Doña Ana Board of Wellness

ACTION PLAN

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| PROFESSIONAL SERVICES CONTRACT , DONA ANA COUNTY HEALTH AND HUMAN SERVICES DEPT

Contents

Introduction

May 15, 2016

On behalf of the members of the Doña Ana County Health-Care Collaborative, it is my honor to introduce this action plan, which is the culmination of eight months of intensive work by Collaborative participants and other community stakeholders. During that period, we have conducted multiple meetings with board members, held a strategic planning retreat, examined data, and assessed our need for core capacities including programs, physical infrastructure, staffing, leadership, and knowledge. We have revised our mission, vision, and values statement to clarify our focus and fundamental beliefs. We have assessed the forces pushing us toward our mission of equitable, high-quality, integrated health-care and community empowerment – and those forces that create barriers to achieving our goals.

Our discussions have been at times serious, comic, frustrating, emotional, and engaging, but have always centered upon one critical focus: how members of the Doña Ana County Health-Care Collaborative can collaboratively create a community-centered, integrated health system to improve the health of Doña Ana County residents

As a result, we have decided to focus our efforts over the next three years in three areas:

- *An established and operational Doña Ana County Board of Wellness:* The Collaborative will establish an independent, well-recognized, and sustainable organization to carry out its mission.
- *A new generation of health and health-care professionals*: Doña Ana County will become recognized as an innovator and leader in inter-professional education for all health-related professions.
- *Systems for community-wide approaches to healthcare, particularly relating to health literacy, behavioral health and diabetes*. The Collaborative will lead in establishing coordinated systems of care that involve all sectors of the community, using new language and behavior around health policy, teaching, and practice that focuses on prevention and wellness.

We remain committed to our vision of a community in which all residents live in physical, cultural, and social environments that support their health from cradle to grave, and to our core strategies of convening, teaching, transforming, sharing, and researching.

Thank you for your interest in the Doña Ana County Health Care Collaborative

Sincerely,

John Andazola, MD
Chairman, Doña Ana County Health Care Collaborative

Doña Ana Board of Wellness Mission, Vision, Values Statement

Mission

The mission of the Doña Ana County Institute of Wellness is to collaboratively create a community-centered, integrated health system to improve the health of Doña Ana County residents.

Vision

All Doña Ana County residents live in physical, cultural, and social environment that supports their health from cradle to grave.

Values

We believe:

- Health care is a common good
- Communities thrive when all people have access to high-quality, cost-effective care
- Effective health care integrates primary, behavioral, and oral health.
- "Upstream" factors -- social determinants -- have the most profound impact on health
- Robust health-care systems are built on solid evidence and supported by sound data and policies

What We Do

- Convene
    - We bring together stakeholders to engage in conversations about health and health care across agencies, sectors, and communities. We share our experience, visions, and ideas, and develop responsive, evidence-based plans and projects to improve community health.
- Transform
    - We develop and test value-based, integrated health-care delivery models that offer coordinated, patient-centered, cost-effective, high-quality care.
    - We develop models for delivery of person-centered care that integrates physical, behavioral, and population health and social services.
    - We develop and test “upstream” interventions to prevent disease and enhance wellness
- Teach
    - Train health-care professionals of the future
    - Work with policymakers to assure they understand health metrics and the impact of all policies on health
- Share
    - Help communities develop the capacity to identify and address their health-care and wellness needs
- Research
    - Gather and analyze data to evaluate the current state of health-care services, how the system can be improved, and how we can optimize health-care delivery

"We have a singular opportunity to re-envision our national approach to health. The health and wellbeing of individuals depends on both quality coordinated health care services and community conditions that support health and safety. A successful, equitable health system will fuse these two areas, merging efficient, accessible, and culturally appropriate care with comprehensive efforts to prevent illness and injury in the first place by improving community environments. This coordinated thrust will produce the most effective, sustainable, and affordable health solutions" (Cantor, Cohen, Mikkelsen, & Valdovinos, 2011).

Background

Organizational History and Profile: The Doña Ana County Health Collaborative

In 2014, a group of Doña Ana County residents gathered and began talking about how they could improve health and health care in the county. The group included health-care providers, payers, public health professionals, researchers, educators, and others. They began meeting regularly, sharing ideas, resources, and information. As the group evolved, they took on a name, an identity, and a mission.

In coming together with energy and dedication, Collaborative participants created more than a group, a coalition, a collaborative, an institute, a board, or an organization.

They created a movement.

> "A movement is a collective state of mind, a public and common understanding that the future can be created, not simply experience or endured"
>
> (De Pree, 1997, p 22)

As the Doña Ana County Health Collaborative, the group has worked to streamline referral processes, reduce duplication of services, and align financial incentives to encourage high-value health care. The early achievements of the Collaborative speak to the power of convening stakeholders across sectors and disciplines. Participants have been able to coordinate and systemize processes such as referrals for people seen in the primary care setting who need behavioral health care, apply quality measures to diabetes care, and develop a pathway for people in behavioral health crises to receive the care they need. La Clinica de Familia, one of the county's three federally qualified health centers (FQHCs), is well on the way developing an effective model of integrated behavioral health and primary care. The Doña Ana County Health and Human Services Department (DAC HHSD) worked closely with the Southwest Family Medicine Program to implement *Nuestra Vida*, an innovative diabetes prevention and management program and that combines clinical prevention with community education.

Collaborative participants continue to volunteer their time and energy, pursuing their vision of a seamless health-care system in Doña Ana County that combines high-quality clinical care with community prevention. It is a vision in which Doña Ana County is home to a comprehensive, community-centered health system that integrates social, behavioral and physical approaches to care while coordinating care across agencies, sectors, and disciplines. By developing and implementing innovative, evidence-based models of care and care coordination, the Collaborative seeks to break down silos,

strengthen the county's health-care infrastructure, and create a social, economic, and physical environment that supports all residents' health.

In their collective work, participants have begun to challenge old ways of thinking about population health issues, which focused on specific diseases, incorporating social services in clinical practices, and creating a more efficient health-care system. Instead, the group sees health as the product of complex environmental influences, including physical, social, and economic factors. Beyond addressing health-care delivery, Collaborative participants have broadened the concept of the patient-centered medical home to a vision of a community-driven health system that links evidence-based, integrated primary, behavioral, and oral health care with social services, environmental change, and other community prevention activities. To support this holistic approach to health and wellness, they have embraced a "Health in All Policies" approach.

Collaborative Participants

The Collaborative is a flexible, dynamic organization, and participants represent a variety of sectors and individuals. While attendance at twice-monthly meetings varies, a core group of stakeholders has emerged as the group has evolved.

Core organizations participating in Collaborative include:

Southern New Mexico Family Residency Program

http://www.nmfamilymedicine.com/article/home

The Southern New Mexico Family Residency program, established in 1996, is a core driver of the Collaborative vision and mission. The Family Residency Program The residency program provides high quality, comprehensive medical education to primary care residents using its highly trained, bilingual, diverse faculty. A leader in health systems transformation, the program specializes in integrated behavioral health, border health, and HIV care. The program produces compassionate, skilled, board-certified family physicians who deliver high-quality, comprehensive care to patients and families throughout southern New Mexico. The Family residency program is dedicated to training physicians who are able to look beyond the walls of the clinic and think critically to address upstream factors that determine health.

Dona Ana County Health and Human Services Department

https://donaanacounty.org/health

A founding member of the Collaborative, the Doña Ana County Health and Human Services (HHS) Department was created by the Doña Ana Board of County Commissioners in 2001. The mission of the Doña Ana County HHS is to improve the quality of life in Doña Ana County by identifying and addressing unmet health and human service needs. The Doña Ana County HHS has established five goals, all of which are closely aligned with the mission of the Collaborative:

1. Reduce the rate of premature death or disability in high-risk categories and improve health status through prevention and early intervention programs.
2. Improve overall mental health and wellness through prevention and by ensuring access to appropriate, quality mental health services.

3. Improve the delivery and coordination of health-care safety-net services in tandem with implementation of the Affordable Care Act.
4. Facilitate and support local programs that improve residential living conditions essential for health and safety
5. Ensure that people throughout the county and of all ages have opportunities for educational, social, and recreational opportunities.

La Clinica de Familia Health Center

http://www.lcdfnm.org/

A federally qualified health center (FQHC) serving southern Doña Ana County and Las Cruces, La Clinica de Familia, Inc. (LCDF) was established in 1978. LCDF provides comprehensive care for all comers through its seven medical clinics, five dental clinics, three school based clinics, behavioral health services, an Early Head Start program, a Healthy Start program and a Promotora program. LCDF health and social services programs are funded by grants, contracts, and fee-for-service.

Molina Healthcare of New Mexico (MHNM):

- www.molinahealthcare.com
- https://www.facebook.com/MolinaHealth

MHNM is an HMO and a managed care organization (MCO) that provides high quality health services to Medicaid and Medicare enrollees in New Mexico. The company serves more than 228,000 New Mexicans, 97 percent of whom are enrolled in Medicaid and 1 percent of whom are dually eligible for both Medicaid and Medicare. MHNM brings its experience as a payer of health-care services to the Collaborative, including managing cost, utilization, and quality of health-care service delivery. In addition, MHNM offers special expertise in county and/or provider specific population health analysis. Through MHNM's participation, the Collaborative has been able to experiment with innovative payment models and analyze county and provider data. .

American Medical Response (AMR):

https://www.amr.net/locations/operations/new-mexico/dona-ana-county.aspx

AMR Doña Ana County is an emergency and non-emergency medical transport service provider for Doña Ana County, and Las Cruces, New Mexico. It was founded in 2007. AMR Doña Ana County employs approximately 100 paramedics and EMTs and handles an average of 23,000 calls annually.
AMR Doña Ana County received CAAS accreditation in 2008. The New Mexico EMS Bureau has recognized the extraordinary care the operation provides to patients and has granted special clinical skills to AMR paramedics at the operation.

New Mexico Department of Health

The mission of the New Mexico Department of Health is to promote health and wellness, improve health outcomes, and assure safety-net services for all people in New Mexico. The Department provides statewide systems of health promotion and community health improvement, chronic disease prevention, infectious disease prevention, injury prevention and other public health services. Local public health offices are actively involved in the Board of Wellness, providing support and information-sharing. The Board of Wellness serves as the community health council for Doña Ana County.

Mesilla Valley Hospital

www.mesillavalleyhospital.com
www.facebook.com/mesillavalley

Mesilla Valley Hospital's provides quality and specialized mental health and addiction treatment to meet the needs of adolescents, adults, and seniors in New Mexico. Mesilla Valley Hospital has been providing behavioral healthcare to the community since 1987. Medical staff and clinical teams provide specialized psychiatric and addiction treatment to adolescents (12-17) and adults throughout New Mexico. Services are available 24 hours a day, seven days a week, and confidential assessments are provided anytime. Walk-ins are always welcome. Mesilla Valley Hospital is a resource for those in need of behavioral health care and is dedicated to partnering with other agencies, providers, and entities to ensure all people receive the care and follow-up they need.

New Mexico State University

Various representatives from health-related departments contribute their expertise and skills to the work of the Collaborative. Departments represented include:

- Research, Health and Social Services College
- Department of Anthropology
- Department of Public Health Sciences
- School of Social Work
- Counseling and Educational Psychology
- School of Nursing

Burrell College of Osteopathic Medicine

- Institute for Health Policy and Research

Community Participants

- Community participants share their knowledge of the community and health systems.

The Environment

Federal and State Policy Frameworks

The Collaborative is a movement for health in Doña Ana County, one that is grounded in an era of national and state health-care transformation. This new era of health care offers promising opportunities for Doña Ana County to realize the Institute for Health Improvement's (IHI's) "triple aim" of patient-centered, high-quality, cost-effective care ("Institute for Healthcare Improvement: The IHI Triple Aim," 2015). In the midst of this quantum shift in thinking about health systems, the Collaborative is poised to become a model for integrated systems, cross-sector collaboration, and innovative design.

When it was signed into law in 2010, the Patient Protection and Affordable Care Act (ACA) ushered in an era of unprecedented change in health care in the United States. In addition to its widely contested provisions for expansion of health-care coverage through Medicaid and the health insurance exchanges, the ACA contains mechanisms for strengthening the U.S. primary care system and investing in prevention of illness and injury.

The federal policy framework created by the ACA provides an opportunity for Doña Ana County to continue its investment in prevention activities, coordination of services, and development of a comprehensive, integrated primary care infrastructure. The ACA broadly defines the "health home" – a core tenet of the Collaborative's work – as a way to provide coordinated, individualized, team-based care, while acknowledging the critical impact of factors outside of the health system on health.

The Collaborative's goal of seamless, integrated care in a community that supports wellness is also supported by state policy initiatives. New Mexico was awarded a Centers for Medicaid and Medicare (CMS) State Innovation Model Design project in 2015 to design a statewide model of integrated, cost-effective, high-quality health systems. The resulting health system innovation model, which was submitted to CMS on April 28, 2016, provides a second framework for Doña Ana County to improve alignment of clinical, behavioral, and oral health care within the patient-centered medical home (PCMH), and to move to a community-centered model in which PCMH clinical care is integrated with public health and social services to improve population health. State design developers envision a statewide system of Community-Centered Health Homes (CCHH), which offer critical links between clinical care and preventive services. The Collaborative is well positioned to become a model for the statewide initiative.

Emerging Theoretical Models

At the same time that huge shifts in policy are occurring statewide and nationally, several theoretical models are emerging – simultaneously driven by the changing health policy landscape and shaping it. Several of these theoretical models are pertinent to the Collaborative's work:

Patient-Centered Medical Home (PCMH)

The PCMH is a philosophy of care that focuses on providing coordinated, team-based care. In the PCMH model, the patient and family define the care that is wanted and needed with the expert guidance and clear communication of physicians and other health-care providers. A PCMH must provide care that is comprehensive, patient-centered, coordinated, accessible, of high quality, and safe.

For more information, see:

- Agency for Healthcare Research and Quality (AHRQ): https://pcmh.ahrq.gov/

- National Center for Quality Assurance (NCQA): http://www.ncqa.org/Programs/Recognition/Practices/PatientCenteredMedicalHomePCMH.aspx
- National Association of Community Health Centers. "What is a Patient-Centered Medical Home?" http://www.nachc.com/Patient%20Centered%20Medical%20Home.cfm

The Prevention Institute, Community-Centered Health Home

The PCMH serves as the building block for the next level of integrated care, the community-centered health home (CCHH). The CCHH concept was developed by a team of researchers from the Prevention Institute, who proposed that the PCMH did not go far enough to address societal determinants of health. The CCHH links the PCMH with community-based prevention efforts. Prevention Institute researchers describe the CCHH as a health-care center that "provides high-quality health care services while also applying diagnostic and critical thinking skills to the underlying factors that shape patterns of injury and illness" (p?). In the CCHH setting, for instance, the practitioner might address a child's asthma in the clinic, but also investigate potential triggers – such as high levels of air-borne particulates – in the child's home and community.

For more information, see:

- http://www.preventioninstitute.org/component/jlibrary/article/id-298/127.html

Accountable Health Communities

The broadest of emerging models, In February, 2016, CMS released a funding opportunity for groups interesting in building accountable health communities (AHC). The CMS vision, as articulated in the RFP, echoes much of the vision that the Collaborative has described. An AHC, according to the Prevention Institute, is "a structured collaboration between healthcare, public health, and a variety of partners outside the healthcare system. Its mission is to improve health, safety, and equity within a defined geographic area through comprehensive strategies including clinical services, behavioral health services, social services and community supports, and community-wide efforts to improve community conditions that influence health" (2016; 3). Like the Collaborative, the AHC integrates clinical and public health tools to improve population health, focusing on specific needs in the context of community inequities and disadvantages that often lead to poor health.

For more information, see:

- CMS: https://innovation.cms.gov/initiatives/ahcm
- The Prevention Institute: http://www.preventioninstitute.org/component/jlibrary/article/id-375/127.html

Robert Wood Johnson Foundation, Roadmaps to Health

This framework provides a roadmap for the "how" of bringing together players from all sectors to create community-wide changes to improve population health. *Roadmaps to Health* is a project of the Robert Wood Johnson Foundation's County Health Rankings, which links data and actions to improve population health through community transformation. *Roadmaps* provides guidance about who needs to be at the table, what roles they can play, and specific action steps to address key community issues.

This framework can provide the "how" in building effective and accountable health-care coalitions. Coaching is also available.

For more information, see:

- http://www.countyhealthrankings.org/roadmaps/action-center

Health in All Policies
Recognizing the impact of social, economic, environmental, and other factors on health requires that all policies be screened for their impact on the health of a community. From zoning ordinances to roadways to trash pickup to investing in recreation centers to economic development to education, policies that affect our daily lives affect our health. The Health in All Policies approach acknowledges that health is a primary task of all local government divisions, not only that of health and human services departments. It uses a Health Impact Assessment (HIA) to determine the impact of new or existing policies on population health, often helping to pave the way for different approaches to building healthy communities.

For more information, see:

- The Public Health Institute. *Health in All Policies: A Guide for State and Local Governments*. http://www.phi.org/resources/?resource=hiapguide
- APHA. Health in All Policies. https://www.apha.org/topics-and-issues/healthy-communities/health-in-all-policies
- Change Lab Solutions. (2015). *From Start to Finish: How to Permanently Improved Government through Health in All Policies.* http://www.changelabsolutions.org/publications/HiAP_Start-to-Finish

Critical Issues

Societal Determinants of Health in Doña Ana County

> *"The role of our health care team is expanding beyond the walls of a health center, integrating more and more with the needs of a community. We're looking at things like food insecurity or housing as part of the formula to move people into optimum wellness. It's an exciting time to think about the data we have, because of our investment in electronic health records. We're also in constant communication with our patients because we've created an app. Many of our patients live in disenfranchised communities. They're poor. But they have the same electronic health record that you have at some of the most affluent health systems. As we continue to invest, we become a partner with them to engage in their health care needs."*
>
> Donna Thompson, CEO
> Access Community Health Network

Over the past three decades, health researchers have increasingly recognized the impact of social, economic, and physical factors on health status (Carey & Friel, 2015; Embrett & Randall, 2014; Sabo et al., 2013). The *Secretary's Advisory Committee on National Health Promotion and Disease Prevention Objectives for 2020* expanded previous thinking about *social* determinants of health to encompass *societal* determinants of health, which they define as "conditions in the social, physical, and economic environment in which people are born, live, work, and age" (2010). Societal determinants of health encompass all dimensions of a community. According to the Committee: "They consist of policies, programs, and institutions and other aspects of the social structure, including the government and private sectors, as well as community factors" (2010).

It is beyond the scope of this report to provide a full assessment of societal determinants of health in Doña Ana County – that, indeed, will be an ongoing program of the Collaborative. The Collaborative is being built upon the premise that effective health care incorporates societal factors and bridges the gap between the interaction of a patient and provider in a clinic and the overall context of the patient's life. Thus, the following discussion provides a brief overview of social, economic, geographic, political, and physical characteristics prevalent in the county.

Dona Ana County residents live in the midst of myriad positive and negative influences on health. The county boasts rich social and cultural heritage, partly as a result of its location in the U.S.-Mexico border (defined by the 1983 La Paz agreement as the area 100 kilometers to the north and south of the political borderline). The county shares borders with El Paso County, Texas, the state of Chihuahua, Mexico, and Luna, Sierra, and Otero counties in New Mexico. Its 3,804 square miles of varied topography include the towering Organ mountain range and the valleys below; the stark Chihuahuan desert landscape; and the Rio Grande River.

About half of the county's population of nearly 220,000 lives in the county seat of Las Cruces, the second largest city in New Mexico. This "City of the Crosses" has long been known to travelers as a place of sanctuary, innovation, and opportunity. Yet Doña Ana County residents face many challenges to achieving optimal health and wellness. The county's population is growing rapidly, at about four to six percent per year, with growth occurring mostly in Las Cruces and the less economically stable southern part of the county.

Nearly seven out of ten residents (66.8%) identify as Hispanic, and more than half (51%) speak a language other than English at home (generally Spanish). Nearly one out of five county residents is foreign-born, most in Mexico. The number of undocumented residents is unknown but significant.

The high proportion of Hispanics in the population is important because policies, environment, and other societal determinants often lead to poorer health outcomes for Hispanic-Americans. For instance, according to Kaiser Health News (2015), the national rate of uninsured U.S. children fell from 7.1% to 6.0% in 2014. For Hispanic children, that drop was less than two percentage points, from 11.5% to 9.7%. This economic disparity leads to disparities in health-care access, which often leads to long-term health disparities. For example, the prevalence of diabetes in Mexican-Americans is about 10 per 100, compared to a prevalence of about 6 per 100 among all whites. Conversely, however, increased social connectedness in the Mexican-American community is thought to be a protective factor, lead to outcomes such as lower infant mortality and fewer low birth-weight neonates (Brown, Chireau, Jallah, & Howard, 2007; Hummer et al, 2007) and cardiovascular disease.

Poverty, likewise, has a profound negative impact on health status (Woolf, 2007) and is thought to be a critical negative influence on health in Doña Ana County. Census Bureau data ("QuickFacts," n.d.) show that compared to state and national averages, Doña Ana County is a low-income region. The 2014 median per capita income of $20,058 is substantially lower than the state median of $23,948 and the US average of $28,555; likewise, the median household income of $38,246 fell far short of the state median of $44,968, which is itself more than 15% lower than the US average of $53,482. Fully 27% of residents have incomes less than the federally established poverty standard, significantly more than the state average of 20.4% and the U.S. average of 14.8%. Nearly four out of ten children (38%) live in households with income below the poverty line (Kids Count New Mexico, 2012); half of children live in households where no parent has full-time, year-round employment. More than half of all families in Doña Ana County face high housing costs.

In its emerging framework for linking clinical care and social needs, the Centers for Medicaid and Medicare Services (CMS) has defined five common unmet needs that affect health: food insecurity; housing instability; interpersonal violence; transportation, and utilities. From this perspective, Doña Ana County residents are at high risk of poor health. People living in rural areas of the county often have limited geographic access to fresh foods, and when those foods are available, they may not be affordable. Housing options are often substandard and costly, affecting low-to-moderate income families as well as significant migrant farmworker and homeless populations. Rates of interpersonal violence are high, with the county domestic violence rate of 14.5 per 1,000 being the third highest in the state; the homicide rate of 4.1 per 100,000 is lower than state or national averages. Public transportation, while available in the City of Las Cruces, is less available in rural areas; many families have only one car of dubious reliability, which may be unavailable while the primary breadwinner is at work.

Health-Care Systems in Doña Ana County

The county's health-care resources include two hospitals, three federally qualified health centers, one behavioral health hospital, a hospice facility, private primary care and specialty care providers, oral health providers, ambulance services, and ancillary services including physical and occupational therapy, imaging, and more. New Mexico State University (NMSU) and the newly launched Burrell College of Osteopathic Medicine provide a wealth health-care professionals, researchers, and educators, including nursing professionals, speech therapists, public health researchers, community health educators, medical anthropologists, sociologists, and others. The Southwest Family Medicine Residency Program trains emerging primary care physicians and other health professionals.

Despite the wide array of well-developed health-care organizations in the county, large gaps in services remain. Parts of Doña Ana County are classified as health professional shortage areas, especially in the areas of behavioral and oral health. Health-care providers who work in this environment must contend with limited resources and unlimited need, disconnected systems of care, cultural and linguistic barriers, and many more challenges. Acute care, primary care, behavioral health, mental health, oral health, ancillary, and social services are generally provided in silos, with little integration. As a result, services are often duplicated, which drives up cost and limits quality and effectiveness of care.

Creating the Future

While its early efforts have been resoundingly successful, the Collaborative is ready to create a sustainable plan and infrastructure to support its work. To that end, health systems researcher Renee Despres, PhD, MPH was contracted to review models of similar organizations across the nation (see Appendix A) and to develop this action plan. Participants reviewed the models in the resulting report and identified core characteristics of each model that they would like to replicate:

1. *Collaboration*: The core purpose of the Collaborative, as reflected in the working name of the group, is collaboration. Members expressed a firm belief that gathering and talking with each other is a key strategy for aligning health resources in the county.
2. *Health-care system transformation*. The group expressed its core commitment to improving health-care delivery models and integrating health care with community services and infrastructure through collaboration, aligning payment models with evidence-based care, evaluation, and program design. Specific methods included:
    a. Use of screening tools to include assessment of unmet social needs
    b. Team-based care
    c. Integrated behavioral health and primary care
    d. Interagency collaboration
    e. Consumer directed/centered care
    f. Alignment of payment models with evidence base to deliver high-value care
    g. Health-care workforce reorientation: Collaborative members recognize that health-care professionals – including physicians, nurses, allied health professionals, and administrative and managerial staff – need training and support to navigate the changing health-care landscape
    h. Culture of commitment to improving health, including knowledge and advocacy from:
        i. Providers and other health professionals
        ii. Health-care administrators
        iii. Public health
        iv. Payers
        v. Philanthropists
        vi. Consumers (individuals and families)
        vii. Policymakers (Health in all Policies)
3. *Data-driven and evidence-based decision-making*. Collaborative members recognize that decisions and interventions need to be based on robust data collection and evidence, which affect policies. The Allegheny program was mentioned repeatedly as a model that could be adapted to Doña Ana County, especially its four-phase approach of evidence, collaboration, community participation, and research.
4. *"Upstream" prevention to addresses societal determinants of health (SDOH)*. Members emphasized the need to recognize and address upstream factors that affect health. While the concept of SDOH has become commonplace in public health parlance, clinical processes and payment models have not traditionally addressed SDOH, seeing these determinants as too complex or irrelevant. However, Collaborative members recognize that health is contextual.

Based on these core characteristics, an outline of a community-centered health system has emerged – one in which patient-centered care occurs not only in the primary care health home, with teams of

health professionals meeting patients' needs, but across clinical settings, social services agencies, communities, and homes. In this system:

- The patient is at the center of all clinical care and social services, and treatment occurs in the context of family and community. A physician might be able to write a prescription for fresh fruits and vegetables that could be used to pay for those fruits and vegetables at a local farmer's market. An alert provider might notice that a child with asthma lives near a freeway overpass and contact environmental health professionals.
- Payment models are aligned with high-value, safe care that supports clinicians in addressing unmet social and community needs.
- Evidence-based best practices are used to build a robust system of primary, behavioral, oral, health care that blends seamlessly with upstream prevention and community action.
- Silos between health-care providers working in primary care, oral health, behavioral health, and specialty care are broken down; physicians, nurses, allied health professionals, community health workers, social workers, and others provide integrated, team-based care; health-care providers, educators, city planners, policymakers, and others work together to create healthy communities.
- Communities throughout Doña Ana County are actively invested and involved in identifying and prioritizing their own needs.
- Policymakers are educated and consider the health impact of every policy they implement, from building roads with safe passage for pedestrians and bicyclists to zoning to
- Data are collected, analyzed, and used to improve care, patient flow through the system, collaboration, and community investments.

Strategic Goals[1]

Through research, retreat, and discussion, Collaborative members agreed on the following strategic goals for the next three years[2]. By 2019, the Collaborative will have in place:

- ***An established and operational Doña Ana County Board of Wellness***
  - The Collaborative will establish an independent, well-recognized, and sustainable organization to carry out its mission.
- ***A new generation of health and health-care professionals.***
  - Doña Ana County will become recognized as an innovator and leader in inter-professional education for all health-related professions.
  - Dona Ana County health-care professionals will use new language and behavior around health policy, teaching, and practice that focuses on prevention and wellness
- ***Systems for community-wide approaches to healthcare, particularly relating to health literacy, behavioral health and diabetes.***
  - The Collaborative will lead in establishing coordinated systems of care that involve all sectors of the community.

Strategic Goal 1: Create a sustainable infrastructure for the work of the Doña Ana Board of Wellness.

Vision:

The Board is established as an independent, well-recognized, and sustainable organization.

Rationale

The Board has identified an ambitious mission, vision, and program goals. Yet all participants are volunteering time, money, and other resources to continue their work, causing strain and limiting the amount of resources both individuals and organizations can invest. To achieve its goals, the Board needs a dedicated staff, governance structure, sustainable funding, and mechanisms to coordinate its work.

Resources

Board Source
https://boardsource.org

The Foundation Center.
http://foundationcenter.org/

Internal Revenue Service. "Tax Information for Charitable Organizations." https://www.irs.gov/Charities-&-Non-Profits/Charitable-Organizations/

NOLO. "How to Form a Nonprofit Corporation: A 50-State Guide."

[1] Objectives and action planning worksheets for all goals are available in Appendix C
[2] On December 17, 2015, the Board held a full-day planning retreat facilitated by Tim Karpoff. Appendix A contains Mr. Karpoff's full summary report.

http://www.nolo.com/legal-encyclopedia/form-nonprofit-501c3-corporation-30228.html

Strategic Goal 2: Train and support a new generation of health and health-care professionals

Vision

Doña Ana County will become recognized as an innovator and leader in inter-professional education for all health professions, including allied health.

Rationale

The emerging health-care landscape requires new skills and knowledge of health-care professionals. While they train in silos, they must work in teams. Where they once were concerned only with prescribing a medicine – and determining whether the patient was "compliant" with their "orders," health-care professionals now must ask *why* the patient is not able to follow a healing regimen. Health-care professionals are being called upon to think outside the boundaries of the clinic, bridging clinical care and public health approaches to provide community centered care. These are not innate skills and knowledge but must be taught and practiced.

Resources

American Medical Association. "Accelerating Change in Medical Education."
http://www.ama-assn.org/ama/pub/about-ama/strategic-focus/accelerating-change-in-medical-education/innovations.page

Association of American Medical Colleges. "Medical Education."
https://www.aamc.org/initiatives/meded/

Community Paramedic
http://communityparamedic.org

Community Paramedicine Inc.
http://communityparamedicineinc.com/

Harvard Medical Education Program
http://hms.harvard.edu/masters_medical_education

National Council of State Boards of Nursing
https://www.ncsbn.org/669.htm

Strategic Goal 3: Bring providers, payers, researchers, and community organizations to develop community-wide approaches to health care.

Subgoals

- 3.1: Improve health and health insurance literacy of residents, providers, and organizations.
- 3.2: Develop a comprehensive, coordinated, community-based system that supports behavioral and mental health upstream and downstream.

- 3.3: Develop a comprehensive, coordinated, community-based system of diabetes prevention and management.

Vision

The Board leads in establishing coordinated and accountable health systems that integrate clinical care, social services, and community-level drivers of health. Priority areas are ***health literacy, behavioral health, and diabetes.***

Rationale

These activities are the core programmatic areas driving the overall mission and vision of the Collaborative. Health literacy, behavioral health, and diabetes were chosen as priorities areas of immediate critical need, based on data from primary care, EMS, hospital discharge, and Molina.

Resources

General

Centers for Disease Control and Prevention. Chronic Disease Prevention and Health Promotion. http://www.cdc.gov/chronicdisease/resources/guidelines.htm

Public Health Institute. *Best Practices for Community Health Needs Assessment and Implementation Strategy Development: A Review of Scientific Methods, Current Practice, and Future Potential.*

http://www.phi.org/uploads/application/files/dz9vh55o3bb2x56lcrzyel83fwfu3mvu24oqqvn5z6qaeiw2u4.pdf

Behavioral Health

Medicaid Health Plans of America, Center for Best Practices. "Best Practices Compendium for Serious Mental Illness."
http://www.mhpa.org/_upload/SMICompendiumFINALweb_744522.pdf

Rural Health Information Hub. *Rural Mental Health and Substance Abuse Toolkit.*
https://www.ruralhealthinfo.org/community-health/mental-health

Substance Abuse and Mental Health Services Administration (SAMHSA).

- "Behavioral Health in Primary Care." http://www.integration.samhsa.gov/integrated-care-models/behavioral-health-in-primary-care
- "Finding Evidence-Based Programs and Practices." http://www.samhsa.gov/capt/tools-learning-resources/finding-evidence-based-programs

Health Literacy

Centers for Disease Control and Prevention. "Health Literacy."
http://www.cdc.gov/healthliteracy/index.html

National Network of Libraries of Medicine. "Health Literacy."

http://nnlm.gov/outreach/consumer/hlthlit.html

Institute of Medicine. *Health Literacy: A Prescription to End Confusion.*
http://www.nap.edu/catalog/10883/health-literacy-a-prescription-to-end-confusion

Health Resources and Services Administration. "Health Literacy."
http://www.hrsa.gov/publichealth/healthliteracy/

Diabetes

American Diabetes Association. Standards of Medical Care in Diabetes.
http://professional.diabetes.org/content/clinical-practice-recommendations

National Institute of Diabetes and Digestive and Kidney Diseases (NIDDK)
http://www.niddk.nih.gov/Pages/default.aspx

Rural Health Information Hub. "Obesity and Weight Control."
https://www.ruralhealthinfo.org/topics/obesity-and-weight-control

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Appendices

Appendix A: Doña Ana Board of Wellness: Evolution and Accomplishments

Coming Together for Health: The Dona Ana County Health Collaborative

John Andazola, MD

MMC Family Medicine Center

Southern New Mexico Family Medicine Residency Program Established in 1996

Introduction

It is well known that the US spends more than any other country on healthcare, and that US health outcomes rank near the bottom of industrialized nations. This contradiction has fostered a movement toward medical system reform through federal legislation (The PPACA), examination of medical education structure (Beyond Flexner and ACGME reform), and emphasis on quality rather than quantity of care (The Triple Aim). Specifically, health professionals increasingly recognize that medicine should move "upstream" to concentrate on social determinants of health such as poverty, neighborhood safety, and racism. However, the healthcare industry generally lacks the skillset to address the social determinants. The healthcare industry must collaborate with community partners who have the required skillsets to address these needs. In addition, organizations that have traditionally worked within silos need to partner to be more effective. To this end, communities are creating collaboratives to decrease waste and redundancy, and to synergize activities to improve community health by moving "upstream".

History

In 2012 the Centers for Medicare and Medicaid Serves (CMS) released $1 billion in awards to applicants across the country to test new payment and service delivery models that will deliver better care and lower costs.

This grant application brought the initial members of the Dona Ana County Health Collaborative (DACHC) together to apply for the funding. They were not awarded the grant, but the convening of the initial community organizations led to the formation of the collaborative.

The members of the collaborative all had a shared purpose: to improve the health of Dona Ana County.

The Mission of the DACHC is to improve the health of Dona Ana County by creating a central collaborative where major stakeholders in the healthcare community innovatively work together to decrease waste and redundancy and synergize activities based on data obtained and disseminated to academic and community outlets.

The Dona Ana County Health Collaborative is a community-centered model for healthcare delivery that integrates social, behavioral, and physical approaches to care. We are an ongoing collaborative interested in health policy and implementation in Dona Ana County. Our vision is to make Dona Ana County the Healthiest county in the United States!

Current Members

NM State University

LCDF

Dona Ana County New Mexico

Molina Healthcare

Memorial Medical Center

New Mexico Department of Health

Mesilla Valley Hospital

- Southern New Mexico Family Medicine Residency (SNMFMRP)
- Memorial Medical Center
- La Clinica de Familia (LCDF)
- New Mexico State University
  - College of Education
  - College of Health and Social Services
  - College of Arts and Sciences
- Dona Ana County Department of Health and Social Services
- New Mexico Department of Health
- Mesilla Valley Hospital
- American Medical Response
- Molina Healthcare
- Others

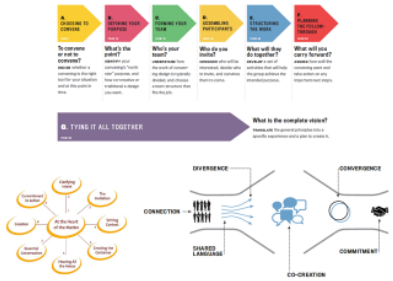
Results/ Accomplishments

- Diabetes Care Initiative with LCDF, NMSU and Molina Healthcare
- Development of Alternative Payment Model with LCDF and Molina Healthcare
- Nuestra Vida—A National recognized community based diabetes intervention. Partnership between Dona Ana County Department of Health and Social Services, Memorial Medical Center, and SNMFMRP
- Development of Pharmacy Clinic at SNMFMRP
- Partnership with Molina Healthcare and SNMFMRP to develop payment process for clinical pharmacists
- Selection of DACHC by NMDOH as Dona Ana Health Alliance
- Partnership with the Domenici Institute to host a regional summit to better serve incarcerated people with mental illness.
- Development of a Health in All Policies Regional Symposium
- Expanding of inter-professional training in Southern New Mexico
- Community wide approach to mental health urgencies

Discussion

DACHC is a coalition of diverse stakeholders who work together to develop innovative, community-centered, systems models of healthcare and wellness. Since its inception in 2012, DACHC has brought together providers, payers, researchers, policymakers, and others to share their expertise and vision. The DACHC has used a powerful tool – convening – to affect change. By connecting people and organizations, DACHC has facilitated the sharing of information, resources, and ideas; aligned healthcare providers and payers; and creation of dynamic systems that respond to community needs. In today's healthcare landscape communities must utilize the power of convening to bring together key players to develop strategic partnerships to improve the heath of their communities.

Steps to successful convening:



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printed by MegaPrint Inc. www.postersession.com

Appendix B: Summary of Strategic Planning Session

Doña Ana County Collaborative Strategic Planning Meeting
Memorial Medical Center • December 17, 2015 • 10:00 a.m. – 4:30 p.m.

Summary of Agreements

Twenty members of the Doña Ana County Collaborative, a broad-based group of health and social service providers, met for a one-day planning retreat on December 17, 2015. The Collaborative has been working together for over a year, and has already realized several accomplishments, including a pilot program for redesigning care for patients with diabetes, an integrated approach to behavioral health services and an inter-professional education program. An overview of the purpose and aims of the Collaborative is below:

Doña Ana County Collaborative Vision Statement
Improve the health of Doña Ana County by creating a central collaborative where major stakeholders in the health care community innovatively work together to decrease waste and redundancy and synergize activities based on data obtained and disseminated to academic and community outlets.

Doña Ana County Collaborative Mission Statement
The collaborative is an innovative community-centered model for health care delivery that integrates social, behavioral and physical approaches to care.

Program Background
The Doña Ana County Collaborative aims to create an innovative community-centered model for healthcare delivery that integrates social, behavioral and physical approaches to care. New Mexico State University (NMSU) in collaboration with the Southern New Mexico Family Medicine Residency Program and La Clinica de Familia, a federally qualified health center (FQHC) are working together to innovate integrative care models for healthcare. Currently the healthcare system is fragmented. In Doña Ana, La Clinica de Familia, the Family Medicine Residency Program at Memorial Medical Center, the Counseling and Education Psychology Department, and the Department of Social Work and Public Health at New Mexico State University are interested in redesigning care to improve the health of populations in the community. All of these entities are well developed and provide various services; however, true integration of these services exists only in a limited fashion. As a result, services are often duplicated or not shared between these silos, which drives up cost and lessens the potential positive impacts on health outcomes. An integrated institute including strong participation by all of the participating organizations can research, design, provide, and share truly innovative and integrated approaches to health care delivery.

Program Summary
The Collaborative will pursue a comprehensive and integrated approach toward delivering health care in Doña Ana County. This integration is intended to create a seamless system of care that offers patients the services they need, when they need them, whatever setting they are in. The integration of the services from the Department of Counseling and Education Psychology in the College of Education, La Clinica de Familia, the Family Medicine residency program at Memorial Medical Center, and the Departments of Nursing, Social Work, and Public Health in the College of Health and Social Services at NMSU among others would allow for the most effective and efficient overall care of patients. This collaborative

approach will result in improved quality and reduced costs. Integrative care models will allow for behavioral and public health strategies to be employed within the medical management of patients.

–This overview was provided by Maya Stefanovic of Molina Healthcare.

Following its initial success, the Collaborative determined to move to a next stage of development by designing a set of longer-term goals to guide its actions and evaluate its impact. To assist with retreat design and management, the Doña County County secured the services of a facilitator from Albuquerque, Tim Karpoff.

The objectives of the retreat were to:

- Establish a set of three-year goals for the Collaborative
- Design an action plan for 2016 to move toward the goals, and
- Reinforce a sense of alignment and energy to realize the mission of the Collaborative.

The agenda consisted of linked series of three main topics: First, participants analyzed the Collaborative's current environment, using a Force Field Analysis framework. Second, the group developed a three-year "Practical Vision" of accomplishments (or goals), using a Consensus Workshop format. Third, the group designed a one-year action plan for each of the goals, identifying one or more objectives for the year, quarterly milestones, and responsible parties.

The Collaborative designed a concise but ambitious set of three-year goals. By 2019, the Collaborative will have in place:

- ***An established and operational Doña Ana County Board of Wellness—***Several items are included under this heading, including the establishment of an independent, well-recognized and sustainable organization, and the adoption of new language and behavior around health policy, teaching and practice—toward prevention and wellness.
- ***A New Generation of Health Providers, Researchers and Emergency Service Providers—*** Doña Ana County will become recognized as an innovator and leader in inter-professional education for all health-related professions.
- ***Systems for Community-Wide Approaches to Healthcare, particularly relating to health literacy, behavioral health and diabetes—***The Collaborative will lead in establishing coordinated systems of care that involve all County agencies.

The following pages present notes from the following discussions:

- *Force Field Analysis*—A table of comments from the discussion, on page 3;
- *2019 Practical Vision*—A matrix of the three three-year goals and the ideas that contributed to their development, on page 4; and
- *2016 Implementation Calendar*—A matrix of objectives, milestones and responsible parties for each of the three goals, on page 5.

Doña Ana County Collaborative Strategic Planning • December 17, 2015

Force Field Analysis of the Collaborative's Current Situation

What forces are driving us?	***What are key considerations for our planning?***	***What forces are constraining us?***
• We are operating in an environment of competing definitions of the "health" and "quality" of healthcare. How do you measure quality, e.g., in PCMHs, etc.? • We *act* as a collaborative, with strongly shared values. • Prevention is becoming more recognized as a way to address health disparities. Along with that, patient and public education is, more and more, a way to address disparities. • There are organizational pressures to produce measurable results. • Economic forces around healthcare: a) the Institute of Medicine study on medical errors; b) the USA is 37th in the world in health outcomes, but 1st in cost; c) 17% of USA GDP is the health sector; d) the differential between private and Medicare reimbursement. Major players are, therefore, changing focus toward prevention and integrated care. • Doña Ana County is an innovator in integrative care approaches—there is a desire to innovate across the county. • We have an innovative—but inconsistently applied—model of integrative care. • There is a shake-up in behavioral health coming in the county. • The local environment if full of innovators in community-based approaches to effective healthcare. We have many partners and potential partners—and a share mental model and values. • Health disparities are so evident in the county….	➢ Focus on social services as a healthcare vehicle. ➢ What are the 3-4 messages that can change lifestyle behavior in the county? ➢ Capital expenditures that make healthy behavior the default should be strongly advocated—change the built environment to that defaults are toward health. ➢ Work across disciplines in every initiative, e.g., mental health and diabetes. ➢ Need to bring the community together to create a pervasive environment toward changing behavior. ➢ Focus on youth now—focus on developing life-long healthy behavior in young people. ➢ Look at (and advocate for) frameworks such as: --Health in All Policies --RWJ County Health Rankings ➢ We need a multi-layered approach, with stronger partnerships. ➢ Adaptability is important! Several concurrent initiatives can be supported.	• Incentives/demands to subordinate health outcomes to "measuring what's easy." • Different/conflicting measures and perceptions of health. • Different accrediting requirements, and different sets of regulations, create tensions; we sometimes chase indicators. • Our laws have not kept up with regulatory pressures we all face. • Present funding practices reinforce silos of healthcare delivery and research. • The public/wider population is burned out on a "bait-and-switch" experience of healthcare. • Power over funding is largely at the state and federal levels. • There is an existing culture of fear, particularly in the public, and among practitioners—fear of change. • The fee-for-service model has created a "Berlin Wall" in healthcare delivery and reimbursement.

Doña Ana County Collaborative Strategic Plan • 2019 Goals ***What will we have in place by 2019?***	
Three-Year Goal	***Contributing Ideas re: Accomplishments***
A Doña Ana County Board of Wellness—Established and Operational	• An organizational structure with health policy, marketing, advocacy and research teams • An organization with paid staff • A financially sustainable organization • Effective lobbying for payment reform and policy change at all levels • A countywide board of health • The Collaborative has become an advisory body • The Collaborative has become a think tank • School-Based Health Centers in all schools in the county • A logo and a website • A 501(c)(3) organization
A New Generation of Health Providers, Researchers and Emergency Service Providers	• An off-campus center for academic community partners • NMSU is integrated into the community • The Collaborative is a facilitator for inter-professional training • Doña Ana County is the most desirable place for healthcare providers to work • The Collaborative is addressing the issue of a lack of providers for underserved areas of healthcare
Systems for Community-Wide Approaches to Healthcare, e.g., ***--Health Literacy,*** ***--Behavioral Health,*** ***--Diabetes***	*Overall:* • Agreements for measuring community health • Three key performance indicators established • Action networks—tobacco, alcohol • Community-wide approaches to behavioral health and other health issues • Ongoing payment strategies with <u>all</u> players *Re: Health Literacy* • Defined marketing objectives and methods for community engagement • Effective responses to community needs include health literacy *Re: Behavioral Health* • Community paramedics programs to decrease inappropriate use of the ER • Community support services to help behavioral health clients remain in the community • Integration of hospital in-patient discharge back into care • EMS responses integrated with behavioral health services *Re: Diabetes* • Increase in diabetes prevention • Decrease in uncontrolled diabetes • Increased physical activity in the community • An Accountable Care Organization • A defined balance of focus between “clinical” and “prevention”

Doña Ana County Collaborative 2016-19 Strategic Planning

2016 Implementation Calendar: *"What will we do this year to move toward our goals?"*

2019 Goal	*Collaborative Leads*	*By March 31*	*By July 31*	*By September 30*	*By December 31*	*2016 Victories!*
Doña Ana County Board of Wellness Established and Operational	• *Joaquin* • *John K.* • *Dawn* • *Jamie* • *John A.* • *Dale* • *Joe* • *Daubney* • *Randee*	• Establish a logo *(Joaquin, John K., Dawn)* • Develop a Team Charter *(Jamie, Dawn)* • Develop narrative and materials • Update By-Laws *(John A., Dale)*	• Present to the NMPHA • Develop a community outreach plan • Conduct a mid-year evaluation/survey of progress-to-date	• Develop a Speaker's Bureau for community presentations	• Convene a *"Health in All Policies"* Symposium *(Joe, Daubney, Randee, John K.)*	• **The Collaborative is well-recognized by providers, policy makers and the public as the DAC "wellness experts"**
A New Generation of Health Providers, Researchers and Emergency Service Providers	• *Daubney* • *Mary Alice*	• Review present plans for all Collaborative members (update of current status); involve FQHCs, NMSU colleges/departments, e.g., Pharmacy, Nursing, etc.	• Develop expanded inter-professional experience—from immersion to longitudinal			• **A longitudinal, integrated, inter-professional experience for all professions** • **Center for Inter-professional Training is on all members' legislative priority lists**
Systems for Community-Wide Approaches to Healthcare	*Health Literacy* • *To be determined*					• **[See Board of Wellness above]**
	Behavioral Health • *Joaquin* • *Jamie* • *Nancy* • *Olga* • *Joe*	• Map the behavioral health system • Conduct an epidemiological study of ER patients and inmates at the Detention Center	• Crisis Triage Center established/in operation	• Develop an outreach plan for the CTC	• Develop protocols for the emergency response system	• **A comprehensive Emergency/Crisis Response System for Behavioral Health** • **Documentation of the system for replication**

	Diabetes • *Jamie* • *Daubney* • *Joe* • *John K.*	• Bring Nuestra Vida, La Clinica, AMR and NMSU together for a common initiative • Assess networking and partnership opportunities	• Develop networking goals and outreach strategies	•	•	•

Appendix B: Action Planning Worksheets

Strategic Goal 1: Create a sustainable infrastructure for the work of the Doña Ana Board of Wellness.

Objective 1a: Develop appropriate organizational structure to carry out the Collaborative mission.

Action	*Tasks*	*Short-Term Outcome(s)*	*Long-Term Outcomes*	*Data Evaluation and Measurements*	*Responsible Person/Area*
Finalize mission, vision, values statement.	•				
Investigate partnerships with existing organizations	• *Develop list of potential partner organizations* •				
Create 501(c)(3) organization.	• *Identify legal counsel to assist* • *Identify three incorporators* • *Develop and submit articles of incorporation* • *Revise and approve bylaws* • *Develop board member job descriptions* • *Recruit board members* • *Submit tax-exemption application to IRS*				

Objective 1b: Secure both start-up and sustainable funding.

Action	*Tasks*	*Short-Term Outcome(s)*	*Long-Term Outcomes*	*Data Evaluation and Measurements*	*Responsible Person/Area*
Develop budget	• *Estimate costs for all action items in plan* • *Estimate overhead and other cost* •				
Create a resource development plan	• *Develop grants calendar* • *Identify and apply for at least two funding opportunities* • *Hold at least one fund-raising event*				
Identify organization to serve as temporary fiscal agent	• *Develop list of potential partner organizations*				
Develop income-generating activities	• *Consider consulting or other strategies* •				
Develop at least three agreements between partners for sustainable funding	•				

Objective 1c: Employ, contract, or share adequate staff to carry out the Institute's mission.

Action	*Tasks*	*Short-Term Outcome(s)*	*Long-Term Outcomes*	*Data Evaluation and Measurements*	*Responsible Person/Area*
Develop a staffing plan based on strategic goals	• *Estimate staffing needs for all action items in plan* • *Create position descriptions* • • *Estimate overhead and other cost* •				
Recruit core staff	• *Hold at least one fund-raising event*	*Contracts in place with core staff*			
	•				
	•				
	•				

Objective 1d: Identify a physical and/or virtual location for the DAC Institute of Wellness

Action	*Tasks*	*Short-Term Outcome(s)*	*Long-Term Outcomes*	*Data Evaluation and Measurements*	*Responsible Person/Area*
	•				
	•				
	•				
	•				
	•				

Objective 1e: Develop and implement a marketing plan for the DAC Institute of Wellness.

Action	*Tasks*	*Short-Term Outcome(s)*	*Long-Term Outcomes*	*Data Evaluation and Measurements*	*Responsible Person/Area*
Create collateral materials	• *Develop a detailed message map* • *Estimate overhead and other cost*				
Create online presence	• *Develop website* • *Create social media accounts* • *Blog*				
Media outreach	• *Develop parameters for press releases and media advisories* • *Develop media list*				
	•				
	•				

Strategic Goal 2: Train and support a new generation of health and health-care professionals

Objective 2a: Develop and implement a longitudinal, integrated, interdisciplinary educational experience for all professions.

Action	*Tasks*	*Short-Term Outcome(s)*	*Long-Term Outcomes*	*Data Evaluation and Measurements*	*Responsible Person/Area*
Review present plans for all Collaborative members (update of current status); involve FQHCs, NMSU colleges/departments, e.g., Pharmacy, Nursing, etc.	•				Daubney Mary Alice Scott
Offer CMEs	•				
	•				

Objective 2b: Develop a sustainable ***Center for Interprofessional Training***

Action	*Tasks*	*Short-Term Outcome(s)*	*Long-Term Outcomes*	*Data Evaluation and Measurements*	*Responsible Person/Area*
	•				
	•				
	•				

Objective 2c: Facilitate the adoption of language and behavior that focuses on prevention and wellness in health policy, teaching, and clinical practice

Action	*Tasks*	*Short-Term Outcome(s)*	*Long-Term Outcomes*	*Data Evaluation and Measurements*	*Responsible Person/Area*
	•				
	•				

Strategic Goal 3: Bring providers, payers, researchers, and community organizations to develop community-wide approaches to health care.

Subgoal 3.1: Improve health literacy of residents, providers, and organizations.

Objective 3.1.1: Clear objective around community members and health literacy? Health insurance literacy?

Action	*Tasks*	*Short-Term Outcome(s)*	*Long-Term Outcomes*	*Data Evaluation and Measurements*	*Responsible Person/Area*
Residents	•				
Providers	•				
Organizations	•				

Objective 3.1.2: Objective around health-care providers and health literacy?

Action	*Tasks*	*Short-Term Outcome(s)*	*Long-Term Outcomes*	*Data Evaluation and Measurements*	*Responsible Person/Area*
	•				
	•				
	•				

Objective 3.1.3: Objective around [health-care] organizations and health literacy?

Action	*Tasks*	*Short-Term Outcome(s)*	*Long-Term Outcomes*	*Data Evaluation and Measurements*	*Responsible Person/Area*
	•				
	•				
	•				

Subgoal 3.2: ***Develop a comprehensive, coordinated, community-based system that supports behavioral and mental health upstream and downstream.***

Objective 3.2.1: *Develop an integrated, multi-agency process for mental health crisis response.*

Action	*Tasks*	*Short-Term Outcome(s)*	*Long-Term Outcomes*	*Data Evaluation and Measurements*	*Responsible Person/Area*
Conduct epidemiological study of ED patients and inmates at detention center	•				
Map the behavioral health system	•				
	•				

Objective 3.2.3: Is there a health-care professional or policymaker objective here?

Action	*Tasks*	*Short-Term Outcome(s)*	*Long-Term Outcomes*	*Data Evaluation and Measurements*	*Responsible Person/Area*
	•				
	•				
	•				

Subgoal 3.3: Develop a comprehensive, coordinated, community-based system of diabetes prevention and management.

Objective 3.3.1: Expand the reach of Nuestra Vida to all areas of the county by September 2016.

Action	*Tasks*	*Short-Term Outcome(s)*	*Long-Term Outcomes*	*Data Evaluation and Measurements*	*Responsible Person/Area*
Assess networking and partnership opportunities	• Expand to NMSU and AMR • Schools • Churches •				
	•				
	•				

Objective 3.3.2: Is there a community-centered or clinic-centered objective regarding diabetes? An integration of behavioral health (after all, food + body = emotional issue)?

Action	*Tasks*	*Short-Term Outcome(s)*	*Long-Term Outcomes*	*Data Evaluation and Measurements*	*Responsible Person/Area*
	•				
	•				
	•				

Objective 3.3.3: Is there a health-care professional or policymaker objective here?

Action	*Tasks*	*Short-Term Outcome(s)*	*Long-Term Outcomes*	*Data Evaluation and Measurements*	*Responsible Person/Area*
	•				
	•				
	•				