New Mexico Health System Innovation Stakeholder Summit  
August 19, 2015  
8:30 am – 3:00 pm  
DoubleTree Hotel, Albuquerque, NM

8:30 - 9:00  Registration, Coffee and Informal Question/Answer Session
9:00 – 9:05  Welcome  
Sean Pearson, Deputy Secretary, Human Services Department
9:05 - 9:40  Framing the NM Health System Innovation (HSI)  
Tres Schnell, Director, Office of Policy and Accountability, DOH
9:40 – 10:40  Conversation About the NM HSI Design  
Mixed Committee Member Roundtables – insights and observations
10:40 – 11:00  The ECHO Model: a Tool for Health System Innovation  
Dr. Miriam S. Komaromy, Associate Director, Project ECHO; Co-Medical Director/IAP Clinic, UNM
11:00 – 11:15  Break and Move into Stakeholder Committees
11:15 – 12:15  Stakeholder Committee Sessions  
Population Health (red)  
Health Care (light blue)  
Payment Models (black)  
Alignment & Integration of Public Health and Primary Care (yellow):  
Health Information Systems (orange)  
Tribal (navy blue)  
Workforce and Training Needs (green)
12:15 – 12:45  Box Lunch Provided  
Please pick up lunch and rejoin your committee
12:45 – 1:45  Stakeholder Committee Sessions (cont.)
1:45 – 2:00  Break and Rejoin the Large Group
2:00 – 3:00  Stakeholder Committee Reports, Wrap Up, and Next Steps

Next Summit: September 16, 2015

Check the website for all things related to New Mexico Health System Innovation: resources, committee work, and information on the developing design.  
www.nmhealthsysteminnovation.org
WELCOME
HEALTH SYSTEM INNOVATION DESIGN
AUGUST 19, 2015

Welcome
Stakeholder Summit # 4

Sean Pearson, Deputy Cabinet Secretary
Human Services Department
New Mexico Health System Innovation Model

Tres Hunter Schnell, Director
Department of Health

Recap Health System Innovation Design

- Centers for Medicare and Medicaid Innovation Award to Department of Health, in collaboration with Human Services Department - $2 million
- Intended 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

- Alignment and integration of public health, behavioral health and primary care
- Reduce costs and slowing the rate of health care inflation, while increasing investments in community wellness
- Increase the number of New Mexicans who have health insurance and access to healthy choices
- Build the health system workforce and support the infrastructure
- 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
Summit objectives

- To learn about next steps and timelines for finalizing New Mexico’s design for health system innovation
- To promote cross-committee dialogue, and contribute design observations and input
- To learn how telehealth contributes to health system innovation, and access to well-being and health services
- To continue a dialogue with stakeholders to collaboratively design an integrated system of well-being and care
- To focus in on committee design recommendations

New Mexico Health System Innovation Model

- Patient-Centered Medical Home
- Integrating: Behavioral Health, Oral Health, Public Health
- Workforce: CHW, CEMS, Residency Programs
- Standards and Criteria Established
- Community Well-Being Center
- Based on Community Centered Health Home Concept
- SDOH
- All sectors contribute to improve health
- Identified center – unknown - may be local public health office
- No established standards or Criteria Established

Health IT System: Information, Analysis, Sharing, Delivery
What does an integrated PCMH look like in NM?

- First Choice Community Healthcare, South Valley Community Commons:
  - Partnerships (Schools, farmers, county government, health council, UNM, Molina, DOH public health) are essential to address social determinants
  - The person and community centered concept drives First Choice
  - Residency program training, work with diverse teams
  - Integration of Community Health Workers (CHW) into primary care using models for Medicaid reimbursement for services

What does integration look like for NM?

- First Choice Community Healthcare, South Valley Community Commons:
  - Screen all patients (e.g., nutrition, housing, transportation, child care, employment, job training, substance use, safety)
  - Environmental conditions
  - WellRx – prescriptions to promote healthy behaviors
  - Respond: Food distribution and cooking classes; diabetes education; child development; walking trails in neighborhood.
  - Increased patient engagement and satisfaction
  - Increased health equity
### NCQA PCMH 2014 Content
(6 standards/27 elements) – June Summit Dr. McGrath

1: Enhance Access and Continuity  
A. **Patient-Centered Appointment Access**  
B. 24/7 Access to Clinical Advice  
C. Electronic Access  

2: Team-Based Care  
A. Continuity  
B. Medical Home Responsibilities  
C. Culturally and Linguistically Appropriate Services (CLAS)  
D. **The Practice Team**  

3: Population Health Management  
A. Patient Information  
B. Clinical Data  
C. Comprehensive Health Assessment  
D. **Use Data for Population Management**  
E. Implement Evidence-Based Decision-Support  

4: Plan and Manage Care  
A. Identify Patients for Care Management  
B. **Care Planning and Self-Care Support**  
C. Medication Management  
D. Use Electronic Prescribing  
E. Support Self-Care and Shared Decision-Making  

5: Track and Coordinate Care  
A. Test Tracking and Follow-Up  
B. **Referral Tracking and Follow-Up**  
C. Coordinate Care Transitions  

6: Measure and Improve Performance  
A. Measure Clinical Quality Performance  
B. Measure Resource Use and Care Coordination  
C. Measure Patient/Family Experience  
D. **Implement Continuous Quality Improvement**  
E. Demonstrate Continuous Quality Improvement  
F. Report Performance  
G. Use Certified EHR Technology  

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### Community Centered Health (Well-Being) Home

No Standards and Criteria  

**tab ula ra sa**

noun: **tabula rasa**  
an absence of preconceived ideas or predetermined goals; a clean slate.  

“stakeholders have complete freedom and a tabula rasa from which to work"
Our challenge... We don’t need to have all the answers
We design how we will get the answers

Community Centered Well-Being is less defined than the Patient Centered Medical Home.

How do we define CCWB?
How does DOH public health and partners transform to serve the model?
How do we formalize collective work to reach common health improvement goals?
What are the criteria that would serve as the framework for CCWB?
What might this look like in your community?
Who are the partners that might contribute?
Prevention Institute questions in your packet!

Public Health Accreditation ... Domains and Standards as a Guide

Standards for how the public health discipline practices provide an excellent foundation for the work to develop a community well-being centered construct for New Mexico... go to:


Also, many models provide guidance:
Collective Impact
Community Health Improvement Process
Place Matters
Health Equity
Evidence Based Approaches: The Community Guide (CDC)
Our Health System Innovation Model So Far...

New Mexico Health System Innovation Model

How did we arrive at this emerging model?

- The Model Design is developing with the following:
  - **Stakeholder Input and Feedback**
    - Summit meetings (May-July) and Workgroup meetings (May-July)
  - **Human Services Department Centennial Care Innovation**
    - Waiver approved by CMS
  - **NM’s Centers for Medicare and Medicaid Services (CMS) State Innovation Model (SIM) Design Proposal**
    - The original proposal is the guiding document CMS uses to evaluate all plan submissions --- is the plan aligned with what we said we would do? (available: www.NMhealthsystem)
The NM HSI Model ...

Stakeholders say the model needs to be:

- Community-centered, focused on prevention and built environments, health in all policies, well-being, and personal responsibility for health;
- Team-based and patient-centered care; coordination of care, built on blended model of practices that have achieved certification (NCQA, AAHC, Joint Commission, NM model);
- Flexible for adaptation in all communities;
- Addresses social determinants of health and improved health equity;
- Phased in over time starting in underserved areas and populations;
- Integration of tribal health systems;
- Multiple entry points/"no wrong door" approach;
- Focus on coordination of care and seamless transition between services and providers;
- "Well-being Coordinator" who helps navigate and improve the system for patients/communities;
- CHWs/CHR within the clinic and in the community; EMS personnel with enhanced primary care roles; and,
- Networks of multi-disciplinary provider teams and services that integrate primary care, behavioral health, public health, and oral health across the lifespan.

The NM HSI Model

- Centennial Care: Comprehensive care coordination system; health literacy; inclusive of individual, cultural, and community needs; whole-person philosophy; utilization of CHWs
- PCMH vision for NM: Team-based and patient-centered care; coordination of care; built on blended model of practices that have achieved certification (NCQA, AAHC and Joint Commission) -- workgroup over past 4 years
- DOH/HSD Proposal: Focus on quality of services; patient-centered care; multi-disciplinary health teams (CHWs and EMS personnel); integration of lay Health Leads model to connect patients to basic resources; strategies to improve recruitment & retention of healthcare professionals; leverage Centennial Rewards program across other payers; robust HIE that enables data-sharing among providers, payers, and patients
Payment Models

- Stakeholders say: Use of value-based payment with shared savings model; incentivize providers to provide "whole person" services that improve population health outcomes; consistent payment structure throughout State; reimbursement for nontraditional services; i.e., social services; expanded CHW and EMS services.
- Centennial Care: Stratification of recipients by risk and capitation payment; tiered reimbursement with incentives tied to target measures for PCMHs; pay for performance, outcome-based reimbursement and bundled payments.
- PCMH Vision for NM: Model is uniform across payers; provide financial support to move practices towards national PCMH certification; standardized, based on level of PCMH achievement and evidence of quality care to patients; provide incentives for patient proactive healthcare
- DOH/HSD Proposal: Payment for health outcomes; implement promising and evidence-based payment models; complement PCMH initiative and aligned with Centennial Care (bundled payments, pay-for-performance, shared savings)

PCMH Requirements

- Stakeholders say: One certifying organization; built on existing successful state programs; improved access to care through flexible scheduling, including same-day appointments, accommodating walk-ins, after hours and weekend office hours; sustained recruitment and training of IT and data input staff
- Centennial Care: Incentivizing proliferation of PCMHs; incorporation of health homes (management of chronic conditions – Medicaid only)
- PCMH Vision for NM: Develop a "Glide Path" open to all practices seeking PCMH status; certification is based on nationally vetted standards; commitment to use of EHRs and MU; data integration and information sharing in real time; integration of PH, BH, OH; provide support to tribal 638 clinics to become FQHCs
- DOH/HSD Proposal: PCMH quality improvement collaborative; TA center for a uniform state approach; integration of behavioral health and oral health services, including Screening, Brief Intervention, and Referral to Treatment (SBIRT); increased utilization of SBHCs
Performance Metrics (Measures)

- Stakeholders say: Focus on clinical and population health outcomes including overall health, race/ethnicity, behavioral health, quality of care, social determinants of health, cost of care, and effectiveness of PCMH model interventions.
- Centennial Care: Measures of process, health outcomes, quality of life, recipient choice, recipient and provider satisfaction and performance.
- PCMH Vision for NM: Measures are aligned with identified State-level health priorities along the lifespan; health equity is foundational lens.
- DOH/HSD Proposal: Standardized quality clinical and population health metrics, based upon nationally vetted measures, i.e., HP2020, NQF, AHRQ, developed via a collaborative process of statewide stakeholders and utilized by providers and payers; measures to evaluation performance of NM PCMH model.

Key Infrastructure, Policies Required

- Stakeholders say: Need state-level oversight entity; data-sharing infrastructure to connect all payers, providers, and patients; technical assistance for providers; development of tribal data exchange; incentivized recruitment of primary care providers, CHWS, and EMS personnel, and IT staff; improved reciprocity laws to enable licensed health care professionals to quickly practice in New Mexico; increased collaboration among payers and providers and shared vision of innovation.
- PCMH Vision for NM: Use of APCD, HIE, and evidence-based interventions; real-time data exchange; develop policies to improve data collection and utilization.
- DOH/HSD Proposal: Expanded options for delivery and payment of services via Centennial Care; expanded and more robust HIE; coordination with NMHIX to further ACA implementation and establish criteria for qualified health plans; development of a standardized set of statewide metrics.
We are grateful for your continued contributions and commitment to this work.

QUESTIONS?

More information: WWW.NMHEALTHSYSTEMINNOVATION.ORG
What’s Next?

Stakeholder Summit Schedule:
September 16, 2015
December 15, 2015 – Final Presentation of HSI Model to Stakeholders
October and November: Stakeholder Summits are cancelled and replaced with committee and workgroup for Health System Innovation Plan finalization

Roundtable Conversations
9:40 AM – 10:40 AM

- Mixed committee member groups
- What are the strengths of the model
- What is missing from the model
- Committee members take notes to capture recommendations, questions, and observations from colleagues
- Deliver key points back to the committee for consideration
- Staff available to support the conversation, answer questions
Roundtable “Jump Start” Questions

- Do you have a clear understanding of the draft NM Health System Innovation design after the framing presentation?
- What are any specific questions you have? *(Any further information you need to better understand the design?)*
- Many of you contribute to different committees:
  - What questions do you have for a member of a different committee?
  - What suggestions, information, insights, observations or helpful comments about committee work would you like to pass on to Roundtable colleagues for specific design recommendations?

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**Project ECHO**
*(Extension for Community Health Outcomes)*

*Miriam Komaromy, MD, FACP*
Associate Professor of Medicine
Associate Director of Project ECHO®
Department of Medicine
University of New Mexico Health Sciences Center

Tel: 505-272-7505
miriamk1@salud.unm.edu
At ECHO, our mission is to democratize medical knowledge and get best practice care to underserved people all over the world.

Our goal is to touch the lives of 1 billion people by 2025.

Supported by New Mexico Department of Health, Agency for Health Research and Quality, New Mexico Legislature, the Robert Wood Johnson Foundation, the GE Foundation and Helmsley Trust
Goals of Project ECHO®

Develop capacity to safely and effectively treat common, complex diseases such as HCV in all areas of New Mexico and to monitor outcomes.

Develop a model to treat common, complex diseases in underserved locations in the US and around the world.

Methods

• Use Technology to leverage scare resources
• Sharing “best practices”
• Case-based learning
• Web-based database to monitor outcomes

Benefits to Rural Clinicians

- No-cost CMEs and Nursing CEUs
- Professional interaction with colleagues with similar interest
  - Less isolation with improved recruitment and retention
- A mix of work and learning
- Access to specialty consultation with GI, hepatology, psychiatry, infectious diseases, addiction specialist, pharmacist, patient educator

Project ECHO® Clinicians

HCV Knowledge Skills and Abilities (Self-Efficacy)

scale: 1 = none or no skill at all 7 = expert-can teach others

<table>
<thead>
<tr>
<th>Community Clinicians N=25</th>
<th>BEFORE Participation MEAN (SD)</th>
<th>TODAY MEAN (SD)</th>
<th>Paired Difference (p-value) MEAN (SD)</th>
<th>Effect Size for the change</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Ability to identify suitable candidates for treatment for HCV.</td>
<td>2.8 (1.2)</td>
<td>5.6 (0.8)</td>
<td>2.8 (1.2) (&lt;0.0001)</td>
<td>2.4</td>
</tr>
<tr>
<td>2. Ability to assess severity of liver disease in patients with HCV.</td>
<td>3.2 (1.2)</td>
<td>5.5 (0.9)</td>
<td>2.3 (1.1) (&lt; 0.0001)</td>
<td>2.1</td>
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<tr>
<td>3. Ability to treat HCV patients and manage side effects.</td>
<td>2.0 (1.1)</td>
<td>5.2 (0.8)</td>
<td>3.2 (1.2) (&lt;0.0001)</td>
<td>2.6</td>
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</tbody>
</table>
**Project ECHO® Clinicians**  
**HCV Knowledge Skills and Abilities (Self-Efficacy)**

<table>
<thead>
<tr>
<th>Community Clinicians</th>
<th>BEFORE Participation MEAN (SD)</th>
<th>TODAY MEAN (SD)</th>
<th>Paired Difference (p-value) MEAN (SD)</th>
<th>Effect Size for the change</th>
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<tbody>
<tr>
<td>Overall Competence (average of 9 items)</td>
<td>2.8* (0.9)</td>
<td>5.5* (0.6)</td>
<td>2.7 (0.9) (&lt;0.0001)</td>
<td>2.9</td>
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Cronbach’s alpha for the BEFORE ratings = 0.92 and Cronbach’s alpha for the TODAY ratings = 0.86 indicating a high degree of consistency in the ratings on the 9 items.


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**Outcomes of Treatment for Hepatitis C Virus Infection by Primary Care Providers**

Results of the HCV Outcomes Study  
## Treatment Outcomes

<table>
<thead>
<tr>
<th>Outcome</th>
<th>ECHO</th>
<th>UNMH</th>
<th>P-value</th>
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<tbody>
<tr>
<td>SVR* (Cure) Genotype 1</td>
<td>50%</td>
<td>46%</td>
<td>NS</td>
</tr>
<tr>
<td>SVR* (Cure) Genotype 2/3</td>
<td>70%</td>
<td>71%</td>
<td>NS</td>
</tr>
<tr>
<td>Minority</td>
<td>68%</td>
<td>49%</td>
<td>P&lt;0.01</td>
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*SVR=sustained viral response*


## Disease Selection

- Common diseases
- Management is complex
- Evolving treatments and medicines
- High societal impact (health and economic)
- Serious outcomes of untreated disease
- Improved outcomes with disease management
## Successful Expansion into Multiple Diseases

<table>
<thead>
<tr>
<th>Time</th>
<th>Mon</th>
<th>Tue</th>
<th>Wed</th>
<th>Thurs</th>
<th>Fri</th>
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</thead>
<tbody>
<tr>
<td>8-10 a.m.</td>
<td><strong>Hepatitis C</strong></td>
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<td></td>
<td>• Arora</td>
<td><strong>Diabetes &amp; Endocrinology</strong></td>
<td><strong>Geriatrics/Dementia</strong></td>
<td><strong>Palliative Care</strong></td>
<td><strong>Neale</strong></td>
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<td>• Thornton</td>
<td><strong>Bouchonville</strong></td>
<td><strong>Herman</strong></td>
<td><strong>Neale</strong></td>
<td><strong>Neale</strong></td>
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<tr>
<td>10-12 a.m.</td>
<td><strong>Rheumatology</strong></td>
<td></td>
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<td></td>
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<tr>
<td></td>
<td>• Bankhurst</td>
<td><strong>Chronic Pain</strong></td>
<td><strong>Integrated Addictions &amp; Psychiatry</strong></td>
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<td></td>
<td></td>
<td><strong>Katman</strong></td>
<td><strong>Komaromy</strong></td>
<td><strong>Complex Care</strong></td>
<td><strong>Komaromy</strong></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td><strong>Neale</strong></td>
<td><strong>Neale</strong></td>
</tr>
<tr>
<td>2-4 p.m.</td>
<td><strong>HIV</strong></td>
<td></td>
<td><strong>Prison Peer Educator Training</strong></td>
<td><strong>Women's Health &amp; Genomics</strong></td>
<td><strong>Cure</strong></td>
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<td></td>
<td>• Iandiorio</td>
<td></td>
<td><strong>Thornton</strong></td>
<td></td>
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<tr>
<td></td>
<td>• Thornton</td>
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### Certification of Buprenorphine Providers by Date in Underserved Areas

Currently, there are 5182 zip codes in the US with the following characteristics:

1. Rural (less than 1,000 people per sq mile).
2. More than 50% of people identify themselves as American Indian or Alaska Native, Asian American, Black or African American, Hispanic or Latino, or Native Hawaiian/Other Pacific Islander.
3. The average household income is less than $52,250.

10,002,084 people reside in these zip codes, with 786,455 of those living in NM. There are 479 licensed providers residing within these zip codes, 110 within New Mexico. This graph shows when each provider became licensed.
Expanding the concept of the primary care team:

Community Health Workers and ECHO

ECHO CHW Training
Multiple Tracks

- CHW Specialist Training
  - CREW: Diabetes, Obesity, Hypertension, Cholesterol, Smoking Cessation, Exercise Physiology
  - CARS: Substance Use Disorders
  - ECHO Care™: Complex Multiple Diagnoses
  - Endo ECHO: Diabetes and other endocrine disorders
  - Family Obesity Intervention: DOH-funded collaboration

- Prison Peer Educator Training
Specialty CHW Program

- Narrow Focus — Deep Knowledge
- Standardized Curriculum
  - 3 Day Onsite
  - Webcam/Weekly Video Based Clinics
    - Health coaching
    - Diet
    - Exercise
    - Smoking Cessation
    - Motivational Interviewing
    - Finger Stick
    - Foot Exam
- Ongoing support via CHW teleECHO clinics
- Part of Disease Management Team

Community Health Workers in Prison
The New Mexico Peer Education Program

First day of peer educator training
Photo consents on file with Project ECHO® and CNMCF
Potential Benefits of **ECHO Model™** to Health System

- Quality and Safety
- Rapid Learning and best-practice dissemination
- Reduce variations in care
- Access for Rural and Underserved Patients, reduced disparities
- Workforce Training and Force Multiplier

**Democratize Knowledge**

- Improving Professional Satisfaction/Retention
- Supporting the Medical Home Model
- Cost Effective Care- Avoid Excessive Testing and Travel
- Prevent Cost of Untreated Disease (e.g.: liver transplant or dialysis)
- Integration of Public Health into treatment paradigm
ECHO Care is a special health care program designed to support Medicaid patients who have complex health care needs.
5% of Medicaid patients account for almost 60% of Medicaid dollars.

Goals of ECHO Care

- Improve quality and access to care
- Decrease cost of care
- Improve patient satisfaction
Collaboration

- Federal CMMI grant
- Partnerships with:
  - NM state Medicaid office (HSD)
  - All of the Medicaid managed care organizations (MCOs)
  - Numerous Community Health Centers (CHCs)
- MCOs jointly provide salaries for the ECHO Care teams
- CHCs provide the clinic locations

Multidisciplinary, Integrated

Patient

RN → CHW

NP

CHW

Endocrinology

Addiction

Psychiatry

Infectious Disease

Pharmacy

Clinical Social Work

ECHO Complex Care Specialists

Cardiology

Etc.
Survey of patients enrolled in ECHO Care, a team-based intervention for Medicaid “Superutilizers”

In the past 6 months....

<table>
<thead>
<tr>
<th></th>
<th>Baseline</th>
<th>6 months</th>
<th>12 months</th>
</tr>
</thead>
<tbody>
<tr>
<td>My primary healthcare teams always spend enough time with me</td>
<td>30</td>
<td>62</td>
<td>74</td>
</tr>
<tr>
<td>My primary healthcare team always shows respect for me</td>
<td>47</td>
<td>66</td>
<td>85</td>
</tr>
<tr>
<td>My primary healthcare team cares about me as a person</td>
<td>47</td>
<td>79</td>
<td>85</td>
</tr>
<tr>
<td>My primary healthcare team talked with me about my health goals</td>
<td>47</td>
<td>86</td>
<td>89</td>
</tr>
<tr>
<td>My primary healthcare team provides the best possible care</td>
<td>8</td>
<td>61</td>
<td>65</td>
</tr>
<tr>
<td>I am very satisfied with the care I receive</td>
<td>28</td>
<td>70</td>
<td>82</td>
</tr>
</tbody>
</table>

PRELIMINARY Results: Non-OB Admissions/1,000

Post-enrollment hospitalization rates were 37% of Pre-enrollment rates (12 mo)
PRELIMINARY Results: Total Cost per Member per Month

Post-enrollment costs were 60% of Pre-enrollment rates (12 mo): $1850 vs $3050 PMPM

ECHO provides a flexible model that can be adapted to expand access to high-quality care for a variety of common complex diseases in high-need communities
### Potential value of the ECHO model for the SIM initiative

<table>
<thead>
<tr>
<th>Level of impact</th>
<th>Benefits</th>
</tr>
</thead>
</table>
| Patient Care    | • Improve Quality and Safety of care  
                  • Reduce variations/disparities in care  
                  • Cost Effective Care:  
                    • Avoid Excessive Testing and Travel  
                    • Triage only highest-need patients to specialists |
| Access          | • Improve Access for Rural and Underserved Patients |
| Healthcare Workforce | • Workforce Training and Force Multiplier  
                           • Improve Professional Satisfaction/Retention  
                           • Rapid Learning and best-practice dissemination |
| Public Health/Population Health | • Integration of Public Health with the treatment arm of the health system  
                                      • Prevent Cost of Untreated Disease (e.g.: liver transplant or dialysis) |

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**Thank you Charlie Alfero and Staff!!**

Lunch generously provided by:
Southwest Center for Health Innovation  
New Mexico Primary Care Training Consortium
THANK YOU!
HEALTH SYSTEM INNOVATION DESIGN
AUGUST 19, 2015
New Mexico Model Design: Overview

Population Health Improvement (Insert content)

New Mexico plans an innovative version of the patient-centered medical home (PCMH) approach that focuses on the quality of services and moves prevention into the community setting. This community-centered approach incorporates networks of multi-disciplinary provider teams and services that integrate primary care, behavioral health, public health, and oral health across the lifespan and includes community health workers (CHWs)/tribal community health representatives (CHRs) who work within the clinic and in the community to enhance the patient experience of care. Emergency Medical Service (EMS) personnel will also have enhanced roles within the community. Strategies will be identified to improve recruitment and retention of healthcare professionals, and utilize successful lay models to support this model.

Comprehensive care coordination and seamless transition between services and providers are cornerstones of the model. All patients will be able to enter the healthcare system through a portal that regards their health holistically, treats them as individuals (knowledge of risk factors, concerns, and specific perspectives), and provides the highest-quality care efficiently (both prevention and treatment). This access will be a “no wrong door” approach that includes multiple entry points with the help of a Well-being Coordinator and others to assist them with navigation of the healthcare system and connect with basic resources that may be needed.

Care must be coordinated within the PCMH practice, but also between it and community settings, labs, specialists and hospitals. The responsibility of the PCMH is not just to be informed by community providers and resources, but to reach out and connect in meaningful ways with other sources of service and link with them, so that information is communicated appropriately, consistently and without delay.

http://www.safetynetmedicalhome.org/change-concepts/care-coordination

This will require a multi-disciplinary team approach with smooth connections and communications among providers, tribal governments and organizations, a Well-being Coordinator trained to coordinate care and collaborate with providers, patients, and partners, a health information system that captures all relevant information to be exchanged, and payment that incentivizes this type of work.

*Population Health – Community Centered Well-Being (Expand here – concepts and strategies)*

*“No Wrong Door”*

Multiple entry points to the system will be established for those needing healthcare or other services. A patient may enter from a PCMH, Indian Health Service, tribal 638 clinic, or other clinical service, another service area such as SNAP, WIC, or due to personal needs such as lack of access to transportation or a healthy food supply. Well-being Coordinators at each entry point will have a standardized intake form including an assessment with core questions to help guide patients in referring them to the right services. Health Information Technology will assist in this process of being able to make automatic referrals based on the answers that are provided (developing concept).
The Model will be focused on prevention, well-being, and personal responsibility for health and take a whole-person philosophy. In the Centennial Care rewards program, there is a focus on helping Medicaid patients to be active participants in their health through rewards for healthy behaviors. This approach will be reviewed and may be leveraged across other payers.

Social determinants of health (i.e., education, food, neighborhood and built environment, social and community context, and economic stability, etc.) will be addressed within this inclusive model of individual, cultural and community perspectives. Improved health equity and health literacy will be cornerstones, as culturally sensitive, relevant, and accessible materials and education are developed, and, based on the premises of Centennial Care, will focus on using the healthcare system wisely and effectively.

The roll-out of this Model will be phased in over time balancing underserved areas and populations with quick-win opportunities, and demand by high volume regions. The unique need and recommendations of the 23 American Indian tribes, pueblos and nations, and urban off-reservation population is essential. In order for the Model to be successful statewide, it must be flexible for adaptation in all communities and be responsive to community needs. It will be necessary for the Model to include a mechanism for communication and collaborations across governments so that tribes, pueblos and nations may consider the value and benefit of participating in this initiative. A first step is consideration of a robust health information exchange that enables data-sharing across tribal and state health systems, and among providers, payers, and patients will need to be instituted. Due to the wide service disparities across New Mexico’s urban, frontier, rural areas, multiple Information technology methodologies such as telehealth, and Mobile (health) Services will be incorporated as alternative health delivery systems.

A robust workforce will be necessary to carry out core components of this model. Resources will be invested in the workforce that currently exists in the State, with policy levers examined to further enable recruitment and expansion beyond current numbers. Project ECHO may be utilized to enhance the skills of the current workforce, including CHWs and Community EMS personnel, and others via telehealth technology.

**Work Force**

**Recruitment and Retention of Health care professionals**  [Developing concept]

*Well-Being Coordinator*  (needs to be clearly defined. What type of professional is the WB Coordinator and what are the credentials/training that would be required for this position, a public health staff member, public health nurse, etc.?)

Some of the responsibilities of this position may be:

- Coordination of services among the providers and staff who interact with a client
- Linkage of clients to community resources that respond to their social service needs.
- Integration of behavioral health and specialty care into care delivery through co-location or referral agreements.
- Tracking and support of patients when they obtain services outside the practice.
- Follow-up with patients within a few days of an emergency room visit or hospital discharge.
- Communication of test results and care plans to patients, families, and care givers.

8/18/2015
The Well-being Coordinator will also coordinate services provided by CHWs and EMS personnel, and align them with the services provided by the primary care physician. For example, a “prescription” for diabetes self-care instruction to be provided by a CHW will be monitored and tracked to ensure alignment with the patient’s overall treatment and wellness regimen. Coordination with services of EMS personnel may include scheduling and tracking non-emergency medical transports, or coordination of basic primary care services provided by EMTs with the primary care physician.

Community Health Workers/Community Health Representatives (expand here)

EMS Personnel (expand here)

Public Health Staff (expand here)

Health Leads

The Health Leads model facilitates prescriptions for basic resources like food, heat, and physical exercise, and referral of patients to the resource. Health Leads Advocates, college students who recruited and trained to fulfill prescriptions, work side by side with patients to connect them with the basic resources they need to be healthy.

When clients visit a clinic, they are screened for basic needs that can affect their health. Healthcare providers prescribe resources to meet these needs, [often using the electronic medical record ???] to refer patients to a Health Leads Advocate who navigate the complexity of the resource landscape – including tracking down phone numbers, printing maps, securing transportation, and completing applications. Advocates follow-up with clients regularly by phone, email, or during clinic visits. Relationships may be long-term or short-term based on clients’ needs and preferences. As part of the clinic team, Advocates also provide ongoing updates on an individual’s progress in securing basic resources to other team members.

[NOTE: It is important not to blur role identities here – the WB coordinator may be a high level position who will be overseeing the entire spectrum of clinical and social services of clients. And EMS personnel may best serve the system by conforming to their own scope of practice. The Health Lead Advocate should be faithful to the original model, i.e., health or social services, college students, retired persons, etc. so as to augment the workforce]

Payment Model

The payment model to support the Model Design will incentivize providers to provide “whole person” services that improve population health outcomes. With the expansion of the multi-disciplinary provider teams, reimbursement mechanisms will be explored for the non-traditional services provided (e.g., social services, expanded CHW and EMS services, prevention/wellness programs, indigenous traditional healers, etc.). This payment model complements the PCMH initiative and will be aligned with Centennial Care’s payment mechanisms, which include pay for performance, outcome-based reimbursement, and bundled payments to providers for episodes of care. Promising and evidence-based payment models will be explored, including a tiered reimbursement with incentives that are tied to targeted PCMH measures.
Incentives may also be used to promote wellness and patient-proactive healthcare, while high cost medical care and procedures may be de-incentivized.

Pay for performance will be explored as providers are charged with influencing population health outcomes, and improvement in their patients’ outcomes may result in reward through compensation. For instance, a provider, who improves low birth weight of patients through referrals to home visiting programs, would be rewarded. A plan to re-evaluate CPT (spell out) codes to de-incentivize high-cost medical procedures and place additional value on lower cost items will be explored. As the expansion of PCMHs in the State moves forward, financial support will be provided to move practices towards achievement of national PCMH certification. Upon certification, payment will be standardized based on level of PCMH achievement and evidence of quality care to patients.

Movement towards a shared savings model may be examined including using a portion of the shared savings to support the community through funding education and prevention in schools, or other community activities. Plan costs and cost-drivers will need to be understood in order to be able to identify opportunities for cost savings. Care coordination among primary care, behavioral, oral, and public health will be included in the payment model, with the patient having the ability to decide where to go based on available metrics of provider performance.

**PCMH Requirements**

With the statewide expansion of the PCMH, a Technical Assistance Center (TAC) will be developed to promote best practices, facilitate education, and encourage a uniform state approach to PCMH. One certifying organization will be established for the State, and a “Glide Path” to certification will be offered to all practices. The “Glide Path” will be modeled on the process successfully implemented by the State of Connecticut to support practices that may be less-resourced or those that are just beginning the PCMH transformation process. Support will also be provided to tribal 638 clinics to become PCMHs via the TAC. The development of PCMHs will be incentivized by certification that is based on nationally vetted standards.

The PCMH model will be built on successful state programs that integrate primary care, behavioral, oral, and public health, including the use of Screening, Brief Intervention, and Referral to Treatment (SBIRT) for patients with substance use and abuse disorders. The Medicaid health home model, as set forth in Centennial Care, will also be incorporated into the State’s PCMH approach. Improved access to care is an important part of the PCMH approach with flexible scheduling including same-day appointments, walk-in accommodations, and after hours and weekend office hours to ensure that the patients’ needs are met.

**Health Homes**

Centennial Care provides for a comprehensive care coordination system with the objective of achieving cost-effective care and improved quality outcomes. The Centennial Care Health Homes will benefit the most vulnerable members of the State’s population and provide integrated and coordinated care for members with complex chronic conditions, specifically those with serious mental illness (SMI) or severe emotional disturbance (SED). The Health Homes focus on these members due to their high personal physical and emotional risk as well the financial risk the pose to the State. This Health Home model will be integrated to address physical and behavioral needs, along with existing comorbidities, and focus on
First DRAFT: NM Model Design

conditions more successfully ameliorated through intensive care coordination. The model will be implemented using providers in the community who are experienced and skilled at addressing member needs through a whole-person philosophy.

The PCMHs must be committed to the use of electronic health records (EHRs) and adherence to meaningful use (MU) requirements of the Office of the National Coordinator (ONC) for Health Information Technology. To better ensure effective care coordination, data integration and information sharing will move towards real-time transmission. For all the necessary requirements of health information technology to occur in a PCMH, an emphasis on recruitment and training of IT and data input staff will be a requirement. A health information technology plan will be developed to incorporate these concepts and develop a three-year road map for implementation. [Expand HIT here]

Performance Metrics (Measures)

Performance metrics will be standardized across quality clinical and population health metrics that focus on outcomes including overall health, race/ethnicity, behavioral health, social determinants of health, and quality of life. Metrics will also be inclusive of process, performance of the PCMH model, quality and cost of care, recipient choice and satisfaction, and provider satisfaction and performance. The metrics will be developed via a collaborative process of statewide stakeholders and utilized by providers and payers. The measures will be based off of nationally vetted measures and will be aligned with state level health priorities across the lifespan with health equity being the foundational lens, and with Centennial Care metrics. It will be inherent that any of the metrics chosen should have reliable, available, and agreeable data for both clinical and population health metrics.
Assessing & Promoting Adoption of the Community-Centered Health Home Model
Sample Interview Questions for Site Visits

I. Leadership Support and Organizational Capacity

1. When you hear the term community prevention, what does it mean to you?

2. How, from your perspective, does your health center address community prevention?

3. How is community prevention institutionalized within the clinic? Can you describe any systems, programs, and/or personnel in place that work directly with community prevention efforts?

4. How do you assign roles or provide sufficient staff to support your community prevention work? How are staffed trained and supported to engage in community change efforts?

5. How does your mission, along with other internal policies and practices, align with your commitment to community prevention?

6. How would a change in leadership influence the clinic’s commitment to community prevention as a priority?

7. How do you set your organizational direction?

8. Is there time and space for community conditions discussions at staff meetings?

9. How are community prevention related programs developed?

10. How do you define health equity? How is health equity embedded in the clinic’s internal practices and mission? How does health equity relate to the clinic’s programs and community prevention activities?

II. Data & Analysis

1. How do you monitor the health of your patient population? How do you recognize and understand emerging health trends among your patients?

2. Do you use any additional data sources beyond clinic data to enhance the understanding of the health status of the population your clinic serves?

3. What are the implications of health information technology implementation on your clinic’s operations? Are you utilizing health information technology to collect information that focuses on the social determinants of health or asks about community conditions? If so, how?

4. How does information get recorded, compiled, and analyzed?

5. How is data used to make decisions about new initiatives, programs, or practice changes to improve population health?
III. Advocacy Efforts and Partnerships
1. What do you see as your clinic’s role in advocacy and policy change? And how do you staff that role?

2. How do you decide which coalitions you are involved with?

3. Are you involved with or connected to any advocacy organizations? If so, which ones? (i.e., CPCA, NACHC, Health Access, housing coalition, food and farm coalition, etc.)?

4. Are you also involved in efforts around policy change or changes to community environments? Are there policies (local, state, federal) that the clinic has helped champion or changes to specific community conditions that support health?

5. How do you pay for staff time to do advocacy work?

6. What partners do you work with outside the health care sector? How do these partnerships inform you work?

7. What is the nature of your partnerships with surrounding or local health care organizations?

IV. Payment and Funding for Primary Prevention
1. What are your major sources of funding, in general? How do the funds break down?

2. How are efforts that focus on changing community conditions currently funded? If you have found any limitations that exist with current funding streams, how do you work through/around those limitations?

3. What are you able to accomplish with current funding streams (Medicaid, Medicare, etc.)?

4. Do you see opportunities within the ACA for paying for community prevention? Do you see any opportunity for intersection with the CDC’s Community Transformation Grants (CTG) or other federal funds?

5. How are philanthropic (or other) dollars leveraged?

V. Clinician Perspective
1. What information are you collecting during the appointment? How are you recording your information?

2. How often are patients asked about other factors (housing, environment) that may contribute to their health conditions during the clinical encounter?

For the Medical Director…

3. How are you standardizing information that is collected by different clinicians? Is data on social, economic, and community conditions collected from individual patients on the patient intake form?
VI. Final Overarching Questions

1. Who are you connected to that would promote changes at the local, state, and federal level to support this work?

2. Who do you look to for leadership around issues related to population health or community prevention?

3. How can we be helpful to you?
**Triple Aims**

Slow the Rate of Growth in Health Care Costs by 2020

- Multi-payer strategy and/or value-based reimbursement for care policies
- Functional, interoperable health information system

Improve Population Health Outcomes by 2020

- 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

Improve Patient Experience and Quality of Care 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

**Primary 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
- Involve consumers in decision-making about their own health and well being options
- Expand use of PCMH to engage patients (assessments, wellness activities and technology)
- Develop a payment model that supports PCMH and community centered wellness
- Train and integrate health professionals and paraprofessionals (e.g. community health workers and community EMS.)
- 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

**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
- Involve consumers in decision-making about their own health and well being options
- Expand use of PCMH to engage patients (assessments, wellness activities and technology)
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- Develop sustainable pricing and payment models to support innovation design
- Improve care coordination, medication management, EHR interoperability, evaluation of health system performance
SIM Timeline

8/30/2015
Model HSI Design 1st Draft

9/1/2015
8/19/2015
Aug Summit - Design Validation

8/19/2015
Sept Summit - Project Status

9/1/2015
9/30/2015
Gap Assessment Report
Input from sustainability, workforce and HIT plans are given to OPA for integration into the Business Plan

10/1/2015
Scale & Scope Roll Out Plan
HIT, Workforce roll-out plans to be integrated in over-all roll out

10/1/2015
10/21/2015
Oct Summit - Cancelled

10/15/2015
10/21/2015
Final HSI Design Draft

11/1/2015
11/18/2015
Nov Summit - Cancelled

11/1/2015
11/30/2015
Final HSI Design Draft

12/1/2015
12/2/2015
Present Final HSI Draft to Steering Committee

12/2/2015
12/5/2015
Present Final HSI Draft to Governor
The Governor will make the final decision on Governance for the Health System

12/16/2015
12/16/2015
Present Final HSI Draft to Public At Dec Summit (final)

1/1/2016
1/15/2016
Submit Final HSI Draft to CMS

1/15/2016
1/15/2016
OPA will combine Business, workforce, HIT and Sustainability plans into a final document.
NM Health System Innovation Committee Member Organizations

- Aging and Long Term Services Department
- Alliance of Health Councils
- Board of Nursing
- Chronic Disease Prevention Council
- Children, Youth, and Families Department
- Department of Information Technology
- General Services Department
- Indian Affairs Department
- Legislators (Democrat and Republican)
- New Mexico Economic Development Department
- New Mexico Hospital Association
- New Mexico Medical Board
- New Mexico Primary Care Association
- New Mexico State University
- Office of the Governor
- Office of the Superintendent of Insurance
- Representative of people with Disabilities
- Presbyterian Healthcare Services
- Public Education Department
- Tribal Representative
- University of New Mexico
### August 19, 2015 Health System Innovation Summit Registration List

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