New Mexico Health System Innovation
Stakeholder Summit
July 15, 2015
8:30 am – 3:30 pm
Taos/Cochiti Meeting Room, Albuquerque Convention Center, Albuquerque, NM

8:30 - 9:00 Coffee and Registration

9:00 – 9:05 Welcome
Retta Ward, Cabinet Secretary, Department of Health

9:05 - 9:30 Framing the NM Health System Innovation
Tres Schnell, Director, Office of Policy & Accountability, Department of Health

9:30 – 10:30 Innovation in NM Native American Health Systems
Moderator Aiko Allen, Tribal Liaison, Department of Health
Melvina Murphy, RN, Albuquerque Area Indian Health Service
David Tempest, MD, Jemez Pueblo
Linda Son-Stone, PhD, First Nations Community Healthsource

10:30 – 10:45 Break and Move into Stakeholder Committees

10:45 – 12:15 Stakeholder Committee Sessions
Population Health (red): Cochiti
Health Care & Payment Models (light blue): Taos
Alignment & Integration of Public Health and Primary Care (yellow):
Laguna
Health Information Systems (orange): Santo Domingo
Tribal (navy blue): Tewa
Workforce and Training Needs (green): Hopi

12:15 – 1:30 Lunch on Your Own

1:30 – 2:30 Stakeholder Committee Sessions continued
Same rooms as morning sessions

2:30 – 2:45 Break and Facilitator Preparation

2:45 – 3:30 Stakeholder Committee Reports, Wrap Up, and Next Steps

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

www.nmhealthsysteminnovation.org
Room # and Name
018-Cochiti
030-Taos
020-Laguna
028-Santo Domingo
070-Tewa
065-Hopi
Highlights:
Health System Innovation Stakeholder Summit
May 19, 2015

SIM Summit Committees

► Population Health
► Alignment and Integration of Public Health, Behavioral Health, Health Care (did not meet in Summit 1)
► Workforce and Training Needs
► Health Care, meeting together with
► Payment Reform
► Health Information Systems
► Tribal
Cross-Cutting Themes from Committees

- Tribal representative on each work group
- Ensure “all voices” heard—that they have input
- Address “what’s in it for participants?” question
- Need to help people understand concepts and components of the plan, especially…
  - What “population health” and “population health outcomes” are
- Language and literacy are obstacles to overcome
- Interoperability of health information systems critical
- Demonstrate cultural sensitivity and responsiveness

Cross-Cutting Themes from Committees

- Address disparities in geographic areas (data to help with this)
- Find balance between needs of young and aging population
- Address health system navigation needs of consumers
- Address big issues re behavioral health service scarcity
- Address integration, alignment, diversity, and training quality of workforce
- Want relevant information from existing models to analyze pros and cons for NM
Different Foci of Certain Committees

► **Health Care/Payment Reform:**
  ► Need for “backbone” (administrative) support in SIM process

► **Population Health:**
  ► Must address social determinants of health and “power” factors

► **Workforce and Training Needs:**
  ► Address or present workforce development as an economic development issue

► **Tribal:**
  ► Questions on the SIM process of consulting with the tribal governments

► **Health Information Systems:**
  ► Issues to be addressed include interoperability of systems, “off the grid” and lack of broadband access in rural areas, sharing of and analysis of data

Who Should be Added to the Table:

► Representatives or advocates for
  ► those with disabilities,
  ► those with behavioral health issues,
  ► veterans,
  ► oral health providers
  ► youth,
  ► faith-based organizations,
  ► social services and public safety
  ► institutes of higher education
  ► nursing home care and early childhood home visiting programs
  ► State Workforce Committee
  ► administrators and finance people
  ► CYFD
Highlights: Tribal Group

- How does SIM fit with tribal (IHS and 638) health system models
  - Perception that SIM will be imposed on tribes/pueblos/nations
  - Perception that federal government “bailing” on its responsibilities
  - Who represents and handles care of urban Native Americans
  - What feedback processes exist if policies “don’t work” for Native Americans
  - How to integrate traditional means of healing
  - How to fit payment models
- Focus on people’s access to and use of services; many have coverage
- Obstacles to address:
  - Frequent change in tribal/pueblo/nation governments
  - Language, literacy (visual learning), health system navigation
  - Access issues: lack of transport, no electricity (no computers), isolation
  - Consultation policy implementation on government to government basis

Highlights: Workforce and Training Needs

- Not just about academics. Need field-level training, mentoring, training via technology (ECHO); cross-sector training/education
- Address diversity, quality, skill needs in training
- Address recruitment and retention issues:
  - “stressors” faced by providers and job burnout
  - lack resources/support in rural areas
  - potential incentives
  - job design and support to keep paraprofessionals “in the field”
- Need cost-effectiveness data on different approaches
- Payment for CHWs fits “fee for service” model SIM wants to avoid
- Need lessons-learned and data on what works in NM
Highlights: Health Care and Payment Reform

- How to best engage “small” providers in process
- Need to inventory state assets and policies, identify barriers
  - Payment reform needs information on existing models
- Need for strong administrative and facilitation support in process
- Address how to best fit behavioral health into the care continuum
- Address health literacy, access, levels of care, non-traditional times for health services, protocols, and community delivery systems
- Consider a physician network communicating with EMS and telemedicine people

Highlights: Population Health

- Must address social determinants of health – poverty, in particular
  - Prevention not well funded in NM
- Be aware of power issues—among providers, hospitals, race/ethnicity
- Address health care system navigation issues for patients
- Bring counties/municipalities to the table; incorporate local planning assessments at county/sub-county levels
- Consider not just PCMH, but also community-centered wellness sites
- Look at who “owns” the data and how we share health data
- Nurses and EMS to be better integrated into system, especially in prevention
Highlights: Health Information Systems

- Health data for policy maker, clinical manager, patient use
- Adopt electronic health records (HER) statewide
- Address rural technology infrastructure needs (telehealth, EHRs)
- Educate health workforce in use of health information technology
- How to get data from IHS, Veterans Admin, behavioral health and non-traditional partners (Walmart pharmacies)
- Payers fear losing competitive edge so reluctant to participate
- Consider use of personal digital devices for patients’ medical info

Highlights: Health System Innovation Stakeholder Summit

June 17, 2015
Cross-Cutting Themes

- A model needs to be identified as so many other things are contingent upon it.
- The model should be wellbeing centered, not illness / injury centered
- A focus on disparities and determinants of health.
- The team is not necessarily headed by an MD, but includes CHWs, EMTs and others in a non-hierarchical approach, with a coordinator.

Highlights from Alignment and Integration Committee

- A shared vision of alignment and integration that includes individual (health consumer) and community input.
- Shared, standardized measurements among public health, providers and payers.
- Commitment to *Health in All Policies* in system development.
- A “backbone” agency that can promulgate and engender a culture of prevention.
- Adherence to the principle of “form follows function.”
- Alignment of the clinical and business (payment) models.
Highlights from Healthcare Committee

- Identify the integration model that works best to fit the needs of New Mexicans.
- Create a blended approach to our payment model.
- Troubleshoot on how to create workforce retention and effective methods for recruitment with adequate reimbursement to our NM providers (in conjunction with the workforce committee).
- Build upon our current infrastructure of evidence-based models, and better utilize existing community resources.

Highlights from Population Health Committee

- There is a need for good data on key population health indicators, and a way to determine whether we are turning the curve.
- There is also a need to inventory resources in the state, and build on those resources or projects that exist and are working well.
- We should focus on counties that currently have limited resources.
- The community-centered health home or wellness home model seems most appropriate to pursue.
- Incorporate non-traditional members into care teams (such as traditional healers), and address prevention from a social determinants lens.
- We should strive to change the view of “de-medicalizing” what are actually social problems and reclaim monies saved from implementing this view of prevention.
Highlights from Payment Models Committee

- Dr. Eugene Sun of BCBS facilitated this group.
- Dr. Sun said that what BCBS is initiating under Centennial Care is closest to Fee For Service (FFS) with Per Member Per Month (PMPM) and Pay for Performance (P4P).
- Quality measures include well child visits, dental visits, and asthma compliance.

Payment Terms

- ACO: Accountable care organization
- FFS: Fee-for-service
- P4P: Pay for performance
- PMPM: Per member per month payment
- PMPY: Per member per year payment
- PPACA: Patient Protection and Affordable Care Act
- PPS: Prospective payment system, a reimbursement mechanism where providers are paid a flat rate per case
- PQRI: Physician Quality Reporting Initiative
Highlights from Tribal Committee

- Incorporate a better understanding of key terms from a cultural perspective (e.g., inequities in lieu of disparities; wellbeing in lieu of wellness).
- Our tribal systems include ITUs (IHS, Tribal, Urban) and to some degree there is integrated care but gaps exist.
- Differences: A 638 clinic or facility can address local issues vs. IHS’s “one size fits all” approach that is constrained by budget formulation. A 638 is more agile and can restructure priorities when needed.
- Some 638s have reached integration (Alamo, Ramah, Isleta).
- Bi-directional data sharing, internet connectivity, and consistent quality measures need to be addressed.

Highlights from Workforce Committee

- Need to break down silos within our workforce between public health and health care (including HC, BH, and OH), beginning with training, which should not just be medical model centered but include public health, reducing hierarchy within teams.
- Do not duplicate model/be able to work together and be conscientious about cost containment.
- Patient centered approach-everyone on team knows that it starts with the patient, wellness alliance, very different from the way providers were trained 20-30 years ago, importance of a coordinator role.
- Criteria for applying an integrated model (need, likely to succeed though learn from failure, strategic, not duplicating services, buy-in, and return on investment).
Highlights from Health Information Systems Committee

- Good population-based health data but not record level information to support PCMH model. No real time data to do real time improvements to health system.
- Need to identify all data sources for diabetes, tobacco use, and obesity.
- Lack of “central nervous system”, no backbone exists.
- Good measures (e.g. NCQA)
  - Gap1: Data not aggregated. Data exists in silos.
  - Gap2: Data not population based, only patients that see certain providers are captured in data.
  - Gap3: No data exists on providers who give care.
THE END IN MIND

The triple aim:

✓ Improved Population Health and Health Outcomes
✓ Enhanced experience of care for the person, ensure quality and satisfaction
✓ Reduced health care costs and invest in health promotion

ROADMAP TO ACHIEVE AIM #1

✓ Improved Population Health and Health Outcomes
  ▪ Integrated and, when possible, co-located primary care, behavioral health, oral health, & public health
    ○ Use community health workers, community EMS
  ▪ New health system access for underserved population
    ○ Enhanced patient centered medical home approach extending into community: public health, CBO, Community Health Councils, and diverse partners
ROADMAP TO ACHIEVE AIM #1

✓ Improved Population Health and Health Outcomes
  ▪ Health system addresses adverse social determinants (housing, transportation, healthy food, etc.) emphasizes prevention and healthy lifestyle choices, and reduces health disparities

ROADMAP TO ACHIEVE AIM #2

✓ Enhanced experience of care for the person, ensure quality and satisfaction
  ▪ Health system is person-centered, culturally sensitive, & meets local needs
    o Involve consumers in decision-making about their own health and well being options
    o Expand use of PCMH to engage patients (assessments, wellness activities, and technology)
    o Develop a payment model that supports a PCMH and community centered wellness system
ROADMAP TO ACHIEVE AIM #2

- Enhanced experience of care for the person, ensure quality and satisfaction
  - Value-based care provided by a multidisciplinary, diverse, geographically distributed health system workforce reflecting NM demographics
    - Train and integrate health professionals and paraprofessionals (e.g. community health workers and community EMS)
    - Develop inclusive recruitment and retention policies and processes

ROADMAP TO ACHIEVE AIM #3

- Reduced health care costs and invest in health promotion
  - Multi-payer strategy and/or value-based reimbursement for care and health promotion policies and services (CHW, built environments)
    - Develop sustainable pricing and payment models to support innovation design
ROADMAP TO ACHIEVE AIM #3

✓ Reduced health care costs and invest in health promotion
  ▪ Functional, interoperable health information system
    o Improve care coordination, medication management, EHR interoperability, evaluation and improvement of health system performance

PRIORITY INDICATORS

✓ Obesity ~ Healthy Weight
✓ Diabetes ~ Prevention and Management
✓ Tobacco Use ~ Prevention and Control

State of Health in New Mexico

State Health Improvement Plan
http://nmhealth.org/publication/view/plan/411/
Community Summit 1 and 2 Focus

- Design a Person Centered Care Model that works for New Mexico

Summit 1 and 2 Focus

- Public health partnerships at the state level: State Health Assessment and State Health Improvement Plan; Collective Impact
- Regional Health Promotion Teams collaborate with Community Health Councils with representatives from all community sectors: health, social services, education, business, faith...to improve health
BUILDING THE BRIDGE TO UNITE AND ALIGN THE HEALTH AND WELLBEING SYSTEM TOWARD INTEGRATION

The community reaching out toward healthcare

Healthcare reaching out to the community

- Add community partners to address social determinants
- Local policies to improve access and opportunities for wellbeing
- Start where the community is and build from there
- Co-locate or align

An Accountable Community – all sectors, individuals
Community-Centered Health Home

Larry Cohen, Founder and Executive Director, Prevention Institute
ALIGNMENT → INTEGRATION

Disorder & Confusion → Individual Impact in isolation → Coordinated Impact with alignment → Collective Impact with collaborative action = integration

Adapted from source: Santa Fe Community Foundation

A Community with isolated impact, everybody doing their own thing, improvements here and there
All Contribute to Improve Population Health, Improve System Experience and Reduce Health Costs

Scenario 1 – Patient with asthma

- **Bucket 1** – Diagnosis, tx action plan, medications, clinical guidance
- **Bucket 2** – Community health worker does home visit; assesses triggers, counsels patient; offers limited remediation
- **Bucket 3** – Community standards on housing; limits to indoor and outdoor pollutants; reductions in smoking rates
COMMITTEE WORK – SUMMIT #3
CREATING AN INTEGRATED SYSTEM

COMMITTEE OBJECTIVES

• What specific recommendations will your committee contribute to the innovative design model for New Mexico today?

• What are the considerations that must be made in light of diverse communities in New Mexico?

• How do we move communities toward alignment with the overall result of an integrated, accessible and equitable system?

STAKEHOLDERS DEVELOP NEW MEXICO’S DELIVERABLES TO THE CENTERS FOR MEDICARE & MEDICAID

• Driver Diagram (in your materials)

• Value-Based Health Care Delivery and Payment Methodology Transformation Plan

• Population Health Plan

• Health Information Technology Plan

• Workforce Staffing Model

• Quality and Performance Measures

• Operational and Sustainability Plan

INNOVATION IN NEW MEXICO
NATIVE AMERICAN HEALTH SYSTEMS
**Triple Aims**

- **Primary Drivers**
  - New health system models and policies support health access for underserved populations
  - Public health, behavioral health, and primary care functions integrated and co-located
  - Health system addresses adverse social determinants, emphasizes prevention and healthy lifestyle choices, and reduces health disparities

- **Secondary Drivers**
  - Improve educational infrastructure to prepare public health/health care professionals
  - Provide appropriate access to essential, quality, consistent, seamless patient-centered services statewide
  - Promote healthy eating/active lifestyles (obesity), diabetes prevention/management, prevent/control tobacco use
  - Address sub-populations that can produce ROI (e.g. ED frequent users, small areas with disparities)
  - Address "social determinants of health" affecting health

**Driver Diagram**

- **NM Department of Health**
- **NM Human Services Department**
- **June 1, 2015**

- **Improve Population Health Outcomes by 2020**
  - Health system is patient-centered, culturally sensitive, meets local needs
  - Primary care, public health, and behavioral health services are integrated & managed for quality
  - Acute and long-term care managed for quality
  - Value-based care provided by a multidisciplinary, diverse, geographically distributed health system workforce reflecting NM demographics

- **Improve Patient Experience and Quality of Care by 2020**
  - Multi-payer strategy and/or value-based reimbursement for care policies
  - Functional, interoperable health information system

- **Slow the Rate of Growth in Health Care Costs by 2020**
  - Develop inclusive recruitment and retention policies and processes
  - Develop sustainable pricing and payment models to support innovation design
  - Improve care coordination, medication management, EHR interoperability, evaluation of health system performance

- **NM Department of Health**
- **NM Human Services Department**
- **June 1, 2015**

Draft Version #3       June 1, 2015
Population Health and the State Innovation Model Grants

John Auerbach
A reminder about the issues...

- Ms. Fran Edwards at doctor for first physical in 5 years
- 55 years old, married, smokes, overweight, little exercise
- Asthmatic, High blood pressure
- Periodically stops medications due to lack of money
Medical care/meds available with insurance
But these also contribute to her health

- **Income** - Low income/family of 5
- **Barriers to eating healthy and exercising** - Lives in neighborhood with rising crime rate, few parks; no supermarket
- **Under stress** - 1 child in junior college; high school-age child with substance problem
- **Housing sub-par** – mold and ventilation problems
New Opportunities to Address Prevention with SIM
3 buckets

#1 - Traditional Clinical Approaches

Focused on Preventive care
### Million Hearts – The Clinical Components

<table>
<thead>
<tr>
<th><strong>Aspirin</strong></th>
<th>People at increased risk of cardiovascular events who are taking aspirin</th>
<th><strong>47%</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Blood pressure</strong></td>
<td>People with hypertension who have adequately controlled blood pressure</td>
<td><strong>46%</strong></td>
</tr>
<tr>
<td><strong>Cholesterol</strong></td>
<td>People with high cholesterol who are effectively managed</td>
<td><strong>33%</strong></td>
</tr>
<tr>
<td><strong>Smoking</strong></td>
<td>People trying to quit smoking who get help</td>
<td><strong>23%</strong></td>
</tr>
</tbody>
</table>

*MMWR. 2011;60:1248-51*
3 buckets

#2 - Innovative Patient-Centered Care

Focused on Preventive care
Community Health Workers

- Links health systems and communities
- Facilitates access to and improve quality and cultural competence of medical care
- Builds individual and community capacity for health by:
  - Increasing health knowledge and self-sufficiency of the patients
  - Serving as community health educators
  - Providing social support
  - Advocating for the health care needs of patients and communities
3 buckets

#3. Community-Wide Health

Focused on Preventive care
Million Hearts: Community-Wide Components

COMMUNITY PREVENTION
Reduce need for treatment

- Tobacco control
- Sodium reduction
- Trans fat elimination
CDC Supports Bucket 3
Partnerships to Improve Community Health (PICH)

PICH (39 Awardees)

Multi-sectoral community coalitions in:

- Large Cities and Urban
- Small Cities and Counties
- American Indian tribes

Examples of Activities:

Boston Public Health Commission - implement citywide strategies to improve built environment - opportunities for walking & biking
Scenario 1 – Patient with asthma

– **Bucket 1** – Diagnosis, tx action plan, medications, clinical guidance

– **Bucket 2** – Community health worker does home visit; assesses triggers, counsels patient; offers limited remediation

– **Bucket 3** – Community standards on housing; limits to indoor and outdoor pollutants; reductions in smoking rates
Possible Approaches

• **Bucket 1**: Prioritize & incentive immunizations, screenings and counseling

• **Bucket 2**: Prioritize & incentivize innovative approaches (e.g. CHWs); Link with/referral to community services

• **Bucket 3**: Channel resources to community wide health efforts; link/coordinate with funders of community-wide efforts
The solution for Ms. Edwards

- Regular access to her doctor – screening, counseling, treatment
- Referral to community agencies for weight
- Home visits to reduce risk factors
- Healthier conditions at home
As we noted in a previous analysis, the State Innovation Model (SIM) Testing Awards that HHS awarded to six states (Arkansas, Maine, Massachusetts, Minnesota, Oregon, and Vermont) were to support states’ work on multi-payer payment and delivery system reform. Strategies to improve the population’s health were a critical aspect of the SIM awards. The SIM Funding Opportunity Announcement (FOA) required that states explain how the model would improve the population’s health in a number of areas including: health disparities, determinants of health, mental health, and substance abuse. The FOA also noted that states should describe how their State Health Care Innovation Plan integrates community health and prevention into their delivery system and payment models.

This chart lays out the population health strategies the selected states plan to implement through their SIM initiatives. These strategies are based on the states’ proposals and other SIM documents that you will find linked in the text below and in our document library. For information on the payment and delivery system reforms that these states are testing, their health information technology and data capabilities, as well as the scope of their models, please see our previous chart. Please note that because the information in both of these charts was abstracted from early documents, we anticipate that this information may change as the states implement their models.

We encourage our community to share and discuss more details, ideas, issues and emerging products and results on State Reform. Especially as SIM Design and Pre-Testing states complete their State Health Care Innovation Plans there is interest in how population health strategies will be integrated. Do you know of state activity or analyses that we should add to this chart? Eager to update a fact we’ve included? Your contributions are central to our community’s ongoing, real-time learning, so tell us in a comment below, or email the author with your suggestion. Larry can be reached at lhinkle@nashp.org.

<table>
<thead>
<tr>
<th>State</th>
<th>Arkansas</th>
<th>Maine</th>
<th>Massachusetts</th>
<th>Minnesota</th>
<th>Oregon</th>
<th>Vermont</th>
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<tbody>
<tr>
<td>Project Narrative</td>
<td><strong>X</strong></td>
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### Population Health Objectives in the Model

**Arkansas’ primary strategy for population health is through its medical home and health care initiatives.** Arkansas plans to expand access to medical homes within 3-5 years. These medical homes will proactively examine the patient’s health with a focus on preventive services and chronic disease management. Arkansas will also change the payment mechanism to underwrite the costs of primary care practice transformation and reward providers for effective population health management.

**Maine’s model will deliver care through patient-centered, primary-care integrated, multi-payer Accountable Care Organizations that are responsible for improving population health, patient experience of care, and controlling healthcare costs. These ACOs will also integrate primary care and behavioral health, align healthcare and public health systems to support improving chronic disease outcomes and address health disparities, and improve health measures and equity. These ACOs will also build on the model of MaineCare (state Medicaid program) Accountable Communities (SIM plan 7-8).**

**Massachusetts will integrate public and population health into its multi-payer model. The state defines primary care providers broadly to include not just primary care practices and hospital-based providers, but also community health/mental health centers that provide primary care services. These provider organizations may be embedded in larger organizations, ranging from integrated delivery systems to independent practice associations to ACOs. Additionally, the Department of Public Health serves with the four other departments as an Implementing and Strategic Partner (see pg. 7).**

**Minnesota’s Health Care Delivery System (HCDS) demonstration aligns with ACO models from other public and private payers creating financial incentives for delivery system innovation to bring better integration and coordination of care across the spectrum of services. Participating organizations are given incentives to partner with community organizations to create 15 Accountable Communities for Health that integrate medical care with behavioral health, mental health, public health, long-term care, social services, and other provider and share accountability for population health.**

**Oregon’s primary focus is the reduction of chronic diseases and the risk factors that contribute to them. Oregon is using SIM to accelerate population health goals in 3 areas:**

1. **Advancing the spread of the Coordinated Care Model – with emphasis on prevention and proactive population health management;**
2. **Providing targeted support for 49 local “flood the zone” collaborations aimed at creating changes in practice around leading causes of death and disease.**
3. **Enabling increased population health performance measurement.**

**Vermont’s SIM model seeks to reach the three overarching priority areas for health improvement as identified in Vermont’s 2012-2015 State Health Improvement Plan:**

1. **Reduction in the prevalence of chronic disease through improving physical activity, nutrition and decreasing the rates of tobacco use.**
2. **Reduction in the prevalence of Vermonters with or at risk of substance abuse and/or mental illness.**
3. **Improvement of childhood immunization.**

Vermont also believes that the primary models it will pursue through SIM – Shared Savings ACOs, Bundled Payments, and Pay for Performance – will help build provider capacity to better manage population health.
Arkansas is designing interventions to specifically address and support challenges faced by its communities such as poor rankings in smoking, early prenatal care, preventable hospitalizations, as well as reducing the disease burden presented by rising rates of obesity and Type 2 diabetes (SIM plan 13).

### Strategies in the Model to Address Social, Economic, and Behavioral Determinants of Health and Health Equity

Arkansas will use the health home model for those with developmental disabilities, long-term services and supports, and behavioral health issues. Arkansas’ health home functions match the CMS definition and aim to ensure provider accountability for the full client experience including health outcomes, and will coordinate all health care and support services needed by a client over time.

### Strategies in the Model to Address Mental Health and Substance Abuse Disorders

Arkansas is using SIM to provide to CCOs in order integrate mental health and addiction services. Oregon has also identified measures related to mental health and substance abuse that CCOs will be required to report.

### The Model Builds

Arkansas is using SIM to implement the Congregate Housing with Services model. This approach targets a low-income population living in subsidized housing apartments or other highly concentrated, naturally occurring communities with a greatly coordinated and efficient model of support. This strategy will target social determinants of health, include prevention and wellness programs, and seek to prevent unneeded emergency and acute health care. Oregon’s model also builds on, and provides operational support to, its existing Regional Health Equity Coalitions. These coalitions seek to reduce disparities and address social determinants of health. SIM support will also be used to expand health care interpreters and other efforts to enhance communication and education across all populations, and to reduce barriers to services.

### The Vermont Department for Health (VDH) is actively developing strategies that can be used by all programs in the model to reduce health disparities. The Department is taking the lead, but is collaborating with other agencies and partners to achieve health equity.

#### Accountable Communities

Accountable Communities are required to serve a minimum number of MaineCare (Medicaid) members and must include MaineCare enrolled providers. Maine notes that in order to change and prevent disparities a multi-level approach such as the one envisioned by its model is required to eliminate health disparities and reach health equity.

The reduction of health disparities is a goal of the Prevention and Wellness Trust Fund (see below). Additionally, the Massachusetts SIM operational plan (see pages 65-66) notes that there is substantial evidence that a strong primary care base delivered through PCMH – as the state is doing – will reduce disparities in care and narrow racial disparities in health outcomes.

The fifteen Accountable Communities for Health will form with a priority on communities in areas with a lower level of ACO penetration, greater disparities, and greater health care needs.

The payment structure and incentives for ACOs will encourage them to adopt strategies such as coordinated and integrated health care and multi-payer Health Care Homes, Community Health Teams, and Service Coordination Teams, which will provide the infrastructure to address social and behavioral determinants of health.

### The十五 Accountsable Communities for Health

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<tr>
<th><strong>Engaging and Integrating Community Health and Prevention into Delivery System and Payment Reform Models</strong></th>
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<td><strong>Maine</strong></td>
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| Maine will employ several strategies to activate consumers and communities including: increased use of **shared decision making tools**, learning collaboratives to disseminate patient engagement tools, and increased public awareness of shared decision making and health care self-management. The model also builds off of existing strategies including consumer supports such as Better Health Better ME and Get Better Maine and existing patient supports including: peer navigators, peer supports, and community health workers. **Accordable Communities** are explicitly set up to be guided by local needs assessments, with wide flexibility in determining which community organizations to partner with and which services to prioritize, as well as how to integrate various health care streams and determine financial allocations. Minnesota’s SIM plan will also link with Health Care Homes and Community Care Teams already underway in Minnesota. Minnesota has also created a Community Advisory Task Force, focused on engaging communities and patients. **Oregon’s model** integrates Non-Traditional Health Care Workers (NTHW), which include Community Health Workers, Peer Wellness Specialists, Patient Navigators, Doulas and Health Care Interpreters. A core requirement for CCOs is that they collaborate with local hospitals, public health agencies, social services organizations, and others to conduct community health needs assessments, and develop a community health improvement plan based on the needs and resources identified. **Vermont’s SHIP** cites its state health assessment (Healthy Vermonters 2020) to describe priority indicators. These include:

- Increase the percentage of adults who meet physical activity guidelines from 59 to 65%.
- Reduce coronary heart disease deaths from 112 to 99 per 100,000 people.

| **Arkansas** |
| Arkansas will monitor progress indicators and intermediate outcomes including: decreased outcomes including: intermediate outcomes including: **decreased** |
| **MaineCare** |
| MaineCare will be submitting an **performance** |
| **Massachusetts** |
| Massachusetts will use the **performance** |

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<th><strong>Possible metrics</strong></th>
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<td><strong>off of Chapter 224, passed in 2012. This law created the Prevention and Wellness Trust Fund, and provides the fund with $57 million over 4 years. This fund is administered by the Department of Public Health and supports community-based partnerships including municipalities, healthcare systems, business, regional planning organizations, and schools to work together to provide interventions that: reduce rates of the most prevalent and preventable health conditions, increase healthy behaviors, increase the adoption of workplace-based wellness or health management programs, and address health disparities. SIM funds will support the development of an electronic open-source referral system to nine community health centers (CHCs) with a minimum of four different community resources. Additionally, 30 CHCs have committed to transforming into PCMH.</strong></td>
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<tr>
<td><strong>Oregon’s model</strong> calls for the OHA and its CCOs to collect several measures related to population <strong>Practices participating in the Vermont Blueprint for Health are complemented by and collaborate with Community Health Teams (mentioned above). These teams connect patients with existing and developing social and community supports and increase the effectiveness and span of primary care in managing population health. These teams will be expanded under the SIM model.</strong></td>
</tr>
</tbody>
</table>
Population Health Metrics Used in Model

- Disease progression (e.g., diabetes, congestive heart failure), greater control of hypertension, reduced re-hospitalization rates and ambulatory sensitive hospitalizations (e.g. pneumonia, asthma), and fewer late-stage cancer diagnoses. (SIM plan 13).
- Specific goals include: reducing premature deliveries (before 39 weeks) to less than 10% statewide, achieving 50% adherence rate of comprehensive diabetes metrics, and measuring and improving documentation of blood pressure control in PCMHs. (SIM plan 15).

Integrated Care Model state plan amendment for its Accountable Communities initiative. This will include a quality framework with goals and objectives, specific quality measures, and how quality measurement will be used to improve care. MaineCare’s Health Homes State Plan Amendment will also include an alignment with CMS Adult and Children’s Core Measure sets. To measure patient experience of care, Maine will conduct a statewide CG-CAHPS survey.

Massachusetts selected measures that are externally validated and already in use, such as measures compiled by HEDIS, AHRQ, CMS, and private payers in the state. These metrics focus on: adult prevention and screening, health care coordination (adult and pediatric), adult chronic conditions, access (adult and pediatric), and behavioral health (adult and pediatric).

for Minnesota Accountable Communities for Health include: reduction in chronic condition exacerbations, chronic disease management, patient satisfaction with quality and care coordination, patient engagement in health care and health, health disparities, preventive care utilization, access to care, community services and partnerships, behavioral and mental health services resources, and others.

Notes:
Produced by Larry Hinkle

Topics:
State Innovation Models
Population Health Components of State Innovation Model (SIM) Plans: Round 2 Model Testing States

*Chart updated March 6, 2015

Amy Clary

The Round Two State Innovation Model (SIM) Test Awards granted by HHS to eleven states (Colorado, Connecticut, Delaware, Idaho, Iowa, Michigan, New York, Rhode Island, Ohio, Tennessee, and Washington) support state efforts to build multi-payer models of health system transformation. As noted in a previous analysis, population health improvement is an important component of the SIM awards. The SIM Funding Opportunity Announcement (FOA) required states to describe how their models will improve population health in a number of areas, including prevention, health equity and the social determinants of health, rates of obesity and diabetes, and healthy behaviors, including reduced tobacco use. The FOA also required states to incorporate new delivery system models into their population health improvement plans.

This chart contains population health strategies, as defined by the states, that the states plan to implement through their SIM Round Two Model Testing initiatives. The information in the chart is derived from the states’ proposals and other documents that you will find linked in the text below. Information on the population health components of the Round One SIM Model Test Awards can be found in our previous SIM population health chart. Please note that because the information in these charts was abstracted from early documents, we anticipate that this information may change as the states implement their models.

We encourage our community to share and discuss more details, ideas, issues and emerging products and results on StateReform.org. Do you know of state activity or analyses that we should add to this chart? Eager to update a fact we’ve included? Your contributions are central to our community's ongoing, real-time learning, so tell us in a comment below, or email aclary@nashp.org with your suggestions.

<table>
<thead>
<tr>
<th>States</th>
<th>Population Health Objectives in the Model</th>
<th>Strategies in the Model to Address Social, Economic, and Behavioral Determinants of Health and Health Equity</th>
<th>Engaging and Integrating Community Health and Prevention into Delivery System and Payment Reform Models</th>
<th>Population Health Metrics Used in Model</th>
<th>Strategies in the Model to Integrate Primary Care and Mental Health and Substance Abuse Disorder Services</th>
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<td>Colorado</td>
<td>Colorado seeks to improve population health by establishing a close partnership between public health, behavioral health, and primary care, and prioritizing ten population health focus areas including obesity, substance use, and mental health (SIM p.1).</td>
<td>Colorado state agencies are collaborating to address the social determinants of health using a “life stages” approach to targeting resources. The plan will include data collection on disparities in tobacco use, diabetes, and obesity (SIM p. 2, 11, 62).</td>
<td>Colorado will examine the possibility of long-term reimbursement models for population-based prevention and wellness services (SIM p. 25).</td>
<td>Population Health Transformation Collaboratives made up of community health leaders will work with the state’s new Health Extension Service on local community health initiatives (SIM p. 4-5, 10). Targeted local public health agencies will receive funding for community prevention activities and to link practices, community resources, and public health (SIM p. 2).</td>
<td>The program’s shared risk and savings payment model will incentivize integrated physical and behavioral health services (SIM p. 2, 12-13, 23). A child mental health coordinator will develop prevention and early intervention programs for mental health challenges in children (SIM p. 5-7).</td>
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<tr>
<td>Connecticut</td>
<td>Connecticut plans to strengthen primary care and integrate community and clinical care. It also aims to improve prevention and screening, including mental health and substance abuse screening, and chronic illness.</td>
<td>Connecticut will convene a multi-sector Population Health Council tasked with setting priorities for health improvement areas, focusing on the barriers most likely to contribute to health disparities. The Health Enhancement Communities initiative focuses resources on the areas of the state with greatest disparities and will include payment.</td>
<td>Connecticut plans to develop sustainable Prevention Service Centers (PSCs) that will offer community-based preventive services. Reimbursement for Community Health Workers (CHWs) may also be part of the plan (SIM p. 2-3; 8). The state will also augment its use of Value-Based Insurance Design (VBID) and shared.</td>
<td>Connecticut will report measures for statewide population health targets including tobacco use, obesity, and diabetes (SIM p. 25). The plan also includes quality targets on preventive screenings, asthma, and premature death from cardio-vascular disease.</td>
<td>The model will complement the state’s existing Behavioral Health Home initiative, which coordinates physical and mental healthcare for Medicaid recipients with serious and persistent mental health conditions.</td>
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<td>Delaware</td>
<td>Delaware aims to integrate population health with value-based payment models. It seeks to attribute every patient to a primary care provider (PCP) who is incentivized to address population health issues (SIM p. 1-8). Delaware emphasizes cross-agency collaboration as part of its strategy to address social determinants of health. Also, as part of its Healthy Neighborhoods strategy, the Delaware Division of Public Health (DPH) will support staff health equity training (SIM p. 5-6). Delaware’s Healthy Neighborhoods strategy seeks to enlist schools, employers, and community organizations in changing health behaviors. The plan will support a multi-stakeholder community coalition focused on identifying and addressing health needs (SIM p. 1-6). The proposed population health metrics include measures related to smoking; nutrition; physical activity; prevalence of hypertension, obesity, and diabetes; cancer deaths per 100,000; heart disease deaths; 30-day post-PCI mortality rate; and infant mortality (SIM p. 37). Delaware’s model will focus on providing team-based, integrated physical and behavioral health care for high-risk patients, including by providing incentives for EHR use to behavioral health providers. It will complement the existing PROMISE program that coordinates care for beneficiaries with mental illness.</td>
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<td>Idaho</td>
<td>Idaho will develop a plan to improve population health by integrating population health with primary care and the healthcare delivery system through the use of Patient-Centered Medical Homes (PCMHs) covering 80% of the population (SIM p. 2-4). Idaho is also planning a virtual PCMH telehealth initiative to serve remote communities. The state’s seven public health districts will also form Regional Collaboratives to integrate public and physical health locally to improve access to care. Idaho will collect data on the social determinants of health as part of a statewide health assessment. PCMH providers will be allowed to practice at the top of their license to ameliorate workforce shortages. Telehealth initiatives and models for using CHWs and community health emergency medical services personnel in health promotion will also be explored (SIM p. 5-6). Idaho will use the following population health performance measures to monitor the success of the Model Test: depression, tobacco use, asthma ED visits, hospitalizations, elective deliveries, low birth weight, adherence to antipsychotic meds for people with schizophrenia, weight counseling for children and adolescents, diabetes, childhood immunizations, adult BMI, and rate of prescribed opioid use for non-cancer pain. Idaho will also collect data on costs and patient experience of care (SIM p. 22-23). PCHMs will coordinate care with Medical Neighborhoods of ancillary providers, including behavioral health providers. The state’s multi-payer common performance measures include screening for depression, adherence to antipsychotics for people with schizophrenia, and rates of prescribed opioid use for non-cancer pain.</td>
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<td>Iowa</td>
<td>Iowa will provide support and technical assistance to encourage ACOs to develop workforce models, including telehealth, that address provider shortages and reduce the disparities between rural and urban areas (SIM p. 1). New Community Care Teams will connect ACOs with social services and local public health resources to address social determinants of health. Value-based payments will be leveraged incentives to address social determinants of health (SIM p. 2-3). The Equity and Access Council watches for under-service that may result from shared savings incentives. Iowa’s model seeks to expand care delivery into the community setting, and will track communities’ progress on population health initiatives. Community Care Teams will integrate public health and local ACOs to improve outcomes, and will facilitate connections with non-ACO providers (SIM p. 1-8). Iowa will measure progress in six population health target areas: reducing tobacco use, obesity, hospital-associated infections, and early elective deliveries; and improving patient engagement and health literacy, including diabetes self-management (SIM p. 3-5). Iowa will continue to incorporate behavioral health providers into its ACO structures, including the use of integrated health homes for individuals with mental illness (SIM p. 7-11).</td>
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Michigan plans to improve wellness and reduce health risks on a population level through the use of Community Health Innovation Regions. PCMHs and integrated care networks called Accountable Systems of Care are also key elements (Blueprint p. 4-6).

Michigan's Community Health Innovation Regions will work with local public health and cross-sector partners to engage patients and community members in wellness and health promotion activities. Michigan will also explore sustainable financing models for population-level prevention and wellness efforts. Michigan will also seek to allow providers to practice at the top of their license and training to increase access to primary care (Blueprint p. 4-5, 10, 132, 157).

New York's plan has five primary population health goals:
1. Prevent Chronic Disease
2. Promote Healthy and Safe Environments
3. Promote Healthy Women, Infants and Children
4. Promote Mental Health and Prevent Substance Abuse; and
5. Prevent HIV, STDs, Vaccine-Preventable Diseases and Healthcare Associated Infections (SIM p. 1).

New York aims to pay for 80% of advanced primary care under a value-based payment model. Further, the project's Public Health Consultants will also connect the community with public health and clinical resources (SIM p. 2-3). The state will also work to ensure that providers are practicing at the top of their license to improve access to care.

The project, including the advanced primary care model, will be evaluated according to an evolving statewide set of industry-standard quality and efficiency metrics, which includes progress toward prevention and public health goals (SIM p. 20-21).

Ohio is testing ways to share data to improve population health, such as building on its current ability to use vital statistics data to indicate when a mother or infant may be at risk of poor health outcomes (SIM p. 6).

Ohio's episode-based payment model and statewide use of PCMHs are intended to incent providers to work with community-based and public health resources to address social determinants of health (SIM p. 12).

Ohio's SIM outcome metrics will include population health measures such as flu immunization and tobacco use, as well as care coordination and chronic conditions measures. Measures will be aligned across quality initiatives (SIM p. 24-28).

Ohio merged the formerly separate departments overseeing mental health and substance use disorders. The state is focused on integrated, person-centered care and care coordination for Medicaid beneficiaries with mental illness and other populations (SIM p. 5).

With the help of community leaders, Rhode Island will develop a population-based plan that responds to the Rhode Island's plan (SHIP p. 73-74), as are reducing over-
<table>
<thead>
<tr>
<th>State</th>
<th>Description</th>
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<tbody>
<tr>
<td>Rhode Island</td>
<td>It is expected that the results of community health assessments, and continues efforts to reduce tobacco use and obesity and improve diabetes care management (SIM p. 4; SHIP p. 80-87).</td>
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<tr>
<td>Tennessee</td>
<td><strong>Tennessee seeks to improve population health in five priority areas: obesity, diabetes, tobacco, child health, and perinatal health (SIM p. 2, 13).</strong> PCMH providers will be incentivized to address social determinants of health through activities such as addressing environmental asthma triggers, tobacco cessation, and connecting patients to social services (SIM p. 4). Tennessee’s project will also facilitate the sharing of real-time hospital Admitting/ Discharge/Transfer (ADT) data with primary care providers and care coordinators to analyze gaps in care and prioritize resources for the most at-risk patients.</td>
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<td>Washington</td>
<td><strong>Washington will implement regional Accountable Communities of Health (ACH) to integrate the delivery of social services and healthcare services. ACHs will work across sectors, aligning housing, education, local government and the private sector to advance population health and address the social determinants of health (SIM p. 2, 6).</strong> Washington also plans to increase the number of communities with environments that promote physical and behavioral health and health equity (SIM p. 5). <strong>Washington plans to engage “individuals, families, and communities” in a system that “supports social and health needs,” as well as improve the health of 90% of Washington residents and their communities by 2019 through prevention and early mitigation of disease (SIM p. 5, 26).</strong> Washington will develop a statewide set of core measures that includes tobacco use, obesity and diabetes (SIM p. 6). It will also incorporate the “Results Washington” performance targets, including children’s vaccination rates, reducing preterm birth and cesarean section rates, increasing the number of residents with a personal healthcare provider, and increasing rates of services for post-discharge mental health consumers (SIM p. 27).</td>
<td><strong>Washington will integrate its SIM funding and Health Homes initiative to provide integrated, value-based “behavioral and primary care services for people with Severe and Persistent Mental Illness (SPMI)” (SIM p. 7).</strong> By 2020, Washington will require integrated physical and behavioral healthcare purchasing (SIM p. 10-11).</td>
</tr>
</tbody>
</table>

**Notes:**

Chart produced by Amy Clary

**Topics:**

State Innovation Models
Upcoming Health System Innovation (HSI) Summits

**August 19, 2015**
Albuquerque, NM
DoubleTree Albuquerque, 201 Marquette Ave NW, Albuquerque, NM 87102
8 am to 5 pm
https://www.surveymonkey.com/r/AugustSIMSummit

**September 16, 2015**
Albuquerque, NM
DoubleTree Albuquerque, 201 Marquette Ave NW, Albuquerque, NM 87102
8 am to 5 pm
https://www.surveymonkey.com/r/SeptemberSIMSummit

**October 21, 2015**
Albuquerque, NM
DoubleTree Albuquerque, 201 Marquette Ave NW, Albuquerque, NM 87102
8 am to 5 pm
https://www.surveymonkey.com/r/OctoberSIMSummit

**November 18, 2015**
Albuquerque, NM
DoubleTree Albuquerque, 201 Marquette Ave NW, Albuquerque, NM 87102
8 am to 5 pm
https://www.surveymonkey.com/r/NovemberSIMSummit

**December 15, 2015**
Albuquerque, NM
DoubleTree Albuquerque, 201 Marquette Ave NW, Albuquerque, NM 87102
8 am to 5 pm
https://www.surveymonkey.com/r/DecemberSIMSummit
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<td>Larry</td>
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<td><a href="mailto:LHDeYapp@rio-arriba.org">LHDeYapp@rio-arriba.org</a></td>
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<td>LCF Research (NMHIC)</td>
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<td>Arthur T.</td>
<td>PHTC</td>
<td><a href="mailto:falconerarthur8@gmail.com">falconerarthur8@gmail.com</a></td>
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<td>HS/Behavioral Health Services Division</td>
<td>Health Information Systems</td>
<td><a href="mailto:Rita.galindo@state.nm.us">Rita.galindo@state.nm.us</a></td>
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<td>PED</td>
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<td>Presbyterian Health Plan</td>
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<td>Gonzales Arturo</td>
<td>Sangre de Cristo CHP</td>
<td>Integration of Public Health and Primary Care</td>
<td><a href="mailto:arturo.gonzales@sdcchp.org">arturo.gonzales@sdcchp.org</a></td>
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<td>Health Information Systems</td>
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<td>NM DOH</td>
<td><a href="mailto:jerry.montoya@state.nm.us">jerry.montoya@state.nm.us</a></td>
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<td>BCBS of NM</td>
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<td><a href="mailto:irene_moody@bcbsnm.com">irene_moody@bcbsnm.com</a></td>
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<td>Paula Morgan</td>
<td>NM Department of Health</td>
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<td><a href="mailto:paula.morgan@state.nm.us">paula.morgan@state.nm.us</a></td>
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<td>Blue Cross Blue Shield of NM</td>
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<tr>
<td>Christina Morris</td>
<td>DOH/PhD</td>
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<td><a href="mailto:christina.morris@state.nm.us">christina.morris@state.nm.us</a></td>
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<td>Julie Morrow</td>
<td>NMDOH</td>
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<td><a href="mailto:julie.morrow@state.nm.us">julie.morrow@state.nm.us</a></td>
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<td>Huong Nguyen</td>
<td>Workforce and Training Needs</td>
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<td><a href="mailto:huong@nmfafc.org">huong@nmfafc.org</a></td>
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<td>NM Higher Education Department</td>
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<td>Christopher Novak</td>
<td>NMDOH</td>
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<td><a href="mailto:christopher.novak@state.nm.us">christopher.novak@state.nm.us</a></td>
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<td>Jackie Pacheco</td>
<td>Doña Ana County</td>
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<td><a href="mailto:jacqueliney@donaanacounty.org">jacqueliney@donaanacounty.org</a></td>
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<td>UnitedHealthcare</td>
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<td>Gabriel Parra</td>
<td>Presbyterian</td>
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<td><a href="mailto:gparra@phs.org">gparra@phs.org</a></td>
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<td>Lore Pease</td>
<td>El Centro Family Health</td>
<td></td>
<td><a href="mailto:lore.pease@ecfh.org">lore.pease@ecfh.org</a></td>
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<td>Jim Peterson</td>
<td>Taos Community Health Plan</td>
<td></td>
<td><a href="mailto:jm@headwaterssolutions.com">jm@headwaterssolutions.com</a></td>
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<tr>
<td>Bryce Pittenger</td>
<td>CYF/DOJJS</td>
<td></td>
<td><a href="mailto:bryce.pittenger@state.nm.us">bryce.pittenger@state.nm.us</a></td>
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<tr>
<td>Julia Platero</td>
<td>BCBSNM</td>
<td></td>
<td><a href="mailto:julia_platero@bcbsnm.com">julia_platero@bcbsnm.com</a></td>
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<td>Sandy Potter</td>
<td>BCBSNM</td>
<td></td>
<td><a href="mailto:sandra_k_potter@bcbsnm.com">sandra_k_potter@bcbsnm.com</a></td>
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<td>Galina Prioultskaya</td>
<td>HealthInsight</td>
<td></td>
<td><a href="mailto:gprioultskaya@healthinsight.org">gprioultskaya@healthinsight.org</a></td>
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<td>Ophelia Reeder</td>
<td>McKinley Community Health Alliance</td>
<td></td>
<td><a href="mailto:ophelia.reeder@pmsnm.org">ophelia.reeder@pmsnm.org</a></td>
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<tr>
<td>Lauren Reichelt</td>
<td>Rio Arriba County</td>
<td></td>
<td><a href="mailto:lreichelt@rio-arriba.org">lreichelt@rio-arriba.org</a></td>
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<td>Terry Reusser</td>
<td>New Mexico Department of Health</td>
<td></td>
<td><a href="mailto:terry.reusser@state.nm.us">terry.reusser@state.nm.us</a></td>
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<tr>
<td>Carolyn Roberts</td>
<td>SFCo. Health Policy &amp; Planning Commission</td>
<td></td>
<td><a href="mailto:crobertsmlsn@gmail.com">crobertsmlsn@gmail.com</a></td>
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<tr>
<td>LeeAnn Roberts</td>
<td>DOH/HSB/Office of Primary Care &amp; Rural Health</td>
<td></td>
<td><a href="mailto:LeeAnn.Roberts@state.nm.us">LeeAnn.Roberts@state.nm.us</a></td>
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<tr>
<td>Darcie Robran-Marquez</td>
<td>Molina Healthcare of New Mexico</td>
<td></td>
<td><a href="mailto:darcie.robran-marquez@molinah.com">darcie.robran-marquez@molinah.com</a></td>
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<tr>
<td>Giovanna Rossi</td>
<td>Collective Action Strategies, LLC</td>
<td></td>
<td><a href="mailto:giovanna@collectiveactionstrategy.com">giovanna@collectiveactionstrategy.com</a></td>
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<tr>
<td>Babette Saenz</td>
<td>Envision Integrated Healthcare</td>
<td></td>
<td><a href="mailto:drbabettesaenz@gmail.com">drbabettesaenz@gmail.com</a></td>
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<td>Jazmine Saenz</td>
<td>NM DOH-SW Division</td>
<td></td>
<td><a href="mailto:jazmine.saenz@state.nm.us">jazmine.saenz@state.nm.us</a></td>
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<tr>
<td>Paula Schaub</td>
<td>BCBS NM</td>
<td></td>
<td><a href="mailto:Paula_Schaub@BCBSNM.COM">Paula_Schaub@BCBSNM.COM</a></td>
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<tr>
<td>Kathleen Schuster</td>
<td>Catron County Health Council</td>
<td></td>
<td><a href="mailto:katsch1955@gmail.com">katsch1955@gmail.com</a></td>
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<tr>
<td>Terry Seaton</td>
<td>NM OSI</td>
<td></td>
<td><a href="mailto:Terry.Seaton@state.nm.us">Terry.Seaton@state.nm.us</a></td>
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<td>Sheila Shortell</td>
<td>The Recovery Club</td>
<td></td>
<td><a href="mailto:TheRecoveryClub@yahoo.com">TheRecoveryClub@yahoo.com</a></td>
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<tr>
<td>Patricia Slowman</td>
<td>Centro Savila</td>
<td></td>
<td><a href="mailto:patricia@centrosavila.com">patricia@centrosavila.com</a></td>
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<tr>
<td>Daryl T. Smith</td>
<td>UNM Health Sciences Center-Pathways Program</td>
<td></td>
<td><a href="mailto:dtsmith@salud.unm.edu">dtsmith@salud.unm.edu</a></td>
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<tr>
<td>Leah Steimel</td>
<td>Brindle Foundation</td>
<td></td>
<td><a href="mailto:leah.steimel@brindlefoundation.org">leah.steimel@brindlefoundation.org</a></td>
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<td>Kim Strass</td>
<td>Presbyterian Health Plan</td>
<td></td>
<td><a href="mailto:tstrickl@phs.org">tstrickl@phs.org</a></td>
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<td>Eugene Sun</td>
<td>Blue Cross Blue Shield of New Mexico</td>
<td></td>
<td><a href="mailto:eugene_sun@bcbsnm.com">eugene_sun@bcbsnm.com</a></td>
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<td>Dona Swenson</td>
<td>Office of Peer Recovery &amp; Engagement</td>
<td></td>
<td><a href="mailto:donahu.swenson@state.nm.us">donahu.swenson@state.nm.us</a></td>
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<tr>
<td>Bill Szaroletta</td>
<td>UNM Project ECHO</td>
<td></td>
<td><a href="mailto:szar@unm.edu">szar@unm.edu</a></td>
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<tr>
<td>David Tempest</td>
<td>Jemez Pueblo Health and Human Services</td>
<td></td>
<td><a href="mailto:dttempest@jemezpueblo.us">dttempest@jemezpueblo.us</a></td>
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<td>Marie Thames</td>
<td></td>
<td></td>
<td><a href="mailto:marie.thames@yahoo.com">marie.thames@yahoo.com</a></td>
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<td>Karla Thornton</td>
<td>Project ECHO</td>
<td></td>
<td><a href="mailto:kthomton@salud.unm.edu">kthomton@salud.unm.edu</a></td>
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<td>Anne Timmins</td>
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<td></td>
<td><a href="mailto:atimmins@healthinsight.org">atimmins@healthinsight.org</a></td>
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<td>Dale Tinker</td>
<td>New Mexico Pharmacists Association</td>
<td></td>
<td><a href="mailto:Daletinker@cs.com">Daletinker@cs.com</a></td>
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<td>Jenny Torres</td>
<td>Doña Ana County</td>
<td></td>
<td><a href="mailto:jenny@donaanacounty.org">jenny@donaanacounty.org</a></td>
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<td>Kiko Torres</td>
<td>NM Health Connections</td>
<td></td>
<td><a href="mailto:kiko.torres@mynnhc.org">kiko.torres@mynnhc.org</a></td>
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<td>Christa Trujillo</td>
<td>NMDOH/NE Region/Health Promotion</td>
<td></td>
<td><a href="mailto:christa.trujillo@state.nm.us">christa.trujillo@state.nm.us</a></td>
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<td>David Van der Goes</td>
<td>UNM</td>
<td></td>
<td><a href="mailto:dvandergoes@unm.edu">dvandergoes@unm.edu</a></td>
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<td>Sallyanne Wait</td>
<td>NM HSD/MAD</td>
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<td><a href="mailto:sallyanne.wait@state.nm.us">sallyanne.wait@state.nm.us</a></td>
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<td>Retta Ward</td>
<td>NMDOH</td>
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<td><a href="mailto:retta.ward@state.nm.us">retta.ward@state.nm.us</a></td>
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<td>Lynda Welage</td>
<td>UNM Health Sciences Center</td>
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<td><a href="mailto:lsWelage@salud.unm.edu">lsWelage@salud.unm.edu</a></td>
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<td>Rachel Wexler</td>
<td>NMDOH</td>
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<td><a href="mailto:rachel.wexler@state.nm.us">rachel.wexler@state.nm.us</a></td>
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<td>Christopher Whiteside</td>
<td>NMDOH</td>
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<td><a href="mailto:christopher.whitesi@state.nm.us">christopher.whitesi@state.nm.us</a></td>
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<td>Susan</td>
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<td>Center for Health Innovation</td>
<td><a href="mailto:swilger@hmsnm.org">swilger@hmsnm.org</a></td>
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<tr>
<td>Williams</td>
<td>Mark</td>
<td></td>
<td>Dept of Health, Public Health Division</td>
<td><a href="mailto:mark.williams@state.nm.us">mark.williams@state.nm.us</a></td>
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<tr>
<td>Wolff</td>
<td>Barak</td>
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<td>Self</td>
<td><a href="mailto:barakwolff@msn.com">barakwolff@msn.com</a></td>
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<td>NMOCH</td>
<td><a href="mailto:shandiin.wood@state.nm.us">shandiin.wood@state.nm.us</a></td>
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<tr>
<td>Zuidema</td>
<td>Sharon</td>
<td></td>
<td>DOH - ITSD</td>
<td><a href="mailto:sharon.zuidema@state.nm.us">sharon.zuidema@state.nm.us</a></td>
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