrics.

**6.2 Establish or designate an entity for the County to: 1) administer and monitor mill levy funds; 2) conduct safety net planning and evaluation; and 3) contract with other providers to fill gaps and test innovative models.** The County needs capacity to administer and monitor programs funded by the mill levy. Proper oversight will require the County to have broad healthcare industry expertise. This expertise should be employed or contracted by the County and should be housed in a designated unit reporting to the County Manager and the Board of Commissioners.

---

<sup>9</sup> Bernalillo County and UNM Hospital, Memorandum of Understanding, 2000, at Sec. II(B).

<sup>10</sup> Bernalillo County and UNM Hospital, Memorandum of Understanding, 2000, at Sec. II(C)(1).

<sup>11</sup> UNM Hospital, Bernalillo County Commissioner Reports, at 18, March 2014.

<sup>12</sup> UNM Health Sciences Center, Summit Reports, Financial Report 1 “Uncompensated Care Gross Patient Billings, Costs and Revenues Funding those Costs” for FY2013, at: [http://hospitals.unm.edu/about/finances/summit\\_fy13/1-report.pdf](http://hospitals.unm.edu/about/finances/summit_fy13/1-report.pdf)

<sup>13</sup> Id.

This entity must be able to engage in a community needs assessment and/or oversee UNM Hospital to conduct such an assessment, in order to determine safety net needs. As described below in recommendation 6.4, a robust public participation process is integral to successful planning.

Importantly, this entity should be given authority to expend mill levy funds for safety net programs – for example, by requiring prevention and primary services that would reduce the need for expensive care later and reduce emergency room overcrowding. Where UNMH is unable to provide services, the County must be able to contract them out to other providers.

Among this entity’s functions could be: a periodic review of County tax sources for potential reallocation to improve public health; finding ways to leverage funds by capturing and re-investing savings from greater emphasis on prevention and primary care; and increased coordination with the City of Albuquerque on healthcare planning and evaluation. Also, this entity should draw from best practices across the nation to pilot model safety net programs with participating healthcare providers. Financing strategies for these pilots might include: using a portion of mill levy funds to pilot programs, leveraging other county tax dollars, and leveraging federal grants and obligations of hospitals that arise from their tax exemptions.

Given the significant resources necessary to develop and maintain this unit, a portion of mill levy funds should be retained by the County to pay for its activities, after 2016 pending approval of the mill levy by county voters. The specific resources required for this unit will be determined after the operating lease with UNMH is renegotiated. Prior to 2016, UNMH should be required to provide funding to a designated entity that can run pilot programs that can serve as the basis for long-term safety net programs.

**6.3 Create a defined system of health planning and tracking of impact for mill levy funds based on community health outcomes.** The mill levy funds will continue to be allocated to UNMH for the provision of indigent care to Bernalillo County residents. However, the manner in which the funds are utilized should be guided by priorities set through a community planning process and monitored through the use of appropriate metrics that track health status and access to care for the entire community. (For examples of reporting and evaluation templates, please see Appendix 6.)

**6.4 Ensure a public participation process, including establishment of a community health board.** There is a fundamental disconnect between the community’s health services needs and its perspective on the services actually provided through the application of the mill levy funds. A more robust public participation process will be needed to assure that public health needs and services are better aligned. This coordination should be provided by a Community Health Board established by the County Commission. The board will help design and implement the community health planning and feedback process. The Community Health Board will be broad based and charged with making recommendations to the Commissioners, UNMH, and other healthcare providers as to what healthcare services should be invested in for Bernalillo County residents.

## APPENDICES

### Appendix 1: Healthcare Task Force Members and Meeting Topics

#### Task Force Members:

Maria Elena Alvarez, CEO  
Deborah Armstrong, PT, JD  
Stephen Forney, MBA, CPA  
Paul Hopkins, DMin  
Nandini Kuehn, PhD, MHA

Sireesha Manne, JD  
Jennifer Metzler, MPH  
Lidia Regino  
Linda Son-Stone, PhD  
William Wiese, MD, MPH

#### Task Force Meeting Agenda Topics:

May 16: Orientation  
May 30: Schedule  
Public Meetings  
Key Questions  
Resources  
June 20: Review of Public Meetings  
June 27: Legal Parameters  
Questions for UNMH  
Additional Community Outreach  
July 11: Listening Session: Incarcerated People at MDC  
July 18: Listening Session: Native American population  
July 25: Listening Sessions Discussion  
UNMH Responses to Task Force Questions  
August 1: MDC/Permanent Supportive Housing Presentation  
UNMH Responses to Task Force Questions  
August 8: Presentation by Urban Indian Representatives  
August 15: Task Force Principles  
Preliminary Recommendations  
August 22: Consultation with UNMH Leadership  
August 29: Preliminary Recommendations Workshop  
September 5: Recommendations Discussion  
September 12: Consultation with Juntos para la Salud Representatives  
Recommendations Discussion  
September 16: Consultation with All Pueblo Council of Governors  
September 19: Consultation with City-County Behavioral Health Task Force Coordinator  
Recommendations Discussion  
September 26: Draft Report  
October 3: Draft Report  
October 10: Final Report

## Appendix 2: Safety Net Models from Other States

### Models for Safety Net Programs • August 15, 2014

Presented by NM Center on Law and Poverty, in consultation with the Juntos Para La Salud campaign.

#### INTRODUCTION

Bernalillo County has the opportunity to design a better healthcare system that draws from the best practices of programs from across the country. This document provides a sampling of programs for the uninsured, highlighting those that strive to improve healthcare access and care coordination.

Some key features of these programs include:

- **Resemblance to health plans** – including discounted premiums, annual renewals, and member identification cards.
- **Simple eligibility criteria** based solely on income, residency and not being qualified for Medicaid.
- **Care coordination through medical homes** – each patient is assigned to a primary care physician and/or community health worker to assure continuity of care through case management and referral tracking.
- **Comprehensive services including behavioral health** – healthcare is provided with an emphasis on primary care and prevention.
- **Funding through partnerships** (ex: county, city, state, federal government, philanthropies, and support from local providers and hospitals)
- **Negotiated provider payments** (ex: volunteer services, coinsurance, grants/contracts for services, or capitated payments for all care.)

#### BERNALILLO COUNTY – CURRENT PROGRAM

The healthcare safety net for Bernalillo County is primarily managed by the University of New Mexico Hospital (“UNMH”). Its main financial assistance program for Bernalillo County residents– “UNM Care” – is undergoing transition and is scheduled to end *in its current form* by December 31, 2014. UNM Care is likely to no longer serve the uninsured, and instead will offer supplemental help only to those who have purchased health plans on the Exchange.

Program	Agency Type	Description	Member Fees & Renewal	Eligibility Criteria	Services	Care Coordination	Provider Payment	Funding Mechanism	# People Enrolled
<b>UNM Care</b> <i>Bernalillo County</i>	Hospital at University of New Mexico	Financial assistance program for uninsured ( <i>changing solely to an Exchange supplement program by Dec. 31</i> )	Copays only; Annual renewal	Income under 300% FPL. Cannot be eligible for Medicaid, Medicare or employer plan. Only citizens and lawful immigrants who are not temporary visa holders.	Comprehensive services through a network of physicians, includes primary, specialty and emergency care.		Fee for service to each provider.	Federal and state funds, as well as about \$90 million from county tax (“mill levy”). Most money is mixed with general operating funds.	30,000 people (in 2012) out of 120,000 uninsured  = 25% uptake

## MODELS FROM OTHER STATES

Program & Location	Agency Type	Description	Member Fees & Renewal	Eligibility Criteria	Services	Care Coordination	Provider Payments	Funding Mechanism	# People Enrolled
<b>Healthy San Francisco</b> <i>San Francisco, California</i>	County (San Francisco Department of Public Health)	Health plan to make healthcare available and affordable to uninsured.	<p>No charges for anyone under 100% FPL.</p> <p>For everyone else, quarterly fee based on income (\$60 to \$450 per quarter), and copays may apply.</p> <p>Annual renewal.</p>	<p>Income under 500% of FPL. Be uninsured for at least 90 days. Cannot be eligible for a public health insurance program (including Exchange).</p>	<p>Patients can access primary, specialty, urgent care, ambulance, and ER services in their medical home network (incl. pharmacy, mental health and substance abuse services), provided by SF Gen Hospital and 4 other hospitals.</p>	<p>Each member chooses one of 30 clinics as a medical home that provides a clinician (ex: physician or NP) and care coordination. Member receives ID card listing medical home.</p>	<p>HSF medical homes get negotiated payments in form of grants. Amount is based on the range of case management and healthcare provided. No payment for participating nonprofit hospitals.</p>	<p>\$121 million in expenditures - \$90 million comes from City and County. The remaining \$36 million from federal government (\$19M), employers (\$14M), and participant fees (\$3M). Also an employer fee.</p>	<p>51,150 people out of 60,000 uninsured (FY 2012)</p> <p>= 80% uptake</p>
<b>Harris County Gold Card Program</b> <i>Harris County, Texas</i>	Harris County Hospital District	Indigent Care Program	Co-pays based on income.	<p>Income under 300% FPL. County Resident. No other health coverage.</p>	<p>Patients have access to primary care services, emergency services, specialist care, pharmacy services, and dental services provided by the Hospital District.</p>	<p>Members assigned to community health clinic for primary care. Hospital District is made up of 16 community health centers, six school-based clinics, a dental center and dialysis center, mobile health units, and two full-service hospitals.</p>		<p>Property Tax, DSH payments, and revenue from insurance, Medicaid, and patient payments.</p>	

Program & Location	Agency Type	Description	Member Fees & Renewal	Eligibility Criteria	Services	Care Coordination	Provider Payments	Funding Mechanism	# People Enrolled
<b>Care Link</b> <i>Bexar County, Texas</i>	University health system public hospitals and clinics	Indigent care program	Monthly payment plan. Enrollees pay portion of all health costs, based on income (max of 2.5%-6.7% of income).	Income under 200% FPL. A "Plus Plan" with limited benefits is available to people between 201-300% FPL. County residents.	Patients can visit the hospital and various clinics within the UHS as needed, but CareLink rates, services, and protections only apply to providers in the UHS system.	Upon enrolling, members are assigned a primary care provider and are not charged a copayment when visiting this physician.	Physicians and clinics receive Medicare rates while hospitals receive Medicaid rates.		41,252 people
<b>New York Health and Hospitals Corp (HHC)</b> <i>New York City, NY</i>	Health and Hospitals Corporation (consortium of four hospital systems)	Hospital charity care programs.	No fees and \$15-\$20 copays for most care. "Artists to Access" – if uninsured, can paint or sing for patients and receive credits to pay for care.	Income under 300% FPL. Must be Uninsured and not eligible for Medicaid or Exchange.	Comprehensive network including home health, school based health centers, mobile medical office	Hospitals got waiver through Medicaid to focus on delivery system reform. Found 100 potential partners to focus on care coordination.	Hospitals reduce charges (charity care is required by state law).	Mostly paid by federal DSH funds for hospital (\$893M), but hospitals could lose this money due to ACA changes.	
<b>DC Health Alliance</b> <i>Washington DC</i>	DC Dept. of Healthcare Finance & Human Services	Cover	No charges	Income under 200% FPL. Cannot be eligible for Medicaid or enrolled in third party medical.	Comprehensive services, but <u>does not include</u> vision, dental, behavioral health, non-ER transportation, long term care, open heart surgery or transplants.	Assigned to Managed Care Organization for care coordination		100% local tax dollars	14,454 people

Program & Location	Agency Type	Description	Member Fees & Renewal	Eligibility Criteria	Services	Care Coordination	Provider Payments	Funding Mechanism	# People Enrolled
<p><b>Hennepin Care,</b> <i>Hennepin County, Minnesota</i></p> <p><b>and</b></p> <p><b>Portico Health Net</b> <i>Hennepin, Ramsey and Washington Counties, Minnesota</i></p>	<p><i>Hennepin Care:</i> Public teaching hospital (Hennepin County Medical Center is run by Hennepin Healthcare System – “arm of a state or local government”<sup>1</sup>)</p> <p><i>Portico:</i> Nonprofit</p>	<p><i>Hennepin Care:</i> Discounted care</p> <p><i>Portico:</i> Prevention based, discount care management program</p>	<p><i>Hennepin Care:</i> Copays depending on income level</p> <p><i>Portico:</i> Monthly fee \$25-\$50, sliding scale. Copays for non-preventive visits. Patient pays 25% coinsurance.</p>	<p><i>Hennepin Care:</i> Income under 200% FPL</p> <p><i>Portico Health Net:</i> Income under 275% FPL</p>	<p><i>Hennepin Care:</i> All services at Hennepin County Medical Center (acute care hospital, primary and specialty clinics)</p> <p><i>Portico:</i> Prevention-based coverage for primary care, urgent, specialty, mental health, and pharmacy, through provider networks aligned with one of nine hospital systems</p>	<p><i>Portico:</i> Care management and navigation for bills, social services, referrals to specialty care, mental health management, and transition to ongoing coverage (help enrolling public programs).</p>	<p><i>Portico:</i> Payment for hospital procedures, such as x-rays and MRIs, at a hospital-negotiated rate (typically 110 % of the Medicaid rate).</p>	<p><i>Portico:</i> Over \$2 million in investment by all hospitals, government, health plans, United Way and private and corporate foundations.</p>	<p><i>Portico:</i> 1,429 people (in 2013)</p>
<p><b>Project Access</b> <i>Buncombe County, North Carolina</i></p>	<p>Nonprofit (run by Western Carolina Medical Society Foundation)</p>	<p>Safety net initiative through physician volunteers</p>	<p>Cost-sharing for doctor visits are \$0 to \$50. Free for hospital care.</p> <p>Enrollment renewed every 6 months.</p>	<p>Income under 200% FPL.</p> <p>County resident.</p>	<p>Comprehensive services including primary care, screening, labs, specialty, surgery, advanced home care, pharmacy, case management services.</p>	<p>Case management service.</p>	<p>Over 600 volunteer physicians.</p>	<p></p>	<p>6,000 out of 15,000 uninsured county residents (in 2008)</p>

<sup>1</sup> According to Guidestar, the Hennepin Healthcare System is registered with IRS and “not required to file an annual return with the IRS because it is an arm of a state or local government”; <http://www.guidestar.org/organizations/42-1707837/hennepin-healthcare-system.aspx>

Program & Location	Agency Type	Description	Member Fees & Renewal	Eligibility Criteria	Services	Care Coordination	Provider Payments	Funding Mechanism	# People Enrolled
<b>Nevada Access to Healthcare Network</b> <i>Nevada</i>	Nonprofit 501(c)(3)	Discount medical plan for the uninsured.	Monthly fee of \$35-\$40 for adults and \$10 for children. Additional fees at time of service that are capped depending on income. Missed appointment locks you out for 3 months.	Income from 100-250% FPL. Available to anyone “not legally required” to get covered under ACA. Cannot be eligible for Medicaid, Medicare, or employer plan.	Greatly discounted services through network of over 2,000 providers including primary care, specialists, behavioral health, clinics and hospitals, dentists, optometrists, radiology, surgery and pharmacy.	Every patient is assigned a Primary Care Physician & “personal care coordinator” to call whenever a service is needed, and is told how much the service will cost.	Hospitals & providers give reduced rates. Walmart is contracted to provide drugs at 30% cost. Plan <u>cannot</u> directly pay providers. Donations taken on behalf of patient.	“Shared responsibility”: providers offer reduced rate. State, county, federal funds. Member premiums pay for half of operating costs. A “Patient Care Fund” is set up by donations to pay providers when patients can’t afford it.	26,000 people
<b>Maine Health Care Partners</b> <i>Cumberland, Lincoln, Waldo and Kennebec counties, Maine</i>	Nonprofit	Donated health services to uninsured and low-income residents	No fee except providers not affiliated with hospital can charge \$10 (most waive fee). Also \$10 to \$25 copay for pharmacy.	Income under 175% FPL. County resident. Cannot be eligible for employer plan unless it costs more than 5% of income.	Patients can visit hospital-affiliated physicians, NP, and PA, and receive hospital and home care services.	Patients are assigned to participating providers. Only 2 to 3 patients assigned to any given provider at a time.	A network of over 900 volunteer physicians and eight hospitals provide care. Over 2/3 of local providers participate in the program.		1,000 people (capped)

## LEARNINGS AND BEST PRACTICES

### 1. Inclusive Safety Net

- Provide assistance based solely on income, residency and eligibility for public insurance programs (immigration status not a factor)
- Do not exclude people who are eligible for the Exchange. (Ex: Texas plans and Nevada Access to Healthcare) – There are many reasons why people are not enrolling in the Exchange even when they are eligible – the plans are unaffordable for lower income families, and many individuals are not required to get insurance because they are Native American, nonresident immigrants, face hardships, etc.

### 2. Comprehensive Services including Behavioral Health

- Offer assistance for mental health and substance use treatment – examples: San Francisco, Healthy Nevada and Portico in Minnesota.

### 3. Patient Navigation and Care Coordination: Safety net programs can improve health outcomes and reduce costs:

- Reduce costs by reducing emergency room visits and hospitalizations:
  - Healthy San Francisco: The 30 day hospital readmission rate is under 8% (much lower than the California Medicaid rate of 19%), and the percentage of patients receiving diabetic tests exceeded national averages for Medicaid. Patients also reported infrequent ER use, little difficulty accessing care, and high quality of care.<sup>2</sup>
  - Project Access in Asheville, NC: The program is cheaper than Medicaid for patient costs (by 25-50%) and administrative costs.<sup>3</sup>
  - Denver Health: Patient costs are lower than Medicaid and insurance by 25-50%; Administrative costs are lower than Medicaid.<sup>4</sup>
  - CareLink in San Antonio, TX: Patient costs are lower than Medicaid and private insurance by 25-50%.<sup>5</sup>
- Emphasize primary care and connect patients to community support systems. Ex: Portico Healthnet in Minnesota provides intensive patient navigation support to help patients manage their health, medical bills and use of the healthcare system.
- Develop innovative delivery systems: For example --
  - Co-location of services and clinic design – a range of healthcare and community services are in one location.<sup>6</sup>
  - Mobile health clinics and telemedicine to bring healthcare into communities.<sup>7</sup>

<sup>2</sup> Healthy San Francisco, Annual Report to the San Francisco Health Commission (Fiscal Year 2012-2013), available at: <http://healthysanfrancisco.org/wp-content/uploads/2012-2013-HSF-Annual-Report.pdf>.

<sup>3</sup> Hall et al, Model Safety-Net Programs Could Care for Uninsured a One-Half the Cost of Medicaid or Private Insurance; Health Affairs, 30, no.9, (2011): 1698-1707; <http://content.healthaffairs.org/content/30/9/1698.full.html>.

<sup>4</sup> Id.

<sup>5</sup> Id.

<sup>6</sup> Quan et al. Designing Safety-Net Clinics for Innovative Care Delivery Models, California Healthcare Foundation (March 2011), p. 4-7.

#### 4. Funding & Payment Ideas

- Seek investment by hospitals to improve primary care - for example, at Portico HealthNet for Minnesota, all hospitals must invest into fund that totals over \$1 million (or about \$1,000 to \$1,250 per person). According to the agency, this benefits hospitals by decreasing ER and inpatient utilization by many who would require charity care.
- Expect hospitals to provide charitable care – Many hospitals receive federal and state funding already to provide charitable care. Nonprofit hospitals must provide “community benefits” to maintain their tax exempt status. Healthy San Francisco includes nonprofit hospitals in the network but they are not reimbursed for services.
- Contract with providers to donate services or discount charges – Ex: In Maine, a network of volunteer physicians and hospitals provide care. Over 2/3 of local providers participate in the program (but note the program serves 1,000 people from three counties). Other programs provide payments at reduced charges. The Nevada program has a deal with Walmart to provide drugs for 30% of costs.
- Consider a “trust fund” for indigent care - Ex: Hillsborough County in Florida has a “Health Care Trust Fund” from a half-cent sales tax for the poor and uninsured (which will remain after the ACA).
- Organize a philanthropic funding entity – Ex: Center for Care Innovations in California provides funding for safety net providers and best practice ideas (including linkage to technological innovations). The organization primarily funds and resources California groups, but it’s also available to nonprofits outside CA.<sup>8</sup>

---

<sup>7</sup> Id. at p. 7-9 and 12-14. See also Keller et al. Promising Practices in Safety-Net Clinic Design: An Overview, California Healthcare Foundation (March 2011).

<sup>8</sup> Center for Care Innovations website - <http://www.careinnovations.org/programs-grants/grants/>

---

## Appendix 3: Exchange Premium Assistance Programs

### EXCHANGE PREMIUM ASSISTANCE PROGRAMS

*Prepared by the New Mexico Center on Law and Poverty*

“Premium assistance” programs help individuals pay for the monthly costs of health insurance through the Exchange. Many people will receive federal subsidies to help with these costs, but they are often not enough to make coverage truly affordable, particularly for low wage workers with incomes under 250% FPL. Premium assistance programs allow for public hospitals (or other entities) to “sponsor” the rest of the costs of the insurance premiums to make healthcare coverage a reality for more people.

#### THE AFFORDABILITY PROBLEM

Costs have been cited as the number one reason for why people are still uninsured after healthcare reform. Many low-income families cannot afford health plans on the Exchange even with the help of federal subsidies. A study by the Economic Policy Institute shows that most families in Albuquerque need an income of at least 200% of the poverty level or higher to make ends meet, particularly if they have small children. For example, a single mother with two children who earns \$14/hour (or \$2,440 per month) is at 150% of the poverty level. In Albuquerque, her family needs \$3,000 per month to cover basic living expenses.<sup>14</sup> She is not eligible for Medicaid, and simply cannot afford health insurance.

#### HOW PROGRAMS HELP TO MAXIMIZE COVERAGE AND FEDERAL FUNDING

A premium assistance program “sponsors” insurance costs, helping people get coverage and take advantage of federal subsidies that are available for the Exchange. They are structured to help patients obtain the “Silver” level coverage on the Exchange, rather than the “Bronze” plan that have less expensive premium costs but much higher out-of-pocket costs in the forms of deductibles and copayments. Federal subsidies limit those costs, but the highest subsidies are provided for Silver level plans. Thus, patients with the least expensive Bronze plans face out-of-pocket maximums each year of more than \$6,000 per family, whereas a patient with a Silver plan would only have approximately \$2,000 of liability.

#### Family Budget Compared to Healthcare Costs in Exchange (with Federal Subsidies)

*30 year old mother with 2 children, no tobacco use, Albuquerque, 2013<sup>15</sup>*

	Monthly Income (w/food stamps)	Monthly Basic Family Budget	Amount Left for Health Care	Bronze Premium	Bronze out-of-pocket	Silver Premium	Silver Out-of-Pocket
<b>150% FPL</b>	\$2,860	\$3,354	-\$494	\$46	\$6,350	\$77	\$2,117
<b>200% FPL</b>	\$3,255	\$3,354	-\$99	\$137	\$6,350	\$167	\$2,117
<b>250% FPL</b>	\$4,069	\$3,354	+\$715	\$137	\$6,350	\$167	\$2,117

*Note: The costs shown are for the lowest cost Bronze and Silver plans after accounting for federal financial help. These estimates use September 2013 data for individual rates and final rates may have changed. Plan rates vary by income, age, family size, location, and tobacco use. For some individuals, Bronze plans will be free.*

<sup>14</sup> Economic Policy Institute, Basic Family Budget Calculator (2013), for Albuquerque, NM, available at: <http://www.epi.org/resources/budget/>.

<sup>15</sup> Analysis by NM Center on Law and Poverty, based on budget data by the Economic Policy Institute and Exchange health plan rates from the NM Office of Superintendent of Insurance in September 2013, and calculated for costs after federal subsidies.

## PROGRAMS IN OTHER STATES

Some states that are implementing premium assistance programs include:

- **Washington Health Benefit Exchange Sponsorship Program (Washington) & Project Access Northwest:** The Washington Exchange Board is required by state law to establish policies that permit city and county governments, Indian tribes, tribal organizations, urban Indian organizations, private foundations, and other entities to pay premiums on behalf of qualified enrollees. Project Access Northwest has pilot programs at two local hospitals. The sponsor pays the entire premiums for Silver plans and patients pay any additional out-of-pocket costs.
- **UW HealthConnect (Wisconsin):** United Way (supported with payment from University of Wisconsin Health system) is developing a \$2 million pilot project to provide premium assistance to residents in Madison, to help them enroll into a Silver level plan with any of health insurance plans on the Exchange. The program will be available for those with incomes between 100% and 138% FPL (note that Medicaid has not been expanded in Wisconsin).
- **TexHealth Program (Austin, Texas):** This program currently provides premium assistance to small businesses in select counties. It reimburses 1/3 of employee premium (up to \$120/month). The agency is working on state sponsored premium assistance program for the Exchange.

## FEDERAL REGULATIONS ON HOSPITAL PREMIUM AND COST SHARING ASSISTANCE

The Department of Health and Human Services (HHS) issued guidance this year that has sent mixed messages whether certain hospitals and healthcare providers can offer premium assistance programs and help with other “cost sharing” including copayments and deductibles. The agency is concerned that “third party payments of premium and cost sharing provided by hospitals, other healthcare providers, and other commercial entities could skew the insurance risk pool and create an uneven competitive field in the insurance market.”<sup>16</sup> The guidance encourages insurance companies to not accept these payments.

However, the federal rules expressly require insurance plans on the Exchange to accept payments by any “state and federal government programs.”<sup>17</sup> There does not appear to be any legal restriction for local counties to implement premium assistance programs through the county itself or a county-funded hospital.

Hospitals across the country are also pursuing premium assistance programs, as the American Hospital Association seeks further clarification of the guidance.<sup>18</sup> The Association, which represents the hospital industry nationally, believes the ability of hospitals to pay for premiums would be greatly beneficial for patients.

---

<sup>16</sup> Department of Health and Human Services, Interim Rule implementing 45 C.F.R. 156.1250 (2014).

<sup>17</sup> See 45 C.F.R. 156.1250 (2014).

<sup>18</sup> Kaiser Health News, Hospitals Seek to Help Consumers with Obamacare Premiums (Aug. 14, 2014), available at: <http://www.kaiserhealthnews.org/stories/2014/august/14/hospitals--seek-to-help-consumers-with-obamacare-premiums.aspx>.



# IAP2 Spectrum of Public Participation

Increasing Level of Public Impact

	<b>Inform</b>	<b>Consult</b>	<b>Involve</b>	<b>Collaborate</b>	<b>Empower</b>
<b>Public participation goal</b>	To provide the public with balanced and objective information to assist them in understanding the problem, alternatives, opportunities and/or solutions.	To obtain public feedback on analysis, alternatives and/or decisions.	To work directly with the public throughout the process to ensure that public concerns and aspirations are consistently understood and considered.	To partner with the public in each aspect of the decision including the development of alternatives and the identification of the preferred solution.	To place final decision making in the hands of the public
<b>Promise to the public</b>	We will keep you informed.	We will keep you informed, listen to and acknowledge concerns and aspirations, and provide feedback on how public input influenced the decision.	We will work with you to ensure that your concerns and aspirations are directly reflected in the alternatives developed and provide feedback on how public input influenced the decision.	We will look to you for advice and innovation in formulating solutions and incorporate your advice and recommendations into the decisions to the maximum extent possible.	We will implement what you decide
<b>Example techniques</b>	<ul style="list-style-type: none"> <li>▪ Fact sheets</li> <li>▪ Web sites</li> <li>▪ Open houses</li> </ul>	<ul style="list-style-type: none"> <li>▪ Public comment</li> <li>▪ Focus groups</li> <li>▪ Surveys</li> <li>▪ Public meetings</li> </ul>	<ul style="list-style-type: none"> <li>▪ Workshops</li> <li>▪ Deliberative polling</li> </ul>	<ul style="list-style-type: none"> <li>▪ Citizen advisory committees</li> <li>▪ Consensus-building</li> <li>▪ Participatory decision-making</li> </ul>	<ul style="list-style-type: none"> <li>▪ Citizen juries</li> <li>▪ Ballots</li> <li>▪ Delegated decision</li> </ul>

## Appendix 5: Pathways Navigator Program Description

### Structure and Key Elements of the Pathways to a Healthy Bernalillo County Program

*An operating health safety net program ready for additional investment*

*Provided by Leah Steimel, August 2014*

#### **Overview:**

The Pathways to a Healthy Bernalillo County program (Pathways) is a community-based care coordination model that has been in operation for six years through contracts with local social and health services organizations. The program has demonstrated success in finding and connecting at-risk adults that have multiple and complex unmet needs, to medical, behavioral health and social services utilizing Community Health Navigators that are employed and supported by the contracting community organizations. Over 2500 unduplicated clients of the program have completed up to three distinct “pathways,” achieving program-defined outcomes for improved health and well-being. Financial incentives are paid to contracting agencies as they successfully identify, assess, and move clients through the step by step process of the program.

The Pathways program structure offers a unique and tested structure for building a stronger health safety net in our County. The program model, adapted to the local context, but derived from an Ohio pediatrician-designed, outcomes-based care coordination model, is versatile and can be molded to focus more intently on specific pathways, such as connection to a health care home; or to target a specific population such as soon-to-be-released prisoners. In addition, community organizations with diverse missions and target populations, such as community health centers, faith based groups, substance abuse treatment programs, food pantries alike have successfully implemented the Pathways model.

The following describes various structural features of the Pathways program that could accommodate a care coordination mechanism for an improved health safety net in Bernalillo County:

**Planning:** An extensive community planning process took place over a 5--month period in late 2007--early 2008 to design the goals of the Pathways program. Community Health Workers and/or other frontline workers of community based organizations from across the city were invited to attend. Over 30 organizations were represented in the planning process and participation stipends were provided to participating organizations.

**Oversight:** The Pathways program is overseen by a Program Manager, housed in the UNM Health Sciences Center, Office for Community Health. A Pathways Community Advisory Group is also required to provide oversight, and meets on a quarterly basis. In addition to quarterly reports to UNMH, the Pathways program provides a “Report to the Community” each year through a community meeting.

**Funds agreement and transfer:** An allotment of \$800,000 per year (plus an annual cost of living increase) is stipulated in the 2008 Memorandum of Understanding between UNM Regents and County of Bernalillo for the provision of community based navigation services to connect indigent County residents to health and social service resources. As the process of designing a program for the county based on the Pathways model from Ohio was already underway, it was understood that this would effectively be the funding mechanism for the Pathways program. The Pathways program description is described in an additional Program Memorandum of Understanding between UNM

HSC and the County of Bernalillo. Finally, a final Memorandum of Understanding describes the funds transfer between UNM Hospital and UNM Health Sciences Center, for the purpose of implementing the Pathways program.

**Emphasis on getting funding out to community--based organizations that are directly serving most vulnerable populations:** The program MOU and the UNMH-HSC MOU stipulate that at least 80% of the funds for the Pathways program must be distributed to community based organizations. This is done through a Request for Proposal process, which has been conducted three times; first for a two-year pilot period to test the program model, data collection tools and such; and a second and third process to award contracts for three-year funding cycles. In this new 3-year funding cycle, approximately 83% of the funds are being committed to community-based partner organizations.

Funding is made available to organizations for programmatic services and to provide emergency funds for clients using clear protocol and invoicing processes.

**Common data collection system:** Participating Pathways organizations utilize a simple, web-based data collection system to record risk assessment results for each Pathways client entering the program, and to track progress toward health improvement outcomes, as described in the selected “pathways” for that client. The data system is useful at three levels: to monitor individual client progress, evaluate contractual compliance, and identify and analyze system barriers in accessing services in our community. More than 330 separate systems barriers have been documented since the program’s initiation in 2009.

**Reduction in Service Duplication/Increase in Community Coordination:** A central entity, called the HUB, is responsible for monitoring client intake so that duplication doesn’t occur and funds are used as effectively as possible. In this role, the HUB encourages community agencies, contracted with the program and others, to communicate with each other and work together to serve clients and improve service systems. The UNM Community Health Worker Initiatives office serves as the HUB for the Pathways program.

**Community Health Workers’ role in program design and adaptations:** Community Health Workers (also called Community Health Navigators) maintain a prominent role, an extension of their role in the planning process, by meeting monthly to discuss and troubleshoot barriers for their clients, analyze systems barriers, and evaluate program progress. They also take a lead role in the annual Report to the Community.

**Additional investment in Pathways would strengthen our county health safety net by:**

- Serving as our local model for community planning and ongoing community engagement
- Identifying and enrolling more at-risk / indigent county residents in the Program
- Connecting additional residents to care coordination services through a Pathways Navigator for improved health and well-being.
- Training and employing more community members as Pathways Navigators
- Supporting shared data collection to ensure accountability and outcomes evaluation
- Incentivizing community health clinics and providers to engage in a collaborative and ongoing coordination effort to provide a health care home for at-risk community members and advocate for improved systems of care.

## Appendix 6: Templates for Reporting and Evaluation

Bernalillo County and UNM Hospital can work in partnership to evaluate community needs and outcomes of healthcare programs designed to meet those needs. Reporting must include:

**County Funding for Healthcare Reports:** Every program either provided through UNMH or sub-contracted by UNMH or the County should provide quarterly or bi-annual reports to the County that reflect the County expectations: e.g. Amount of Funding, reason for funding, numbers served and numbers of encounters/interventions, scope of service and any outcomes that the County wishes to define connected with that funding. These could be developed in conjunction with the service. All programs submit reports that respond to each of these criteria and provide budgeted versus actual deliverables.

**Patient Demographics:** UNMH as a priority should collect comprehensive demographic information which includes race and ethnicity data on all patients as required under the Affordable Care Act (for reporting under Medicaid and Medicare). All other hospitals in the city are collecting this data and are not reporting problems with getting the information.<sup>19</sup> UNMH may make a proposal to the County to use mill levy funds to improve training of staff to ensure comprehensive data collection. UNMH is also obliged to provide culturally sensitive care to its patients and this data collection will enhance the quality of its services.

**Community Needs and Outcomes:** The use of the mill levy funds should be guided by the health and well-being of all county residents, including those who are indigent, and on improving specific measures of health. These measures must address the social determinants of health as well as acute physical illness. Ultimately, the unit evaluation is the entire population system and its impact on the health of the population. This is in addition to assuring that personal health care services are performed at high levels of quality and safety.

**Healthcare Access Reports:** UNMH should submit annual data from its site that provides all of the utilization of all services and payer sources. UNMH should make available to the County its utilization data and associated billing data for all services (hospital inpatient, Emergency, Outpatient services) for independent analysis of how Bernalillo County residents are using hospital services, specifically those who are using subsidized care. Data should be de-identified and available at unduplicated patient level, and should include the following:

- **Access to Coverage and Financial Assistance:** Data showing growth or reductions in coverage reflected by changes in number of patients enrolled in Medicaid, Exchange, and UNMH financial assistance programs (broken down by each program), with the corresponding amount of financial help provided for each program shown in costs, not gross charges.
- **Medical Debt Analysis:** Data showing:
  - number of patients with “bad debt”

---

<sup>19</sup> During the taskforce's public listening session with the Urban Indian community, speakers referred to the fact that Presbyterian asks them for their race/ethnicity, but their perception was that staff at UNMH rarely asks for this information. How, they asked, could they get services they are entitled to if the staff does not know who is Indian? It may also be less intrusive to have patients fill in personal information themselves on a form at registration.

- demographic composition of these patients with debt including racial/ethnic data, income level, zip code and age (including children under 5, between 6-19 years old, adults under 65, and adults over 65)
  - the payer sources for these patients (including any financial assistance programs)
  - how many accounts were audited for errors and for financial assistance
  - reasons why patients were sent to collections rather than given financial assistance
  - number of Native Americans in collections with corresponding amounts
  - reasons for why bills were charged to Native Americans patients.
- **Utilization Data:** Data on the number of Bernalillo County residents and their utilization of UNM services. This provides the picture of how all residents of Bernalillo County are served through UNMH:
    - a. # of individuals served through UNM Care or any program that replaces it (including premium subsidy programs). Analysis of the following
      - i. Demographics: age, gender and race
      - ii. Sites of services (E.D., specialty, primary care, inpatient, mental health services in each of these sites) and key diagnostic information
      - iii. Billing by service
      - iv. Estimate of mill levy funds used
      - v. Repeat visits by service
    - b. # of individual Urban Indians (with Bernalillo County addresses) and Pueblo Indians who are served by site of service (E.D., specialty, primary care, inpatient and mental health services in each site) and key diagnostic information.
      - i. Coverage, payer source
      - ii. Billing by service
      - iii. Estimate of mill levy funds used
      - iv. Repeat visits by service
    - c. Number of repeat visits to Emergency and Hospital Inpatient units of patients who could be assigned to medical homes
    - d. Analysis of preventable admissions by people who are indigent
  - **Waiting Times:** UNMH should also provide waiting times for appointments for patients discharged from acute or Emergency (with Indians identified separately) who need the following services:
    - a. Primary Care
    - b. Specialist Services
    - c. Mental Health provider
    - d. Other appropriate services
    - e. Emergency Room Departments<sup>20</sup>

---

<sup>20</sup> See <http://lobo375students.wordpress.com/2013/12/07/multimedia-journalism-student-at-the-university-of-new-mexico/>. This story was reported on December 2013. CMS in late 2013 released data on the median time patients spent in the ED before they were admitted to hospital as an inpatient. UNM Hospital was #4 nationally of 10 hospitals with the longest times: 945 minutes (15.75 hours). These patients are sick and need to be admitted but these waiting times indicate both unavailability of beds and potentially the impact of unnecessary patient crowding in the E.D. This story also reported that Presbyterian Hospital introduced a “patient navigator” system to assist E.R. patients to a proper primary care or urgent care.

- **Personal Experience Accessing Care:** (1) All persons (or their representatives) identified as being in this category are (1) aware of UNMH availability for (a) emergency care, (b) primary care and medical home, (c) behavioral health care, (d) other specialty care and (e) referral to social support services, and (2) Users of UNMH and of its partners are receiving full and equal services at indigent billing rates. And (3) Users are satisfied with care received. Measure: Biennial community survey (\*Examples include telephone surveys, random residential, and samples generated at community service organizations.)
  
- **Emergency Department Utilization**
  - Calculate E.D. visit data by acuity at triage. This will provide the numbers who show up with low acuity codes.
  - Assess numbers of repeat users by acuity. All repeat users should be referred to primary care medical homes either at UNMH or to those in the community who are contracted to accept this referral from UNMH's E.D.
  
- **MDC-UNMH benchmarks:**
  - Monitor selected strategies implemented for reducing recidivism.
  - Assess the need to expand these services.
  - Assess also cost savings.

## **Appendix 7: Potential County Sources for Leveraging Healthcare Funding**

### **Current Funding Sources**

The County Currently has two Gross Receipts Tax (GRT) enacted that are currently used for the following services:

1. The 2<sup>nd</sup> 1/8<sup>th</sup> \$1,000,000 used for partners in healthcare which is paid through UNMH.
2. The 1/16<sup>th</sup> indigent care (\$10,000,000 approximately) funding provides the follow:
  - Medical services contract (MDC)
  - Medical observation (DSAP)
  - Wellesley clinic (Bernalillo County Health Center) utilities
  - Zuni property lease (MATS)
  - YSC Medical UNMH Psych contract
  - Methadone contract (MDC)
  - Nurse advice hotline

The County should consider evaluating the current services provided to ensure the funds are spent for appropriate and suitable services.

### **Other Funding Sources:**

The County could consider adopting an ordinance prior to the next election cycle for the Countywide Emergency Medical and Behavioral Health Services Tax. The purpose of this tax would be for providing behavioral health services, by operating or contracting for the operation of a behavioral health services facility providing alcohol abuse, substance abuse and inpatient and outpatient behavioral health treatment. The tax can be implemented by adoption of one or more ordinances in tax rate increments of one-sixteenth of one percent (.0625%), which is approximately \$10,000,000 dollars annually up to one-fourth of one percent (.25%).

## Appendix 8: Summary of Public Comments

### Bernalillo County Healthcare Task Force Community Meeting Comments • June-July 2014

The following comments are from notes that were written on flip charts during the seven Healthcare Task Force community meetings held in June and July 2014:

- June 3, at the Raymond G. Sanchez Community Center;
- June 5, at the James Dwyer Memorial Substation;
- June 16, at the South Valley Multi-Purpose Senior Center;
- June 18, at the North Valley Library;
- June 19, at the Taylor Ranch Community Center;
- June 30, at the Los Vecinos Community Center; and
- July 10, at the La Mesa Presbyterian Church.

At each meeting, following a brief presentation on the Healthcare Task Force's purpose, participants were invited to offer ideas about how to improve healthcare in Bernalillo County, particularly how to improve the healthcare safety net. Ideas include both areas of concern, and recommendations for the Task Force to consider. All comments are presented in chronological, rather than thematic, order. Each primary bullet represents a different speaker; indented bullets are part of that person's comments. The notes from the June 30<sup>th</sup> meeting follow a question-and-answer format, which reflects the discussion at that meeting.

#### Questions:

- **What concerns do you have about health care services in Bernalillo County?**
- **What can be done to improve health care services in the County?**

---

#### **June 3, 2014 Community Meeting Comments • Raymond G. Sanchez Community Center**

- Medical debt is a huge burden on families. Recommendation: Make medical care available to all County residents.
- Prioritize people who are uninsured. Focus on early, preventive care.
- We have had to choose between paying for insurance and paying the mortgage, and have chosen to pay the mortgage.
  - We do not qualify for affordable insurance, and we haven't heard whether we qualify for Medicaid.
  - People who go to urgent care still have to pay, so they may choose to go to the ER anyway.
  - The guidelines [for eligibility for subsidies] don't consider major expenses, e.g., mortgages.
- Many people are in collections. UNMH should not be allowed to refer people to collections.
- We need a comprehensive safety net plan.

- Recommendation: There should be a policy that County residency is the only criterion for receiving health care.
    - There was a reference to Dr. Kaufman’s article on this subject.
  - All residents share the same sky, yet some are not included when it comes to healthcare.
    - Emergency rooms are poorly run. My mother waited three days in the emergency room. (She finally healed herself!)
    - There is an imbalance between the high cost of services and people’s [in]ability to pay.
  - Target resources to those who most need them.
  - Tying one’s ability to pay for insurance to last year’s income tax return is unfair (especially for those whose income fluctuates).
  - Wait times [to see doctors] is very long. Are more doctors (and other professionals) needed?
  - We should focus on rational, preventive care, not only on emergency care.
  - Conduct a gaps analysis about services—then identify strengths and recommendations.
    - UNMH should partner with other [community-based] service agencies—need more outpatient care services.
    - Focus more on mental health prevention
    - Specific outcomes need to be identified and monitored, e.g., wait times.
    - Emphasize equality of care.
  - What should be done to help people with mental/behavioral health issues who do not want help?
    - What happens is that there are multiple releases from care.
    - The Task Force should consider mandatory care or assisted outpatient care in some cases.
  - It is past time for Bernalillo County to “take charge” of overseeing the funding it provides to assist UNMH’s services.
    - Look to the Pathways Program for ideas and insights.
  - Hold a community meeting near the end of this process so that the public can review the preliminary recommendations the Task Force comes up with.
  - Recent refugees do not remain eligible very long after they arrive in Bernalillo County.
    - They had no choice in being relocated here, and now may not remain eligible to receive health care.
  - Expand the Pathways Program in the next mill levy cycle.
  - Review Kelly O’Donnell’s impact study. (Cover everyone in the County.)
-

## **June 5, 2014 Community Meeting Comments • James Dwyer Memorial Substation**

- There is a lack of easy accessibility of healthcare.
  - This includes geographical access and access to different services, e.g., where can you go for various services? Also, parents cannot make decisions for adult children with mental health concerns—what can they do?
  - There should be a 311-type of service.
  - Healthcare should be “comfortable, accessible and available.”
  - There should be an umbrella for all services, then smaller “umbrellas” for types of services.
- We are throwing money in three directions—at the State, the County and the City.
  - There are overlapping services, and this reduces effectiveness as well as efficiency.
  - There should, immediately, be a complete UNMH audit.
- Access should be a concern not only when there is a crisis. There should be more geographic locations for providing healthcare services.
- Recommendation: There should be a different annual budgeting process, including:
  - A formal survey of the community to determine needs and priorities.
  - A televised public goal-setting process.
  - Formal public involvement in and transparency of the decision making process.
- (Strong agreement with the above comment. Then: Collection services for healthcare on poor people is an outrage.
- Access to healthcare includes all aspects of health:
  - This includes mental and behavioral (as well as physical) health.
  - It also includes social services, housing services, and other preventive services.
- (Strong agreement with the above comment. Then: This also includes oral health and other preventive care.
  - Prevention—early addressing of all these issues, should be at the core of community-based health.
- Recommendation: Reserve 2.5 mils in the next mill levy cycle for social services. Eligibility should be up to 250% of the poverty line.
- People have difficulty getting appointments, so they give up trying to get an appointment, creating a cycle where problems get worse until they have to go to the emergency room.
- There is lots of miscommunication between healthcare providers and consumers:
  - Many providers say “I don’t know,” so it seems “nobody knows” the answer to even basic questions.
  - People open up to providers who they know and trust, but there are very few of these.
  - Consumers need more information/education about prevention, but do not get it.
- More training of providers on how to access the community is needed:
  - Appointment reminders always mention that copayments are required—this scares off many people.
  - Treatment that makes people feel welcome is very much needed.

- There are many “rocks in the road” for consumers.
  - The County should direct funding to community health clinics and community providers, or require UNMH to direct funding there.
  - There should be a “changing of the guard” from UNMH to Bernalillo County. (That is, the County should have more authority in determining how the money should be spent.
  - Look at mill levy best practices: Dona Ana County, Sandoval County, Washington State, etc.
  - There should be better provider training all along the line, especially in all facets of customer service.
    - UNMH does not always make sure that its own policies are followed.
  - No low-income people should be sent to collections.
    - Also, promote what is available. (Services/options may not be known.)
  - We should expect an outcomes report from UNMH. The County should have more flexibility in determining how the funding is used.
  - There should be a UNMH audit for accountability—then to help planning.
    - Also, UNMH should have simpler educational materials, such as using the tri-fold format.
  - Policies that are in place are not being enforced. The highest levels of UNMH are disrespectful of the community, and this permeates all levels of administration and healthcare practice.
  - It is very aggravating that the County cannot get a financial report from UNMH. When my group asks for \$5000 from the County, we have to provide very detailed information.
    - We must require the head of the organization (UNMH leadership) to follow the agreements. Right now, this way of operating separates the community.
  - We are all part of the community—we are all entitled to receiving health care.
  - How can we help the County to have more control over the funding it provides to UNMH? There should be categorical funding that can be tracked.
  - There should be pilot programs before the 2016 mill levy proposal is put together to try certain policies out.
  - We need to define health outcomes to monitor, and we know how to do that.
-

## June 16, 2014 Community Meeting Comments • South Valley Multi-Purpose Senior Center

- Greater transparency is needed with regard to how the money (the County provides UNM) is used: Where does it go? How can people see this?
- Uninsured people/patients should not be sent to collections to recover medical debt.
  - All Bernalillo County residents should have access to charity care.
- All people [in the County] should maintain the ability to receive health care. Those families living at 250% of the poverty level still need help in getting health insurance.
- We have an opportunity to make a paradigm shift in health care in Bernalillo County: To focus more on prevention rather than on acute care. We need *human care*.
  - The better way is to educate people about prevention, and to educate one another and ourselves about prevention.
- Mill levy funding should cover legal immigrants who are presently ineligible for insurance.
  - All residents should be eligible, without a co-pay.
  - Many community-based agencies are providing this kind of care already.
  - County health care should be based on a social determinants of health model.
  - Funding should also help with system navigation—helping people through the administrative and clinical challenges and options.
- Health care in Bernalillo County should be made a human right, not a privilege.
- The Affordable Care Act does not cover everyone; many people do not have access, or are limited by “access” that is too expensive.
  - Create a system that is based on a) income and b) residency.
- Replicate (and expand) the EMSA program for women who are pregnant. EMSA provides same-day, presumptive Medicaid eligibility, with retroactive coverage (to the beginning of the pregnancy).
  - EMSA does a good job, and it should be expanded to include women who are undocumented.
  - While EMSA does a good job covering mothers and mothers-to-be, there are problems with covering the children. There are many cases where the mother will receive a bill for the child’s expenses 3-4 months after birth, too late to correct. Also, notice of this (new expense) is not well communicated (because of language differences, or only through a written notice, etc.). Then after 90 days, the [child’s] bill goes to collections—when the family already had Medicaid!
- Maria’s story was related—a case study in how one woman has had several challenges in navigating the system, and how her health problems were exacerbated through delay, stress, and other factors.
  - The Pathways Program provides great assistance to people in Maria’s situation.
  - Income and residency should be the only criteria for eligibility for comprehensive health care in Bernalillo County.
- From the Community of Interns and Residents (CIR): All County residents at or under 250% of poverty should be afforded care, especially preventive care. This will greatly increase the efficiency of the use of funding.

- The County should take back a portion of the mill levy funding for the purpose of filling gaps in the system.
- Look at successful models for comprehensive health care services and planning in other counties across the USA.
  - There are many models/examples, including in Oregon and Washington State.
  - More transparency is needed throughout all aspects of the system, including the budgeting process, the programming process, and the evaluation process. A public budget is needed, to assure effective use of the \$90 million per year supporting UNMH.
  - Do not merely ask the medical professionals (providers and administrators) when planning, budgeting and evaluating effectiveness—the whole community must be involved.
- People who are Spanish-speaking, and/or are undocumented, and have mental health issues, have very few places to go for health care in the County.
  - People are suffering. There is already stigma around mental health, and these people face compounded challenges.
  - We must harness the power of the ACA, and focus on behavioral health/mental health preventive services. This can free up resources for other situations, particularly at MDC.
    - The prison system is for-profit (although this doesn't include the County).
    - Also, the health care system is most interested in the financial side of health care, if not “for-profit.”
  - UNMH could become the place, the institution, that welcomes people (instead of a place that many people fear).
  - The Pathways Program provides needed services—access to housing, assistance with medical debt, mental health and behavioral health services, etc.
- The County should provide services that prepare people at MDC for leaving, that is, supports to prevent homelessness, to help avoid substance abuse and mental health problems, and other related issues.
- There is “pharmacology overuse” at MDC. Drugs merely treat the symptoms of problems that were developed in the community.
  - Improve the food at MDC—too much white bread, low-quality meat, etc.
  - People come to clinics and UNMH in acute withdrawal; then they (and we) face the paradox of people getting subscriptions for opioids and referrals to Turquoise Lodge at the same time.
- People with medical debt live in constant fear. Therefore, they don't get the care that is immediately or evidently needed. Also, they are afraid of revealing information that may hurt them or members of their families.
- Undocumented immigrants—this is a problem in the Asian community. People who overstay legal visas, even a day, then go into hiding. We need to reach out to these and all people and help restore their dignity.

## June 18, 2014 Community Meeting Comments • North Valley Library

- It is distressing to me, as a human, that there are too many uninsured and underinsured people in the County. As a professional, there are too many of instances of people not receiving care.
  - Expand coverage to marginalized people.
  - Story of a woman who cannot leave the hospital because she is ineligible to obtain a dialysis chair.
- We need to have assurance that people not on Medicaid or in UNM Care have access to care.
  - There are 4000 people on the streets each night; and 40-60,000 who are not covered by the Affordable Care Act.
  - Story of a person who received excellent acute care at UNMH but was released directly to the streets, and could not get into Respite Care. We need to have real continuity of care. Also, the County should designate a specific indigent care budget.
- Provide healthcare—especially preventive/primary care—to undocumented people, who are in various states of housing [in]security.
  - It seems arbitrary who is covered by UNM Care. Enrollment needs to be opened up.
  - Re: MDC: People who become incarcerated have Medicaid suspended.
  - Better addictions treatment is needed. Provide incentives, such as authorization for Nurse Practitioners to prescribe suboxone under a physician's license.
- Invite community representatives to serve on UNMH boards and commissions.
  - This needs to be done, though, with continuity and sincerity. In the past, people are named to advisory boards, and then the boards are disbanded and reconstituted under another name. This contributes to serious mistrust between UNMH and the community.
- In the courts, we see secondary effects/problems of poor healthcare, e.g., child abuse in families where the parents have substance abuse and mental health issues.
  - There need to be more locations, more facilities, to treat people with SA/MH issues. All Faiths Receiving Home is just about the only one.
- Continuity (and transitions) of care is a critical system need. This is not only related to suboxone treatment; it also relates to housing and other supports as well as direct care. Healthcare needs to be comprehensive and integrated.
- For substance abuse and mental health treatment, there is a lack of facilities—outside of MDC.
- Direct some of the County funding to community health providers.
  - Adopt a “No Wrong Door” policy.
  - Support community-based enrollment [in Medicaid and indigent care].
  - Make residency and income the only criteria for receiving care.
- Invest in having more community health workers.
- Direct some of the mill levy funding to community health providers, e.g., the Pathways Program.
- Build a safety net that is humane and compassionate—that tries to capture everyone in the County, and that provides more opportunities to participate in it.

- Build a safety net that is inclusive. Also, take 1/3 of the mill levy and build on the Pathways Program.
- Expand the scope, availability and amount of funding to address the needs of the most vulnerable people in the County. Follow people comprehensively, by a multi-disciplinary team of providers.
- Improve the coordination/integration between facilities/providers/agencies, e.g., UNMH, MDC, community health providers.
  - There are examples of other county programs that may be models for this.
  - This may include better automation in enrollment/better software systems, etc. Eliminate the “churning” of people in and out of programs.
- The Milagro and Focus Programs at UNMH do a great job. They follow people beyond acute care. Expand these programs to be on a larger scale.
- Build a shared data system to track people, evaluate whether performance goals have been met, etc.
- Provide Respite Care for women who are on the street.
- Take 5-10% of the MDC budget and designate it for substance abuse and mental health facilities—treatment, transition, etc. This will be a much more efficient use of these funds.

---

**June 19, 2014 Community Meeting Comments • Taylor Ranch Community Center**

- Doña Ana and Sandoval Counties have healthcare models (for indigent care) to emulate.
  - For charity care, the County should retain 2.4 mils to build a healthcare safety net for all County residents; and to build a system where the County and the community are real partners in providing healthcare.
- We have an opportunity to create a system of healthcare that is a model for the whole state.
  - Up till now, UNM has seemed resistant to making any changes toward this end. UNM needs to negotiate in good faith with the County to establish an effective healthcare safety net.
  - UNMH refers people to collections very quickly—much too quickly, exacerbating the medical debt problem.
  - It is in UNM’s interest to help build a more community-based system: Many people may oppose the mill levy when it comes up in 2016, and it is in everyone’s interest to work together to make sure that it is passed and that it supports a more community-friendly system.
- Is there a Native American on the Task Force? Who is representing the interests of Native Americans? What is the plan for collaborating with neighboring Tribes during this process?
  - More training and overall awareness is needed of the social disparities in Native communities. Native Americans face many examples of social injustice, which contributes to people having health problems. We need to all work on decolonizing our attitudes and relationships.
  - There are offices/agencies within UNM that advocate for tribal communities and members, who could be helpful in improving healthcare in the County.

- It is important, working with Native Americans, to use a recovery model to help overcome the stigma attached to mental health issues.
- We need to do more outreach to get people to attend [these] community meetings.
  - Reach out to the West Side Coalition and other neighborhood associations.
- UNMH sends 90% of uninsured patients to collections—but only has a 3-5 % recovery rate/response. Also, UNMH sends Native American patients to collections—which may be illegal.
- Provide more funding to the Pathways Program. People leave MDC without healthcare.
- Sending people to collections is not part of a wellness model. And it further impoverishes people.
- There are UNMH programs that are good—if you can get people into them.
- There are not very many opportunities to plan together as a community. We need a genuinely community-based process with more transparency in planning, establishing performance indicators, and monitoring progress.
  - Also, programs that rely on a social determinants of health model, such as Pathways, should be strengthened.
  - At this point, the barriers to care that people face—administrative forms, unfriendly attitudes, a difficult-to-navigate system—seem purposeful.
- I am concerned about access to women’s reproductive health, especially within immigrant communities in the County.
- The rationale that Federal law prohibits UNMH from providing healthcare to undocumented people lease to a policy that excludes legal immigrants, as well. Also, it turns clerical personnel into immigration agents.
  - Also, non-profit and charitable organizations are exempt from the Federal law referenced above.

**June 30, 2014 Community Meeting Questions and Comments • Los Vecinos Community Center**

*What percentage of population are non-residents of BC served by UNMH? Are they financially assessed? Does UNMH track this?*

- 70% BC residents/30% non-residents
- UNMH tracks residency and bills patients. Non-residents may apply to their county for assistance with the bill

*Do some counties (e.g., Sandoval) pay for healthcare differently than Bernalillo County?*

- State law establishes various maximum mil levy rates for counties (e.g., 4.25 mils in Sandoval County; 6.5 mils in Bernalillo County). In addition, other counties can assess a sales tax to pay for healthcare.

*Does UNMH help facilitate claims by the patient in his county?*

- The mil levy assessment doesn't go to UNMH; it goes into an indigent claims pool in the particular county.
- UNMH checks if the patient has insurance or Medicaid.
- If the patient is eligible for Medicaid, UNMH provides assistance for the patient to apply for it.
- If the patient is not eligible, then UNMH bills for the patient for services.

*Who provides services in the jail for people with mental health?*

- Inside the jail there is a contractor to provide care; BC pays for those medical services.
- If an inmate needs hospital care, the patient goes to UNMH, and BC pays.

*What is UNMH's assessment of mental health needs in the community?*

Examples provided by UNMH:

- An estimated 119 beds are needed in Bernalillo County; that is about the number available.
- The available services not always what people need, e.g., case management.
- Sometimes people sent out of state for residential services.
- There are unaddressed addiction problems among people discharged from jail, which leads to crime/trespassing. One of the root causes is the need for housing, which helps to prevent re-incarceration and re-hospitalization.
- ACA requires mental health coverage.

Recommendation: Identify funding streams to support mental health; use it to expand access to mental health services outside of MDC.

- If a person goes to prison, it is 2 years before he receives treatment outside the law enforcement system

*What is the percentage of the population with mental health needs?*

- Fifteen to 20% of the jail population has a serious mental illness compared to 5% in the general population.

*Is UNM looking at using clinics to keep people out of the hospital?*

- UNMH has 6 clinics in the community and has acquired 2 properties to build 2 more. Behavioral Health services will be available in the new clinics.
- UNMH works with federally qualified health centers (such as First Nations and Albuquerque Healthcare for the Homeless); people can access those clinics and be in the UNM system.

*What parts of the County make the greatest use of the emergency room? Do you know where the high-use areas are, and are you going there to provide services?*

- UNMH gives patients handouts with information on alternatives to access the system.
- There is a caseworker that sets patients up with primary care.
- UNMH has an urgent care center for non-emergencies.
- UNMH has reciprocity with the Sandoval County Medical Center.

Recommendation: UNMH should provide care to all county residents of the County, even those who have no insurance coverage and are unable to pay for services.

Recommendation: More of the mil levy funding should go to Pathways program.

*In response to a question to the County Commissioner*: The County has no say over the budget for the mil levy funding; the state statute requires funding must go to a hospital. However, Bernalillo County should be involved in the budget process in an advise-and-consent role, which the statute allows.

*What percentage of the UNMH budget is from the mill levy?*

- 12%. \$90 million out of an \$840M budget.

*What is the level of emergency room funds that is not reimbursed?*

- The unreimbursed cost of ER care is \$46M annually.
- The share of that assumed by BC is \$110M.
- In the last legislative session there was a bill to allow taxation of all NM counties to fund a 1<sup>st</sup> class trauma center. The taxpayers are supporting a high degree of emergency room and trauma care at UNMH.
  - *UNM response*: 20% of ER/trauma care is from outside Bernalillo County—and it is profitable.

*What kind of funding can be used to expand intervention and the number of beds for behavioral health?*

- \$50 million of UNMH budget goes to behavioral health.
- UNMH is working on proposals to improve the psychiatric centers.
- There are few services for people coming out of MDC. Recommendation: Increase the continuity of care after discharge from MDC.
- People need a safety net, so they don't delay care. Recommendation: Do not send unpaid bills by uninsured patients to collections.
- There are more than 4,000 homeless students in the APS system. How many homeless are signed up for ACA?

---

### **July 10, 2014 Community Meeting Questions and Comments • La Mesa Presbyterian Church**

- There is no psychiatrist on call on evenings and weekends
  - Recommendation: We need more physicians on call.
  - Recommendation: Doctor who files the petition is the one who testifies. UNMH sets schedule
- Continuity of care essential for mental health patients. Lost psychiatrist and psychologist
  - UNM taxes to the hilt to provide services—it's a crisis situation
  - Recommendation: County should set aside funding for education, e.g., booklet giving the criteria for mental illness and recommendations for a recovery plan
  - Recommendation: additional funding (\$225K in new funding) for interventions besides medication that could improve patients, e.g., educational DVD to be played in waiting rooms
  - Recommendation: \$75,000 for an educational coordinator to create this program
  - Recommendation: create peer support groups. NAMBI provides training in peer support groups

- Education should be part of hospitalization and outpatient care. Should be integral to care. It is easier to manage a disorder when you know the symptoms
  - Recommendation: Consider independent management agency to teach UNMH total quality management—give voice to the customer.
  - Recommendation: create privacy room for patients to meet with doctors
- Recommendation: County attorneys should take the lead with the State/City to amend the Treatment Guardian statute.
- Recommendation: start a mental health program in the jail. Treatment in jail has link to treatment afterward.
- UNMH does not provide charity care—we pay for care!
- I hope the voters approve another \$90M. And this time there should be monitoring and oversight of the funding to make sure we are getting our true value for it.
- There is a void in leadership. UNMH is not fulfilling its commitment. It provides tertiary care, but primary care and mental health are not priorities.
- Many counties in the US have a health commission and/or a health department, but that is not the case in Bernalillo County. Decisions about healthcare should be made in the county.
  - County residents are not getting their fair share of state funds.
  - Create a process to get funding and create the BC Health Authority, a system for primary care with experts in public health and primary care
- One example of system failure: Opiate death rate is 1 of highest in US. UNM has not done enough in this area.
  - There is a 3-month waiting list for treatment for opiate addiction
- UNM hasn't met the needs people with illnesses.
- Recommendation: services should be community based (knowledgeable people, resources), not based from an organizational behemoth that has no flexibility to meet community needs.
- UNMH does a great job with acute care and meeting state needs.
- Locally, a lot of people are falling through the cracks.
- Recommendation: need more paraprofessionals. Let's get legislation to do this and have UNM put its lobbyists behind this
- Recommendation: need better UNMH management.
- A lot of people don't know where to go for services.
- Recommendation: UNM, city, and county should partner to provide crisis team of nurses who know the hospital system. Law enforcement doesn't know where an individual should be treated—e.g., the person could appear to be psychotic when the issue is substance abuse.
- Accountability. When I get my tax bill, I think of UNM.
- Recommendation: more care for immigrants, especially elderly.

- A lot of people go to the ER because they have no other options.
- Provide better access for low-income people to HC services.
- Recommendation: do not send low-income people to collections.
- Recommendation: increase the number of primary care clinics to cover UNM Care because ACA enrollment is not working well.
- A large % of transients are on UNM Care.
  - Gap in coverage: transgender care.
  - Expand UNM Care to cover services that should be covered by insurance.
- Immigrants have real difficulty accessing services; example: hungry immigrant without documents, job, or housing.
- Recommendation: allocate more funding for Pathway program; it helps people find the resources they need.
- People wait until they have an emergency before they go for care.
- Lack of transportation is part of this problem: 45 minute trip on 3 buses.
- Recommendation: have an urgent care, community-based program that is not at the hospital and that is within walking distance of IV drug users, sex workers, etc.
- UNMH has a history of disrespectful patient treatment: “I don’t want to go to UNM.”
- St. Martins does a weekly check on clients, but there is a 1-year wait at UNM.
- The taxpayers pay to incarcerate people for treatment.
- I expect service in return for my taxes.
- Recommendation: more funding to Pathways; increase from 1 mill to 2.5 mills.
- Recommendation: invest in mental health and substance abuse treatment. No one cares when a Chicano ODs in this neighborhood, but people care when it is a privileged youth in another neighborhood.
- Jail is the #1 mental health provider in Bernalillo County.
- Recommendation: Address the people at rock bottom—how do we move them to a better place? People who don’t read well are at risk.
- Recommendation: Keep the mil levy but put more funding into services. Keep people out of jail and off the streets.
- All these recommendations have been suggested to the hospital administration. Result: inaction.
- Recommendation look at the history of recommendations made to the hospital (e.g., 2005 summit), especially recommendations dealing with prevention, diabetes, etc.
- Recommendation: Get something in writing from the hospital to improve services. Accountability is a big issue.

- DOH study showed how services are paid for. It costs UNMH more to provide a visit than private insurance or Medicaid. We are paying more.
- Recommendation: MOU between the County and UNMH: more funding should go to primary care; no bonuses for administrators.
- It is time consuming to work with UNM Pathways; efforts to get services for a client is a fight.
- We all pay taxes, so we deserve services.
- Recommendation: better communication and access to client services.
- ACA mandates parity between mental health and health treatment.
- Many incarcerated don't qualify for Centennial Care; after discharge, there is no community-based public health services.
  - Need access to mental health services. Also primary care, family health services, preventive care, and early intervention.
- Recommendation: decentralization of UNMH services across ½ dozen clinics to provide services that are located on bus routes.
- Regional Medicaid to do audit of services.
- Recommendation: Place navigators in MDC to help with the transition to services outside jail.
- UNMH has an opportunity to partner with nonprofits, and they need funding to continue to provide services.
  - Our therapists can't get under UNM Care.
- Establish accountability metrics to measure performance: short waits, access, warm hand-offs, etc.
- NM is #1 in mental illness, and UNM is overwhelmed.
- Recommendation: need quality BH and substance abuse services including prevention. Some of the funding should go here. Partnerships a key.
- I had to go to Mesilla Valley when I had a manic episode because service wasn't available in Bernalillo County.
- There is no place to detox from spice. Early intervention is essential. This is a place for partnership.
- Hospital needs to partner to improve access. Task Force: look at options!
- Recommendation: Clinic to handle urgent care.
- Recommendation: put funding into communities for full range of services including mental health and services to undocumented.
- Recommendation: extend hours for BH, primary specialists.
- Recommendation: funding to train and maximize community health workers/partnerships; they set up direct communication with client.

## Appendix 9: Listening Session: People Incarcerated at MDC

### Bernalillo County Healthcare Task Force Task Force Meeting #5

Albuquerque Health Care for the Homeless • July 11, 2014 • 2:00-4:00 p.m.

#### Meeting Notes

---

The July 11, 2014 meeting of the Healthcare Task Force focused on healthcare-related issues faced by people who have been incarcerated at the Metropolitan Detention Center (MDC). Albuquerque Health Care for the Homeless (AHCH) hosted the meeting in its Community Room at 1217 Mountain NW, Albuquerque.

Although a great deal of information has been gathered through the seven community meetings open to the general public, Task Force members felt that the perspective of people who have been incarcerated at MDC, and their families, was missing, and had decided at the June 27 Task Force meeting to make the July 11 meeting a listening session with invited guests. Twelve people in addition to Task Force members participated in the meeting.

The agenda followed the format used at the community meetings. Jenny Metzler, Executive Director at AHCH and a member of the Task Force, welcomed the Task Force and invited guests. Tim Karpoff, the Task Force facilitator, presented the background and purpose of the Task Force. The remainder of the meeting was a general discussion, with the guest participants offering both their concerns about healthcare services in the County, and their recommendations. The questions posed were:

- **What concerns do you have about health care services in Bernalillo County?**
- **What can be done to improve health care services in the County?**

The comments below are remarks from the flip chart notes taken during the meeting. The format follows the format used at the other community meetings.

Following the listening session, Task Force members briefly met and determined that one of their next steps is to identify the major themes and findings that have emerged from the community meetings and listening sessions.

---

#### ***Discussion Comments:***

- Only one person at MDC is enrolling people in Medicaid.
- The continuity of care stops when a person goes to jail.
  - A person cannot get Medicaid while at MDC, and it takes up to 45 days after release from MDC to get on Medicaid (for the enrollment process). However, people are released with just three days of medication—there is a huge gap, and many people may relapse during that time.

- The current MDC contractor is not reaching out to community providers, which also disrupts the continuity of care.
- Inmates at MDC are charged for healthcare services. Each person maintains an account, and some amount is deducted for each medical visit and for each prescription. If you don't have any money, you have a negative account, and it is collected the next time you are in MDC. Or, you may not get seen for services.
- There is a huge backlog, especially for mental health services. Sometimes, only five people a day may be seen—there can be a two-week wait.
- Also, mental health providers easily get defensive and threatening.
- At UNMH, if you don't meet their criteria for stabilization, you just don't get care. UNMH needs different criteria.
  - The criteria include threats of suicide, being [visibly] under the influence, threats of homicide, etc., i.e., very violent or visibly unstable behavior. This does not meet the actual needs of people.
  - UNMH will not evaluate a person's mental health if he/she is under the influence.
  - An example: I was released after two hours with a referral for an appointment in two weeks.
  - An example: My mom was having a lot of trouble, and UNMH would not take her. We had to call Adult Protective Services to get her stabilized.
  - There are extreme criteria for people to qualify for healthcare. Therefore, people lie and act out in order to be seen.
  - Both UNMH and MDC see people at their worst (and they must be at their worst to get healthcare at both places).
- There are places willing to help, e.g., AHCH, Crossroads, but these providers don't have enough funding to handle all the people out there.
  - A lot of people are trying to get better, but they need a little help.
- At UNMH, people have to be separately evaluated [even if they have been evaluated at MDC or elsewhere].
- When you get out of MDC, there is nowhere to go.
- Housing is a big problem that needs to be addressed.
  - There is lots of red tape—difficult to get through the process.
  - Organizations are very skeptical of people with MH/SA issues.
  - People [with MH/SA issues] get stereotyped—people need to be seen as individuals, and their situations addressed individually.
  - There is not as much space for men.
- Housing is the #1 problem at the Public Defender's Office.
  - Housing is healthcare!

- HUD eligibility criteria for getting housing are extremely difficult to meet, and they do not reflect people’s real situations.
- Staff at MDC can make problems worse.
  - Example: I was maced and thrown in a cell for three days for an anxiety attack.
  - Example: I had my medications taken away for not reason.
- People with MH/SA issues have trouble expressing themselves—staff at MDC and healthcare providers need to be patient, e.g., MDC guards, UNMH administrators and providers.
- Probation officers “want to see your place”—There needs to be an “in-between” criterion. (In between MDC and some kind of permanent housing.)
- Homelessness increases a person’s instability in many ways. There needs to be an increase in Transitional Living programs.
- People—unqualified or uncaring—are as much the problem as funding.
  - Everyone with mental illness and everyone who is providing care to people with mental health issues, needs to be trauma-informed.
- Don’t assume Medicaid is the answer. Under the Medicaid expansion, comprehensive community health services has replace case management as the system model.
  - There needs to be a core agency in place for this system to work.
  - Case management is important for people with co-occurring disorders. (The continuity and follow-up it provides.)
  - There is no transparency in the reimbursement process.
  - Who establishes relationships? Who builds trust? Who provides the system of care?

## Appendix 10: Listening Session—Native Americans

### Bernalillo County Healthcare Task Force Task Force Meeting #6

All Nations Wellness and Healing Center • July 18, 2014 • 6:30-8:15 p.m.

#### Meeting Notes

---

The July 18, 2014 meeting of the Healthcare Task Force focused on healthcare-related concerns of Native American residents of Bernalillo County. First Nations HealthSource hosted the meeting at its All Nations Wellness and Healing Center, 6416 Zuni SE, Albuquerque.

Although a great deal of information has been gathered through the seven community meetings open to the general public, Task Force members felt that the perspective of Native Americans who work or reside in Bernalillo County was missing, and had decided at the June 27 Task Force meeting to make the July 18 meeting a listening session with invited guests. Over twenty people, in addition to Task Force members, participated in the meeting.

The agenda followed the format used at the community meetings. Linda Son-Stone, Executive Director at First Nations and a member of the Task Force, welcomed the Task Force and invited guests. Tim Karpoff, the Task Force facilitator, presented the background and purpose of the Task Force. The remainder of the meeting was a general discussion, with the guest participants offering both their concerns about healthcare services in the County, and their recommendations. The questions posed were:

- **What concerns do you have about health care services in Bernalillo County?**
- **What can be done to improve health care services in the County?**

The comments below are remarks from the flip chart notes taken during the meeting. The format follows the format used at the other community meetings.

---

#### ***Discussion Comments:***

- The contract with the Federal government to provide healthcare services to the Native American community, whether administered directly by the County or through the Lease Agreement with UNM, has never been adhered to.
  - Refer to the letter submitted to the Task Force by the Albuquerque Metro Native American Coalition for background and a fuller explanation. The AMNAC also has a complete presentation that would benefit the Task Force to see.
  - Example: There are 52,000 Native Americans in the County that are not eligible for catastrophic care.
  - Example: UNMH used to have a Patient Advisory Committee and a Community Advisory Committee. These do not exist any longer.

- Example: Dr. Roth (Health Sciences Center Chancellor) agreed to provide care for Native Americans, but has not lived up to his agreement.
- Native Americans must either sign up with the ACA or waive that and sign up with their local IHS Service Area, which determines eligibility.
- The County needs to understand all dimensions of the 1952 Federal-County agreement, which is signed in perpetuity.
- IHS has not fulfilled its Trust responsibility. (Therefore, none of the responsible agencies—Indian Health Service, Bernalillo County, or the University of New Mexico, has fulfilled their responsibilities.)
  - “American Indians,” in the contract, was originally meant to be inclusive. However, over time, it has become exclusive, and has come to mean “Pueblo.”
  - Why is the All Indian Pueblo Council the recognized contractor? Who decided this? This disregards the urban Indian population.
- We must remember that UNMH does not have responsibility over IHS. IHS has its own rules. We need to develop information regarding what services are actually available.
- Services at the IHS Hospital have dwindled to outpatient services. And, tribes have been blamed for the decrease in IHS funding, because of many tribes contracting services under P.L. 93-638. The Federal government is not fulfilling its responsibility. IHS funding must be restored. “This is in our own backyard.”
  - Also, mental health, behavioral health and substance abuse services are very meager.
  - The IHS Hospital is “divided, not united” in providing services to Native Americans. “They ship us somewhere else” for services.
- There are not enough services for elders, e.g., hospice care. Children are neglected, too. Native Americans are not paid attention to in the hospital—Native people are pushed to the back of the line.
- Non-natives must educate themselves with regard to the legacy of historical trauma—and the current atrocities—perpetrated on Native people. This shows up in the lack of services provided to Native people.
  - The 1952 Contract has the status of a treaty, and UNM, as a contractor of the County, takes on all of the Contract’s responsibilities. The Contract is “in perpetuity.” How long is that?—Forever.
  - Also, there should be no fee-for-service care. Yet, Native people are sent to collections.
  - Native Americans should not be referred to a collection agency. The PAC recommended this—UNMH should follow through!
  - Also, UNMH asks if you are eligible for Medicaid. (If you are on Medicare, you cannot get Medicaid.)
- Native people get the run-around at IHS and at UNMH; however, at First Nations, I have received good services and I have learned to speak for myself. Consumers must educate themselves as well.

- Does it matter how long one has lived here to get services? We need to collaborate to solve our problems.
- Recommendation: More funding for community-based clinics.
  - Community-based clinics have their finger on the pulse of the community. They can better monitor the health status of people, and their health progress.
  - Also, they can listen to people and respond with new approaches.
  - Health occurs in the community—not just in the clinic or hospital. We need to use a Social Determinants of Health model for our health system.
- What is the responsibility—and the performance—of IHS reimbursing UNM for services?
- Native Americans enrolled as members of tribes outside the Albuquerque Service Area, are treated by UNMH like undocumented immigrants.
  - Presbyterian Hospital asks if you are a Native American; UNMH does not.
- The Native American Health Office at UNMH is understaffed!
  - However, UNMH needs to change its whole operation—it should not be the responsibility of one office to work with Native Americans.
- At UNMH, having a “bed” does not mean having a “room.”
  - This is like the whole system at UNMH—doctors don’t communicate with patients, making them wait for very long periods of time. One time, a doctor would not sign a form I needed, without explanation.
- Recommendation: Give the urban population a voice!
- Also, educate health providers and staff at IHS and UNMH in cultural competence.

## Appendix 11: Website Comments

### Comments from Website Survey 5/30/14 through 6/19/14

- Metro Albuquerque is aging rapidly. We must make sure that there are health and social services for people that need them, even if not covered by Medicare, Medicaid/Centennial Care, or the ACA.
- Our community is in serious trouble! UNMH does not provide mental health services according to patient needs. A person in need of therapy does not get better with an appointment every two weeks, or once a month. Those who are insured with Medicare, also have the problem of providers being paid after long, periods, intermittently, and at low reimbursement rates. Patients who cannot afford it often are required to pay out-of-pocket, seriously affecting monies that are required for things like home and auto repair, healthy diet, etc. Our community is in DIRE need of mental health services. A perfect example is the outrageous number of killings by police. Some by untrained officers, too many by suicide-by-cop. Can't the use a stun gun or shoot them in the leg instead of putting multiple bullets in them? We are really in trouble. Resources need to be in place to literally STOP THE INSANITY!
- Better care for East Mountain residents, starting with a public meeting that is not in town.
- Uninsured visitors to the Emergency room or other UNM Hospital facilities should be routinely and persistently introduced to the process of becoming insured through the ACA.
- As a physician having worked with indigent Bernalillo County residents for many years, I have seen many of the shortcomings of our current system. My recommendations to the task force are: 1) All Bernalillo County residents regardless of citizenship status, should qualify for access to care; 2) Health Care should include not only medical visits, laboratory, radiology etc. but also safety net services to ensure that patients understand their disease and can become co-managers of their chronic conditions; 3) Incarcerated populations should receive adequate care for their medical, behavioral and substance abuse needs. Special programs to help reintegrate them into society and into their families are crucial to lower recidivism rate; 4) Funding for those safety net services may be better used by nonprofit community groups, public health and others who have a track record of working effectively with low income and incarcerated populations; and 5) Some of the funding should be allocated for preventive services and given to those nonprofit organizations that have a track record of being effective in this work. Maria Goldstein, MD
- Mental health care is a priority.
- Please make sure that the Mill Levy funds don't go exclusively to UNMH. BernCo needs to fund other health clinics that truly assist the uninsured in our community regardless of immigration status. Undocumented Immigrants who reside in this county pay taxes and deserve to be covered by the funds designated to provide healthcare to the indigent populations residing in our county. The Mill Levy should also support agencies that hire navigators to connect low income residents with resources to overcome health and other socio-economic factors that compromise their health outcomes (poverty, housing, employment, domestic violence, etc.). The Pathways to a Healthier Bernalillo County Program should be expanded and pay for directly with funds from the County without having to depend on funds the County gives to UNMH and UNMH passes through to the Pathways program. This is a conflict of interest since moneys that UNMH allocate to Pathways decrease the amount the hospital uses for their operations.

### Comments from Website Survey 6/20/14 through 6/26/14

- A FEW LINKS TO HEALTH SAFETY NET MODELS THAT WORK
    - CALIF Designing Safety-Net Clinics for Innovative Care Delivery Models [www.chcf.org/~media/MEDIA%20LIBRARY%20Files/PDF/D/PDF](http://www.chcf.org/~media/MEDIA%20LIBRARY%20Files/PDF/D/PDF)
    - MINN Recommendations Access Work Minnesota's Safety Net 2014 [mn.gov/health-reform/...16-PANEL-MN-Safety-Net-Coalition.pdf](http://mn.gov/health-reform/...16-PANEL-MN-Safety-Net-Coalition.pdf)
    - CALIF <http://www.careinnovations.org>
    - CALIF <http://www.chcf.org/publications/2011/03/promising-practices-clinic-design>
    - CALIF [http://healthpolicy.ucsf.edu/article/healthcare\\_safety\\_net](http://healthpolicy.ucsf.edu/article/healthcare_safety_net)
    - NATIONAL <http://eclkc.ohs.acf.hhs.gov/hslc/tta-system/health/center/link-between/docs/link-health-and-school-readiness.pdf>
  - Safety Net Resources link: <http://www.ppic.org/main/publication.asp?i=1080> (see social safety net)
- 

### Comments from Website Survey 6/27/14 through 7/07/14

- When Mayor Berry and Gov. Martinez are out, our healthcare systems will be back on track. They are cutting funding and with cutting funding, they are cutting morale. Since they have entered office, we have suffered in all areas. There's an uneasy quietness in our state.
- 

### Comments from Website Survey 7/08/14 through 7/11/14

- Necesitamos servicios de salud para TODOS los residentes del Condado de Bernalillo, principalmente para las personas de mas bajos ingresos economicos. Los cuidados de SALUD son para todos los individuos sin importar edad, raza, religion, estatus migratorio, economico, preferencia sexual, genero y demas. Estamos ante una gran oportunidad de hacer un cambio benefico para la comunidad, Bernalillo County puede crear un Departamento de Salud del Condado el cual brinde primary care para todos. El UNMH no esta cumpliendo con este servicio. Hay muchas quejas de la gente porque hay algunas que no califican para ser atendidos, largas esperas para las citas, negar el servicio de operaciones a la gente que no tenga dinero en efectivo para pagar por una operacion carisima, las deudas medicas (la gente esta temerosa de las deudas) malos interpretes, muchisimas horas de espera en la sala de emergencia. Y mas cosas, pero por el momento creo que son las principales cuestiones en las que se debe trabajar para mejorarlas. Tambien apoyo un incremento economico para el Programa de Pathways en el Condado de Bernalillo el cual es de mucho beneficio para los residentes del Condado. El programa lo a demostrado y tiene que ser apoyado economicamente para que tenga mas condiciones de seguir sirviendo como lo ha hecho hasta ahora. Sim mas por el momento y esperando que ustedes sean parte del cambio positivo que necesitamos en nuestra sociedad, reciban un calido agradecimiento por su labor. Gracias.

We need health care for all residents of Bernalillo County, mainly for people of more low-income economic. HEALTH care is for all individuals regardless of age, race, religion, immigration status, economic, sexual preference, gender and so forth. We have a great opportunity to make a beneficial change to the community, Bernalillo County may create a Department of health County which provides primary care for all. The UNMH is not complying with this service. There are many complaints of people because there are some who do not qualify to be attended, long waits for appointments, deny operations service to people who do not have money in cash to pay for a fast operation, the medical debts bad (people are fearful of debt) interpreters, many hours of waiting in

the emergency room. And most things, but at the moment I think are the main issues that will need to work to improve them. Also support an economic increase for the Pathways program in Bernalillo County, which is of great benefit for the residents of the County. Program it to shown and should be supported economically so that you have more conditions of continuing to serve as it has done until now. YES more at the moment and waiting for you to be part of the positive change we need in our society, receive a warm thanks for their work. Thank you

- We need to continue to promote the importance of people taking better care of themselves through better nutrition and more exercise.

---

#### **Comments from Website Survey 7/12/14 through 7/17/14**

- There are many factors that influence health outcomes, but among the most significant predictors are income, education, health insurance, neighborhood life, family, and environmental and work conditions. We need to find innovative solutions to addressing the social determinants of health.
- As long as UNMH receives that money they should provide healthcare through UNM Cares especially for all the people who fall between the cracks of Obamacare.
- All county residents must have affordable access to comprehensive medical, preventive and behavioral health services, regardless of their immigration status. And UNMH administrators have failed to give us this so, now, the county must provide oversight and leadership to assure this care. We all pay taxes here so none of us should be left behind. County Commissioners must use most of the mil levy to expand UNM Care to all residents, and some funds to build Pathways program capacity into an independent, comprehensive and sustainable program for systems navigation and public health planning. We can do this here, and lead the nation in filling preventable and tragic health systems gaps.
- Thank you for your hard work on this important issue. Please do your best to push the county and UNMH to work together to make sure our county tax dollars go towards addressing the county's major health needs and that all financially eligible county residents have access to high-quality, affordable health care that doesn't leave them in crippling medical debt.
- Access to dental services continues to be a huge issue here, particularly for adults and the uninsured. It would be great if the amount of funding allocated for dental services could be increased.
- Please, Bernalillo County, be very specific in requiring the UNMH to be a truly responsive safety net for the healthcare needs of those residents who do qualify for or cannot afford healthcare under the ACA, regardless of immigration status. Hold the UNMH accountable to this requirement. Thank you!
- It is essential that this money is used to address the issues of still too-costly health care and for the population of immigrants that don't qualify for any other assistance. Expansion of innovative models like Pathways to a Healthier Bernalillo County are key to addressing the health needs of Bernalillo County residents.
- Please consider an assessment center for the homeless, the hungry, the undocumented, the intoxicated, the addicted, the abused, & the exploited. Focus more services to the people with the greatest needs. Use a client-centric system in order to maintain the client in services for the needed treatment. Use a diversion court. Expand crisis intervention teams to include mental health/substance abuse counselors & take the person in crisis to a health facility instead of booking. Stop sending inmates out of county for incarceration when the monies could be used to divert, to

treat, and to stabilize the recidivists and to help the nonviolent inmates receive mental health services. Housing for the homeless is a fundamental need to deal with the people on the street with addictions. Develop a stable housing program for all homeless and newly released inmates - mental health and physical health and addiction treatment can be built once stable housing is established. Use MDC just for violent offenders pending transfer to state or federal prisons. Do more integration efforts among the city, county and state in developing and implementing a consistent, sustainable healthcare system in which no one is left on the street to be stepped over. Thank you.

- I am aware of the Mill Levy and some of the ways in which the funding is utilized. I feel expenditures need to be monitored closely so they benefit the community as a whole.
- I feel that the Mill Levy should continue to support the UNM/HSC Pathways Program
- The best opportunities for use of mill levy funding could be leveraged thru an emphasis upon prevention and early intervention as a strategy to address issues that take precedence in dealing with the social determinants of health and negative health outcomes. For example, such interventions that have a proven track record like an emphasis upon School based health, early childhood programs, and immunizations, harm reduction, would curb many of the outcomes related to poverty, and risky behaviors.
- I am a harm reduction specialist certified by the State of New Mexico and a first-year medical student at UNM. I have worked in Albuquerque serving the needs of homeless and drug addicted individuals for the last 10 years. I have done outreach at MDC. I can tell you that lack of access to alcohol and substance abuse treatment is a huge problem in Bernalillo County. It contributes to emergency room and surgical costs, and crime in the county. It is much less expensive to treat addiction than to incarcerate non-violent offenders. Having worked in the jail I have seen a huge number of people with medical problems that are going unaddressed because of lack of access in that setting. Keep in mind that a great deal of people incarcerated in our jail have not been convicted of anything. The jail in Albuquerque serves as the largest psychiatric hospital in the state—except it functions more as a storage area than a hospital. Expanding access to psychiatric urgent care at UNM could go a long way in keeping mentally ill people out of jail. See, jail is a very dangerous place and people do not get better there. I have met people in Bernalillo County who are deceased now for lack of medical, psychiatric and substance abuse treatment. We can address this and we can do so in a way that prevents incurring more cost.
- Behavioral health counseling is limited in our communities, especially for those from low income neighborhoods/undocumented children and families. Services and capacity should be broadened in this respect. Metropolitan Detention Center: An agreement should be established with bidders from outside of the prison system. These should be private contractors that can provide services to inmates. Oversight needs to be provided by entities who are not part of the current system (outside evaluator). Bids should also be opened to small practice and organizations who can provide direct services in areas of mental health, counseling, other health services etc...
- Currently, access to emergency psychiatric services at UNMH are virtually impossible unless one meets the defining characteristics of suicidal or homicidal behavior; and for the latter, it is unclear if they will get psychiatric help or be carted off to jail. UNMH also will not admit for psychiatric services anyone who is under the influence of drugs/alcohol (self-medicating). UNMH also will not hold anyone, even if represented by a qualified psychiatrist, for a 72 hour evaluation and stabilization period. Essentially, when someone is at the point of needing psychiatric services, they cannot get them from UNMH unless the threshold for homicide/suicide has been reached. There are

many other mental health challenges faced by individuals that warrant emergency care and not a referral for an appointment weeks down the road.

- The community needs better access to providers of services that are outside the UNM network. It would be helpful for community members to be able access a broader list of providers in the area who are not affiliated with UNM.
- The Health Science Center leadership, hospital leadership, and affiliated clinics and programs have failed in their duties as guardians of the public's health and health care, a charge they have through the mill levy obligation. Low-income residents are still put into collections; a reasonable sliding fee scale has not been developed to help the uninsured and low-income patients; service sites have not been developed in the most high need parts of the community (but rather investments made in Rio Rancho); the failure to offer services in Spanish and other community languages or at least offer adequate translation services for the monolingual English speaking health personnel. The Hospital and its leadership are held in low esteem by public hospital officials around the country for their lack of imagination and attention to community health. The situation will only change if the entire HSC leadership is replaced by leadership with the community's health as its primary goal rather than using the mill levy monies for empire building. Our community deserves better and property tax payers should expect better health and health care returns from our tax dollars for all residents of Bernalillo County.
- There are still nearly 175 thousand uninsured in New Mexico. We can make a big dent in that number by making sure that no one in the Bernalillo County goes without the healthcare attention they need.
- Dear Bernalillo County Healthcare Task Force: Mental health should not be left in the hands of our policeman or bureaucrats. There has been a decrease in behavioral health care for over 90,000 people in our communities since January. The decrease of services is a direct result of our state government canceling reimbursements of Medicaid dollars to many of our providers without due process. These actions have serious consequences. Our communities can't handle the economic and emotional "fall out" from depression, substance abuse, suicides, domestic violence, etc. that are a direct result of the lack of mental health services. We desperately need more behavioral health providers in our state and who from our own state. The money that we use towards prevention is truly worth a pound of cure. Mental illness is treatable with the help of trained mental health and medical specialists. Encourage your state legislators to help by passing behavioral health legislation that will attract more capable people into this field of work. Time is of the essence. Victims are suffering today as we delay! Sincerely, Susan Klebanoff, Bernalillo property owner
- I THINK THAT THE UNM HOSPITAL DOES A GOOD JOB OF SERVING PEOPLE'S PHYSICAL NEEDS, BUT LACKS IN THEIR TREATMENT OF THEIR MENTAL HEALTH NEEDS.
- Why did we not receive the above public meeting schedules before the meetings?
- Isn't it obvious? Mental Healthcare!
- Please guarantee affordable access to medical, behavioral and preventive healthcare for all county residents who need it. Please expand UNM Care into the healthcare-home program for all county residents that keeps us from life-crushing medical debt, and dedicate funds to an independently-run Pathways Program that plans services to close the gaps in our county healthcare systems.
- The nearer we can get to taxpayer-funded medical care for those who need it, the better.

- We certainly need to be sure that our Health Care is maintained at the UNM hospital. This is where people go who do not have insurance or not good insurance. Even with the new ACA, there is definitely still a need for this important facility.
- Since not only Bernalillo county residents use this facility, I believe the hospital and its clinics should get more help from the state.
- The people need healthcare to help them with staying healthy so do what you can for them and pass this.
- I think that UNMH does outstanding work in providing care to the members of the community. I do not believe that there is a reason to change the Lease agreement between UNM and Bernalillo County.
- Monies that went to UNMH for mental health services should go to all qualified providers, not just the UNM group.
- All of these meetings have already taken place-- is there a summary of the meetings concerning viable options?
- There are no pediatric psychiatrists taking patients right now. UNM has put a hold on intakes because they are short staffed. Our Suicide rate is one of the highest in the nation as are drug overdoses. The Juvenile Justice System has gone away from rehabilitation back to corrections and is housing seriously mentally ill clients at half the required Behavioral Health Staffing. The core service agencies have gone away and mentally ill individuals need case management services they don't have. Metropolitan Detention Center has cancelled all adult education programs with the exception of GED. All of this increases mental illness on the streets.
- Additional funds should be appropriated for mental health services at the MDC as well as additional funding for health care clinics in low income neighborhoods.

---

#### **Comments from Website Survey 7/18/14 through 7/24/14**

- The healthcare-home program will be a great help especially for the elderly and will cut down on emergency room visits.
- Are there no citizens among Bernalillo County physicians or New Mexico state medical society who are ever speaking positively for patient care and safety? Never see anything in media, never. I do favor the millage for health care in county. I think that physicians should be required nationally to accept Medicaid patients.
- Please remember the basics of life, on which healthcare is build- food, shelter= meals programs, food pantries, etc.
- Uninsured, incarcerated and low-income Bernalillo County residents, regardless of immigration status, MUST NOT BE DENIED access to preventative health care, substance abuse treatment and mental health services.
- I didn't know about the public meetings. They didn't seem to be widely advertised. Also, I would like to see a survey that asks standard questions instead of just a narrative. Since this is the tool given to me, I would say that we need more attention to behavioral healthcare needs in Bernalillo County to both people with chronic conditions and those with acute problems. We need more education on how to access the services that are included in the \$90 million give to UNM. We need more

education in the community about behavioral healthcare access and usage. How is that \$90 million being spent?

- UNM Hospital needs more transparency regarding how it uses the Mill levy money. There needs to be more collaboration between the UNM outpatient clinics and the detention center, along with Healthcare for the Homeless.
- My personal feeling is that UNMH needs to be held more accountable for how they spend the roughly \$90 million that they receive through the mill levy funds each year. The language in their MOU between the County and UNMH should be less generic and more specific to the needs of Bernalillo County residents. In addition, UNMH should be required to provide annual expenditure reports to the public for these tax dollars that they are receiving.

In terms of health care needs, it is obvious that something needs to be done to provide coverage for those residents who are not eligible for the Affordable Care Act, Medicaid, or any other type of coverage. Many of them are delaying the care that they need so that they do not accrue a huge medical debt that they can ill afford, and this usually results in higher costs down the road. The County could demand this from UNMH.

There is a strong need for expanded navigation-type services in the County (e.g. Pathways), as I have heard repeatedly that so many people do not know how to effectively access health and social services, and all-too-often simply do not even try because the experience is too overwhelming. As a result, many people's needs are not being met. This also applies to navigation services within the BernCo Detention Center. If there were navigators working with the inmates prior to their release, establishing a trusting relationship and having a better understanding of the person's needs once they get released, the navigators could then provide the important intervention and case management services upon their release, which is usually when they are most vulnerable for recidivism. Placing navigator-type positions in the jail could begin to address the overcrowding issues and hopefully reduce re-incarceration.

Finally, there is a dire need for more behavioral health services, including harm reduction, substance use treatment and both outpatient and inpatient facilities. Now that Medicaid has agreed to reimburse for many of these services, the timing is perfect for expanded services. Personally, my feeling is that a higher percentage of the mill levy funds should be dedicated to behavioral health/substance use treatment, and to expand the navigation services both in the community and jail by significantly increasing the funding for the Pathways Program.

Thank you for providing the opportunity for public input.

- I'm uncertain if mental health care is included in the responsibilities of this taskforce. We need a coordinated, well-funded program for prevention, assessment, treatment and evaluation of mental illness that is well integrated with physical healthcare. Currently it is not well integrated or funded. Although Mental Health Parity is law it is not being enacted in our health care settings.
- There are too many gap areas not being addressed in the County particularly related to all aspects of Behavioral Health.
- The meetings were great the only problem I have is that Mr. Steve McKernan never pay attention of what the community had to say, he ignore all of us, and was on his computer all the time. I think is very disrespectful of him. It shows me that he know nothing will be done since he has been in the same position for many years, he gets pay regardless of people getting treated or not. No respect for the patients. No accountability! We need a new solution, if the contract needs to be change at

the legislation then it needs to be change in order for the UNMH Hospital treat patients with dignity and respect?

- Continuation of the tax should be contingent upon an independent commission's study of hospital charges at UNMH. National studies show that such charges are wildly inconsistent and often have little relationship to actual costs. Voters need to know whether alleged costs are credible.
  - We need to have access to primary care and specialty care for the people who reside in our county but do not have authorization (documents). They are a large group who work in our county and economy, pay taxes and contribute to our community. Please encourage UNMH to use freed up mil levy dollars to provide coverage of non-emergent care and well as not to send people to collections.
  - It's essential that these funds be prioritized for low income County residents who do not have any/sufficient health coverage from other plans.
- 

#### **Comments from Website Survey 7/25/14 through 7/31/14**

- Behavioral health needs are very important!
  - There need to be more hospital beds available for psychiatric patient needs. At present, individuals who require hospitalization are unable to receive the necessary medical interventions. This is one of the most urgent of needs. Submitted by Shirley Kondo, Albuquerque 87104
  - Information of services offered is never in the forefront. Please provide notices for urgent care. Please provide access to emergency behavioral health, substance & alcohol, psychiatric treatment. Intense case management to navigate through UNMH. Financial supports for low income and undocumented clients.
  - More STD/STI Testing sites. More funding for the Milagro Program. Smoking Cessation programs in pregnancy. Shelters/protection/education for pregnant women in abusive relationships.
- 

#### **Comments from Website Survey 8/01/14 through 8/30/14**

- There needs to be money available for a stronger collaboration between behavioral health and the APD.
- At least half of the 90 million should be allocated to prevention. 90 million from mill levy property tax should not go for operations and maintenance - administrators salaries and new buildings DO NOT improve population health. UNM still sends indigent people to collection even though they receive 90 million to provide care to indigent population of the county. Since UNM does not allocate the funds specifically to health and behavioral care should not be the recipient of our tax dollars. The County should demand equal allocation of resources to each area of county specifically for health and behavioral health services. UNM operates the 1% of mil levy fund allocated to Pathways program that use community health workers - they mandate high level of accountability to all the not for profit organization for the funds - outcome based payment. WHY the county does not ask an outcome base payment to UNM for 90 million dollars? County should change the allocation of the funds from operation and maintenance to health and behavioral services. Please use the money to improve health not buildings and income of incompetent administrators at UNM - invest in our population health needs. What has UNM done to improve health and social indicators of Bernalillo County?

- The health care needs of uninsured, incarcerated, low-income and behavioral health needs of the county residents must first and foremost address the trauma and oppression of Native NM's (native people, Hispanics, black etc.). People who move to NM have not experienced the decades of life without care (health, behavioral health etc.) or even been afforded the potential to participate in the economics of our state like those who move to NM. Healthcare organizations and administrators need to be heavy handed with people from NM so that systems can be designed for the people who need them. The current situation best reflects the economic colonization that has always plagued the NM people. Lots of \$\$ that goes to pay 6 figure incomes to people who are not from here to tell people from here how to "be healthy." It is ineffective, wasteful, oppressive and unhelpful to the quality of life and overall health of the county residents as it only serves to re-traumatize an already traumatized people/county.
- Please prioritize those that are undocumented. They are the most underserved and have the lowest access to health care services. Please increase funding for housing and for harm reduction services. Please support community efforts to increase training and education on substance abuse and mental health.
- As a community pharmacist on the frontline of the behavioral health epidemic that we are facing, I definitely see the need for increased access to medications and behavioral health specialist. People with mental health issues are an extremely vulnerable population and when they are undiagnosed and/or not-treated, their quality of life may be compromised. These people have a harder time functioning in society, as their mental health can compromise their abilities to perform daily functions that you or I may take for granted. Some mental illnesses can contribute to an individual's ability to work and therefore their ability to be financially stable and maintain a home, thus contributing to homelessness. UNM is one of the most widely accessible hospitals in Albuquerque, and as such, I think the money should go towards helping this particular population. I support UNM outpatient pharmacy providing discounted or even free psych meds to patients who absolutely cannot afford them but need them. I also would like to see more funding towards Crisis intervention teams at UNM and more behavioral therapy groups open to more people who need community support, but cannot afford a counselor or therapist. Thank you for taking the time to review my comment.
- What are we doing to ensure that new released incarcerated population are set for success? How are we handling mental health crisis, when officers are called to domestic disputes?
- Re: healthcare of incarcerated @ MDC. After talking with several recently released persons, I learned that persons receiving med. care need or are "charge" on their account fees for services. Medical care is paid for by contract to an outsourced company to provide services. Why are inmates charged? Also upon release, individuals should be almost mandatory to be enrolled into Centennial Care--which is not happening now. Upon release, individual should have access to 1 month of medically approved medications (psy., diabetes, hypertension, ...)
- I am particularly concerned about the identification of and delivery methods of care to the homeless and mentally ill in our community.
- One of the most pernicious things going on is the steady increase in copays and deductibles. Copays in many cases are now as much or more than insurers pay for the service. For example, Presbyterian pays only \$43.73 for acupuncture, but City of Albuquerque employers have a \$55 copay! We pay out of pocket for copays, we pay premiums, and we pay in tax dollars. Even with insurance, care is out of reach for a great many of our citizens.

- The survey is not specific in how to address what I think are the needs of Bernalillo County. The needs are great, I'm not sure how to be specific enough to be helpful

## **Appendix 12: Glossary of Acronyms**

BIA	Bureau of Indian Affairs
BC	Bernalillo County
DSAP	Department of Substance Abuse Prevention
FPL	Federal Poverty Level
HSC	Health Sciences Center
IAP2	International Association of Public Participation
IHS	Indian Health Service
MATS	Metropolitan Assessment Treatment Services
MDC	Metropolitan Detention Center
MOU	Memorandum of Understanding
PCMH	Patient Centered Medical Home
UNM	University of New Mexico
UNMH	University of New Mexico Hospital