

# New Mexico Integrated Wellness Initiative

*A Denti-Medical Health and Wellness Collaborative*

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A pilot dental/medical healthcare integration program designed to yield significant wellness results for New Mexico

**A Healthier US Initiative**

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A PATIENT STORY

# MARY

45

YEARS OLD

*"No pain, so everything else  
must be good ... right?"*

**Wrong.**

**5 YEARS**

since her last dental visit

**10 YEARS**

since seeing a physician —  
since her son was born

THE HIDDEN HEALTH STORY

## A routine dental visit exposed a risk Mary could not feel

01

VISIBLE TRIGGER

Part of a tooth broke while Mary was eating nuts. The jagged edge — not pain — brought her to the dental office.

02

HIDDEN FINDING

The dentist found swollen gums. Mary had never noticed them.

03

SYSTEMIC WARNING

Plaque was creating an invisible problem, seeping through her gums and beginning to accumulate beyond her mouth.

GUMS  
entry point

ARTERIES  
heart-attack context

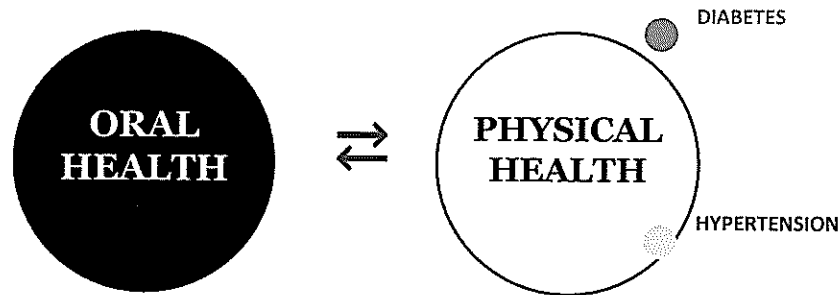
PANCREAS  
diabetes risk

# Dental practices can reconnect oral and physical health across New Mexico

Mary's issue is not uncommon: fragmented care can leave systemic risks hidden until a routine visit reveals them.

## THE MISSED CONNECTION

Many people do not know these systems influence one another.

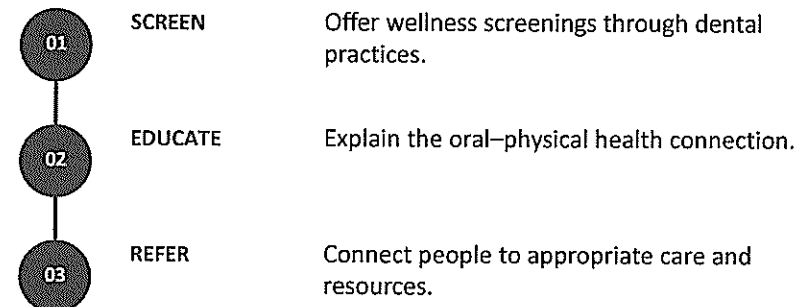


The relationship is bidirectional — oral health affects physical health, and physical health affects oral health.

## HEALTHIER NEW MEXICO

### An integrated wellness initiative

Use the dental visit as a practical entry point to whole-person care.



## INTENDED IMPACT

**Increase wellness capacity • Improve access to care • Reduce healthcare costs**

# Chronic disease is what New Mexico actually funds

The conditions driving the State's health spending are detectable for years before they become expensive. The system encounters most people only after that window has closed.

**90%**

of national health spending is attributable to chronic and behavioral conditions

**10 yrs**

typical silent runway before type 2 diabetes is diagnosed

**1 in 3**

New Mexicans are enrolled in Medicaid — the State carries this cost directly

**\$11B**

spent by the State in a year, serving 31,000 fewer people than in 2016

The same disease, found at two different times

## Found at 38

Lifestyle program, generic metformin, quarterly labs. A few hundred dollars a year, and a meaningful share never progress at all.

## Found at 55

Neuropathy, retinopathy, stage 3 kidney disease, a cardiac event. Multiples of the cost, every year, permanently — and it does not resolve.



## Dental as part of primary care

• AN UNTAPPED SCREENING RESOURCE

Dentists see patients on a regular cadence that primary care often doesn't — and oral health links periodontal disease to systemic conditions. We treat dental as a support service to primary care.

***Every dental visit becomes an early-warning signal — catching diabetes and hypertension before symptoms send patients to the ER.***

Standing training, protocol, and coaching are delivered through community oral health teams — building lasting competency, not a one-time in-service. Screening runs under CLIA-waived point-of-care testing and NM dental scope-of-practice protocols, with defined supervision and referral documentation.

### A SHARED DENTIMEDICAL PROTOCOL



#### Every dental visit

includes blood-pressure and glucose screening

*cross-referral both ways*



#### Every medical visit

includes an oral-health check

Decades of evidence show medical–dental cross-referral improves clinical outcomes.



# The opportunity: address the preventive-care gap

## • THE OPPORTUNITY

The cost of delayed care is quite costly! Because access is uneven, most people wait to engage the health system only when something already hurts — a pattern that is clinically risky and expensive.



### No symptoms, no visit

Most adults seek care only once something hurts — chronic disease develops silently for years before that point.



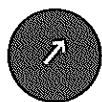
### Care feels far away

Clinics sit outside daily routines, competing with work, childcare, and transportation for people's time.



### Risk builds unseen

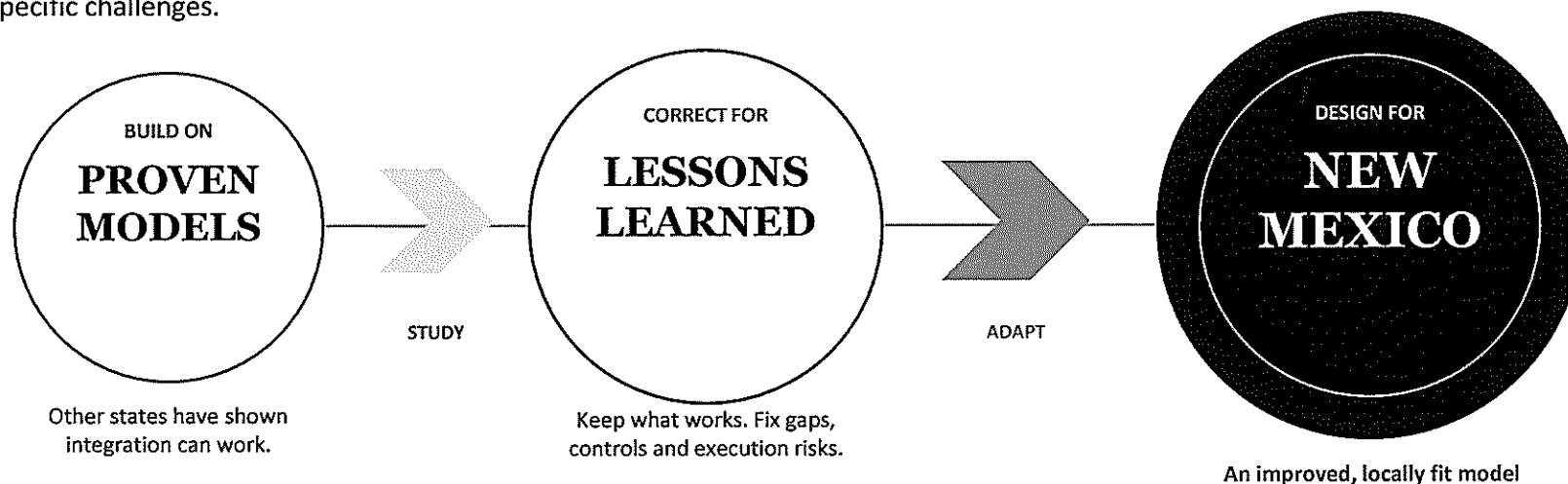
Diabetes, hypertension, and periodontal disease progress quietly until an ER visit forces the issue.



# New Mexico can build on proven models — then solve what they missed

• AN IMPROVED MODEL

We are not reinventing the wheel. After years of studying medical–dental integration programs, we propose a model adapted to New Mexico’s specific challenges.



## BUILT FOR NEW MEXICO

### 01 IDENTIFY EARLIER

Disease identification and prevention

### 02 REACH RURAL NM

The rural health access crisis

### 03 SUPPORT IHS CARE

Disease-management challenges

### 04 CONTROL COST

Program controls to bend healthcare cost trends

# Colorado proved the model. New Mexico adds what failed.

Colorado did not invent a delivery system. It trained an existing workforce to screen for diabetes and hypertension and built referrals between dental and medical providers. The evaluation's most useful finding is what went wrong.

## WHAT COLORADO BUILT

**80,000+**

screening visits delivered

**26**

partner organizations funded

**71%**

of patients reached were Medicaid-covered

*Integration never failed clinically. It stalled on billing knowledge, scope clarity, workflow design, and technical assistance — every one of which is a management problem.*

## WHAT NEW MEXICO ADDS

1

### A SFCC-trained coordinator who carries the hand-off

Colorado closed loops clinic to clinic. New Mexico's distances, languages and transport barriers need a person, not a fax-back.

2

### Local, centralized technical assistance

Scope guidance, coding, contracting and coaching held centrally so no single site is researching alone.

3

### Loop closure as the reported measure

Not referrals made. Attendance confirmed and the finding returned — auditable within months.

# The screening channel already exists

Nobody has been assigned to use it. Three delivery points already touch New Mexicans who rarely see a primary care provider. Given one shared dentimedical protocol, they become the State's early-detection and referral engine — without a new facility, a new licence, or a new category of provider.



## Dental offices

Patients attend twice a year, on a schedule they set themselves, and sit for the better part of an hour with a clinician they have known for years. Nationally, tens of millions of adults see a dentist and no physician in a given year.



## Mobile units

Dental and screening vans already reach pueblos, frontier communities, schools and worksites where no fixed clinic is viable. CMS's 2025 State Plan Amendment lets IHS and Tribal clinics deliver Medicaid services beyond the four walls.



## Community health workers

CHWs enter homes and community settings that no clinic reaches, and carry the cultural and linguistic trust that determines whether advice is acted on at all. We support the clinical need with telehealth support.

*The marginal cost of capturing a blood pressure in a chair that is already occupied, during an appointment that is already scheduled and already paid for, is close to zero. The State is not buying access. Access already exists. It is buying the protocol and provider support mechanism that turns an existing visit into a documented clinical finding someone can act on — at a low cost.*

# Cultural competency is the delivery mechanism

A screening that is declined produces nothing. In a state this diverse, acceptability is not a soft feature of the model — it is the variable that determines whether any clinical value is created at all.

1

## Hired from the community served

Coordinators are recruited and trained in the communities they will work in — pueblo, colonia, frontier town, and metro neighbourhood alike.

2

## Delivered in the person's language

Spanish, Diné, Keres, Tewa, Tiwa, Towa and Zuni where needed. Interpretation is budgeted, not improvised.

3

## Respectful of traditional practice

Health education is framed alongside traditional healing rather than in opposition to it, in coordination with tribal health departments.

4

## Consent-first, tenancy-neutral

Participation is voluntary everywhere it is offered, is never a condition of housing, employment or benefits, and refusal carries no consequence.

*Every measure in the evaluation is reported by language, tribal status, county and payor class. A program that improves the average while leaving a community behind will show that on the face of its own report.*

# A \$6 million, three-year pilot – a structured approach to reducing the cost of chronic disease.

One appropriation funds a dental-medical care-coordination structure designed to improve access and reduce costs with audited evidence New Mexico needs before scaling statewide.

**\$6.0M**

Three-year appropriation

**\$250**

Per person screened - most of whom have not recently visited a physician, to assess early onset of disease

**24,000**

New Mexicans screened who are currently high-risk and low-utilization

**4**

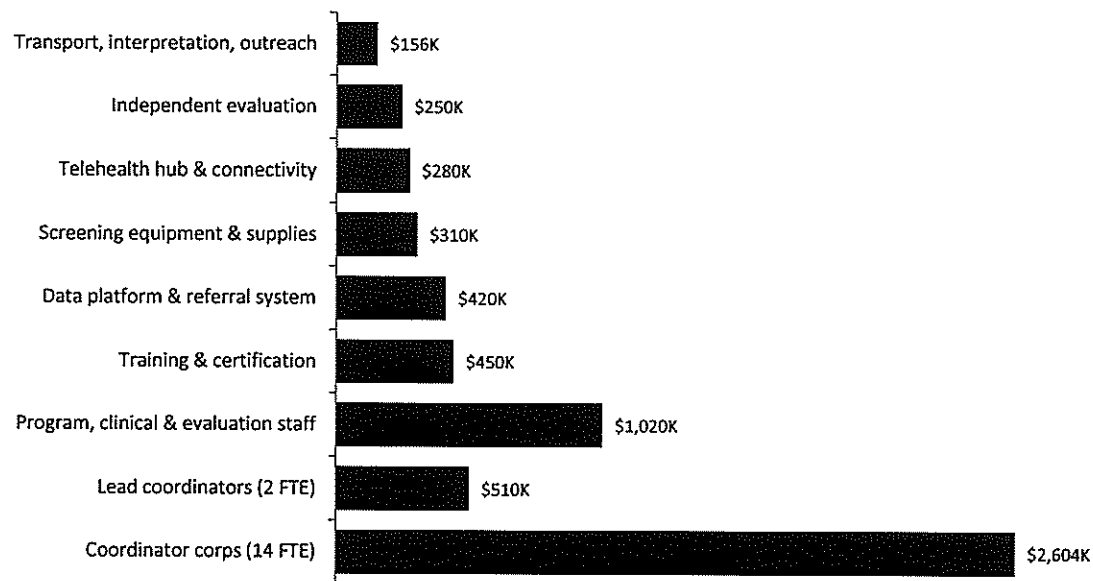
Payor channels evaluated side by side — Medicaid, Medicare Advantage, IHS and commercial

## What the State gets for it

- A modeled \$15.3 million in avoided medical cost over five years — a 2.6× return
- An independently evaluated, published specification other states can adopt
- Job creation in the communities that need them most
- A go / no-go decision point at month 30, based on audited results rather than advocacy

# Where the \$6 million goes

Sixty-nine percent of the appropriation is workforce. This is a people program, and the budget says so.



## \$4.13M

Personnel — 69%

## \$1.87M

Program, training, technology and evaluation — 31%

## \$2.0M

Per year, across three years

*No capital construction. No new facility. No new licence category. The program buys people, training, and the systems that let them prove what they did.*

Coordinator cost modeled at \$62,000 fully loaded including taxes and benefits; lead coordinators at \$85,000. Figures are planning assumptions to be confirmed against New Mexico market wage data.

### Verified Savings from Medical-Dental Integration

| Patient Profile                 | Annual Medical Cost Savings | Primary Driver of Savings                            | Source                                          |
|---------------------------------|-----------------------------|------------------------------------------------------|-------------------------------------------------|
| Diabetes & Heart Disease (Both) | \$515 to \$1,718            | 25%–36% lower inpatient healthcare costs             | <a href="#">USABLE Life Dental4Health Study</a> |
| Diabetes (Only)                 | \$549                       | Reduced inpatient service usage and hospitalizations | <a href="#">Mayo Clinic / Blue Cross Study</a>  |
| Coronary Artery Disease (Only)  | \$548                       | Reduced inpatient service usage and hospitalizations | <a href="#">Mayo Clinic / Blue Cross Study</a>  |
| Medicaid Patients with Diabetes | 14% total cost reduction    | Routine periodontal (gum disease) treatments         | <a href="#">CareQuest Institute Analysis</a>    |

Large-scale medical claims studies show that integrating preventive dental care for patients with diabetes and cardiovascular disease yields major cost reductions:

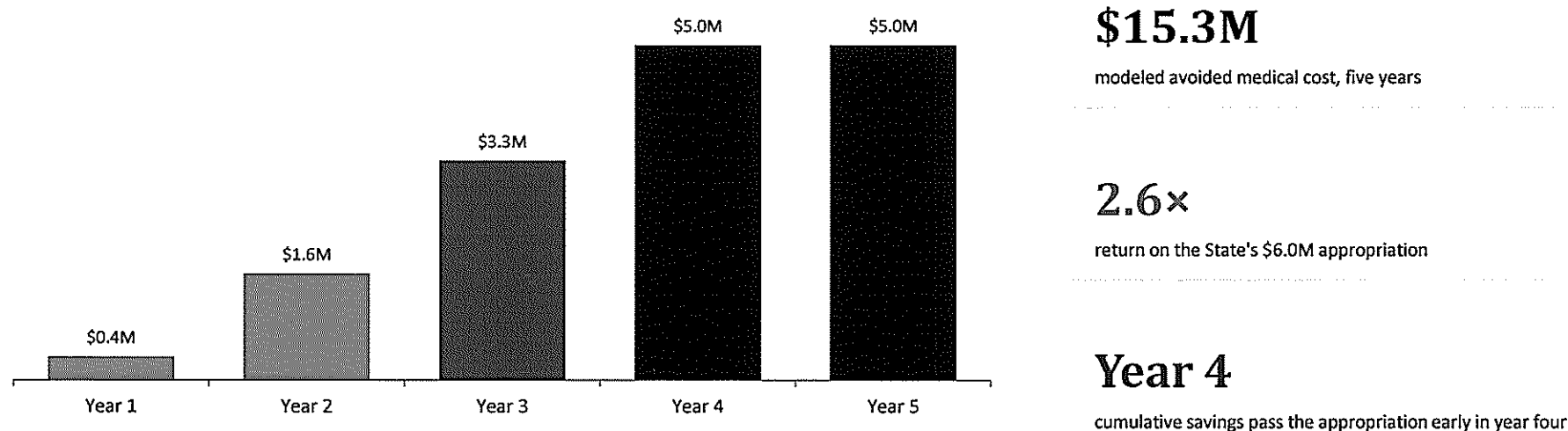
#### How these savings are achieved

The DCVDOHI framework targets the "bi-directional" link between oral health and systemic diseases:

- 1. Lowering Blood Sugar:** Treating periodontal disease reduces full-body inflammation, which improves HbA1c levels in diabetics and lowers the need for expensive crisis care.
- 2. Early Detection:** Performing blood pressure screenings in a dental chair catches undiagnosed hypertension early, preventing costly cardiovascular events like strokes or heart attacks.

## A modeled \$15.3 million in avoided cost over five years

Conservative by design. The model counts prevented diabetes cases, sustained blood pressure control, and avoided emergency dental episodes. It excludes cardiovascular events avoided, productivity gains, and every benefit that accrues after year five.



*Driven by 300 diabetes cases prevented or delayed, 1,080 people brought into sustained blood pressure control, and roughly 600 avoided emergency dental episodes a year at steady state.*

Modeled illustration. Savings basis: ADA Economic Costs of Diabetes (2022); CDC National DPP return-on-investment analysis; Colorado DCVDOHI program results. Assumptions documented in the technical appendix.



# Healthier US: the operating backbone

• ADMINISTRATIVE & MANAGEMENT SERVICES

Local providers lead care, community, and research. Healthier US provides the operational backbone that turns a compelling model into a running, compliant, financially sustainable enterprise.

## THE DENTIMEDTRICS TECHNOLOGY STACK



**Wellness network app** connecting patients and providers



**Huddleset** daily practice-performance reporting



**Healthier TV platform** the member education system



**OHI and SFCC learning management** provider & CHW training curriculum

## What Healthier US manages

- ✓ Dental data management & compliance support, incl. bidirectional EHR referral tracking
- ✓ Reimbursement strategy & revenue-cycle integrity, mapped separately across Medicaid, Medicare, Tribal/IHS, and commercial
- ✓ Provider training & the shared protocol
- ✓ Membership administration
- ✓ Performance data & KPI reporting, validated by an independent evaluation framework
- ✓ Payor & value-based contracting framework
- ✓ Business collaborator & partner network
- ✓ Innovation & financial administration

# From one pilot to four payor channels

STATEWIDE SCALE-UP · MEDICAID · MEDICARE ADVANTAGE · IHS & TRIBAL HEALTH · COMMERCIAL AND EMPLOYER PLANS

The Albuquerque pilot proves the unit economics. The same screening, education, and referral engine plugs into four existing payer channels that already cover most New Mexicans — each one funding the model from savings it captures directly.

## MEDICAID

**~700K**

covered lives under Turquoise Care

Fold screening and CHW referral into the four Turquoise Care MCO contracts as a value-added benefit and a quality measure. Managed care plans carry the downstream risk, so avoided admissions accrue to the same payer that funds the screening. Dual-eligible beneficiaries are coordinated through this same MCO relationship.

**\$37M**

modeled 5-year avoided medical cost

## IHS & TRIBAL

**244K+**

Navajo Area user population, plus 27 Albuquerque Area tribes and pueblos

CMS's 2025 State Plan Amendment lets IHS and Tribal clinics bill Medicaid for clinic services beyond the four walls — in homes, schools, and community sites. Mobile dental units and CHWs become a reimbursable extension of tribal health systems at 100% federal match.

**\$9M**

modeled 5-year avoided medical cost

## COMMERCIAL & EMPLOYER

**555K**

New Mexicans covered by employer plans

Employers buy the screening package for worksites and self-funded plans, following the Million Hearts and National DPP playbooks. Returns land as lower claims trend, fewer disability days, and reduced absenteeism for the businesses that pay the premium.

**\$19M**

modeled 5-year avoided medical cost

**\$65M**

in modeled avoided medical cost across the four channels over five years — roughly 11× the state's \$6.0M pilot appropriation, with each channel carrying its own share of the operating cost once the model is proven. A fourth channel — Medicare, via CMS's 2024 Community Health Integration and SDOH risk-assessment payment codes — reaches the same rural population through dual-eligible coverage.

Modeled illustration scaled from the Albuquerque pilot's per-participant economics. Coverage counts: NM Health Care Authority Turquoise Care enrollment; IHS Navajo and Albuquerque Area user population; AHIP New Mexico employer-sponsored coverage. Savings basis: ADA Economic Costs of Diabetes (2022) and CDC National DPP ROI analysis.



# The result: a win-win-win

Earlier detection for patients · new clinical roles and standing support for providers · measurable, value-based savings for payors and the State.

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*The New Mexico Integrated Wellness Initiative turns the places people already live, work, and socialize into front doors for health — for long-term gain for the entire population.*

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