New Mexico Health System Innovation
Stakeholder Summit
May 19, 2015
8:00 am – 5:00 pm
Albuquerque International Balloon Museum

8:00-8:30  Registration

8:30-9:00  Vision for New Mexico
Brent Earnest, Cabinet Secretary, Human Services Department
Retta Ward, MPH, Cabinet Secretary, Department of Health
Shannon Barnes, MA, Project Director, DOH ~ Summit Objectives

9:00-9:30  State Innovation Model Success – State of Colorado
George Del Grosso, CEO, Colorado Behavioral Healthcare Council

9:30-10:00  Overview of New Mexico Health Status and the State’s Health System
Mike Landen, M.D., New Mexico State Epidemiologist

10:00 – 10:15  Break

10:15-10:30  Centennial Care Innovation
Brent Earnest, Cabinet Secretary, Human Services Department

10:30-11:30  New Mexico Innovations Panel
Moderator: Jerry Montoya, Health Promotion Manager, DOH

Improving Population Health
Michelle Melendez, PA, Development Director
First Choice/South Valley Health Commons

Enhancing Patient Experience of Care
Pawitta Kasemsap, MD, Albuquerque Health Partners

Reducing Health Care Cost
Charlie Alfero, MA, Executive Director
Center for Health Innovation, Hidalgo Medical Services

Questions
11:30 – 12:15 Lunch

12:15-12:45 A New Mexico Health System Perspective
Kathy Davis, Sr. Vice President, CNO
Presbyterian Healthcare Services

12:45-1:00 Committee Objectives
Camilla Hull Brown, Iatric Systems

1:00 - 1:15 Break

1:15 – 3:15 Stakeholder Committees Convene to Initiate Innovative Design

3:15 – 3:30 Break

3:30 – 5:00 Stakeholder Committee Reports and Questions – Camilla Hull Brown
Dates for Future Summits and Closing – Shannon Barnes
Many Thanks for Contributing!!

Thank you, Lunch Sponsors!

New Mexico Hospital Association

New Mexico Primary Care Association

Check out the website for all things New Mexico Health System Innovation, resources, committee work, and information on the developing design.

www.nmhealthsysteminnovation.org
WELCOME
HEALTH SYSTEM INNOVATION DESIGN

BRENT EARNEST
CABINET SECRETARY
NEW MEXICO HUMAN SERVICES DEPARTMENT

WELCOME!

RETTA WARD, CABINET SECRETARY

• Health System Innovation will be built on strong partnerships
• We seek to achieve the triple aim:
  ✔ Improved Population Health and Health Outcomes
  ✔ Reduced health care costs and investment in health promotion
  ✔ Enhanced experience of care for the person, quality and satisfaction
A SHARED COMMITMENT TO ACHIEVE RESULTS

1. Alignment and integration of public health, behavioral health and primary care
2. Reduce costs and slowing the rate of health care inflation, while increasing investments in community wellness
3. Increase the number of New Mexicans who have health insurance and access to healthy choices
4. Build the health system workforce and support the infrastructure
5. Expand the use and integration of the state’s health information system, including technology, personal access and transparency

HEALTH IMPROVEMENT PRIORITIES

- Obesity
- Diabetes
- Tobacco Use

A HEALTHIER NEW MEXICO
SUMMIT OBJECTIVES

• To introduce and describe the opportunity to improve health outcomes and for all New Mexicans through the State Innovation Model design.
• To learn about other innovations occurring around the state.
• To begin a dialogue with stakeholders to collaboratively design an integrated system of care and wellness.

WHAT IS COLORADO SIM?

• SIM: State Innovation Model
• SIM is an initiative of the Center for Medicare & Medicaid Innovation (CMMI).
• Colorado was awarded a $2 million planning grant and $65 million implementation grant to strengthen Colorado’s Triple AIM strategy.
• Encourages states to develop and test models for transforming health care payment and delivery systems.
• Colorado received the 4th largest award based on the State’s population.
COLORADO’S SIM VISION

• To create a coordinated, accountable system of care that will provide Coloradans access to integrated primary care and behavioral health in the setting of the patient’s medical home.

COLORADO’S SIM GOAL

• Improve the health of Coloradans by providing access to integrated physical & behavioral health care services in coordinated systems, with value-based payment structures, for 80% of Colorado residents by 2019.

COLORADO SIM: WHY IT MATTERS

- Of the time, the 14 most common physical complaints have no identifiable organic cause (84%)
- Of referrals from primary care to an outpatient behavioral health clinic do not make the 1st appointment (>50%)
- Of people with a behavioral health disorder will visit primary care at least once a year (80%)
- Of people with a behavioral health disorder are treated in primary care (50%)
- Of people with a behavioral health disorder do not get behavioral health treatment (67%)
COLORADO CHALLENGES

- High rates of suicide
  - Average of 3 per day
- Drug abuse deaths are greater than car accidents or firearms deaths per year
- Higher rate of illicit drug use
- Increased number of marijuana-related hospital admissions

SIM ORGANIZATION CHART

- Governor
  - SIM Office
  - Advisory Board
  - Practice Transformation
  - Health Information Technology
  - Population Health
  - Consumer Engagement
  - Payers
  - Policy
  - Evaluation

RECOMMENDATION PATHWAY

- Consumers
- Stakeholders
- Workgroups
- Sub-Groups
- Advisory Board
- SIM Office
- Key Partners
- Vendors
- Input
- Conclusions
- Deliverables
- Effects
CROSS-POLLINATION

Steering Committee

Workgroup

Workgroup

Workgroup

Workgroup

Sub-Group

Sub-Group

Sub-Group

Payers, Purchasers & Payment Reform

• Standardized fee schedule and payment model.
• Proposed model design for value based insurance.
• Payment system focused on the usage of integrated physical and behavioral health care.

Payers, Purchasers & Payment Reform

You Get What You Pay For

Observation Phase
• Identify current & future spending benchmarks
• Understand needs to transform practice, delivery & payment
• Identify outcome & quality baselines

Care Coordination & Savings
• Increased coordination through additional payments
• Support in practice transformation
• Performance, quality & cost measurement

Shared Risk & Savings
• Increased provider responsibility
• Extra payment built into cost of care
• Support in practice transformation
• Performance, quality & cost measurement

Roads & Budgeting for Comprehensive Primary Care
• Learning collaborative
• Payment based on total cost of care & coordination
• Performance, quality & cost measurement
PRACTICE TRANSFORMATION AND SERVICE DELIVERY

- Integration of physical and behavioral health care in 400 practices over the four-year grant period.
- Implementation, assessment, and technical requirements for practices to move toward integrated care and new payment model implementation.
  - Toolkits, Learning Collaboratives, Disseminating Best Practices, Technical Support, etc.
- Develop inventory of all practices and behavioral health providers in Colorado and what services are being provided.

SERVICE DELIVERY & PRACTICE TRANSFORMATION

RIGHT CARE, RIGHT TIME, RIGHT PLACE

- Traditional model does not address community needs
- Colorado SIM: supports, strengthens, and reaches 400 practices

<table>
<thead>
<tr>
<th>Year</th>
<th>Practices</th>
</tr>
</thead>
<tbody>
<tr>
<td>2015</td>
<td>Initial 100 practices on-boarded</td>
</tr>
<tr>
<td>2016</td>
<td>Additional 150 practices on-boarded</td>
</tr>
<tr>
<td>2017</td>
<td>Additional 150 practices on-boarded</td>
</tr>
<tr>
<td>2018</td>
<td>Additional 150 practices on-boarded</td>
</tr>
</tbody>
</table>

POPULATION HEALTH

- Improve physical and behavioral health integration for Colorado communities
- Reduce stigma regarding behavioral health at both the individual and population levels in the State
- Award 4-5 grants to communities using collaboration and evidence-based best practices to improve awareness of integrated behavioral and physical health care in Colorado
- Provide T.A. to grantees to monitor and evaluate programs
CONSUMER ENGAGEMENT WORKGROUP

• Create sustainability and cost reduction plans for Colorado communities.
• Determine how primary and behavioral health integration can help the consumers healthcare experience.
• Provide recommendations to other workgroups regarding the consumer aspect of their respective work.

POPULATION HEALTH & CONSUMER ENGAGEMENT
ALL HEALTH IS LOCAL

• Building from Winnable Battles framework
• SIM will: identify, review, engage & facilitate
  Regional planning; review community assessments

  Launch collaboratives; align funding with regional needs; bi-annual convening of collaboratives

  2015 2016 2017 2018

HIT, DATA & QUALITY MEASURES
IF YOU CAN'T MEASURE IT, YOU CAN'T IMPROVE IT

• Clinical IT support for practices
  • HIT assessments: practice, community & state level
  • Support in HIT adoption & integrating HIT tools into workflow
• A governance structure with data policies to support data driven planning & implementation via:
  • Centralized data repository
  • Collecting, merging & analyzing clinical & claims data
QUALITY MEASURES

<table>
<thead>
<tr>
<th>Hypertension</th>
<th>Obesity</th>
<th>Tobacco</th>
<th>Prevention</th>
</tr>
</thead>
<tbody>
<tr>
<td>Asthma</td>
<td>Diabetes</td>
<td>Ischemic Vascular Disease (IVD)</td>
<td>Safety</td>
</tr>
<tr>
<td>Depression</td>
<td>Anxiety</td>
<td>Substance Use</td>
<td>Child Development</td>
</tr>
<tr>
<td>Postpartum Depression Screening</td>
<td>Developmental Screening</td>
<td>Safety</td>
<td>IVD</td>
</tr>
</tbody>
</table>

WORKFORCE DEVELOPMENT

- Identify training and credentialing required for community health workers to be certified as nonclinical health care providers.
- Reimbursement and payment policies for community health workers.
- Access to Care objectives:
  - Determine a methodology for assessing integrated care capacity and how to measure.
- Training of an integrated care workforce:
  - Maximize workforce by identifying the support professionals integrated care in primary care settings, behavioral health settings, and the community.
  - Plan for future needs of Colorado’s integrated care workforce.
- Economic Development:
  - Create a plan for policy and regulatory levers to assist integrated care workforce capacity.
  - Develop plan to support impact of payment reform on integrated care workforce.

POLICY WORKGROUP

- Review incentives and payment reform that Colorado would engage in for providers and patients.
- Review shared savings that will align with communities statewide.
- Identify and recommend legislative and policy changes which may need to be implemented due to an integrated physical and behavioral health care system.
EVALUATION WORKGROUP

- Evaluate the sustainability of the SIM Program and workgroup recommendations.
- Ensure effectiveness of SIM projects in completing set goals.

CONTACT INFORMATION

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THANK YOU!

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Health Status of New Mexico

Michael Landen
New Mexico Department of Health
May 2015

Purpose

• Review highlights of the health status of New Mexico
  – Risk and Resiliency
  – Morbidity
  – Birth
  – Death
  – Trends
  – Disparities

New Mexico Health Regions
NM Urban-Rural County Classification

- Metropolitan Counties
- Small Metro Counties
- Mixed Urban/Rural Counties
- Rural Counties


Source: Behavioral Risk Factor Surveillance System

Percentage of NM Adults Living in Households with Annual Income of Less Than $20,000 by Region, 2013

Source: Behavioral Risk Factor Surveillance System

Percentage of NM Adults With Less Than High School Education by Region, 2013

Source: Behavioral Risk Factor Surveillance System
General Health Status Reported As Fair or Poor
Among New Mexico Adults
by Education, 2013

<table>
<thead>
<tr>
<th>Education</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>High School Grad</td>
<td>41.6</td>
</tr>
<tr>
<td>High School</td>
<td>22.1</td>
</tr>
<tr>
<td>Some College/Tech</td>
<td>16.9</td>
</tr>
<tr>
<td>College Grad</td>
<td>8.2</td>
</tr>
</tbody>
</table>

General Health Status Reported As Fair or Poor
Among New Mexico Adults
by Race/Ethnicity, 2013

<table>
<thead>
<tr>
<th>Race/Ethnicity</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>AIAN</td>
<td>21.6</td>
</tr>
<tr>
<td>Asian</td>
<td>9.2</td>
</tr>
<tr>
<td>NHOPI</td>
<td>20.6</td>
</tr>
<tr>
<td>Black</td>
<td>26.1</td>
</tr>
<tr>
<td>Hispanic</td>
<td>15.4</td>
</tr>
</tbody>
</table>

General Health Status Reported As Fair or Poor
Among New Mexico Adults
by Region, 2013

<table>
<thead>
<tr>
<th>Region</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>NW</td>
<td>20.3</td>
</tr>
<tr>
<td>NE</td>
<td>18.2</td>
</tr>
<tr>
<td>Metro</td>
<td>19.0</td>
</tr>
<tr>
<td>SE</td>
<td>23.6</td>
</tr>
<tr>
<td>SW</td>
<td>24.0</td>
</tr>
</tbody>
</table>
Obesity – BMI ≥ 30
Among New Mexico Adults by Annual Household Income, 2013

Obesity – BMI ≥ 30
Among New Mexico Adults by Education, 2013

Source: Behavioral Risk Factor Surveillance System

* Addition of Cellular Telephones and new weighting process.
Percentage of Workers who are Obese* by Occupation, New Mexico, 2012

Percentage of Students Obese by Grade, New Mexico, 2010-2014

Percent of Kindergarten Students Overweight and Obese by Race/Ethnicity, New Mexico, 2013


Source: New Mexico Department of Health Childhood Obesity Surveillance System.

Source: New Mexico Department of Health Childhood Obesity Surveillance System.
Diabetes Hospitalizations by Region
New Mexico 2000-2002 and 2011-2013

*The increase in rates, from earlier to later period, is statistically significant.
Source: NM Hospital Inpatient Discharge Data collected by NM Health Policy Commission (data via http://ibis.health.state.nm.us/query/selection/hidd/HIDDSelection.html). Notes: Includes diabetes as first-listed ICD-9 discharge diagnosis (250 - 250.9). These do not include Indian Health Service, VA or military hospital data.

<table>
<thead>
<tr>
<th>Region</th>
<th>2000-2002</th>
<th>2011-2013</th>
</tr>
</thead>
<tbody>
<tr>
<td>Northwest</td>
<td>14.5</td>
<td>16.5</td>
</tr>
<tr>
<td>Northeast</td>
<td>12.2</td>
<td>12.7</td>
</tr>
<tr>
<td>Bernalillo County</td>
<td>9.9</td>
<td>13.6</td>
</tr>
<tr>
<td>Southwest</td>
<td>15.2</td>
<td>13.7</td>
</tr>
<tr>
<td>Southeast</td>
<td>11.1</td>
<td>11.9</td>
</tr>
</tbody>
</table>

Source: New Mexico Department of Health Hospital Inpatient Discharge Data
Rates are age-adjusted to the U.S. 2000 Standard Population

Top Five Ambulatory Care Sensitive Condition Hospitalization Rates, NM, 2013

<table>
<thead>
<tr>
<th>Condition</th>
<th>Rate per 100,000 Population</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pneumonia</td>
<td></td>
</tr>
<tr>
<td>Diabetes</td>
<td></td>
</tr>
<tr>
<td>CHF</td>
<td></td>
</tr>
<tr>
<td>UTI</td>
<td></td>
</tr>
<tr>
<td>COPD</td>
<td></td>
</tr>
</tbody>
</table>

Source: New Mexico Department of Health Hospital Inpatient Discharge Data
Rates are age-adjusted to the U.S. 2000 Standard Population

Ambulatory Care Sensitive Condition Hospitalization Rates by Region, NM, 2013

<table>
<thead>
<tr>
<th>Region</th>
<th>Rate per 100,000 Population</th>
</tr>
</thead>
<tbody>
<tr>
<td>Northeast</td>
<td></td>
</tr>
<tr>
<td>Southeast</td>
<td></td>
</tr>
<tr>
<td>Metro</td>
<td></td>
</tr>
<tr>
<td>Northwest</td>
<td></td>
</tr>
<tr>
<td>Southwest</td>
<td></td>
</tr>
</tbody>
</table>

Source: New Mexico Department of Health Hospital Inpatient Discharge Data
Rates are age-adjusted to the U.S. 2000 Standard Population
Teen Birth Rates by Region
New Mexico, 2013

Source: NM Bureau of Vital Records and Health Statistics

DALYs

From head to toe
High-income countries, people under 70, 2012
Disability-adjusted life-years* caused by:

- mental-health disorders 17.4
- neurological conditions 3.7
- respiratory diseases 4.4
- musculoskeletal diseases 9.2
- cancers 15.9
- cardiovascular diseases 14.8
- injuries 12.9

% of total

Sources: WHO; The Economist

*Sum of years of life lost to premature death plus disability

Life Expectancy by Sex
New Mexico, 2013

Number of Years

<table>
<thead>
<tr>
<th>Gender</th>
<th>Total</th>
<th>Male</th>
<th>Female</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>78.5</td>
<td>75.7</td>
<td>81.4</td>
</tr>
</tbody>
</table>
Infant Mortality Rates by Rural/Urban Categories
New Mexico, 2011-2013

<table>
<thead>
<tr>
<th>Category</th>
<th>Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rural</td>
<td>5.9</td>
</tr>
<tr>
<td>Mixed Urban-Rural</td>
<td>5.9</td>
</tr>
<tr>
<td>Small Metropolitan</td>
<td>3.9</td>
</tr>
<tr>
<td>Metropolitan</td>
<td>2.9</td>
</tr>
</tbody>
</table>

Source: NM Bureau of Vital Records and Health Statistics

Total Death Rates by Region
New Mexico, 2013

<table>
<thead>
<tr>
<th>Region</th>
<th>Deaths per 100,000 population</th>
</tr>
</thead>
<tbody>
<tr>
<td>North</td>
<td>828.5</td>
</tr>
<tr>
<td>Central</td>
<td>730.8</td>
</tr>
<tr>
<td>South</td>
<td>839.1</td>
</tr>
<tr>
<td>Total</td>
<td>747.6</td>
</tr>
</tbody>
</table>

Note: Rates are age-adjusted to the standard 2000 U.S. population.
Source: NM Bureau of Vital Records and Health Statistics

Total Death Rates by Race/Ethnicity and Sex
New Mexico, 2013

<table>
<thead>
<tr>
<th>Race/Ethnicity</th>
<th>Males</th>
<th>Females</th>
</tr>
</thead>
<tbody>
<tr>
<td>Amer Indian</td>
<td>784.4</td>
<td>364.2</td>
</tr>
<tr>
<td>API</td>
<td>986.1</td>
<td>702.8</td>
</tr>
<tr>
<td>Black</td>
<td>904.4</td>
<td>605.3</td>
</tr>
<tr>
<td>Hispanic</td>
<td>862.1</td>
<td>44.4</td>
</tr>
<tr>
<td>White</td>
<td>892.6</td>
<td>59.6</td>
</tr>
</tbody>
</table>

Rates are age-adjusted to the standard U.S. 2000 population.
Source: NM Bureau of Vital Records and Health Statistics
Years of Potential Life Lost (YPLL) Before Age 75, New Mexico, 2013

Top 8 Leading Causes of Death, New Mexico, 2013 and U.S., 2010

5 Leading Causes of Death, New Mexico, 2013, and U.S., 2010

<table>
<thead>
<tr>
<th>Death Category</th>
<th>NM</th>
<th>U.S.</th>
<th>Ratio</th>
</tr>
</thead>
<tbody>
<tr>
<td>Smoking-attributable death rate</td>
<td>100.6</td>
<td>111.3</td>
<td>0.9</td>
</tr>
<tr>
<td>Alcohol-attributable death rate</td>
<td>53.1</td>
<td>29.4</td>
<td>1.8</td>
</tr>
<tr>
<td>Drug overdose death rate</td>
<td>21.8</td>
<td>13.8</td>
<td>1.6</td>
</tr>
</tbody>
</table>

1Rates are deaths per 100,000 population, age-adjusted to the 2000 U.S. standard population.
2Smoking-Attributable Mortality, Morbidity, and Economic Costs (SAMMEC), apps.nccd.cdc.gov/sammec/index.asp
3Alcohol-Related Disease Impact (ARDI), nccd.cdc.gov/DPH_ARDI/default/default.aspx
4Defined as International Classification of Diseases, tenth revision (ICD-10) codes X40-X44, X60-X64, X85, and Y10-Y14

Health Care Spending

• Health care spending per person (2009)
  - NM $6,651
  - U.S. $6,815

Source: State Health Access Data Assistance Center

Conclusions

• In general, chronic disease mortality rates continue to decrease in New Mexico
• In general, injury and substance abuse death rates are stable or increasing
• Vaccination continues to reduce infectious disease rates and disparities
• The infant mortality rate reduction in NM is a major success but disparities remain
• Geographic, particular unfavorable to rural areas, and racial/ethnic disparities persist in New Mexico
New Mexico Centennial Care

- On January 1, 2014, New Mexico implemented its "next generation" Medicaid managed care program, called Centennial Care.
- The goals of Centennial Care are to align incentives to promote better health outcomes and reduce the growth in costs. The program was designed on four guiding principals:
  1. Developing a comprehensive delivery system
  2. Promoting personal responsibility
  3. Paying for quality instead of just the quantity of health care
  4. Simplifying administrative structures

Better health, lower costs.
Efficient use of health services
Early identification
Managed Care Organizations
Primary care delivery system
Integrated care coordination
Administrative simplification management integration

Better health, lower costs.
Physical health, behavioral health, and long-term services and supports are integrated under the managed care system.

- Health Risk Assessment (HRA) to determine the level of care coordination needed.
- Implementing care coordination
- From “monitoring” for healthy members with few health care needs
- To robust care coordination for members with more complex health care needs, including connecting members to other social services.

Centennial Rewards Program designed to encourage member engagement in their own health.

- Members earn credits for completing healthy behaviors and can use credits for products not traditionally part of the Medicaid program.

- Dental
- Step-Up Challenge
- HRA/CNA
- Bone Density
- Diabetes
- Healthy Pregnancy
- Mental Health

Provider Focus: Health Homes

- Coordinating medical, behavioral and related social service needs and supports by a community provider and/or arranged through a network of providers.
  - Intensive and individualized
  - Treatment of chronic conditions and comorbidities
  - Engages beneficiaries in their treatment
  - “Whole-Person” philosophy of care
  - Emphasizes education, activation and empowerment through interpersonal interactions.
  - At the center are the patient and their relationship with their primary and behavioral health team.

- Target implementation in January, initially with two pilot areas and sites.
Community Health Workers (CHWs) included in Centennial Care to address population health issues and supplement primary care:

- Improve health and health care literacy;
- Make linkages to community supports; and
- Support care coordination.

The MCOs report using CHWs to:

- Educate referred members about alternatives to ER use;
- Locate members to obtain Health Risk Assessments;
- Assist members with making and keeping health care appointments and setting up transportation, if needed; and
- Refer members to local resources found within communities (i.e., food pantries, utility assistance, housing, etc.)

Centennial Patient Support pilot program is being developed to promote a statewide approach to improve Medicaid patient support through a continuum of services.

Participants include:

- UNM – Health Sciences Center Office for Community Health
- Molina Health Care of NM
- BCBSNM
- Hidalgo Medical Services (FQHC)
- NM Medicaid (Human Services Department)

Pilot leverages care coordination to improve community health and help members maintain or improve their health status.

CHW Pilot

- CHW pilot will implement three levels of Medicaid patient support through the deployment of CHWs:
  - Community Health Improvement
    - Interventions to address local policy, system and environmental change to improve the underlying causes of ill health
  - Patient Support
    - Interventions to stop the further progression of disease or ensure access to preventive services
  - Care Coordination
    - Intensive support for high-risk and high-cost patients
    - Specific intervention strategies that are urgent and designed to improve health and reduce cost
    - Development of individualized plans
As part of Centennial Care, HSD is requiring the MCOs to pilot new payment reform projects.

Focus of payment reform in Centennial Care is to:
- Improve quality and health outcomes while also reducing the cost of care;
- Viably achieve and measure cost savings;
- Implement sustainable reforms;
- Engage, include and support a variety of providers;
- Obtain data to inform care management; and
- Align with existing HSD initiatives and fit with the state’s long-term strategic vision.

MCO payment reform pilots build upon existing efforts to move away from volume-based payments, allow provider incentives and encourage shared risk.

The MCO pilots vary, but include:
- Performance-based models with bonuses for achieving valued outcomes to reduce gaps in care;
- Targets to reduce emergency room visits, hospital admissions and readmissions, and improve depression medication adherence;
- Pursuit of bundled payment initiatives for certain conditions/procedures;
- Tiered reimbursement, with incentives tied to target measures, for Patient Centered Medical Homes (PCMHs).

Centennial Care operates through a five-year agreement with the federal government (2014 through 2018), including evaluation of the model.

As these projects develop – an opportunity for shared learning.

Opportunity to align Medicaid initiatives with other components of the system.
SOUTH VALLEY COMMUNITY COMMONS:
Extending the feedback loop further upstream

Michelle Melendez
First Choice Community Healthcare

Agenda

- A brief description of the genesis of First Choice; how and when the organization was started, guiding principles
- The patient-centered care concept that drives First Choice
- Residency program training providers to work in diverse teams
- Integration of CHWs into primary care and models for Medicaid reimbursement for services
- Increased patient engagement and satisfaction

Community Origins

Like most community health centers, First Choice Community Healthcare was born in the War on Poverty. We knew then that health was related to education, jobs, housing, food and environment.
43 Years of Quality Health Care

Fee for Service and PCMH model
- Payment system drove our delivery model and growth over the years
- Leaders in effective TREATMENT for chronic diseases

Quality Indicators
We meet or exceed many of the Healthy People 2020 Goals.
Yet the population health indicators are still pitifully low.

The wait list for housing assistance is two years.

Food insecurity is at an all-time high, especially among children and senior citizens.
Community members are demanding real, systemic solutions.

Education Reform

Immigration Reform
Police Reform

Long-term, viable solutions to homelessness

The Door Knob Confession
Warning: Chronic Poverty can be hazardous to your health and to that of your children.

Well Rx for Poverty

Screen Everyone
Intervene (with partners)
Evaluate

Survey Responses N=906

Questions on Help You May Need
1. A regular income, and you have enough to live on
2. Medical insurance
3. Housing
4. Food
5. Employment or Income
6. Transportation
7. Childcare
8. Subst. Abuse
9. Safety
0. Utilities
Intervene
- Community Health Workers
  - Frontline public health workers
  - Trusted by the community by way of their close understanding of the community served
  - Help to bridge healthcare/social services/community
  - Experts in connecting individuals with needed resources

Pilot with Family Medicine Residents
- All 10 clinicians and 10 family medicine residents work with CHWs when needs arise without screening
- 3 Family Doctors and 10 Family Medicine Residents
- Screen every patient, every visit for 3 months with WellRx

Lessons Learned
- Clinic staff either minimally impacted or inspired to help with this aspect of care
- Community health workers not overwhelmed - Mixed Case Load
- Patients Utilizing resources Trends changing
- Patients answering yes to at least 1 question on Well Rx went from 50% to 30%
Impact on health system

- 1/3 of Family Medicine Residents from UNM Family Medicine Residency
- 24 Residents trained at First Choice South Valley
- 16 working in FQHC, IHS
- 18 practicing in NM
- 8 in rural practice

Sustainability

- Partnership with UNM office for Community Health, Blue Cross and Molina Centennial Care – Medicaid MCOs
- Expansion of pilot to 3 UNM clinics
- Study the impact of community health workers on Medicaid Patients
- Study will pay for continuation of CHW pilot NM Medicaid Office
- If we can show benefit may mandate MCOs to pay

Community-Oriented Primary Care

- Proposed first choice Community Healthcare extension of the medical model
- Feedback from primary care provider gives much better outcomes
Continuum

Passive…………………………Active…………………………..Advocate

Traditional Family Medicine  PCMH  Community-Centered Healthcare Home

Engage

La Cosecha CSA – subsidized local food distributed at the Health Commons

Break Bread

- Community cooking classes, in Spanish, with guest chefs, child care and diabetes education
Build Community

- Community farm
- Jobs

Thank you! For more information, please visit:
Website: www.fcch.com
FirstChoiceHealthNM
Facebook: South Valley Community Partnership

PCMH in the Primary Care Office

Pawitta Kasemsap, MD, FAAP
ABQ Health Partners Pediatric Rio Rancho
Objectives

• The proposed PCMH model
• PCMH model in the Primary Care Office
• Quality improvement using the PCMH model

Proposed PCMH model

• NCQA PCMH recognition is very costly and time consuming.
• 6 main sections:
  – Patient-Centered Access
  – Team Based care
  – Population Health Management
  – Care Management and Support
  – Care Coordination and Care Transition
  – Performance measurement and Quality Improvement

Patient Centered Access

• Same Day access
• Telephone triage 24/7, with afterhours calls answered by provider and documented in EMR
• Continuity of care with PCP, as relationship matters
• Access to EMR after hours
• Patient portal for electronic messaging
Team Based Care

- Structure and train our teammates to work at the top of their license
- Pre-visit planning, post-visit discharge
- In Between visit
  – Patient engagement
  – Patient self-management
  – Follow-up that is patient centric via telephone or electronic messaging
Care Management and Support

• Giving patients tools and resources for patients to take a more active role
• LPN as Asthma Educator
• Pediatric Nutritionist on site for same day visit
• Cognitive Behavioral Therapy counseling for anxiety and depression
• Partnership with Sage Neuroscience for pediatric Psychiatry

Care Coordination and Care Transitions

• Lab and imaging tests are follow-up and patients are notified of all results
• Outreach to patients with overdue tests
• Referrals are follow-up and specialist notes entered into EMR
• ER and Admission follow-up
  – Lacking real time claim based data from payer for patients who self referred to ER

Performance Measurement and QI

• QI projects partnering with Envision NM for Developmental Screening, Asthma, Pediatric Overweight and Obesity
• Population Health Management for Overdue WCC and Immunization
• Cost Containment
• Patient Experience
Asthma QI

Baseline 12 mo. and 18 mo. follow-up
Population Health Management
24 mo. Old immunization Rate

Generic Rx rate

CAHPS Medical Practice

Displayed by Received Date and Total Sample
Future

- Patient-Centered Care—Physician becomes a member of the healthcare team with the patient as an active member
- Value-Based care
- Triple Aim—Better Care, Better Experience, at a lower cost

What is CHI?

- A Division of Hidalgo Medical Service
- A new Non-Profit: Southwest Center for Health Innovation
- A Non-Profit Administrative Support Provide
  - NM Primary Care Training Consortium
  - National Center for Frontier Communities
  - National REACH Coalition

Purpose: Develop and implement strategies and models to improve quality of life, health status and equity for partnering organizations and the people we collectively serve.

Medicaid Patient Support and Community Health System
Value Investments in High Return CHW Services

UNM Healthcare Center
Office for Community Health
Level I — Contract Services

- Community Health Priorities
- Outreach
- Enrollment
- Eligibility — Social Services
- Health Fairs
- Community Health Education — Primary Prevention

Level II — Contract Services

- Chronic Disease Management
  - Warm Hand-Offs
    - Primary Care
    - Hospitals
    - MCO Referrals
  - Clinical Preventive Services
  - MCO Quality Indicators
  - Primary Care and Behavioral Health Coordination
  - Patient Education
  - Aggregated Compliance Monitoring and Reporting
Level III – Contract Services

- MCO Identified High Risk / High Cost Patients
- ER, Inpatient, Pharmacy, Other
- Case Load 15-30 per Care Coordinator
- Individual Care Plans and Monitoring
  - 100% Case Review
  - Pre-Approved Payments
  - Cost Monitoring and Reporting

Integrated PC Training

- FORWARD NM – AHEC
  - Public Schools
  - Undergraduate
  - Graduate
  - Residency
  - Policy
- NM Primary Care Training Consortium
- Medicaid THC – FQHC Scope Change

LUNCH BREAK

RECONVENE FOR KEYNOTE WITH LUNCH AT 12:15 PM
New Mexico State Innovation Model Summit
Kathleen Davis, RN, Senior Vice President and Chief Nursing Officer
Presbyterian Healthcare Services
May 19, 2015

The Triple Aim

Health of a Population
Experience of Care
Per Capita Cost

Principles of Interventions

- Data-driven
- Clearly stated, easy-to-understand purpose
- Evaluated, monitored
- Practical, realistic
- Sustainable
- Age appropriate, culturally relevant
- Promote equity, reduce disparities
- Collaborative
- Strengthen existing interventions

The Triple Aim is a framework developed by the Institute for Healthcare Improvement.
Our Role in Community Health

- Improve the health of the communities we serve
- Priorities: healthy eating, active living, and prevention of unhealthy substance use
- Serve as a convener and help people work across boundaries in service of overarching community health priorities
- Partner to strengthen what exists; improve effectiveness of health care interventions
- Targeted support for interventions to be sustained by partners with expertise

Centers for Disease Control and Prevention REACH Grant

- $2.9 million to Presbyterian to partner within the community
- Focus on improving community health in at-risk areas of Albuquerque and Bernalillo County
- Emphasis on healthy eating
  - Mobile Farmers’ Market
  - Support for healthy food in schools
  - Development of farm cooperative

Determinants of Health

- Programs & Policies
- Health Factors
- Health Outcomes
- Physical Environment (10%)
- Social & Economic Factors (40%)
- Clinical Care (20%)
- Health Behaviors (30%)
- Mortality (length of life) 50%
- Morbidity (quality of life) 50%
- Built Environment
- Environmental Quality
- Community Safety
- Family & Social Support
- Income
- Employment
- Education
- Quality of Care
- Access to Care
- Unsafe Sex
- Alcohol Use
- Diet & Exercise
- Tobacco Use
Patient Centered Medical Home

Expanded Care Team
- Primary Care Provider
- Access Provider
- Primary Support Role (Nurse/MA)
- Team Nurse
- Care Manager
- Behavioral Health Clinician
- Pharmacist Clinician
- Nurse Navigator (new patients)
- Care Coordinator (high risk patients)

Presbyterian Health Plan’s Member-Centric Care Model

Collaborating for Better Health - Hypertension

Health Plan | Primary Care | Million Hearts Campaign

Graph: Percentage of Hypertension Patients whose Blood Pressure is Controlled

Community EMS

- Home visits to uninsured, high-need patients
- On-call with Hospice and Home Health
- Transition Visits
- Surveillance

Referral and follow-up on social service needs - Connections

Thank You

COMMITEE PROCESS

CAMILLA HULL BROWN
STRATEGIES FOR TOMORROW
IATRIC
Committee Structure

Driver Committees

- Population Health
  - Life Stages
  - Disease Spectrum
  - Risk Factors

- Health Care
  - PCMH
  - Quality

- Alignment & Integration
  - Public Health
  - Behavioral Health
  - Health Care

Enabler Committees

- Workforce & Training Needs
  - Capacity
  - Workforce Longitudinal Workforce Analysis

- Health Info System
  - Data Exchange
  - Adoption
  - Workforce Longitudinal Workforce Analysis

- Tribal
  - Access
  - Multiple Systems Integration

- Payment Models
  - Value-Based Care Coordination
  - Data Exchange
  - Analytics

JOB OF YOUR COMMITTEE
DEVELOP A PLAN

1. Assessment
   - Current status and gaps

2. Strategies
   - What you want to do

3. Road Map
   - When you will do it
   - 6-month increments over 3 years

4. Alignment
   - Your Road Map with Other Groups

WHEN AND HOW

- 8 Monthly Summit Meetings
  - All groups work at the same time

- Interim Meetings
  - Work from Prior Meeting: Prep for Next
  - All groups will have
    - Facilitator
    - Consultant with Content Expertise
    - Resources and Trouble shooting by Leadership Team
PLANNING COMPONENTS
AT MONTHLY SUMMITS

<table>
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<tr>
<th>Monthly Summit Meeting</th>
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<tr>
<td>1. May 19</td>
<td>Orientation</td>
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<td>Assessment</td>
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<td>3. July 21</td>
<td>Strategies</td>
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<td>6. October 20</td>
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<td>7. November 17</td>
<td>3-Year Road Map of Key Strategies</td>
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TODAY
COMMITTEE BREAKOUTS

- Discuss Meetings and Roles
- Discuss Your Committee Charge
- List Opportunities and Issues
- ID Questions and Issues for the Large Group
  - Content and logistics
- Payment Model Committee
- Join Health Care Committee
- Health Information Systems Committee (HIS)
  - Cam to help kick off

BREAK
1:00 – 1:15 PM

COMMITTEES CONVENE
1:15 – 3:15 PM
CMS Priority Population Health Indicators

**Tobacco**
Adults: Four level smoking status – Smoke every day, Smoke some days, Smoked formerly, Smoke currently

**Obesity**
Adults: Weight classification by Body Mass Index (BMI) – Underweight, Normal weight, Overweight, Obese
Youth: Students above 95th percentile for BMI (based on 2000 Centers for Disease Control Growth Charts)

**Diabetes**
Percentage of adults with diabetes having two or more A1c tests in last year

Source: [http://innovation.cms.gov/Files/x/SIMPopHlthMetrics.pdf](http://innovation.cms.gov/Files/x/SIMPopHlthMetrics.pdf)

New Mexico State Health Improvement Plan Priority Indicators

**Tobacco**
Adults: Percent of adults who currently smoke cigarettes
Youth: Percent of youth who currently smoke cigarettes

**Obesity**
Children: Percent of third grade students who are obese

**Diabetes**
Percent of adults with diagnosed pre-diabetes
Percent of counties with either National Diabetes Prevention Program (NDPP) or accredited/recognized/licensed chronic disease or diabetes self-management education programs (DMSE/DSMP)
Percent of selected health center organizations with systems to support patient self-management of high blood pressure
New Mexico Health System Innovation Design
State Innovation Models (SIM) Initiative
Stakeholder Committee Process and Charges

Population Health Committee

**Background:** "The State Innovation Models (SIM) Initiative is providing financial and technical support to States for the development and testing of State-led, multi-payer health care payment and service delivery models that will improve health system performance, increase quality of care, and decrease costs for Medicare, Medicaid and Children’s Health Insurance Program (CHIP) beneficiaries and for all other residents of participating states."
*http://innovation.cms.gov/initiatives/state-innovations/

New Mexico is taking the Triple Aim approach to the design of its state innovation model. The Triple Aim has three objectives:

1) improve the health of populations
2) improve the experience of care
3) reduce per capita costs of health care

The Stakeholder Committees will develop a consensus-based design for a statewide wellness and healthcare system that uses a Patient Centered Medical Home (PCMH) model and meets the needs of its diverse communities and population groups.

Committee charges will be addressed consistent with the NM State Health Improvement Plan (SHIP) and Centers for Medicare and Medicaid Services (CMS) SIM requirements.

**Charge:** The charge to the **Population Health Stakeholder Committee** is to assess the current health status of New Mexicans, develop strategies for improving individual and population health at the community level within three years based on a key health improvement strategies, the PCMH model, and the development of a three-year Road Map with six-month increments for implementation of strategies.

Health promotion strategies that thread through all age groups, for example:

1) Active Lifestyles
2) Health Eating
3) Health Promoting Decision-Making (prevention, early intervention, disease management (MyCD); Screening, Brief Intervention, Referral To Treatment (SBIRT) in clinical environments)

Alignment and Integration of Public Health, Behavioral Health, and Health Care Committee

**Background:** "The State Innovation Models (SIM) Initiative is providing financial and technical support to States for the development and testing of State-led, multi-payer health care payment and service delivery models that will improve health system performance, increase quality of care, and decrease costs for Medicare, Medicaid, and Children’s Health Insurance Program (CHIP) beneficiaries and for all other residents of participating states."
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**Charges should be addressed consistent with the NM State Health Improvement Plan (SHIP) and CMS SIM requirements.**

**Charge:** The integration of public health, behavioral health and primary care has long been considered a best practice priority, but difficult to achieve. The greater demand for improved healthcare outcomes at a reasonable cost creates a new opportunity for the integration of the three areas.

The Charge of this Stakeholder Committee is to develop an integrated person centered model in which public health and behavioral health initiatives are actively supported by healthcare providers (PCMH and other service models), and PCMH and other service models are integrated into public health and behavioral health initiatives.

**Workforce and Training Needs Committee**

**Background:** “The State Innovation Models (SIM) Initiative is providing financial and technical support to States for the development and testing of State-led, multi-payer health care payment and service delivery models that will improve health system performance, increase quality of care, and decrease costs for Medicare, Medicaid and Children’s Health Insurance Program (CHIP) beneficiaries and for all other residents of participating states.”*

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**Charges should be addressed consistent with the NM State Health Improvement Plan (SHIP) and CMS SIM requirements.**

**Charge:** Expansion and retention of the New Mexico’s healthcare workforce has been the subject of intense study by the UNM HSC, state agencies, and the State Legislature. It is considered to be a critical
requirement toward addressing the improvement of healthcare delivery statewide. In addition, 32 of New Mexico’s 33 counties are classified as Health Professional Shortage Areas (HPSAs).

The charge to the Work Force and Training Committee is to identify ways to expand the roles of indigenous and community-based health promotion and healthcare providers, to integrate this workforce into statewide public health, primary care, and behavioral health settings; as well as, to recommend strategies to improve recruitment and retention practices of all healthcare professional categories, especially primary care physicians and nurses at all levels.

The Committee will develop a three-year Road Map with six-month increments for implementation of strategies.

**Health Care Committee**

**Background:** “The State Innovation Models (SIM) Initiative is providing financial and technical support to States for the development and testing of State-led, multi-payer health care payment and service delivery models that will improve health system performance, increase quality of care, and decrease costs for Medicare, Medicaid and Children’s Health Insurance Program (CHIP) beneficiaries and for all other residents of participating states.” *http://innovation.cms.gov/initiatives/state-innovations/

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2. improve the experience of care
3. reduce per capita costs of health care

The Stakeholder Committees will develop a consensus-based design for a statewide healthcare and wellness system that uses a Patient Centered Medical Home (PCMH) model and meets the needs of its diverse communities and population groups.

**Charges should be addressed consistent with the NM State Health Improvement Plan (SHIP) and CMS SIM requirements.**

**Charge:** The charge to the **Health Care Committee** is to make recommendations for a statewide healthcare delivery system that is modeled on the PCMH model and integrates primary care, public health, behavioral health, dental health, and social services into a seamless continuum of care. The model should emphasize prevention and personal responsibility for wellness, build upon existing models already underway in the State, other promising models from around the country, and address the three goals of the Triple Aim.

The Committee will develop a three-year Road Map with six-month increments for implementation of strategies.

**Health Information Systems Committee**

**Background:** “The State Innovation Models (SIM) Initiative is providing financial and technical support to States for the development and testing of State-led, multi-payer health care payment and service delivery
models that will improve health system performance, increase quality of care, and decrease costs for Medicare, Medicaid and Children’s Health Insurance Program (CHIP) beneficiaries and for all other residents of participating states."

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The Stakeholder Committees will develop a consensus-based design for a statewide healthcare and wellness system that uses a Patient Centered Medical Home (PCMH) model and meets the needs of its diverse communities and population groups

Charges should be addressed consistent with the NM State Health Improvement Plan (SHIP) and CMS SIM requirements.

*Charge:* The Charge to the Health Information Systems Committee is to develop a statewide framework of health information interoperability among PCMH and PCMH-like providers and payers, enables patient engagement, and is consistent with the separate development of an All-Payer Claims Data Base (APCD).

The Committee will develop a three-year Road Map with six-month increments for implementation of strategies. Committee charges will be addressed consistent with the NM State Health Improvement Plan (SHIP) and CMS SIM requirements, and aligned with the federal interoperability model of HHS Office of the National Coordinator for Health Information Technology (ONC).

**Payment Models**

*Background:* "The State Innovation Models (SIM) Initiative is providing financial and technical support to States for the development and testing of State-led, multi-payer health care payment and service delivery models that will improve health system performance, increase quality of care, and decrease costs for Medicare, Medicaid and Children’s Health Insurance Program (CHIP) beneficiaries and for all other residents of participating states."*

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3) reduce per capita costs of health care

The Stakeholder Committees will develop a consensus-based design for a statewide healthcare and wellness system that uses a Patient Centered Medical Home (PCMH) model and meets the needs of its diverse communities and population groups
Committee charges will be addressed consistent with the NM State Health Improvement Plan (SHIP) and CMS SIM requirements.

**Charge:** The charge of the **Payment Models Committee** is to design comprehensive payment reform mechanisms that align economic incentives with population health goals, and the use of policy levers to advance New Mexico's Health System Innovation Design. The Committee will develop a multi-payer strategy and gain-share opportunities that incorporate concepts and themes from the Population Health Improvement Plan (PHIP), and a three-year Road Map with six-month increments for implementation of strategies.

**Tribal**

**Background:** “The State Innovation Models (SIM) Initiative is providing financial and technical support to States for the development and testing of State-led, multi-payer health care payment and service delivery models that will improve health system performance, increase quality of care, and decrease costs for Medicare, Medicaid and Children’s Health Insurance Program (CHIP) beneficiaries and for all other residents of participating states.” *

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The Stakeholder Committees will develop a consensus-based design for a statewide healthcare and wellness system that uses a Patient Centered Medical Home (PCMH) model and meets the needs of its diverse communities and population groups.

Committee charges will be addressed consistent with the NM State Health Improvement Plan (SHIP) and CMS SIM requirements

**Charge:** The charge to the **Tribal Committee** is to assist the other Committees with integration of tribal health improvement and healthcare needs into the proposed model design. It is recognized that community needs vary among individual tribal Pueblos, Tribes and Nations. However, the Committee should strive to develop recommendations that enable integration of tribal health services (i.e., federal or 638) into a statewide system of coordinated care that improves overall health outcomes. The Committee will also contribute recommendations to the development of a three-year statewide Road Map with six-month increments for implementation of strategies.
Upcoming State Innovation Model (SIM) Summits

**June 17, 2015**
Albuquerque, NM location TBD
8 am to 5 pm
https://www.surveymonkey.com/r/JuneSIMSummit

**July 15, 2015**
Albuquerque, NM location TBD
8 am to 5 pm
https://www.surveymonkey.com/r/JulySIMSummit

**August 19, 2015**
Albuquerque, NM location TBD
8 am to 5 pm
https://www.surveymonkey.com/r/AugustSIMSummit

**September 16, 2015**
Albuquerque, NM location TBD
8 am to 5 pm
https://www.surveymonkey.com/r/SeptemberSIMSummit

**October 21, 2015**
Albuquerque, NM location TBD
8 am to 5 pm
https://www.surveymonkey.com/r/OctoberSIMSummit

**November 18, 2015**
Albuquerque, NM location TBD
8 am to 5 pm
https://www.surveymonkey.com/r/NovemberSIMSummit

**December 15, 2015**
Albuquerque, NM location TBD
8 am to 5 pm
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<td>Mary</td>
<td>Tribal</td>
<td>Kewa Family Wellness Center</td>
<td><a href="mailto:mabeita@kewa-nsn.us">mabeita@kewa-nsn.us</a></td>
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<td>Adams</td>
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# State Innovation Model Summit Registration

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