Legislative Health and Human Services Committee
August 22, 2018
Presenter Bios

Welcome to Presbyterian

Dale Maxwell
President and
Chief Executive Officer
Presbyterian Healthcare Services

Dale Maxwell has been president and chief executive officer of Presbyterian since 2017. He first joined the organization in 2000 and has held a variety of senior leadership positions with the integrated healthcare system. As executive vice president and chief administrative officer, he oversaw all financial aspects of the organization, as well as information technology, data and analytics, and market development and expansion.

Mr. Maxwell serves on the Boards of Directors for the Greater Albuquerque Chamber of Commerce and United Way of Central New Mexico. He is also a member of the Albuquerque Economic Forum. He previously served on the Boards of Directors at Haven House, a domestic violence shelter in Sandoval County, the New Mexico Association of Commerce and Industry, and the Albuquerque Downtown Action Team.

Mr. Maxwell earned a Master's in Healthcare Administration from Seton Hall University in New Jersey and a bachelor of accountancy degree from New Mexico State University in Las Cruces.

Angela Ward, RN
Chief Hospital Executive
Presbyterian Rust Medical Center

With more than 20 years of leadership experience, Angela Ward entered healthcare as a second career in 2004 as a registered nurse. In 2010, she joined Presbyterian Rust Medical Center as chief nurse executive and became chief hospital executive at Rust in 2015.

Ms. Ward is chair of the Board of Directors and the Executive Committee for the Sandoval Economic Alliance and co-chair of the Board of Directors for the Sandoval Health Collaborative. She is on the New Mexico Healthcare Association's Quality Committee, a graduate of Leadership Sandoval County and a member of the American College of Healthcare Executives. Ms. Ward received Central New Mexico Community College's Distinguished Alumni Award in 2016 and was named a top 30 Women of Influence in 2016 by Albuquerque Business First. She has bachelor's and master's degrees in nursing from Chamberlain College of Nursing.

Value-Based Programs: Partnerships and Successes

Jordan Erp
Senior Vice President and
Chief Integration Officer
Presbyterian Health Plan

Jordan Erp leads Presbyterian Health Plan's strategy for improving healthcare quality, outcomes and financial efficiency via strengthening partnerships with internal and external healthcare providers. He creates and leads the organization's vision and objectives in integrated healthcare financing and delivery, value-based purchasing and medical cost management. Mr. Erp has been at Presbyterian for four years, and prior to his current role served as chief actuary.

Before joining Presbyterian, Mr. Erp held actuarial roles in several regional and national managed care and health insurance organizations. He is a fellow of the Society of Actuaries, a member of the American Academy of Actuaries, a member of the Board of Directors for the New Mexico Medical Insurance Pool, and graduated from the University of Kentucky with bachelor's degrees in mathematics and mathematical economics.

Doug Smith
Executive Vice President
Presbyterian Medical Services

Doug Smith has served as executive vice president for Presbyterian Medical Services in Santa Fe, which is not affiliated with Presbyterian Healthcare Services, since 2000; he first joined the organization in 1995. In his current role, Mr. Smith provides operational oversight of the organization's more than 100 programs statewide, including approximately 55 Federally Qualified Health Centers (FQHC) Homecare and Hospice programs, Head Start/Early Head Start, Residential Treatment programs and other community-based collaborative projects.

Mr. Smith is involved with many community and professional organizations, and currently serves as a member of the Board of Directors of Leadership New Mexico and Presbyterian Health Plan as well as a member of the American College of Healthcare Executives.

Mr. Smith received a bachelor's of business administration in finance from New Mexico State University.

New Models of Care

Denise Gonzales, MD, MS, FCCM, FCCP
Medical Director,
Adult Medical Specialties
Presbyterian Medical Group

In addition to her leadership role at Presbyterian, Denise Gonzales, MD, works with patients with breathing disorders and those who need critical care. She joined Presbyterian in 2007.

Dr. Gonzales was raised along the U.S.-Mexico border in rural southern New Mexico and her experiences engendered a passion for improving the lives of others. Her mission to improve the health of all New Mexicans includes changing how we deliver care by using telemedicine in rural communities and focusing on population health.

She has bachelor's and master's degrees in biomedical engineering as well as a medical degree from the University of New Mexico. She completed her residency in internal medicine at the University of Texas Health Science Center, the joint National Institutes of Health and Johns Hopkins Pulmonary and Critical Care fellowship program.

Nancy Guinn, MD
Medical Director
Presbyterian Healthcare at Home

Nancy Guinn, MD, joined Presbyterian in 2010 and under her leadership the organization's home healthcare programs have grown and earned national recognition. Before joining Presbyterian, she worked as a primary care physician in a community health center and as a solo practitioner. She is one of the authors of the Medical Orders for Scope of Treatment (MOST) document and serves on the Advisory Committee for the MOST.

Dr. Guinn trained in family and community medicine at the University of New Mexico and completed her fellowship in palliative and hospice medicine at Stanford Medical Center.

Presbyterian Healthcare at Home has created innovative programs in home care, palliative care, hospice, and hospital at home. The program has received national attention for reducing readmissions, lowering costs and increasing patient satisfaction. In recognition of its efforts to expand palliative care in community settings, Presbyterian was named one of the nation's 11 Palliative Care Leadership Centers™ in 2015.

The Social Determinants of Health and Community Health

Jason Mitchell, MD
Chief Medical Officer
Presbyterian Healthcare Services

Jason Mitchell, MD, leads Presbyterian's team of 1,000 employed providers spanning 50 ambulatory clinics and eight hospital campuses in addition to medical staff operations and provider clinical quality. He oversees $600 million in fully capitated delivery system risk arrangements, delivery system care and case management, clinical informatics and enterprise population health services.

Dr. Mitchell focuses on redesigning clinical practice at the system level and is transforming the role of the physician executive to better serve clinicians and patients during a time of rapid healthcare change. He has been with Presbyterian since 2006 and continues to see patients as a family practice physician. He earned his medical degree and completed a residency in family medicine at the University of New Mexico and is board certified in family medicine and clinical informatics.

Leigh Caswell
Director of The Center for
Community Health at
Presbyterian Healthcare Services

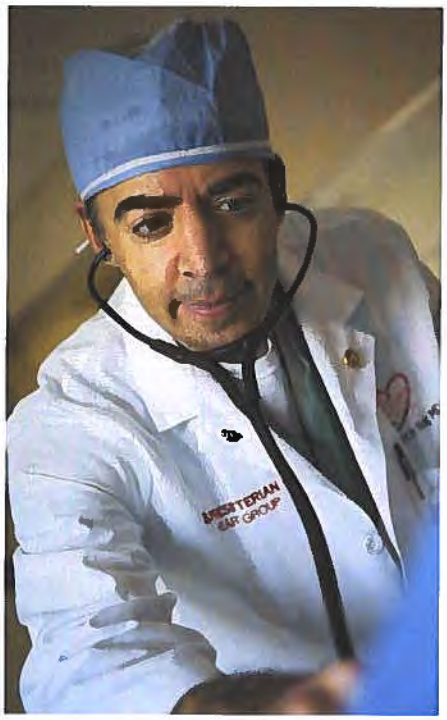
The Healthy Here Wellness Referral Center, Mobile Farmers' Market and FreshRX, which provides prescriptions for fresh produce to patients, are a few of the many initiatives Leigh Caswell has developed to promote prevention, increase health equity and enhance the quality and effectiveness of clinical interventions at Presbyterian. In May 2018, The Center for Community Health also launched a free weekly Food Pharmacy for specific patients in need and since 2016 has collaborated with federal and state agencies to provide free meals for children at five Presbyterian hospitals.

Ms. Caswell was named a Robert Wood Johnson Foundation Culture of Health Leader. She holds a bachelor's degree in environmental health from Colorado State University and a Master's of Public Health from the University of New Mexico.

PRESBYTERIAN IN THE NEWS

Tiny Pacemaker, Big Advantages

By Rosalie Rayburn
June 19, 2018



Dr. Lawrence Nair, director of electrophysiology at Presbyterian Heart and Vascular Care, reports positive results with 10 patients who have received Micra pacemakers.

Small size means device is easier to implant than predecessors

ALBUQUERQUE, N.M. — A new, minimally invasive surgery option is now available in New Mexico for patients who need a pacemaker to regulate an abnormally slow heartbeat.

Doctors with Presbyterian Healthcare Services have begun using the Micra, dubbed the "world's smallest pacemaker," using a technique that delivers the device directly into the patient's heart.

Each year, about 350,000 people in the U.S. receive a pacemaker to correct an irregular heart rhythm caused by the electrical impulses within the heart firing erratically. Patients may be as young as infants, if they are born with a heart problem. More often, older people need a pacemaker because of heart disease.

Pacemakers have been around for several decades; first as devices worn externally, then implanted in the chest with electrical wires leading from the heart to a generator.

But the leads can cause problems, said Dr. Lawrence Nair, director of electrophysiology at Presbyterian Heart and Vascular Care.

They can fracture or become a source of infection that can even harm the inner lining of the heart. Removing problematic leads involves a complicated surgery, he said.

A big advantage of the Medtronic Micra Transcatheter Pacing System is that it contains all the electronics needed to control a patient's heartbeat packed into a cylinder-shaped device about one-tenth the size of a traditional pacemaker. It was approved by the Food and Drug Administration in 2016.

"It's quite a big difference," Nair said.

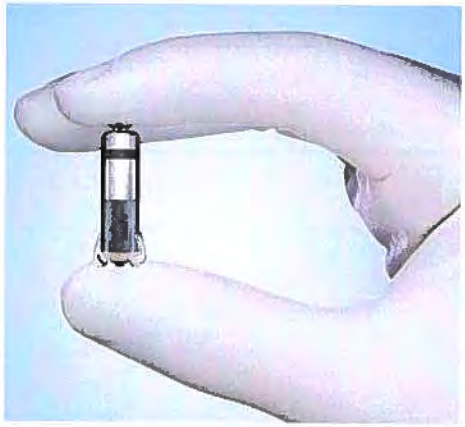
The Micra is most suitable for patients who are getting a pacemaker for the first time. It is approved for those with symptomatic bradycardia – an abnormally slow heartbeat – who experience symptoms such as dizziness, shortness of breath, fatigue and fainting spells. It will regulate beating of a single heart chamber. Patients who need a device to control more than one chamber will still need a traditional type pacemaker, Nair said.

Surgery to implant the Micra involves a small incision in the groin area through which doctors insert a catheter and guide it to the heart. The Micra device is implanted directly into the tissue of the right ventricle.

For a traditional pacemaker, doctors make an incision under the collarbone, and patients have to keep an arm at their side and avoid any exertion for weeks. With the Micra, there is no arm restriction, no visible bulge from the pacemaker in the chest and no risk of infection from leads, Nair said.

He said Presbyterian doctors have performed the Micra pacemaker surgery on 10 patients since early March, and all are currently doing well.

Lovelace Health System and the Heart Hospital of New Mexico can also do the procedure but as of late May had not selected any patients, said spokeswoman Whitney Marquez.



The Medtronic Micra Transcatheter Pacing System, called the"world's smallest pacemaker".

AlbuquerqueJournal

UNM, Presbyterian Partnering on Pediatrics

By Marie C. Baca, Journal Staff Writer
June 6, 2018

ALBUQUERQUE, N.M. — The University of New Mexico Health Sciences Center and Presbyterian Healthcare Services have announced a partnership aimed at improving access to pediatric specialty care within the state.

The partnership includes discussions about the creation of a pediatric specialty outpatient center that would combine the resources of both entities to provide clinical, diagnostic, procedural and urgent care services.

Leaders from UNM Health Sciences Center and Presbyterian told the Journal the partnership is still in the early stages, though the two have been in talks since last year. Both organizations said they have had to direct families to out-of-state providers for certain pediatric services because of the small number of specialists in New Mexico.

"With highly specialized physicians, you may only have three or four for the entire state, and that creates non-sustainable practices if those physicians are on call every other night," said Dr. Jason Mitchell, Presbyterian's chief medical officer. "And, of course, we are a beautiful state, but recruiting to New Mexico is always still a challenge."

Asked why two competing organizations would form such a partnership, Dr. Michael E. Richards, vice chancellor for clinical affairs for the UNM Health Sciences Center, said that "health care today requires a much greater degree of collaboration."

"With a limited population size in New Mexico, a collaborative approach gives us better sustainability, and better care for the patient," said Richards.

According to information provided by UNM and Presbyterian, 20 percent of New Mexico children have chronic or complex medical conditions.

Mitchell and Richards said clinicians across both systems have expressed enthusiasm about the partnership. The most common question, according to Mitchell, has been whether or not the partnership will also focus on pediatric primary care at this time. Mitchell and Richards said it will not.

The two organizations say they are participating in a pediatric specialty care task force through the New Mexico Pediatric Society. The task force was created during the legislative session earlier this year through a memorial introduced by Rep. Debbie Armstrong, D-Albuquerque.

In a statement, Armstrong said the partnership between UNM and Presbyterian in conjunction with the work of the task force "will make a difference" by increasing access and coordination to specialty care.

Presbyterian Program to Help Patients Eat Healthier

By Rosalie Rayburn
June 5, 2018

Community Health Manager Tatiana Falcon Rodriguez sets out eggplants delivered by Roadrunner Food Bank to the "Food Pharmacy" on the Presbyterian Kaseman Hospital campus. (Roberto E. Rosales/Albuquerque Journal)

ALBUQUERQUE, N.M. — Presbyterian Healthcare Services has launched a pilot program built around the concept of food as medicine.

Lack of access to healthy food can have a long term negative impact on a patient's overall health, especially those with a chronic disease like diabetes, and those are the patients Presbyterian hopes will benefit from the Food Pharmacy, said Leigh Caswell, director of the Presbyterian Center for Community Health.

Patients at the Presbyterian Kaseman Hospital campus will be screened for "food insecurity." For those who, through economic or geographic factors lack access to a source of healthy food, providers can give them a prescription for the Food Pharmacy. That prescription will enable them to receive 10 pounds of fresh produce and low-sodium, low-sugar shelf-stable items, such as oatmeal, canned beans, eggs, soup and peanut butter.

"We are really trying different ways to support patients' access to healthy food," said Caswell.

She said Presbyterian will buy some of the items or obtain them through food drives.

Presbyterian has a partnership with Roadrunner Food Bank, which will deliver fresh fruits and vegetables each week.

Caswell was on hand on opening day, May 16, when a Roadrunner truck delivered pallets of oranges, eggplant and spaghetti squash. The shelves were stocked with items like canned tuna, pasta and dried beans. A chiller contained cartons of fresh eggs from Galloping Grace, a Rio Rancho nonprofit that educates children about raising animals and crops.

Presbyterian created the Food Pharmacy based on a model developed by ProMedica, an Ohio health system.

The Food Pharmacy is located at 8300 Constitution Place NE., near Kaseman Hospital. It is run by Presbyterian staff with help from volunteers. Opening hours are noon to 3 p.m. on Wednesdays. Patients will be able to visit each week.

By seeing patients weekly, Caswell said, the hope is to develop relationships that will help Presbyterian identify the underlying issues behind their food insecurity and help them find a sustainable source of healthy food.

Presbyterian has several other programs designed to increase access to healthy food. They include a free meal program at five Presbyterian hospitals, the Healthy Here Mobile Market and the Fresh RX program that provides patients with "prescriptions" for fresh fruits and vegetables.

For information about these programs, go to the Presbyterian Healthcare Services website, www.phs.org and search for "community health program highlights."

The Roadrunner Food Bank truck delivers fresh produce on May 16, the opening day of the Food Pharmacy on the Presbyterian Kaseman Hospital campus. (Rosalie Rayburn/ Albuquerque Journal)

Local SEARCH Students Finish Job Training

Rio Rancho Observer
June 3, 2018

Presbyterian Rust Medical Center's second class of Project SEARCH students graduated May 8.

Now in its second year at the hospital, Project SEARCH is a 36-week program that provides skills training and workplace internships for high school students ages 18-22 with disabilities. Students complete certification training and three rotations in areas such as food and nutrition, patient transport, administration and security.

"We are very proud of our students and excited for what the future has in store for them," said Sandy Aschenbrenner, Project SEARCH program instructor at Rust. "They have spent the past 36 weeks gaining the skills and experience they need to be successful in whatever career path they choose."

In addition to gaining work experience and job skills, students learn professional communication, teamwork, résumé writing and interview skills. Many of the students already have jobs secured at Rust or other businesses, such as Chick-Fil-A and Dion's.

"We are also so grateful for the continued support of Presbyterian and the staff at Rust Medical Center," Aschenbrenner said. "We could not do it without them or our partners at Rio Rancho Public Schools, Adelante Development Center Inc., Division of Vocational Rehabilitation, New Mexico Department of Health and the University of New Mexico Center for Development and Disability."

Nine interns have been selected for the 2018-19 program, which begins in August. Erika Black, a teacher with RRPS, will join the program, as Aschenbrenner is retiring.

Project SEARCH graduates celebrate with a supporter. They are, back from left, Alex Aguirre, Alexis Velasquez, Ethan Bean, Rio RanchoPublic Schools Director of Secondary Special Education Theresa Griffin-Golden, Cherry Jiang and James Preston; and, front from left, Kris Kujat, Ben Maes and Faith Farrell. Program graduate Dylon Rougier is not shown.

3 Keys for Population Health Success That Don't Require Capitation

By Philip Betbeze
June 1, 2018

There's probably no bigger buzz phrase right now in healthcare than *population health.*

Applying population health—the formulation of healthcare interventions to maximize the long-term health outcomes of a given group—can seem intimidating, because it could conjure thoughts about the expensive infrastructure and transformational business model healthcare leaders may believe are prerequisites for deploying it.

They rightly recognize the difficulty of changing the way healthcare is provided in such a way that cost and quality are improved without hurting the bottom line, in what's still largely a fee-for-service system.

While Presbyterian Healthcare Services, an eight-hospital Albuquerque, New Mexico-based system has many of the prerequisites, such as a proprietary health plan, to execute on population health strategies, Jason Mitchell, MD, its chief medical officer, insists such elements aren't necessary for other organizations to emulate strategies they've employed to cut costs, improve quality, and extract more value out of healthcare services.

Following are three tactics Presbyterian has successfully launched that don't necessarily need capitation to succeed.

1. Commit to 24/7 Services

You might say you already do commit to round-the-clock services, in that you have a 24/7 emergency room, but we're not talking about that kind of super-expensive care here.

Mitchell says Presbyterian's Complete Care program, which features a 24/7 call center care team, was developed to help "bend the cost curve" on the health system's highest-cost members—those who are frequently admitted to the ER and who generally have hard-to-manage chronic conditions.

"When they want to call 911, instead they call our 24-hour team," says Mitchell. "[The program] addresses the next segment of patients who are not homebound and not critically ill, but who are expected to be high spend."

Presbyterian identifies this patient cohort through analytical algorithms that identify patients likely to die within the next two years but are not showing signs of it yet, such as critical illness.

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3 Keys for Population Health Success That Don't Require Capitation (continued)

Presbyterian can access behavioral, pharmacy, and intensive teams to help triage and arrange care for the patient and determine whether he or she really needs emergency room care.

The data that populate Presbyterian's algorithm are data any system would likely have, but it took over a year to figure out how to analyze it properly.

"It's based partially on the number of diagnoses, the number of meds, and the frequency of their ED visits," he says. "When we put it together to model it, it was about 80% predictive of mortality in the next two years. There's magic in data, and population health is identifying who will benefit most from an intervention and applying that to them."

Perhaps not surprisingly, the patients end up preferring this system over just showing up at the ER, he says.

He attributes the 24/7 call center to a decrease in hospital admissions from the group by 50% and says it's had a big impact on length of life and patient satisfaction.

2. Commit to Standardization

Presbyterian's Complete Care program generally caters to around 600 unique patients, "which doesn't sound like a lot, but if you think about the spend, keeping them out of the hospital can save millions and millions of dollars," says Mitchell.

That also leaves dollars to do things for other populations because population health begets population health, as Mitchell likes to say.

"In time, you drop the cost of care across large swaths of patients," he says.

Mitchell says Presbyterian follows the data to make sure it's recognizing all the possible benefits. For instance, with some of the savings, Presbyterian instituted a small blood utilization team to standardize how the health system uses blood.

"The truth is blood products are dangerous, costly, and in short supply," he says. "We were using more than we needed to, but by promoting stewardship and appropriate utilization, we saved half a million dollars last year focusing on reducing variation."

That's population health, too, he says.

Another area dollars have been invested is in standardizing care in the health system's cardio program. The cardio team's efforts decreased length of stay in the ICU by 1.5 days on all procedures and by 2.5 days in valve replacement surgery.

"We provide resources and enable [the cardio team] to do the work, and they'll become autonomous with standardization over three to five years," he says. "We make population health a component of our culture by helping them lead and not telling them what we expect them to do."

3. Commit to Investing the Savings

Mitchell says with population health strategies, at some point, health systems will need to invest in areas that don't generate revenue, but that do generate savings for the benefit of the patients. "If it doesn't work, we can turn it off after a year," he says. "Anywhere you can drop the total cost of care and improve quality, that's great. Even if you're all fee-for-service with no risk arrangements, think about where you are, in theory, capitated."

Medicare DRGs are, in effect, capitated. Assuming resources are finite, hospitals could save enough money to furtherinvest in population health. "I don't see a fee-for-service model interfering with this, but you have to find the right place to start," he says.

Demonstrated savings thanks to standardization or improving care or patient satisfaction opens the door to value-based alignment for payers.

"Go to payers and ask what their biggest challenges are and how you can help," he says. "Maybe you can work out a special payment to provide additional services."

Doctors Perform NM's First Pancreas Transplant

By Rosalie Rayburn
May 15, 2018

Dr. Hannah Choate, transplant surgical director for Presbyterian

ALBUQUERQUE, N.M. — The pancreas produces the insulin vital to processing carbohydrates the body needs for energy and when it doesn't work properly, serious things like kidney failure can develop.

Fortunately for those who live with that condition – mostly patients with Type 1 diabetes – it is possible to get a functioning pancreas through transplant surgery.

Until recently, however, patients needing a pancreas transplant had to travel out of state for the surgery.

Last year, a medical team with Presbyterian Healthcare Services successfully performed the first pancreas transplant in New Mexico.

"It's not a new procedure nationally, but it's new to New Mexico," said Dr. Hannah Choate, transplant surgical director for Presbyterian.

Presbyterian has been performing kidney transplant surgeries for several years. Choate said it took about two years to develop the pancreas transplant program, and obtain the required certifications from the Centers for Medicare and Medicaid Services.

Before launching this program, Choate said they had to refer patients out of state.

The Presbyterian patient who had the pancreas transplant received a kidney at the same time. In about 80 percent of cases, patients need both organs, Choate said. The organs must be recovered from a donor who has recently passed away.

"It's hard to find a perfect donor. We're very, very careful and particular about the type of donor used for a kidney and pancreas transplant because they have to be very young and healthy," Choate said.

In a small number of cases, a pancreas can be transplanted after a patient has already had a kidney transplant. In that situation, they would have organs from two donors. A patient with Type 1 diabetes might also just get a pancreas if they don't have kidney failure.

All transplant surgeries present significant risks for the patient. Choate said they have to screen patients carefully to be sure the individual will be a good fit. She estimates Presbyterian will likely perform only two or three pancreas transplants annually.

"This surgery is more for younger patients who present less risk," she said.

Patients who have pancreatic cancer will not be candidates for this surgery. She said the imuno-suppression drugs they have to use to prevent the body rejecting the transplanted organ can be dangerous for cancer patients.

Wayne Dunlap, executive director of New Mexico Donor Services, is excited about the pancreas transplant program. The nonprofit works with donors and their families. Its services include helping to find suitable recipients, and coordinating surgical recovery of and transportation of organs.

"This truly is a great thing for the state of New Mexico," Dunlap said.

April is National Donate Life Month

New Mexicans can register to be organ donors on their driver's license/ID card or at RegisterMe.org.

AlbuquerqueJournal

Q&A with Presbyterian Healthcare Services CEO Dale Maxwell: 'We've answered many of the questions other systems are just beginning to ask'

By Steven Ross Johnson
March 31, 2018

Dale Maxwell, CEO of Presbyterian Healthcare Services

Presbyterian Healthcare Services, a not-for-profit, integrated health system based in New Mexico, has succeeded in lannching care models that keep patients out of the hospital. Dale Maxwell, who officially took over as CEO just over a year ago, says the organization will continne to advance new delivery models. Presbyterian has also been at the forefront in addressing end-of-life care and social determinants of health. Maxwell recently spoke with Modern Healthcare public health reporter Steven Ross Johnson. The following is an edited transcript.

Modern Healthcare: What are some of the characteristics of the types of patients you serve in New Mexico?

How do they reflect what we're seeing nationally?

Dale Maxwell: We operate in a challenging business environmeut. First off, New Mexico has not fully recovered from the economic downturn of 2009. We're not seeing job growth, and we're not seeing any significant population growth like onr neighboring states Arizona, Colorado and Texas.

The second piece is that situation drives a pretty high concentration in Medicaid business. So with a lack of job growth, we're not seeing private payer or commercial business grow on a year-over-year basis. What we are seeing are continned increases in Medicaid.

According to the Kaiser Family Foundation, New Mexico now has the second-highest percentage of residents served by Medicaid, and it's estimated that in the near future that 1 in 2 New Mexicans will be served by Medicaid.

Third, we continne to see declines in our government reimbursement from Medicaid as our state struggles with budget concerns, and from a federal standpoint with pressure to reduce overall costs.

MH: We continue to hear talk in Washington about changes to Medicaid. What kind of impact would that have on your business?

Maxwell: My impression of what's going on right oow is it's about how we pay for the program, whether it's from a federal standpoint or a state standpoint.

New Mexico did participate in Medicaid expansion, and that has had a significant benefit to our state. We now cover about 220,000 more New Mexicans and it's dropped our uninsured population from 22% to just a little over 9%.

If we see reductions in ... the match dollars we get from the federal government, it will put significant pressure on the state to fund those additional 220,000 lives. My concern going forward is just understanding the funding mechanism and that those currently insured may fall off the rolls and fall back into an uninsured status.

MH: How does that high proportion of Medicaid beneficiaries affect your care delivery approach?

Maxwell: We're very fortunate that our bnsiness model is an integrated system, meaning that we have an insnrance company, we have hospitals and we have a provider group that employs a little over 1,000 clinicians. Because of this integrated model and the expertise and knowledge that we've gained over the last 30 years, we have to find innovative ways to take care of the population and to provide high-quality care at a lower overall cost.

Just to give you a conple of examples: first is a program that we call Complete Care, which provides iotensive home-based care to our Medicare Advantage members in their last two years of life, who make up about 5% of that total population but about 64% of the total medical costs. Through this program, we take high-risk members and provide access and interventions in

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their homes. This includes providing care coordination, telemonitoring, palliative-care home health, social workers, etc. This is what we call a "never discharge" model so patients are always in service, and we have a team that is available to assist these patients on a 24/7 basis. The benefits of this program reduce hospitalizations, reduce the overall cost of care, and when we look at hospitalization rates for this population on a predictive basis, we fall about 50% of where that population normally would be.

MH: Speaking of palliative care, your system has been a national leader on that front. Could you discuss your involvement with the Center for Advanced Palliative Care?

Maxwell: It's an important part of how we think care should be delivered. We're proud of the accreditation that we have. And again, it leads back to our integrated model of delivering care and doing the right thing for those patients at their end of life.

MH: How has being an integrated health system helped you address some of the biggest challenges many healthcare providers face when it comes to reimbursement, rising healthcare costs or even physician shortages?

Maxwell: We have the knowledge and expertise that we've gained over the last 30 years. We have answered many of the questions that other health systems are just beginning to ask themselves as they begin to transform from fee-for-service to pay-for-value. It aligns our incentives very differently. We are concentrated more on taking care of a population than just trying to run services through a hospital and a physician group.

Another example is our hospital-at-home program where we provide comprehensive care for patients whose illness is severe enough to warrant hospitalization, but who can be treated safely in the comfort of their own home. Hospital-at-home has been found to be safer for patients, more cost-effective, and the outcomes are equal to or better than a traditional hospitalization. It also allows us to look at access to care in a different way.

You asked about the shortage of physicians. One of the soft launches that we've done in the last quarter of 2017 and in the first two months of this year implemented what we call MD Smart Exams. These are visits where you log into a computer or your phone and conduct an exam in an asynchronous manner. In the first two months of 2018, we provided over 1,400 of these visits, and that's equivalent to about two primary-care physicians as well as their staff. So we can provide quicker access to care, better satisfaction for the patients and our members, and we can do it at a reduced cost.

MH: Your organization has been involved quite heavily in trying to address social determinants of health. What are some of your more recent population health initiatives?

Maxwell: We believe that addressing social determinants of health is part of our responsibility as a health system and it actually falls right in line with our integrated model of taking care of the population. There was a study that was released by the National Survey of Children's Health, and it showed that New Mexico ranks the highest for children who have suffered from adverse childhood experiences, or what is called ACEs. These are events in a child's life that are traumatic in nature that would include abuse and neglect, hunger or extreme economic insecurity. Hunger is a big part of that, and that's an issue where we have played an important role in the community and in the state.

In New Mexico, 1 in 6 residents struggle with hunger and we're actually tied with Arkansas for the second-highest rate of food insecurity among children. We have a food pharmacy pilot in place. This is a program that we're currently testing where you can actually receive a prescription for food. So a patient or member gets a prescription for healthy food and then they visit our food pharmacy to get their prescription filled.

We also have a free meal program. We are partnering with the U.S. Department of Agriculture, and any child under the age of 18 who presents at one of five of our hospitals, we actually give them a free meal.

MH: Have you seen the business case for employing these types of initiatives? Have you been able to generate any type of cost savings as a result of these efforts?

Maxwell: Absolutely. As an integrated system a big portion of our revenue comes in through our health plan. So if I look at our revenue stream, about 65% of that is fixed, it's on a per member, per month basis. We are directly incentivized to provide quality care at an overall lower cost of care. We do have examples of population health management that show benefit and return on the investments that we're putting in place. You know a significant part of that is the data and analytics. We're investing a substantial amount to stand up a robust data and analytics platform that not only looks at clinical information but also looks at the claims information that comes into our health plan. So we can manage that population and have better outcomes for example with diabetic patients or patients with high blood pressure that show pretty significant outcomes.

MH: How have your religious affiliations influenced your care mission?

Maxwell: Presbyterian was started in 1908 as a tuberculosis sanatorium. Rev. Hugh Cooper, who was a pastor at the Presbyterian church here in Albuquerque, saw a need; there was a high prevalence of tuberculosis, and not enough institutions to take care of those patients. So he actually started Presbyterian 109 years ago. Since then, we have obviously transformed into a hospital system, and into an integrated healthcare delivery system.

Although Presbyterian is in our name, we are no longer affiliated with the Presbyterian church. Our legacy of caring continues to move us forward and our purpose of taking care of the citizens of New Mexico remains with us.

Home is where the hospital is

By Chad Mulvany
August 1, 2018

An innovative payment model may bring home hospitalizations into the mainstream of "inpatient" care delivery, pulling more volume out of traditional acute care facilities.

The provision of inpatient-level acute care for low-acuity medical conditions in patients' homes is not a new practice. But current Medicare payment restrictions have prevented this care delivery model from seeing widespread use. Those health systems that have deployed the hospital-at-home model, however, report higher-quality outcomes achieved at a lower cost compared with outcomes for patients with similar conditions admitted to acute care facilities.

Recently, a proposal for a 30-day bundled payment model for the "hospital-at-home" approach to care was recommended by the Physician-Focused Payment Model Technical Advisory Committee (PTAC) to the Centers for Medicare and Medicaid Innovation (CMMI) for further development and deployment.a If the CMMI elects to deploy the model, the implications for hospitals are significant, given the volume of admissions involved. Hospitals therefore should understand who might be interested in the model and what the financial impact of various participation alternatives will be.

How Home Hospitalization Works

Hospital-at-home models are being piloted in a limited number of health systems across the United States. Typically, these are health systems that have a health plan; examples include Johns Hopkins Medicine in Baltimore, Presbyterian Healthcare Services (PHS) in Albuquerque, N.M., and Marshfield Clinic Health System in Marshfield, Wis. However, a 2011 Commonwealth Fund report points to the successful deployment of the model in other countries for many years.b

A patient can be referred to the program from a community physician practice or an urgent care center, or by a hospital emergency department (ED) physician. In Marshfield Clinic Health System's model, 70 percent of hospital-at-home admission referrals occur in the ED. A care coordinator performs triage on patients to determine which ones are appropriate for the model, and a hospitalist confirms the likelihood that each identified patient will fall into one of the appropriate MS-DRG categories. Narrowly defined eligibility criteria help identify patients who require intensive services and/or multiple visits from a specialist and, therefore, should be treated in an acute setting. Further, many models use either Milliman or InterQual guidelines to verify that the patient meets appropriate criteria for a hospital admission.

The patient evaluation can occur in person—most often in an ED—or by telephone from a community setting. As the suitability of the patient's home is evaluated and necessary durable medical equipment is delivered to the home, required medical care begins (e.g., intravenous administration of antibiotics) and responsibility for care is assigned to a physician.

A caregiver meets the patient at home, and a physician—either in person or through an online communication medium—explains the treatment protocol. Orders are written, and clinical staff—including respiratory therapists, physical therapists, and other caregivers—arrive as needed to administer intravenous medications and fluids, provide nebulizer treatments, and perform examinations, including ultrasounds, X-rays, and electrocardiograms. Meals are arranged, if necessary. The patient's vital signs are monitored electronically.

The physician visits the patient daily either in person or, more likely, via a telemedicine platform. To capture any decline in the patient's condition when clinicians are off site, providers use remote patient-monitoring technology.

Once a patient is stabilized and well enough to return to activities of daily living, the patient is handed off to his or her primary care physician. In some models, participating providers maintain oversight of the patient for at least 30 days, to ensure the patient is keeping appointments and is not suffering any adverse consequences. During this period, the physician provides updates to the patient's primary care physician.

Impact on Cost and Quality

A home hospitalization model has the potential to reduce the total cost of care while improving outcomes. Early pilots have achieved savings of

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30 percent per admission. The lion's share of savings has been attributed to factors such as lower costs for diagnostic testing and pharmacy, less clinical service consumption, cost avoidance due to prevention of complications, and flexibility in the staffing model.c

These savings have been achieved with fewer complications and greater patient satisfaction, according to the previously cited Commonwealth Fund report. For example, early trials have found incidence of delirium was approximately 63 percent lower for patients admitted to the hospital-at-home model. An HFMA member whose organization is currently using this model with members of its Medicare Advantage plan reports patient satisfaction is 27 percent higher than clinically comparable patients who were hospitalized.

Although patient selection may explain some of the difference in readmissions rates, a hospital-at-home model has advantages over an acute care admission that help realize lower return rates. Having caregivers in the patient's home (either in person or virtually) for 30 days post-discharge provides a better opportunity to perform a range of activities such as assessing fall risks, screening for and addressing social determinants of health (e.g., food insecurity or mal-diet), reconciling medications, and providing detailed patient education. Nonetheless, despite the ability of home hospitalizations to produce superior patient outcomes at a reduced cost, they have seen minimal use for want of a viable financing model.

Details of the Payment Model Proposed to the PTAC

The 30-day episode of care for a home hospitalization was presented to the PTAC at its meeting on March 26, 2018. Under the proposal, an episode would begin three days prior to admission and end 30 days post-discharge from the hospital at home service. A risk-adjusted target price, based on the regional average, would be developed based on each MS-DRG included in the program. The prospectively set target price would include the following:

The MS-DRG payment for services provided during the "initial hospitalization" reduced by 30 percent to reflect a lower-cost setting

- Physician services provided during the home hospitalization
- Physician services related to the admitting diagnosis furnished in the 30-day post- discharge period

Other outpatient services (e.g., ED visits, diagnostic imaging) related to the admitting diagnosis incurred in the 30-day post- discharge period

- Post-acute care (PAC) services provided during the 30-day post-discharge period related to the initial home hospitalization
- Subsequent hospitalizations (e.g., readmissions) related to the admitting diagnosis incurred in the 30-day post-discharge period

The model offers CMMI a 3 percent discount on the full target price. Although quality measures are not currently used to adjust the benchmark, the model includes a robust measure set that could be incorporated into the payment model. The proposed measures include scores on Consumer Assessment of Healthcare Providers and Systems (CAHPS); rates of hospital-acquired conditions; and condition-specific outcomes with respect to mortality, readmission, ED utilization, and patient-reported experience. Because quality measures are integral to the model, if CMMI develops a model, it is likely a track that qualifies for the advanced alternative payment model (APM) bonus under the Medicare Access and CHIP Reauthorization Act (MACRA) will be offered.

The hospital-at-home model was proposed as a "retrospective model." If accepted, CMS will continue to make fee-for-service payments to any provider who delivers a service related to the episode of care. Results will be determined using a retrospective reconciliation process similar to that used with the Comprehensive Care for Joint Replacement (CJR) and Bundled Payment for Care Improvement (BPCI) models. As it is currently presented, the model caps maximum gains at 10 percent.

IMPACT OF PRESBYTERIAN HEALTHCARE SERVICES' HOSPITAL-AT-HOME PROGRAM

	Hospital-at-Home	Clinically Similar Inpatients	Difference
LOS	3.20	4.11	-0.91
Readmissions	5.60%	15.20%	-9.60%
In Stay Mortality	0.93%	3.40%	-2.47%
Fall Rate	0.00%	0.80%	-0.80%

Note: The readmissions rate listed for "clinically similar" inpatients is the Medicare hospitalwide risk standardized readmissions rate. See CMS.gov, Hospital Quality Initiative: Outcomes Measures, page last modified Oct. 13, 2017.

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Applicable Conditions

The hospital-at-home model typically is used for a limited number of medical MS-DRGs. As an example, the exhibit below lists the MS-DRGs included in PHS's hospital-at-home model. To give a sense of the potential volume impact, the chart also includes the total number of Medicare admissions, the Medicare "allowable," and the percentages of each MS-DRG relative to the national total Medicare volume.

If it is adopted, a Medicare hospital-at-home payment model could have a significant impact on hospitals in markets where it is deployed. The limited number of conditions targeted by PHS's program likely include many of the conditions that would be covered by a CMMI pilot. These conditions account for approximately 6 percent of Medicare discharges and 2.5 percent of total Medicare inpatient payments. Although these MS-DRGs are typically unprofitable, their contribution margins cover the fixed and step-fixed costs inherent in running a hospital. Further, the number of MS-DRGs covered would likely expand quickly with CMMI's and providers' growing experience with home hospitalizations.

Although the seven MS-DRGs listed in the exhibit represent the majority of hospital-at-home admissions, the proposal presented to the PTAC includes about 150 MS-DRGs. This breadth is supported by HFMA's conversations with senior finance executives whose organizations are experimenting with home hospitalizations. These executives believe the model will support an expansion in the number of surgeries that can be performed on an outpatient basis. Common examples cited include low-complexity hip and knee replacements for Medicare

MS-DRGS AS A PERCENTAGE OF PRESBYTERIAN HEALTHCARE SERVICES' HOSPITAL-AT-HOME CASES AND TOTAL MEDICARE VOLUME*

Diagnosis	Primary MS-DRG	Percentage of PHS Hospital-at-Home Cases	2015 Medicare Discharges	Percentage of Total Discharges	2015 Medicare Allowable	Percentage Total Medicare Allowable
Deep Vein Thrombosis or Stable Pulmonary Embolism	176	70%	36,141	0.37%	$206,082,477	0.19%
Chronic Obstructive Pulmonary Disease	192	90%	64,976	0.67%	$268,593,441	0.25%
Community-Acquired Pneumonia	195	170%	56,244	0.57%	$216,895,245	0.20%
Congestive Heart Failure	293	200%	60,200	0.62%	$246,622,264	0.23%
Cellulitis	603	170%	123,261	1.27%	$619,774,852	0.58%
Dehydration or Volume Depletion	641	150%	106,865	1.10%	$467,710,672	0.44%
Complicated Urinary Tract Infection or Urosepsis	690	150%	153,314	1.57%	$720,638,117	0.68%
Total			600,001	6.16%	$2,746,317,068	2.59%

* Klein, S., Hostetter, M., and McCarthy, D., *The Hospital at Home Model: Bringing Hospital-Level Care to the Patient*, The Commonwealth Fund, Aug. 22, 2016; CMS.gov, Medicare Provider Utilization and Payment Data: Inpatient, page last modified, April 4, 2018; and HFMA analysis

beneficiaries. Given the potential for volume disruption, hospitals and health systems need to understand what types of entities might vie for this market share.

Increased Competition for 'Inpatient' Services

A 30-day Medicare home hospitalization episode payment model would attract a mix of incumbents and new entrants into the market for low-acuity inpatient services. The relatively low capital requirements would encourage physician groups (or entities that employ physicians) that are involved in the decisions to refer patients for admission to participate on an experimental basis. Beyond a new revenue stream, such a model would buttress existing population health management strategies. The exhibit below illustrates the types of organizations (both existing competitors and new entrants) that might participate in a pilot.

As discussed below, each of the potential participants and brings specific advantages to a hospital-at-home model and has a different rationale for joining a CMMI pilot.

Academic medical centers (AMCs). Many AMCs have reached or are close to exceeding inpatient capacity. They may look to a hospital-at-home model as a way to serve more patients without having to invest a million or more dollars per bed to create additional capacity.

Moreover, the model provides a way to divert lower-acuity admissions to sites where care could be provided at reduced per unit labor costs. Joint venturing with primary care physicians in adjacent markets also may create an opportunity to leverage an AMC's traditionally strong brand and gain market share at the expense of other hospitals.

Aligned, integrated health systems. Aligned, integrated health systems typically employ many of the physicians that provide care in the system and own a health plan. Almost all of them also are involved in some form of Medicare fee-for-service accountable care organization (ACO). For these health systems, deploying the hospital-at-home model within their own health plans and to the Medicare fee-for-service population provides a means for supporting their population health management strategies and leveraging existing care coordination capabilities.

ED staffing groups. ED physicians triage and write admission orders for

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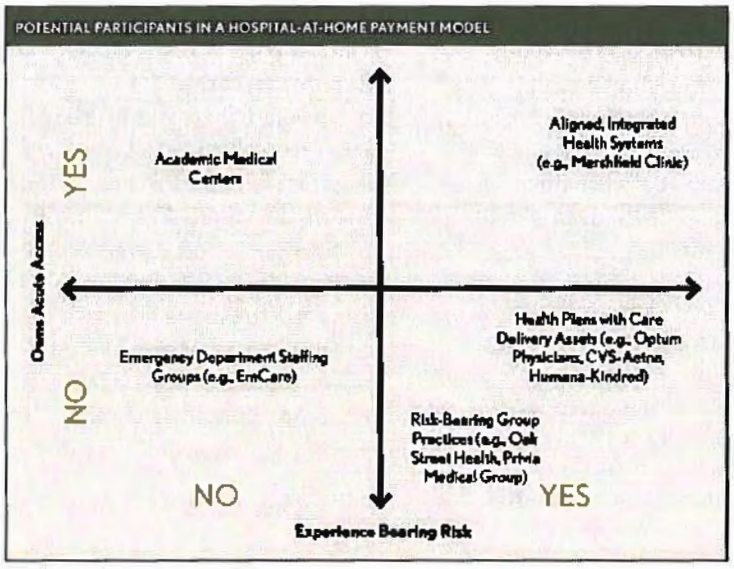
many patients who have low-acuity medical conditions that could be treated in a hospital-at-home model. Participating in a hospital-at-home model could create a new revenue stream for ED staffing companies. Further, assuming the model has a qualifying track, episodic payments for home hospitalizations could provide an avenue for ED physicians to receive the advanced APM incentive payment available under MACRA. Most ED staffing groups lack the capabilities to deliver home-based care.

However, a joint venture between one of the national ED staffing companies, a national home care provider, and one of the companies that provide the necessary technology platform isn't hard to imagine.d

Risk-bearing group practices. Given their relationship with and proximity to Medicare fee-for-service patients with multiple chronic conditions, a number primary care group practice models stand to gain financially from a hospital-at-home model. One example is Oak Street Health in Chicago. Oak Street Health focuses on delivering care to historically underserved populations. Although its business model is predicated on sub-capitated payments for primary care from Medicare Advantage plans, the organization does deliver care to Medicare fee-for-service patients. Such group practices have the analytic capability, experience with virtual monitoring and care delivery, and patient navigation skills to successfully execute the model. Beyond creating an additional revenue stream for the practice, adopting the model could enable these practices to develop relationships with patients that serve as stepping stones to migrating them into an aligned Medicare Advantage plan.

Health plans with care delivery assets. Recently, the market has experienced a wave of mergers in which health plans have acquired providers or increased their direct healthcare delivery capabilities. Such efforts are likely focused in part on decreasing utilization and costs for the health plans' members and increasing the plans' market share. However, this strategy also provides health plans with a platform to generate incremental revenue by managing Medicare fee-for-service lives. With its acquisition of DaVita Medical Group (DMG), Eden Prairie, Minn.-based Optum now has approximately 37,000 employed physicians.e The transaction is a prime example of a health plan expanding its reach into the Medicare fee-for-service, because DMG practices participate in Medicare ACOs in a number of markets. In the 30 markets where Optum has physician practices, the practices' existing relationships with Medicare patients coupled with their analytic and care coordinating capabilities make them a natural entrant.



For acute care providers, participating in a hospital-at-home model likely will decrease revenue related to the impacted MS-DRGs. However, the question management teams need to answer is whether there's greater financial risk in cannibalizing this revenue stream or ceding the volume to other, well positioned competitors.

Understand your exposure. How much of a hospital's margin is attributable to admissions that could be managed at home? If a hospital elects to develop its own hospital-at-home model, what net-net impact would this strategy have on the cost of care delivery. A review of the list of MS-DRGs in the exhibit on page 47 and the proposal to the PTAC are good places to start. However, finance staff should work with medical staff to understand the full universe of low-acuity, high-volume admissions where care could be effectively delivered in the patient's residence with home and telehealth visits. They also should seek to understand the sources of admission for these cases and identify which physicians (or physician groups) are responsible for referrals.

Understand your opportunity. Two key questions should be addressed in assessing the opportunity: For the MS-DRGs that will likely be targeted, what will the target price be? And is there excess clinical utilization or testing that can be reduced? Reviewing a hospital's Medicare data on spending per beneficiary for each MS-DRG

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can provide clues as to potential opportunities to offset lower MS-DRG revenue through downstream savings.

Understand your market. To understand the types of entities a hospital will compete with for home-based admissions, it is necessary to assess, first, which physician practices are responsible for referrals for the conditions that can be managed at home and, second, which entities in the market are capable of organizing and managing care delivery at home. Organizations that meet both criteria are the most likely entrants, but it's unclear how many entities can check both boxes. Therefore, any entity satisfying one of the criteria should be viewed as a potential competitor (or partner). It's probably best to err on the side of caution instead of prematurely discounting a potential entrant. As noted above, there are firms that can help potential entrants fill capability gaps to enable the entrants to successfully execute a hospital-at-home model.

Understand your capabilities. Among other questions, acute care organizations that execute a hospital-at-home model will need to answer the following.

First, how will the suitability of a patient and the patient's home for the model be determined? This can be an especially challenging undertaking given the potential multiple referral points (e.g., ED, physician office, urgent care clinic) and may imply a centralized call center solution for patient assessment.

Second, once a patient is deemed suitable for the model, how will the necessary medical equipment be promptly delivered to the home? Beyond considering geographic boundaries, a hospital may need to develop deeper relationships with a durable medical equipment (DME) provider in the market(s) where they offer a hospital-at-home model.

Third, how will care be delivered once the patient is "admitted" to his or her home? The mix of services delivered will depend on the condition-specific care protocol and the severity of the patient's condition. To address this consideration, hospitals may need to develop a "hospitalist at home" program, deepen existing relationships with home health agencies, or beef up their telehealth and monitoring capabilities.

Fourth, once the patient is "discharged," how will the provider monitor and support the patient during the 30-day post-discharge window? Providers will need to develop a mechanism to track patients after discharge to ensure the patients are adhering to their care plans. Further, given the role of social determinants of health in readmissions, hospitals will need to develop deeper relationships with social service providers to address nonmedical needs and reduce readmissions.

Develop a response plan. A hospital's response will depend on its perceived exposure to the model and other pressing priorities. Actions could range from monitoring events in the market and payment environment to executing a limited pilot program focused on one condition even before a clear payment model emerges. Using a limited pilot will allow a hospital to develop essential relationships and gain experience before bringing the delivery model to scale.

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Footnotes

a. See Murali, N.S., "Home Hospitalization: An Alternative Payment Model for Delivering Acute Care in the Home: A Proposal to the Physician-Focused Payment Model Technical Advisory Committee," Personalized Recovery Care, LLC, Oct. 27, 2017; and Miller, H.D., Meadows, R., and Nichols, L.M., Preliminary Review Team Report to the Physician-Focused Payment Model Technical Advisory Committee (PTAC) on the PRC Home Hospitalization Alternative Payment Model, PTAC, Feb. 23, 2018.

b. Klein, S., "Hospital-at-Home" Programs Improve Outcomes, Lower Costs but Face Resistance from Providers and Payers," The Commonwealth Fund, Quality Matters, August-September 2011.

c. Foubister, V., "Hospital at Home Program in New Mexico Improves Care Quality and Patient Satisfaction While Reducing Costs," The Commonwealth Fund, Case Study, August-September, 2011.

d. Castellucci, M., "Innovations: Bringing Hospital-Level Care Home," Modern Healthcare, Aug. 6, 2016.

e. Haefner, M., "With 8k More Physicians Than Kaiser, Optum Is 'Scaring the Crap Out of Hospitals,'" Becker's Hospital Review, April 9, 2018.

Presbyterian Healthcare Services

PRESBYTERIAN

At-a-Glance

- New Mexico's most preferred healthcare system, according to independent surveys
- Serving one in three New Mexicans
- Not for profit
- More than 1,000 physicians and advanced practice clinicians in Presbyterian Medical Group
- More than 100 Presbyterian Medical Group clinics
- Nine hospitals in eight communities (includes Presbyterian Santa Fe Medical Center opening in October 2018)
- 450,000 Presbyterian Health Plan members in commercial, Medicare Advantage and Medicaid plans
- More than 18,000 providers in the Presbyterian Health Plan network
- New Mexico's largest private employer with nearly 12,000 employees

Presbyterian Healthcare Services exists to improve the health of the patients, members and communities we serve. Founded in New Mexico in 1908, it is a locally owned, not-for-profit healthcare system known nationally for its extensive experience in integrating healthcare delivery and financing.

Integrating Healthcare Delivery and Financing

With hospitals, a large medical group of physicians and advanced practice clinicians, and a statewide health plan, Presbyterian brings all the pieces of healthcare together to improve health. This unique approach allows us to coordinate and advance care models while aligning payment.

With a common purpose and shared culture, everyone at Presbyterian from our surgeons to our primary care physicians to our call center employees and claims processing staff work together to ease the way for our patients and health plan members.

Our programs include:

Integrated Substance Use Disorder and Community Collaborative Initiative
Our Integrated Substance Use Disorder Initiative is a robust collaboration among our health plan, delivery system, community and population health departments, and the greater community. The initiative employs innovative and evidence-based care and maintains protocols for managing patients at any point of entry into the healthcare system, provides seamless transitions among acute care, primary care and the recovery community, and uses community supports, wrap-around services and funding channels. The goals are to sustain a replicable model of care that compassionately identifies, engages and treats patients with substance use disorders; to improve the patients' physical and mental health, as well as quality of life; to reduce harm; to reduce recidivism; and to avoid unnecessary costs related to care. Early indications show the interventions are reducing recidivism and supporting engagement in treatment for those with substance use disorders.

Complete Care
Complete Care focuses on Presbyterian Health Plan's Medicare Advantage patients with the most serious illnesses, who make up about half of all costs for our Medicare Advantage population. These patients are given one telephone number to call 24 hours a day and have access to intensive RN in-home case management that is integrated with our palliative care and house calls programs. The program has resulted in readmission and hospitalization rates 50 percent lower than expected for this population, fewer Emergency Department visits and $700 in monthly savings per member.

Video Visits
Presbyterian Health Plan's video visit program allows members to connect with healthcare providers licensed in New Mexico anytime, without an appointment, from the comfort of their homes, offices or other locations with mobile data or Wi-Fi access. From a smartphone or computer with a working webcam, members can speak securely and confidentially with a provider 24 hours a day, 365 days a year and be diagnosed for non-urgent illnesses. When clinically appropriate, medications can be prescribed, and most Presbyterian Health Plan members access video visits at no cost.

Partnering with Healthcare Systems Outside New Mexico

In addition to having extensive experience in healthcare delivery and financing, Presbyterian, through our health plan, has for more than a quarter century contracted with the state of New Mexico as a managed care organization for Medicaid. Our integrated system has long been structured to accept "budgeted" payment and provide care coordination. We are bringing our managed care expertise to other states by partnering with healthcare systems that may not have such experience. Our first out-of-state partnership is in North Carolina. There, 11 leading health systems chose us as a partner as that state transitions its Medicaid program to managed care.

To learn more, please contact:
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