WELCOME

HEALTH SYSTEM INNOVATION DESIGN

For A Healthier New Mexico
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.
HEALTH TRANSFORMATION IN COLORADO: HOW SIM CAN LEVERAGE AND SUPPORT COLORADO’S HEALTHY SPIRIT
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

84%
Of the time, the 14 most common physical complaints have no identifiable organic cause

> 50%
Of referrals from primary care to an outpatient behavioral health clinic do not make the 1st appointment

67%
Of people with a behavioral health disorder do not get behavioral health treatment

80%
Of people with a behavioral health disorder will visit primary care at least once a year

50%
Of behavioral health disorders are treated in primary care

Of people with a behavioral health disorder will visit primary care at least once a year
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

- Input
  - Consumers
  - Stakeholders

- Recommendations
  - Workgroups
  - Sub-Groups

- Advisory Board

- Deliverables
  - SIM Office

- Conclusions

- Effects
  - Key Partners
  - Vendors
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

SHARED RISK & SAVINGS
• Increased provider responsibility
• Extra payment built into cost of care
• Support in practice transformation
• Performance, cost & quality measurement

CARE COORDINATION & SAVINGS
• Increased coordination thru additional payments
• Support in practice transformation
• Performance, quality & cost measurement

PAYMENTS & 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

Ramp-up, including practice assessment tool & IT infrastructure

2015
Initial 100 practices on-boarded

2016

2017
Additional 150 practices on-boarded

2018
Additional 150 practices on-boarded
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**

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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>
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<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.
<table>
<thead>
<tr>
<th>Name</th>
<th>Title</th>
<th>Organization</th>
<th>Email</th>
<th>Phone</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vatsala Pathy</td>
<td>SIM Director</td>
<td>Office of the Governor</td>
<td><a href="mailto:Vatsala.pathy@state.co.us">Vatsala.pathy@state.co.us</a></td>
<td>720.471.3162 - cell</td>
</tr>
<tr>
<td>Lynnette Hampton</td>
<td>SIM Operations Manager</td>
<td>HCPF</td>
<td><a href="mailto:Lynnette.Hampton@state.co.us">Lynnette.Hampton@state.co.us</a></td>
<td>720.724.6214 - cell</td>
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</table>
THANK YOU!

The Project described was supported by Funding Opportunity Number CMS-1G1-14-001 from the US Department of Health and Human Services, Centers for Medicare and Medicaid Services.
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
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
Percentage of NM Adults Without Health Care Coverage by Region, 2013

Source: Behavioral Risk Factor Surveillance System
General Health Status Reported as Fair or Poor
Adults 18+ years
New Mexico and US, 1995 - 2013

Source: Behavioral Risk Factor Surveillance System

* Addition of Cellular Telephones & New Weighting Process
General Health Status Reported As Fair or Poor
Among New Mexico Adults
by Annual Household Income, 2013

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

SOURCE: Behavioral Risk Factor Surveillance System
General Health Status Reported As Fair or Poor
Among New Mexico Adults
by Race/Ethnicity, 2013

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

SOURCE: Behavioral Risk Factor Surveillance System
General Health Status Reported As Fair or Poor
Among New Mexico Adults
by Urban/Rural, 2013

19.2
20.7
22.7
23.6

SOURCE: Behavioral Risk Factor Surveillance System
Current Smoking
Adults 18+ years
New Mexico and US, 1995 - 2013

Source: Behavioral Risk Factor Surveillance System

* Addition of Cellular Telephones and new weighting process
Current Smoking
Among New Mexico Adults
by Annual Household Income, 2013

<table>
<thead>
<tr>
<th>Income Range</th>
<th>Percentage</th>
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<tbody>
<tr>
<td>&lt; $10,000</td>
<td>22.6</td>
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<tr>
<td>$10,000 - $19,999</td>
<td>25.6</td>
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<tr>
<td>$20,000 - $49,999</td>
<td>21.8</td>
</tr>
<tr>
<td>$50,000 +</td>
<td>13.1</td>
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</table>

SOURCE: Behavioral Risk Factor Surveillance System
Current Smoking Among New Mexico Adults by Education, 2013

<table>
<thead>
<tr>
<th>Education</th>
<th>Percentage</th>
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<tbody>
<tr>
<td>&lt; High School</td>
<td>26.4</td>
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<tr>
<td>High School Grad</td>
<td>20.4</td>
</tr>
<tr>
<td>Some College/Tech</td>
<td>20.6</td>
</tr>
<tr>
<td>College Grad</td>
<td>9.5</td>
</tr>
</tbody>
</table>

SOURCE: Behavioral Risk Factor Surveillance System
Current Smoking
Among New Mexico Adults
by Race/Ethnicity, 2013

Percentage

100
80
60
40
20
0

13.1 17.3 18.7 19.9 19.7

AIAN AsianNHOP BlackAA Hispanic White

SOURCE: Behavioral Risk Factor Surveillance System
Current Smoking
Among New Mexico Adults
by Region, 2013

<table>
<thead>
<tr>
<th>Region</th>
<th>Percentage</th>
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<tbody>
<tr>
<td>NW</td>
<td>19.2</td>
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<tr>
<td>NE</td>
<td>16.9</td>
</tr>
<tr>
<td>Metro</td>
<td>19.1</td>
</tr>
<tr>
<td>SE</td>
<td>21.7</td>
</tr>
<tr>
<td>SW</td>
<td>19.0</td>
</tr>
</tbody>
</table>

SOURCE: Behavioral Risk Factor Surveillance System
Current Smoking
Among New Mexico Adults
by Urban/Rural, 2013

SOURCE: Behavioral Risk Factor Surveillance System
Current Cigarette Use by Region, Grades 9 – 12
New Mexico, 2013

Northwest 13.3
Northeast 18.7
Central Metro 18.8
Southeast 14.3
Southwest 15.2

Percent (%)

Source: New Mexico Risk and Resiliency Survey, NM DOH and NM PED; Youth Risk Behavior Survey, CDC

Source: NM YRRS

Updated 10/20/2013
Any Tobacco Use by Year
Grades 9-12, New Mexico, 2013

*Any tobacco use: Past 30-day use of cigarettes, cigars, or spit tobacco. Hookah added in 2011.
Source: NM YRRS
Obesity – BMI ≥ 30
Adults 18+ years
New Mexico and US, 1995 - 2013

Source: Behavioral Risk Factor Surveillance System

* Addition of Cellular Telephones and new weighting process
Obesity – BMI ≥ 30
Among New Mexico Adults
by Annual Household Income, 2013

SOURCE: Behavioral Risk Factor Surveillance System
Obesity – BMI ≥ 30
Among New Mexico Adults
by Education, 2013

<table>
<thead>
<tr>
<th>Education Level</th>
<th>Percentage</th>
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<tbody>
<tr>
<td>&lt; High School Grad</td>
<td>34.5</td>
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<tr>
<td>High School Grad</td>
<td>26.7</td>
</tr>
<tr>
<td>Some College/Tech</td>
<td>27.5</td>
</tr>
<tr>
<td>College Grad</td>
<td>18.3</td>
</tr>
</tbody>
</table>

SOURCE: Behavioral Risk Factor Surveillance System
Obesity – BMI $\geq 30$
Among New Mexico Adults
by Race/Ethnicity, 2013

<table>
<thead>
<tr>
<th>Race/Ethnicity</th>
<th>Percentage</th>
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</thead>
<tbody>
<tr>
<td>AIAN</td>
<td>36.4</td>
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<tr>
<td>AsianNHOPi</td>
<td>13.6</td>
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<tr>
<td>BlackAA</td>
<td>38.0</td>
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<tr>
<td>Hispanic</td>
<td>29.3</td>
</tr>
<tr>
<td>White</td>
<td>21.8</td>
</tr>
</tbody>
</table>

SOURCE: Behavioral Risk Factor Surveillance System
Obesity – BMI ≥ 30
Among New Mexico Adults
by Region, 2013

SOURCE: Behavioral Risk Factor Surveillance System
Obesity – BMI $\geq 30$
Among New Mexico Adults
by Urban/Rural, 2013

SOURCE: Behavioral Risk Factor Surveillance System
Percentage of Workers who are Obese* by Occupation, New Mexico, 2012

SOURCE: NM BRFSS, 2012. *BMI >= 30  Percentages are age-adjusted
Childhood Obesity

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

Source: New Mexico Department of Health Childhood Obesity Surveillance System
Percent of Kindergarten Students Overweight and Obese by Race/Ethnicity, New Mexico, 2013

- **American Indian**
  - Overweight: 18.0
  - Obese: 21.6

- **Hispanic**
  - Overweight: 14.0
  - Obese: 14.6

- **White**
  - Overweight: 12.9
  - Obese: 9.3

Source: New Mexico Department of Health Childhood Obesity Surveillance System
Diagnosed Diabetes
Adults 18+ years
New Mexico and US, 1995 - 2013

Source: Behavioral Risk Factor Surveillance System

*Addition of Cellular Telephones and new weighting process
Diagnosed Diabetes Among New Mexico Adults by Annual Household Income, 2013

SOURCE: Behavioral Risk Factor Surveillance System
Diagnosed Diabetes Among New Mexico Adults by Education, 2013

- < High School: 17.5%
- High School Grad: 11.1%
- Some College/Tech: 9.4%
- College Grad: 6.9%

SOURCE: Behavioral Risk Factor Surveillance System
Diagnosed Diabetes
Among New Mexico Adults
by Race/Ethnicity, 2013

<table>
<thead>
<tr>
<th>Race/Ethnicity</th>
<th>Percentage</th>
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<tr>
<td>AIAN</td>
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<td>AsianNHOPI</td>
<td>9.4</td>
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<td>BlackAA</td>
<td>13.6</td>
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<tr>
<td>Hispanic</td>
<td>12.5</td>
</tr>
<tr>
<td>White</td>
<td>8.1</td>
</tr>
</tbody>
</table>

SOURCE: Behavioral Risk Factor Surveillance System
Diagnosed Diabetes Among New Mexico Adults by Region, 2013

SOURCE: Behavioral Risk Factor Surveillance System
Diagnosed Diabetes Among New Mexico Adults by Urban/Rural, 2013

Percentage

100
80
60
40
20
0

Metro 13.1
Small Metro 14.6
Mixed Urban-Rural 10.5
Rural 14.3

SOURCE: Behavioral Risk Factor Surveillance System
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.
Top Five Ambulatory Care Sensitive Condition Hospitalization Rates, NM, 2013

Other ACSC conditions: Asthma, Hypertension, Angina, and Dehydration

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

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

Rates are age-adjusted to the standard 2000 U.S. population

Source: NM Bureau of Vital Records and Health Statistics
Diabetes Death Rates by Rural/Urban Categories, New Mexico, 2011-2013

<table>
<thead>
<tr>
<th>Category</th>
<th>2011-2013 Death Rate</th>
</tr>
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<tbody>
<tr>
<td>Rural</td>
<td>30.1</td>
</tr>
<tr>
<td>Mixed Urban-Rural</td>
<td>33.1</td>
</tr>
<tr>
<td>Small Metropolitan</td>
<td>23.4</td>
</tr>
<tr>
<td>Metropolitan</td>
<td>25.8</td>
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</tbody>
</table>

Source: NM Bureau of Vital Records and Health Statistics
Teen Birth Rates

Source: National Center for Health Statistics and NM Bureau of Vital Records and Health Statistics
Teen Birth Rates by Region
New Mexico, 2013

Source: NM Bureau of Vital Records and Health Statistics
From head to toe
High-income countries, people under 70, 2012
Disability-adjusted life-years* caused by:

other
21.7

neurological conditions
3.7

respiratory diseases
4.4

musculoskeletal diseases
9.2

mental-health disorders
17.4

cancers
15.9

cardiovascular diseases
14.8

injuries
12.9

Sources: WHO; The Economist

*Sum of years of life lost to premature death plus disability
Life Expectancy by Sex, New Mexico, 2013

<table>
<thead>
<tr>
<th></th>
<th>Number of Years</th>
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<tbody>
<tr>
<td>Total</td>
<td>78.5</td>
</tr>
<tr>
<td>Male</td>
<td>75.7</td>
</tr>
<tr>
<td>Female</td>
<td>81.4</td>
</tr>
</tbody>
</table>
Life Expectancy by Race/Ethnicity
New Mexico, 2013

- White: 79.2
- Hispanic: 78.5
- Black or African American: 76.7
- Asian or Pacific Islander: 85.4
- American Indian or Alaska Native: 74.3
- Total: 78.5
Life Expectancy by Health Region
New Mexico, 2013

Source: NM Bureau of Vital Records and Health Statistics
Life Expectancy from Birth by Rural/Urban Categories, New Mexico, 2011-2013

- Metropolitan: 79.1
- Small Metropolitan: 79.7
- Mixed Urban-Rural: 77.1
- Rural: 76.7

Source: NM Bureau of Vital Records and Health Statistics
Life Expectancy Trend
New Mexico and United States, 1999-2013

Deaths per 100,000 population

Source: NM Vital Records and Health Statistics; CDC NVSS
Life Expectancy Trend by Race/Ethnicity
New Mexico, 1999-2013

AI/AN: American Indian or Alaska Native
Source: NM Vital Records and Health Statistics

Deaths per 100,000 population


White

AI/AN

Hispanic
Infant Mortality Rates
New Mexico 1930-2013 and U.S., 1930-2010

Source: National Center for Health Statistics and NM Bureau of Vital Records and Health Statistics
Infant Mortality Rates by Rural/Urban Categories
New Mexico, 2011-2013

Source: NM Bureau of Vital Records and Health Statistics
Total Death Rates by Region
New Mexico, 2013

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

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

Unintentional Injury
Malignant Neoplasms
Heart Disease
Suicide
Liver Disease
Perinatal Period
Homicide
Diabetes Mellitus
Chronic Low. Respiratory Disease
Congenital Anomalies
All Others

All Causes: 156,158 years

Source: CDC, WISQARS (Web-based Injury Statistics Query and Reporting System)
# Top 8 Leading Causes of Death, New Mexico, 2013 and U.S., 2010

<table>
<thead>
<tr>
<th>New Mexico</th>
<th>Rank</th>
<th>United States</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cancer</td>
<td>1</td>
<td>Heart Disease</td>
</tr>
<tr>
<td>Heart Disease</td>
<td>2</td>
<td>Cancer</td>
</tr>
<tr>
<td>Accidents (unintentional injuries)</td>
<td>3</td>
<td>Chronic lower respiratory diseases</td>
</tr>
<tr>
<td>Chronic lower respiratory diseases</td>
<td>4</td>
<td>Cerebrovascular diseases</td>
</tr>
<tr>
<td>Cerebrovascular diseases</td>
<td>5</td>
<td>Accidents (unintentional injuries)</td>
</tr>
<tr>
<td>Diabetes mellitus</td>
<td>6</td>
<td>Alzheimer's disease</td>
</tr>
<tr>
<td>Chronic liver disease and cirrhosis</td>
<td>7</td>
<td>Diabetes mellitus</td>
</tr>
<tr>
<td>Intentional self-harm (suicide)</td>
<td>8</td>
<td>Nephritis, nephrotic syndrome &amp; nephrosis</td>
</tr>
</tbody>
</table>

Source, New Mexico: Vital Records and Health Statistics

United States: National Center for Health Statistics
5 Leading Causes of Death
New Mexico, 2013, and U.S., 2010

Rates are age-adjusted to the standard U.S. 2000 population

Source: National Center for Health Statistics; NM Vital Records and Health Statistics
Smoking-attributable, alcohol-attributable, and drug overdose death rates\(^1\), NM and U.S., 2013

<table>
<thead>
<tr>
<th></th>
<th>New Mexico</th>
<th>U.S.</th>
<th>Risk Ratio</th>
</tr>
</thead>
<tbody>
<tr>
<td>Smoking-attributable death rate(^2)</td>
<td>100.6</td>
<td>111.3</td>
<td>0.9</td>
</tr>
<tr>
<td>Alcohol-attributable death rate(^3)</td>
<td>53.1</td>
<td>29.4</td>
<td>1.8</td>
</tr>
<tr>
<td>Drug overdose death rate(^4)</td>
<td>21.8</td>
<td>13.8</td>
<td>1.6</td>
</tr>
</tbody>
</table>

\(^1\)Rates are deaths per 100,000 population, age-adjusted to the 2000 U.S. standard population

\(^2\)Smoking-Attributable Mortality, Morbidity, and Economic Costs (SAMMEC), apps.nccd.cdc.gov/sammec/index.asp

\(^3\)Alcohol-Related Disease Impact (ARDI), nccd.cdc.gov/DPH_ABDI/default/default.aspx

\(^4\)Defined 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.
Centennial Care Innovation
State Innovation Model (SIM) Summit
Brent Earnest, Secretary, HSD
May 19, 2015
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
New Mexico Centennial Care

Members
- Efficient use
- Healthy Behaviors
- Early identification

Managed Care Organizations
- Comprehensive delivery system
- Early identification
- Care coordination

Providers
- Integrated care
- Care coordination
- Payment reform

HSD
- Administrative Simplification
- Management integration

Better Health
Lower Costs

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 Care Enrollment

- Molina HC, 214,904
- PHP, 199,374
- BCBS-NM, 118,322
- UHC, 78,215
Member Focus: Centennial Rewards

- 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  
Asthma  
Bone Density  
Step-Up Challenge  
Diabetes  
Healthy Pregnancy  
HRA/CNAs  
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.
Spotlight: Community Health Workers

- 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.
Centennial Care Payment Reform

- 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 and SIM

- 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

NM Health System Innovation Design Stakeholder Summit
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.

<table>
<thead>
<tr>
<th>Indicator</th>
<th>US</th>
<th>NM</th>
<th>FCCH</th>
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<tr>
<td>Immunization</td>
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<tr>
<td>Tobacco</td>
<td>64</td>
<td>61</td>
<td>69</td>
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<tr>
<td>HbA1c</td>
<td>68</td>
<td>73</td>
<td>75</td>
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<tr>
<td>Coronary</td>
<td>72</td>
<td>97</td>
<td>72</td>
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</table>
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.
Police Reform
Long-term, viable solutions to homelessness
The Door Knob Confession
THE OVERLOOKED CONNECTION BETWEEN SOCIAL NEEDS AND GOOD HEALTH

4 IN 5 PHYSICIANS SURVEYED

SOCIAL NEEDS MEDICAL CONDITIONS

4 IN 5 PHYSICIANS surveyed say patients’ social needs are as important to address as their medical conditions.

4 IN 5 PHYSICIANS surveyed are not confident in their capacity to address their patients’ social needs.

UNMET SOCIAL NEEDS → POOR HEALTH

4 IN 5 PHYSICIANS surveyed say unmet social needs are directly leading to worse health for everyone, not only for those in low-income communities.
Well Rx for Poverty

Screen Everyone

Intervene (with partners)

Evaluate

Warning: Chronic Poverty can be hazardous to your health and to that of your children.
Survey Responses

N=906

Questions on Help You May Need

1. In the past 2 months, did you or others you live with eat smaller meals or skip meals because you didn't have money for food?
   [ ] Yes  [ ] No

2. Are you homeless or worried that you might be in the future?
   [ ] Yes  [ ] No

3. Do you have trouble paying for your utilities (gas, phone)?
   [ ] Yes  [ ] No

4. Do you have trouble finding or paying for a ride?
   [ ] Yes  [ ] No

5. Do you need daycare, or better daycare, for your kids?
   [ ] Yes  [ ] No

6. Are you unemployed or without regular income?
   [ ] Yes  [ ] No

7. Do you need help finding a better job?
   [ ] Yes  [ ] No

8. Do you need help getting more education?
   [ ] Yes  [ ] No

9. Are you concerned about someone in your home using drugs or alcohol?
   [ ] Yes  [ ] No

10. Do you feel unsafe in your daily life?
    [ ] Yes  [ ] No
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

$ Cost Curve

Feedback loop from health care provider goes much further upstream
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 A Skilled Workforce

- Campus for Health Leadership High School
Build a Better Future

- Child Development Center
Built Environment

- Wellness Center
- Walking trails
Build Community

- Community farm
- Jobs
Thank you! For more information, please visit:

Website: www.fcch.com

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 Heath 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
Pre Visit

- Check CHADIS and follow workflow for reminder. Get education material, SR vaccine forms, immunizations

- Insure 30 min, ACT, AAP, and Eval

- Insure 30 min, Vanderbilts and post visit

- Check immunizations and call or NMSIIS

- WCC?
  - YES: ASTHMA?
  - NO: ADHD?
    - YES: ADHD?
      - YES: Hospital Follow up?
        - YES: Request hospital records
        - NO: NEW?
          - YES: Check immunizations and call or NMSIIS
          - NO: ADHD?
            - NO: ADHD?
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PATIENT CENTERED VISIT

PCC greets and checks insurance, PCP, address/phone, race/ethnicity. Checks CHADIS, gives intake document and appropriate paperwork. Then arrives.

MA rooms patient and collects paperwork and gives educational material. Collects necessary vitals, pharmacy, meds, allergies, smoking status. Then visit specific input. (ACT, motivation to change, BMI %, BP%)

Nurse will perform spirometry and check inhaler technique if Asthma visit.

Provider sees the patient, provides MI, diagnosis, and treatment

Nurse gives treatments, immunizations, etc.

Post visit discharge MA orders necessary labs, referrals, and follow ups. Reviews clinical summary. Discharges patient.
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

<table>
<thead>
<tr>
<th>Assessment and Medications</th>
<th>First Review</th>
<th>12 mo. And 18 mo. follow-up</th>
</tr>
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<tbody>
<tr>
<td></td>
<td>Pass</td>
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</tr>
<tr>
<td>Is Asthma Severity Documented?</td>
<td>74%</td>
<td>23</td>
</tr>
<tr>
<td>Exercised induced asth?</td>
<td>45%</td>
<td>14</td>
</tr>
<tr>
<td>Asthma Control Test (ACT) done?</td>
<td>58%</td>
<td>18</td>
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<tr>
<td>Control rating documented?</td>
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<td>18</td>
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<tr>
<td>Daily controller prescribed?</td>
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<tr>
<td>Quick relief med prescribed?</td>
<td>100%</td>
<td>31</td>
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<tr>
<td>Patient has spacer?</td>
<td>71%</td>
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<tr>
<td>Asthma Action Plan documented?</td>
<td>35%</td>
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<tr>
<td>Spirometry within year of visit?</td>
<td>68%</td>
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<td>Tobacco use assessment?</td>
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## Education

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<th>Follow-Up scheduled?</th>
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<td>Inhaler Technique instruction?</td>
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<tr>
<td>Triggers/allergen testing discussed?</td>
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<tr>
<td>Flu vaccine?</td>
<td>71%</td>
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<th>Fifth Review</th>
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<td>Height</td>
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<td>Treatment Controller</td>
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<td>FVC Pre-Test</td>
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<td>FEV1</td>
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<tr>
<td>FEV1/FVC</td>
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<tr>
<td>FVC % of Predicted - Pre-Test</td>
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<td>104 %</td>
<td>106 %</td>
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<td>FEV1 % of Predicted - Pre-Test</td>
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<td>98.6 %</td>
<td>95 %</td>
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<td>FEV1/FVC % of Predicted ...</td>
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<td>92 %</td>
<td>87 %</td>
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<td>PEF % of predicted</td>
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<tr>
<td>FEF 25.75 % of Predicted ...</td>
<td></td>
<td>83 %</td>
<td>77 %</td>
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<td>Hospitalizations</td>
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<tr>
<td>ER Visits</td>
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<td>Adherence (% x medication...</td>
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<td>School/work days missed</td>
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<td>Environmental changes</td>
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<td>Comments</td>
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<td>ACT Score</td>
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Population Health Management
24 mo. Old immunization Rate

<table>
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2014/2015 Immunization Rates
### Generic Rx rate

#### 6A 3 Report from Molina Indicating percentage of Generic vs Name Brand Medications

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<tr>
<th>Prescribing Provider Name</th>
<th>Generic</th>
<th>Brand</th>
<th>Generic</th>
<th>Brand</th>
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<tr>
<td>BRANDT, KASEY L</td>
<td>90.54%</td>
<td>9.46%</td>
<td>88.37%</td>
<td>11.63%</td>
</tr>
<tr>
<td>GARCIA, JODIE L</td>
<td>88.36%</td>
<td>11.64%</td>
<td>79.71%</td>
<td>20.29%</td>
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<tr>
<td>GOOD, JOHN M</td>
<td>78.25%</td>
<td>21.75%</td>
<td>87.41%</td>
<td>12.59%</td>
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<tr>
<td>GUTIERREZ-BARELA, KRISTINA</td>
<td>84.45%</td>
<td>15.55%</td>
<td>87.94%</td>
<td>12.06%</td>
</tr>
<tr>
<td>KASEMSAP, PAWITTA</td>
<td>76.33%</td>
<td>23.67%</td>
<td>83.71%</td>
<td>16.29%</td>
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<tr>
<td>MYERS, LORI</td>
<td>78.32%</td>
<td>21.68%</td>
<td>84.43%</td>
<td>15.57%</td>
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</table>

#### 6A 3 Report from BC/BS Indicating percentage of Generic vs Name Brand Medications

<table>
<thead>
<tr>
<th>PRSCRBR_FST_NAME</th>
<th>PRSCRBR_LST_NAME</th>
<th>BRAND SCRIPTS</th>
<th>GENERIC SCRIPTS</th>
<th>TOTAL SCRIPTS</th>
<th>GENERIC RATE</th>
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<tbody>
<tr>
<td>KASEY</td>
<td>BRANDT</td>
<td>44</td>
<td>191</td>
<td>235</td>
<td>81%</td>
</tr>
<tr>
<td>JODIE</td>
<td>GARCIA</td>
<td>88</td>
<td>394</td>
<td>482</td>
<td>83%</td>
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<tr>
<td>JOHN</td>
<td>GOOD</td>
<td>314</td>
<td>820</td>
<td>1134</td>
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<tr>
<td>KRISTINA</td>
<td>GUTIERREZ-BARELA</td>
<td>142</td>
<td>420</td>
<td>562</td>
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<tr>
<td>PAWITTA</td>
<td>KASEMSAP</td>
<td>162</td>
<td>490</td>
<td>652</td>
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<tr>
<td>LORI</td>
<td>MYERS</td>
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<td>CAHPS</td>
<td>Jul '14 - Sep '14</td>
<td>Oct '14 - Dec '14</td>
<td>Jan '15 - Mar '15</td>
<td>Apr '15 - Jun '15</td>
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</tr>
<tr>
<td>Rate provider 0-10</td>
<td>94.0</td>
<td>90.6 ▼</td>
<td>89.7 ▼</td>
<td>90.5 ▲</td>
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<td>Recommend this provider office</td>
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<td>95.7 ▲</td>
<td>96.3 ▲</td>
<td>93.2 ▼</td>
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<td>96.7 ▲</td>
<td>94.1 ▼</td>
<td>93.0 ▼</td>
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<td>Office Staff Quality</td>
<td>86.6</td>
<td>90.6 ▲</td>
<td>91.5 ▲</td>
<td>85.1 ▼</td>
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<td>Access to Care 3 month</td>
<td>79.6</td>
<td>90.4 ▲</td>
<td>88.8 ▼</td>
<td>94.6 ▲</td>
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<td>Care Coordination</td>
<td>75.9</td>
<td>80.1 ▲</td>
<td>74.6 ▼</td>
<td>77.0 ▲</td>
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</table>

Display 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
Medicaid Patient Support and Community Health System

Value Investments in High Return CHW Services
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.
Partners - Collaborators

- Human Services Department – Medical Assistance Division
  - Medicaid
- Blue Cross / Blue Shield of New Mexico – Levels I, II (7/1/15), III
- Molina Health Plan – Levels I, II (7/1/15), III
- Presbyterian Health Plan - Level III
- United - Level III
- Hidalgo Medical Services, First Choice Community Health, UNM SE Heights Clinic, UNM Care Program
4 Core Primary Care Services Model

Primary Care Providers
- Medical
- Dental
- Behavioral
- Patient / Community Support
- CHW

Range of Care
- Prevention
- Diagnosis
- Treatment
- Management
The Flow of Patient Support and Costs

Integrated Primary Care

Sub-Specialty Care

Social Determinants / Community Health

Horizontal Integration

Prevention
Diagnosis
Treatment
Management

Vertical Coordination
Context for Medicaid Patient Support

POPULATION FOCUS LEVEL I

INDIVIDUAL / FAMILY SUPPORT AND EDUCATION LEVEL II

INTENSIVE INTERVENTION LEVEL III

Population Health

% Population

% of Cost

Excellent Health

Good Health

Average Health

Poor Health

Very Poor Health

CDM & Patient Support

Care Coordination

Center for Health Innovation

A Division of Hidalgo Medical Services
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
    - Hospital
  - 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, In-Patient, Pharmacy - Other
  • Case Load 25-30 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

Triple Aim is a framework developed by the Institute for Healthcare Improvement
## Principles of Interventions

<table>
<thead>
<tr>
<th>Data-driven</th>
<th>Integrated with existing Presbyterian plans</th>
<th>Clearly stated, easy-to-understand purpose</th>
<th>Evaluated, monitored</th>
</tr>
</thead>
<tbody>
<tr>
<td>Practical, realistic</td>
<td>Sustainable</td>
<td>Engaging</td>
<td>Age appropriate, culturally relevant</td>
</tr>
<tr>
<td>Promote equity</td>
<td>Based on evidence/contributes PHS expertise</td>
<td>Collaborative</td>
<td>Strengthen existing interventions</td>
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</tbody>
</table>
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

Targeted support for interventions to be sustained by partners with expertise

Partner to strengthen what exists; improve effectiveness of health care interventions
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%)
  - Built Environment
  - Environmental Quality

- Social & Economic Factors (40%)
  - Community Safety
  - Family & Social Support
  - Income
  - Employment
  - Education

- Clinical Care (20%)
  - Quality of Care
  - Access to Care

- Health Behaviors (30%)
  - Unsafe Sex
  - Alcohol Use
  - Diet & Exercise
  - Tobacco Use

- Mortality (length of life) 50%
- Morbidity (quality of life) 50%
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

Heath Plan  Primary Care  Million Hearts Campaign

Percent of Hypertensive Patients whose Blood Pressure is Controlled

- Percent of patients
- Linear (Percent of patients)

June 2013 - Dec 2014

83.00%
78.00%
73.00%
68.00%
63.00%
58.00%

Percent of Patients
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
Committee Structure

Driver Committees

Populatio n Health
- Life Stages
- Obesity
- Tobacco
- Diabetes

Health Care
- PCMH
- Equity (Tribal, Rural, Immigrant)

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

Enabler Committees

Workforce & Training Needs
- Capacity
- Skills & Training
- Remote Care
- Shortage Areas

Health Info System
- Data exchange
- Adoption
- Workflow Integration
- Analytics Tools
- Metrics

Tribal
- Multiple Systems
- Disparities
- Access

Payment Models
- Shared Risk
- Value-Based
- Care Coordination
- Data Exchange
- Analytic Tools
- Metrics
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>
<thead>
<tr>
<th>Monthly Summit Meeting</th>
<th>Issues</th>
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<tr>
<td>1. May 19</td>
<td>Orientation</td>
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<td>2. June 16</td>
<td>Assessment</td>
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<td>3. July 21</td>
<td>Strategies</td>
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<td>4. August 18</td>
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<td>5. September 15</td>
<td>Cross-fertilize Committees</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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<td>8. December 15</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