HUMAN SERVICES DEPARTMENT

NEW MEXICO PRIMARY CARE COUNCIL MEETING
FEBRUARY 26, 2022

INVESTING FOR TOMORROW, DELIVERING TODAY.

BEFORE WE START…

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 Apache, Diné and Pueblo 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.

PHOTO COURTESY: HSD Employee

CELEBRATING BLACK HISTORY MONTH

- HSD pays tribute to generations of African Americans who struggled with adversity to achieve full citizenship in American society.
- Smithsonian National Museum of African American History & Culture Black History Month theme "Black Health and Wellness."
  - Acknowledges history and legacies of medical practitioners over generations from across Black diaspora.
  - Explores importance of public and community health initiatives that focus on exercise, nutrition, mental health, and preventative care.

HUMAN SERVICES DEPARTMENT

MISSION

To transform lives. Working with our partners, we design and deliver innovative, high quality health and human services that improve the security and promote independence for New Mexicans in their communities.

GOALS

We help NEW MEXICANS

1. Improve the value and range of services we provide to ensure that every qualified New Mexican receives timely and accurate benefits.

We communicate EFFECTIVELY

2. Create effective, transparent communication to enhance the public trust.

We make access EASIER

3. Successfully implement technology to give customers and staff the best and most convenient access to services and information.

We support EACH OTHER

4. Promote an environment of mutual respect, trust and open communication to grow and reach our professional goals.

NEW MEXICO PRIMARY CARE COUNCIL

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.

GOALS

Health Equity

Develop and drive investments in health equity to improve the health of New Mexicans.

Health Technology

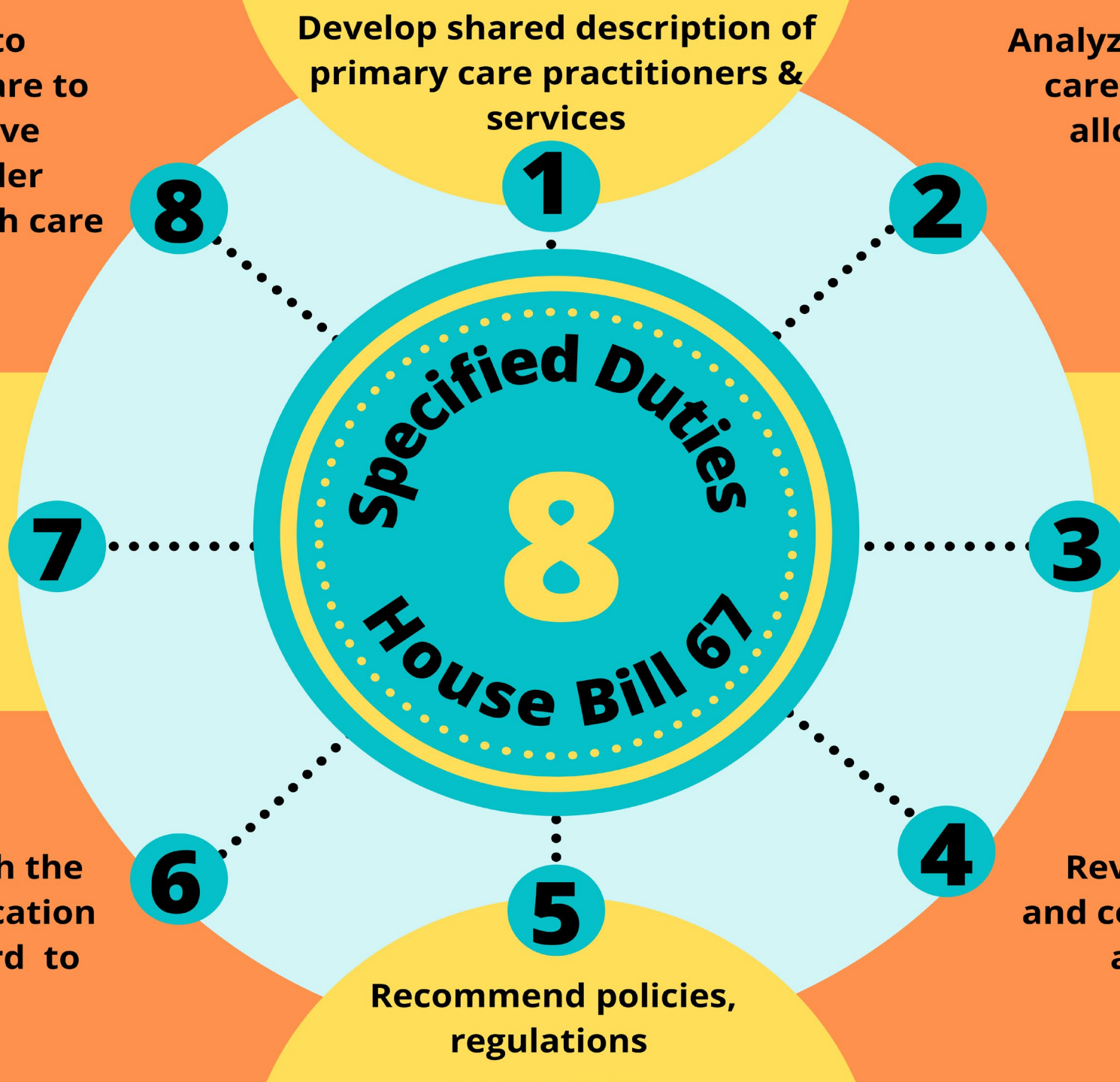
Develop and drive health information technology improvements and investments that make high quality primary care seamless and easy for Primary Care Interprofessional Teams, patients, families, and communities.

Payment Strategies

Develop and make recommendations regarding sustainable payment models and strategies to achieve high quality and equitable primary care for all New Mexicans.

Workforce Sustainability

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



1. Develop shared description of primary care practitioners & services
2. Analyze proportion of health care delivery expenditures allocated to primary care statewide
3. Review national and state models of primary care investment
4. Review New Mexico state and county data barriers to accessing primary care services faced by New Mexicans
5. Recommend policies, regulations
6. Coordinate efforts with the graduate medical education expansion review board to address primary care workforce shortages
7. Report annually to Legislative Finance Committee & Legislative Health and Human Services Committee
8. Develop a 5 year plan to investing in primary care to increase access, improve quality, address provider shortages, lower health care costs

DEFINITON OF HIGH-QUALITY PRIMARY CARE

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.

Adapted from the National Academies' of Science, Engineering, and Medicine definition of Primary Care.

AGENDA

Time	Agenda Item	Facilitator(s)	Desired Outcome
9:00	Welcome	Alex	Frame meeting and objectives, review agenda, and establish quorum.
9:05	Icebreaker	Alex	Build rapport and foster a productive learning and working environment
9:20	Opening Remarks	Jen & David	
9:30	PCC Housekeeping	Alex	Provide update on Council activities and developments.
9:45	PCC Deliverables • 9:45 – 10:10: Paving road to health equity • 10:10 – 10:15: NM payment model update • 10:15 – 10:40: Calculating PC Spending • 10:40 – 11:00: PC Team – patient benchmarks • 11:00 – 11:25: PC interprofessional team • 11:25 – 11:40: Group reflections	Workgroups	Solicit feedback from Council on variety of findings designed to advance Council mission.
11:40	*Public Comment Period*		
11:50	Closing Remarks	Jen & David	
12:00	*Adjourn*		

NORMS FOR TODAY'S MEETING

- Listen actively and speak respectfully to and about others.
- Take space, make space.
- If you wonder, ask.
- Take breaks when needed.
- Raise your hand using zoom to make a comment/ask a question.
- During discussion, engage in popcorn style facilitation and call on the next speaker when hand is up.
- **Revolutionize, revolutionize, revolutionize!**

Raincloud Medicine, Rebecca Lee Kunz

Source: Tree of Life Studio

ICEBREAKER: WHAT DO WE HAVE IN COMMON?

- We'll break into small groups for 10 minutes.
- If needed, allow time for brief introductions.
- Each group identify a scribe.
- Group discuss what they all have in common and identifies as many commonalities as they can.
  - Hobbies, music, interests, favorite foods, family traditions, etc.
- Scribe records group's commonalities on group's Jamboard.
- Report out as larger group for 5 minutes; group identifying most commonalities wins!

OPENING COMMENTS

Jen Phillips, M.D.
PCC Chair

David R. Scrase, M.D.
HSD Cabinet Secretary

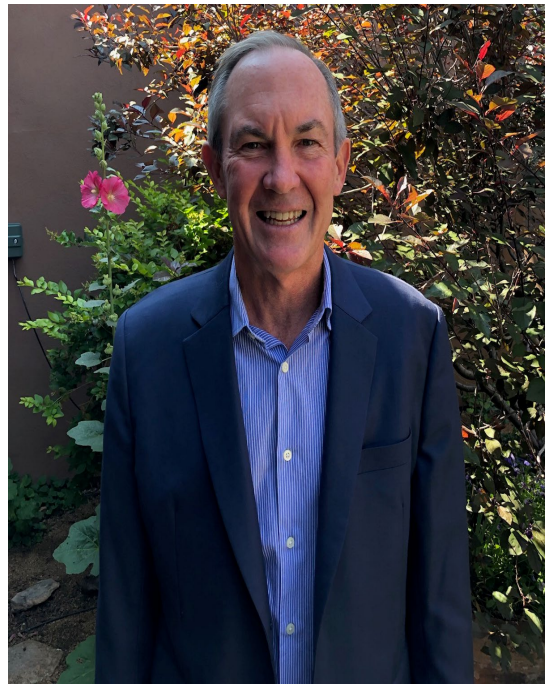
COUNCIL UPDATES

Welcome new Advisory Members!

Mercy Jones, Senior, College of Population Health
UNM Health Sciences Center

Pamela Stanley, LPCC, ACT Director, Value-Based Contracting & Provider Engagement; Interim Director, Quality Improvement Western Sky Community Care

Fond Farewell



Jeff Clark

KUDOS

Congratulations to **Dr. Val Wangler** on being selected as *Physician of the Year* by NM Society of Hospital Medicine as result of her leadership and drive to make a difference!

Milbank Memorial Fund

Fact Sheet

Diversifying the physician workforce can have a significant impact on improving access for underserved populations and in underserved areas.

State-Level Efforts to Increase the Number of Primary Care Residencies in Underserved Areas. Twenty years ago, the federal government, which funds residency positions through the Medicare program, limited the number of medical residencies. Federal efforts to increase the number of primary care residencies have been insufficient and some states have stepped in to find creative ways to create more residency spots.

- ***What Has Been Attempted?*** New Mexico leveraged federal Medicaid funding and regulations governing federally qualified health centers to develop additional primary care residencies in underserved locations across the states. The Texas and Georgia legislatures appropriated money to support the creation of new residency programs, particularly for primary care and in geographic areas lacking existing programs.
- ***Has It Worked?*** There is some evidence that these state efforts are seeing results. New Mexico's efforts created 10 primary care residency slots in high-need areas, which while modest is still an important development in a state that has struggled with health professional shortages. A 2019 report evaluating Texas's new programs found that they had created almost 400 new residency positions. As of 2018, 64% of new residency positions in Georgia were located in federally designated health professional shortage areas (HPSAs).

NM's PC **Graduate Medical Education Expansion Review & Advisory Board** recognized in Milbank Memorial Fund January report highlighting PC policy improvements!

PRIMARY CARE COUNCIL UPDATES

2022 PCC STRATEGIC PLAN

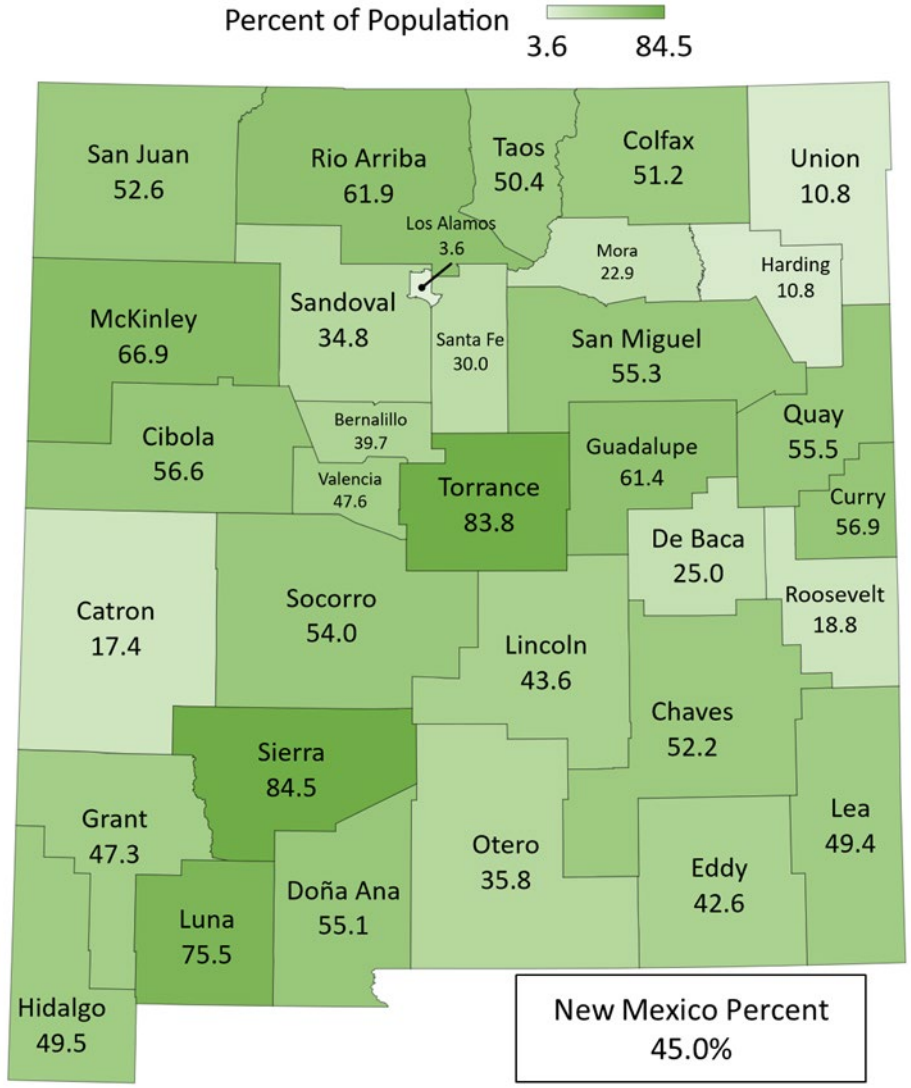
FY 2023 FUNDING

- PCC will have $1M funding for state Fiscal Year 23 (7/1/22 – 6/30/23)
- May PCC meeting will focus on FY23 spending priorities
  - HSD will solicit feedback from PCC members during March & April
  - HSD also survey PC societies and associations, working with PCC members

MEDICAID OF THE FUTURE

- In 2022, HSD will begin MCO procurement process, with contract start date of 1/1/2024.
- Also in 2022, HSD will submit new 1115 waiver, outlining pilot projects that advance Medicaid.
- Both waiver and contracts will include:
  - Women's health
  - Children's health
  - Equity and social determinants of health
  - Primary care
  - Technology (e.g. customers, MCOs, providers, HSD)
- **We want to hear from you!** Public comment period tentatively scheduled for August-October 2022.

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



Primary Care Council Annual Strategic Planning Cycle

February 2022

HUMAN SERVICES DEPARTMENT

JAN-MAR

- Legislative Session
- Review enacted legislation and revise Strategic Plan, if needed

APR

- Solicit stakeholders for feedback on mission, goals, and strategic priorities

MAY

- Revise mission and goals, if needed
- PCC leaders propose new initiatives (e.g., “Pitches for the People)

JUN

- Interim legislative hearings begins
- Evaluate strategic priorities based on stakeholder feedback
- Determine strategic priorities

Ongoing: PCC quarterly and workgroup meetings, strategic plan implementation, monitoring and updates, performance measure monitoring and evaluation.

JUL

- Revisit PCC strategic plan considering newly identified strategic priorities

AUG

- HSD submits budget request, strategic plan, and legislative requests
- HSD determines Special nonrecurring, Deficiency, and Supplemental Requests

SEP-NOV

- Create PCC budget request factsheets
- HSD submits Special nonrecurring, Deficiency, and Supplemental Requests

DEC

- HSD presents budget request to Legislative Finance Committee

2/26 PCC Meeting Deliverables			
Goal	**Objectives**	**HB 67 Duty**	**Deliverable**
GOAL 1: Equity	Increase sustained investment in historically marginalized and divested populations. (20 mins)	1, 3, 5	Embed equity metrics across PCC to ensure sustained investment in historically marginalized and divested populations.
GOAL 2: Payment Strategies	Recommend state policies to establish PC delivery investments required to achieve high-quality, equitable PC for all New Mexicans.	1, 2, 3, 5	Develop shared description of primary care practitioners and services and develop standardized processes for measuring the volume and cost of primary care provided in NM.
GOAL 4: Workforce Sustainability	Develop statewide FTE benchmark analysis of interprofessional PC Team in NM to determine service sufficiency standards.	1, 2	1. Outline interprofessional PC team members that reflect professional composition in NM. 2. Conduct an FTE primary care healthcare workforce analysis. (Appendix, slides 53 – 60)
	Recommend comprehensive statewide plan to recruit and retain diverse primary care workforce that reflects the communities they serve.	1, 5, 6	Develop comprehensive inventory and analysis of public-sponsored PC recruitment/retention programs that will inform a plan to improve workforce. (Appendix, slides 71 – 74)
	Develop statewide FTE metrics to address the unique health and social vulnerability of New Mexicans	3, 5	Solicit feedback from PCC as first step to develop recommendations on PC Team- Patient benchmarks.

NMDOH
NEW MEXICO DEPARTMENT OF HEALTH

Investing for tomorrow, delivering today.

PAVING THE ROAD TO HEALTH EQUITY

PCC: GOAL 1 EQUITY WORKGROUP

ROBERTO MARTINEZ, INTERIM HEALTH EQUITY DIRECTOR, NMDOH

FEB 26, 2022

NM PRIMARY CARE COUNCIL GOALS, OBJECTIVES & TACTICS

PRIMARY CARE COUNCIL GOAL 1: EQUITY

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

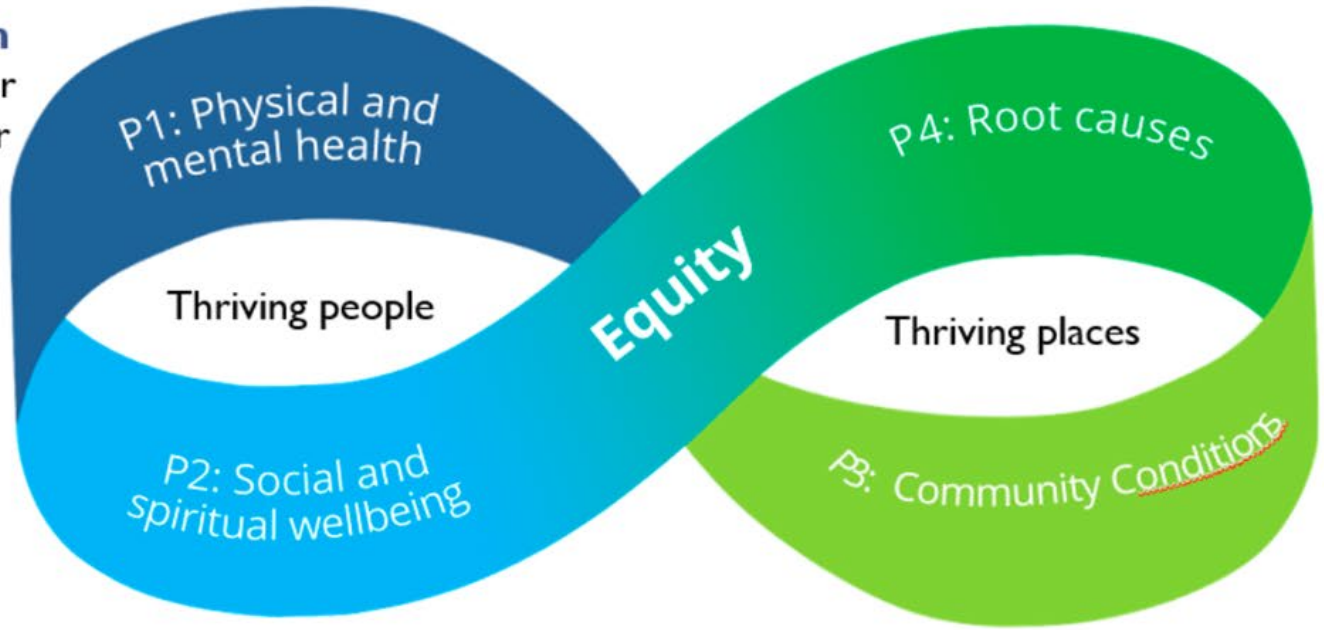
- **Objective 1.3**: Increase ***sustained investment*** in historically marginalized and divested populations.
- **Tactic 1.3.2:** Employing national, state, and local standards, embed ***equity metrics across PCC workgroups*** to ensure sustained ***investment in historically marginalized*** and ***divested populations.***

ADAPTED BALANCED PORTFOLIOS OF PATHWAYS TO POPULATION HEALTH EQUITY

Improve the health and well-being of people

Downstream
Meet needs for physical and/or mental health service delivery

Midstream
Advance prevention and address social needs

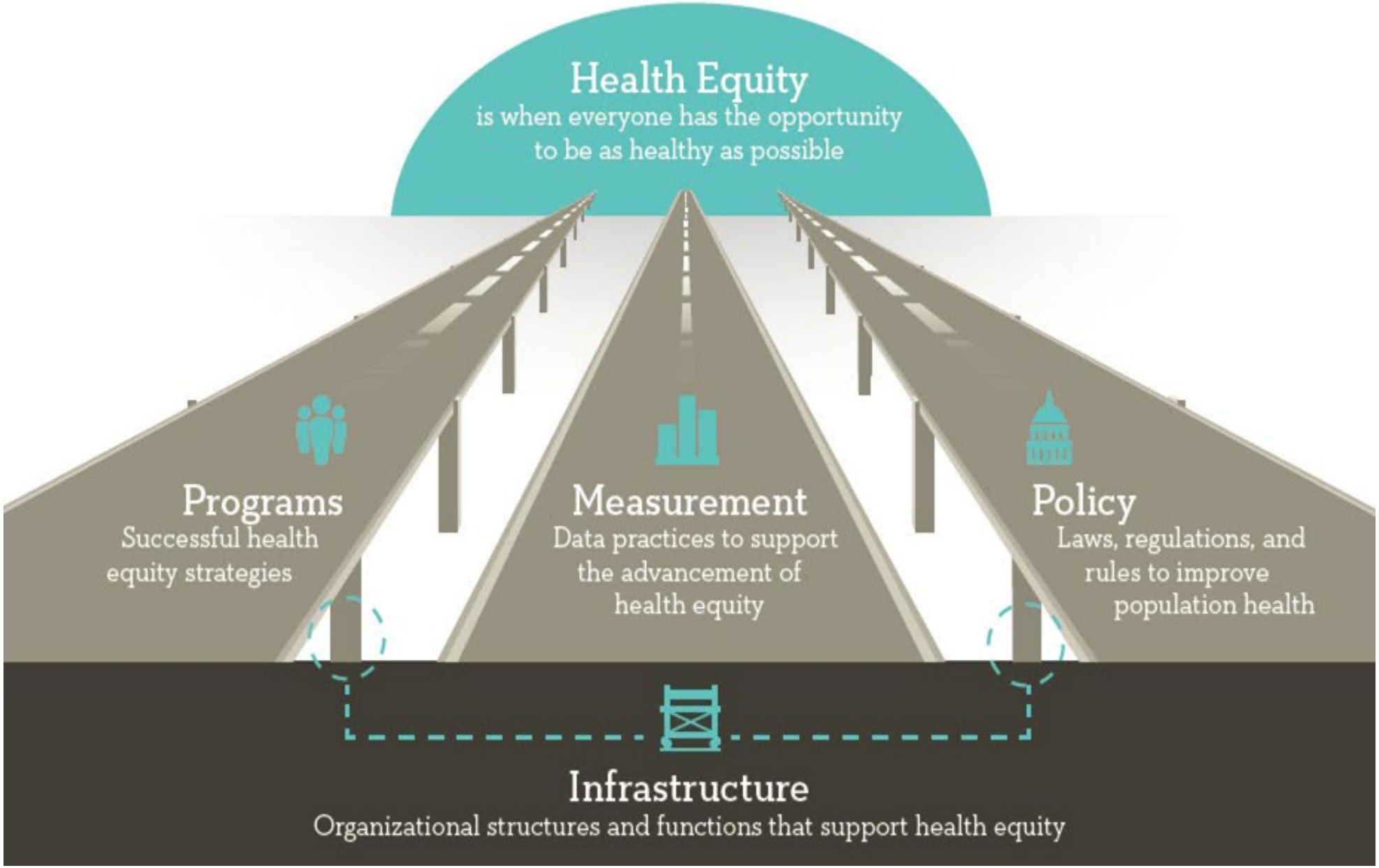


Root causes
Foster community power, transform inequitable policies and systems to equitable ones

Upstream
Work to address focused community conditions (food, housing, work, etc.)

Improve the health and well-being of places and communities

www.weintheworld.org


Health Equity
is when everyone has the opportunity to be as healthy as possible
Programs
Successful health equity strategies
Measurement
Data practices to support the advancement of health equity
Policy
Laws, regulations, and rules to improve population health
Infrastructure
Organizational structures and functions that support health equity

PCC EQUITY WORKGROUP RECOMMENDATIONS

1. **Develop an Equity Data Working Group** that can advise on key metrics, data collection, and interpretative frameworks to drive towards health equity. Strategically partner with Chief Data Officers (CDOs) by adding CDOs to the Equity Data Working Group.

1. **Expand data collection.** Equity Data Working Group members to Identify a set of Primary Care Indicators using a Consensus Building Process in the following domains: 1) Primary health-care financing, 2)Primary health-care access, 3) Primary health-care outcomes, 4) Demographics and Social Determinants of Health.

PCC EQUITY WORKGROUP RECOMMENDATIONS

1. **Invest in data sharing platforms** that allows for integration of multiple curated datasets. This integration would improve population health and well-being by assuring accurate prioritization of health issues of importance to address, more responsive planning of programs, and better tracking of progress on indicators.

1. Equity Data Working Group **draft policies** resulting in common data practices that support sharing and analysis.

EVALUATION QUESTIONS

1. How are the activities in the PCC Strategic Plan increasing understanding and awareness of health disparities and equity?
2. How are the activities in the PCC Strategic Plan supporting the development and dissemination of solutions to increase equity among primary care patients?
3. How are the activities in the PCC Strategic Plan leading to sustainable actions that increase investment in PC to achieve Health equity?
4. How are we analyzing and reflecting on our data with a health equity lens with stakeholders across sectors and those most affected to co-design short and long term improvement initiatives?

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Examples of Indicators

Investing in Primary Care

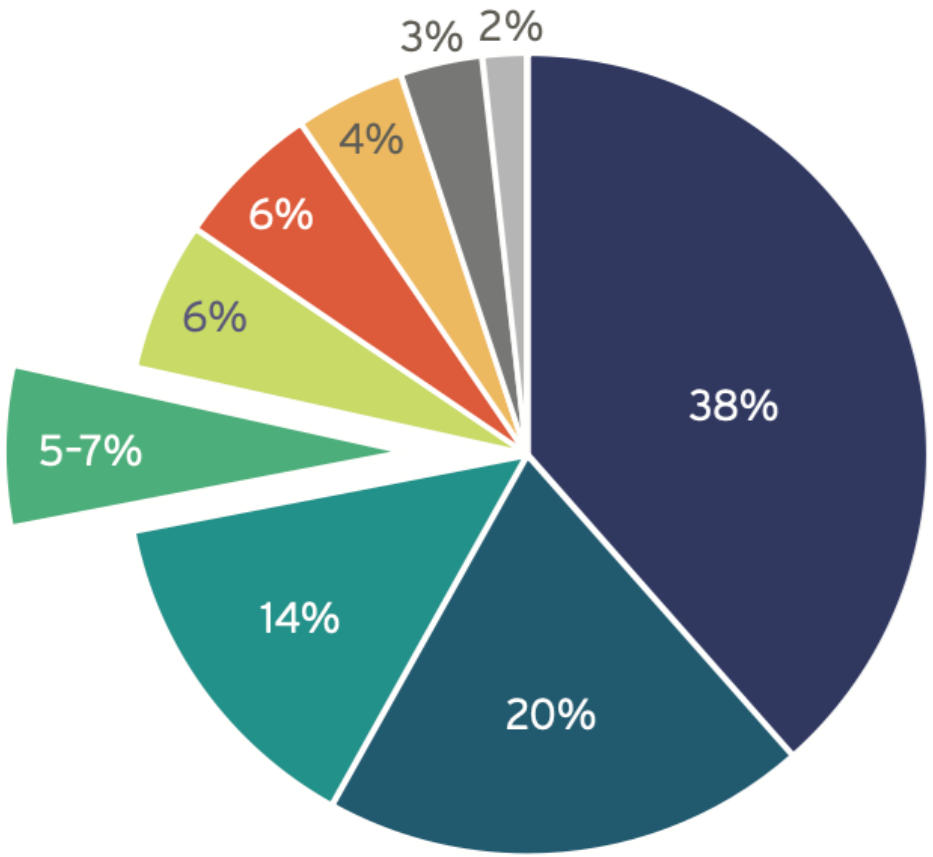
A STATE-LEVEL ANALYSIS

https://www.graham-center.org/content/dam/rgc/documents/publications-reports/reports/Investing-Primary-Care-State-Level-PCMH-Report.pdf

FIGURE 1.1

Health Care Spending

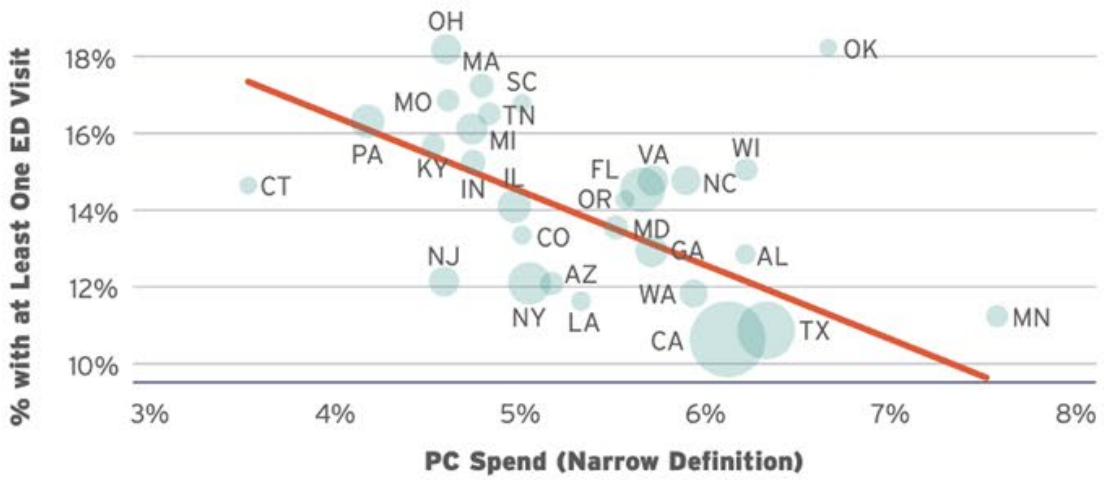
- Hospital care
- All other physician and professional services
- Prescription drugs and other medical nondurables
- Primary care
- Nursing home care
- Other health, residential, and personal care
- Dental services
- Home health care
- Medical durables



Healthcare utilization

FIGURE 2.3

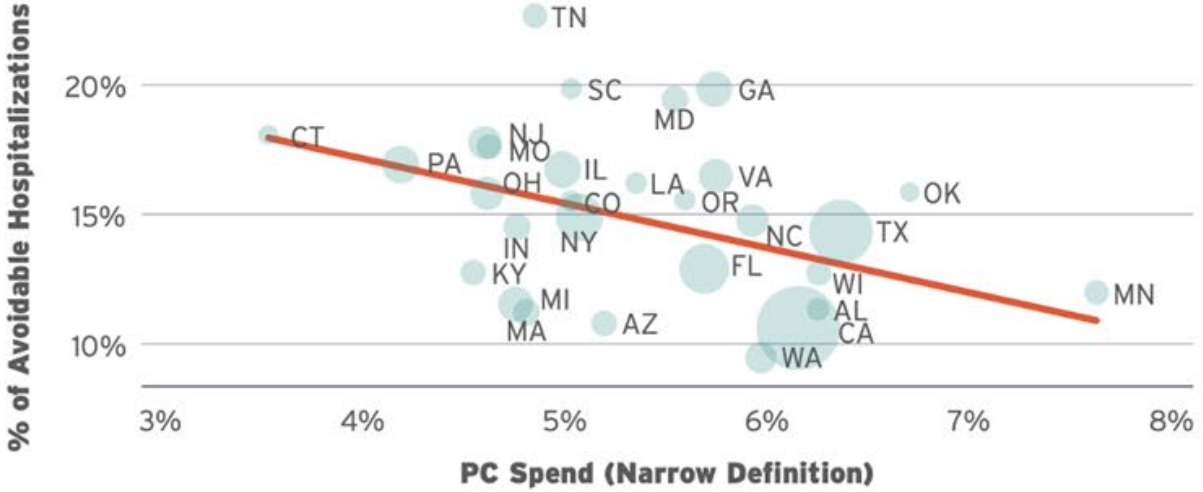
PC Spend-Narrow vs. Percent with at Least One ED Visit in Last 12 Months



R = -0.58. Note: Size of circles represents the population size of the state.

FIGURE 2.5

PC Spend-Narrow Vs. Percent Avoidable Hospitalization



R = -0.44. Note: Size of circles represents the population size of the state.

Insurance coverage (Domain: Primary Care Access)

- New Mexico opted to expand Medicaid under the Affordable Care Act (ACA), providing coverage for all legal residents with household incomes up to 138% of poverty.
- Total enrollment in the program grew by 66% from the end of 2013 to July 2016. By the end of 2017, total enrollment was 63% higher than it had been in late 2013, indicating that ***enrollment growth had leveled off by 2016***.
- And according to U.S. Census data, the **uninsured rate** in New Mexico fell from 18.6% in 2013 to 9.2% in 2016 — a drop of more than 50%, versus the national average drop of a little more than 40%. The 2020 uninsured rate was at 11.9%, following the trend of states' uninsured rates increasing during the COVID-19 pandemic.

State of Rhode Island

Department of Health

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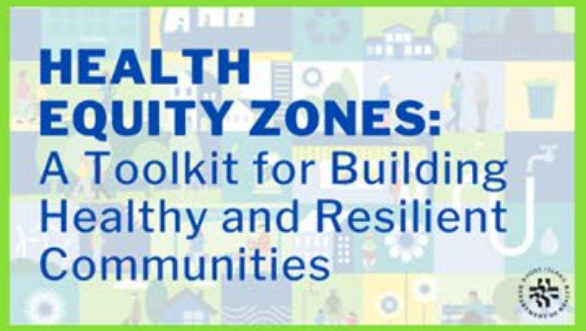
Health Equity

- About
- Rhode Island Data
- Programs
- Partners
- Publications



Rhode Island Health Equity Measures

Imagine a Rhode Island where every person has a fair and just opportunity to be healthy. This is known as health equity. We all want to live in a place without obstacles to health like poverty and discrimination. And we all want to live in communities where we and our loved ones can access good jobs with fair pay, quality education, and safe environments. Yet in every neighborhood, a range of conditions affect people's health and safety every day.

HEALTH EQUITY ZONES: A Toolkit for Building Healthy and Resilient Communities

Up to 80 percent of our health is determined outside the doctor's office and inside our homes, schools, jobs, and communities. (more) Generations-long social, economic, and environmental inequities have resulted in adverse health outcomes. They affect communities differently, and have a greater influence on health outcomes than individual choices or one's ability to access healthcare.

Reducing these inequities can help improve opportunities for every Rhode Islander. To improve surveillance of the socioeconomic and environmental factors that drive health inequities, the Rhode Island Department of Health (RIDOH) collaborated with community partners to form the Community Health Assessment Group and develop Rhode Island's first set of statewide health equity measures.

Domain	Determinant	Measure	Data Source
Integrated Healthcare	Healthcare Access	Percentage of adults who reported not seeking medical care or dental care due to cost (2 measures)	Behavioral Risk Factor Surveillance System (BRFSS)
	Social Services	Ratio: Number of individuals receiving to number of individuals eligible for SNAP benefits, based on income	Supplemental Nutrition Assistance Program (SNAP), US Census Bureau
	Behavioral Health	Ratio: Number of naloxone kits distributed to number of overdose deaths	RIDOH, Prevent Overdose RI website
Community Resiliency	Civic Engagement	Percentage of registered voters participating in the most recent presidential election	Rhode Island Board of Elections
	Social Vulnerability	Index score that reflects the social vulnerability of communities	Centers for Disease Control and Prevention (CDC) Social Vulnerability Index, Agency for Toxic Substances and Disease Registry (ATSDR)
	Equity in Policy	Ratio: Number of low to moderate-income housing units to number of low to moderate-income households	HousingWorks RI, Comprehensive Housing Affordability Strategy
Physical Environment	Natural Environment	Percentage of overall landmass with tree canopy cover	US Department of Agriculture (USDA) Forest Service i-Tree Tools
	Transportation	Index score that reflects the affordability of transportation for renters	US Department of Housing and Urban Development (HUD) Low-Cost Transportation Index

GOAL 2: PAYMENT STRATEGIES

UPDATE: DETERMINING NM PC PAYMENT MODEL

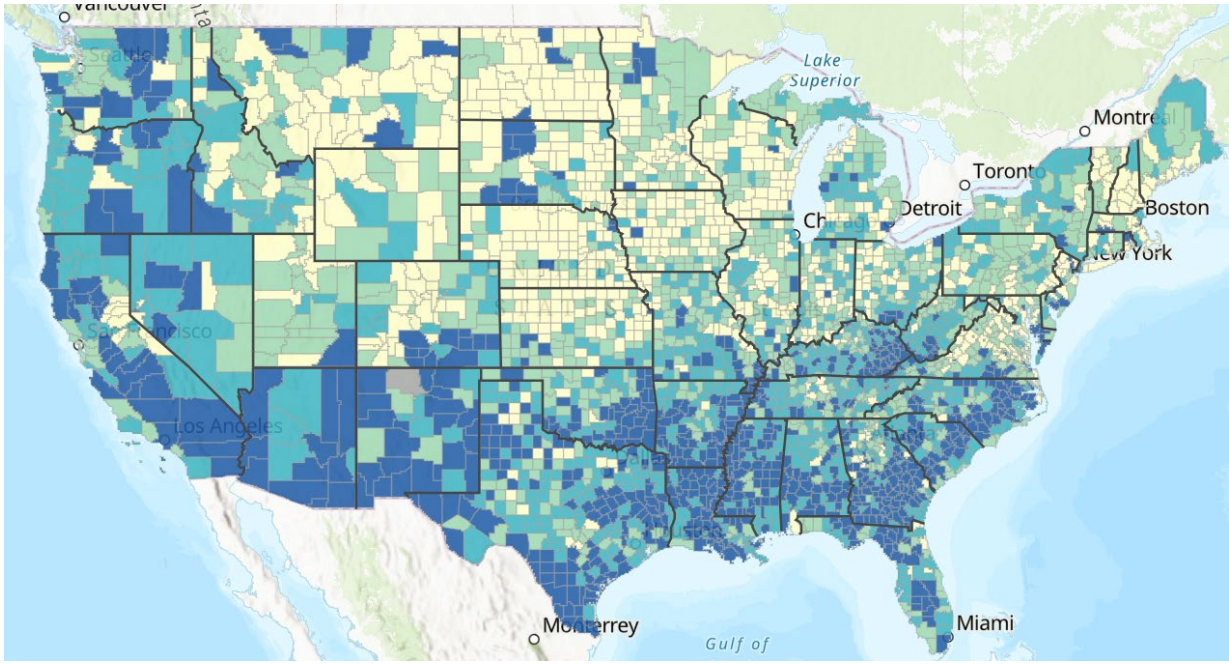
Presented by Susan Wilson, Executive Director, NM Coalition for Healthcare Value

REVOLUTIONIZING NM'S PC PAYMENT MODEL

- Goal 2 workgroup reviewed 12* state models designed to achieve high quality and equitable PC. This review includes:
  - Adoption of goal related to percent increase PC spend
  - Establishment of organization to oversee PC reform long-term
  - Strategies on provider engagement throughout reform implementation
  - Legislative actions designed to spur reforms
- **Next steps: Workgroup will identify and recommend specific PC payment/financing models for PCC consideration, including models meet unique needs of NM.**

**States evaluated include RI, OR, CO, CT, WA, NY, MD, CA, MN, MI, PA, NC*

U.S. Social Vulnerability, 2018



Source: CDC

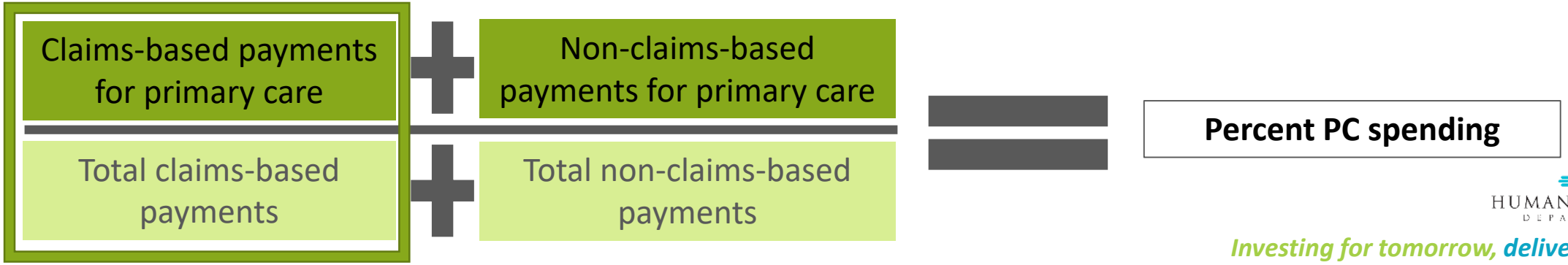
GOAL 2: PAYMENT STRATEGIES

DELIVERABLE: CALCULATING PC SPENDING

Presented by Alex Castillo Smith, Chief Dumpster Fire Extinguisher & Cat-Herder, NMHSD
&
Anastacia Sanchez, HSD Policy Fellow

CALCULATING PRIMARY CARE SPENDING

- NM All-Payer Claims Database launch Summer 2023, allow comprehensive analysis of PC spending across all payers.
- Until then, PCC will calculate PC spending in NM Medicaid, focusing on claims-based payments.
- To be considered PC expenditure, claim must meet these criteria:
  - Designated **PC practitioner** who practices in…
  - Designated **PC place of service** and provides service that is…
  - Designated **PC revenue code**.
  - Additionally, BH claim categorized as PC claim *only* if it is integrated PC service.
- **Desired outcome: PCC designates practitioners, places of service, and revenue codes as PC.**



CALCULATING PC SPENDING: PRACTITIONERS

Practitioner	% PCC workgroup included as PC
1. Acupuncturist	66.7
2. Licensed Marriage & Family Therapist	50
3. Naturopath/Homeopath	50
4. Homeopath	50
5. Pediatric Physician, Development and Behavioral	50
6. Licensed Alcohol & Drug Use Counselor	40
7. Certified Community Support Worker	33.3
8. Dietician/Nutritionist	33.3
9. Licensed Substance Use Associate	33.3
10. Certified Alcohol & Drug Use Counselor	33.3
11. General Psychiatrist	-

PCC workgroup members voted on 63 practitioner types, reaching consensus on 52. Slide XX in Appendix outlines whether practitioner designated as PC.

CALCULATING PC SPENDING: PLACE OF SERVICE (POS)

POS TO INCLUDE AS PCP

1. Federally Qualified Health Center
2. Home
3. Indian Health Service Free Standing Facility
4. Indian Health Service Provider-based Facility
5. Independent Clinic (not urgent care)
6. Office
7. Rural Health Clinic
8. State Local Public Health Clinic
9. Services Received thru Telecomm Technology
10. Tribal 638 Free Standing Facility
11. Tribal 638 Provider-based Facility
12. Hospital-based clinics

POS WHERE CONSENSUS *NOT* REACHED

1. Employee Worksite
2. School
3. Shelter

CALCULATING PC SPENDING: PROCEDURE CODES

Code	Description	% PCC workgroup included as PC
1. T1016	Case management	60
2. 90847	Family psychotherapy with patient	50
3. G0152	Occupational therapy 15 minutes	50
4. 99355	Prolonged service	50
5. T2022	Case management/month	40
6. H2000	Comprehensive multi-disciplinary assessment for Serious Emotional Disturbance	40
7. n/a (supported with state general fund)	Initial service plan-juvenile community corrections	40

PCC workgroup members voted on 60 procedure codes, reaching consensus on 54. Slide XX in Appendix outlines whether code designated as PC. Additionally, previous Medicaid PC spend analysis identified 584 codes, which will be designated as PC in future analyses.

HUMAN SERVICES DEPARTMENT

QUESTIONS & COMMENTS

INVESTING FOR TOMORROW, DELIVERING TODAY.

GOAL 4: WORKFORCE SUSTAINABILITY

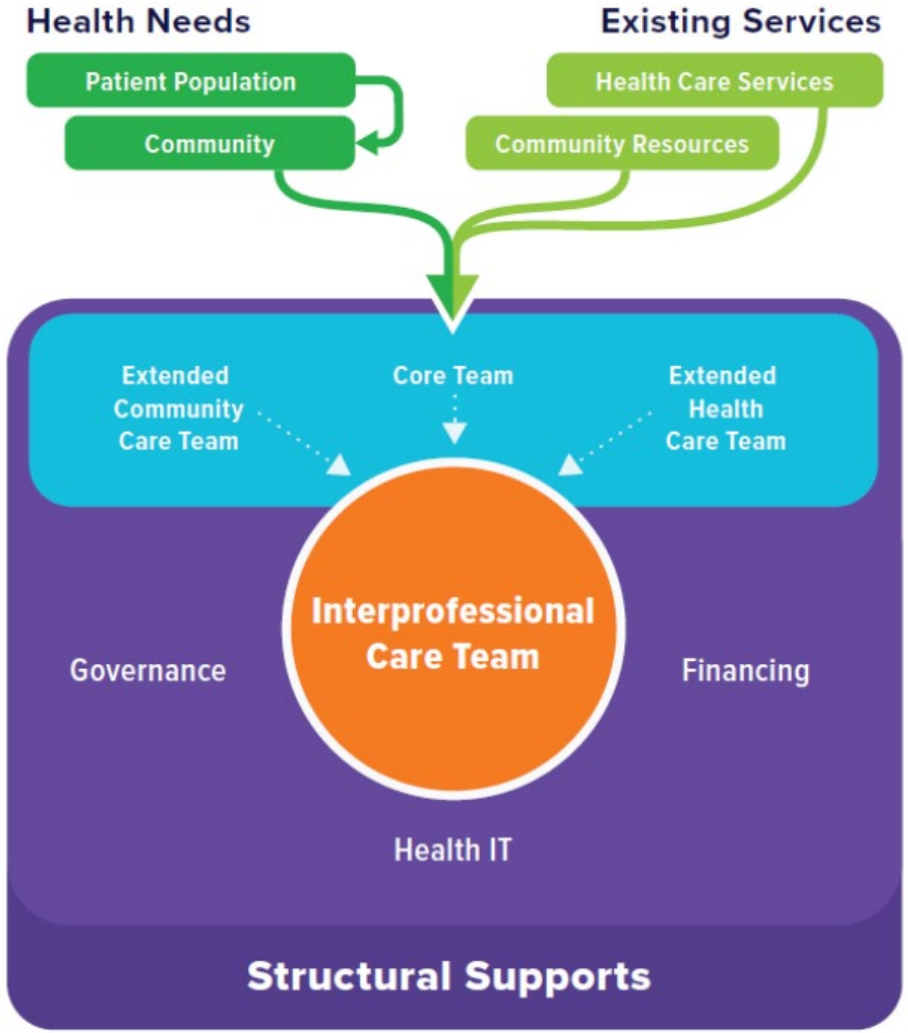
DEFINING PC INTERPROFESSIONAL TEAM

Presented by Maggie McCowen: Executive Director, Behavioral Health Providers' Association of New Mexico

INTERPROFESSIONAL PRIMARY CARE TEAM

- Interprofessional, team-based PC model can take several forms. These teams:
  - Increase access to services.
  - Diversify and enhance provider's care and support.
  - Give patients more opportunities to get questions answered and needs met.
  - Improve quality of care and service.
  - Reduce workforce burnout.
- PCC Goal 4 workgroup members identified 51 possible members of NM interprofessional PC team.
- **Desired outcome: PCC defines NM interprofessional primary care team.**

Structure to Support Team-Based Integrated PC



Source: National Academies of Science, Engineering & Medicine.

DEFINING NM INTERPROFESSIONAL PRIMARY CARE TEAM

CLINICAL

1. Primary Care Physicians
2. Specialists
3. Physician Assistants
4. Medical Assistant
5. Certified Nursing Assistant
6. School Nurses
7. Licensed Practical Nurses
8. Registered Nurses
9. Advanced Practice Nurses
10. Pharmacists
11. Pharmacist Clinicians
12. Pharmacy Technicians
13. Nutritionists
14. Native healers (curandero, medicine person, shaman)
15. Acupuncturists
16. Lab Technologists
17. Radiology Technologists
18. Occupational Therapist
19. Physical Therapists
20. Dentists
21. Dental Assistants
22. Dental Hygienists
23. Dental Therapists

NON-CLINICAL

1. Special Education teacher/counselor
2. Comprehensive Community Support Worker
3. Case Manager
4. Patient Navigator
5. Community health worker/*promotora*
6. Health Educator
7. Clergy/Faith-based outreach worker
8. Personal Care Attendants
9. Senior center staff
10. Caregivers
11. Clinic Coordinator
12. Medical Records Specialist
13. Financial Counselor
14. Billing Specialist
15. Scheduler

DEFINING NM INTERPROFESSIONAL PRIMARY CARE TEAM

BEHAVIORAL HEALTH

1. Psychologist
2. Psychiatrist
3. Licensed Clinical Social Worker
4. Licensed Independent Social Worker
5. Licensed Professional Clinical Counselor
6. Mid-level Social Workers and Counselors
7. Peer Support Specialists
8. School Social Worker/Counselor
9. Behavior Management Specialist
10. Licensed Alcohol and Drug Use Counselor
11. Treatment Foster Care Family

Why Integrated Behavioral Health?

1 in 5 adults face mental health illness yearly.	1 in 6 children (6-17) face mental health illness yearly.	50% of lifetime mental illness begins by age 14.
18.4% of U.S. adults with a mental illness also had a substance use disorder in 2019.	Those with depression have 40% higher risk for cardiovascular and metabolic diseases.	55% of U.S. counties do not have a psychiatrist.

Source: National Alliance on Mental Illness. (2021).

GOAL 4: WORKFORCE SUSTAINABILITY

DELIVERABLE: PC TEAM – PATIENT PANEL SIZE FRAMEWORK

Presented by Hala Reeder, HSD Data Analyst

PC TEAM - PATIENT BENCHMARKS

PRESENTATION OBJECTIVES

- Summarize available research/findings
- Identify knowledge gaps
- **Desired outcome: Solicit PCC feedback on PC Team- Patient benchmark that addresses unique health and social characteristics of New Mexicans.**

BENCHMARKS ARE IMPORTANT

- Appropriate benchmarks ensures timely access to care, promotes quality care, and prevents provider burnout
- Population health characteristics key consideration for benchmarks because service utilization often shaped by factors such as age, sex, race, language, disease burden.
- Patient demographics impact number of patients a provider can treat

HOW DO WE REVOLUTIONIZE PC TEAM - PATIENT BENCHMARKS?

- We'll split into breakout groups for 10 minutes and provide feedback using Jamboard
- We'll debrief for final 5 minutes

REVOLUTIONARY PC MEDICAL MODEL

- Benchmark that incorporate PC team
- Benchmark that promote health equity, addressing obstacles to health and well-being
- Risk stratification: benchmarks advance patient health and well-being and prevent workforce burnout

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PCC GROUP DISCUSSION & REFLECTIONS

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PUBLIC COMMENT

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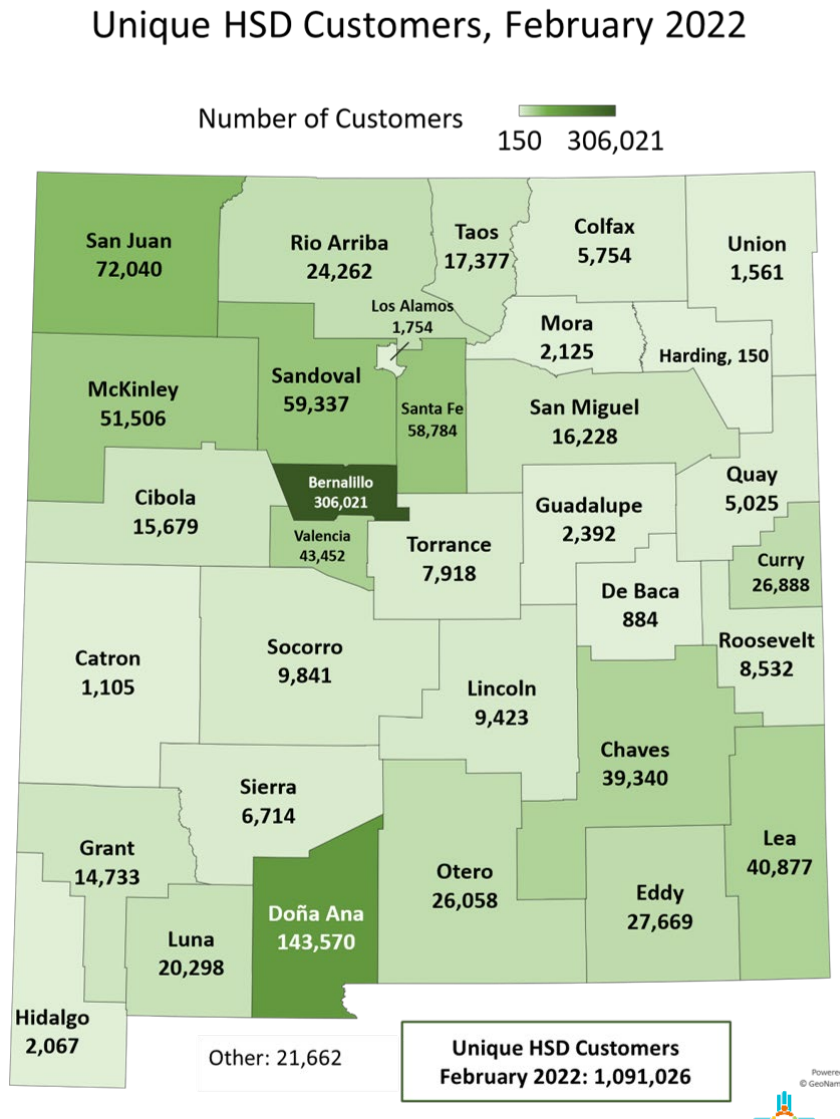
MAY MEETING PROPOSED AGENDA

- FY23 PCC Spending Priorities
- PCC Performance metrics and evaluation
- Stakeholder engagement report-out
- Promoting provider wellness



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CLOSING COMMENTS

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APPENDIX

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APPENDIX TABLE OF CONTENTS

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NEW MEXICO HEALTHCARE WORKFORCE ANALYSIS

FTE COUNT FOR CERTIFIED NURSE PRACTITIONERS AND PHYSICIAN ASSISTANTS WORKING IN PRIMARY CARE BY COUNTY

HALA REEDER, HSD DATA CONTRACTOR

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OVERVIEW

FULL-TIME EQUIVALENT (FTE) COUNT

FTE is a unit of measurement quantified as the workload of a single employee. For the purposes of this analysis, 1 FTE will be equivalent to one full-time provider working 35 hours in direct non-inpatient care per week 48 weeks per year. FTE count provides a more representative depiction of New Mexico's Healthcare Workforce capacities and provider need with greater accuracy.

Objective: Expanding on 2020 Healthcare Workforce Capacity Analysis using Certified Nurse Practitioner (CNP) and Medical Physician Assistant (PA) licensure and survey data to estimate Full-Time Equivalent (FTE) contribution by County in 2020.

PRIMARY CARE PROVIDER CATEGORIES

- **Certified Nurse Practitioners (CNPs):** Activity licensed Certified Nurse Practitioners currently employed and practicing in Adult Health, Community Health, Family Health, Geriatric/Gerontology, Home Health, Pediatrics, Public Health, Women's Health, and Psychiatric/Mental Health/Substance Abuse.
- **Physician Assistants (PAs):** Actively licensed Medical Physician Assistants (Pas) that specialize in Psychiatry, Family, General, Pediatrics, General Internal, Geriatrics, Adolescent, Occupational, Preventative Practice or Medicine (subspecialties not included).

METHODOLOGY LIMITATIONS

SURVEY DATA

- Survey not mandatory: respondents and non-respondents
- Not all survey questions mandatory: lacking data for some responders

Certified Nurse Practitioner (CNP) Data:

****FTE contribution calculation based on an estimated 48 weeks per year contribution.**

- Self-reported data: overreporting of activity levels, various specialty distinctions

LICENSURE DATA

- Actively licensed does not equate to actively practicing or employed
- Home zip code county distinction used as a proxy for primary employment location

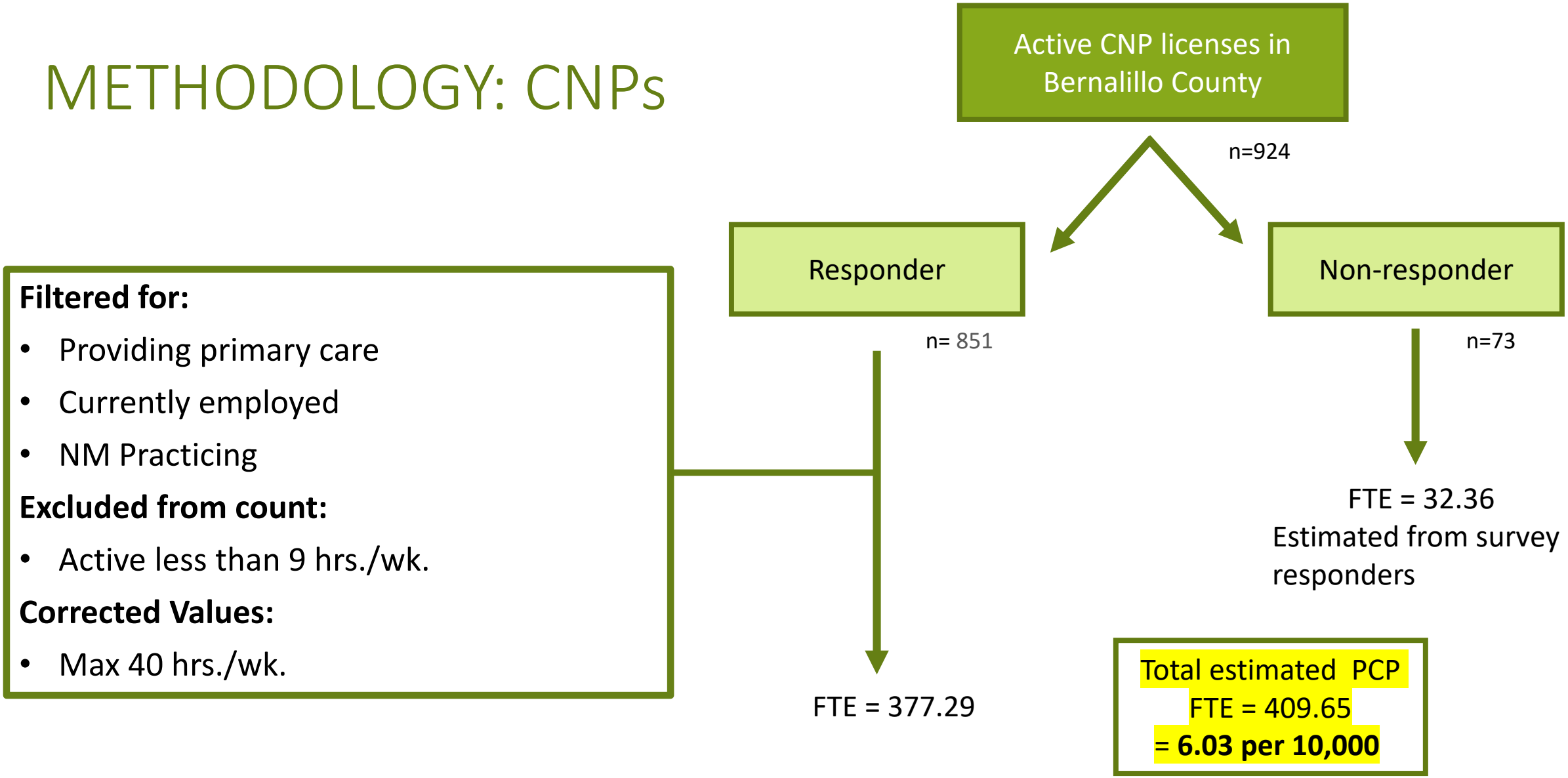
FTE COUNT

- Limited survey responses, n<5
- Care coordination and organization not considered in FTE count of providers

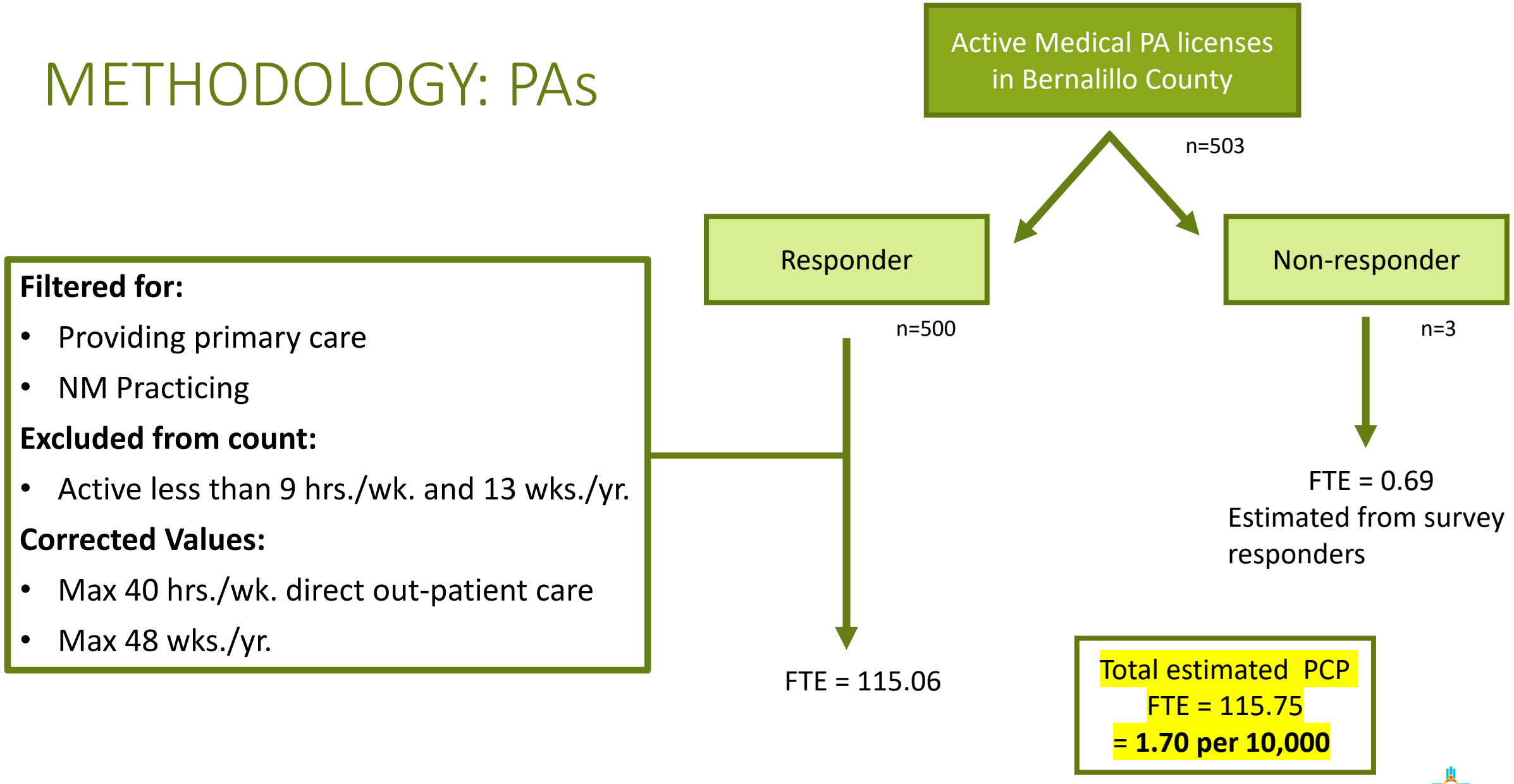
METHODOLOGY: RESOURCES

- Provider data for 2020 was obtained through licensure survey responses collected by the **New Mexico Regulation & Licensing Department** (RLD).
- Methodology for determining FTE provider count developed by HSD Policy Fellow **Rohini McKee, MD, MPH, FACS, FASCRS**.
- Population data by county was obtained from the **Census Bureau Population Division**, "Annual Estimates of the Resident Population for Counties," 2019.
- Prior provider count methodology established in **New Mexico Health Care Workforce Committee's** New Mexico Health Care Workforce Committee 2020 Annual Report
- Consultation with the contributor of the NM 2019 FTE Health Care Workforce Analysis by County HSD Policy Fellow **Roxanne Humphries, MPH.**
- Data for Benchmark Ratios determined **Health Resources and Services Administration's** (HRSA) **Health Professional Shortage Designation** (HPSA).

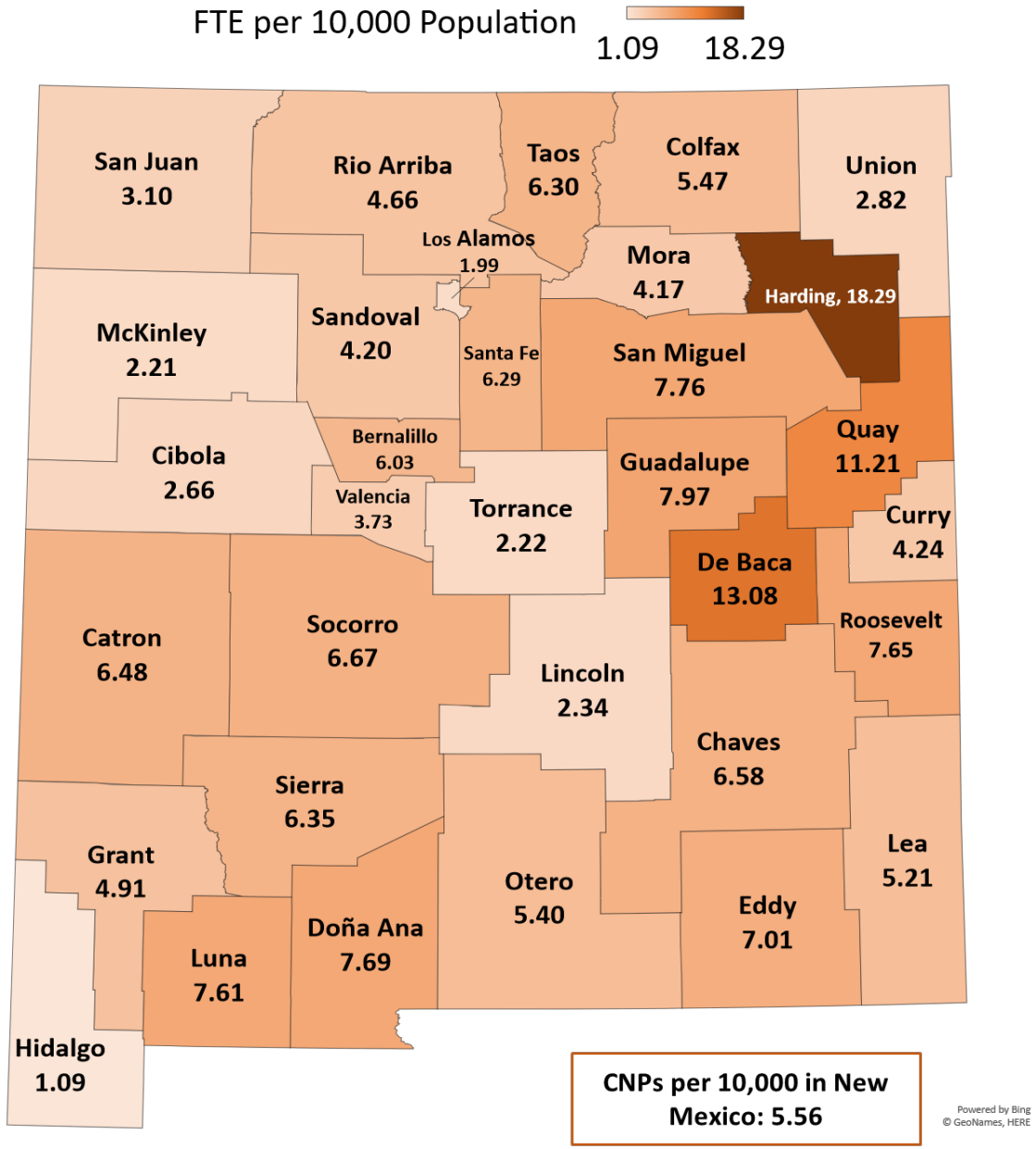
METHODOLOGY: CNPs



METHODOLOGY: PAs



CERTIFIED NURSE PRACTITIONERS (CNP) RESULTS



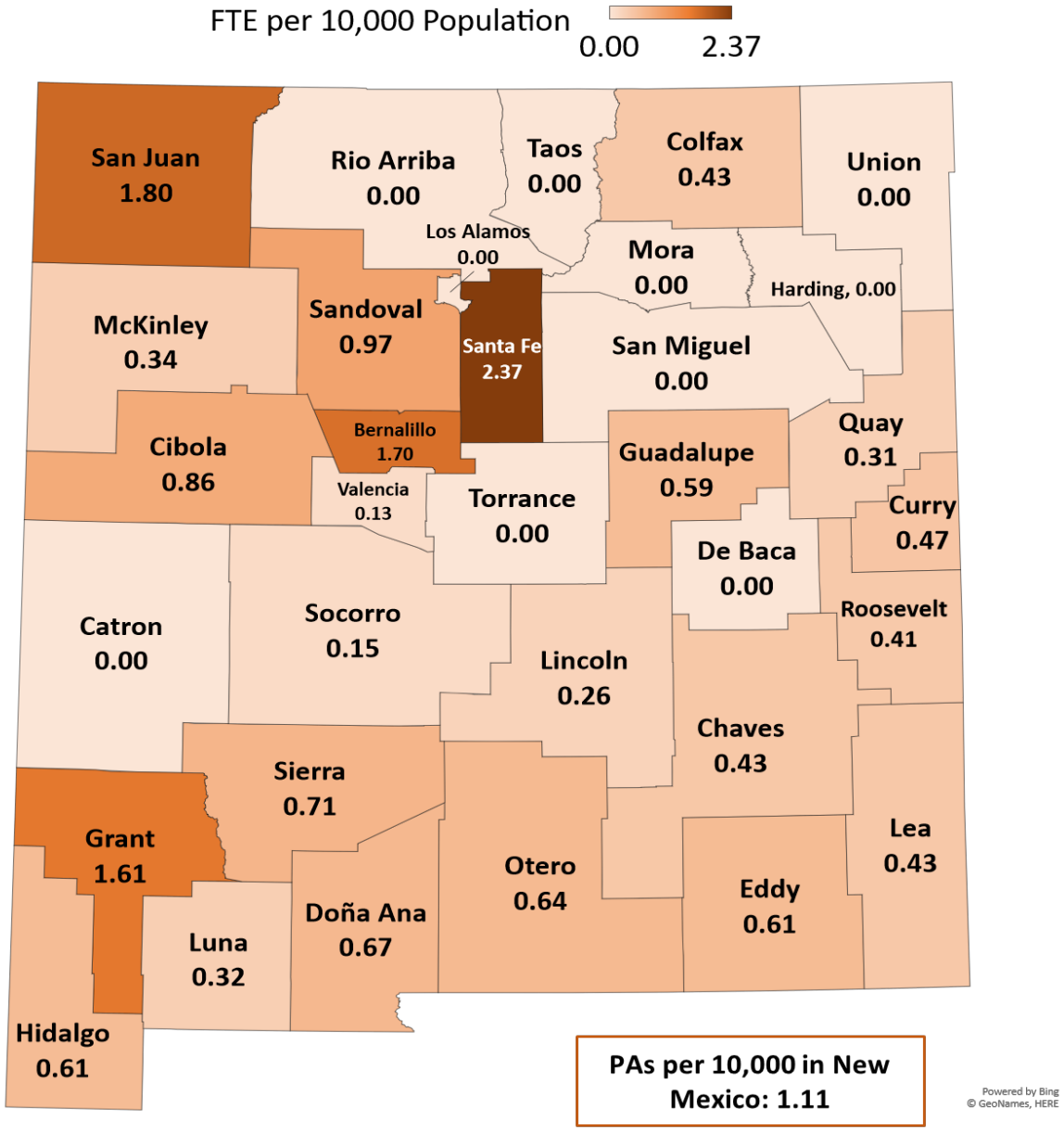
Highest Values

1. Harding: 18.29
2. De Baca: 13.08
3. Rio Arriba: 11.21

Lowest Values

1. Hildalgo: 1.09
2. Los Alamos: 1.99
3. McKinley: 2.21

PHYSICIAN ASSISTANTS (PA) RESULTS



Highest Values

1. Santa Fe County: 2.37
2. San Juan: 1.80
3. Bernalillo County: 1.70

Lowest Values

1. Catron County: 0.00
2. De Baca County: 0.00
3. Harding County: 0.00
4. Los Alamos: 0.00
5. Mora County: 0.00
6. Rio Arriba: 0.00
7. San Miguel: 0.00
8. Taos County: 0.00
9. Torrance: 0.00
10. Union: 0.00

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CALCULATING PC SPENDING: PRACTITIONERS & CODES WITH WORKGROUP CONSENSUS

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CALCULATING PC SPENDING: PRACTITIONERS

Practitioner	Designated as PC (Yes/No)
1. Peer Support Worker, Certified	No
2. Family Support Worker, Certified	No
3. Psychiatric Nurse RN, Not Board Certified	Yes
4. Nurse Practitioner	Yes
5. Family Nurse Practitioner	Yes
6. Adult Health Nurse Practitioner	Yes
7. Gerontology Family Nurse Practitioner	Yes
8. Pediatric Nurse Practitioner	Yes
9. Women's Health Nurse Practitioner	Yes
10. Nurse Practitioner, Acute Care	Yes
11. Nurse Practitioner, General	Yes
12. Nurse Practitioner, Psychiatric	Yes
13. Licensed Professional Clinical Counselor	Yes

CALCULATING PC SPENDING: PRACTITIONERS

Practitioner	Designated as PC (Yes/No)
14. Licensed Clinical Social Worker	Yes
15. Licensed Associate Marriage & Family Therapist	No
16. Master's Level Psychologist	Yes
17. Licensed Master's Level Social Worker	Yes
18. Psychologist Associate	Yes
19. Master of Arts, Psychology Related	Yes
20. Licensed Baccalaureate Social Worker	Yes
21. Licensed Mental Health Counselor	Yes
22. Licensed Professional Counselor	Yes
23. Licensed Professional Art Therapist	No
24. Master's Level Behavioral Health Intern	Yes
25. Psychology Intern	No
26. Pre-Licensure Psychology Post-Doctorate	Yes

CALCULATING PC SPENDING: PRACTITIONERS

Practitioner	Designated as PC (Yes/No)
27. Obstetrics & Gynecology Advanced Practice Midwife	Yes
28. Advanced Practice Midwife	Yes
29. Clinical Nurse Specialist, Family Medicine	Yes
30. Clinical Nurse Specialist, Internal Medicine	Yes
31. Clinical Nurse Specialist, Women's Health	Yes
32. Clinical Nurse Specialist, Pediatrics	Yes
33. Clinical Nurse Specialist, Geriatrics	Yes
34. Psychiatric Registered Nurse	Yes
35. School Nurse	No
36. EPSDT Screening Nurse	No
37. Other Ordering, Referring, or Prescribing Practitioners	Yes
38. Certified Community Health Worker	Yes
39. Pharmacist Clinician	Yes

CALCULATING PC SPENDING: PRACTITIONERS

Practitioner	Designated as PC (Yes/No)
40. Pharmacist Prescriber	No
41. Family Medicine Physician	Yes
42. Family Medicine Physician, Addiction Medicine	Yes
43. Preventative Medicine	Yes
44. General Pediatric Physician	Yes
45. Adolescent Physician	Yes
46. Geriatric Medicine Physician	Yes
47. General Practice Physician	Yes
48. Internal Medicine Physician	Yes
49. Internal Medicine Physician, Addiction	Yes
50. OB-GYN Physician	Yes
51. Physician's Assistant	Yes
52. Psychiatric Clinical Nurse Specialist	Yes

CALCULATING PC SPENDING: PROCEDURE CODES

Code	Description	Designated as PC (Yes/No)
1. H23033	Multi-systematic therapy (MST)	No
2. H2010	Comprehensive med service	Yes
3. H2014	Behavior management services	Yes
4. 97150	Observation & Assistance	No
5. T1002	RN services	Yes
6. 90846	Family psychotherapy without patient	No
7. T1027	Family training for child	Yes
8. 90849	Multi-family group therapy	No
9. 90853	Group psychotherapy	No
10. H2019	Therapeutic BH services	Yes
11. H0038	Peer support services	Yes
12. H0050	Brief intervention	Yes

CALCULATING PC SPENDING: PROCEDURE CODES

Code	Description	Designated as PC (Yes/No)
13. G0515	Cognitive skills development	Yes
14. 99341	New patient home service	Yes
15. 99347	Established patient home service	No
16. 90832	Individual psychotherapy	No
17. 90833	Individual psychotherapy- 30 min. Add-on	No
18. 99342	Home visit- New patient	Yes
19. 99357	Prolonged stand-by	No
20. 90834	Psychotherapy- 45 min	No
21. 90836	Psychotherapy- 45 min with an E&M	No
22. 99353	Prolonged visit	No
23. 99349	Home visit-established	Yes
24. 99356	Prolonged service	No

CALCULATING PC SPENDING: PROCEDURE CODES

Code	Description	Designated as PC (Yes/No)
25. 99358	Prolonged service without patient	No
26. 90863	Pharmacological management with E&M	Yes
27. 90838	Psychotherapy- 60 min	No
28. 99354	Prolonged services	No
29. 90785	Interactive complexity	No
30. 90837	Individual psychotherapy	Yes
31. 99345	New patient-home services	Yes
32. G0176	Activity therapy	Yes
33. G0493	Skilled services of an RN	Yes
34. S5190	Home care training	Yes
35. G0175	Interdisciplinary team conference	Yes
36. S0220	Interdisciplinary team conference-other	Yes

CALCULATING PC SPENDING: PROCEDURE CODES

Code	Description	Designated as PC (Yes/No)
37. S0221	Interdisciplinary team conference- other BH	Yes
38. T2023	Targeted case management	No
39. T2024	Services assessment/plan of care development	Yes
40. 90791	Diagnostic evaluation	Yes
41. 90792	Diagnostic evaluation with medical services	Yes
42. T1007	Service plan update	Yes

CALCULATING PC SPENDING: NON-MEDICAID PROCEDURE CODES

Code	Description	Designated as PC (Yes/No)
43. JCC01:SGF	Family services-JCC	No
44. BHS-C2A0	Youth group mentoring	No
45. JCC01:SGF	Group services- JCC	No
46. BHS-C10A0	Life skills coaching-group-ASURE	No
47. JCC01:SGF	Limited menu-group services-JCC	No
48. JCC01:SGF	Intensive parenting family services-ASURE	No
49. BHS-C10A0	Life skills coaching-Individual-ASURE	No
50. YM01:SGF	Individual youth mentoring	No
51. JCC01:SGF	Individual services-JCC	No
52. JCC01:SGF	90-day service plan for juvenile justice	No
53. JCC01:SGF	Discharge service plan-JCC	No
54. BHS-C10A0	Individual service plan-ASURE	Yes

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FINANCIAL INCENTIVES FOR HEALTHCARE PROVIDER RECRUITMENT & RETENTION

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FINANCIAL INCENTIVES FOR HEALTHCARE PROVIDER RECRUITMENT & RETENTION

PROGRAM NAME	DESCRIPTION	ELIGBLE DISCIPLINES	AWARD AMOUNT	SERVICE COMMITMENT	SPECIAL POPULATION ELIBIBILITY	FUNDING SOURCE	NM RESIDENT	APPLICATION TYPE
Allied Health Loan-for-Service	Loan Repayment/Loan Forgiveness	CNM, CRT, DO, MD, NP, OT, PA, PharmD, PT, RDH, SLP, etc.	Up to $12,000 per year	1-4 years (full-time)	Financially disadvantaged	State	Yes	FAFSA and Independent
Health Professional Loan Repayment	Loan Repayment	CNM, DMD, DO, LPC, MD, NP, OD, PA, etc.	Up to $12,500 per year	2 years (full-time)	None	State and Federal	Yes	Independent
Indian Health Services Loan Repayment	Loan Repayment	CNM, DMD, DO, LPC, LSW, MD, NP, OD, OT, PA, PhysD, PT, PharmD, RDH, RN, SLP, etc.	Up to $40,000	2 years (full-time)	American Indian or Alaska Native (prioritized)	Federal	No	Independent
Medical Student Loan-for-Service	Loan Repayment	MD, DO, PA	Up to $25,000 per year	1-4 years (full-time)	Financially disadvantaged	State	Yes	FAFSA and Independent
New Mexico Rural Health Care Practitioner Tax Credit Program	Tax income credit	CNM, CRNA, DMD, DO, DPM, DM, NP, OD, PA, PsyD, RDH	$3,000 or $5,000	N/A	N/A	N/A	Yes	Independent
NHSC Loan Repayment	Loan Repayment	CNM, DMD, DO, HSP, LCSW, LPC, MD, MFT, NP, PA, PNS, RDH	Up to $50,000 (full-time) OR $25,000 (part-time)	2 years (full-time) or 4 years (part-time)	None	State	Yes	Independent
NHSC Rural Community LRP	Loan Repayment	CNM, CRNA, DO, HSP, LCSW, LPC, MD, MFT, NP, PA, PharmD, PNS, RN, SUD Counselors	Up to $100,000 (full-time) OR $50,000 (part-time)	3 years (full-time) or 6 years (part-time)	None	State	Yes	Independent

FINANCIAL INCENTIVES FOR HEALTHCARE PROVIDER RECRUITMENT & RETENTION

PROGRAM NAME	DESCRIPTION	ELIGBLE DISCIPLINES	AWARD AMOUNT	SERVICE COMMITMENT	SPECIAL POPULATION ELIBIBILITY	FUNDING SOURCE	NM RESIDENT	APPLICATION TYPE
NHSC SUD Workforce Loan Repayment	Loan Repayment	CNM, DO, HSP, LCSW, LPC, MD, MFT, NP, PA, PharmD, PNS, RN, SUD Counselors	Up to $75,000 (full-time) OR $00 (part-time)	3 years (full-time) or 6 years (part-time)	None	State	Yes	Independent
Nursing Student Loan-for-Service	Loan Repayment	RN	Up to $12,000 per year	1-4 years (full-time)	Financially disadvantaged	State	Yes	FAFSA and Independent
VA Education Debt Reduction	Loan Repayment	DO, LPN, LSW, MD, PsyD	Up to $40,000 per year	1-5 years	None	Federally	No	Independent
Nurse Corps Loan Repayment Program	Loan Repayment	RN, APRN, Nurse Faculty	pays up to 85% of unpaid nursing education debt	minimum 2 years in critical shortage facility or an eligible nursing school	Preference to those who need financial help. Must graduate from accredited school of nursing in the U.S.	Federal	No	Independent
National Health Service Corps Scholar Program	Scholarship	physician, dentist, nurse practitioner, nurse midwife, physician assistant students	Pays tuition, fees, living stipend and some other costs	2 - 4 year commitment in a community-based high need site (2 year commitment + a full year of scholarship support)	can apply in final year of undergrad work - related to but not same as NHSC loan repayment	Federal	no	Independent

Abbreviation	Credential
CNM	Certified Nurse Midwife
CRNA	Certified Registered Nurse Anesthetists
CRT	Certified Respiratory Therapist
DMD	Doctor of Medicine in Dentistry
DO	Doctor of Osteopathic Medicine
DPM	Doctor of Podiatric Medicine
HSP	Health Service Psychologists
LCSW	Licensed Clinical Social Worker
LPC	Licensed Professional Counselor
LSW	Licensed Social Worker
MD	Medical Doctor
MFT	Marriage and Family Therapist
NP	Nurse Practitioner
OT	Occupational Therapist
PA	Physician Associate (Assistant)
PharmD	Doctor of Pharmacy
PhysD	Doctor of Psychology
PNS	Psychiatric Nurse Specialist
PT	Physical Therapist
RDH	Registered Dental Hygienist
RN	Registered Nurse
SLP	Speech and Language Pathologist
SUD Counselor	Substance Use Disorder Counselor