

2018 New Mexico Legislative Session
Senate Memorial 44
Task Force Report and Recommendations

EXECUTIVE SUMMARY

Senate Memorial 44 requested that the New Mexico Alliance of Health Councils convene a task force to “identify steps to strengthen the *structure, effectiveness and sustainability* of county and tribal health councils.” The Task Force includes health council members, representatives of the New Mexico Department of Health (NMDOH), the University of New Mexico Health Sciences Center, and other public and private entities that make up the state’s public health system. (Task Force members are listed in the Appendix to this report.)

History: The New Mexico Legislature created the health councils in 1991 through the County Maternal and Child Health Plan Act, amended in 2007 to include tribal communities. The health councils form the hub of a decentralized, community health planning system, providing a mechanism for local communities to assess local health needs, create comprehensive health plans, and coordinate the implementation of the community health plans. The State supported this system with a \$2.8 million annual budget that provided health councils with full-time or part-time staff to follow up on health council decisions and actions. State funding also supported a system to build health council skills and capacity, coordinate their activities, and evaluate outcomes. There are currently 39 health councils, in 33 counties and 6 tribal communities.

Accomplishments: Over their 27-year history, the health councils have identified local health priorities and led community interventions to address urgent problems, including access to health care, diabetes and obesity, alcohol and drug use disorders, infant mental health, suicide, environmental health, and many other areas. The health councils have benefited New Mexico communities by reducing gaps and duplications in programs and services, by providing effective health assessment and planning, and by serving as an effective means of communication and dissemination of information to and from communities throughout the state. The health councils have also been a wise investment, attracting \$4 in additional funding for every \$1 invested by the State (Community Health Consulting Group study, 2003).

Roles, functions, and outcomes: A 2006-2010 Health Council Evaluation conducted by the University of New Mexico and the NM Department of Health found that *health councils serve at the center of local public health systems*, accomplishing systemic outcomes resulting in improved health status.

Roles, functions, and outcomes: A 2006-2010 Health Council Evaluation conducted by the University of New Mexico and the NM Department of Health found that *health councils serve at the center of local public health systems*, accomplishing systemic outcomes resulting in improved health status in a the following functional areas:

1. Convening communities to improve health
2. Community health assessment
3. Community health planning
4. Coordination to enhance efficiency, identify gaps in services, and prevent duplication
5. Developing programs and services
6. Building and supporting issue-specific partnerships, networks, & coalitions
7. Leveraging financial resources
8. Policy development
9. Facilitating communication between local communities and State agencies

Task Force Recommendations

A. Structure: Health councils adopt organizational structures that reflect local needs, conditions, and resources.

1. **The enabling legislation needs to be changed to reflect the evolution of health councils from maternal and child health councils into into comprehensive, community health councils.**
2. **Counties and tribal communities should designate a single health council** for state recognition. Councils in rural or sparsely populated regions should be free to combine activities and resources with councils from other jurisdictions.
3. **Each health council is by definition representative of its community**, including citizens, health and social service providers, early childhood services, education, elected representatives, the business community, philanthropy, and faith communities.
4. **Additional tribal communities are encouraged to establish health councils**, and to adapt council structures appropriate to tribal needs and conditions.
5. **Each health council should maintain a formal relationship with its county or tribal governing body** through a memorandum of understanding or similar arrangement.
6. **Organizational structures:** Health councils may operate (a) As an independent, non-profit organization, (b) As an adjunct to a unit of local or tribal government; (c) Under a fiscal sponsorship arrangement with a nonprofit organization.

7. Each health council should be responsible for creating an officially sanctioned community health assessment and community health plan in coordination with the local governing body at regular intervals, as well as advising its county or tribal government on the potential impacts of policies on health and wellness.

B. Effectiveness: The health council system should provide for continuous quality improvement, outcome evaluation, health council training and technical assistance, and integration with local, regional, and statewide public health and health care systems.

1. County and tribal health councils will serve as community hubs, and will fulfill the roles and responsibilities identified by the 2006-2010 Health Council Evaluation (as outlined above).

2. **Evaluation and quality improvement:** An evaluation system should include clearly defined outcomes and ways to measure and achieve those outcomes. Councils should be guided by explicit benchmarks and standards of good practice, with mechanisms to ensure continuous quality improvement. Councils and State government should work together to gather outcome evaluation data.¹

3. **Building health council capacity:** All health councils need to be adequately staffed, with a paid coordinator (full-time or part-time), depending on the scope and complexity of its work and the population served. Health councils should be provided with regular training and technical assistance in community health improvement and organizational effectiveness, with capacity-building coordinated and/or provided by the NM Alliance of Health Councils, the NM Department of Health, and collaborating organizations and institutions.

4. **Partnerships.** Health councils by their very nature work with, and through, other entities. The councils were developed as an integrated health planning system, and they need to be managed as a system. They operate most effectively with structured, interdependent relationships with other key partners: cabinet agencies, university systems, New Mexico Public Health Association, NM Public Health Institute, NM Association of Counties, and others.

C. Sustainability: Health councils and the system as a whole must be provided with sufficient funding to accomplish the goals and outcomes stated in the Maternal & Child Health Plan Act and subsequent enabling legislation.

1. **State investment:** State General Funding should provide core funding to each health council for a paid coordinator to carry out the decisions and actions of the council. State funds should also be used to ensure continuous training and technical assistance to the health councils. The NM Department of Health should assist the health councils with overall coordination, outcome evaluation, travel, and fiscal accountability systems.

1 An on-line evaluation system has been developed and resides at the University of New Mexico Health Sciences Center, Master's in Public Health Program.

2. Local investment: Counties and tribal governments may be expected to provide financial, administrative, and in-kind support, such as office space and equipment, telephone, and other resources.

3. Additional resources: The health councils have demonstrated their ability to leverage other resources through grants and contracts from Federal, other state, private, and philanthropic sources.

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TASK FORCE REPORT AND RECOMMENDATIONS

I. Introduction and Background

Senate Memorial 44 requests that the New Mexico Alliance of Health Councils create and lead a task force to “identify steps to strengthen the structure, effectiveness and sustainability of county and tribal health councils.” The Task Force includes health council members, representatives of the New Mexico Department of Health, the University of New Mexico Health Sciences Center, statewide public health organizations and coalitions, and other statewide entities that are part of the state’s public health system.

This report provides background information and a set of proposed recommendations that address improvements in the *structure, effectiveness, and sustainability* of the health council system, as outlined in SM44.

History

New Mexico’s county and tribal health councils were created by the Legislature through the 1991 Maternal and Child Health Plan Act, in order to improve the health of New Mexico residents by creating a system of health councils to provide community-based health assessment, planning, coordination, and community action. New Mexico is one of a handful of states that has a centralized public health system, and as such does not have local county and tribal health boards that would otherwise be responsible for community health planning. The health councils were envisioned as a core, integrated component of New Mexico’s public health system; they were intended to identify and assess local health needs, develop recommended solutions to address those needs, and receive or facilitate funding to support recommended programs and services.

New Mexico’s health councils have served the state for over 27 years, beginning as Maternal and Child Health Planning Councils, and evolving in the early 2000’s into comprehensive health planning bodies. From 1991 through 2010, State funding administered through the NM Department of Health provided local staffing by health council coordinators, some support of direct services programs to address identified local needs, and support for a statewide infrastructure to build and sustain the capacity of the health councils. Major funding of the health councils was suspended in 2010, along with other post-recession budget cuts for health promotion and disease prevention. At the time of the suspension of funding, the health council system was supported with an annual State budget of \$2.8 million, administered through the NM Department of Health.

New Mexico currently has health councils in 33 counties and 6 tribal communities: Acoma, Tesuque, Santa Clara, San Ildefonso, and Cochiti Pueblos, and To'Hajilee/Cañoncito Band of Navajos. Currently recognized county and tribal health councils can elect to receive limited funding through the NM Department of Health (between \$4,000 and \$5,000 per year).

Benefits of the Health Council System

Over the years, New Mexico's health councils have provided substantive, documented benefits to their communities and to the state of New Mexico. They have proven themselves to be innovative, creative, and resilient, and able to accomplish a great deal with available resources.

(Note: This description of health council activities, accomplishments, and outcomes are based on data from the years 1991 – 2015, when the health council system was funded by State general funds -when each council had a paid coordinator, and the NMDOH and its contractors provided training, technical assistance, and outcome evaluation to enable the system to operate at full capacity.)

The health councils have served as a key component of New Mexico's statewide public health and health care system, connecting communities to State government, and often serving as “backbone” organizations in mobilizing community coalitions, public/private partnerships, and multi-agency projects. The health councils have enhanced the effectiveness of the NM Department of Health and other state agencies, through state-local communication, planning, education, health advocacy, and outreach. The councils play an important role in qualifying the NM Department of Health for national accreditation through the National Public Health Accreditation Board (PHAB).

The health councils have played a central role in creating local health systems that improve the health of New Mexicans. These health systems include planned and coordinated programs and services to meet locally identified needs, improving access to primary care, behavioral health, and supportive social services—all while seeking to maximize efficiencies and avoid duplication. Under health council leadership, communities have created parks, trail systems, and recreational facilities that improve health and fitness. Communities have become healthier through addressing environmental issues, such as traffic and pedestrian issues, air and water pollution, and cleanup efforts. Communities in so-called “food deserts” have developed public/private partnerships to create greater access to healthy food choices.

The health councils have leveraged major funding for communities throughout New Mexico—attracting, according to one study, four dollars for every dollar invested by the State. The councils have helped to stimulate positive economic development from increased health sector employment and savings resulting from a healthier workforce.

Role and functions of the health councils

A 2006-2010 University of New Mexico/NM Department of Health evaluation of the health councils identified a core set of functions and associated outcomes—i.e., changes in community health systems resulting in improved health status. The Health Council Evaluation involved participation of approximately 1,000 health council members and coordinators from throughout New Mexico, along with use of an internet-based data system located at UNM. *Health councils mobilize communities through a set of core functions and associated outcomes:*

- 1. Convening:** Health councils serve as the core hub of public health systems at the local level, creating a space and mechanism for communities to come together to address health-related issues, share information, propose programs, and implement solutions for community health improvement.
- 2. Assessment:** Conducting regular assessments of local health needs, resources, and priorities, using primary and secondary health and health-related data. These community health assessments are used extensively in program planning and bringing in additional resources to communities.
- 3. Health planning:** Creating and revising comprehensive community health plans, with extensive community participation. When fully funded, the health councils developed new health plans every 3 - 5 years—often in collaboration with local hospitals, community health centers, and other entities.
- 4. Coordination:** Monitoring and coordinating local health programs and services--identifying gaps, reducing duplication, and improving efficiency through interagency collaboration.
- 5. Program development:** Developing programs and services in collaboration with local partners to address identified needs and conditions.
- 6. Policy:** Developing and influencing policies at state, regional, and local levels that lead to public health improvement.
- 7. Network development:** Establishing and strengthening networks, partnerships and coalitions to address specific health issues and priorities, such as access to health care, diabetes, obesity, substance use disorders, mental health, fitness and nutrition, interpersonal violence, and addressing social determinants of health.
- 8. Attracting resources:** Health councils have helped communities to raise and leverage millions of dollars in public and private funding, bringing in as much as \$4 for every \$1 invested through State funding.
- 9. Communications and community involvement:** According to a 2018 legislative Fiscal Impact Report, the health councils “serve as a vital link between state agencies and local communities, improving understanding and communication, and serving as a two-way conduit for information, resources, programs, and services.”

Outcomes

The UNM/DOH multi-year evaluation found that health councils were able to accomplish *significant changes in local community health systems and in the capacity of communities to achieve health improvements*. Changes in community health systems—i.e., programs, services, practices or policies—are intermediate-term changes that, according to extensive national research studies, are likely to lead to improved health status outcomes. Community systems include not only those typically associated with the health care sector, but also assets like transportation, early childhood programs, care for the elderly, access to healthy food, economic development opportunities, and myriad policies that affect health directly, or that address the social and economic determinants of health.

Associated health status outcomes include reductions in such areas as alcohol and drug use disorders, teen births, suicide, cardiovascular disease, obesity, diabetes and others; and increases in immunization rates, healthy eating, exercise, senior safety, and others. These changes are often difficult to attribute to a single intervention; rather, they result from multifaceted, coordinated, and evidence-based community initiatives—the kind made possible through the efforts of health councils.

The 2006-2010 Health Council Evaluation documented intermediate outcomes that included changes in health systems and community capacity in health planning and assessment, program development, policy change, network development, and resource development. As community health hubs, the health councils have been able to mobilize community leaders, health care providers, decision-makers, and citizens representing broad community sectors. Improvements in population health result from coordinated, community-wide interventions, with contributions from multiple entities—the kind of interventions that health councils were designed to mobilize and lead.

This health council evaluation also demonstrated a strong relationship between State funding and levels of activities and accomplishments, showing clear and sometimes drastic reductions in accomplishments following the 2010 suspension of State funding of the health councils.

II. Task Force Recommendations

Overview

In reviewing New Mexico's health council system and its enabling legislation and regulations, it is clear that policy makers saw this as an *integrated system* that could incorporate community-based health assessment, planning, and community mobilization into an effective, statewide public health and health care system. Built into that system were elements and assumptions to ensure its success: adequate state and local funding; mechanisms to build capacity (through training, technical assistance, and administrative oversight) at the state and local levels; standards for quality assurance; and built-in evaluation and quality improvement mechanisms.

For these reasons, the SM44 Task Force has chosen to look at the system as a whole, and to identify ways in which the system can be improved. The following recommendations are organized according to the framework laid out in SM44: *Structure, Effectiveness, and Sustainability*. **The recommendations presuppose adequate funding of the system as a whole, with support coming from State, local, and private funding sources.**

SM44 Task Force Methodology

The Task Force has held monthly meetings, beginning on April 2, 2018, engaging in a series of activities:

- Identifying statewide and regional partners that should be involved or consulted as part of the process (See Appendix).
- Agreeing on a timetable for completing the Task Force’s mandate.
- Identifying and reviewing written materials from the past 27 years, including strategic plans, reports, training curricula, evaluation studies, and program summaries (see Appendix).
- Conducting a survey to determine the current status of health councils.
- Identifying strengths and areas for improvement in the health council system.
- Identifying issues with respect to structure, effectiveness, and sustainability, with respect to individual health councils and the statewide system as a whole.
- Writing and revising the Task Force findings and recommendations.

A. STRUCTURE

The central purpose of New Mexico’s health council system is to create a mechanism for community-based health planning that is fully integrated with the rest of the state’s public health system. The structure and composition of the health councils are key to a system that guarantees representation of county and tribal communities, that provides them with a strong voice in developing health policy, and that facilitates communication between state government and local jurisdictions.

1. Composition: The composition of health councils is spelled out in the 1991 Maternal and Child Health Plan Act (amended in 2007). The health councils are designed to reflect the geographic, demographic, social, and economic make-up of their communities, with key community sectors at the table. Sectors to be represented are outlined in the legislation, which also provides for local determination and control of health council membership, through approval of council membership by county commissions and tribal governments. The SM44 Task Force recommends continuing

local recognition and control—with flexible guidelines that accommodate the broad diversity of New Mexico’s rural, urban, and frontier communities. The Task Force recommends that each health council (one council for each county or tribal community) receive formal designation or approval as the health council representing that jurisdiction. Each health council should maintain a formal relationship with its local governing body through a memorandum of understanding or similar arrangement.

2. Geographic representation: The system provides for one officially recognized and designated health council for each county and tribal community. Each health council represents an entire county or tribal community, and not just a portion of a jurisdiction. The Task Force recommends that two or more health councils be allowed to join together to address common issues—perhaps creating a single health council to represent more than one jurisdiction—for example, in less densely populated, rural counties or pueblos with relatively limited resources.

3. Criteria for official designation or recognition. State legislation and regulations should provide clear criteria and guidelines for official designation/recognition by a county commission or a tribal governing body.

4. Relationship to local government: Each health council should have a clear and strong relationship to its county or tribal government, through official recognition and a formal memorandum of understanding that outlines the role of the health council in relation to other local planning bodies.

5. Administrative structure: Health councils may operate (a) as an independent, non-profit organization, (b) as an adjunct to a unit of local or tribal government; (c) under a contractual arrangement with a unit of local or tribal government, or (d) under contractual arrangement with a nonprofit organization or fiscal sponsor.

6. County and tribal health plans: Each health council will be responsible for developing a community health assessment and community health plan, to be approved by the county commission or tribal governing body. Adjacent jurisdictions may combine resources to create joint health assessments and plans.

7. Health policy: Each health council may be given responsibility for assessing the potential health impacts of proposed county and tribal laws and policies, including policies outside the traditional spheres of health and health care.

8. Tribal health councils: Tribal health councils may be better served by using structures and procedures that are different from those of county-based health councils, given the unique features and tenure of tribal government officials. Currently only a small percentage of New Mexico tribes have active health councils, although others have expressed interest in developing councils (including possible councils serving multiple pueblos or multiple chapters of the Navajo Nation).

B. EFFECTIVENESS

The effectiveness of the health council system is dependent on a number of factors:

1. Shared understanding of the role and functions of health councils
2. Clear expectations regarding outcomes and ways to measure them
3. Building and maintaining health council capacity
4. Effective partnerships with state, local, and tribal governments, and the private and non-profit sectors

1. Functions: In order for the system to work well, there needs to be a shared understanding of the role, functions, and expected outcomes of health councils. The functions (and associated outcomes) of health councils are:

- a. Convening:** Councils serve as a local hub for assessment, planning, information, and resources for community health improvement.
- b. Community health assessment:** Councils conduct assessments of local health needs, resources, and priorities, using primary and secondary health and health-related data along with community input and participation.
- c. Community health planning:** Health councils create and update comprehensive community health plans, using local and state data and incorporating extensive community participation.
- d. Coordination:** Health councils monitor health programs and services, identifying gaps, reducing duplication, and facilitating interagency collaboration.
- e. Program development:** Health councils develop collaborative, community programs and services to address identified needs and improve health.
- f. Policy development:** Health councils assist local and state governments and non-governmental entities in developing and advocating for policies to improve health.
- g. Network development:** Health councils develop and strengthen networks, partnerships, and coalitions to address issues, priorities and solutions to improve health.
- h. Resources:** Health councils work with county and/or tribal governments and non-governmental entities to attract and leverage financial and other resources to improve health.
- i. Communications and community involvement:** Health councils serve as a two-way conduit for information and communication between communities and state and local agencies and non-governmental entities.

2. Outcomes: The operation of the health council system should be guided by clear standards, expectations, and monitoring of intermediate outcomes and associated improvements in health status.

- a. The health council system will continue to be driven by outcomes:** Health councils will identify and address changes and enhancements in local health systems, capacity, and social determinants of health that result in improved health status outcomes.
- b. Data collection:** Health councils will work with the New Mexico Department of Health, health providers, and university systems to gather and report appropriate data to evaluate community health systems and capacity, as well as changes in health status outcomes.
- c. Evaluation system:** Health councils will work with other statewide entities to conduct continuing evaluation of achievement of outcomes or goals, using uniform assessment standards and focusing on locally identified health priorities.
- d. Quality assurance:** The health council system will be guided by explicit standards of good practice, with regular review and quality improvement processes by NMDOH, UNM, and/or the NM Alliance of Health Councils.

3. Capacity-Building: The health council system needs to incorporate ways to build and sustain the capacity of the councils to accomplish their intended goals and benchmarks.

- a. Organizational:** Health councils will use organizational best practices with respect to decision-making, regular meetings, community engagement, information dissemination, and public accountability. Health council coordinators must be skilled in facilitation, organizational processes, collaboration building, planning, data collection, outcome measurement, and evaluation systems.
- b. Administrative and fiscal capacity:** Health councils will have sufficient administrative and fiscal capacity (internal and/or contracted) to ensure effectiveness and accountability, and to manage public funds responsibly.
- c. Programmatic capacity:** The health councils will receive continuing education in the role and functions of health councils; public and population health concepts and practices; health in all policies; social determinants of health; and health equity.
- d. Training and technical assistance:** Appropriate education and training will be provided to health councils through statewide, regional, and on-site training and technical support, coordinated and provided by the NM Alliance of Health Councils and the NM Dept. of Health, and using additional resources, which may include the University of New Mexico (College of Population Health and Office for Community Health), New Mexico State University, NM Public Health Association, NM Public Health Institute (SWCHI), and other entities. Possible

training models include quarterly regional meetings and trainings, a summer, week-long training conference (like the previous MCH College in Socorro), UNM Public Health 101 courses, and curricula developed by the NM Department of Health and the Area Health Education Centers.

4. Key Partnerships: The health councils need to be part of a supportive infrastructure to ensure continued integration as part of New Mexico's overall public health system.

a. State Government: The State of New Mexico will provide staff liaison, logistical, and capacity-building support from multiple State agencies including but not limited to: Department of Health, Human Services Department, Children Youth and Families Department, Aging and Long-Term Services Department, Environment Department, Transportation, and other programs as appropriate. Many State agencies use, and benefit from, the connections with communities that the health councils provide.

b. Other key partnerships: The health council system, under the leadership of the New Mexico Alliance of Health Councils, will seek and maintain collaborative relationships with key partners, which may include the New Mexico Association of Counties, Mexico Public Health Association, New Mexico Public Health Institute/Southwest Center for Health Innovation, New Mexico's university systems, public and private philanthropy, local and regional partners, and other community and tribal coalitions and organizations.

c. Local collaboration: Health councils will provide coordination and mutual support with other community planning bodies, such as DWI Councils, Local Behavioral Health Collaboratives, Councils of Governments, and issue-specific coalitions and groups.

C. SUSTAINABILITY

Sustainability requirements need to address the health council system as a whole, and not just partial funding of individual health councils. The health council system needs sufficient resources to carry out its legislative and executive branch mandates, to maintain statewide standards of best practice, and to accomplish desired outcomes in improving the health of New Mexicans. Funding should come from a combination of core state funding, local financial and in-kind support, and resources leveraged by the health councils.

1. State Investment: The State of New Mexico needs to provide sufficient, multi-year funding to enable each health council to hire or contract with a Health Council Coordinator to provide administrative and programmatic support to the council including: convening and recording meetings, developing and supporting council leadership, assisting the council in carrying out its decisions and actions, serving as liaison with county, tribal, and other local governments and non-governmental entities, and working with statewide entities to build and sustain health council capacity.

In 2003, The NM Department of Health estimated the cost of supporting a single full-time health council coordinator at \$75,000; health councils serving smaller populations may be able to function

with a part-time staff coordinator, or to combine efforts with neighboring jurisdictions. The 2006-2010 Health Council Evaluation demonstrated that health council productivity showed a dramatic decrease when councils were no longer supported by paid staff coordinators.

2. Administration of State funding: Levels of State funding must be consistent and predictable from year to year, in order to support effective, long-range planning. Administration, monitoring, and reporting of State funding of the health council system needs to be efficient and equitable. Reporting requirements must be reasonable and flexible, providing accountability without reducing efficiency and program effectiveness. State funding should support continuing training, technical assistance, and coordination through the NM Alliance of Health Councils, the NM Department of Health, and other entities listed elsewhere in this report.

3. Local investment: Local county and tribal governments should provide financial and in-kind support to the health councils as needed, such as office space, supplies, information technology, communications, and logistical support. Counties and/or tribes may join with other adjacent jurisdictions to provide such support.

4. Private sector investment: Health councils will be able to supplement State and local government support with grants and other forms of financial assistance from philanthropic and nonprofit organizations, health plans and HMOs, health providers, educational institutions, businesses, and community coalitions. Health councils may be assisted in finding additional resources by the New Mexico Alliance of Health Councils and State agencies.