NEW MEXICO
PRIMARY CARE
COUNCIL

2022

5-YEAR STRATEGIC PLAN

HOW PRIMARY CARE INVESTMENTS CAN INCREASE ACCESS, IMPROVE QUALITY, LOWER COSTS, PROMOTE HEALTH EQUITY & ADDRESS WORKFORCE NEEDS

NEW MEXICO HUMAN SERVICES DEPARTMENT

Contents

Honor Native Land

The New Mexico Human Services Department and the members of the Primary Care Council humbly acknowledge we are on the unceded ancestral lands of the original peoples of the Apache, Diné and Pueblo past, present, and future.

With gratitude, we pay our respects to the land, people, and communities in New Mexico.

JEMEZ MOUNTAINS

Executive Summary

A wealth of research shows that 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.[1] High-quality primary care is the foundation of the health care system. 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.[2] The primary care workforce is also a key in the promotion of health equity, supporting their patients and families attaining their full health potential, while ensuring neither social position nor other socially determined circumstances disadvantages them from achieving their potential.[3]

In addition to improving population health and well-being, primary care delivers a significant return on invest. A 2020 study[4] reviewed Medicare billing claims data and compared health care use, costs, and where beneficiaries received care after losing the primary care relationship. After losing a primary care physician, there was a significant shift in care to specialty physicians. In the first year after losing a primary care physician, the study found:

- An 18.4% decrease in primary care visits and a 6.2% increase in specialty care visits;
- A decrease in preventive health services, including influenza vaccines;
- 17.8% more urgent care visits and 3.1% more emergency department visits; and,
- $189 increase in medical costs per patient.

A 2019 analysis from The Commonwealth Fund[5] 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). 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.

Improving the state of primary care in New Mexico is urgent, including in areas such as increasing access, improving the quality of care, pursuing promising financing reforms, and promoting workforce sustainability. The New Mexico Human Services Department (HSD), in collaboration with members of the community-based Primary Care Council (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 five years.

A primary care framework that also incorporates the many and complex behavioral health needs of New Mexicans through a fully integrated behavioral health primary care model is paramount. Research illustrates 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.[6] PCC activities expand on years-long efforts from the State and community members to expand primary care physician graduate medical education programs and the behavioral health provider network. (See Appendix for additional information on provider growth).

Background and Introduction

The 2021 House Bill 67 (Primary Care Council Act)[7] 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 lower the cost of primary care delivery while reducing 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.

U.S. Projected Primary Care Physician Shortage Range, U.S., 2019-2034

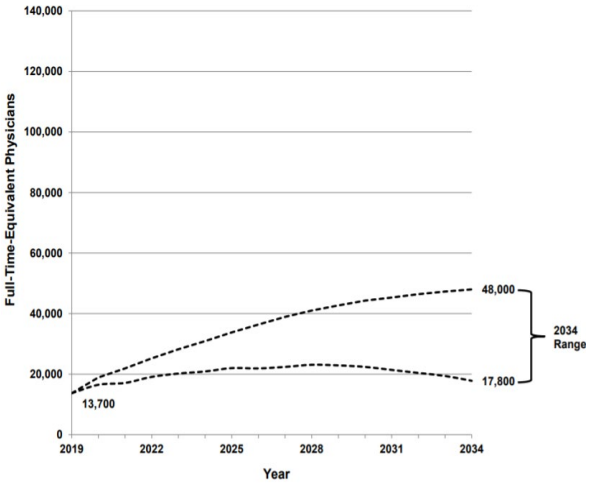

FIGURE 1 SOURCE: THE COMPLEXITIES OF PHYSICIAN SUPPLY AND DEMAND: PROJECTIONS FROM 2019 TO 2034[11]

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.

Today, the New Mexico state population is 2,106,319[8], with over 68% identifying as racial or ethnic minorities.[8] 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.[9] Further 18.5%[8] 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.[10] 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. Two estimates project a national primary care physician shortage of over 20,000 by 2033[11] and a registered nurse shortage of over one million between 2020 and 2026.[12] 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 ($46,338, 3rd lowest).[13,14] New Mexico ranks third in U.S. child poverty (24.9%[15]), and first in the U.S. in elder poverty (13.5%[16]). The substantial enrollment in the Medicaid program reflects the extent of the state's poverty: 958,342 New Mexicans enrolled in the Medicaid public health insurance program in December 2021, (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.

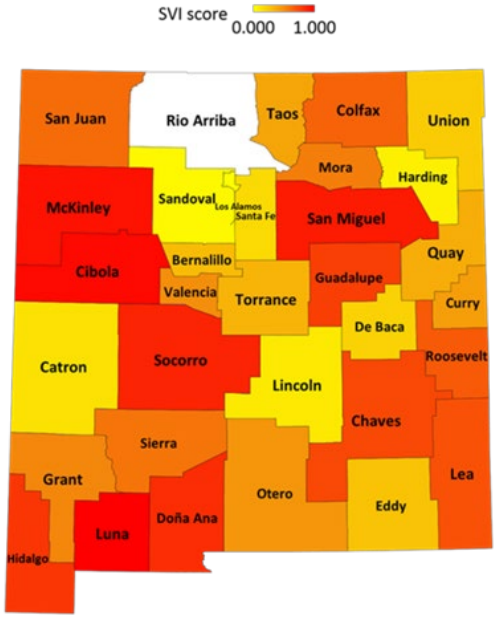

FIGURE 2, NM SOCIAL VULNERABILITY BY COUNTY. SOURCE, U.S. CENTERS FOR DISEASE CONTROL AND PREVENTION[32]

A 2021 federal report[18] on health equity describes how many communities face significant disparities in health care quality, outcomes, and access. Racial and ethnic minorities, lower-income individuals, sexual and gender minorities, individuals with disabilities, and individuals living in rural areas are disproportionately affected. For example:

- In 2017, across nearly every state and territory Black, Hispanic/Latino, Asian Pacific Islander, and American Indian and Alaska Native Medicare beneficiaries have a higher prevalence of chronic conditions including hypertension, diabetes, chronic kidney disease, and heart failure than Whites.
- The LGBTQ population has the highest rates of tobacco use, and certain LGBTQ subgroups have more chronic conditions as well as higher prevalence and earlier onset of disabilities than heterosexuals.
- Individuals with disabilities experience worse health and poorer access to mental health care services compared to people without a disability. Women with disabilities are less likely to receive regular breast and cervical cancer screenings and are more likely to have cancer and then be diagnosed at a later stage, than women without disabilities.
- The prevalence of diabetes is 8.6% higher in rural areas than in urban areas, and those diagnosed with diabetes in rural areas are at higher risk of amputations and inpatient death. They are less likely to receive a professional foot exam, and less likely to be able to access diabetes self-care education than their urban counterparts.

Communities achieve health equity when every person attains their full health potential, and neither social position nor other socially determined circumstances disadvantages anyone from achieving their potential. Differences in length of life, quality of life, rates of disease, disability, and death severity of disease; and access to treatment are examples of outcomes that reflect health inequities.[3]

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.[2]"

The PCC developed the following Mission, Vision, and Goals of the PCC in 2021:

- **Mission**: *Revolutionize* primary care into Interprofessional, sustainable teams delivering high-quality, accessible, equitable health care across New Mexico through partnerships with patients, families, and communities.
- **Vision**: By 2026, New Mexico will exemplify same-day access to high-quality, equitable primary care for all persons, families and communities.
- **Goal 1, Health Equity**: Develop and drive investments in health equity across New Mexico to improve the health of New Mexicans.
- **Goal 2, Payment Strategies**: Develop and make recommendations regarding sustainable payment models and strategies to achieve high quality and equitable primary care for all New Mexicans.
- **Goal 3, Health Technology**: Develop and drive health information technology improvements and investments that make high quality primary care seamless and easy for Primary Care Interprofessional Teams, patients, families and communities.
- **Goal 4, Workforce Sustainability**: Create as sustainable workforce, financial model, and budget to support our mission and secure necessary state and federal funding.

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.

Primary Care Council Timeline of Strategic Activities

The Primary Care Council (PCC) held its inaugural meeting in July 2021 and will meet four times each year. In 2021, it 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 and listed on pages 3-4 of this document. 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**
Incentivize model of integrated public health, primary care, and behavioral health integration.	2, 3, 4	1. Inventory NM Department of Health (NMDOH) services across NM primary care settings, including staff presence, grants, and contracts for services. 2. Conduct needs and assets assessment for public health services in primary care settings across NM. 3. Develop NM models of public health, primary care, and behavioral health integration.	• NMDOH Office of Primary Care and Rural Health (1, 2) • NM Primary Care Association (3)	FY23
Create meaningful partnership between governmental agencies, non-profit organizations, businesses, and academic centers to support health equity.	2	1. Inventory existing linkages across key state agencies, non-profits, businesses, and academic centers that support health equity. 2. Determine resource allocation priorities within the NMDOH State Health Improvement Plan through a comprehensive literature review of the NMDOH State Health Assessments with Community Health and State agency assessments. 3. Create an integrated network of community health workers to address population and behavioral health needs and link primary care to public health services.	• NMDOH Office of Health Equity, NMDOH Public Health Division Health Equity Director • NMDOH Epidemiology and Response Division, NMDOH Public Health Division, Offices of the Secretary for Health Agencies in Collaboration with the Governor's Office (2) • NMDOH Office of Community Health Workers (3)	• FY22 (1) • FY23 (2) • FY23—FY24 (3)
Increase sustained investment in historically marginalized and	1, 3, 5	1. Conduct cross-sectional assessment of key state agencies, municipal, county, tribal, as well as private and non-profit entities focused on investment in historically	• NMDOH Office of Primary Care (1) • NMDOH Office of Health Equity (2, 3)	• FY23 (1) • FY23—FY26 (2, 3)

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**
divested populations.		marginalized and divested populations. 2. Employing national, state, and local standards embed equity metrics across PCC workgroups to ensure sustained investment in historically marginalized and divested populations. 3. Develop and implement state-led community engagement process with historically marginalized and divested communities to co-learn about institutional and structural determinants of health and promote community led solutions.		

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**
Recommend state policies to establish primary care delivery investments required to achieve high-quality, equitable primary care for all New Mexicans.	1, 2, 3, 5	1. Review and recommend national and state models of optimal primary care investment. 2. Develop a shared description of primary care practitioners and services and develop standardized processes for measuring the volume and cost of primary care provided in NM. 3. Upon availability of state's All Payer Claims Database (APCD), determine statewide primary care expenditure. In the interim, determine primary care expenditure for Medicaid and other available payers.	• PCC (1, 2) • NM Human Services Department (HSD) (3)	• FY22 (1, 2) • FY23—FY26 (3)

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**
Implement Medicaid care investment and payment strategies aligned with NM PCC Mission and Vision.	4, 5	1. Incentivize Medicaid primary care access, quality, and patient experience to begin the transition from volume-based reimbursement to paying for outcomes. 2. Establish Medicaid payment models that reward Interprofessional PC Teams and community partners for providing high-quality primary care; pay for outcomes, not volume.	HSD	FY23—FY24

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**
Work to ensure NM Health Information Exchange is seamless and easy for Interprofessional Primary Care Teams, provides pragmatic comprehensive aggregate patient data to enable Interprofessional Primary Care Teams to provide high-quality care and facilitates high-quality continuity of care.	4	1. Develop means to assess, track, and improve the Interprofessional Team's use of New Mexico's Health Information Exchange in providing high-quality primary care and in achieving quantifiable patient and system outcomes. 2. Summarize interoperability requirements that allow the HIE to meet or exceed all federal requirements for interoperability, which is the extent to which health systems and devices can exchange data and interpret that shared data.	• HSD (1) • PCC (2)	• FY23 (1) • FY22 (2)

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**
Ensure online, comprehensive high-quality primary care educational and training resources are available to NM Interprofessional Primary Care Team members.	5	1. Assess the core educational and training assets and needs of the members of the Interprofessional Primary Care Team related to chronic disease management and behavioral health. 2. Coordinate with Project ECHO on Interprofessional Primary Care Team education and training.	PCC	• FY22—23 (1) • FY22—FY26 (2)

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**
Develop a statewide full-time equivalent (FTE) benchmark analysis of Interprofessional Primary Care Team members in NM to determine Primary Care service sufficiency standards.	1, 2	1. Outline Interprofessional Primary Care Team members that reflect the specific professional composition in New Mexico. 2. Conduct an FTE primary care healthcare workforce analysis	• PCC (1) • HSD (2)	• FY22 (1) • FY22—FY26
Recommend comprehensive statewide plan to recruit and retain a diverse primary care workforce throughout NM that reflects the communities they serve.	1, 5, 6	1. Develop a comprehensive inventory and analysis of public-sponsored primary care recruitment/retention programs that will inform a plan to improve Interprofessional Primary Care Team workforce. 2. Coordinate with the NM Graduate Medical Education Expansion Review Board and Advisory Group to increase	• HSD (1, 2) • NMDOH Office of Primary Care and Rural Health (3)	• FY22 (1) • FY22—FY26 (2) • FY23—FY24 (3)

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**
		number of primary care residents trained and retained in NM. 3. Develop cost-effective recruitment and retainment strategy to provide and sustain the Interprofessional Primary Care Team required to provide high-quality primary care for every community in NM.		
Develop statewide FTE metrics to address the unique health and social vulnerability of New Mexicans	3, 5	1. Make recommendations on national and state models for FTE benchmark metrics, equity adjustments, and factoring complex care needs to assess health system optimal staffing. 2. Make recommendations statewide FTE benchmarks metrics. 3. Report on statewide FTE benchmarks based on recommendations and research.	• NMDOH Public Health Division Health Equity Director (1) • HSD (2, 3)	• FY23 (1, 3) • FY22 (2) • FY23—FY26 (3)

Primary Care Council Organization

As outlined in statute[7], 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. A call for volunteers provided the opportunity to recruit a diverse group of additional participants, such as primary care providers, payers, insurers, advocacy groups, and patient advocates.

Primary Care Return on Investment

Healthcare System Savings

A 2019 analysis from The Commonwealth Fund[5] 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.[19]

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.[20]

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.[21]

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.[1,22] 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).[23,24] 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.[6] 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.[6,25]

Primary Care Reform Foundational Documents

The Primary Care Council (PCC) commits to adapting national innovating and promising practices, policies, and procedures to meet the State's unique primary care challenges, also supporting what many health care reformers describe as the "Quadruple Aim": better care, better health, lower costs, and greater joy for clinicians and staff in delivery of care.

Implementing High-Quality Primary Care: Rebuilding the Foundation of Health Care
The 2021 report from the U.S. National Academies of Sciences, Engineering, and Medicine (the national organization formerly known as the Institute of Medicine) puts forth an evidence-based plan with actionable objectives and recommendations for implementing high-quality primary care in the United States. The implementation plan of this report balances national needs for scalable solutions while allowing for adaptations to meet local needs.

The report describes high-quality primary care is the foundation of the health care system. Primary care is the only health care component where an increased supply results in improved population health and more equitable outcomes. For this reason, primary care is a common good, which makes the strength and quality of the country's primary care services a public concern.[2]

Investing in Primary Care: A State-Level Analysis
A 2019 report from the non-profit Primary Care Collaborative examines states' primary care spending patterns, including spending across payer types, and considers the implications of these results for select patient outcomes. The report shows that primary care investment as a percentage of total health care expenditures was low between 2011 and 2016, and it varied considerably across states, payers, and age groups.

Specifically, the national average for primary care spending across public and private payers during this time period was 5.6% (narrow definition of primary care), compared to 10.2% (broad definition of primary care). This broad and narrow definition of primary care is important, because there is not a standard method to measure primary care investment. Finally, the report shows an association between more primary care investment and better patient outcomes and describes legislative/regulatory efforts in 10 states to shift more resources into primary care.[26]

Unified Voice, Unified Vision, Changing Primary Care Finance
In a 2020 open letter to policymakers, payers, purchasers, and the public the American Academy of Family Physicians, American Academy of Pediatrics, American Board of Family Medicine, American Board of Internal Medicine, American Board of Pediatrics, American College of Physicians and hundreds of other healthcare organizations and providers across the country describe a broken U.S. health system with the COVID-19 pandemic expediting its collapse, citing declining life expectancy, the rise in chronic illness, and deepening disparities in health outcomes. The signatories call for advancing primary care as a public good, which will require changing primary care financing, creating a unified approach among all payers, and dismantling the regulatory and financing structures that institutionalize the status quo.[27]

In addition to these documents, the PCC is considering the following national developments related to primary care:

Medicare & Medicaid

The U.S. Centers for Medicare & Medicaid Services (CMS) 2021 Medicare physician fee schedule contained Medicare increases exceeding 10% in allowed charges for family physicians.[28] (Medicare is the federal health insurance program for people 65 or older, certain younger people with disabilities, and people with End-Stage Renal Disease).

In the New Mexico Medicaid program, reimbursement rate increases in 2019 positively affected providers across primary care settings, including behavioral health. A more comprehensive rate review is currently underway, and HSD will seek input from providers and patients in 2022.

Medicaid & CHIP Recipients as a Percentage of Population by County, October 2021

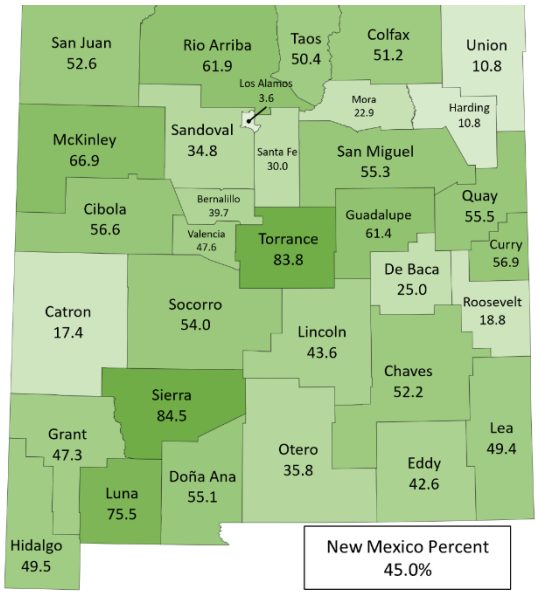

FIGURE 3, SOURCE: NM HSD, INCOME SUPPORT DIVISION. RECIPIENTS AS OF OCTOBER 2021.[33] CHIP IS THE CHILDREN'S HEALTH INSURANCE PROGRAM. PERCENTAGES CALCULATED USING DATA FROM U.S. CENSUS BUREAU, POPULATION ESTIMATES PROGRAM (PEP), VINTAGE 2020.

Value-based Health Care

Rather than a fee-for-service care model, which historically encouraged volume of care and greater spending, many states and payers are now shifting to a value-based care model. Value-based programs reward health care providers (including those in primary care) with incentive payments for the quality of care they give to patients.[29] Value-based care is part of a larger quality strategy to reform health care delivery and payment. Specifically, it shifts the role of primary care from chronic disease management to prevention medicine, reimbursing providers on their ability to improve the quality of care in a cost-effective manner.[30] In New Mexico, HSD requires Medicaid Managed Care Organizations to implement Value Based Health Care models and performance measures designed to improve outcomes.

Patient-Centered Medical Homes

Patient-Centered Medical Homes are models of team-based healthcare, emphasizing primary care that is comprehensive, accessible, coordinated, and has high quality and safety standards. According to the U.S. Agency for Health Research and Quality, Patient-Centered Medical Homes have five functions and attributes:[31]

1. **Comprehensive Care:** The Patient-Centered Medical Home is accountable for meeting most of each patient's physical and mental health care needs, including prevention and wellness, acute care, and chronic care. Providing comprehensive care requires a team of care providers. This team might include physicians, advanced practice nurses, physician assistants, nurses, pharmacists, nutritionists, social workers, educators, and care coordinators.
2. **Patient-Centered:** The Patient-Centered Medical Home provides health care that is relationship-based, holistic, and respecting each patient's unique needs, culture, values, and preferences. The

Medical Home actively supports patients in learning to manage and organize their own care at the level the patient chooses.

3. **Coordinated Care:** The Patient-Centered Medical Home coordinates care across all elements of the broader health care system, including specialty care, hospitals, home health care, and community services and supports. Medical Homes also excel at building clear and open communication among patients and families, the medical home, and the broader care team.
4. **Accessible Services:** The Patient-Centered Medical Home delivers accessible services with shorter waiting times for urgent needs, enhanced in-person hours, around-the-clock telephone or electronic access to a member of the care team, and alternative methods of communication such as email and telephone care. The medical home practice responds to patients' preferences regarding access.
5. **Quality and Safety:** The Patient-Centered Medical Home shows a commitment to quality improvement by ongoing engagement in activities such as using evidence-based medicine and clinical decision-support tools to guide shared decision making with patients and families, engaging in performance measurement and improvement, measuring and responding to patient experiences and patient satisfaction, and practicing population health management.

Conceptual Blueprint for Provision of Patient-Centered Team-based Care

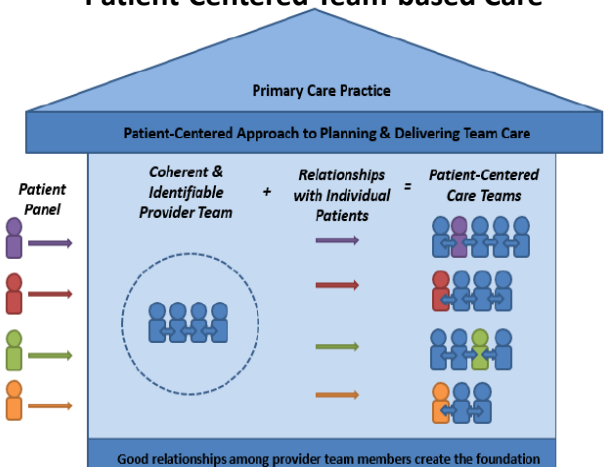

FIGURE 4, SOURCE: U.S. AGENCY FOR HEALTHCARE RESEARCH & QUALITY[34]

The PCC summarizes its reflections on facilitating improvements in primary care below:

NASEM Recommendation to Improve Primary Care	What are we trying to accomplish? (Goal)	What are we already doing?	How will we know a change is an improvement? (Outcome)	What change can we make that will result in improvement? (Metrics)
(1) Pay for primary care teams to care for people, not doctors to deliver services.	Achieve high-quality primary care as a common good	Payers evaluate payment models based on their ability to deliver high-quality PC	Observe a shift away from fee-for-service and towards hybrid payment models	Facilitate multi-payer collaboration and increase health care spending on PC
(2) Ensure that high-quality primary care is available to every individual and family in every community.	A community-oriented model that places patients, families, and community members at the center	COVID-era rule revisions and interpretations of Medicaid and Medicare benefits	New health centers, rural health clinics, and Indian Health Services in areas with shortage of PC	Permanently support COVID-era rule revisions and interpretations
(3) Train primary care teams where people live and work.	Expand and diversify the PC workforce. Ensure that care delivered is culturally appropriate.	Research areas that are medically underserved and have a shortage of health professionals	Augment funding to support interprofessional training in community-based environments	Adopt alternative financing sources for HRSA-developed PC training
(4) Design information technology that serves the patient, family, and interprofessional care team.	Adopt a comprehensive aggregate patient data system to enable PC clinicians to access patient data and provide whole-person care	Understand that current certification requirements are a barrier to high-quality PC	Electronic health record certification standards ensure health systems are interoperable and hold HIT vendors, state, and national support agencies financially responsible	Collaborate with vendors, state, and national support agencies to implement new policies and authorizations
(5) Ensure that high-quality primary care is implemented in the United States.	Every New Mexican can receive high-quality PC by their primary care team, and within 48 hours when needed.	Establishing a Primary Care Council to achieve the vision of high-quality PC	Prioritize funding for PC research	Serve as the unified voice to organize PC stakeholders, assess implementation, hold actors accountable, and catalyze a common agenda

Conclusion

The New Mexico PCC is making great progress in its first seven months of operation. Current PCC activities include the development of a health equity framework, methodology for calculating primary care expenditures, strategizing on provider recruitment and retention, and formalizing a comprehensive list of Interprofessional Primary Care Team members. Later in 2022, the PCC will establish performance measures, solicit feedback on strategic priorities from community members, and identify ways to promote provider wellness and prevent burnout. A broad and far reaching effort encompassed by the PCC mission and four strategic goals will create a roadmap for New Mexico for future primary care innovations and improvement.

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:

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Appendix

Primary Care Physician Graduate Medical Education Expansion

Since the establishment of the Graduate Medical Education (GME) Expansion Program in 2019, HSD, in collaboration with members of the community based GME Expansion Review Board & Advisory Group, have worked together to create and expand primary care physician residency programs throughout the state.

Over a 5-year period, starting in 2019, the strategic plan anticipates GME primary care programs would grow from 8 to 16 (100% increase) (see Figure 6). Over this same 5-year period the number of residents in training is expected to grow from 142 to 275 (94% increase). Finally, the number of graduates each year would grow from 48 to 84 (starting in 2025), a 75% increase. Assuming physicians remain in NM, expanded workforce serve additional 100,000 New Mexicans annually.

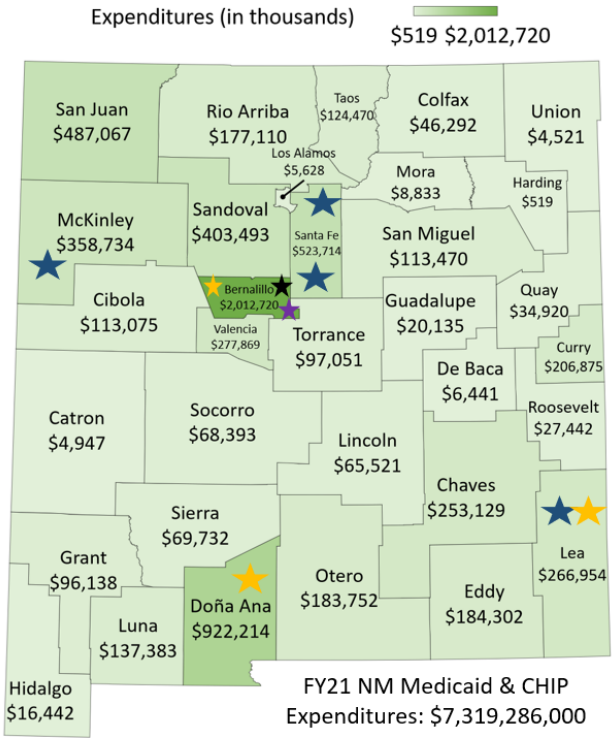

FIGURE 6, NEW AND EXPANDING PRIMARY CARE PHYSICIAN GME PROGRAMS, 11/2021; FY21 MEDICAID AND CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP) EXPENDITURES. SOURCE, NM HUMAN SERVICES DEPARTMENT, 11/21.

Behavioral Health Workforce Expansion

Since 2019, New Mexico has made significant steps to fix its broken behavioral healthcare system:

- Rebuilding New Mexico's behavioral health provider infrastructure (Figure 7).
- Ensuring we have necessary continuum of care (inpatient and outpatient).
- Providing evidence-based treatment for opioid addiction.
- Addressing Adverse Childhood Experiences (ACEs).

- Getting nonviolent offenders treatment for mental illness and addiction.

Optimizing federal fund spending is a priority. Since 2019, the State has leveraged federal funds (e.g. Medicaid and federal grants) for behavioral health. This includes more than $7.1 M in general fund savings by leveraging Medicaid funding for Adult Accredited Residential Treatment Centers.

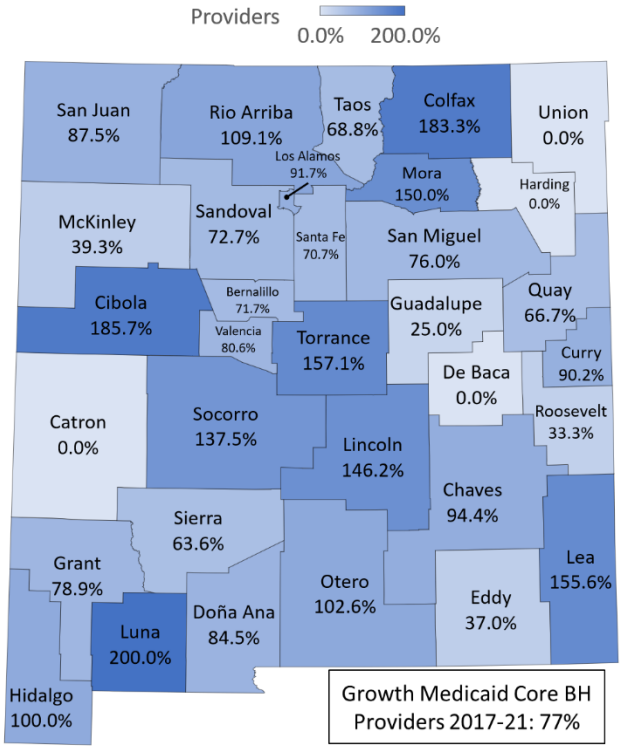

FIGURE 7, MEDICAID CORE BEHAVIORAL HEALTH PROVIDER GROWTH (%) 2017 - 2021. SOURCE: NM HUMAN SERVICES DEPARTMENT. CORE BEHAVIORAL HEALTH PROVIDERS: LICENSED MASTER SOCIAL WORKER, LICENSED CLINICAL SOCIAL WORKER, LICENSED MENTAL HEALTH COUNSELOR, LICENSED PROFESSIONAL CLINICAL COUNSELORS AND NON-PRESCRIBING PSYCHOLOGIST.

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