NEW MEXICO
PRIMARY CARE
COUNCIL

2023

5-YEAR STRATEGIC PLAN

Version 2: Updated from 2022

NEW MEXICO HUMAN SERVICES DEPARTMENT

Contents

Honor Native Land

On behalf of all colleagues at the Human Services Department, we humbly acknowledge we are on the unceded ancestral lands of the original peoples of the Pueblo, Apache, and Diné past, present, and future.

With gratitude we pay our respects to the land, the people and the communities that contribute to what today is known as the State of New Mexico.

Evening drive through Corrales, NM in October 2021.
By HSD Employee, Marisa Vigil

Letter from the Primary Care Council Chair

Welcome to New Mexico's Primary Care Council.

In 2019, providers, clinicians, and primary care advocates across New Mexico urged the state legislature to form the New Mexico State Primary Care Council (PCC). Passed as House Bill 67 in 2021, the PCC is tasked with addressing the immediate and urgent issues plaguing primary care.

I have the honor of serving as chair of the Primary Care Council since its formation. The PCC understands the urgent need for a primary care revolution to ensure health equity for patients, families, communities, and primary care workforce; initiate payment strategies to support high-quality primary care; make health technology investments and improvements; and build a sustainable workforce. At the heart of our work, is a desire to:

- revolutionize primary care through innovation and creativity;
- ensure primary care data is valid, reliable, and specific to understand our system;
- develop equitable interprofessional primary care teams who value and honor every member of the team equally and provide person-centered care;
- use an intersectional approach to ensure primary care is fairly and justly provided for all New Mexicans;
- support holistic primary care, factoring in a unique array of ancestral approaches to living and healing;
- ensure healthy communities through partnerships designed with the needs of community at the center.

Over the past year, the Council has focused on developing primary care payment and care delivery reforms for Medicaid. In 2023, we will announce the new payment models which were developed in collaboration with, and to meet the needs of, providers and clinicians across the state. I look forward to sharing and learning together with you as we provide technical assistance and training for the adoption of these reforms.

Revolutionizing, reimagining, and investing in primary care in is an enormous, yet essential task, for ensuring the health of all New Mexicans. As you review the Primary Care Council's 2023 Strategic Plan, I hope you see a future where New Mexico exemplifies same-day access to high-quality, equitable, primary care for all persons, families, and communities.

With sincere gratitude,

Jennifer K. Phillips, M.D.

Family Medicine Physician

Executive Summary

Over the past twenty years, there has been a significant shift in health care resulting in only one in five Americans having access to a routine or usual source of care. [1] In New Mexico we refer to this usual source of care as "primary care." The COVID-19 crisis has brought to the forefront shortcomings in the current primary care system including a declining workforce experiencing severe burnout; a decline in patient-physician relationships; profound societal health inequities; and an overall underinvestment in Primary Care. [2] [3] [4] [5]

A wealth of research shows primary care helps prevent illness and death, and findings in both national and international studies illustrate primary care results in a more equitable distribution of community health. [6] Primary care is the only health care component where an increased supply results in improved population health and more equitable outcomes. Primary care is a common good, which makes the strength and quality of the country's primary care services a public concern. [7] The primary care workforce is also key in the promotion of health equity by supporting patients and families in attaining their full health potential, while ensuring neither social position nor other socially determined circumstances disadvantages them from achieving their potential. [8]

In 2022, the Primary Care Council (PCC) and New Mexico Human Services Department (HSD) led a state-wide collaborative process in to establish new primary care payment models for Medicaid that will launch on January 1, 2024. Stakeholders across all aspects of primary care were engaged in listening sessions, surveys, focus groups, and individual conversations. These payment reforms are built to support the needs of the New Mexico primary care workforce, patients, families, communities, and payors. Medicaid Turquoise Care Managed Care Organizations (MCO) will be required to adhere to any payment reform recommendations promulgated by the New Mexico Primary Care Council. The work of the PCC is also reflected in the State of New Mexico Medicaid federal 1115 waiver demonstration including:

- Expanded Centennial Home Visiting Pilot Programs
- Expanded Access to Supportive Housing
- Medicaid Services for High-Need Justice-involved Populations 30 Days Before Release
- Member-Directed Traditional Healing Benefits for Native Americans
- Home-Delivered Meals Pilot Programs
- Addition of a Closed-Loop Referral System
- Medical Respite for Members Experiencing Homelessness
- Primary Care Residency Expansion funding and program technical assistance

In 2023, the PCC will continue their work to revolutionize primary care across the four goals of the council. Health Equity and wellness for the primary care workforce will continue to be at the center of the work of the PCC. We will partner with NM Department of Health in the increasing the Community Health Worker workforce, collaborate on strategies to address health disparities in the state, and begin to modernize the state's health IT systems.

HSD, in collaboration with members of the community-based PCC, worked together to develop this strategic plan. This strategic plan outlines a thoughtful, achievable, and bold plan to improve the many elements of primary care throughout New Mexico; and the PCC will update it annually over the next four years.

Background and Introduction

The 2021 House Bill 67 (Primary Care Council Act) [9] charges HSD to establish an unpaid, statewide PCC to advise the State in finding means to increase New Mexicans' access to primary healthcare while improving overall health and lowering total healthcare costs. As enacted, the statute outlines eight duties for the Council, which are outlined below:

1. Develop a shared description of primary care practitioners and services;
2. Analyze annually the proportion of health care delivery expenditures allocated to primary care statewide;
3. Review national and state models of primary care investment with the objectives of increasing access to primary care, improving the quality of primary care services and lowering the cost of primary care delivery statewide;
4. Review New Mexico state and county data and information about barriers to accessing primary care services faced by New Mexico residents;
5. Recommend policies, regulations and legislation to increase access to primary care, improve the quality of primary care services and reduce overall health care costs;
6. Coordinate efforts with the graduate medical education expansion review board and other primary care workforce development initiatives to devise a plan that addresses primary care workforce shortages within the state;
7. Report annually to the interim legislative health and human services committee and the legislative finance committee on ways that primary care investment could increase access to primary care, improve the quality of primary care services, lower the cost of primary care delivery, address the shortage of primary care providers and reduce overall health care costs; and,
8. Develop and present to the [Human Services Department] secretary a five-year plan to determine how primary care investment could increase access to primary care, improve the quality of primary care services, lower the cost of primary care delivery, address the shortage of primary care providers and reduce overall health care costs.

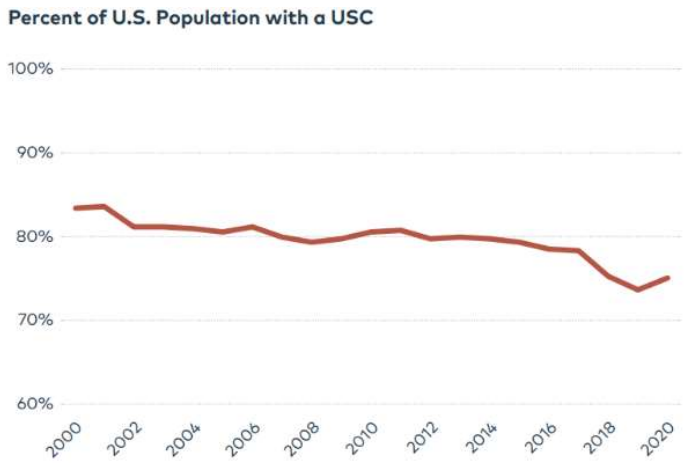

FIGURE 1: PERCENT OF POPULATION WITH A USUAL SOURCE OF (PRIMARY) CARE

New Mexico Overview

Prior to their encounter with the Spanish in 1540, the Pueblo, Navajo, Ute, and Apache communities (including the Fort Sill, Jicarilla and the Mescalero) lived on the land known today as the state of New Mexico.

In 2021, the New Mexico state population is 2,106,319 [10], with over 68% identifying as racial or ethnic minorities. [10] Though the State's population centers are in urban areas, New Mexico is a rural and frontier state, with an average population density of 17.5 persons/square mile. [11] Further 18.5% [10]

of state residents in 2020 were 65 years or older, and is projected to reach 26.5% by 2030, making it the third oldest state in the U.S. [12] This older population, low population density combined with long distances make the provision of healthcare particularly challenging. New Mexico has a shortage of healthcare providers across all specialties, including in primary care. One estimate projects a national primary care physician shortage of over 20,000 by 2033. [13] Another estimate lists New Mexico among three states with the largest shortage of registered nurses by 2030. [14] This healthcare workforce shortage means healthcare access is challenging, as many New Mexicans cannot access timely primary care, especially rural and frontier communities.

In many health and socioeconomic indicators, New Mexico fares worse when compared to other states such as per capita personal income ($50,311 4th lowest). [15] New Mexico ranks third in U.S. child poverty (24%), and third in the U.S. in elder poverty (12.8%). [16] The substantial enrollment in the Medicaid program reflects the extent of the state's poverty: 984,335 New Mexicans enrolled in the Medicaid public health insurance program in December 2022, (45% of the State's population). [17] Although NM has lower death rates than the national average for heart disease and cancer, it has much higher death rates for unintentional injuries, specifically overdose, motor vehicle injuries, and falls.

The PCC has outlined several activities to support health equity in New Mexico. Care coordination and Community Health Workers (CHWs) are particularly important for achieving access to care and connection to social supports such as healthy food, housing, employment, and transportation. Additionally, HSD is requesting funding for a closed-loop referral service to connect patents to social services in their community.

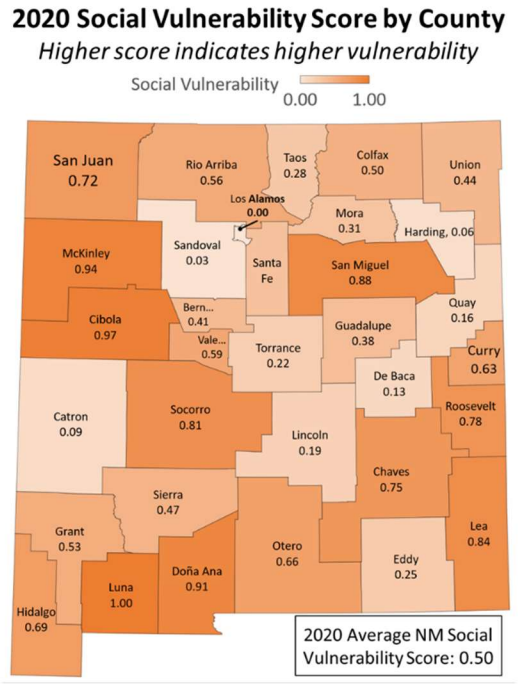

FIGURE 2: NM SOCIAL VULNERABILITY BY COUNTY. SOURCE, U.S. CENTERS FOR DISEASE CONTROL AND PREVENTION **[66]**

Primary Care Council Overview

The following definition of primary care (adapted from the National Academy of Sciences, Engineering and Medicine) guides the work of the PCC, setting the stage for the PCC's mission, vision, and goals:

"High-quality primary care is the provision of whole-person, integrated, accessible, and equitable healthcare by inter-professional teams and community partners who are accountable for addressing the majority of individuals' health and well-being across settings and through sustained relationships with patients, families, and communities." [7]

FIGURE 3: PRIMARY CARE COUNCIL MISSION, VISION, AND GOALS

The PCC definition of high-quality primary care is not a description of the current state of primary care in New Mexico. It is aspirational and defines what the foundation of the health care system can, should, and must be for all New Mexicans. Thus, the PCC mission is to *revolutionize*—to change radically and fundamentally—how we deliver primary care; to transform primary care into a team-based approach that values and rewards equitable, accessible, comprehensive, coordinated, high-quality, and cost-efficient care.

As outlined in statute, [9] the PCC is a public-private body that includes nine voting members and thirteen advisory members, appointed by the Human Services Department (HSD) Secretary. Members include representatives from HSD, Department of Health, Office of Superintendent of Insurance, and the NM Primary Care Association. In 2022, the PCC expanded to include community partners who participate in quarterly meetings and workgroups to provide additional perspectives.

Primary Care Council Timeline of Strategic Activities

In 2022, the PCC developed and adopted the list of strategic activities below designed to be accomplished in the next several years. These activities align with the eight duties outlined in House Bill 67. The PCC will annually publish updates in subsequent strategic plans.

GOAL 1: Develop and drive investments in health equity across New Mexico to improve the health of New Mexicans.				
Objectives	**HB 67 Duty**	**Activities**	**Lead**	**Timeframe**
1. By 2026, establish a standard for health equity in New Mexico that includes the expectations, tools, and resources are available for Primary Care.	1,4,8	1a. In partnership with the Department of Health (DOH), develop a framework for equity at the clinic level, community, patient, and family levels. 1b. DOH in partnership with state agencies, tribal, and community stakeholders, will identify and implement strategies to improve primary care and health equity in the State Health Improvement Plan (SHIP). 1c. Submit a 5-year 1115 waiver renewal application to CMS that includes strategies to address health equity in the state's Medicaid program with an anticipated effective date of January 1, 2024. 1d. Implement strategies in Goal 3 (Health Equity) of the 1115 waiver to identify groups that have been historically and intentionally disenfranchised and address health disparities through strategic program changes to enable an equitable chance at living healthy lives.	HSD (1c,e) DOH (1b) HSD & DOH (1a,d)	SFY23 (1c) SFY23 (1a,c) SFY23-26 (1b) SFY24-26 (1d)
2. By 2026, integrate public health, primary care, and behavioral health.	4,5	2a. In coordination and alignment with payment reforms, develop models for interprofessional team-based care with an emphasis on behavioral health integration. 2b. In coordination and alignment with payment reforms, provide technical assistance and training for clinics to succeed under models of interprofessional team-	HSD (2a,b,c) DOH (2d,f) HSD & DOH (2g) New Mexico Primary Care Association (NMPCA) (2e)	SFY23 (2a,d,e) SFY23-SFY26 (2b,c,f,g)

GOAL 1: Develop and drive investments in health equity across New Mexico to improve the health of New Mexicans.				
Objectives	**HB 67 Duty**	**Activities**	**Lead**	**Timeframe**
		based care with an emphasis on behavioral health. 2c. Implement Certified Community Behavioral Health Clinics (CCBHCs) to support behavioral health access; care coordination including services provided to assist and support individuals in developing their skills to gain access to needed medical, behavioral health, housing, employment, social, educational, and other services and help advance primary care integration. [18] 2d. Inventory DOH services across New Mexico primary care settings, including staff presence, grants, and contracts for services. 2e. Conduct needs and assets assessment for public health services in primary care settings across New Mexico. 2f. Develop and implement strategies to build out co-located public health in primary care settings. 2g. Invest in public health and the public health workforce to improve disease surveillance systems and expand and diversify the public health workforce so we can address the impacts of the social and structural determinants of health, health inequities, counter spread of health misinformation and disinformation, strengthen		

GOAL 1: Develop and drive investments in health equity across New Mexico to improve the health of New Mexicans.				
Objectives	**HB 67 Duty**	**Activities**	**Lead**	**Timeframe**
		partnerships across clinical and community settings and consider other societal factors that shape well-being.		
3. By 2026, create meaningful partnerships between governmental agencies, nonprofit organizations, businesses, and academic centers to support health equity.	4,5	3a. Align efforts and develop partnerships with social support organizations who will provide social services to patients connected to the closed-loop referral system. 3b. Align efforts and develop partnerships with state agencies and community groups to establish Accountable Communities of Health (ACH). [19]	New Mexico CONNECT Collaborative (3a, b)	SFY23-26 (3a,b)
4. By 2026, establish networks of care coordinators who support patients in equitable access to care, connection to social services, and facilitate action between interdisciplinary care teams.	4,5	4a. Improve linkages between Community Health Workers (CHW), Community Health Representatives (CHR), and Community Peer Support Workers (CPSW) with primary care clinics to support integrated team-based models in primary care. 4b. Standardize training and certification for CHWs. 4c. Provide training and technical assistance to CHWs and other care coordinators on how to use tools, support equity, connect patients to social resources, and facilitate connections and conversations with interdisciplinary care teams. 4d. Submit a Medicaid state plan amendment to allow reimbursement for CHWs and other care coordinators.	HSD (4d) DOH (4b,c) HSD & DOH (4a)	SFY23 (4b,d) SFY24-26 (2a,c)

GOAL 1: Develop and drive investments in health equity across New Mexico to improve the health of New Mexicans.				
Objectives	**HB 67 Duty**	**Activities**	**Lead**	**Timeframe**
5. Analyze proportion of health care delivery expenditures allocated to primary care.	2	5a. In alignment with HB67 duty 2, annually analyze the proportion of health care delivery expenditures allocated to primary care. 5b. Identify and implement policy changes that can increase the proportion of health care delivery expenditures allocated to primary care. 5c. Once available, utilize the All-Payer Claims Database to calculate percentage of primary care spend.	HSD (5a,b,c)	SFY24-26 (5a,c) SFY25-26 (5b)

GOAL 2: Develop and recommend sustainable payment models and strategies to achieve high quality and equitable primary care for all New Mexicans.				
Objectives	**HB 67 Duty**	**Activities**	**Lead**	**Timeframe**
1. By 2024, develop and implement sustainable primary care payment model(s) for Medicaid that move away from fee-for-service and volume to payment for quality, health outcomes, and patient wellness.	3,4,5	1a. Design a new primary care payment model(s) that aligns with the Health Care Payment Learning and Action Network (HCP-LAN) [20] framework to incentivizing performance and population-level health outcomes, aligns with the core features and principles adopted by HSD and PCC, and applies to a variety of settings. 1b. Test and evaluate primary care payment model(s) for efficacy and outcomes prior to start date of new Medicaid MCO contracts (1/1/2024). 1c. Develop Medicaid MCO contract language for primary care payment reforms in accordance with the Code of Federal Regulations (CFRs) and other	HSD (1a,b,c,e,h,I,j,k) HSD & DOH (f) OSI (1d) NMFA & DOH (1g)	SFY23 (1a,b,c,e,k) SFY23-26 (1d,f,g,h,i,j)

GOAL 2: Develop and recommend sustainable payment models and strategies to achieve high quality and equitable primary care for all New Mexicans.				
Objectives	**HB 67 Duty**	**Activities**	**Lead**	**Timeframe**
		state/federal rules and regulations. 1d. Provide fiscal, policy, and/or legislation that may be needed to advance and support primary care payment reform; and a multi-payor roll-out of primary care payment reform. 1e. Develop and define the quality metrics (including health equity) that will be a part of the Medicaid payment model and harmonized across the different Medicaid MCOs. 1f. Create investment opportunities that support practices engaged in Medicaid payment reform implementation and progression from tier 1 to 4 (e.g., PMPM investments for a year before moving to additional tier, up-front investment in staffing, tech, training, resources). 1g. Through its Primary Care and Behavioral Health Capital Fund, the State will provide capital project financing to community-based nonprofit clinics located in rural and underserved areas of New Mexico. 1h. Work with MCOs to create consistency across administrative processes and reduce administrative burden. 1i. Work with legislature to sustainably fund continued primary care payment reform growth and improvements.		

GOAL 2: Develop and recommend sustainable payment models and strategies to achieve high quality and equitable primary care for all New Mexicans.				
Objectives	**HB 67 Duty**	**Activities**	**Lead**	**Timeframe**
		1j. Engage with CMS to leverage federal funding and programs to support primary care payment model success. 1k. Participate in the Center for Health Care Strategies "Medicaid Primary Care Population-Based Payment Learning Collaborative" to receive technical assistance focused on developing, implementing, and improving primary care population-based payment models within Medicaid.		
2. Build the foundation for long-term engagement with stakeholders that began in 2022 to prepare for and promote adoption of primary care payment reforms in Medicaid.	3,4,5,8	2a. Conduct meetings of the Primary Care Transformation Collaborative (TC), providing primary care practitioners supports related to NM Medicaid primary care payment model implementation. 2b. Continue to build relationships with stakeholders through listening sessions, webinars, and ongoing support to address common areas of need to support the adoption and success for clinics in adopting primary care payment reforms. 2c. Publish survey findings and recommendations for clinician and provider readiness in adopting primary care payment reforms. 2d. Identify underserved areas where additional technical assistance is needed to support and/or to enhance provider and clinician adoption of primary care payment reforms.	HSD (2a,b,c,d,e,f)	SFY22 (2c,e) SFY22-23 (2f) SFY23 (2d) SFY23-26 (2a,b)

GOAL 2: Develop and recommend sustainable payment models and strategies to achieve high quality and equitable primary care for all New Mexicans.				
Objectives	**HB 67 Duty**	**Activities**	**Lead**	**Timeframe**
		2e. Identify and distribute best and promising practice activities that enhance provider and clinician primary care payment reform adoption. 2f. Develop a measurement instrument and evaluate success of technical assistance services, and revise supports as needed.		
3. Provide supports for Medicaid primary care clinicians and providers to reach HCP-LAN Category 4 by 2026.	3,5,8	3a. Provide clinicians and providers incentive payments that advance their capacity to adopt increasingly more advanced primary care payment reforms. 3b. Establish a value-based data intermediary to help evaluate and monitor population health metrics. 3c. Provide technical assistance for the use of a value-based data intermediary to help evaluate and monitor population health metrics. 3d. Provide technical assistance to providers and clinicians in supporting adoption of increasingly more advanced primary care payment and interprofessional-team models.	HSD (3a,b,c,d)	SFY23-26 (3d) SFY24 (3b) SFY23-26 (3a,c)
4. By 2026, create an environment where primary care providers and clinicians have opportunities to learn how to adopt new payment and interprofessional	5,8	4a. Continue primary care payment and interprofessional technical assistance to grow the number of providers and clinicians participating in advanced primary care in the state.	HSD (4a)	SFY23-26 (4a)

GOAL 2: Develop and recommend sustainable payment models and strategies to achieve high quality and equitable primary care for all New Mexicans.				
Objectives	**HB 67 Duty**	**Activities**	**Lead**	**Timeframe**
team-based models and how those models will improve their practice.				
5. By FY 2026, develop and implement sustainable payment reforms for self-insured plans, commercial insurers, IBAC plans, and federal plans aligning with Medicaid models.	3,5,8	5a. Building on Medicaid payment reforms, create and present a multi-payer vision providing recommendations to commercial insurers, self-insured employers, and other stakeholders. 5b. Invest in infrastructure, training, and capital to ensure the success of multi-payor primary care payment reforms broadly across the state. 5c. Launch a multi-stakeholder initiative collaborating with NM health care payers and organizations to adopt standardized advanced primary care payment models, increase investments in advanced primary care, and provide technical assistance to primary care practices. 5d. Issue rules and guidance for contracting using PC APM structures. 5e. Request legislature to allow specific authority for OSI to require advanced primary care payment structures and team-based care models. 5f. OSI to help convene carriers to build consensus and adopt PC APMs and team-based care models.	HSD (5a,b,c,g) OSI (5d,e,f)	SFY24 (5a,c) SFY25-26 (5b,d,e,f)

GOAL 2: Develop and recommend sustainable payment models and strategies to achieve high quality and equitable primary care for all New Mexicans.				
Objectives	**HB 67 Duty**	**Activities**	**Lead**	**Timeframe**
6. Measure the improvements in health outcomes and system-wide cost savings of improving an innovative and integrated system that encourages care coordination, optimally designed care management, and care transition.	3,5,8	6a. Create state-level metrics to measure population health outcomes and system-wide health care savings under primary care payment reforms.	HSD, DOH (6a)	SFY25 (6a)

GOAL 3: Develop and drive health information technology improvements and investments that make high quality primary care seamless and easy for Interprofessional Primary Care Teams, patients, families, and communities.				
Objectives	**HB 67 Duty**	**Activities**	**Lead**	**Timeframe**
1. By 2026, develop, invest in, and implement health IT improvements to support advanced PC practice, payment, and interprofessional teams.	2,3,4,8	1a. Assess the needs for providers to connect their EHRs to the HIE to adopt advanced primary care payment in their practice. 1b. Contract with business analysts and project managers to revalidate requirements for EHRs and modernize current DOH systems and begin implementation. 1c. Establish an Office of Informatics to help manage data and information exchange between systems. 1d. The All Payor Claims Database (APCD) will begin collecting data from various data submitters throughout the state with an implementation date in 4Q SFY23.	HSD (1a,e,i) DOH (1b,c,d,e,f) Syncronys (1g,h)	SFY23 (1a,b,d,f) SFY24 (1c,e,h) SFY24-26 (1g)

GOAL 3: Develop and drive health information technology improvements and investments that make high quality primary care seamless and easy for Interprofessional Primary Care Teams, patients, families, and communities.				
Objectives	**HB 67 Duty**	**Activities**	**Lead**	**Timeframe**
		1e. Create a collaborative plan for implementation of health technologies across multi-payors to reduce administrative burdens, enable successful PC APM implementation, and team-based care models that include patient and provider identity management, attribution, care management and coordination, financial benchmarking and management, quality reporting, and feedback. 1f. Collect data from various data submitters throughout the state with an implementation date in 4Q SFY23. 1g. If funding becomes available, partner with HSD on a Social and Structural Determinants of Health (SDOH) referral system which is designed to better connect patients who need social services with the resources through creating HIE data collection and reporting capabilities. 1h. Expand operability of the Healthcare Information Exchange (HIE) to support advanced primary care payment models including risk stratification and population management. 1i. Receive Centers for Medicare and Medicaid Services (CMS) certification to be a modular system which will allow the HIE to be a National Committee for Quality Assurance (NCQA) data aggregator validator.		

GOAL 4: Create a sustainable workforce, financial model, and budget to support our mission and secure necessary state and federal funding.				
Objectives	**HB 67 Duty**	**Activities**	**Lead**	**Timeframe**
1. By 2026, develop a system for data and monitoring of the heath care workforce across state and private entities responsible for collecting workforce data.	1,3,5,6	1a. Conduct a comprehensive, statewide primary care workforce analysis to determine the current provider-to-population ratios, provider demographics, utilization of primary care interprofessional teams. 1b. Understand effectiveness of loan repayment programs in recruitment and retention in rural areas, understand the current state of provider well-being, and healthcare career programs that will inform tactics to address workforce shortages and sustainability. 1c. Collaborate with primary care licensure boards to improve data collection and analyses.	HSD (1a,b,c)	SFY23-26 (1a) SFY24 (1b) SFY23-26 (1c)
2. By 2024, implement sustainable Medicaid PC rate adjustments.	2,5	2a. Develop fair and equitable methodology for Medicaid provider rate reimbursements that support the healthcare workforce. 2b. Raise Medicaid reimbursement rates for primary care, behavioral health, and maternal and child health to 120% of Medicare. 2c. Raise Medicaid reimbursement rates for all other services to 100% of Medicare.	HSD (2a,b,c)	SFY23 (2a,b,c)
3. By 2024, develop plans to expand existing workforce capacity and future workforce development.	3,5,6	3a. Expand the capacity of Certified Peer Support Workers (CPSWs) through training and certification of existing and future workforces. 3b. Expand the capacity of and community health workers (CHWs)	HSD (3a,c-g) DOH (3b)	SFY24 (3c) SFY24-26 (3a,b,d) SFY26 (3e-g)

GOAL 4: Create a sustainable workforce, financial model, and budget to support our mission and secure necessary state and federal funding.				
Objectives	**HB 67 Duty**	**Activities**	**Lead**	**Timeframe**
		through training and certification of existing and future workforces. 3c. Identify strategies the State can take to promote healthcare providers and clinicians practice at the top of their license. 3d. Promote the New Mexico Health Service Corps (NMHSC) to recruit, place, and offer financial assistance to designated health professionals in rural and medically underserved areas of the state. 3e. Expand the number of accredited primary care residency programs from 8 to 16. 3f. Increase the number of community primary care residency positions (from 142 to 264) in NM by 2025 through expansion of existing residency programs and development of new programs, especially in rural areas. 3g. A minimum of 60% of primary care residents who complete an HSD-affiliated residency program remain in NM and practice primary care by 2025, reaching 70% by 2030.		
4. By 2024, expand and make improvements to current recruitment and retention efforts.		4a. Make financial incentives and assistance opportunities for the health care workforce clear, transparent, and easy to find. 4b. Identify financial and nonfinancial barriers to the recruitment and retention of the non-licensed primary care workforce.	DOH (4a,d) HSD (4b) HSD & DOH (4c)	SFY24 (4a,b,c) SFY23-26 (4d)

GOAL 4: Create a sustainable workforce, financial model, and budget to support our mission and secure necessary state and federal funding.				
Objectives	**HB 67 Duty**	**Activities**	**Lead**	**Timeframe**
		4c. Examine NM state policies that may be punitive for health care workers seeking mental health care, advancing legislation to protect health workers seeking help if appropriate. 4d. Provide financial assistance to rural primary care clinics to sustain a minimum level of delivery of primary care services pursuant to the provisions of the Rural Primary Health Care Act (RPHCA). [21]		
5. By 2026, implement recommendations provided by the US Surgeon General on addressing health worker burnout and implement programs relevant needs in NM. [2]		5a. Examine state health professional licensing board questions in applications and renewal forms for licensure so that health workers are only asked about "conditions that currently impair the clinicians' ability to perform the job," as recommended by The Joint Commission in 2020, Federation of State Medical Boards, and aligned with the American with Disabilities Act. 5b. Determine extent of workplace violence against health workers, and pass legislation to address it if needed. 5c. Ensure that state boards and legislatures approach burnout from a nonpunitive lens by considering offering options for "safe haven" non-reporting for clinicians and providers receiving appropriate treatment for mental health or substance use. 5d. Increase access to quality, confidential mental health, and	HSD (5a,b,c,d,e, f,g,h,i)	SFY23 (5,d,e,f) SFY24 (5a,b,c,g,h)

GOAL 4: Create a sustainable workforce, financial model, and budget to support our mission and secure necessary state and federal funding.				
Objectives	**HB 67 Duty**	**Activities**	**Lead**	**Timeframe**
		substance use care for all health workers. 5e. Track timeframes for Medicaid provider enrollment, simplify enrollment process and develop a manual on how to enroll. 5f. Propose updates to the current MCO credentialling process to make the process more streamlined. 5g. Engage with NM Health Professional Wellness Program (NMHPWP) to re-design Physician Health Programs and wellness programs to provide early intervention and destigmatize seeking help. 5h. Analyze licensure questions about diagnoses and treatment and determine how to limit questions to only those necessary for safety, lowering barriers to seeking treatment, and easing physician concerns about their medical license being suspended or revoked.		

Medicaid Primary Care Payment Reforms

The PCC is beginning its payment reform efforts with the Medicaid program, shifting primary care financing from a fee-for-service to payments that drive population and patient wellness. This new payment model will begin January 2024 aligning with the launch of New Mexico Medicaid Turquoise Care.

Designing the parameters of the new payment model

HSD has begun the preliminary work to develop the framework for the payment model, and the approach is strongly influenced by the Health Care Payment Learning and Action Network's alternative payment model framework. The framework will enable primary care providers and clinicians to engage

in value-based payment at a level of risk that is appropriate for their organizations and to move to more advanced levels of payment over time, in phases. As part of the analysis, HSD and the PCC identified the benefits of the payment model to patients and providers, including designing a preliminary tiered measurement framework to create appropriate incentives to improve patient health outcomes and minimize provider burden. The PCC team will continue to refine the payment model and determine appropriate incentives and quality measures, and other performance metrics.

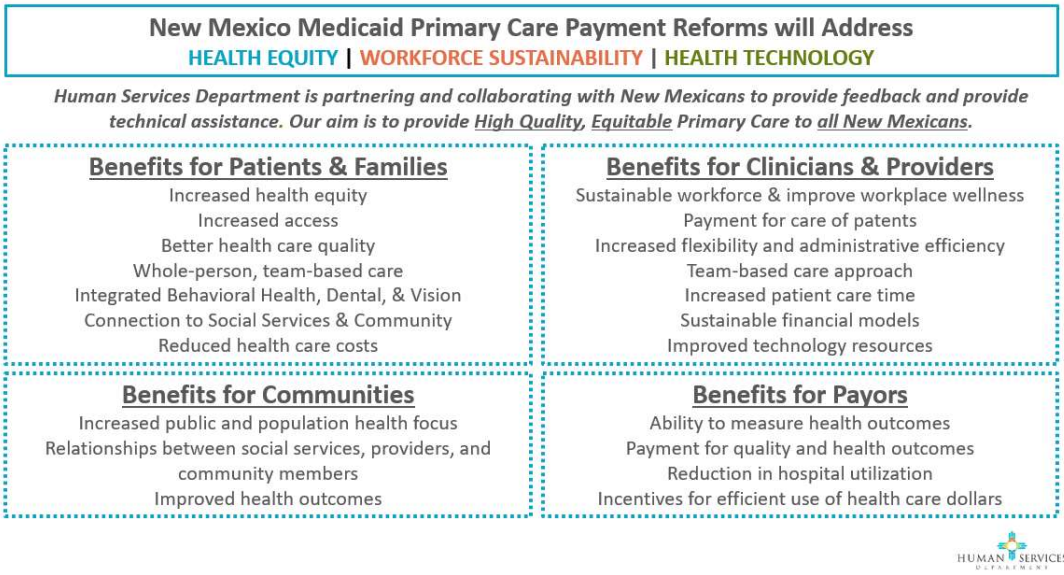

FIGURE 4: NEW MEXICO MEDICAID PRIMARY CARE PAYMENT REFORM BENEFITS

Building a new payment model built on community wisdom

Throughout 2022 HSD has met with providers, clinicians, professional societies and associations, and community-based organizations to obtain input on considerations for payment reform design and implementation, including provider associations such as:

- New Mexico Medical Society
- Native American Technical Advisory Committee
- New Mexico Pediatrics Association
- New Mexico Primary Care Association
- New Mexico Medical Society
- New Mexico Behavioral Health Providers Association

This engagement was a precursor to conducting a primary care payment reform provider and clinician readiness survey, where we received 70 responses across the state. The purpose of this survey was to better understand clinical organizations' capacity to accept risk, barriers and facilitators to payment reform implementation, actionable information on primary care providers' readiness to succeed in payment reforms, and to identify critical gaps that need to be addressed. The survey was coupled with four focus groups with representatives of federally qualified health centers, small and medium-sized physician practices, hospitals, and interprofessional teams (i.e., behavioral health providers, oral health

providers, and pharmacies). The findings from the survey and focus groups are presented in the readiness assessment report included in this strategic plan.

Finally, in 2022 the PCC established the Primary Care Clinician and Provider Transformation Collaborative and its Governing Council and Collaborative Cohort as a mechanism to provide input to payment reform development and implementation and to bidirectionally communicate with communities and constituencies.

During 2023, the PCC will continue to refine the new, primary care payment model, meet with community members and stakeholders, and offer training and technical assistance to primary care clinical organizations to help them succeed in preparation for the launch of the new payment model in 2024.

Primary Care Residency Expansion

A key strategy to PCC Goal 4 is the expansion of primary care physician residency programs. Pursuant to 2019 House Bill 480 (Graduate Medical Education Expansion Program Act), HSD provides funding to new and expanded primary care residency programs (Family Medicine, General Pediatrics, General Internal Medicine, and General Psychiatry). The statute also creates a governing body to oversee the program and make funding recommendations to the HSD Secretary.

Since 2019, HSD, in collaboration with members of the community-based Primary Care Residency Expansion Board & Advisory Group, have worked together to develop a strategic plan for residency expansion throughout the state by:

- Financially supporting new residency development and expansion of existing residencies, particularly in rural and frontier communities. (Since FY 2019, 6 programs have received development funding, totaling $1,554,811).
- Increasing in-state retention post-residency.
- Developing a statewide technical assistance resource center that supports programs with resident recruitment and retention, staff and faculty development, curriculum development etc.
- Amending state Medicaid policies, rules, and regulations to incentivize primary care residency development.

As a result of these activities and the dedicated work of residency program leaders, over a 5-year period, starting in 2019, primary care residencies are expected to grow from 8 to 16 (a 100% increase) in New Mexico. At program maturity, this is expected to result in an increase in the number of primary care residents in training from 142 to 264 (86% increase), and an increase in the number of graduates each year will grow from 48 to 82, a 71% increase.

	5-Year Timeline of Primary Care Residency Expansion in NM							
	Number of New First-Year Residents							
Program	2020	2021	2022	2023	2024	2025	Total new Residents	New Graduates per Year
Family Medicine	3	9	11	12	14	12	61	14
General Psychiatry	0	0	0	5	10	10	25	10
General Pediatrics	0	5	5	5	5	0	20	5

General Internal Medicine	2	2	2	0	5	5	16	5
Total Residents per Year	**5**	**16**	**18**	**22**	**34**	**27**	**122**	**34**

TABLE 1: 5-YEAR TIMELINE OF PRIMARY CARE RESIDENCY EXPANSION IN NM

The organizations outlined below have consulted with the New Mexico Primary Care Training Consortium (NMPCTC) and HSD to begin developing or expanding their programs. Access to necessary resources may impact projected start dates. Table 1 provides a high-level overview of residency expansion and Tables 2 and 3 describes expansion in more detail (by program and specialty).

Sponsoring Institution	Type	Location	Specialty	Resident Capacity	Status	Notes
NMPCTC	New	Las Cruces	Gen. Psychiatry	3	2024	ACGME application under development
NMPCTC	New	Española	Family Medicine (FM)	4	2023	ACGME application submitted, awaiting site visit
Covenant Health Hospital	New	Hobbs	FM	6	2024	Early Development
Covenant Health Hospital	New	Hobbs	Gen. Psychiatry	2	2024	Early Development
Covenant Health Hospital	New	Hobbs	Internal Medicine	TBD	TBD	Early Development
San Juan Regional	New	Farmington	FM	TBD	TBD	Early Stages
Three Crosses Regional Hospital	New	Las Cruces	IM	5	2024	Early Development
Hidalgo Medical Services	Reaccreditation	Silver City	FM	2	2024	Actively recruiting to re-establish program

TABLE 2: 5-YEAR TIMELINE OF PRIMARY CARE RESIDENCY EXPANSION IN NM

5-Year Timeline of New or Expanded Primary Care Residency Programs in NM (detailed)							
	Number of New First-Year Residents						
Program	**2020**	**2021**	**2022**	**2023**	**2024**	**2025**	**Total new Residents**
Family Medicine (3 Year Program)							

Memorial Medical Center (MMC) & Gerald Champion	3	3	3	-	-	-	9
MMC & La Clínica de Familia	-	4	4	4	-	-	12
UNM & Shiprock	-	-	2	2	2	-	6
CHRISTUS St. Vincent	-	2	2	2	-	-	6
El Centro Family Health	-	-	-	4	4	4	12
Covenant Health Hospital	-	-	-	-	6	6	12
Hidalgo Medical Services	-	-	-	-	2	2	4
General Psychiatry (4 Year Program)							
UNM (expansion)	-	-	-	5	5	5	15
DAC Psychiatry	-	-	-	-	3	3	6
Covenant Health Hospital	-	-	-	-	2	2	4
General Pediatrics (3 Year Program)							
UNM (expansion)	-	5	5	5	5	-	20
General Internal Medicine (3 Year Program)							
UNM (expansion)	2	2	2	-	-	-	6
Three Crosses Regional Hospital	-	-	-	-	5	5	10
Total Residents Per Year	**5**	**16**	**18**	**22**	**34**	**27**	**Total new residents trained =122**

TABLE 3: 5-YEAR TIMELINE OF NEW OR EXPANDED PRIMARY CARE RESIDENCY PROGRAMS IN NM (DETAILED)

Conclusion

The NM Primary Care Council was established because the legislature listened to providers and clinicians who demanded an urgent response to the crises in primary care. The current work of the council is in response to that need. Payment reforms for Medicaid that will go live on January 1, 2024, have been created in collaboration with providers and clinicians, and was built for the specific needs of New Mexicans. As we prepare for these payment reforms, HSD and the PCC will offer technical assistance and training. Establishing payment reforms will lay a foundation for future initiatives of the PCC in supporting workforce sustainability, health equity, and health technology.

Acknowledgments

The contributions, wisdom, and talents of our esteemed colleagues make this five-year strategic plan designed to improve primary care in New Mexico possible:

Primary Care Council Board and Advisory Members

1. Eileen Goode, RN: CEO, NM Primary Care Association
2. Jennifer K. Phillips, MD: CMO UNM Medical Group, Professor, Family Medicine, UNM School of Medicine
3. Kathy R. Fresquez-Chavez, NP: CEO, Bella Vida Healthcare
4. Aaron Jacobs, MD: Physician, Associate Professor, Pediatrics Critical Care, UNM Health Sciences
5. Matthew Probst, PA: Chief Quality Officer, El Centro Family Health
6. Valory Wangler, MD: Founding Executive Director, Gallop Community Health
7. Deputy Secretary Laura Parajon, M.D.: NM Department of Health
8. Julie Weinberg: Director, Life and Health Division, NM Office of Superintendent of Insurance
9. Alisha Parada, MD: Chief Division of General Internal Medicine, Geriatrics and Integrative Medicine, UNM Health Sciences Center
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11. Keenan Ryan, PhC: Pharmacist, UNM Health
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13. Jon Helm, RN: Nurse Flow Manager, First Choice Community Healthcare
14. Maggie McCowen, LISW: Executive Director, NM Behavioral Health Provider Association
15. Rohini McKee, MD: Chief Quality & Safety Officer, UNM Hospital
16. Ruby Ann Esquibel: Health Policy Coordinator, NM Legislative Finance Committee
17. Mercy Jones: Patient Advocate, Senior, College of Population Health UNM Health Sciences Center
18. Susan Wilson: Executive Director, NM Coalition for Healthcare Value
19. Pamela Blackwell: Director, Government Relations & Communications, NM Hospital Association
20. Wei-Ann Bay, MD: Retired
21. Carolyn Thomas Morris, PhD: Psychiatrist
22. Alanna Dancis, MSN, CNP, Medicaid Medical Director, New Mexico Human Services Department

Community Partners

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2. Dan Otero, DBA: Chief Executive Officer, Hidalgo Medical Services
3. Jessica Osenbrügge, Community Initiatives Manager – Health & Nutrition, Road Runner Food Bank
4. Nancy Rodriguez, Executive Director, NM Alliance for School-Based Health Care

Primary Care Council Staff

1. Secretary David R. Scrase, M.D.: Secretary, Human Services Department
2. Nicole Comeaux: State Medicaid Director, Human Services Department
3. Alex Castillo Smith: Acting Deputy Cabinet Secretary, Human Services Department
4. Tim Lopez: Director, Office of Primary Care and Rural Health, New Mexico Department of Health
5. Roberto Martinez, M.D., MPH: Interim Health Equity Director, New Mexico Department of Health, Public Health Division
6. Elisa Wrede: Project Manager, Food Security & Primary Care, New Mexico Human Services Department

Appendix

Primary Care Return on Investment

Healthcare System Savings

A 2019 analysis from The Commonwealth Fund [22] found several rigorous studies that incorporate a variety of care management models — which link high-risk patients to needed medical and nonmedical community supports — reduce utilization of costly health care services, lower costs of care, and produce a return on investment (ROI). A few programs provided care management through multidisciplinary teams made up of social workers, case managers, nurses, or physicians and connected patients with community-based resources as needed. These demonstrated reduced ED visits, hospitalizations, home health episodes, and skilled nursing home admissions. Several studies also evaluated the impact of community health workers (CHWs) that connected at-risk patients with social services. A subset of these studies showed CHWs contributed to a higher follow-up visit show rate, lower ED visits, reduced Medicaid spending, and an ROI as high as $2.92 for every $1 spent.

Return on Investment: Local Economies

We can consider the economic value of increasing the primary care workforce in several ways. For example, we can estimate the direct and indirect economic impact of physicians across medical revenues generated during patient care (output), jobs, wages and benefits, and state and local tax revenue. We calculate the direct impact from physician activity, and the indirect economic impact from the industries supported by physicians. On average, each physician supports $3,166,901 in output, an average of 17.07 jobs, approximately $1.4 million in total wages and benefits, and $126,000 in state and local tax revenues. [23]

Primary care dividends are not limited to physicians. Research shows other members of the primary care interprofessional team produce economic savings. For example, a systematic review of 37 studies found consistent evidence that cost-related outcomes such as length of stay, emergency visits and hospitalizations for nurse practitioner care are equivalent to those of physicians. [24]
Primary care generates additional revenue into the healthcare economy. A study of the economic impact of a family practice clinic illustrated that for every $1 billed for ambulatory primary care, there was $6.40 billed elsewhere in the healthcare system. Each full-time equivalent family physician generated a calculated sum of $784,752 in direct, billed charges for local hospitals and $241,276 in professional fees for other specialists. [25]

Return on Investment: Population Health

Research has shown the availability of a primary care physician in a rural area to lead to better health outcomes, such as those relating to all-cause mortality (including cancer) and heart disease. An increase in one primary care physician per 10,000 individuals results in: 1) an 11% decrease in emergency room visits; 2) 6% decrease in hospital inpatient admissions; and, 3) 7% decrease in surgery utilization. [6] [26] These improvements persist after controlling for sociodemographic characteristics. Ultimately, people who identify a primary care physician as their primary source of care are healthier, regardless of health status or demographics.

New Mexico had the 12th highest drug overdose death rate in 2019 (30.4 per 100,000 population), and the highest alcohol-related death rate in the U.S. (73.8 deaths per 100,000 population). [27] Addressing

the many and complex behavioral health needs of New Mexicans through a fully integrated behavioral health primary care model is paramount. It is possible to deliver behavioral health services that are integrated with primary care at relatively low cost, of high quality, and result in improved access. [28] Integrating behavioral healthcare in primary care settings provides opportunities to address concerns before they escalate to crises: screenings to diagnosis an illness; warm handoffs to reduce barriers to transitioning into behavioral healthcare; guidance from behavioral health specialists acting as consultants rather than direct service providers; and assessment and triage to short-term therapy or coaching. [28] [29]

Primary Care Logic Models

LOGIC MODEL: HEALTH EQUITY

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GOAL 1: Develop and drive investments in health equity across New Mexico to improve the health of New Mexicans.

Current State	Future State (Long-term Outcomes)
1. Longstanding, systemic, structural, social inequities, and racism have existed in health care for many decades. 2. Some of the health challenges specific to New Mexico include: a. 25% of New Mexicans live at or below the federal poverty level. b. 1 in 3 of New Mexicans live in rural areas. c. New Mexico has a health care provider shortage which negatively impacts preventative care and access to treatment. d. Obesity and diabetes among New Mexico youth are disproportionately higher in Native and Hispanic populations. e. Diseases of despair are highest among Native Americans, with NM ranking highest for alcohol related deaths in the nation. f. LGBT youth are more likely to suffer depression and anxiety and to have attempted suicide. g. Teen pregnancy rates among Hispanic and Latino females are higher than any other racial or ethnic group. h. Infant mortality and poor maternal health outcomes are highest among Black and African American women. i. 35% of New Mexicans speak a language other than English. j. NM's minority-majority population has suffered root shock, generational/historical trauma and the effects of colonization leading to systemic racism and social injustices. 3. Many New Mexicans live in rural and frontier areas and have limited access to healthcare and lack the transportation necessary to for in-person visits. 4. Access to broadband internet is limited in many areas of New Mexico therefore limiting access to telehealth and other health care technology. 5. Some areas of New Mexico are without running water and other infrastructure that promote health and wellbeing. 6. Current health care pay structures including fee-for-service do not incentivize patient wellness, but rather incentivize treatment of illness resulting in less-than-optimal health outcomes.	1. Continual efforts to improve structural and social determinants of health greatly increase health equity for all New Mexicans. 2. All New Mexicans will have access to equitable, sustainable, and culturally appropriate health care. 3. Whole-person, team-based primary care increases the likelihood individuals are connected to behavioral health, dental, and vision treatment. 4. An increased focus on patient health outcomes reduces rates of obesity and diabetes. 5. Integrated behavioral health helps to reduce stigma in seeking treatment, increases access, reduces alcohol related deaths, and improves services for LGBT youth. 6. Improved partnerships across the state support informed decision-making that centers the voices of those most affected.

Reference: NMDOH Office of Health Equity: https://www.nmhealth.org/about/asd/ohe/

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LOGIC MODEL: HEALTH EQUITY

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GOAL 1: Develop and drive investments in health equity across New Mexico to improve the health of New Mexicans.

Inputs	Interventions	Activities	Outputs	Outcomes
1. HSD & DOH Staff, and other agencies 2. Legislation 3. State Funding 4. Federal Funding 5. Philanthropic Funding 6. Equipment and materials 7. Time 8. Community Partners 9. Government (local, county, state, federal, Tribal) 10. Primary Care Council 11. Research 12. Collaboration 13. Data 14. Data Systems 15. Training & technical assistance 16. Tricare, Medicare, Medicaid, commercial, self-insured employers, and IHS 17. Patients and Families 18. Primary care practitioners 19. Specialists 20. Primary care workforce development programs	1. By 2026, integrate public health, primary care, and behavioral health. 2. By 2026, create meaningful partnerships between governmental agencies, nonprofit organizations, businesses and academic centers to support health equity. 3. By 2026, increase sustained investment in historically marginalized and divested populations.	1a. Develop NM models of public health, primary care and behavioral health integration. 1b. Create a network of community health workers (CHW), Community Health Resource (CHR), and Community Peer Support Workers (CPSW) who are integrated with PC. 1c. Implement CCBHCs to support behavioral health access, and primary care integration. 1d. Implement a State Plan Agreement for Medicaid to pay for CHWs, CPSWs, and other peer support workers who play an important in primary care teams. 2a. Partner with the Social Determinants of Health Coalition in their vision for all New Mexicans [to] live in communities with equitable access to adequate community-based resources. 2b. Inventory NM Department of Health (NMDOH) services across primary care. 2c. Partner with NMDOH Office of Health Equity (OHE) to collaborate on strategies addressing disparities. 2d. Align NMDOH State Health Improvement Plan with PCC Strategic plan activities. 3a. Place primary care at the center of Medicaid and propose initiatives for Turquoise Care that will support the five populations designated as historically and intentionally disenfranchised (a. Prenatal, postpartum, and members parenting children, including children in state custody (CISC); b. Seniors and members with LTSS needs; c. Members with behavioral health conditions; d. Native American members; and e. Justice-involved individuals.) 3b. Invest in and expand Medicaid's non-emergency transportation (NEMT) program to improve access to care particularly for those in rural areas. 3c. Increase enrollment and eligibility in Medicaid's Supportive Housing Program and expand support activity eligibility. 3d. Request approval from CMS to continue telemedicine expansion after the Federal Public Health Emergency has ended. 3e. Work with DOH to improve access to reproductive health. 3f. Inventory state-wide supports using the community and resource data exchange to manage what is available for SDOH services. (DOH) to create a full state-wide assessment to support the closed loop resource.	1. List of NMDOH services across primary care. 2. Report on assets and needs within public health services. 3. Recommendations on NM models of public health, primary care, and behavioral health integration. 4. Catalog of linkages between public and private sector groups supporting SDOH and health equity. 5. Ccomprehensive literature review of the NMDOH State Health Assessments with Community Health and State agency assessments. 6. Networks of integrated CHWs, CHRs, and CPSWs. 7. Investments in historically marginalized and divested populations. 8. Meetings, focus groups, surveys, and site visits with community groups leading to community-led solutions that address health equity. 9. Creation of Alternative Payment Models that address health equity. 10. Online, real-time SDOH referral system. 11. Partnerships that ensure inadvertent adverse outcomes are avoided and that the voices of those most affected are included in decision-making. 12. Comprehensive plan that begins to address disparities related to language, food access, housing needs, and rural health care access.	1. PC teams begin to integrate. 2. Improved health for historically marginalized and divested communities. 3. High-quality primary care is accessible to all New Mexicans throughout the state. 4. Sustained investments in historically marginalized and divested populations begin to improve health outcomes. 5. Co-learning about institutional and structural determinants of health. 6. Improved health equity. 7. Patients begin to receive resources through the SDOH closed-loop, patient-provider referral system. 8. PC providers experience reduced burnout due to streamlined communications within health teams and online tools.

Assumptions: Primary Care APM will address health inequities; integrated teams will form; PC clinicians and community stakeholders will participate in meetings and focus groups; implementation efforts will be successful; socialization efforts will be successful; investments will be made; and online systems will be used.

External Factors: Competing interests, potential change in administration, objectors, time constraints, federal CMS approval.

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LOGIC MODEL: ALTERNATIVE PAYMENT MODEL (MEDICAID)

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GOAL 2, Objective 2: Implement Medicaid investment and payment strategies aligned with NM PCC Mission and Vision.

Current State	Future State (Long-term Outcomes)
1. As of June 2022, Medicaid and CHIP served 1,099,278 New Mexicans (52% of the population). NM has the highest percentage of people on Medicaid in the US. 2. High-quality and equitable Primary Care (PC) is not available to Medicaid customers. 3. NM Medicaid Primary Care is primarily reimbursed through managed care and is not linked to quality outcomes. 4. NM Medicaid does not pay prospectively for interprofessional, integrated, team-based care; 5. Is not risk adjusted for medical and social complexity; 6. Does not allow for investment in team development, practice transformation resources, and infrastructure to design, use, and maintain necessary digital technology; 7. Does not align with incentives for measuring and improving quality outcomes for patient populations assigned to interprofessional care teams; 8. Does not incorporate population and public health focus to promote health equity; 9. Does not integrate primary care behavioral health; 10. Does not address unique challenges in provision of care to children; 11. Does not incorporate regional assets and resources; 12. Does not have a multi-payor vision; 13. Does not fully empower patients and families to be partners in health care transformation. 14. Medicaid PC payment models have systemic structural inequities causing mistrust, lack of access, and increased health disparities. 15. For routine use in PC, technology has not fundamentally expanded beyond electronic health records, registration systems, and patient portals created two decades ago. 16. Technology is a leading cause of clinician burnout (add more details). 17. More information is needed about the extent to which providers have connected their EHRs to the HIE in New Mexico. 18. Need to understand more about what percentage of Tribal clinics are fee for service.	1. High-quality and equitable Primary Care is available to Medicaid customers. 2. NM Medicaid pays prospectively for interprofessional, integrated, team-based care, including incentives for incorporating non-clinician team members and for partnerships with community-based organizations; 3. Is risk-adjusted for medical and social complexity; 4. Allows for investment in team development, practice transformation resources, and infrastructure to design, use, and maintain necessary digital technology; 5. Aligns with incentives for measuring and improving quality outcomes for patient populations assigned to interprofessional care teams; 6. Incorporates population and public health focus to promote health equity; 7. Integrates primary care behavioral health; 8. Addresses unique challenges in provision of care to children; 9. Incorporates regional assets and resources; 10. Multi-payor, multi-stakeholder vision; 11. Empowering patients and families to be partners in health care transformation.

Reference: National Academies of Sciences, Engineering, and Medicine. 2021. Implementing High-Quality Primary Care: Rebuilding the Foundation of Health Care. Washington, DC: The National Academies Press. https://doi.org/10.17226/25983.

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LOGIC MODEL: NEW MEXICO MEDICAID ALTERNATIVE PAYMENT MODEL

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GOAL 2, Objective 2: Implement Medicaid investment and payment strategies aligned with NM PCC Mission and Vision.

Inputs	Interventions	APM Activities SFY23-SFY24	TC Activities SFY23-SFY24	Outputs	Outcomes (SFY23-24)
1. HSD & DOH Staff, and other agencies 2. Legislation 3. State Funding 4. Federal Funding 5. Philanthropic Funding 6. Equipment and materials 7. Time 8. Community Partners 9. Government (local, county, state, federal, Tribal) 10. Primary Care Council 11. Research 12. Collaboration 13. Data Systems (i.e. APCD) 14. Data 15. Training & technical assistance 16. Tricare, Medicare, Medicaid, commercial, self-insured employers, and IHS 17. Patients and Families 18. Primary care practitioners 19. Specialists 20. Primary care workforce development programs	**SFY23-24** 1. By 2024, develop and implement sustainable PC payment model for Medicaid. 2. By 2024, engage with stakeholders to prepare for and promote adoption of the PC APMs. **SFY25-26** 3. Provide supports for Medicaid PC clinicians and providers to reach HCP- LAN APM Category 4 by 2026. 4. The State will create an environment where PC clinicians have opportunities to learn how to adopt new APMs and how the APMs will improve their practice.	1a. Design a new PC APM(s) aligning with the HCP-LAN framework that is designated to incentivize performance and population-level health outcomes, aligns with the core features and principles adopted by HSD and PCC, and applies to a variety of settings. 1b. Test and evaluate APMs for efficacy and outcomes prior to start date of new MCO contracts (1/1/2024). 1c. Develop Medicaid MCO contract language for PC APMs in accordance with CFRs and other state/federal rules and regulations. 1d. Provide fiscal, policy, and/or programmatic implementation recommendations for the NM Medicaid program, including any legislation that may need to advance to support the APM; and multi-payor roll-out of a primary care APM, including any legislation that may need to advance to support the APM.	2a. Conduct monthly meetings of the primary care transformation collaborative (TC), providing primary care practitioners supports related to NM Medicaid primary care APM implementation. 2b. Build relationships with stakeholders. 2c. Using survey findings, determine level of APM provider readiness adoption among NM providers. 2d. Conduct focus groups and provide regular, ongoing support indicated by assessment and designed to address common areas of need in adopting PC APMs and team-based care models. 2e. Identify underserved areas where TA is needed to support and/or to enhance provider APM adoption. 2f. Identify best and promising practice activities that enhance provider APM adoption. 2g. Include fiscal, policy, and/or programmatic implementation recommendations for the NM Medicaid program, and/or PC TC, including any legislation that may need to advance to support the collaborative. 2h. Develop a measurement instrument to evaluate success of TA services, and revise supports as needed.	1. State policy recommendations are presented, which may include legislative proposals. 2. APM for NM Medicaid program is finalized and integrated. 3. Transformation Collaborative workforce assessment drafted. 4. Governing body will develop documents 5. Medicaid MCO contract language drafted 6. Transformation Collaborative holds sessions on APM and Interprofessional Care Teams 7. White paper on other payer recommendations. 8. Ongoing presentations and updates to the PCC 9. Present results of evaluating activities, output, and outcomes to the PCC 10. Value-based methodology and tools for measuring and reporting performance and outcomes. 11. Closed-loop, real-time, patient-provider-SDOH referral system	1. State policy recommendations are funded by the legislature 2. A new PC APM is operationalized for Medicaid using the HCP-LAN category 4 (population-based payments); aligns with the core principles and features adopted by HSD and PCC; and applies to a variety of settings. 3. Interprofessional Care Teams begin supporting patients with whole-person care. 4. Reduced administrative burdens begin to increase patient time and improve provider wellness. 5. Medicare customers begin to receive improved quality of care, equity, access, and decreased health disparities.

APM & TC Activities SFY25-26

3a. Provide clinicians and providers incentive payments that advance their capacity to adopt increasingly more advanced PC APMs.
3b. Establish and provide technical assistance for the use of a value-based data intermediary to help evaluate and monitor health metrics.
3c. Work with legislature to sustainably fund continued PC APM growth and improvements.
3d. Engage with CMS to leverage federal funding and programs to support PC payment model success.
4a. Continuation of PC APM technical assistance to grow the number of providers participating and advance their level of adoption.

Assumptions: Primary Care APM will address health inequities; providers buy-in to new APM; integrated teams will form; data integration for quality measures will be implemented; model design and testing will be completed; clinicians will attend learning opportunities; implementation efforts will be successful; and socialization efforts will be successful.

External Factors: Competing interests, potential change in admiration, objectors, time constraints (i.e. MCO RFP).

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LOGIC MODEL: ALTERNATIVE PAYMENT MODEL

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GOAL 2: Develop and recommend sustainable payment models and strategies to achieve high quality and equitable primary care for all New Mexicans.

Current State	Future State (Long-term Outcomes)
1. Primary Care (PC) practices are part of larger health care systems organized around administrative and reporting requirements, compensation based on relative value unit productivity, and pay-for-performance metrics. In 2016, practice revenue from fee-for-service in the US was 83.6. Also, across the US, more than 35% of patient visits are to PC physicians, yet PC receives only 5% of all health care related spending. 2. Financing health care is complex and PC practices receive revenue from multiple sources including public payers, commercial insurers, self-insured employers, and directly from patients. 3. There is a shortage of PC practitioners across all specialties and practices are not organized under an interprofessional team model and are not meaningfully connected to SDOH support organizations. 4. Current models have systemic structural inequities causing mistrust, lack of access, and increased health disparities. 5. For routine use in PC, technology has not fundamentally expanded beyond electronic health records, registration systems, and patient portals created two decades ago. 6. Technology is a leading cause of clinician burnout due to lack of interoperability between systems, poor system design, and amount of time spent with technology vs. patient time.	1. High quality and equitable primary care is available to all New Mexicans. 2. Primary Care (PC) pays prospectively for interprofessional, integrated, team-based care, including incentives for incorporating non-clinician team members and for partnerships with community-based organizations 3. PC is risk-adjusted for medical and social complexity. 4. PC allows for investment in team development, practice transformation resources, and infrastructure to design, use, and maintain necessary digital technology. 5. PC aligns with incentives for measuring and improving quality outcomes for patient populations assigned to interprofessional care teams. 6. PC incorporates population and public health focus to promote health equity. 7. PC Integrates behavioral health. 8. PC addresses unique challenges in provision of care to children. 9. PC incorporates regional assets and resources. 10. Interprofessional Care Teams are supporting patients with whole-person care. 11. Other payers adopt APMs. 12. Close alignment in models with commercial payers and Medicaid 13. Empowered patients and families become partners in healthcare transformation. 14. Digital health makes it easier for people to receive and clinicians to know how to deliver the right care at the right time, while also supporting relationships between individuals, families, clinicians, and communities. 15. Reduced administrative burden to allow for more patient time and reduce clinician burnout.

Reference: National Academies of Sciences, Engineering, and Medicine. 2021. Implementing High-Quality Primary Care: Rebuilding the Foundation of Health Care. Washington, DC: The National Academies Press. https://doi.org/10.17226/25983.

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LOGIC MODEL: ALTERNATIVE PAYMENT MODEL (MULTI-PAYOR)

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GOAL 2: Develop and recommend sustainable payment models and strategies to achieve high quality and equitable primary care for all New Mexicans.

Inputs	Interventions	Activities	Outputs	Outcomes
1. HSD & DOH Staff, and other agencies 2. Legislation 3. State Funding 4. Federal Funding 5. Philanthropic Funding 6. Equipment and materials 7. Time 8. Community Partners 9. Government (local, county, state, federal, Tribal) 10. Primary Care Council 11. Research 12. Collaboration 13. Data Systems (i.e. APCD) 14. Data 15. Training & technical assistance 16. Tricare, Medicare, Medicaid, commercial, self-insured employers, and IHS 17. Patients and Families 18. Primary care practitioners 19. Specialists 20. Primary care workforce development programs	**SFY24-SFY26** 1. By FY 2026, develop and implement sustainable PC payment model for self-insured plans, commercial insurers, IBAC plans, and federal plans aligning with Medicaid models. 2. By 2026, create an environment of cross-collaboration across commercial, non-profit, public health, and state agencies to ensure broad success of PC APMs and interprofessional team-based care models.	**SFY24-SFY26** 1a. Building on the Medicaid APM, create and present a multi-payer vision providing recommendations to commercial insurers, self-insured employers, and other stakeholders. 1b. Invest in infrastructure, training, and capital to ensure the success of PC APM broadly across the state. 1c. Launch a multi-stakeholder initiative collaborating with NM health care payers and organizations to adopt standardized PC payment models, increase investments in advanced primary care, and provide technical assistance to primary care practices. 1d. OSI to issue rules and guidance for contracting using PC APM structures. 1e. Request legislature to allow specific authority for OSI to require PC APM structures and team-based care models. 1f. OSI to help convene carriers to build consensus and adopt PC APMs and team-based care models. 1g. Evaluate overall activities, outputs, and outcomes to measure the success of the work. 2a. Using data and experiences from Medicaid, create partnerships with commercial payors to build technical assistance, training, infrastructure, and capital to support and increase the adoption of advanced PC APMs and interprofessional teams state-wide.	1. PCC recommendations, which may include legislation. 2. APMs (Medicaid, commercial) 3. TC governing documents. 4. TC technical assistance sessions, focus groups, surveys, communication materials. 5. Guiding document on other payer recommendations and implementation plan. 6. Ongoing presentations and updates to the PCC. 7. Evaluation results. 8. Infrastructure enhancements and integration including health IT, EHR alignment, APCD, and HIE. 9. Timelines & Gantt charts.	**SFY24** 1. PCC recommendations are funded by the legislature. 2. Legislature enacts PCC recommended actions. 3. Evaluation of Medicaid APM provides information on performance and gaps. 4. APM is functioning within Medicaid. 5. Beginning to see improved quality of care, increased equity, increased access, improved health outcomes, reduced fee-for-service, and increased value. 6. Despite CTC rollout, clinicians and payors will experience frustration and confusion due to change. **SFY25-SFY26** 1. Patients are connected to SDOH supports. 2. Adoption of interprofessional teams. 3. PC workforce is expanded to include behavioral health, dental, and other PC support staff, and grows in numbers. 4. PC clinicians experience less burnout. 5. Change fatigue. 6. Community consensus around multi-payor vision.

Assumptions: Primary Care APM will address health inequities; providers buy-in to new APM; integrated teams will form; data integration for quality measures will be implemented; model design and testing will be completed; clinicians will attend learning opportunities; implementation efforts will be successful; socialization efforts will be successful; and commercial insurers will adopt new APMs.

External Factors: Competing interests, potential change in administration, objectors, time constraints, federal CMS approval.

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LOGIC MODEL: HEALTH TECHNOLOGY

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GOAL 3: Develop and drive health information technology improvements and investments that make high quality primary care seamless and easy for Interprofessional Primary Care Teams, patients, families, and communities.

Current State	Future State (Long-term Outcomes)
1. PC technology has not fundamentally expanded beyond electronic health records (EHRs), registration systems, and patient portals created two decades ago. 2. Technology is a leading cause of burnout for the workforce. 3. Digital Health is used for documenting care, collecting and storing information, delivering care, and communicating. 4. The COVID-19 pandemic has forced many primary care practices to rapidly transform their processes to make virtual care and population care the new norm. 5. Congress passed the Health Insurance Portability and Accountability Act (HIPAA) in 1996 to promote and support health information exchange. However, HIPAA has largely been a barrier to information exchange and is badly in need of updating. 6. There is a lack of interoperability between different technologies. In some cases, the lack of interoperability results in continued use of paper charts and fax machines. 7. Poorly designed systems introduce frustrating processes into the care delivery experience and even make the experience more difficult and error prone.	1. Digital health makes it easier for people to receive, and clinicians to know, how to deliver the right care at the right time, while also supporting relationships between individuals, families, clinicians, and communities. 2. Primary Care digital health tools include EHRs, patient portals, mobile applications, telemedicine platforms, electronic registries, analytic systems, remote monitoring, wearable technology, care-seeker and care team communication support, and geographical and population health displays. 3. Population health tools allow the State to be proactive in caring for communities through alerts, reminders, and quality or health maintenance tabs built into EHRs. 4. Health Information Technology (HIT) supports: a. Easy retrieval of accurate, timely and reliable native and imported data b. Simple and intuitive data displays c. Easy navigation d. Evidence at the point of care to aid decision making e. Enhancements to workflow, automating mundane tasks, and streamlining work, never increasing physical or cognitive workload f. Easy transfer of information to and from other organizations and clinicians g. No unanticipated downtime h. financing PC using data-driven decision making, paying teams for improved patient outcomes

Reference: National Academies of Sciences, Engineering, and Medicine. 2021. Implementing High-Quality Primary Care: Rebuilding the Foundation of Health Care. Washington, DC: The National Academies Press. https://doi.org/10.17226/25983.

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LOGIC MODEL: HEALTH TECHNOLOGY

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GOAL 3: Develop and drive health information technology improvements and investments that make high quality primary care seamless and easy for Interprofessional Primary Care Teams, patients, families, and communities.

Inputs	Interventions	Activities	Outputs	Outcomes
1. HSD & DOH Staff, and other agencies 2. Legislation 3. State Funding 4. Federal Funding 5. Philanthropic Funding 6. Equipment and materials 7. Time 8. Community Partners 9. Government (local, county, state, federal, Tribal) 10. Primary Care Council 11. Research 12. Collaboration 13. Data Systems (i.e. APCD) 14. Data 15. Training & technical assistance 16. Tricare, Medicare, Medicaid, commercial, self-insured employers, and IHS 17. Patients and Families 18. Primary care practitioners 19. Specialists 20. Primary care workforce development programs	1. By 2026, develop, invest in, and implement health IT improvements to support advanced PC practice, payment, and interprofessional teams. 2. By 2026, provide technical assistance to support adoption of health IT infrastructures required for advanced PC APMs and adoption of interprofessional team-based care. 3. By 2026, recommend, develop, and implement health IT improvements to support population health, patients, families, communities to make high quality primary care seamless and easy. **Assumptions:** Primary Care health IT will address health inequities and reduce administrative burden; providers and clinicians adopt new or existing technologies; integrated teams will adopt interprofessional team tools; funding will be available for system enhancements; clinicians will attend learning opportunities; implementation efforts will be successful; and socialization efforts will be successful.	1a. Assess the needs for providers to connect their EHRs to the HIE to advance PC APMs in their practice; and request GF subsidies for providers who need support (if applicable). 1b. Conduct a comprehensive assessment of current health IT resources, needs, and capabilities statewide that informs a plan and funding for current tool improvements, new technology implementation, and training that supports advanced PC practice, payment, and teams. 1c. Review the interoperability of data sharing tools that support advanced PC across the state and recommend policy to ensure systems are meeting requirements. 1d. Create a collaborative plan for implementation of health technologies across multi-payors to reduce administrative burdens, enable successful PC APM implementation, and team-based care models that include patient and provider identity management, attribution, care management and coordination, financial benchmarking and management, quality reporting, and feedback. 2a. Provide technical assistance to providers and clinicians to support the adoption of health IT that supports advanced PC practice, payment, and teams. 3a. Assess **patient engagement tools** and patient portals currently available and in use in NM Medicaid and develop recommendations for improvements and expansion. 3b. Request legislative funding to provide a **closed-loop** patient-provider online referral system to help providers and clinicians connect patients to SDOH supports. 3c. Assess **decision support technologies** being used by PC providers and identify gaps and opportunities for platforms to support population health issues (i.e. diabetes, substance use). **External Factors:** Competing priorities and interests, potential change in admiration, objectors, time constraints, prohibitive cost, availability of broadband, varying levels of computer/technology literacy.	1. Improved implementation and funding support for health technology across the state. 2. Implement dashboards for access to real time data that addresses gaps in priority areas such as workforce and health equity. 3. Training programs for PC workforce. 4. Funding for providers to connect their EHRs to the HIE (if needed). 5. Funding and creation of a closed-loop patient-provider online referral system. 6. Written request from CMS seeking federal approval for telemedicine post-PHE. 7. Assessment and recommendation reports on patient engagement tools, patient portals, decision support technologies and heath equity. (one bullet for each) 8. Policy, guidance, or regulation. 9. Community outreach. 10. Infrastructure projects. 12. Investments in health IT.	1. More meaningful relationships that promote trust will begin. 2. Patients and their interprofessional teams will engage in co-created care plans. 3. Engagement with community resources through the closed-loop patient-provider referral system results in food, shelter, job, and other SDOH supports for patients. 4. Technology burnout by clinicians, providers, and patients. 5. Better access to health IT. 6. Providers and clinicians will begin to advance their practice. 7. Short-term increase in provider burden, followed by a decrease once technologies are implemented and learned.

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LOGIC MODEL: WORKFORCE

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GOAL 4: Create a sustainable workforce, financial model, and budget to support our mission and secure necessary state and federal funding.

Current State	Future State (Long-term Outcomes)
1. There is no real retention program for mid-career health professionals (other than the rural health provider income tax program). Employers see benefit packages as retention programs. 2. New Mexico has the highest population of physicians over 60 years old, and the lowest population of physicians under 40. Causing large waves of retirement among physicians. 3. Many professions show low tenures of working in healthcare positions. For example, nurses average only three years in active health care work. 4. Existing providers keep large patient panels, making it difficult for new providers to come in, especially in rural areas. 5. Rural communities are isolated from updated primary care practices. 6. Large out-of-state institutions are recruiting New Mexican physicians, offering better benefits and more pay, and no income taxes. 7. Lack of healthcare career secondary education including clinician rotations and continuing education, and affordable CME opportunities. 8. In rural areas, there is a lack of employment for significant others, and poor childcare/school options, leading many providers with families to stay in large cities or move out of state entirely. 9. Low adoption of interprofessional teams in non-FQHC settings. 10. The healthcare workforce is small to begin with, and New Mexico is currently suffering from a huge workforce shortage. 11. Early education healthcare career programs are found in some communities in New Mexico, but they are not offered state-wide. 12. Structural inequities in New Mexico, especially in rural areas are a deterrent to recruitment and retention of health care professionals. 13. Patient wait times to see clinicians are frequently 3 or more months resulting in higher hospital and urgent care utilization. 14. Current pay structures including fee-for-service and payments not linked to quality or outcomes are driving a culture of high-volume focus on illness treatment resulting in provider and clinician burnout and poor patient outcomes.	1. Sustainable models for recruitment and retention are resulting in a diverse workforce across urban and rural areas. 2. The population of physicians becomes more diverse in age range and less likely to be affected by large waves of retirement. 3. A robust focus on wellness for health care professionals improves reduces burnout, improves workplace satisfaction, increases tenure, and retains workers in the state. 4. Patient panels are sized appropriately improving quality of care, patient time, patient outcomes, and worker satisfaction. 5. Rural Primary Care clinics receive financial, technical, recruitment, and administrative supports resulting in increased health equity and sustainable clinics. 6. Consistent analysis of workforce pay and payment adjustments reduces the likelihood of a provider or clinician leaving the state for higher pay. 7. Robust secondary education training programs that provide continuing education, affordable CME opportunities, and graduate medical education increase the number of highly trained professionals. 8. The adoption of interprofessional teams reduces administrative burdens, increases patient time, and improves health outcomes. 9. Early education programs including STEAM-H are sustained through public and private partnerships and result in more youth having interest in health care careers. 10. Structural inequities are addressed in rural communities increasing the likelihood for recruitment and retention of health care professionals. 11. Increase in health care workforce improves patent times, health outcomes, and health care worker wellness. 12. Sustainable Primary Care Alternative Payment Models support a model of patient wellness that improves patient health outcomes, reduces provider clinician burnout, and pays prospectively for the care of patient wellness.

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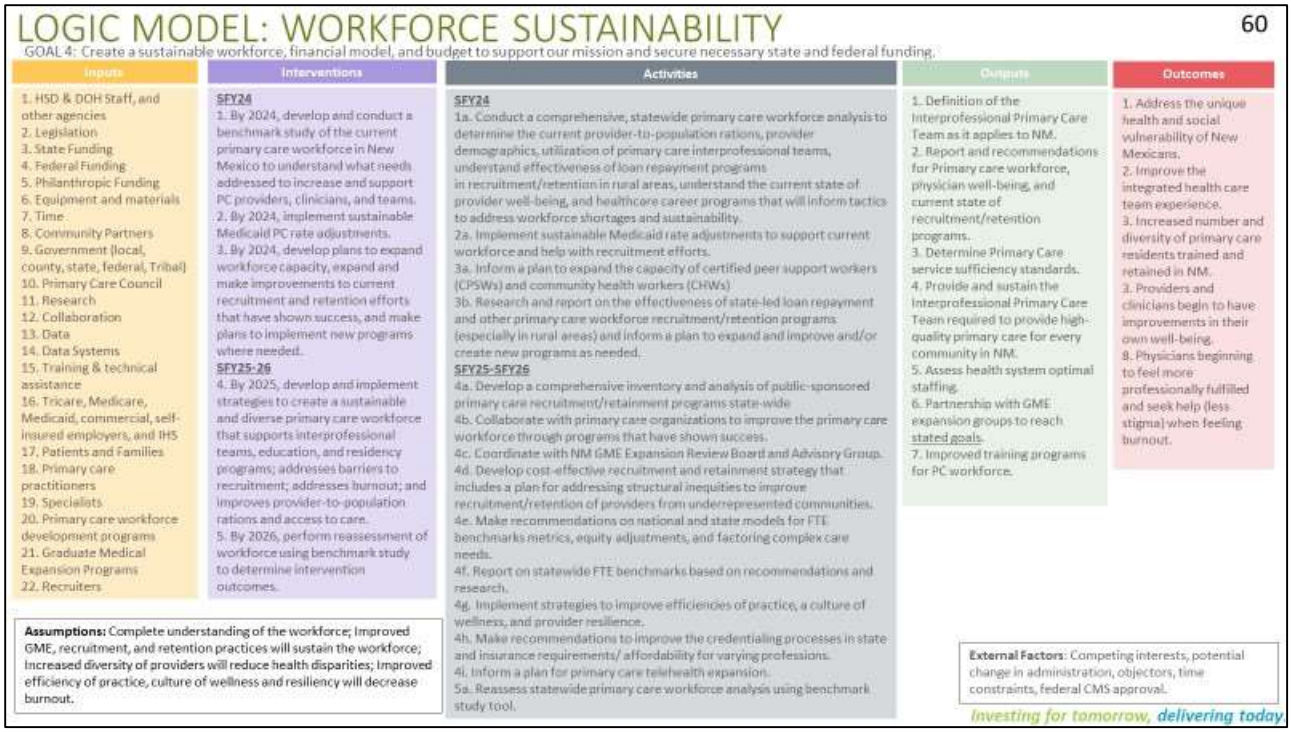

LOGIC MODEL: WORKFORCE SUSTAINABILITY

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GOAL 4: Create a sustainable workforce, financial model, and budget to support our mission and secure necessary state and federal funding.

Inputs

1. HSD & DOH Staff, and other agencies
2. Legislation
3. State Funding
4. Federal Funding
5. Philanthropic Funding
6. Equipment and materials
7. Time
8. Community Partners
9. Government (local, county, state, federal, Tribal)
10. Primary Care Council
11. Research
12. Collaboration
13. Data
14. Data Systems
15. Training & technical assistance
16. Tricare, Medicare, Medicaid, commercial, self-insured employers, and IHS
17. Patients and Families
18. Primary care practitioners
19. Specialists
20. Primary care workforce development programs
21. Graduate Medical Expansion Programs
22. Recruiters

Interventions

SFY24

1. By 2024, develop and conduct a benchmark study of the current primary care workforce in New Mexico to understand what needs addressed to increase and support PC providers, clinicians, and teams.
2. By 2024, implement sustainable Medicaid PC rate adjustments.
3. By 2024, develop plans to expand workforce capacity, expand and make improvements to current recruitment and retention efforts that have shown success, and make plans to implement new programs where needed.

SFY25-26

4. By 2025, develop and implement strategies to create a sustainable and diverse primary care workforce that supports interprofessional teams, education, and residency programs; addresses barriers to recruitment; addresses burnout; and improves provider-to-population rations and access to care.
5. By 2026, perform reassessment of workforce using benchmark study to determine intervention outcomes.

Activities

SFY24

1a. Conduct a comprehensive, statewide primary care workforce analysis to determine the current provider-to-population rations, provider demographics, utilization of primary care interprofessional teams, understand effectiveness of loan repayment programs in recruitment/retention in rural areas, understand the current state of provider well-being, and healthcare career programs that will inform tactics to address workforce shortages and sustainability.
2a. Implement sustainable Medicaid rate adjustments to support current workforce and help with recruitment efforts.
3a. Inform a plan to expand the capacity of certified peer support workers (CPSWs) and community health workers (CHWs)
3b. Research and report on the effectiveness of state-led loan repayment and other primary care workforce recruitment/retention programs (especially in rural areas) and inform a plan to expand and improve and/or create new programs as needed.

SFY25-SFY26

4a. Develop a comprehensive inventory and analysis of public-sponsored primary care recruitment/retainment programs state-wide
4b. Collaborate with primary care organizations to improve the primary care workforce through programs that have shown success.
4c. Coordinate with NM GME Expansion Review Board and Advisory Group.
4d. Develop cost-effective recruitment and retainment strategy that includes a plan for addressing structural inequities to improve recruitment/retention of providers from underrepresented communities.
4e. Make recommendations on national and state models for FTE benchmarks metrics, equity adjustments, and factoring complex care needs.
4f. Report on statewide FTE benchmarks based on recommendations and research.
4g. Implement strategies to improve efficiencies of practice, a culture of wellness, and provider resilience.
4h. Make recommendations to improve the credentialing processes in state and insurance requirements/ affordability for varying professions.
4i. Inform a plan for primary care telehealth expansion.
5a. Reassess statewide primary care workforce analysis using benchmark study tool.

Outputs

1. Definition of the Interprofessional Primary Care Team as it applies to NM.
2. Report and recommendations for Primary care workforce, physician well-being, and current state of recruitment/retention programs.
3. Determine Primary Care service sufficiency standards.
4. Provide and sustain the Interprofessional Primary Care Team required to provide high-quality primary care for every community in NM.
5. Assess health system optimal staffing.
6. Partnership with GME expansion groups to reach stated goals.
7. Improved training programs for PC workforce.

Outcomes

1. Address the unique health and social vulnerability of New Mexicans.
2. Improve the integrated health care team experience.
3. Increased number and diversity of primary care residents trained and retained in NM.
3. Providers and clinicians begin to have improvements in their own well-being.
8. Physicians beginning to feel more professionally fulfilled and seek help (less stigma) when feeling burnout.

Assumptions: Complete understanding of the workforce; Improved GME, recruitment, and retention practices will sustain the workforce; Increased diversity of providers will reduce health disparities; Improved efficiency of practice, culture of wellness and resiliency will decrease burnout.

External Factors: Competing interests, potential change in administration, objectors, time constraints, federal CMS approval.

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Primary Care Best and Promising Practices

Topic: Dental Medicaid Managed Care

State: Oklahoma

Description: The Oklahoma Health Care Authority (OHCA) released on September 1, 2022, a request for proposals (RFP) seeking at least two Medicaid dental managed care plans to serve 919,000 members. [30] [31] Contracts will run from the award date, which is expected to be between January and June 2023, with six one-year renewal options. Enrollment will begin on October 1, 2023, and proposals are due by October 31, 2022. Current dental benefit plans are DentaQuest, Liberty Dental Plan of Oklahoma, and MCNA Dental.

Performance measures and outcome measures are on pp. 289-291 of the RFP. The quality measures are:

- Percentage of children receiving an oral evaluation
- Percentage of children receiving fluoride treatments
- Percentage of children who receive sealants on their first molars
- Percentage of all members who receive an annual dental visit
- Percentage of periodontal evaluations for adults with periodontitis

Each of the measures includes specifications for data source, improvement targets, and the payment incentive (withholds from the capitation rate).

State: New Hampshire

Description: The New Hampshire Department of Health and Human Services released on August 25, 2022, an RFP for a Medicaid dental managed care organization to serve approximately 88,000 adults. [32]The program will be implemented on April 1, 2023, and run through March 31, 2026, with an additional two-year option. Proposals are due September 30, 2022. The contract does not specify quality

measures but rather asks the bidders to propose their quality management plan metrics, APM strategy, and quality expectations for the bidders' provider network.

Relevance/applicability to New Mexico:
These three states' RFPs for managed Medicaid dental care could help inform New Mexico's alternative payment model and how oral health is integrated into primary care. The Oklahoma performance metrics seem to be particularly useful as a starting point for New Mexico's performance measures for oral health services.

Topic: Behavioral Health
State: Colorado
Description: Since 2019, CMS has worked with six states – Colorado, Illinois, Michigan, New Mexico, Oregon, and South Dakota – to add additional behavioral health services to their state "benchmark" plan. [33] Colorado recently created a Behavioral Health Administration (BHA) led by a cabinet-level commissioner. [34] The BHA will lead a statewide behavioral health strategy, coordinating policy, payment, and system design through the networked government with other state agencies. This includes leading policy for children and youth behavioral health strategy with a senior child and youth advisor working with the commissioner to ensure a coherent child and youth system of care. The BHA's governance structure includes an advisory council that will raise individual and community voice in the state and a commitment to ensuring community-centered practices. The BHA intends to establish a system for addressing complaints and grievances with behavioral health care; a system for monitoring the performance of behavioral health providers; a comprehensive behavioral health safety-net system, including emergency care, outpatient services, and case management; and a new system for licensing behavioral health organizations and providers.

State: Minnesota
Description: The Minnesota Department of Human Services released on August 15, 2022, an RFP seeking a current Minnesota Health Care Programs provider agency to provide school-linked substance use disorder (SUD) services to students and families. [35] The contract is anticipated to begin on January 1, 2023 and run through June 30, 2026. Proposals are due on October 17, 2022. The detailed obligations and additional measures of performance will be defined in the final negotiated contract.

Relevance/applicability to New Mexico:
The Colorado beneficiary advisory council may be a worthwhile model to emulate for engaging members with lived experience and obtaining their input on quality measures and benchmarks.

The Minnesota school-based SUD model may help inform primary care SUD performance measures, particularly once the contracts are awarded, and the performance measures are established.

Topic: Benchmarks for Health Equity
States: (multiple; Massachusetts)
A Kaiser Family Foundation survey conducted in 2021 found that 12 states are measuring health disparities as a focus for financial incentives: California, Colorado, Connecticut, Hawaii, Illinois, Iowa, Massachusetts, Michigan, Oregon, Pennsylvania, Tennessee, and Wisconsin. This is an increase from only two states doing so just two years previously. [36]

Massachusetts is requesting a new Section 1115 waiver amendment to provide incentive payments to provider networks and hospitals that collect accurate social risk factor data, identify and monitor inequities through stratified data reporting, and achieve measurable reductions in health disparities. [37]

Relevance/applicability to New Mexico:
Focusing on these 12 states' – and in particular, Massachusetts's – health equity benchmarks and performance measures could help inform the development of health equity measures in New Mexico.

Topic: Behavioral Health Integration with Primary Care
The Substance Abuse and Mental Health Services Administration (SAMHSA) and the Health Resources and Services Administration (HRSA) created a framework for progressive levels of integration between behavioral health (BH) and primary care providers (PCPs). The three levels are:

1. Coordinated Care: Screen & Consultation | Minimal Collaboration

Care is provided in geographically disparate facilities. Providers communicate about shared patients. BH providers work to meet care goals established by PCPs.
Examples of this approach include:

- PCPs refer BH patients to services: Screening, Brief Intervention, and Referral to Treatment (SBIRT) [38]
- BH providers work with patients to meet goals identified by PCPs: Vermont's Hub and Spoke Model

2. Co-Located Care: Co-Located | Better Collaboration

BH providers and PCPs share the same facility, aiding in better coordination.
Examples of this approach include:

- BH providers are embedded with primary care practices, provide treatment, and monitor progress: Collaborative Care Model and Comprehensive Primary Care Plus Model
- PCPs and BH providers are embedded in the same facility: Common in FQHCs, [39] like the Cherokee Heath Systems [40] and Golden Valley Health Centers. [41]

3. Integrated Care: Fully Transformed Care (also see: National Center of Excellence for Integrated Health Solutions) [42]

Close collaboration in partly integrated practices or comprehensive partnerships in fully merged practices. Integrated, patient-centered care plans, coordination, complex care management, SDoH considerations, shared information systems, measurement of patient outcomes, and shared decision-making.

Examples of this approach include:

- Ongoing complex care management, treatment, and referrals: Medicaid Health Homes [43]
- PCPs and BH providers operate under one management system: Intermountain Healthcare [44]

State: Colorado
Sustaining Healthcare Across Integrated Primary Care Efforts (SHAPE) aimed to examine the integration of behavioral health and primary care through a global payment system. Practices that received global payments showed a 4.8% lower total cost of care for attributed patients. [45]

State: Texas
The Harris County Hospital District Community Behavioral Health Program (CBHP) program integrates behavioral health services into 12 Harris County (Houston suburbs) community primary care centers, two school-based clinics, and a homeless services program. Services include evaluation and treatment of scheduled patients and walk-in services for patients in crisis, including "curbside" consultations with PCPs to support psychiatric care. CBHP expanded its capacity to address acute psychiatric service shortages, reducing average wait times for new appointments from seven months to three weeks, and admissions to hospital psychiatric emergency centers by 18%. [46]

State: Massachusetts
The Massachusetts Child Psychiatry Access Program (MCPAP) is an interdisciplinary healthcare initiative that assists PCPs who treat children and adolescents for psychiatric conditions. [47] MCPAP's goal is to expand access to BH treatment across the Commonwealth by making child psychiatry services available to all PCPs. The model staffs each program team with two full-time child and adolescent psychiatrists, licensed behavioral health clinicians, resource and referral specialists, and program coordinators. The team aligns with and assists PCPs with the following integrated BH services:

- Screening, identification, and assessment.
- Treating mild to moderate cases of behavioral health disorders.
- Making effective referrals and coordinating care for patients who need community-based specialty behavioral health services.

State: Utah
Intermountain Healthcare, a non-profit healthcare system serving metropolitan Salt Lake City, launched a project to integrate mental healthcare services into primary care practices. [48] Early results showed that patients with depression treated in integrated clinics were 54% less likely to visit the emergency department. In addition, patients treated in the integrated clinics had a 27% lower growth in the total cost of care.

Relevance/Applicability to New Mexico:
Integrated care is crucial for expanding access to and improving the quality of behavioral health services in New Mexico. Given the widespread barriers to accessing behavioral healthcare, especially with an acute shortage of behavioral health providers, primary care practitioners may be seen as the default for seeking behavioral health services. Integrated care becomes necessary to enable comprehensively managed and optimally coordinated care, in addition to giving New Mexico primary care practitioners practical tools for diagnosis and treatment. It also expands a culturally and linguistically tailored workforce, including community health workers or peer support specialists who offer counseling, care management, and social support. This approach has empirical support in improved behavioral health access and outcomes across age groups and diagnoses. The approaches of other states may be useful models for HSD payment systems and/or provider operations.

Topic: Leadership and Governance Considerations for Movement Toward Value-Based Care
Leadership must be committed to pursuing value-based care (VBC) and payment (VBP). There needs to be a clear VBP strategy that includes the "why" and the "how" and it must be communicated throughout the organization. A multidisciplinary committee structure charged with in-depth analysis and making recommendations to the leadership governance board is often pivotal, where healthy discussion and debate can occur to inform critical strategic decisions.

The framework for these recommendations is primarily based on the Accountable Care Learning Collaborative Atlas framework, [49] evidence-based practices from large clinically integrated networks that operate in risk contracts across lines of business, [50] and models of leadership principles.

Success factors for operating a high-performing value-based organization:

1. Experienced and respected leadership governance board with an established track record of growth and success.
2. Broad representation on the leadership board, including physicians.
3. Mix of young emerging leaders with more senior leadership.
4. Shared leadership and organizational vision for pursuing advanced alternative payment models.
5. Leaders engaged in rigorous analysis and debate of recommendations; these conversations should be viewed as a constructive exercise.
6. The decision to pursue risk should be based on rigorous analysis of historical claims data, identification of opportunities for improvement, a strategic and operational plan to address these opportunities, and a financial pro forma that estimates cost and probability for profitability.
7. Leaders should be guided by performance metrics, timelines, and targets to monitor the successful management of risk.
8. Leadership incentive structure should be aligned with key performance indicators to succeed in global risk.
9. The leadership group should focus on success in value-based care and payment, including global risk and a committee structure (clinical, operational, information technology, and finance) to feed recommendations to this group.
10. Achieve consensus among leadership and staff in pursuing global risk.

Applicability to New Mexico

The New Mexico HSD and New Mexico Medicaid provider organizations are now at an inflection point where they must pivot from the fee-for-service environment into a value-based environment with delegation, capitation, upside, and downside risk. Organizations must accept that the healthcare landscape is an environment of continual change, so the leadership of primary care provider organizations must guide their staff and teams to embrace and benefit from a changing environment rather than resist change. Marginal improvements, multiplied by time and teamwork, can magnify actions, and these modest successes can catalyze the momentum for organizational change. Harnessing the power of small incremental changes will gradually transform the organization and position it to succeed under APMs.

Governance Structure

The following leadership governance structure designed for larger clinical organizations can serve as a broad recommendation for more tailored governance within individual healthcare entities. Smaller organizations will not need as elaborate a structure, but the critical processes and measures to track are similar.

1. Establish an Executive Leadership Team (ELT) responsible for the vision and setting of the strategic priorities and a multidisciplinary Operations Leadership Team (OLT) comprised of clinical and non-clinical staff to execute the strategic priorities.
2. The ELT should comprise the senior executive leadership. The ELT will identify the organization's strategic priorities and allocate resources. The ELT must align in the pursuit of value-based care and payment timelines. Once the strategy is identified, they need to articulate the rationale and methodology to the entire organization and review performance across the organization. This could

include dashboards with membership trends, quality, and utilization trends for the practice and individual providers. Any "adverse trends" or outliers should be identified and prioritized for intervention by the OLT.

3. The OLT should be comprised of multidisciplinary leadership (physician and nursing leadership, operations, and finance) and tasked with analyzing the data and dashboards to identify the root cause of adverse trends. Once identified, they will share findings with the ELT and recommend potential strategic interventions to mitigate or reverse the negative trends. This team will ideally utilize LEAN and Six Sigma methods to plan, implement, evaluate, and modify initiatives to improve population health and care coordination and the performance of strategic utilization management and quality initiatives. This group will ideally have subcommittees focusing on VBC/VBP, population health, HEDIS, Stars, and CAHPs results. They will track month-over-month and year-over-year trends. These meetings should be a safe space where diverse perspectives are welcomed with constructive dialogue leading to collaborative decision-making. Agreed-upon performance metrics, timelines, and goals should guide resource allocation and prioritization. Organizational priorities, interventions, and outcomes should be communicated with all staff to understand their unique role in optimizing individual patient outcomes, clinical performance, and organizational/enterprise performance. Dissemination of best practices with recognition of individual and team contributions should also be shared and successes recognized and celebrated.
4. OLT priorities may include (modified from *NEJM* Catalyst):
    a. Improve Quality of Care. Multiple measures of quality can be utilized and may include but are not limited to Stars, HEDIS, Never Events, readmissions, and ambulatory sensitive (inappropriate) ER utilization. As New Mexico Medicaid moves toward APMs that reward outcomes, organizations can leverage LEAN principles to incentivize every employee to identify opportunities to improve quality, care coordination, and population health to impact clinical outcomes and cost-effectiveness positively.
    b. Improve Operational Efficiencies. According to LEAN principles, idle time for patients or employees is an opportunity for improvement. Patients sitting in waiting areas, a late start for team meetings, appointment waiting lists, and unused equipment are all areas that represent opportunities for healthcare organizations to become more efficient.
    c. Optimize Capital Allocation and Cost Control. Surplus real estate, medical supplies, medications, and outdated equipment may contribute to suboptimal performance.

Leadership | Culture and Trust

Organizational culture offers a mechanism for leaders to influence and propel extensive change management efforts, such as the move toward value-based care. Leaders need to understand and incorporate the values of internal stakeholders and approach change with empathy. Leaders are more successful when they operate within the framework of transparency, fairness, and objectivity. A. Bhardwaj[3] explains that recruiting and retaining the right leaders is critical, and the cultural fit between the organization and leadership is a crucial determinant of success.

Figure 5: Factors that Influence Organizational Culture [51] represents common factors that act as influencers on

FIGURE 5: FACTORS THAT INFLUENCE ORGANIZATIONAL CULTURE

organizational culture. Each element offers consideration for leadership to understand, accommodate, and influence. These considerations include:

- Sharing a compelling vision
- Inspiring a shared purpose
- Team engagement and accountability
- Nurturing proficiency
- Promoting collectivism and group thinking
- Promoting collaborative teamwork among groups and departments
- Hierarchical governance
- Distributive model of leadership with shared responsibility and accountability propels the growth and development of future leaders

Figure 6: Importance of Trust for Effective Leadership

[51] illustrates leadership that lends itself to promoting a culture of trust with disparate constituents is crucial for alignment and directly affects consistency in teamwork and organizational cohesiveness. Key considerations include (adapted from Bhardwaj A., Organizational Culture and Effective Leadership):

- Leaders should consider operating as a meritocracy
- Display transparency, fairness, and objectivity toward programmatic development and growth
- This transparency framework extends to realizing staffing needs, including recruitment, and retention of personnel, operating and capital budgets, analyzing clinical outcomes and operational performance, cost-containment, compensation, and incentive plans.

FIGURE 6: IMPORTANCE OF TRUST FOR EFFECTIVE LEADERSHIP

As New Mexico's primary care environment negotiates the movement toward value-based care, leaders must negotiate the revenue model, identify, and help mitigate gaps in systems, processes, and services, serve as trusted advisors to team members across the organization, and collaborate and build trust across the practice.

Topic: Existing Value-Based Payment Programs & Messaging Strategies

Introduction

Value-based payment program implementation requires stakeholder buy-in, including from clinical organizations. Achieving provider buy-in may be easier when models focus on increasing provider compensation or financial stability than on cost savings and the extent to which value-based payment is seen as a threat or an opportunity. [52] In addition, aligning with federal policy helps garner support from providers and health systems.

According to the Center for Health Care Strategies report cited above, a fundamental goal of a value-based payment program is quality improvement. Using or adapting existing quality programs can minimize administrative burden and align quality incentives across Medicaid programs and statewide through a multi-payer approach. Several states are also increasing the focus on health equity.

This report summarizes the value-based payment programs in seven states, highlights the state's quality measurement and tracking approach, and presents how the state is messaging the payment model's quality improvement components to stakeholders.

State: Colorado
Value-based payment program: Known as APM2, Colorado's payment model is a partially capitated primary care model influenced by the Center for Medicare and Medicaid Innovation (CMMI) Comprehensive Primary Care Plus Model. The state pays a portion of primary care reimbursement as a capitated payment and the remainder through fee-for-service (FFS). The focus is on chronic conditions: primary care providers (PCPs) can earn shared savings by decreasing the total cost of care (TCOC) for patients with one or more chronic conditions.

Quality measurement and tracking: The state has appropriated funds to build a data dashboard to help PCPs track and address utilization in real time. PCPs are accountable for ten quality measures from a menu of 30 (3 are mandatory, and the PCPs choose 7). PCPs must meet a quality threshold to be eligible for gainsharing payments and can earn an enhanced capitation rate based on quality performance. [53]

Messaging quality improvement: The Primary Care Alternative Payment Model (APM) Guidebook cited above includes a section on support and resources available to PCPs. Regional Accountable Entities are responsible for helping PCPs in the following ways: assist PCPs in implementing practice transformation and process improvement efforts; designate and communicate a single point of contact for questions and support with the APM; help PCPs select appropriate measures for participating in the APM (accounting for the PCP's client panel and/or community); provide ongoing education and support to help ensure successful participation in the APM; and attest to the PCP's achievement of structural measures and patient-centered medical home (PCMH) recognition. The Guidebook includes links to the APM Measure Set, measure specifications, and workbooks to help PCPs model performance; PCMH recognition resources; and information specific to federally qualified health centers (FQHCs).

State: Maryland
Value-based payment program: Maryland's Total Cost of Care (TCOC) Model is a multi-payer partnership with CMMI and an all-payer hospital population-based payment – hospitals are paid with consistent rates across Medicare, Medicaid, and commercial payers. The model also includes a care redesign program in which hospitals can spend savings on incentives to clinical partners to help achieve the hospitals' care delivery goals and a partially capitated primary care provider program.

Quality measurement and tracking: Medicare, commercial payers, and Medicaid select quality metrics and incentives for their respective primary care models.

Messaging quality improvement: The Maryland Health Services Cost Review Commission developed the Episode Quality Improvement Program as an episodic incentive payment model for specialist physicians that will help increase participation in advanced APMs and allow for physician alignment with hospitals under the TCOC Model. [54] [55]

State: Massachusetts
Value-based payment program: In Massachusetts' Accountable Care Partnership Plan (ACPP), providers and managed care organizations jointly form an accountable care organization (ACO). ACOs are paid a

capitated per member per month (PMPM) rate and may receive shared savings if quality benchmarks are met, including for health equity.

Quality measurement and tracking: MassHealth defined 22 quality measures that started as pay-for-reporting and evolved to pay-for-performance. Capitated payments are medical and socially risk-adjusted (for disability, behavioral health, housing stability, rural status, and for a Neighborhood Stress Score).

Messaging quality improvement: Goals for the program extension approved earlier this year include (1) continue the path of restructuring and re-affirm accountable, value-based care – increasing expectations for how ACOs improve care; (2) reform and invest in primary care, health, and pediatric care that expands access and moves the delivery system away from FFS health care; (3) and to advance health equity, addressing health-related social needs and disparities. [56] [57]

State: New York

Value-based payment program: New York's Value-Based Payment Innovator Program is for providers willing to take on full risk. Managed Care Organizations (MCOs) must pass 90-95% of premiums to the innovator (the exact amount is determined during contract negotiations). The state sets administrative requirements for utilization review, utilization management, and disease management, plus five additional tasks to be determined during negotiations.

Quality measurement and reporting: The innovators and the MCOs select their own quality metrics but must use at least one that the Delivery System Reform Incentive Program (DSRIP) Clinical Advisory Group recommends for each subpopulation.

Messaging quality improvement: Through its Medicaid Analytics Performance Portal, the state enables providers to use state-of-the-art data and analytics tools to explore their performance on key quality measures, identify members, providers, or ZIP codes responsible for high or low scores, monitor trends, and explore some of the common drivers of better or poorer performance. New York publishes the total risk-adjusted cost of care available per provider and MCO for the total population and per integrated care service (e.g., maternity care, integrated primary care, HIV/AIDS). This tool combines 3M™ Clinical Risk Grouping (CRG) groupers for population-based analyses and the Health Care Incentive Improvement Institute (HCI^3)/ Prometheus episode grouper, including the appropriate risk-adjustment methodologies. The state believes having these costs and the outcomes of these services available and transparent is crucial for any transformation towards payments based on value rather than volume. [58]

State: Oregon

Value-based payment program: The Coordinated Care Organization (CCO) program provides financial rewards to CCOs for improving the quality of care provided to Oregon Health Plan members.
Quality measurement and reporting: The Oregon Health Authority's (OHA) Quality Incentive Program published a new CCO performance metric dashboard in December 2022. The dashboard is OHA's first presentation of quality measures broken out by race, ethnicity, language, and disability (REALD) data. The state uses 14 incentivized performance measures.

Messaging quality improvement: To explain its dashboard that presents REALD data, the state says the purpose is to foster conditions needed for communities to engage in data justice, provide data back to the communities that advocated for and led to the creation of the REALD legislation and standards,

identify strengths and inequities in communities that experience structural racism and other forms of discrimination, and inform how OHA allocates resources to increase health equity effectively. In their words, "people are not numbers." [59]

State: Pennsylvania

Value-based payment program: Pennsylvania's Rural Health Model collaborates with CMMI – this all-payer program pays rural hospitals a global budget. The global budget covers all inpatient and outpatient services, and Medicare, Medicaid, and commercial plans contribute.

Quality measurement and reporting: There are eight statewide quality measures, and each participating hospital must develop its transformation plan to improve quality and population health outcomes.

Messaging quality improvement: Pennsylvania does not include statements about quality on its website; rather, it defers to the Rural Health Redesign Center and CMMI.

State: Washington

Value-based payment program: Washington's Multi-Payer Primary Care Transformation Model will be designed to support quality improvement and payment alignment across Medicaid managed care, public employee, and commercial plans (this model is still in the design phase). There are three certification levels: Level 1 providers will receive additional PMPM transformation payments for up to 3 years; Level 2 participants will receive transformation payments and possibly a hybrid fee-for-service (FFS)/population-based payment to help graduate to Level 3 and may receive quality incentive payments; and Level 3 providers will be paid prospective comprehensive care payments and quality incentive payments. Participating providers will have to demonstrate competencies across ten domains.

Quality measurement and reporting: The Washington Health Care Authority (HCA) Primary Care Measure Set Workgroup has defined a core set of 12 measures to be included in payer and provider contracts. The core set of measures to gauge the clinical quality delivered by an integrated, whole-person care model, using HEDIS measurement standards where feasible:

1. Child and Adolescent Well-Care Visit (WCV)
2. Childhood Immunization Status (CIS) (Combo 10)
3. Breast Cancer Screening (BCS)
4. Cervical Cancer Screening (CCS)
5. Colorectal Cancer Screening (COL)
6. Depression Screening and Follow up for Adolescents and Adults (DSF-E)
7. Controlling High Blood Pressure (CBP)
8. Asthma Medication Ratio (AMR)
9. Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%)
10. Antidepressant Medication Management (AMM)
11. 11. Follow-up after ED visit for Alcohol and Other Drug Abuse of Dependence (FUA)
12. Ambulatory Care - Emergency Department (ED) Visits per 1,000 (AMB) [60]

Messaging quality improvement: According to the state, aligning quality measurement has the potential to reduce the administrative burden for both providers and payers. It also increases the likelihood of success on the most important measures by reducing focus fragmentation.

Topic: Tribal stakeholder engagement

State: Oregon

The Oregon Health Authority (OHA) developed the SHARE (Supporting Health for All through REinvestment) Initiative to implement the legislative requirements in Oregon House Bill 4018 (2018) regarding social determinants of health. [61] The SHARE Initiative began in 2020, and its primary goals are to safeguard public dollars by requiring that a portion of coordinated care organizations' (CCOs') profits be reinvested in their communities and to improve member and community health by requiring reinvestments go toward upstream factors that impact health (e.g., housing, food, and transportation). One of the requirements (Requirement 4) for CCOs established by the Oregon Health Policy Board's CCO 2.0 policies is that CCOs must designate a role for their community advisory councils (CACs) related to SHARE Initiative spending decisions regarding Social Determinants of Health and Equity (SDOH-E) organizations. The CACs must have a majority representation by consumers, and tribal representatives must be invited to participate. An SDOH-E partner is defined by Oregon as an organization, local government, federally recognized Oregon tribal governments, the Urban Indian Health Program, or a collaborative that delivers SDOH-E-related services. The CCO must invite the tribe to participate in the shared community health assessment and community health improvement plans. [62]

Relevance/applicability to New Mexico:

- The Oregon SHARE Initiative is a potential model for requiring managed care organizations and/or accountable care organizations to engage tribal communities in planning and spending decisions for their communities.
- Model suggests a framework for developing coordinated community health assessments and community health improvement plans driving population health improvement.

Topic: Behavioral Health

State: Florida

Description: On August 3, 2022, Florida announced a new pilot program in seven counties to address the opioid epidemic (a subsequent phase will expand the program to five additional counties; this program was initially piloted in Palm Beach County). [63] According to state officials, the Coordinated Opioid Recovery (CORE) initiative is the first of its kind in the nation, coordinated through the Department of Health, the Department of Children and Families, and the Agency for Health Care Administration. [64] Governor DeSantis also announced the appointment of Dr. Courtney Phillips as the first Statewide Director of Opioid Recovery. Florida asserts that standard treatment programs have had limited success in creating long-term recoveries for opioid addiction and other substance use disorders. This model of care will establish the following patient flows: (1) overdose occurs; (2) emergency response and care navigation; (3) bypass other hospitals; (4) transport to a specialty subject matter hospital (similar to a trauma center); (5) stabilize the patient; (6) initiate medication for opioid use disorder (MOUD); (7) transfer the patient to a sustained multi-specialty medical group; and (8) focus on a sustainable clinical pathway and system of care.

Relevance/applicability to New Mexico:

- Opioid use disorder is a challenge for New Mexico and the Florida model may be worth considering. The three-phase pilot structure (single county, then seven counties, then five more counties) may also be of interest, as well as creating a Statewide Director of Opioid Recovery position.
- Model of care suggests pragmatic coordination and continuity of care framework which addresses the epidemiology, pharmacology, screening, assessment, and treatment of OUD.

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