LEGISLATIVE HEALTH & HUMAN SERVICES COMMITTEE

Terri Stewart – President and Chief Executive Officer
Phillip Gibbs – Director, Customer Engagement
November 5, 2025

SYNCRONYS
BETTER DATA. BETTER HEALTH.

AGENDA

SYNCRONYS
BETTER DATA. BETTER HEALTH.

1. Who is SYNCRONYS?
2. What does SYNCRONYS do?
3. What can SYNCRONYS do.
4. Overview of SYNCRONYS Solutions
5. How NM Legislators could help.
6. Questions & Answers

SYNCRONYS

SYNCRONYS
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- SYNCRONYS is a New Mexico not-for-profit multi-stakeholder organization.
- Formed in 1990 as a research organization, previously known as the Lovelace Clinic Foundation d/b/a NMHIC.
- In 2010 evolved to interoperability to securely exchange health records, including public health reporting for the NM Department of Health.
- Is the State's designated health information exchange (HIE), 2009 and the agent of NMDOH for electronic lab reporting (ELR) and Syndromic Surveillance since 2012.
- In October 2020, the organization changed its name to SYNCRONYS.

SEPTEMBER 2020 INVESTMENTS

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- NM significantly invested in its HIE supported with state and enhanced federal (HITECH) matching funds through an agreement with SYNCRONYS and the NM Human Services Department.
  - Build and maintain interfaces with health care facilities and providers
  - Maintain secure online access to the longitudinal clinical record,
  - Maintain an Enterprise Master Patient Index (EMPI) to identify individuals across systems, settings and populations to create a single record,
  - Develop use cases, insights and tools with the data
    - Substance Use Disorder
    - Hepatitis C Treatments
    - Mental Health Insights
    - Maternal Care

WHAT IS AN HIE?

SYNCRONYS

Solutions | Our Network | Resources | Company | News & Events | Connect with Us

HIE PURPOSE

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- Is to securely exchange, manage and store health information from across the state and to provide role-based access to health-related information in a centralized and secure database.
- SYNCRONYS includes:
  - Patient demographics, medical encounters, clinical notes, prescriptions, diagnostic procedures, diagnostic images, notifiable public health data, and all New Mexico Medicaid claims, among different and unrelated healthcare organizations to create a longitudinal clinical data repository (CDR).
- Utilizing an enterprise master patient index (EMPI) SYNCRONYS aggregates an individual's data across its platform.
- **Why**: having enhanced data within the SYNCRONYS data warehouse, not only helps medical providers, but can inform state agencies and legislators on outcomes and progress of programs.

SECURITY & PRIVACY

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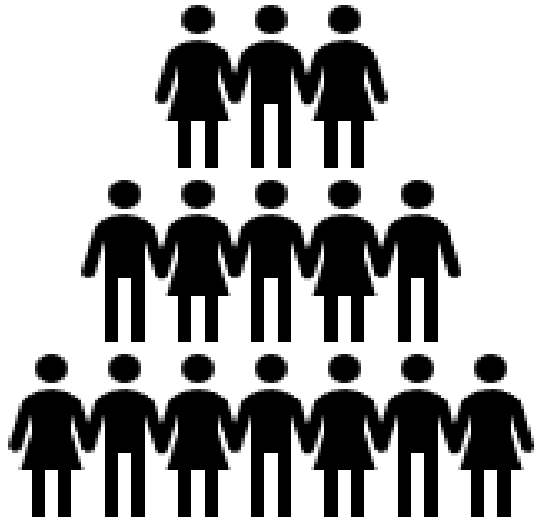
- Disclosure of the data are governed by:
  - Participation Agreements, and
  - Disclosure is aligned with federal HIPAA disclosure statutes, as well as the New Mexico Electronic Records Act.
  - New Mexico is an Opt Out State.
- Security and privacy programs are structured around multiple nationally recognized frameworks.
  - SYNCRONYS has **SOC 2 Type 2** certification. An independent audit is performed annually evaluating controls for Security, Availability, Confidentiality.
  - Are in the process of certification under **HITRUST** CSF r2 (2025, and aligning controls with NIST SP 800-53 rev 5, ISO/IEC 27001:2022, and HIPAA Security Rule. The HITRUST certification is expected in 2026.
  - Have adopted **NIST SP 800-30** and **800-39** for Risk Analysis and Risk Management methodology for ongoing threat identification and control validation.



> 2.5 Million individuals

95% of NM hospital beds are represented within the data

National Connections

RICH SOURCE OF HEALTH DATA

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SOLUTIONS

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- SYNCRONYS has developed a **three-pillar** care solution that enables providers, payers and policy makers to improve individual health, community health, and help to reduce healthcare costs in New Mexico. The solution pillars span from the individual patient and provider interaction at the point of care to the identification of population insights necessary for policy and statewide strategic planning.
- These **three pillars**:
  - build upon information available at the *Point of Care*;
  - offer a care and risk management solution to improve *Population Health + Quality*; and
  - provide access to a unique blend of health, regional data, and SDoH to inform *Community Insights + Policy + Strategic Planning*.

POINT OF CARE SOLUTIONS

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Clinical Portal

Access the longitudinal clinical record

Acute Care Notification

Daily report hospital and ED admit and discharge events. Report identifies frequency of admissions and ED visits with diagnoses

Coordinate

Integrated software suite for care management

Substance Use Disorder Use Case

Substance Use Disorder (SUD) Management provides SUD MAT notifications and reports sent to various clinical settings.

POINT OF CARE SOLUTIONS

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Mental Health Use Case

Identifies mental and behavioral health risks and alerts the appropriate providers

Emergency Department Optimization

Criteria based patient's notification sent real-time to emergency departments

Post Acute Care Management

Provides real-time visibility into members care and treatment while admitted at a skilled nursing facility

Conditions of Participation (CMS)

Enables hospitals to send electronic patient event notifications of a patient's admission, discharge, and/or transfer (ADT) to other healthcare facilities or to community providers or practitioners

POPULATION HEALTH SOLUTIONS

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Population Health Analytics Dashboards

- Suite of Risk Management Solutions, attributed patients
  - Population Risk
  - Transition Risk
  - Performance Report
  - Behavioral Health

Hepatitis C Dashboard

- Provides data ascertaining the presence of HCV, providing a Summary of Care Gaps and Risk Factors. Maternal Health Dashboard

Maternal Health Dashboard

- Provides risk management and care coordination solutions for the prenatal and postpartum populations

Certified Community Behavioral Health Clinic (CCBHC)

- Provides a customized BH dashboard for state CCBHCs to monitor their Quality Measure compliance and the BHSD to report to CMS on required metrics.

POLICY & COMMUNITY INSIGHTS

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Population Health Analytics Dashboards

- Suite of Risk Management Solutions, *Aggregated data*
  - Population Risk
  - Transition Risk
  - Performance Report
  - Behavioral Health

Health Equity Map

- Health Equity Map (HEM) is a geospatial mapping and dashboarding tool to analyze trends, hotspots, and disparities in health equity and access

Custom Analytics

- Ability to generate custom reports for one-time requests or a reoccurring report. (E.g. ORCNM & UNM Researchers)

Public Health

- eCR is the automated, real-time exchange of case report information between the HIE and public agencies, to support CDC Data Modernization Initiative.
- Custom Reports/extracts

ADDITIONAL SOLUTIONS

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Direct Secure Messaging

Provides point to point secure encrypted communications

NCQA Certified Continuity of Care Documents

CQA Certified CCDA that provides a summary of a patient's care over a specified period. CCDA can be leveraged to support clinical operations and HEDIS reporting.

HealthXNet

Access to insurance eligibility and benefits platform.

Inbound Data Sharing

Send a standard data set to SYNCRONYS in a patient centric model of healthcare and wellness.

Outbound Data Sharing

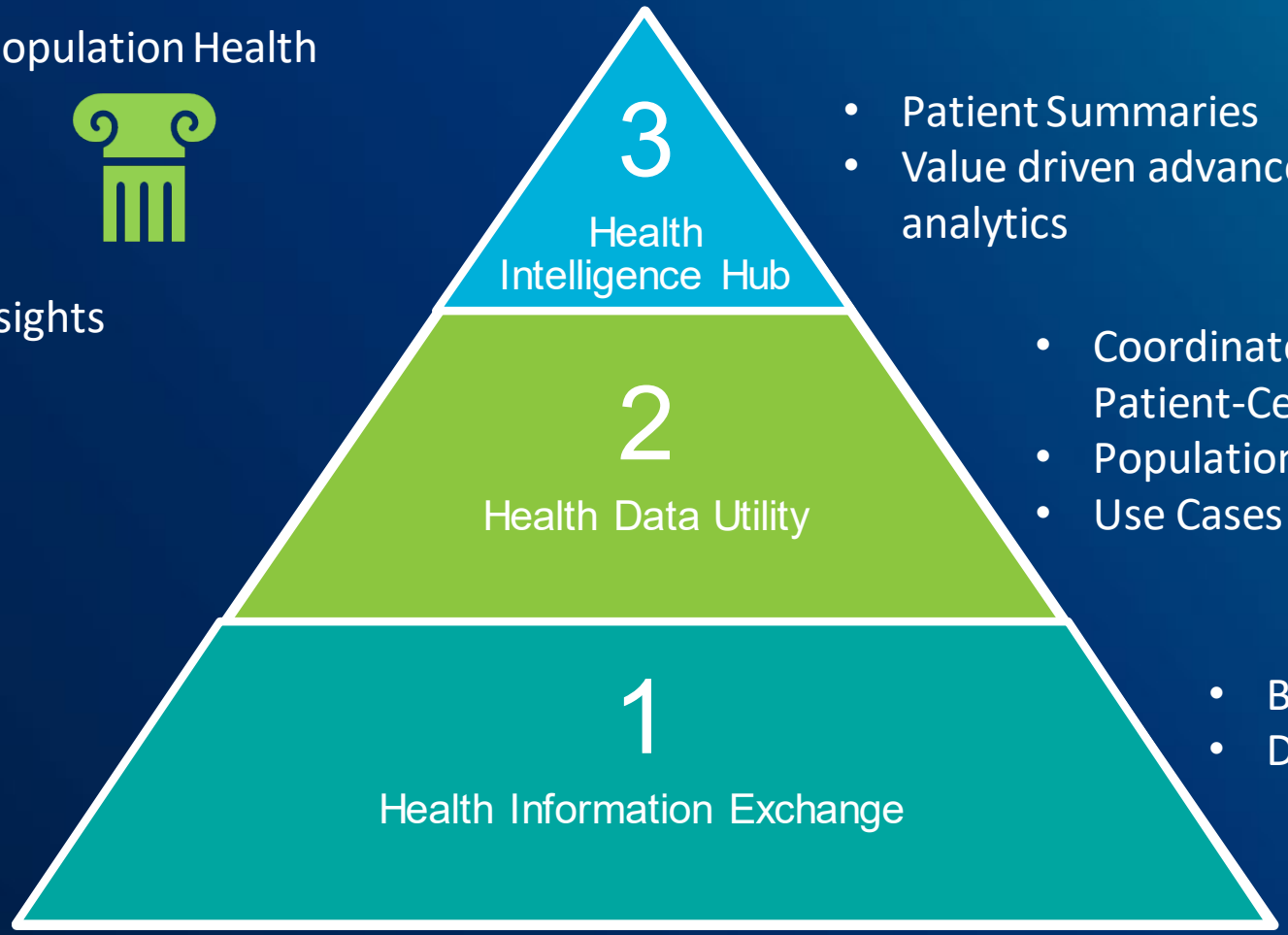
Send a standard data set to Participant in a patient centric model of healthcare and wellness.

OUR JOURNEY

Point of Care

Population Health

Community Insights



- Patient Summaries
- Value driven advanced analytics

- Coordinate Whole Person Care with a Patient-Centric Approach
- Population Health Analytics
- Use Cases Growth beyond Data Sharing

- Better Health thru Better Data
- Data Quality & Exchange

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WHAT COULD SYNCRONYS DO?

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Assistance with Medicaid utilization and outcomes data

UTILIZATION

- Number of Medicaid Patients
- Per member per month cost
- Stratification by provider type and MCO
- Data ranking for most prevalent ICD10 BH Codes
- Expenditure trends

OUTCOMES

- Outcomes and Quality Metrics
- Maternal Health

ACCESS & ADEQUACY

- Up-to-date Provider Directory
- Research to determine non-BH providers prescribing BH meds to fill in gaps

WHAT COULD SYNCRONYS DO?

SYNCRONYS could support Medicaid Utilization and Outcomes Reporting for the Period FY17 to FY25

- 8 years - Medicaid claims,
- 9 years of physical health records from DSO,
- 2 years BH, and
- 1 years Skilled Nursing Facility data)

UTILIZATION DATA

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Sample Cost and Spending Reports - Using Medicaid Claims

- **Number of Medicaid Patients Served (Enrollment data)**
  - FFS Expenditures
  - Per member per month costs
- **Expenditure trends: (BH, Long Term support services)**
  - 20 most used BH codes by Medicaid Patients
  - Developmental Disabilities Support Division (DDSD)
    - Expected cost per client and actual cost per client (Mi Via Waivers)
    - Wellness visits for DD and waiver participants (Abuse/Neglect - ANE rate)

DO INCREASES IN UTILIZATION CORRELATE TO BETTER OUTCOMES?

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Comparative Reports matching Medicaid Claims with Clinical Metrics

- Physical Health x 1,000 members
- BH x 1,000 members
- Telemedicine Visits
- ER visits for non-emergency needs
- Count of members by type of BH service received (Timely data)
- Outcome measures for BH (NMBHPA and CCBHC measures, Timely data)
- Physical Health utilization % change in utilization and cost per unit (Inpatient - admissions, days-, Physician services, ED visits, Outpatient visits, Pharmacy scripts)

SOLUTIONS FOR POLICY MAKERS

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Health Equity Map

Population Health Analytics Dashboards (Aggregate Level)

Aggregated, Custom Extracts and Reporting

Clinical Documents
Showing All Mark All As Read
Group By Category Sort By Date

- Patient Summary
- Bulk Print Results
- Medication Claim History
- PDMP Report URL
- Advance Directives / MOST
- Dynamic Documents (1)
  - Patient Snapshot
- Hep C Summary (1)
  - Hep C Summary
- **Laboratory** (**12** / 22)
  - **Chemistry** (**9** / 19)
  - **Hematology** (**2** / 2)
  - **Immunology** (**1** / 1)
- **Radiology** (**26** / 27)
  - **CAT Scan** (**6** / 6)
  - **Intervention** (**3** / 3)
  - **MRI** (**4** / 4)
  - **Radiology** (**2** / 2)
  - **Radiology Ultrasound** (**6** / 6)
  - **XRAY** (**5** / 6)
- **Transcribed Documents** (**1** / 2)
  - **Insights** (**1** / 2)

Demographics

Other Identifiers
998877 (Collective Medical)
83458-3454 (Christus St Vincent Regional Med Ctr)
76239 (Miners Colfax Medical Center)
76240 (Miners Colfax Medical Center)

Emergency Contact	
Name	ARCHIE, ELLEN
Phone	5554455084 (Home)

Demographics	
Address	6599 Jaguar Drive, Santa Fe, NM, 87507, (Home)
Phone	5059552828 (Mobile)
Phone	+1(505) 9552828 (Home)

Allergies

Details	Reactions	Overall Severity	Onset Time	Type	Source
Allergy to Peanuts	Anaphylaxis	Severe	On Date 15-Jan-2012	Food	Christus St Vincent Regional Med Ctr
No Known Allergies	UNKNOWN	UNKNOWN		Miscellaneous	Miners Colfax Medical Center
NEOMYCIN/POLYMYXIN/DEXAME 0.1 % Suspension	redness/puffiness	UNKNOWN		Miscellaneous	Miners Colfax Medical Center

Encounter History

	Admission	Discharge	Admit Reason	Discharge Diagnosis	Visit Type	Specialty	Facility	Clinician	Attenders
	Jan-10-2021	Jan-10-2021	LEFT SIDE PAIN	Calculus of ureter	Emergent		Miners Colfax Medical Center		RENEE KING
	Apr-20-2020	Apr-20-2020	L		Outpatient		Miners Colfax Medical Center		CHRISTINE LOPEZ MD
	Apr-11-2008	Apr-16-2008			Inpatient	Medical Service	Red Regional Hospital	Dr Joe MARTIN	Joe Martin
	Apr-11-2008	Apr-14-2008	Nausea (finding)	Hepatitis A - current infection (finding) (1 of 2 diagnoses)	Inpatient	Medical Service	Red Regional Hospital	Dr Joe MARTIN	Joe Martin
	Apr-11-2008	Apr-11-2008	Low Back Pain		Inpatient	Medical Service	Red Regional Hospital	Dr Joe MARTIN	Joe Martin

Clinical Documents
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Problems

Problem	Type	Treating Provider	Status	Onset Time	Resolution	Severity
Pain, not elsewhere classified	Pain, not elsewhere classified	901	Active	Since Date 14-Sep-2020		
Congestive Heart Failure	I50.2	DMoore	Active	Since Date 31-Aug-2020		
Hyperlipidemia	Hyperlipidemia	Francis MCNAMARA	Active	Since Date 10-Feb-2020		
Obesity	Obesity	Francis MCNAMARA	Active	Since Date 10-Aug-2018		
Metobolic Syndrome	Metobolic Syndrome	Francis MCNAMARA	Active	Since Date 25-Feb-2016		

Procedures

Procedure Code	Description	Procedure Date	Provider	Source
36415	Routine venipuncture	Jan-09-2021		MCMC_CLIN_NM
74176	Ct abd	Jan-09-2021		MCMC_CLIN_NM
80053	Comprehen metabolic panel	Jan-09-2021		MCMC_CLIN_NM
81003	Urinalysis auto w/o scope	Jan-09-2021		MCMC_CLIN_NM
30410	Complete primary rhinoplasty of external nose	Sep-28-2013		CSV_HOSP_NM
86703	Combined assay for Human immunodeficiency virus 1 (HIV-1) antibody and Human immunodeficiency virus 2 (HIV-2) antibody	Oct-11-2010		CSV_HOSP_NM
81200	Aspartoacylase (ASPA) gene analysis for detection of common variant	Feb-19-1985		CSV_HOSP_NM

INSIGHT DOCUMENTS

Standard EDIE criteria:

- 3+ ED Locations in 90 days
- 5+ ED Visits in 12 Months
- Care Insights
- COVID Pending and Positive Lab Results
- Security and Safety Event
- History of Sepsis (12 mo.)

Substance Use Disorder Management criteria (Hospital MAT Clinic):

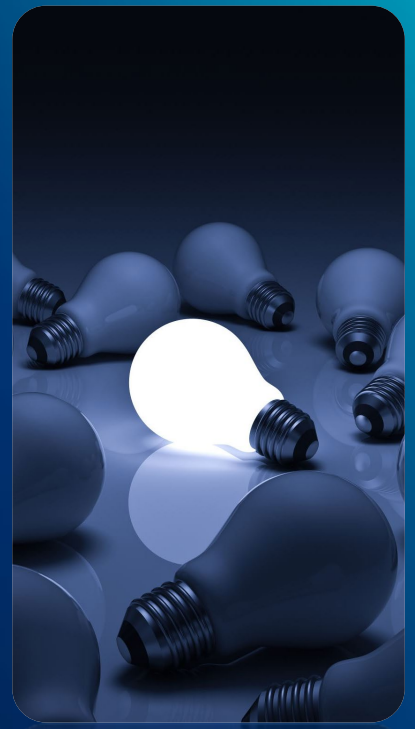
- ED Visits – Alcohol Use Disorder
- ED Visits – Opioid Overdose
- ED Visits – Opioid Use Disorder
- ED Visits – Substance Use Disorder
- History of Alcohol Use Disorder (12 mo.)
- History of Opioid Use Disorder (12 mo.)
- History of Opioid Overdose (12 mo.)
- History of SUD (12 mo.)

Emergency Dept. Optimization criteria:

- Anticoagulant Medication Filled (3 mo.)
- History of Housing Insecurity (6 mo.)
- History of MDRO (6 mo.)
- Recent Imaging – CT/MRI (3 mo.)

Collaboration and Coordination of Mental Health criteria:

- ED Visits – Mental Health Dx
- ED Visits – Suicide Ideation or Self-Harm
- History of Mental Health Dx (12 mo.)
- History of Suicide Ideation or Self-Harm (12 mo.)



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INSIGHT DOCUMENTS

SNF Stay Summary

- Has a SNF discharge in the past 7 days, OR
- Had a SNF admission in the last 60 days with no SNF discharge

Readmission

- ED Visit with Inpatient Admission in last 30 days at any facility
- ED Visit with SNF Admission in last 30 days

SDOH

- Recent Housing Insecurity
- Other SDOH (future development)

Patient Return from SNF

Visit Summary

Admit Date & Time	Facility Name	Diagnosis
10/19/2023 11:02 AM	Madeline's Skilled Nursing	• Congestive Heart Failure • Bilateral primary osteoarthritis of hip • Essential (primary) hypertension

Facility & Practitioner

Attending Physician	Phone	Facility
Gregory Taylor M.D.	(571) 248-6100	Madeline's Skilled Nursing 7501 Heritage Village Plz, Gainesville, VA, 20155-3078

Medications

Last administered date for each medication within the last 14 days

Medication Name	Dosage	Dose Per Unit	Administration Date *in the last 14 days*
acetylcysteine inh/oral (MucOMYST) 20 % solution 2 mL	2 ml inhale orally two times a day for respiratory	NULL	10/19/2023 11:32 AM
atorvastatin (LIPITOR) 20 MG tablet	Give 1 tablet by mouth at bedtime for Hyperlipidemia	20 MG	10/19/2023 11:32 AM
ipratropium-albuterol (DUO-NEB) 0.5 mg-3 mg(2.5 mg base)/3 mL INH NEBU	1 vial inhale orally every 6 hours for SOB/Congestion	NULL	10/19/2023 11:32 AM
levothyroxine (SYNTHROID) 75 mcg PO TABS	Give 1 tablet by mouth one time a day for hypothyroidism related to HYPOTHYROIDISM, UNSPECIFIED (E03.9)	75 MCG	10/19/2023 11:32 AM
QUEtiapine (SEROQUEL) 25 MG tablet	Give 1 tablet orally at bedtime related to DEMENTIA IN OTHER DISEASES CLASSIFIED ELSEWHERE WITH BEHAVIORAL DISTURBANCE (F02.81)	25 MG	10/19/2023 11:32 AM

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POPULATION HEALTH DASHBOARDS

Risk Models can help identify:

- Members expected to have high cost and utilization (ED/IP) who may benefit from care management.
- Members at increased risk for specific chronic conditions and events, enabling preventive interventions.
- Members at increased risk for inpatient readmission or ED revisit within 30 days to prioritize transitions of care support.
- Groups of patients needing care management.
- Gaps in care to be addressed for individual patients to improve HEDIS measure scores.

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AI/ML - PREDICTIVE ANALYTICS FOR POPULATION RISK MANAGEMENT

SYNCRONYS

Population Risk Management | Transition Risk Management | Performance Report | NMBHPA Quality Measures | Filters

< Back **Individual Profile**

[redacted] (Male)

MPI: [redacted]

Status: Discharged

Date Of Birth: [redacted] (Age 43)

PCP: N/A

Payer: Blue C

Address: Hobbs

FUTURE RISK

BH Key Metrics

Patient is eligible for th

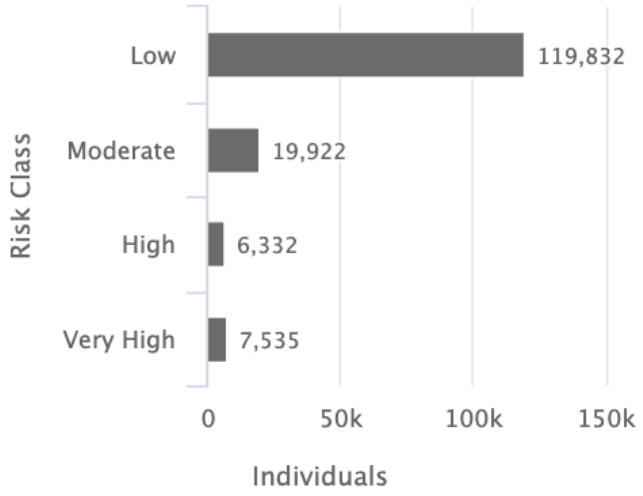
Measure Year CUR

Patient Based Meas

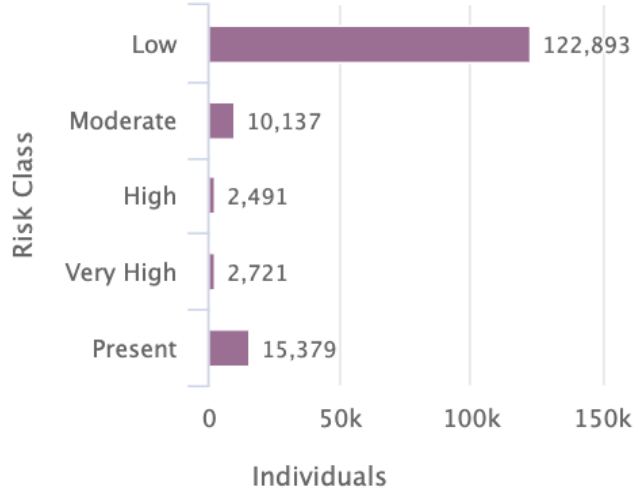
Last 12 Months Statistics

IP ADMISSIONS	ED VISITS	OUTPATIENT VISITS	MEDICAL COSTS
0	0	1	$278

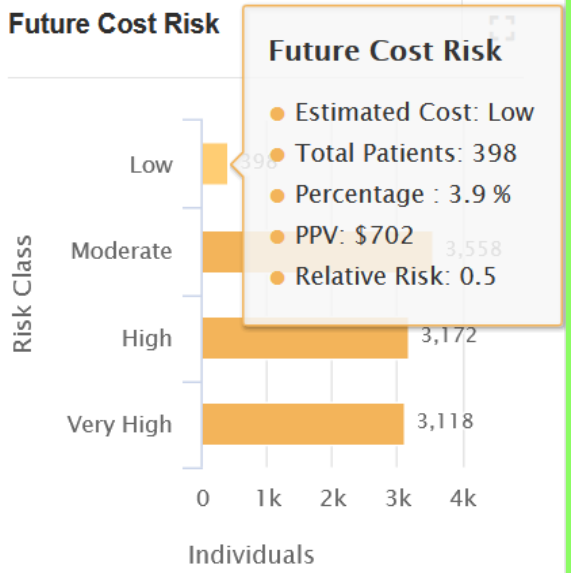
Inpatient Admission Risk



Diabetes Risk



Future Cost Risk



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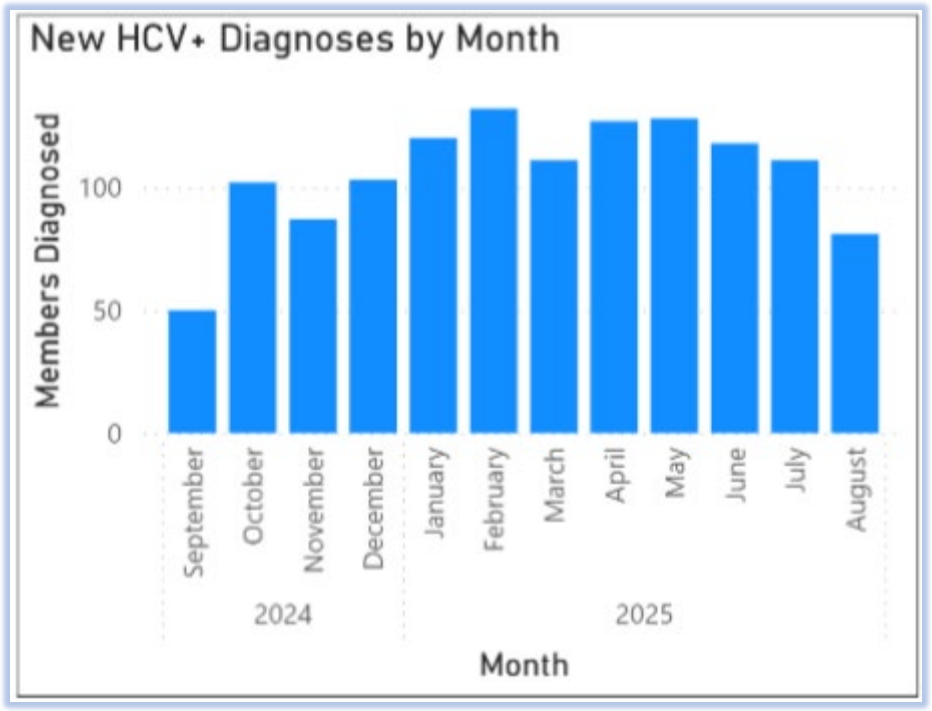
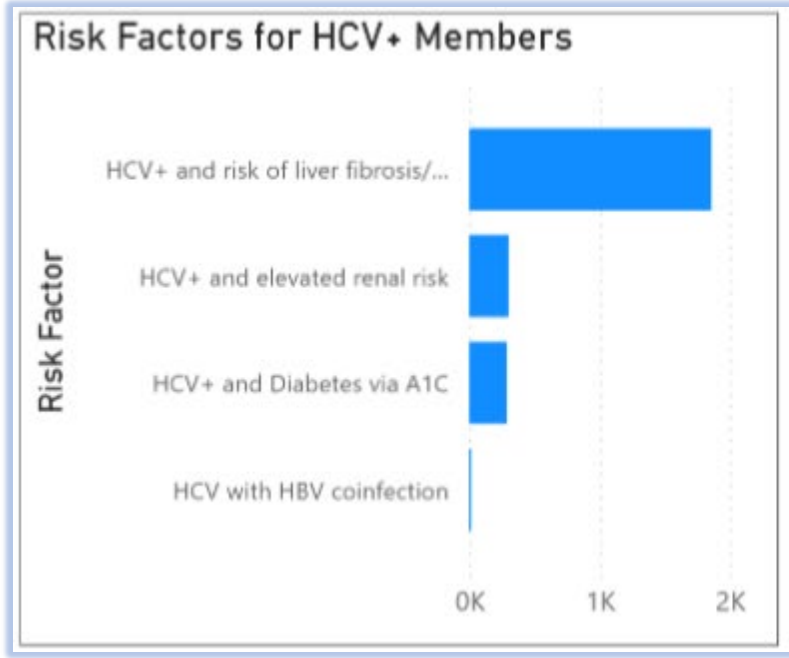


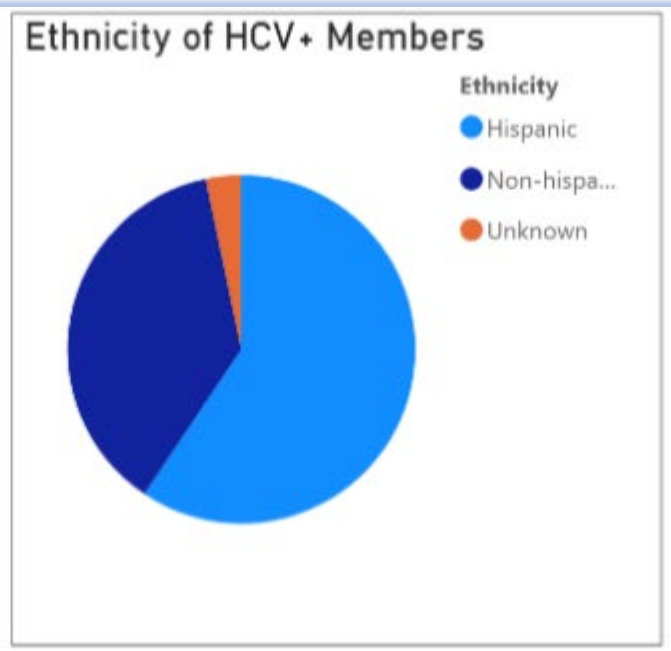
Hepatitis C Diagnoses

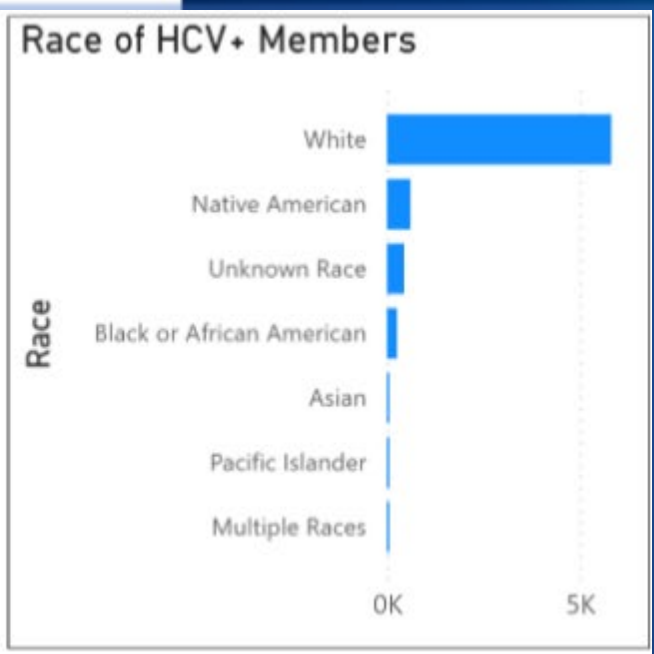
+ Risk Factors

+ Ethnicity

+ Race





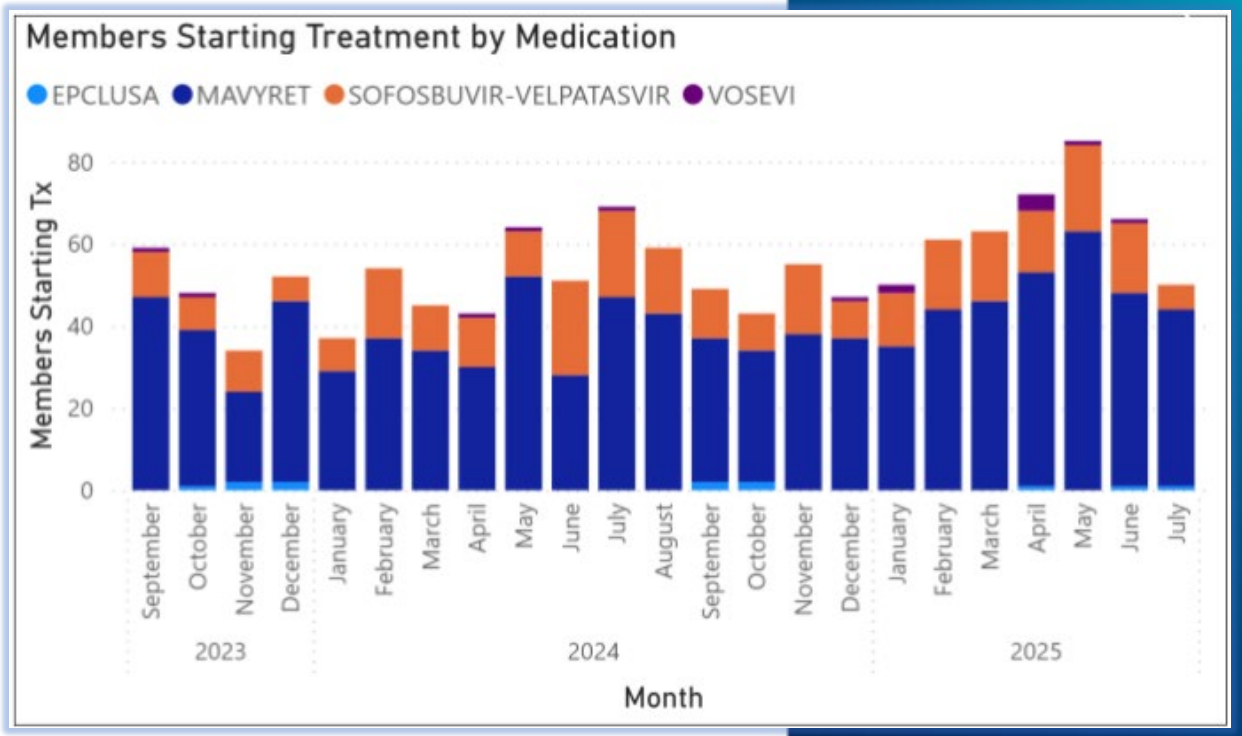


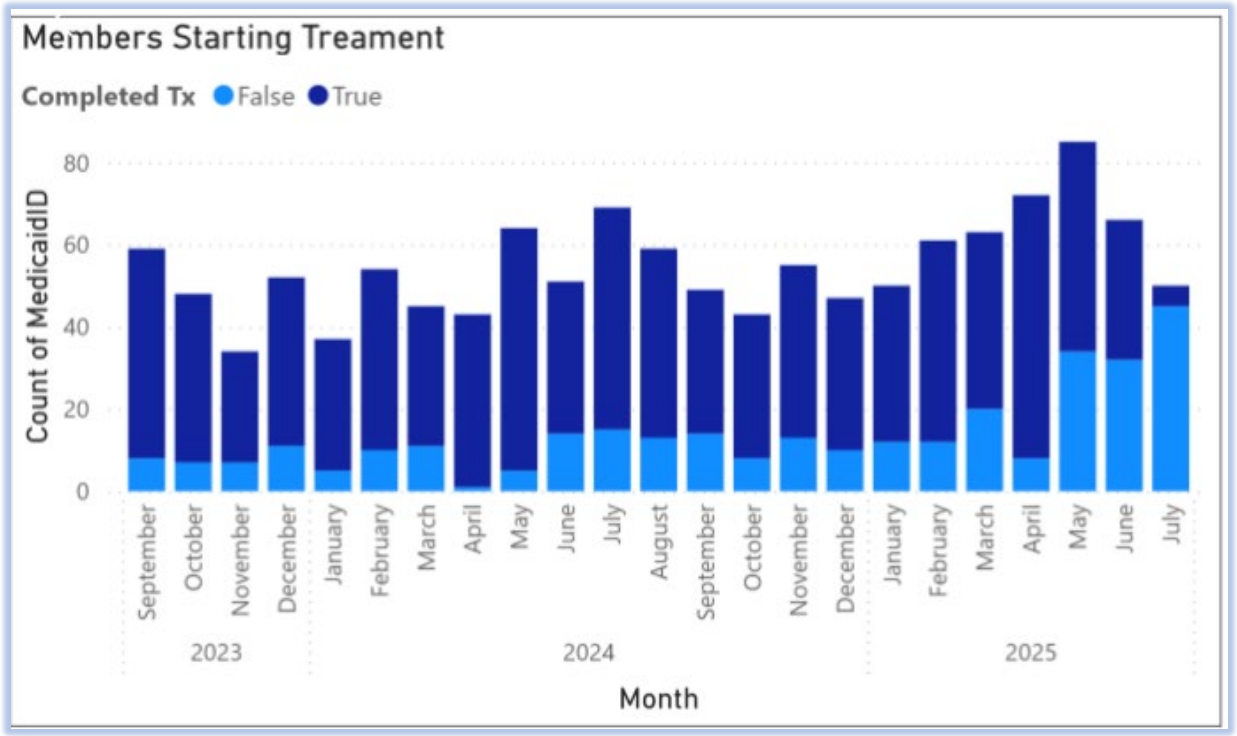
Hepatitis C Treatment

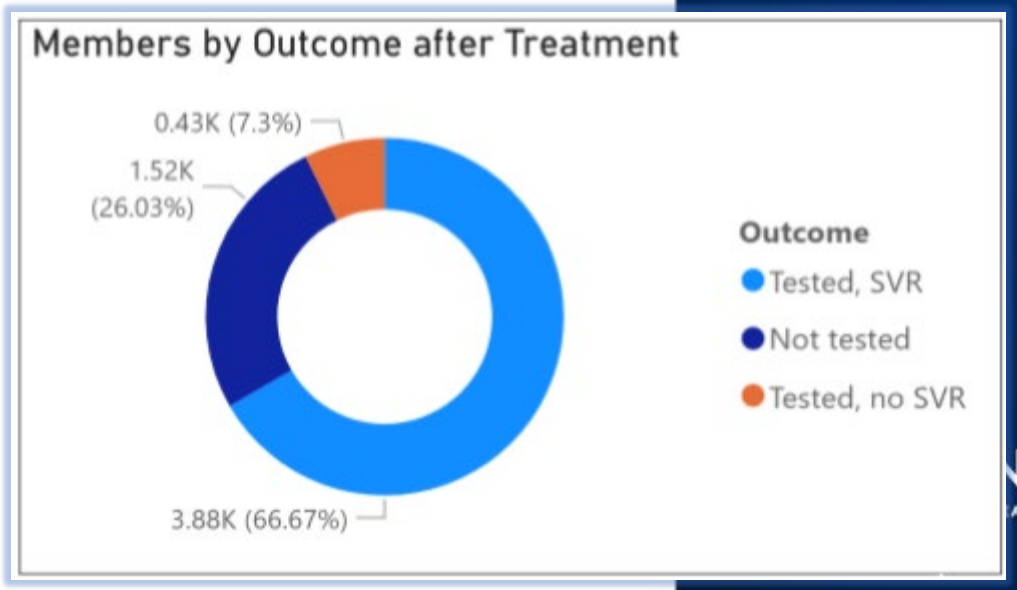
+ Drug

+ Completion

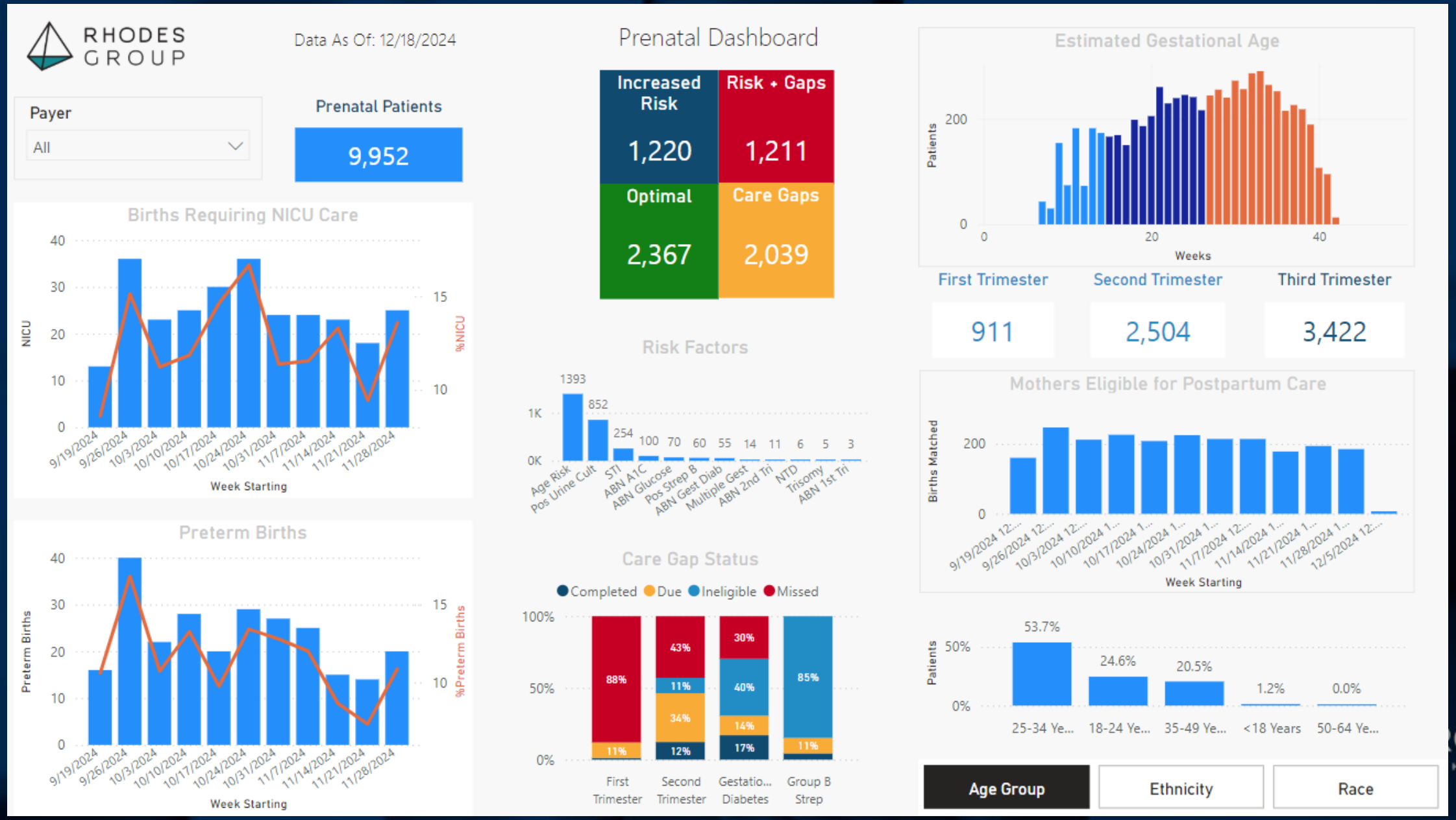
+ SVR







Prenatal Dashboard



Prenatal Dashboard

HEALTH EQUITY MAP

Supporting health equity and targeted interventions by using geo-spatial mapping technology

- Healthcare Professionals
- Policy Makers
- Community Organizations

Who?

- Leverages advanced geospatial technology to visualize complex healthcare data across different demographic categories and regions.

How?

- Enables users to derive actionable insights through the extensive analysis of trends, hotspots, and disparities.

Why?

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WHERE DOES THE DATA COME FROM?

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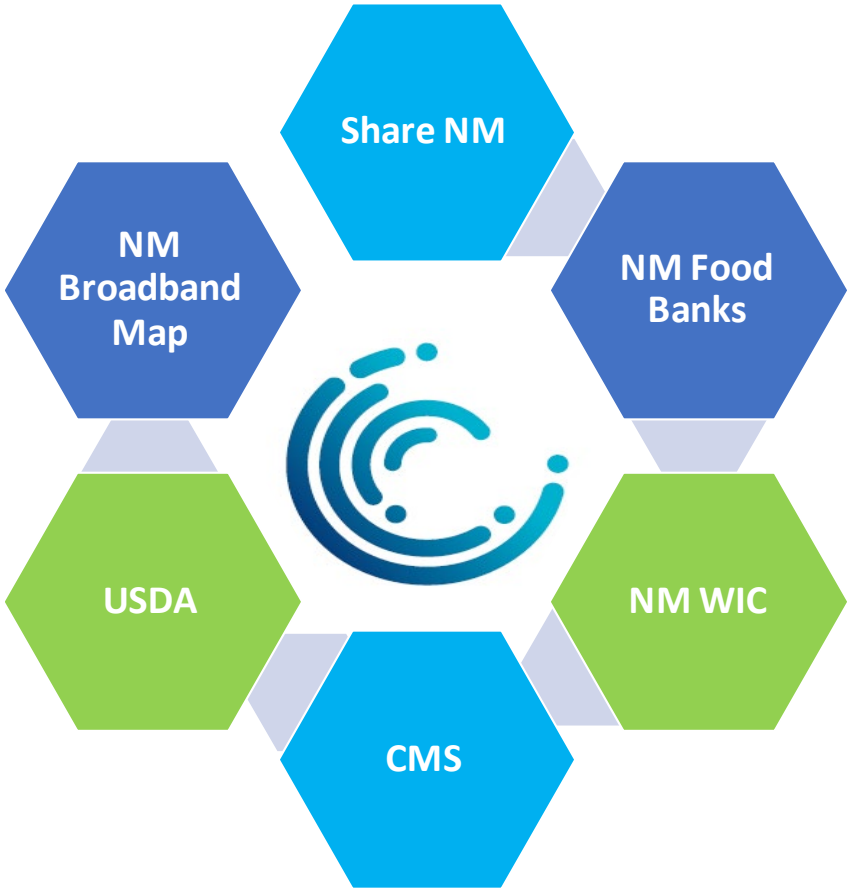

157 DATA SETS ACROSS 10 CATEGORIES

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- Community Characteristics
- Digital Access
- Environmental Risk
- Health Indicators
- Food Insecurity
- Housing Insecurity
- Transportation Insecurity
- Safety
- Social Vulnerability Index
- Vizient Vulnerability Index

FILTERS

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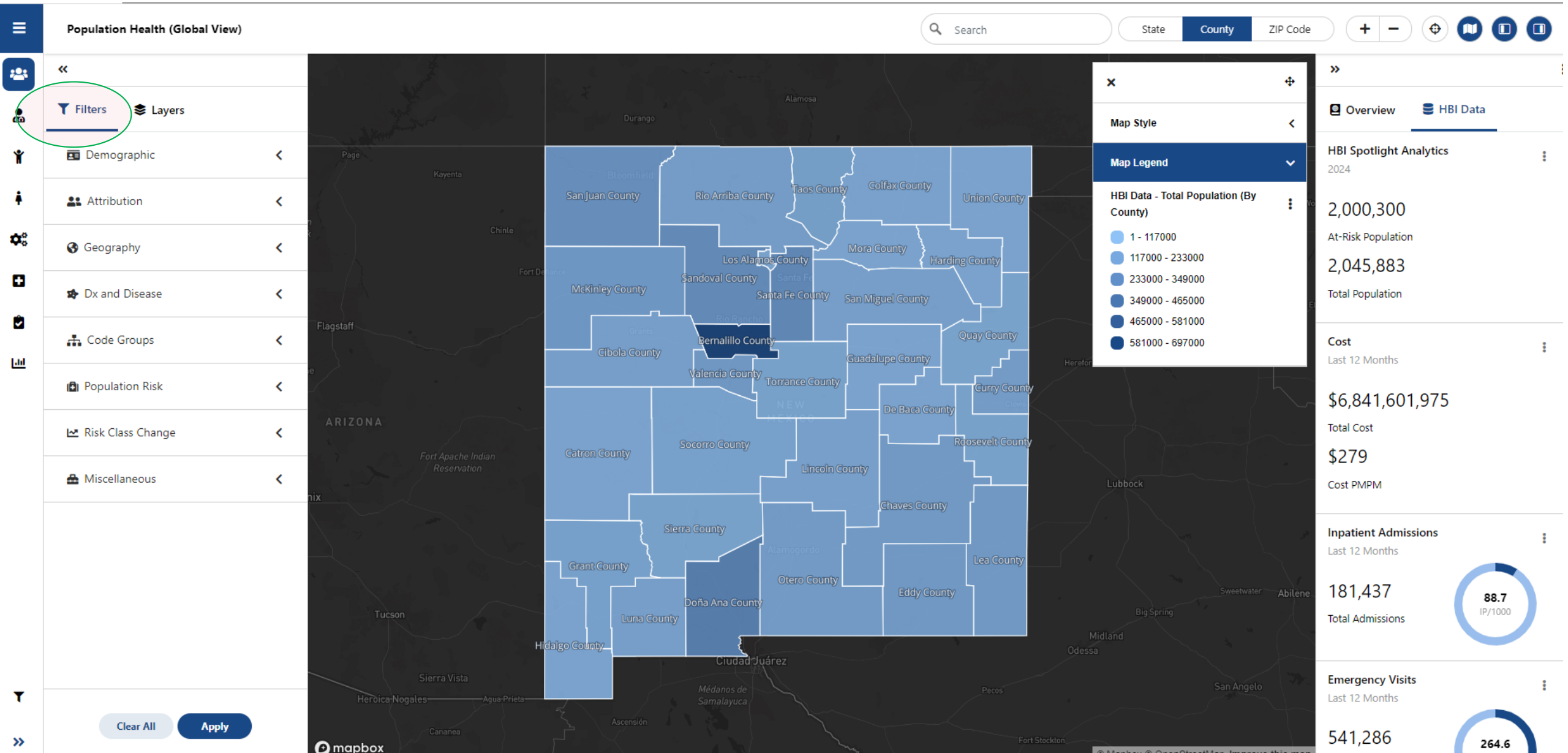

LAYERS

SYNCRONYS
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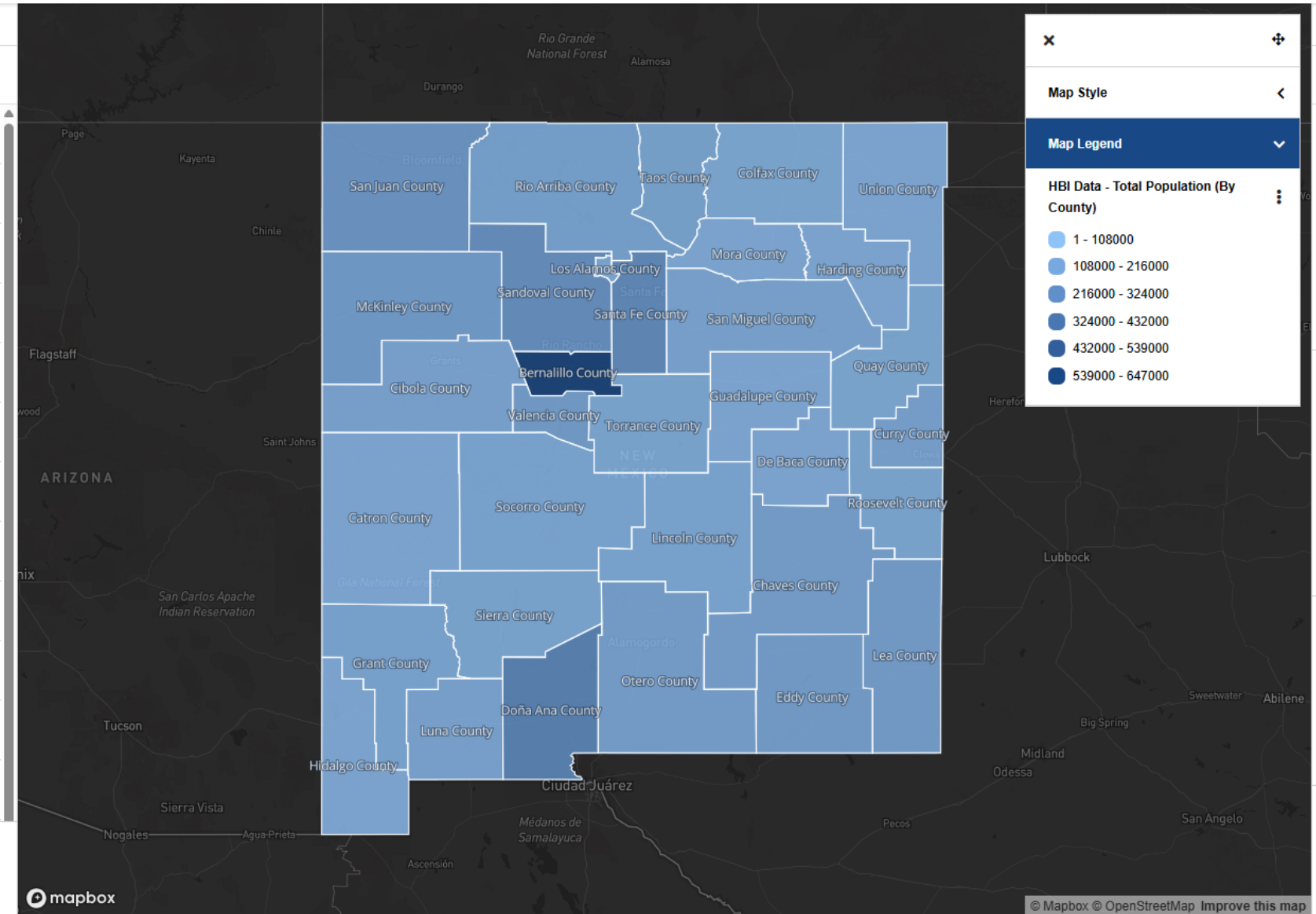
Population Health (Global View)

Search | State | County | ZIP Code

Filters | Layers

- Access to Services
- Community Characteristics
- Digital Access
- Environmental Risks
- Geography
- Health Indicators
- Insecurities: Food
- Insecurities: Housing
- Insecurities: Transportation
- Safety: Community & Personal
- Social Vulnerability Indices
- Vizient Vulnerability Indices

Clear All Layers



Map Style

Map Legend

HBI Data - Total Population (By County)

- 1 - 108000
- 108000 - 216000
- 216000 - 324000
- 324000 - 432000
- 432000 - 539000
- 539000 - 647000

Overview | HBI Data

HBI Spotlight Analytics
Data Refreshed: 2025-10-19

1,833,646
At-Risk Population

1,873,225
Total Population

Cost
Last 12 Months

$6,476,963,802
Total Cost

$288
Cost PMPM

Inpatient Admissions
Last 12 Months

185,452
Total Admissions

99.0
IP/1000

Emergency Visits
Last 12 Months

589,484

314.7

FILTERS WITH LAYERS INTEGRATION

SYNCRONYS
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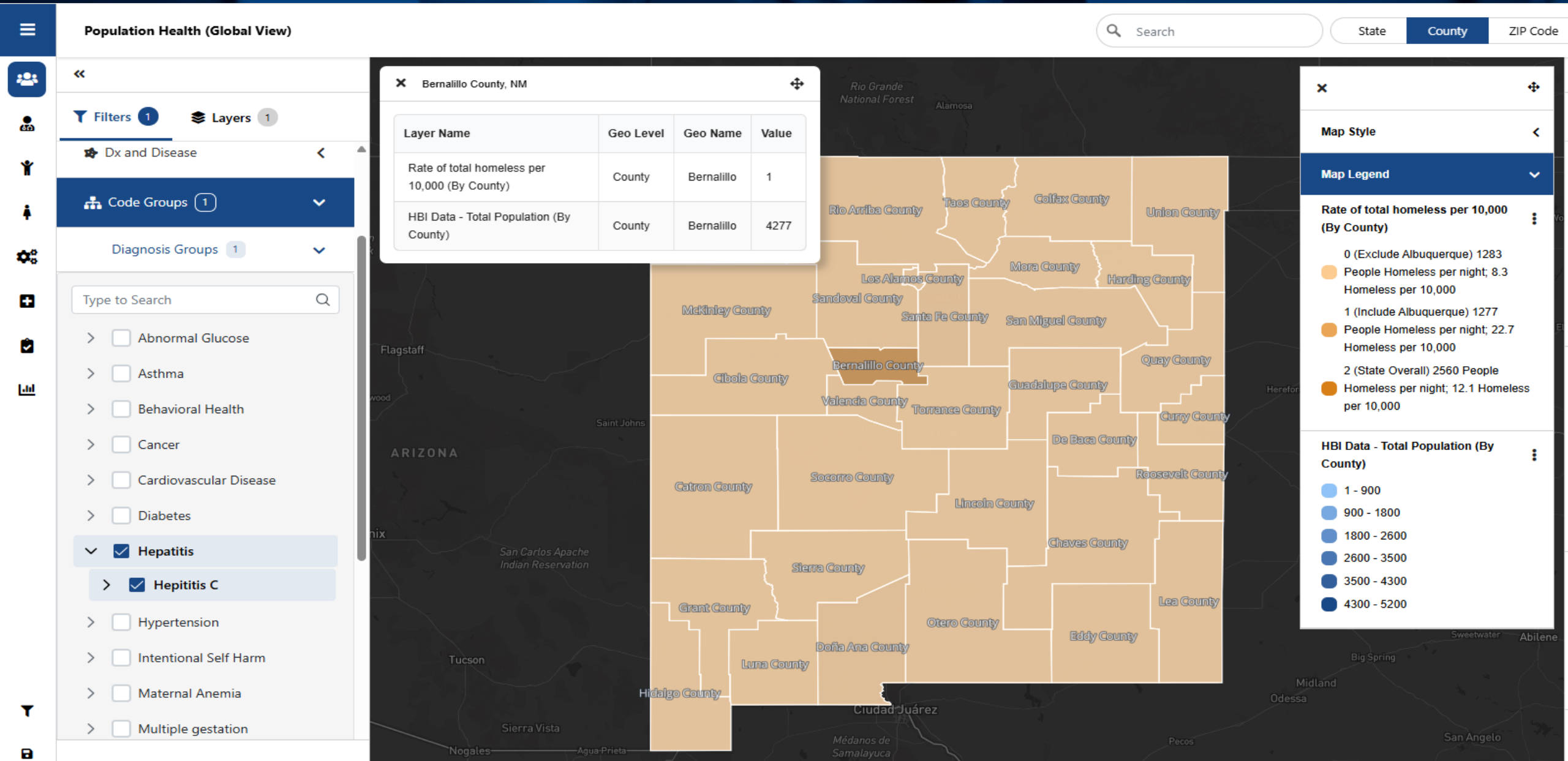
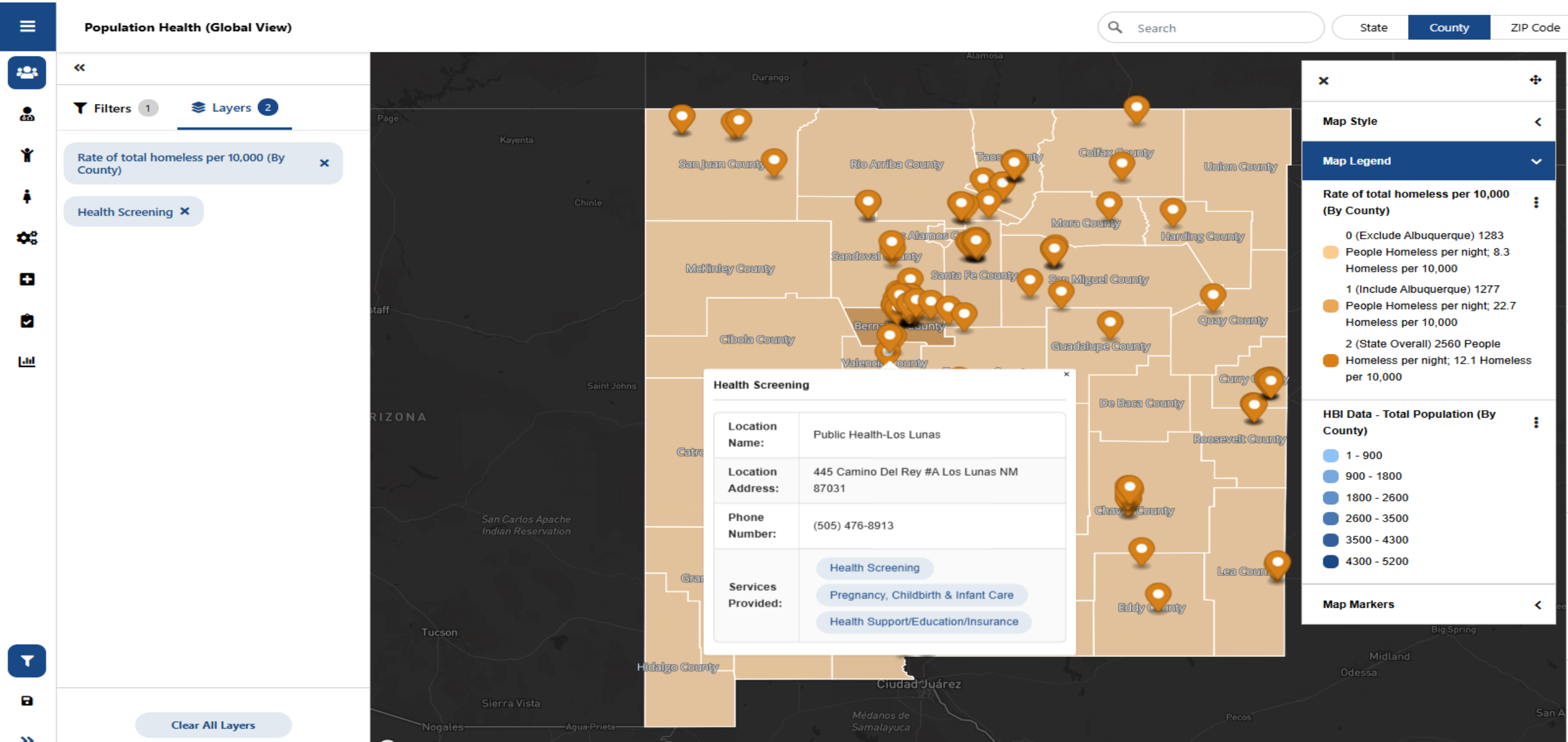


ACCESS TO SERVICES INTEGRATION

SYNCRONYS
BETTER DATA. BETTER HEALTH.



HEM ANALYTICS

Cost
Last 12 Months

$6,476,963,802

Total Cost

$288

Cost PMPM

Inpatient Admissions
Last 12 Months

185,452

Total Admissions

99.0
IP/1000

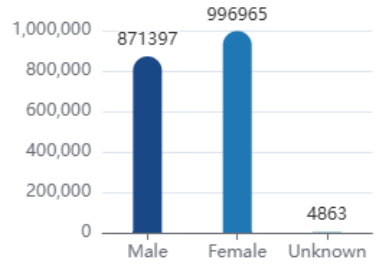
1,833,646

At-Risk Population

1,873,225

Total Population

Gender Distribution



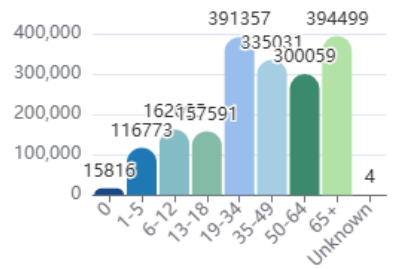
Emergency Visits
Last 12 Months

589,484

Total Visits

314.7
ED/1000

Age Group Distribution



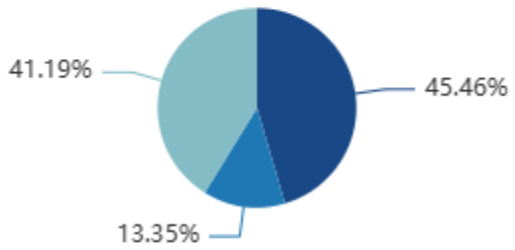
Mortality
Last 12 Months

12,343

Mortality

6.6
#/1000

Chronic Condition Distribution



No Chronic
Single Chronic Condition
Multiple Chronic Conditions

Chronic Disease
Top 10

Disease: I10 Essential (primary) hypertension

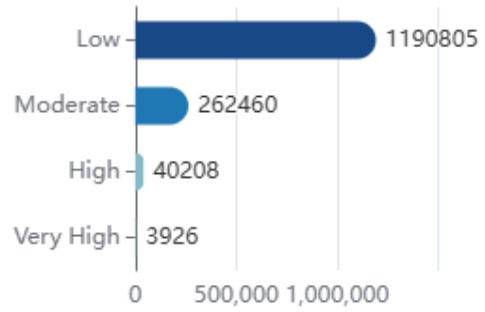
275,226

Total Patients

14.69%
Prevalence

Risk Class Distribution

Model: Hypertension Risk



Risk Class Distribution

Model: Future Cost Risk

Future Cost Risk
Emergency Visit Risk
Inpatient Admission Risk
Acute Myocardial Infarction Risk
Congestive Heart Failure Risk
Chronic Kidney Disease Risk

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HOW THE COMMITTEE CAN SUPPORT THE HIE

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- NMSIIS – Immunization Records Available for providers in the HIE
  - Potential amendment
- Funding for financial barriers to share data
  - Potential funding in the CMS Rural Health Transformation Program Application
- Data sharing mandates

- Establish a Health Data Utility in NM

FUNDING

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- $4M a year to pay for SYNCRONYS subscription for Medicaid providers and hospitals.
- State funds to pay the one-time connection charged by the facilities electronic medical record vendor to the HIE.
- Sustainability Options:
  - State payment for one-time connection and then first 2-3 years of HIE subscription, then have facilities pay annual subscription.
  - State could continue to cover rural ambulatory providers, FQHCs and critical access hospitals.

MANDATES

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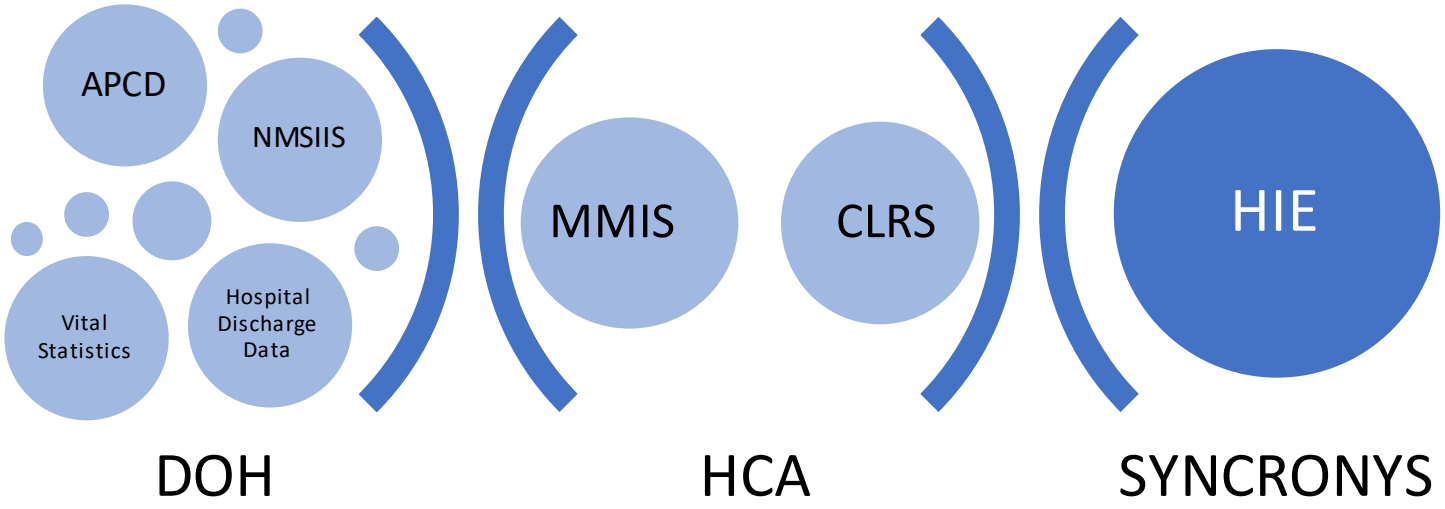
- California passed the Data Exchange Framework Enforcement (SB660) reinforces accountability and participation in the CA DxF.
- Nebraska mandates all medications and immunizations dispensed in their state to be reported to their HIE.
- Maryland mandates that hospitals connect to the state designated HIE.
- Arizona includes HIE participation in their Medicaid managed care contracts and requires MCOs to ensure high-volume providers connect to the state's HIE.

STATE HEALTH DATA UTILITY

NM Health Information is siloed. Examples:



- At State and National level, the need to incorporate social needs, BH, Public Health data with the Medical Health data in the HIE has been identified to appropriately **manage health for the whole person** as well as the overall health for the community

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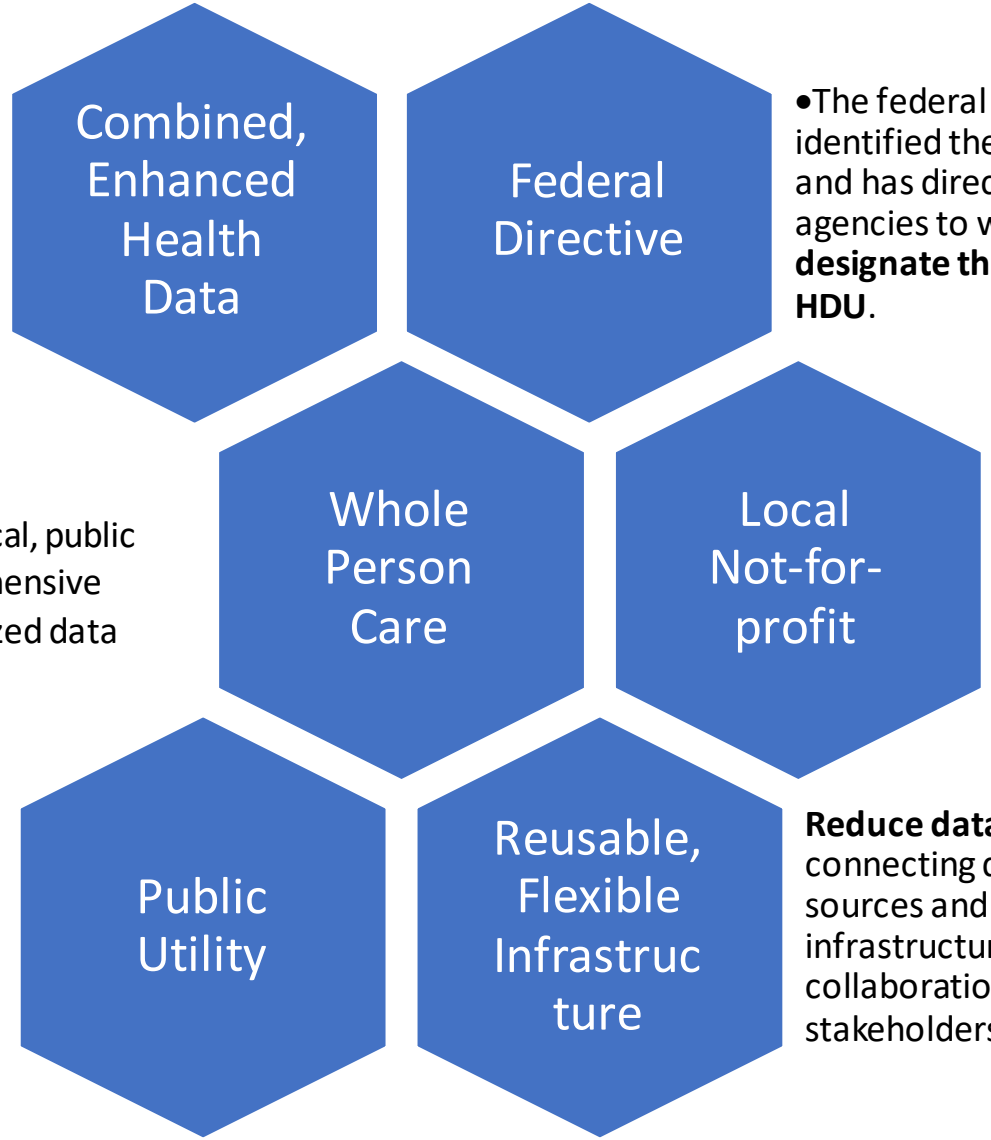
WHY AN HDU?

HDUs combine, enhance, and exchange electronic health data for treatment and care coordination, delivering quality improvement, population health insights, public health, emergencies, and other public and community health and social support needs.

HDUs incorporate social data alongside clinical, public health, and claims data, providing a comprehensive view of both individual health and a centralized data source for community needs and programs.

HDU authority is designated by the state and designed in alignment with each States priorities, policies and programs to address the needs of New Mexicans.



- The federal government has identified the need for HDUs and has directed federal agencies to work with **States to designate their HIE to be the HDU**.

Reduce data silos by connecting disparate data sources and reusing infrastructure that fosters collaboration across all stakeholders.

HDUs are **local not-for-profit entities with advanced technical capabilities**, multi-stakeholder shared governance, and local leadership, which will use the HIE infrastructure **funded by state and federal funding**

SYNCRONYS
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SANTA FE NEW MEXICAN

MY VIEW KRISTY RINIKER AND JOANNA TOEWS

Synchronized medical records help patients, doctors

By Kristy Riniker and Joanna Toews Feb 23, 2025 Updated Feb 24, 2025 0

In New Mexico, we have a designated health information exchange that does just that. Syncronys is a nonprofit organization powered by Orion Health that compiles results of labs, imaging, diagnostic tests and clinical notes from participating health care organizations and organizes them in a HIPAA-compliant searchable database.

Is it perfect? No. Many health care organizations do not participate, and sometimes the data is cumbersome to find. But it is better than waiting days or weeks for records to be sent or logging into six different portals or repeating tests because you don't have results.

Dr. Kristy Riniker is associate medical director at Optum NM and sees patients in Rio Rancho. Dr. Joanna Toews is an internal medicine physician and sees patients in Santa Fe.

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QUESTIONS

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