HUMAN SERVICES DEPARTMENT

NM PRIMARY CARE COUNCIL UPDATE TO LEGISLATIVE HEALTH AND HUMAN SERVICES COMMITTEE

NICOLE COMEAUX, J.D. MPH; AUDREY COOPER, RN; JEFF CLARK, MD; ROHINI MCKEE, MD

OCTOBER 26, 2021

BEFORE WE START...

On behalf of all colleagues at the Human Services Department, we humbly acknowledge we are on the unceded ancestral lands of the original peoples of the Apache, Navajo and Pueblo past and present.

With gratitude we pay our respects to the land, the people and the communities that have contributed to what today is known as the State of New Mexico.

PHOTO COURTESY: HSD Employee

HUMAN SERVICES DEPARTMENT

MISSION

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

GOALS

We help NEW MEXICANS

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

We communicate EFFECTIVELY

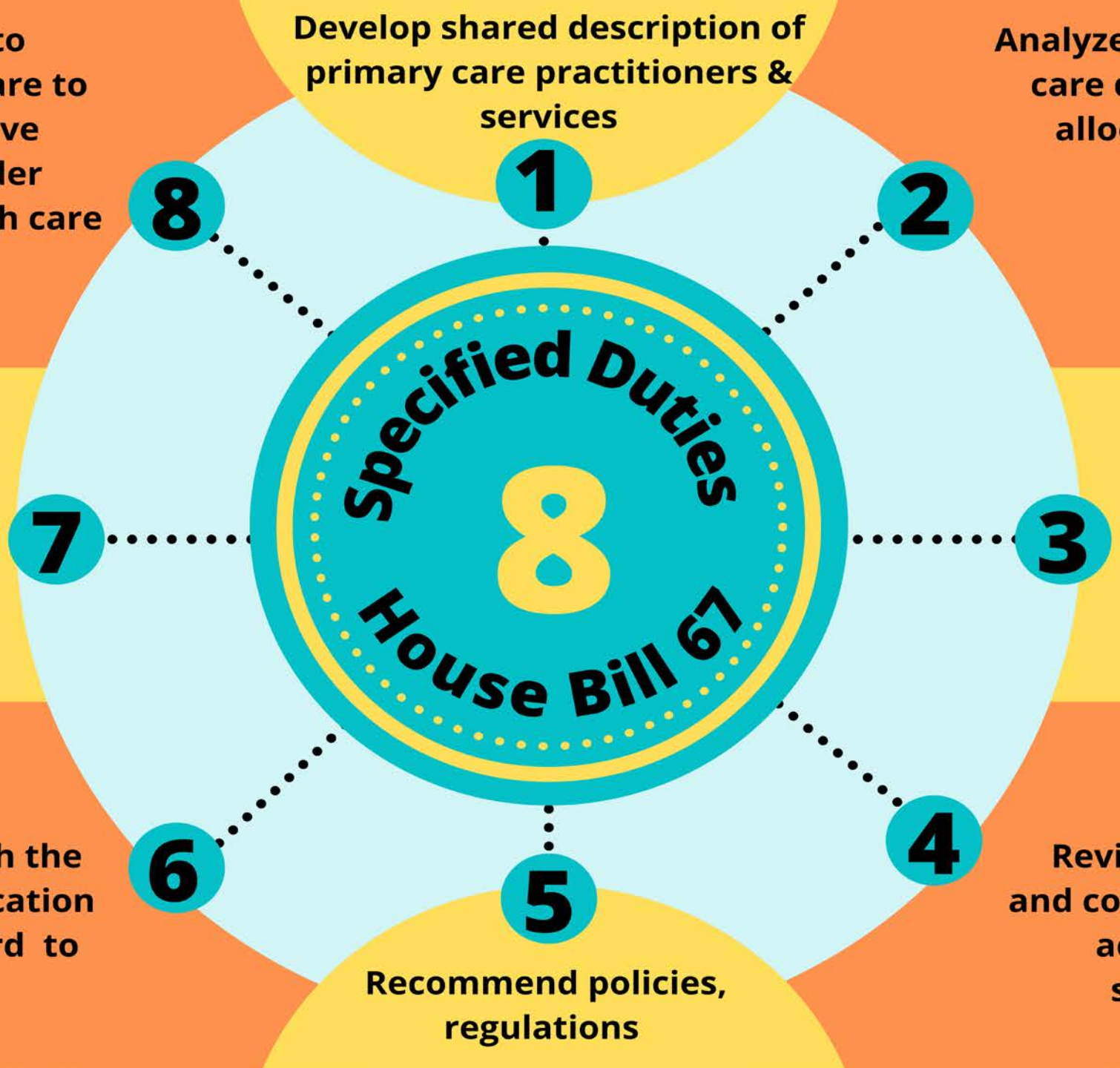
2. Create effective, transparent communication to enhance the public trust.

We make access EASIER

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

We support EACH OTHER

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



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

Specified Duty 8 House Bill 67

NEW MEXICO PRIMARY CARE COUNCIL

MISSION

Revolutionize primary care into InterProfessional, sustainable teams delivering high-quality, accessible, equitable health care across New Mexico through partnerships with patients, families, and communities.

VISION

By 2026, New Mexico will exemplify same-day access to high-quality, equitable primary care for all persons, families, and communities.

GOALS

Equity

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

Health Technology

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

Payment Strategies

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

Workforce Sustainability

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

AGENDA & PRESENTERS

- State of Primary Care in U.S.
- State of Primary Care in New Mexico
- House Bill 67 (2021)
- New Mexico Primary Care Council
  - Mission, Vision, & Goals
  - Composition
  - Revolution to Improve Lives

SPEAKERS

Nicole Comeaux, J.D., MPH
NM Medicaid Director

Audrey Cooper, R.N.
Manager, Primary Care & Food Security

Jeffrey B. Clark, M.D.,MPH, MSS, FAAFP, HSD Primary Care Council Representative

Rohini McKee, M.D.,MPH,
Chief Quality & Safety Officer, UNM Hospital

MEET EDDIE

- Eddie lives in NM, is in his 60's, and active.
- He was seemingly healthy until he started to get more and more tired by the day.
- When he finally saw a doctor (Dr. Rohini McKee, UNMH) it was first time he had seen a physician in 15+ years.
- **Colonoscopy revealed large colon cancer and severe anemia (very low red blood cell levels).**
- He asked Dr. McKee if he could postpone surgery until elk hunting season was over. Dr. McKee stated surgery could not wait.
  - He required overnight stay in ICU and blood transfusion before surgeons could attempt cancer removal.

* Based on a real patient whose name and photo are changed.

PRIMARY CARE NATIONAL TRENDS AND INNOVATIONS

GUIDING RESOURCES

- National Level
  - National Academy of Science, Engineering and Medicine: *Primary Care Report*
  - New Primary Care Paradigm Open Letter: *Unified Voice, Unified Vision, Changing Primary Care Finance*
- State Level: 2021 House Bill 67
- Community Level: NM Primary Care Council Inaugural Meeting Themes, Mission, Goals, Objectives, Tactics

Unified Voice, Unified Vision, Changing Primary Care Finance

Dear policy makers, payers, purchasers, and the public:

Our health system is failing, and the pandemic is expediting its collapse. Life expectancy is in decline, the prevalence of chronic illness has risen, and disparities in health outcomes have deepened. Our health system isn't just broken – it is bankrupting many in our country.

The current financing of U.S. health care was designed almost 60 years ago to shield against financial loss from serious illness, rather than to meet modern society's desire to invest in health and our future. This is a pivotal moment for our nation's health, requiring a new paradigm for financing primary care and health promotion.

As physician societies and boards, our greater than 400,000 members are the source of trusted, healing relationships for 8 in 10 Americans, serving the health needs of the U.S. population through over half a billion annual patient visits.[1] This essential role in the health system is currently supported by only 6% of all resources spent on health care,[2] which is inadequate. The views of our seven organizations are not always the same, but in this we are united: in order to help the people of our nation achieve better health outcomes, reduce unnecessary health care costs and rectify social inequities, the U.S. must recognize and invest in primary care as a public good. To bring U.S. primary care on par with high performing countries would mean a relatively small shift in resources that stands to create tremendous improvement in health outcomes.

As leaders in the provision of primary and comprehensive care, we regard the responsible stewardship of the health of our nation as a sacred trust. There is a direct relationship between the kind of primary care we deliver and the way in which it is financed and paid. *Advancing primary care as a public good will require shifting the paradigm of primary care financing, creating a unified approach among all payers, and dismantling the regulatory and financing structures that institutionalize the status quo.*

We understand that what we are calling for is significant and will take substantial time and effort. We are committed to doing this hard work together. We invite other clinician groups and professional societies to join us in this journey toward better health for all of our patients. We will work in partnership with payers, purchasers, policymakers, and patients to bring a modern system into being. The health of the public cannot wait. The time for partnership and action is now.

Sincerely (Elected leaders & CEOs),

American Academy of Family Physicians
Ada D. Stewart, MD, FAAFP, President
Shawn Martin, MD, Executive Vice President and CEO Designee

American Academy of Pediatrics
Sara H. Goza, MD, FAAP, President
Mark Del Monte, JD, CEO and Executive Vice President

American Board of Family Medicine
John Brady, MD, Chair
Warren Newton, MD, MPH, President and CEO

American Board of Internal Medicine
Marianne M. Green, MD, Chair
Richard J. Baron, MD, MACP, President and CEO

American Board of Pediatrics
Victoria F. Norwood, MD, Chair
David G. Nichols, MD, MBA, President and CEO

American College of Physicians
Jacqueline W. Fincher, MD, MACP, President
Darilyn V. Moyer, MD, FACP, FRCP, FIDSA, Executive Vice President and CEO

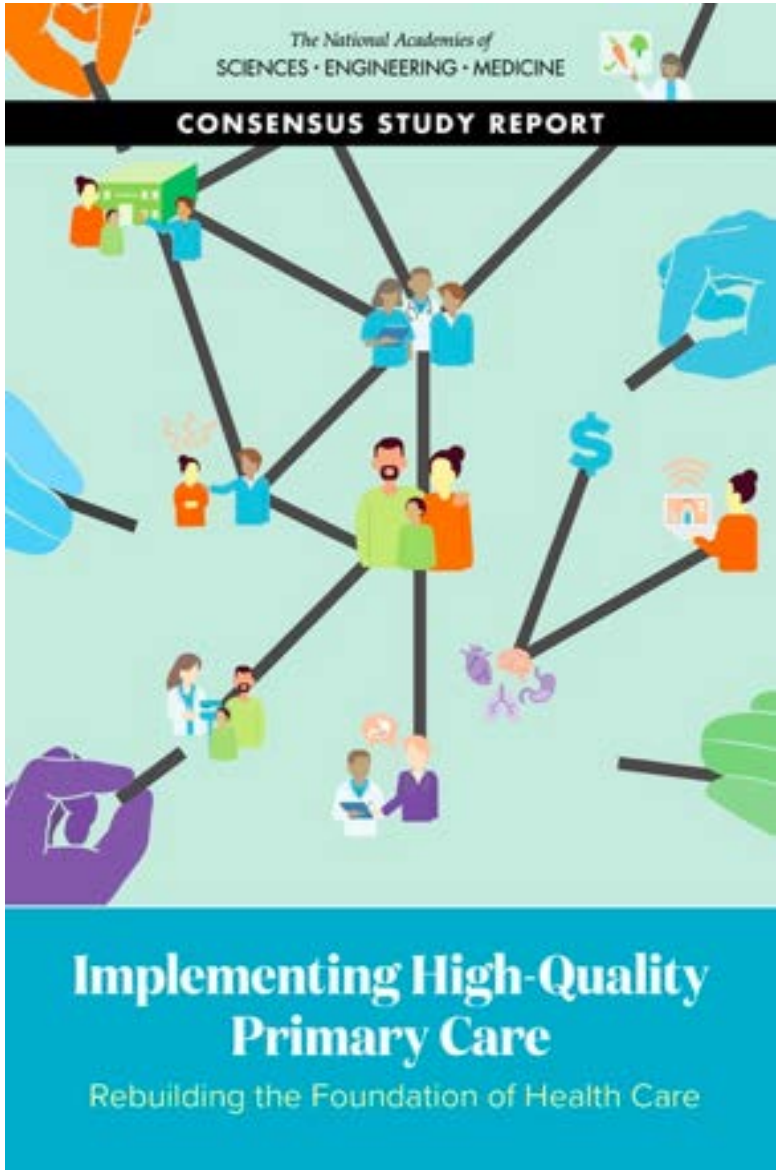
Society of General Internal Medicine
Jean S. Kutner, MD, MSPH; President
Eric B. Bass, MD, MPH, CEO

[1] National Ambulatory Medical Care Survey: 2016 Summary Tables. Accessed November 25, 2020.
[2] Martin S, Phillips RL, Petterson S, Levin Z, Bazemore AW. Primary Care Spending in the United States, 2002-2016. JAMA Intern Med. 2020;180(7):1019–1020. doi:10.1001/jamainternmed.2020.1360

www.newprimarycareparadigm.org

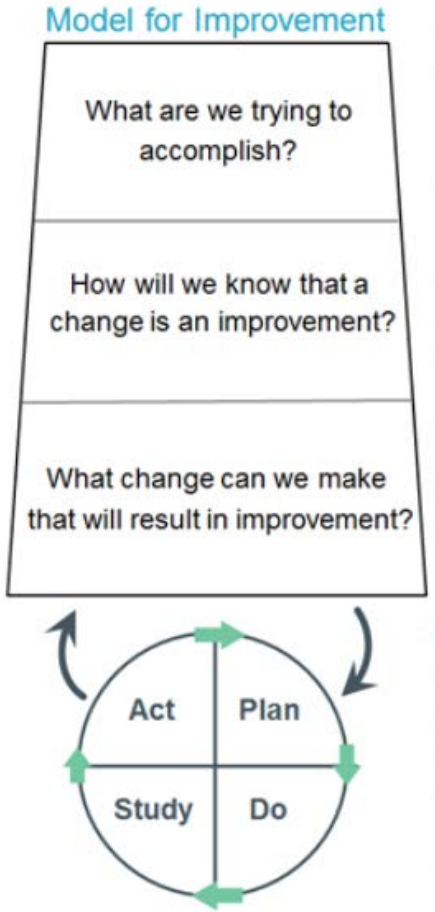
NATIONAL ACADEMY OF SCIENCE, ENGINEERING, & MEDICINE

- Pay for primary care teams to care for people, not doctors to deliver services.
- Ensure that high-quality primary care is available to every individual and family in every community.
- Train primary care teams where people live and work.
- Design information technology that serves the patient, family, and interprofessional care team.
- Ensure that high-quality primary care is implemented in the United States.



RECOMMENDATIONS TO IMPROVE PRIMARY CARE

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



HUMAN SERVICES DEPARTMENT

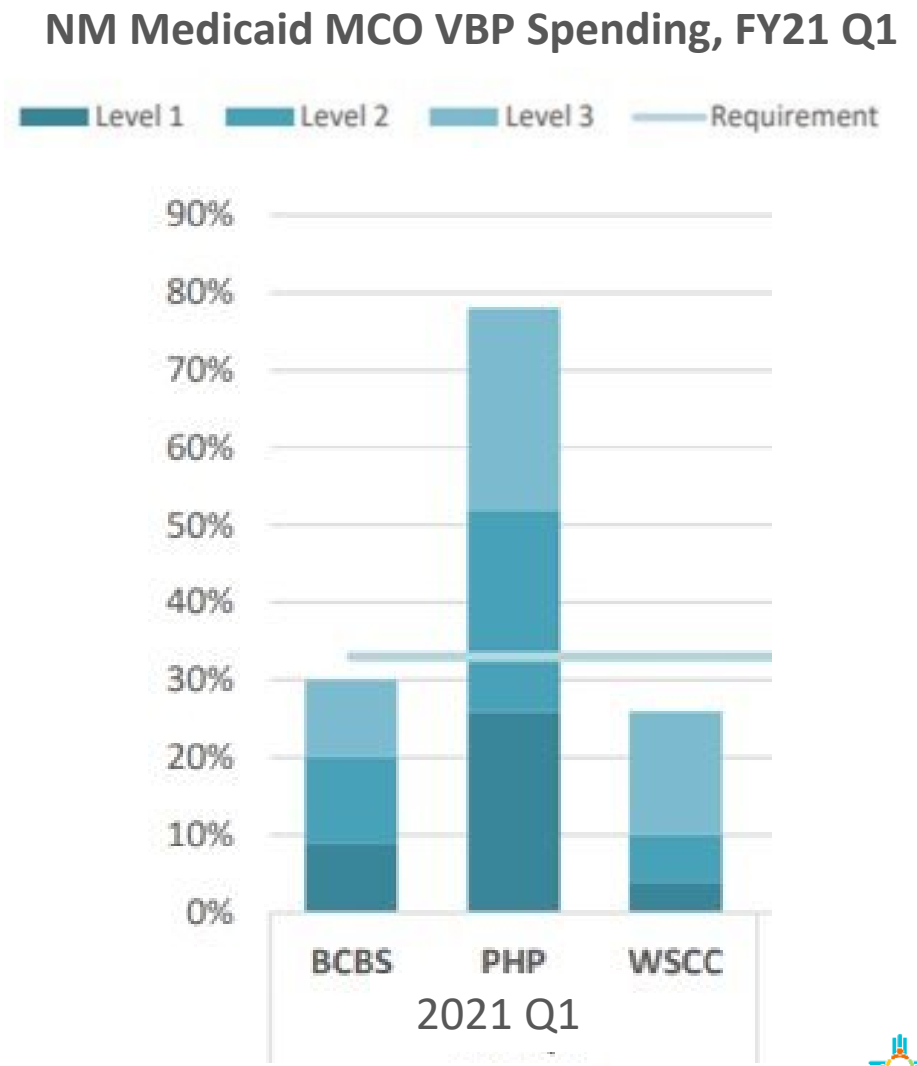
MEDICAID AND MEDICARE REIMBURSEMENT

- US Centers for Medicare & Medicaid Services (CMS) 2021 **Medicare** physician fee schedule contained increase of 10%+ in Medicare allowed charges for family physicians.
- 2019 **NM Medicaid** rate increases across primary care (including behavioral health) settings.
- **Comprehensive NM Medicaid rate review underway.**

2019 NM Medicaid Provider Rate Increases (TOTAL $475 M)	
Item	**Amount**
E&M Codes	$374.4 M
Outpatient Behavioral Health Codes	$58.6 M
Non-profit Hospitals	$14.6 M
Long-term Supports & Services	$11.9 M
Dental	$4.6 M
Federally Qualified Health Centers	$4.4 M
Community-based Pharmacies	$2.1 M
Topical fluoride varnish	$2.0 M
Project ECHO	$900,000
TCM and CCM Codes	$800,000
Program of All-Inclusive Care for the Elderly (PACE)	$650,000
Assisted Living Facilities	$320,000
Supportive Housing Services	$230,000

VALUE-BASED HEALTH CARE

- Fee-for-service incentivizes volume of care and greater spending.
- Value-based care incentivizes accountability for outcomes and cost.
  - Providers reimbursed based on ability to improve quality of care in cost-effective manner while lowering cost.
  - Role of Primary Care shifts from chronic disease management to prevention medicine.
  - HSD requires Medicaid Managed Care Organizations (MCOs) to implement Value Based Purchasing (VBP) based on improved outcomes.
    - MCOs must meet minimum targets for three levels of VBP arrangements.

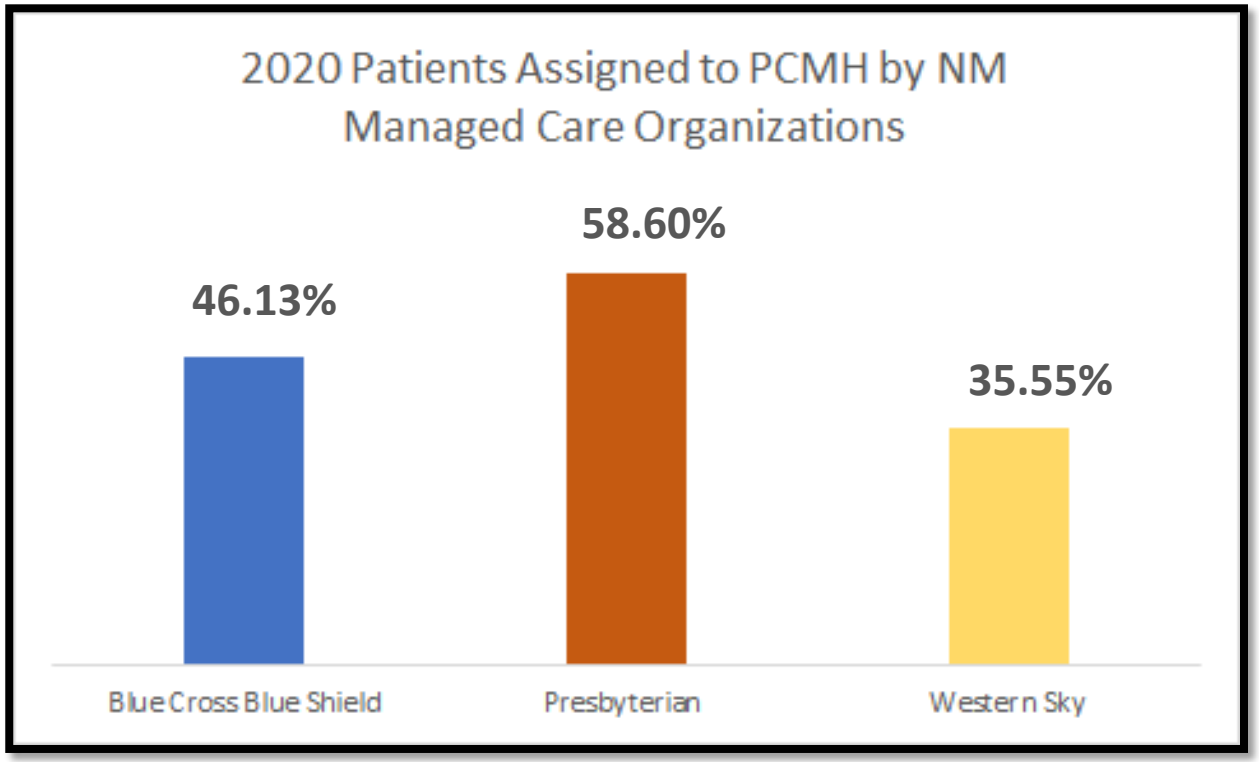


Link: https://www.hsd.state.nm.us/wp-content/uploads/NM_1115-DY8Q2_CMS-Quarterly-Monitoring-Report_20210827.pdf

PATIENT-CENTERED MEDICAL HOME (PCMH)

Patient Centered Medical Homes is a philosophy of team-based healthcare:

- Patient-centered care primary care.
- Comprehensive: Primary Care team works as one to meet each patient's physical and mental health care needs.
- Access: Patient has access to the Primary Care team.
- Quality and safety: Uses evidence-based medicine, patient satisfaction, quality improvement metrics.
- Coordination: Works with health services and specialists.



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ADAPTING NATIONAL TRENDS TO NEW MEXICO

Patient Centered Medical Homes

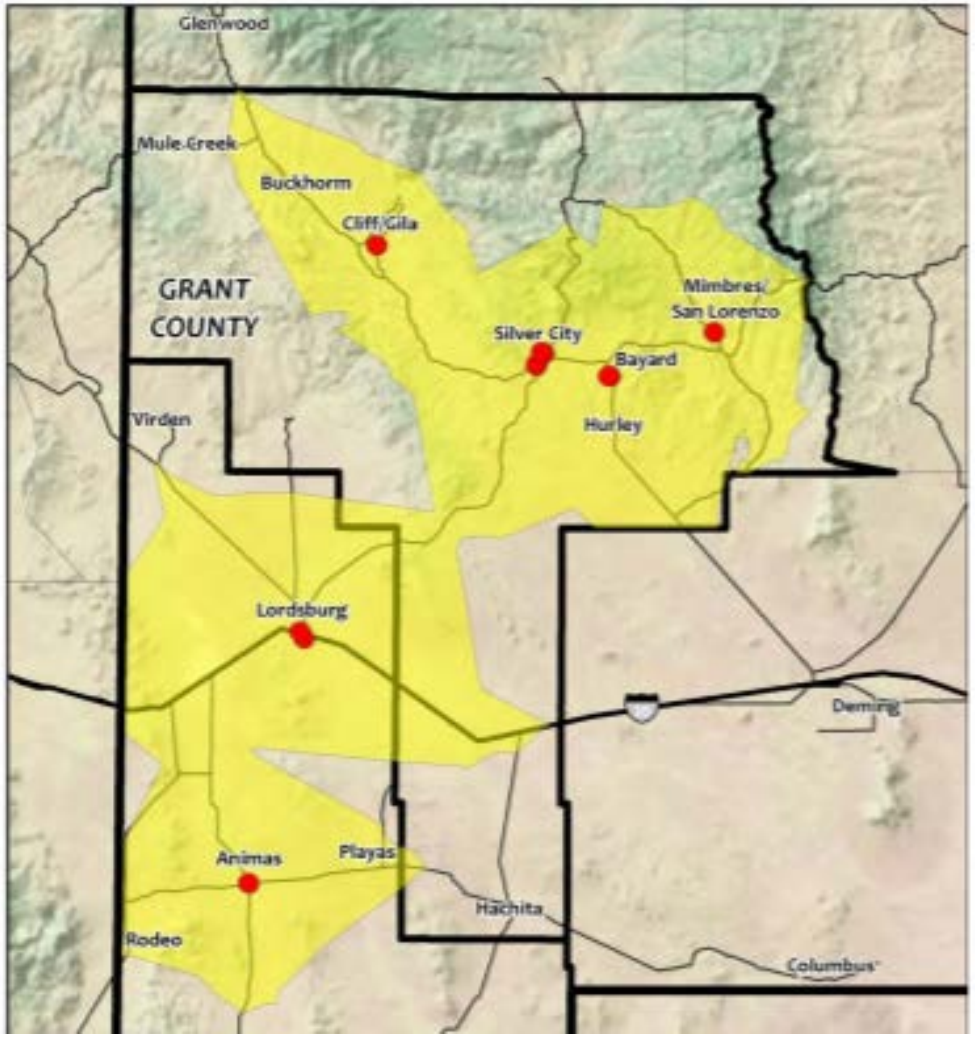
Hidalgo Medical Services (Federally Qualified Health Center) has 13 PCMH sites recognized by Accreditation Assoc. for Ambulatory Health Care serving 16,000 people annually.

High-fidelity wrap around services

Team-based, structured best practice approach for the planning and coordination of services and supports including Primary Care.

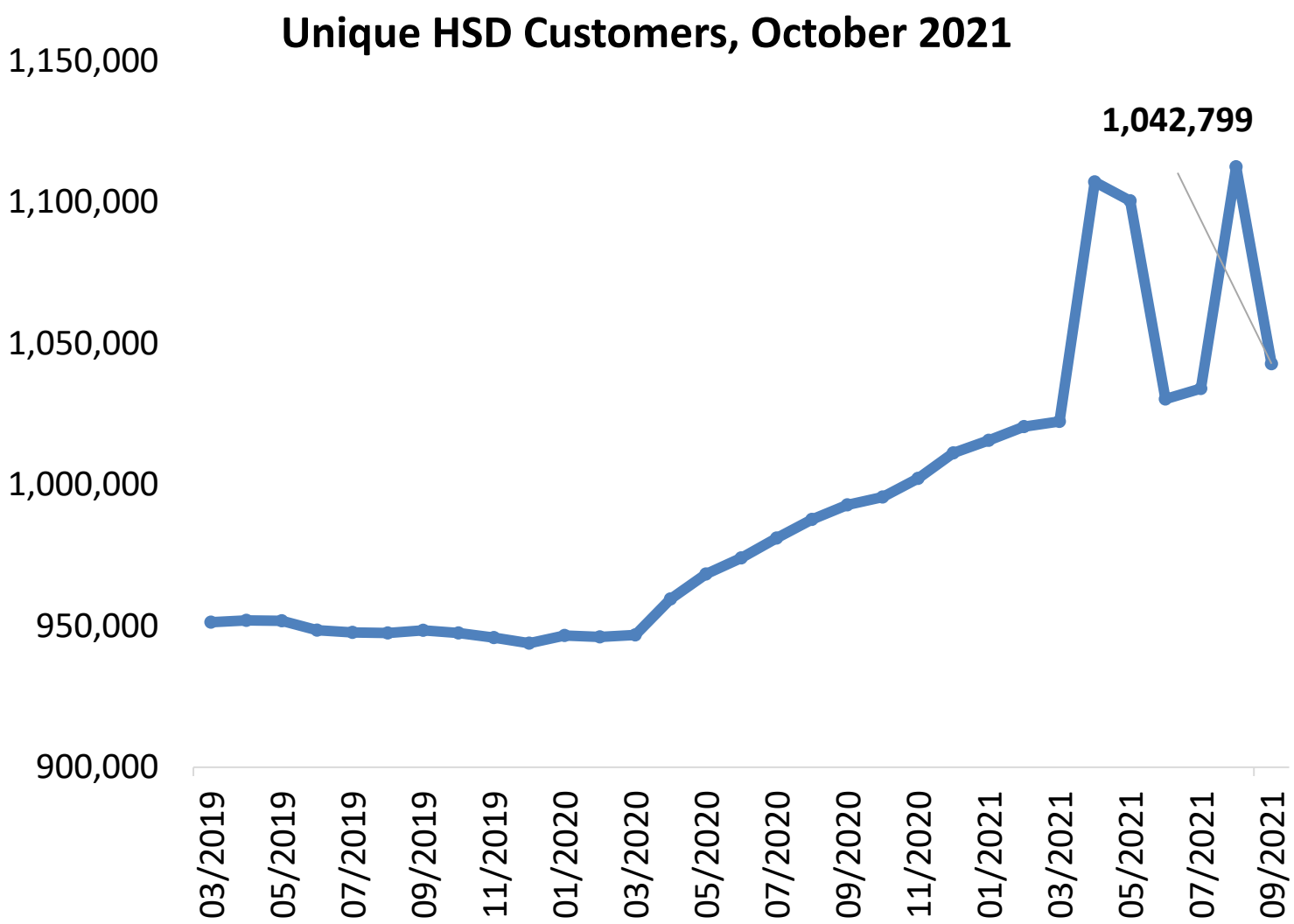
Link: https://www.nmlegis.gov/handouts/LHHS%20070918%20Item%208%20Hidalgo%20Medical%20Services%20Presentation.pdf

Hidalgo Medical Services PCMH Sites (Red) and Catchment Areas (Yellow)

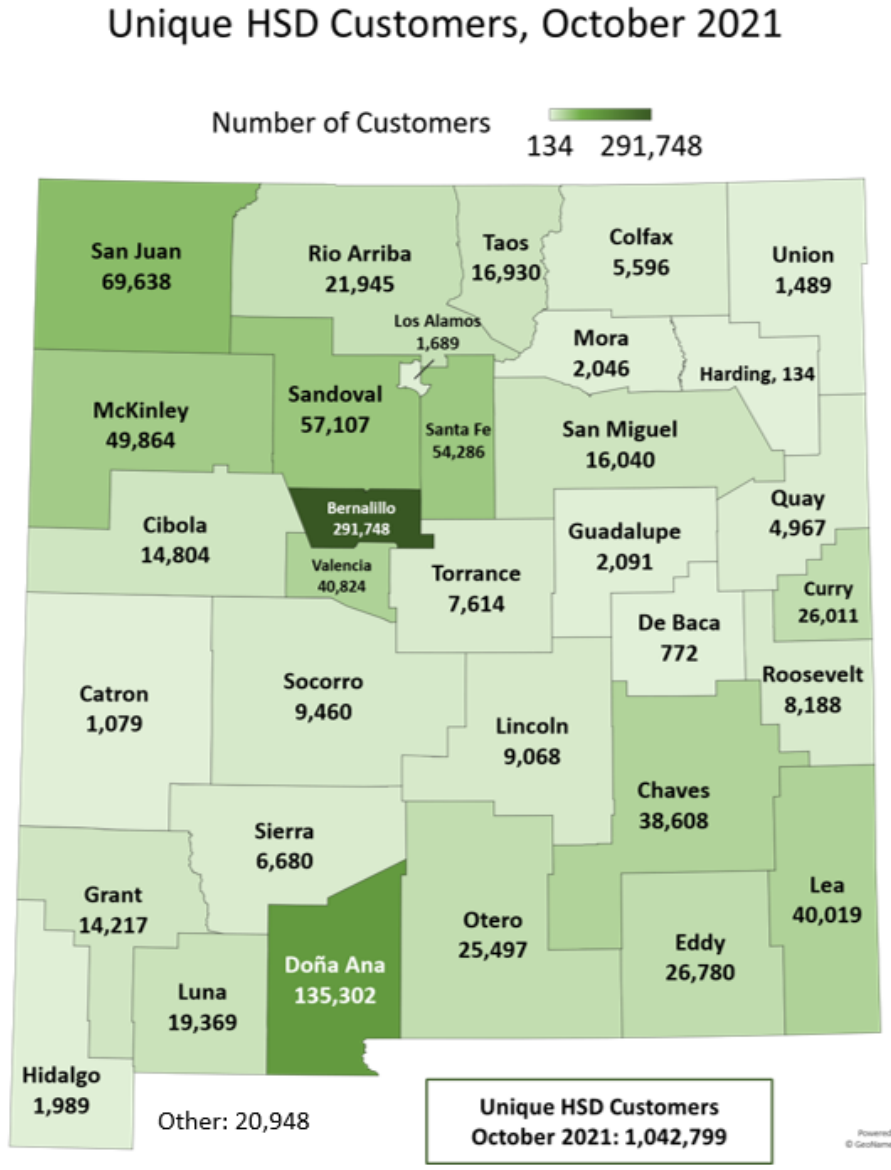


PRIMARY CARE IN NEW MEXICO

HSD SERVES HALF OF NEW MEXICANS



Note: P-EBT participants added to the totals in April 2021, May 2021, and August 2021



HSD'S SOCIAL IMPACT: NM BENEFITS FROM MODERN AND RESPONSIVE SOCIAL SAFETY NET

HSD's Programs have had the following social impact:

385,275,290 meals provided to New Mexicans through Supplemental Nutrition Assistance Program (SNAP) **since January 2021**

946,718 individuals provided the ability to visit a doctor, afford medication and immunizations through Medicaid **in September 2021**

63,378 homes heated and cooled for New Mexico families through Low Income Energy Assistance Program (LIHEAP) **in Federal Fiscal Year 2021**

12,650 families provided shelter and necessities through Temporary Assistance for Needy Families (TANF) Program **in September 2021**

$134.74* per month on average through child support to help kids be happy and healthy **over the last 12 months**

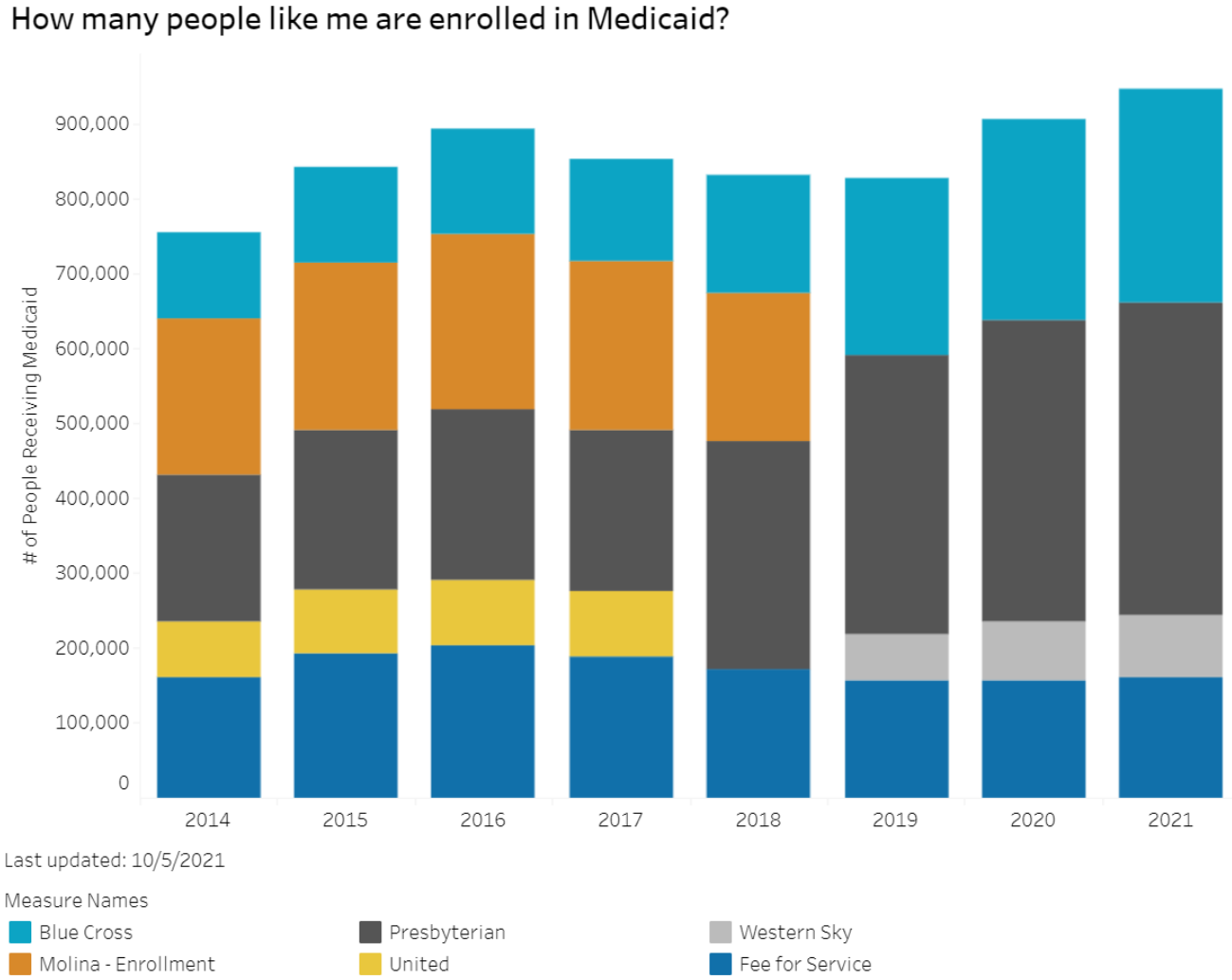
last updated: 10/15/2021

*collections include current support and arrears debt to the custodial parent and/or the state.

Source: https://www.hsd.state.nm.us/

GUIDING MEDICAID PRINCIPLES

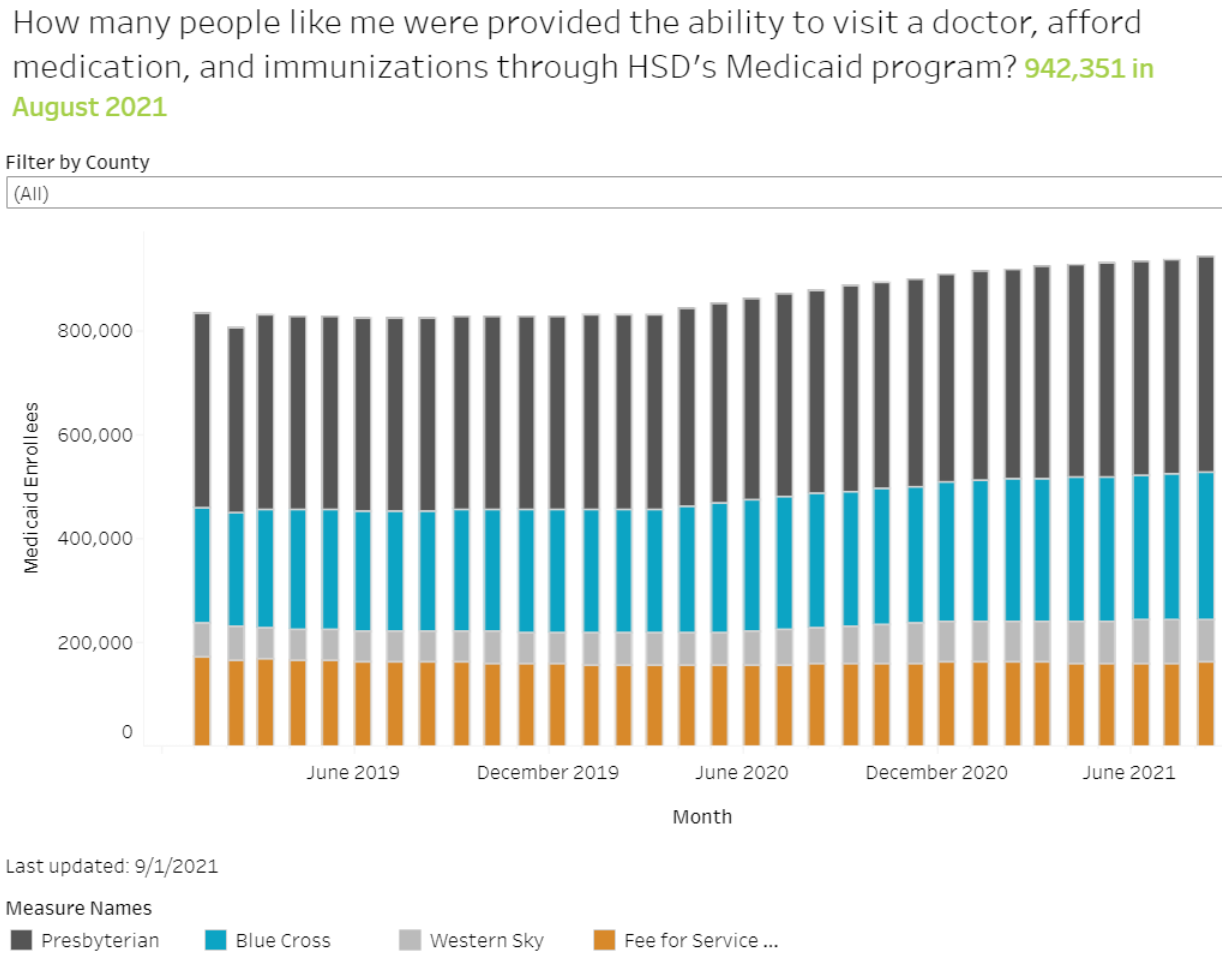
- NM has highest population percentage covered by Medicaid, which creates greater HSD responsibility to our healthcare market and to fair payments.
- Overwhelming majority of federal Medicaid dollars must be spent on providing direct services to Medicaid beneficiaries.
- HSD aims to optimally leverage federal funds to improve the health of New Mexicans, while maintaining strict compliance with the law.



Source: https://sites.google.com/view/nmhsdscorecard/goal-1/access-to-care-medicaid-and-snap

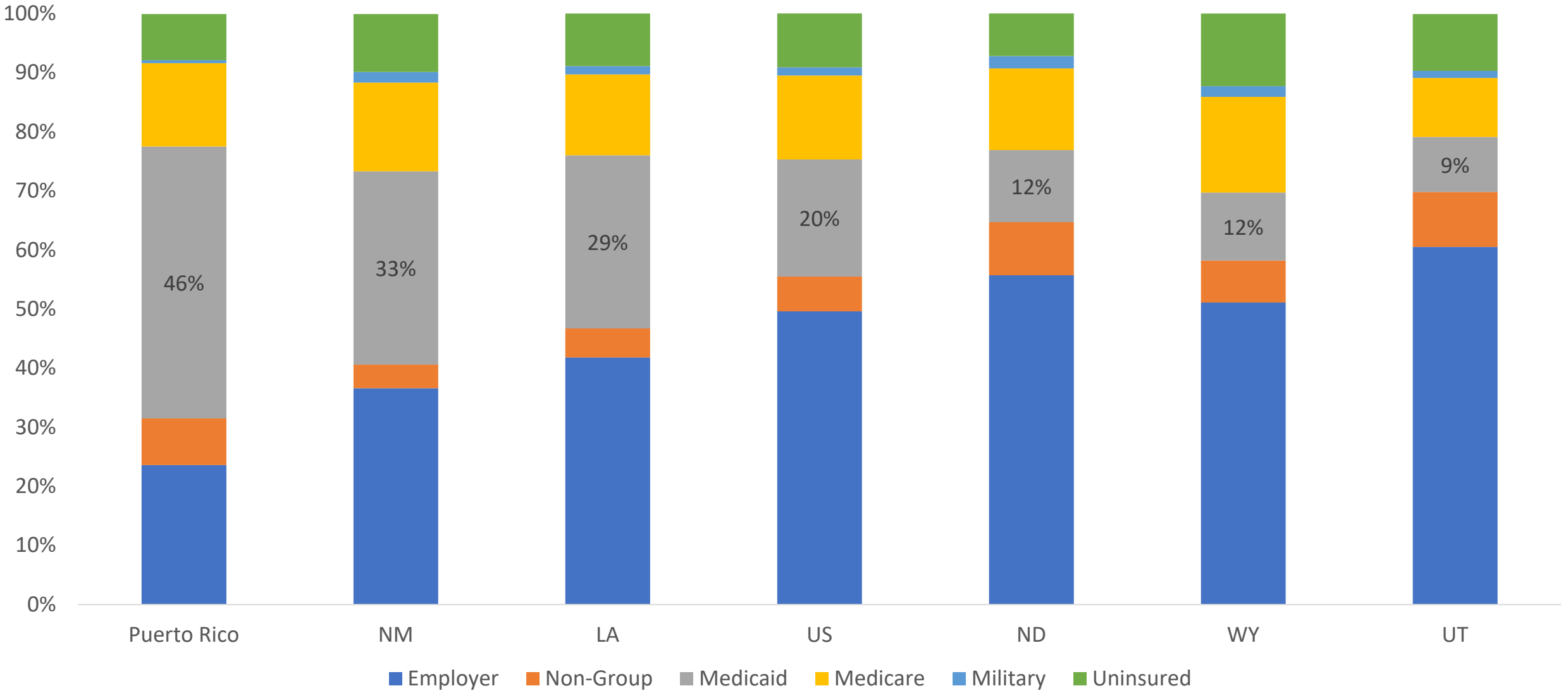
MEDICAID ENROLLMENT PROJECTION IN CONTEXT

- 937,200 total beneficiaries in June 2021
  - 957,600 anticipated by December 2021
  - 899,000 anticipated by March 2022
- 82% enrolled in managed care
- 45% (up from 40% pre-COVID) of all New Mexicans enrolled in Medicaid
- 43% of beneficiaries are children
  - 58% (up from 56% pre-COVID) of NM children enrolled in Medicaid
  - 71% of all births in NM covered by Medicaid



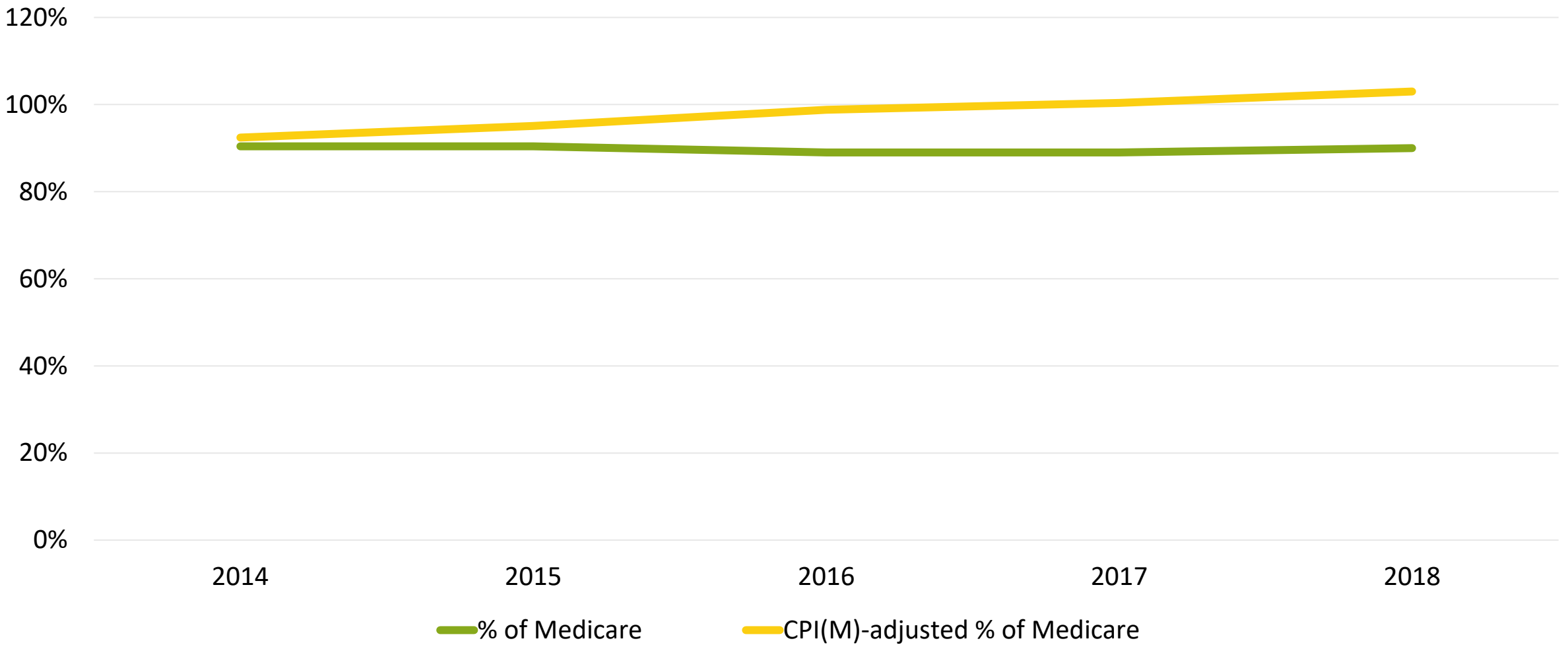
Graphic source: https://sites.google.com/view/nmhsdscorecard/social-impact

Medicaid Coverage as % Total Population, Top and Bottom 3 Locations and US Average, 2019



Source: https://www.kff.org/other/state-indicator/total-population/?currentTimeframe=0&selectedDistributions=employer--non-group--medicaid--medicare--military--uninsured--total&sortModel=%7B%22colId%22:%22Medicaid%22,%22sort%22:%22desc%22%7D

MAINTAINING PROVIDER NETWORK: HISTORIC MEDICAID PROVIDER RATES VS. CPI (MEDICAL) INFLATED RATES

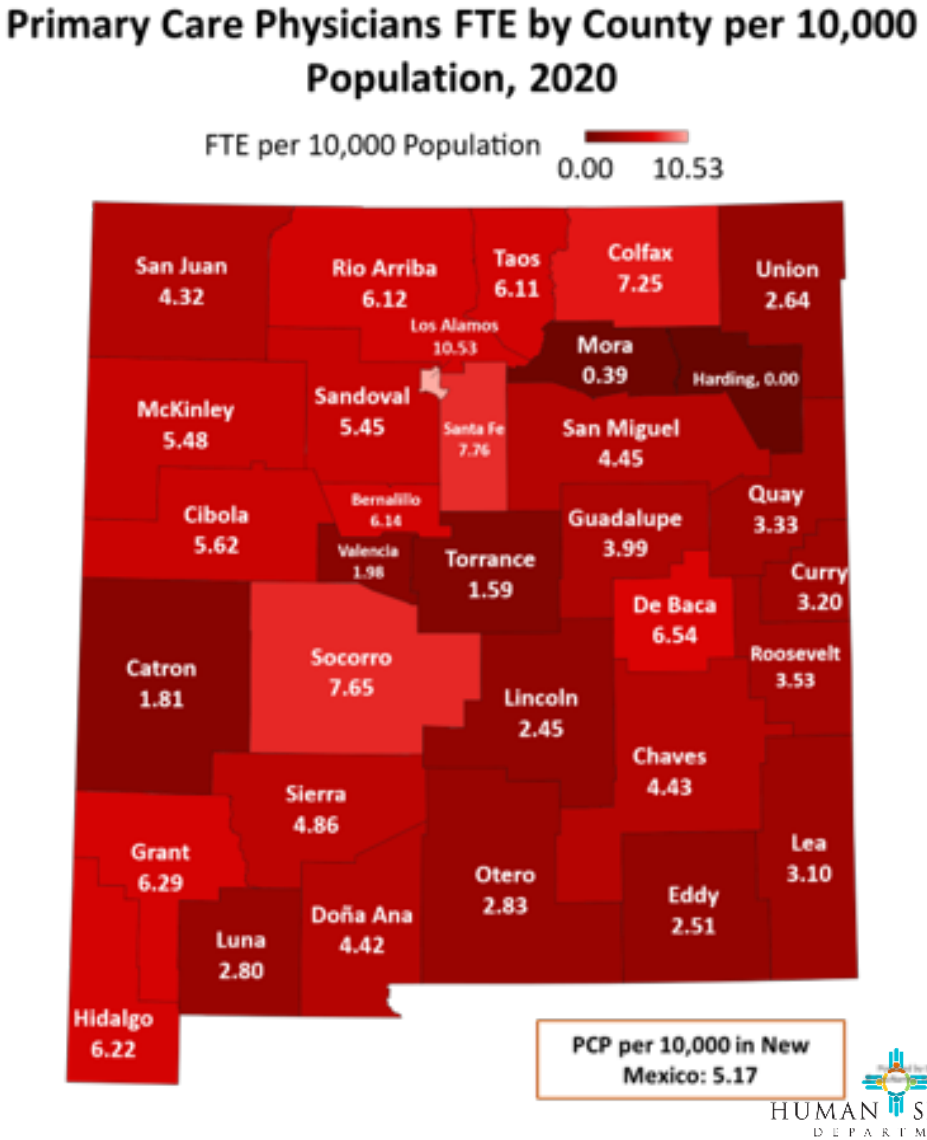


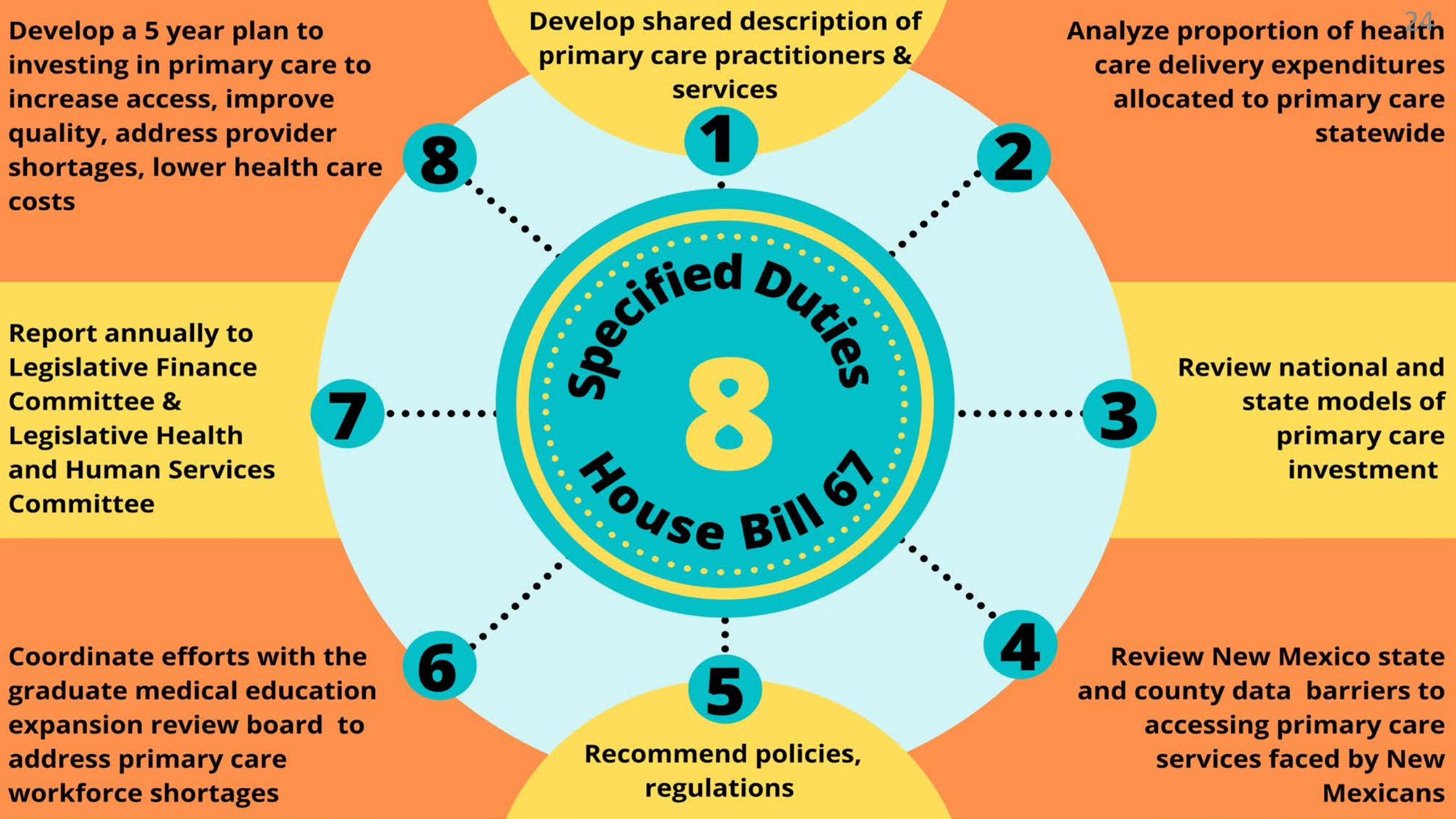
Sources: https://www.kff.org/medicaid/state-indicator/medicaid-to-medicare-fee-index/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D; https://www.bls.gov/charts/consumer-price-index/consumer-price-index-by-category-line-chart.htm

HUMAN SERVICES DEPARTMENT

PRIMARY CARE IN NM: REASONS FOR A REVOLUTION

- **Access:** Patients cannot access timely primary care, especially rural and frontier communities.
- **Workforce:** NM has Primary Care Clinician shortage statewide.
- **Quality**: Currently paying for services instead of outcomes.
- **Payment innovation:** Past increases in behavioral health, FQHCs, and dental; commitment to market responsibility remains.
- **Equity**: Health outcomes are worse in populations with fewer resources, especially in rural and frontier areas.




Specified Duties
8
House Bill 67
1
Develop shared description of primary care practitioners & services
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Analyze proportion of health care delivery expenditures allocated to primary care statewide
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Review national and state models of primary care investment
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Review New Mexico state and county data barriers to accessing primary care services faced by New Mexicans
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Recommend policies, regulations
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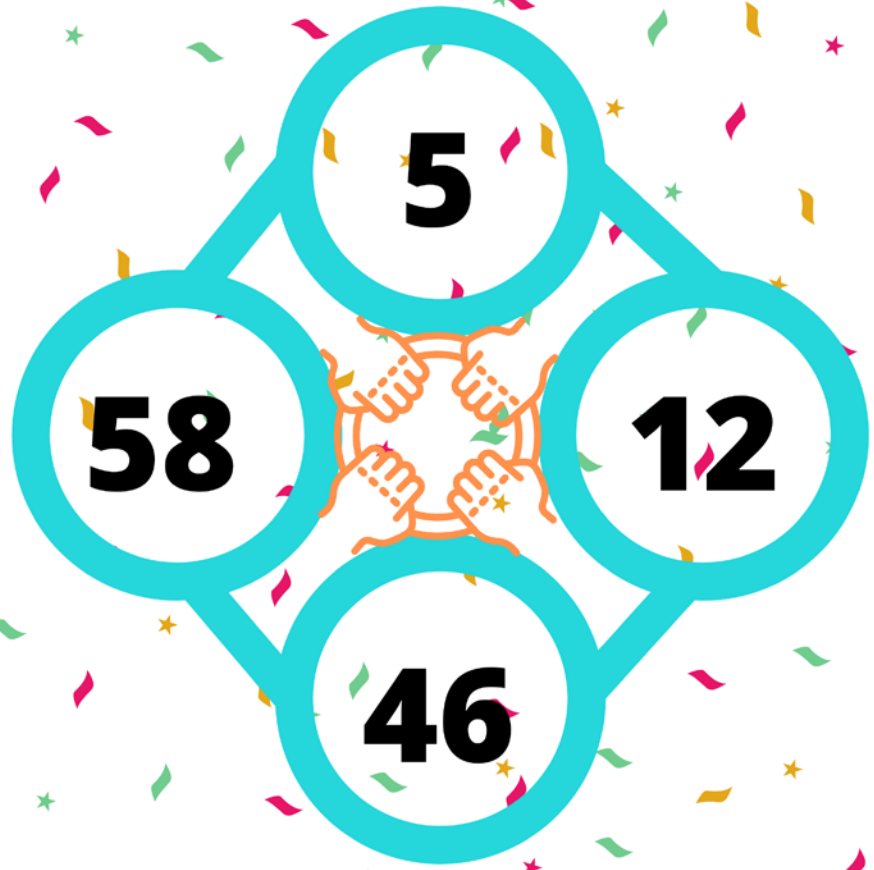
Coordinate efforts with the graduate medical education expansion review board to address primary care workforce shortages
7
Report annually to Legislative Finance Committee & Legislative Health and Human Services Committee
8
Develop a 5 year plan to investing in primary care to increase access, improve quality, address provider shortages, lower health care costs

Primary Care Council Member	Organization	County
Jennifer Phillips, MD (Chair)	UNM	Bernalillo
Kathy R. Fresquez-Chavez, NP	Bella Vida Health Care Clinic	Valencia
Valory Wangler, MD	Rehoboth McKinley Christian Health Care Services	McKinley
James Skeet	Spirit Farm	McKinley
Alisha Parada, MD	UNM	Bernalillo
Anjali Taneja, MD	Casa de Salud	Bernalillo
Gretchen Ray, PharmD	UNM	Bernalillo
Jason Mitchell, MD:	Presbyterian	Bernalillo
Jon Helm, RN	First Choice Comm. Healthcare	Bernalillo
Rohini McKee, MD	UNM	Bernalillo
Matthew Probst, PA	El Centro Family Health	San Miguel
Scott Flury, Patient Advocate	La Clínica del Pueblo de Rio Arriba	Rio Arriba
Lori Zink, MD	BCA Pediatrics	Eddy
Eileen Goode, RN	NM Primary Care Assoc.	Statewide
Dep. Sec. Laura Parajon, MD	NMDOH	Statewide
Jeff Clark, MD	NMHSD	Statewide
Julie Weinberg	NMOSI	Statewide
Troy Clark	NM Hospital Assoc.	Statewide
Wei-Ann Bay, MD	Blue Cross and Blue Shield of NM	Statewide
Maggie McCowen, LISW	NM Behavioral Health Provider Assoc.	Statewide
Ruby Ann Esquibel	Legislative Finance Comm.	Statewide
Susan Wilson	NM Coalition for Healthcare Value	Statewide

WHAT WE DID TOGETHER

WORKGROUPS



HOURS

WEEKS

MEETINGS

HUMAN SERVICES DEPARTMENT

Investing for tomorrow, delivering today.

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Workforce Sustainability

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

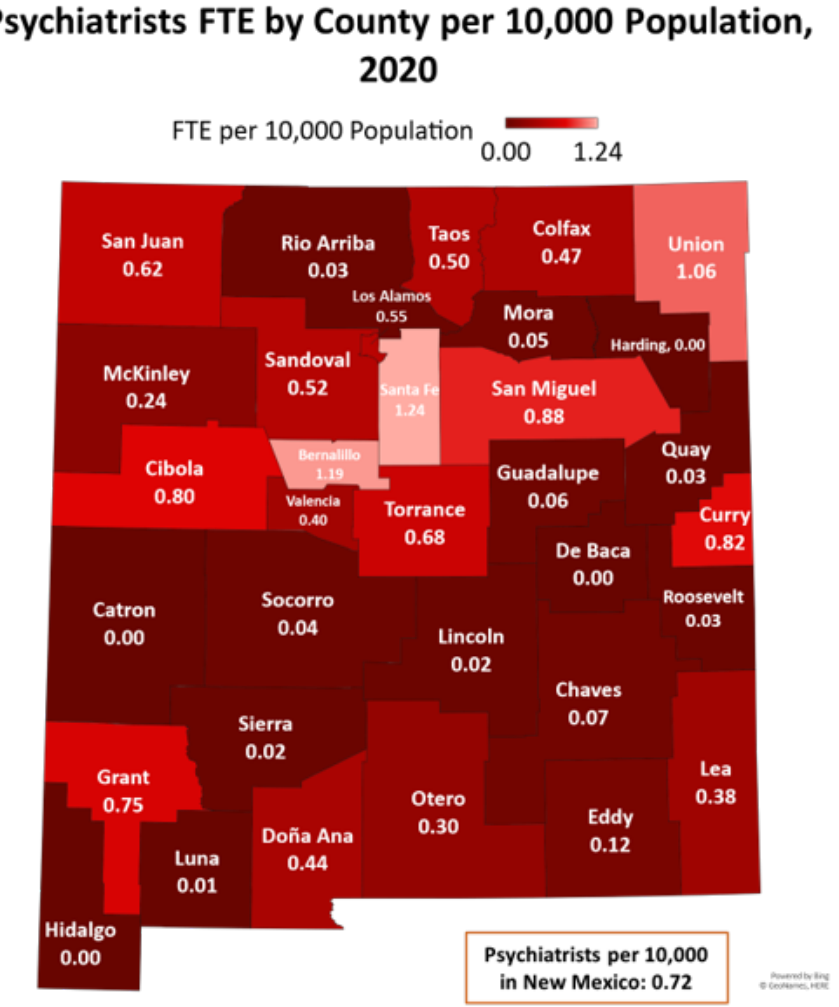
DEFINITON OF HIGH-QUALITY PRIMARY CARE

High-quality primary care is the provision of whole-person, integrated, accessible, and equitable healthcare by inter-professional teams and community partners who are accountable for addressing the majority of individuals' health and well-being across settings and through sustained relationships with patients, families, and communities.

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

GOAL 4: CREATE SUSTAINABLE WORKFORCE, FINANCIAL MODEL, AND BUDGET TO SUPPORT OUR MISSION AND SECURE NECESSARY STATE AND FEDERAL FUNDING.

- **Objective 1:** Develop a statewide full-time equivalent (FTE) benchmark analysis of Interprofessional Primary Care Team members in NM to determine Primary Care service sufficiency standards.
- **Objective 2:** Recommend comprehensive statewide plan to recruit and retain a diverse primary care workforce throughout NM that reflects the communities they serve.
- **Objective 3:** Develop statewide FTE metrics to address the unique health and social vulnerability of New Mexicans.



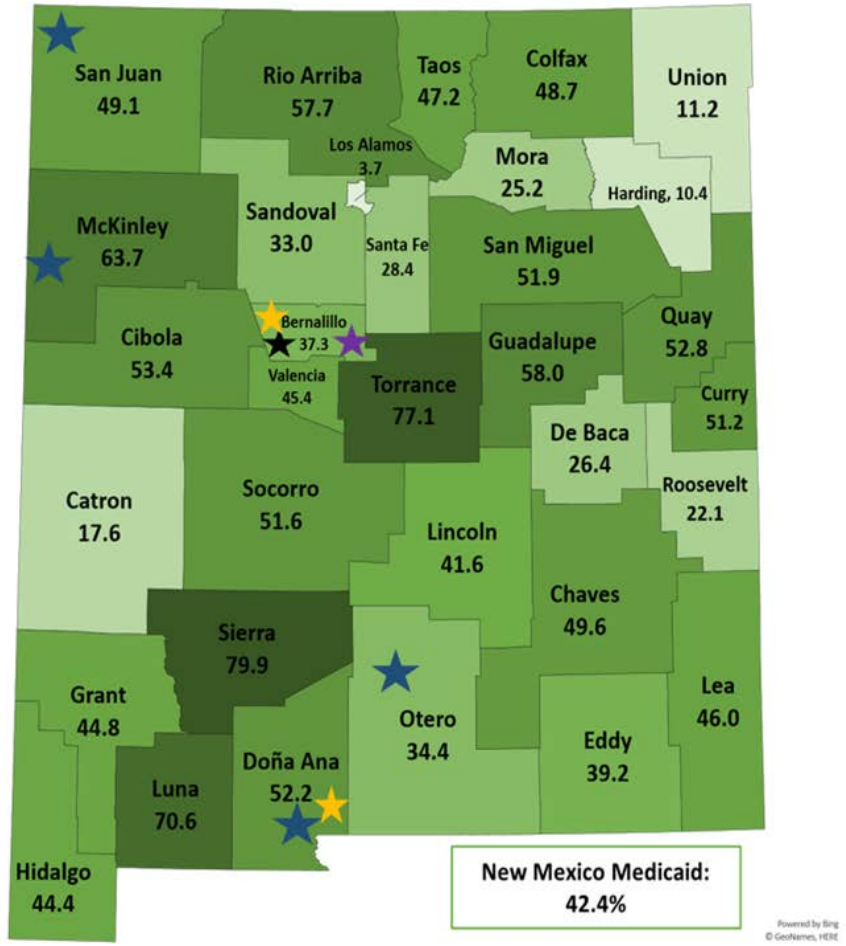
HUMAN SERVICES DEPARTMENT

Investing for tomorrow, delivering today.

PRIMARY CARE GRADUATE MEDICAL EDUCATION EXPANSION

- 5-Year GME Strategic Plan anticipates **46 *new* primary care physicians graduating annually, starting in 2025.**
  - Assuming physicians remain in NM, **expanded workforce serve *additional* 100,000 New Mexicans annually.**
- Primary care GME programs expected to grow from 8 to 13 (63% increase).
- **Since FY2020, HSD selected 5 programs for funding, totaling $1,611,208:**
  - Programs include expansion of existing programs (as well as new programs) in Family Medicine and General Psychiatry.
  - Programs will add ~60 new residents.
- Third round of applications currently open.

New and Expanding GME Programs as of 11/20; Medicaid and Children's Health Insurance Program Enrollment as Percentage of Population by County, October 2020



Programs Under Development or Considering Expansion, by Specialty

- Family Medicine
- General Pediatrics
- General Internal Medicine
- General Psychiatry

Source: New Mexico Human Services Department, Income Support Division. Recipients as of October 2020. U.S. Census Bureau, Population Estimates Program (PEP), Vintage 2019, QuickFacts. Retrieved from https://www.census.gov/quickfacts, December 10, 2020.

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GOALS

Equity

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

Health Technology

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

Payment Strategies

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

Workforce Sustainability

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

MEET EDDIE

- Eddie's surgery went well, removing 9 cm tumor (~size of a grapefruit) along with third of his colon.
- Eddie visited Dr. McKee a year after his surgery and reported he was feeling well, bringing a gift of elk meat from a recent hunt.
- Access to high quality primary care would have meant Eddie would have received a colonoscopy screening at age 50.
  - He would have been counseled that his family history put him at high-risk.
  - He would have had colonoscopy every 5 years.
  - His cancer would have likely been discovered early and removed endoscopically (at the time of colonoscopy) with ~day of recovery time.

* Based on a real patient whose name and photo are changed.

HUMAN SERVICES DEPARTMENT

QUESTIONS & COMMENTS

HUMAN SERVICES DEPARTMENT

APPENDIX

NM PRIMARY CARE COUNCIL MEMBERS

1. Eileen Goode, RN: CEO, NM Primary Care Association
2. Jennifer K. Phillips, MD: Professor & Associate Chair, Family Medicine, UNM School of Medicine
3. Kathy R. Fresquez-Chavez, NP: CEO, Bella Vida Healthcare
4. Lori Zink, MD: Physician, BCA Pediatrics
5. Matthew Probst, PA: Chief Quality Officer, El Centro Family Health
6. Valory Wangler, MD: Family Medicine Program Director, Rehoboth McKinley Christian Health Care Services
7. Dep. Sec. Laura Parajon, MD: NM Department of Health
8. Jeff Clark, MD: NM Human Services Department
9. Julie Weinberg: Director, Life and Health Division, NM Office of Superintendent of Insurance
10. Alisha Parada, MD: Chief, Division of General Internal Medicine, Geriatrics and Integrative Medicine, UNM Health Sciences Center
11. Anjali Taneja, MD: Executive Director, Casa de Salud
12. James Skeet: Executive Director, Spirit Farm
13. Gretchen Ray, PharmD: Assoc. Professor of Pharmacy Practice, UNM College of Pharmacy
14. Jason Mitchell, MD: Senior Vice President, Chief Medical and Clinical Transformation Officer, Presbyterian Healthcare Services
15. Jon Helm, RN: Nurse Flow Manager, First Choice Community Healthcare
16. Maggie McCowen, LISW: Executive Director, NM Behavioral Health Provider Association
17. Rohini Mckee, MD: Chief Quality & Safety Officer, UNM Hospital
18. Ruby Ann Esquibel: Health Policy Coordinator, NM Legislative Finance Committee
19. Scott Flury: Patient advocate, La Clinica del Pueblo de Rio Arriba
20. Susan Wilson: Executive Director, NM Coalition for Healthcare Value
21. Troy Clark: President & CEO, NM Hospital Association
22. Wei-Ann Bay, MD: Chief Medical Officer, Blue Cross and Blue Shield of NM

INVESTING IN PRIMARY CARE: A STATE-LEVEL ANALYSIS (PRIMARY CARE COLLABORATIVE)

- Currently, there is not a standard methodology to measure primary care investment. The leading approaches apply a narrow definition and a broad definition of primary care practitioners.
- Between 2011 and 2016, spending on primary care as a percentage of overall health care expenditures was low. It varied considerably across states, across payer types, and across age groups.
- National average for primary care spending across public and private payers 5.6% (narrow definition), compared to 10.2% (broad definition).
- Clear association between increased primary care spending and fewer emergency department visits, total hospitalizations, and hospitalizations for ambulatory care-sensitive conditions.

UNIFIED VOICE, UNIFIED VISION, CHANGING PRIMARY CARE FINANCE (NEW PRIMARY CARE PARADIGM)

- Current healthcare financing nearly 60 years old, and it no longer serves our aspiration to invest in the health & wellbeing of our patients, families, and communities.
- Primary care must be seen as a public good.
- "Advancing primary care as a public good will require shifting the paradigm of primary care financing, creating a unified approach among all payers, and dismantling the regulatory and financing structures that institutionalize the status quo."

Unified Voice, Unified Vision, Changing Primary Care Finance

Dear policy makers, payers, purchasers, and the public:

Our health system is failing, and the pandemic is expediting its collapse. Life expectancy is in decline, the prevalence of chronic illness has risen, and disparities in health outcomes have deepened. Our health system isn't just broken – it is bankrupting many in our country.

The current financing of U.S. health care was designed almost 60 years ago to shield against financial loss from serious illness, rather than to meet modern society's desire to invest in health and our future. This is a pivotal moment for our nation's health, requiring a new paradigm for financing primary care and health promotion.

As physician societies and boards, our greater than 400,000 members are the source of trusted, healing relationships for 8 in 10 Americans, serving the health needs of the U.S. population through over half a billion annual patient visits.[1] This essential role in the health system is currently supported by only 6% of all resources spent on health care,[2] which is inadequate. The views of our seven organizations are not always the same, but in this we are united: in order to help the people of our nation achieve better health outcomes, reduce unnecessary health care costs and rectify social inequities, the U.S. must recognize and invest in primary care as a public good. To bring U.S. primary care on par with high performing countries would mean a relatively small shift in resources that stands to create tremendous improvement in health outcomes.

As leaders in the provision of primary and comprehensive care, we regard the responsible stewardship of the health of our nation as a sacred trust. There is a direct relationship between the kind of primary care we deliver and the way in which it is financed and paid. *Advancing primary care as a public good will require shifting the paradigm of primary care financing, creating a unified approach among all payers, and dismantling the regulatory and financing structures that institutionalize the status quo.*

We understand that what we are calling for is significant and will take substantial time and effort. We are committed to doing this hard work together. We invite other clinician groups and professional societies to join us in this journey toward better health for all of our patients. We will work in partnership with payers, purchasers, policymakers, and patients to bring a modern system into being. The health of the public cannot wait. The time for partnership and action is now.

Sincerely (Elected leaders & CEOs),

American Academy of Family Physicians
Ada D. Stewart, MD, FAAFP, President
Shawn Martin, MD, Executive Vice President and CEO Designee

American Academy of Pediatrics
Sara H. Goza, MD, FAAP, President
Mark Del Monte, JD, CEO and Executive Vice President

American Board of Family Medicine
John Brady, MD, Chair
Warren Newton, MD, MPH, President and CEO

American Board of Internal Medicine
Marianne M. Green, MD, Chair
Richard J. Baron, MD, MACP, President and CEO

American Board of Pediatrics
Victoria F. Norwood, MD, Chair
David G. Nichols, MD, MBA, President and CEO

American College of Physicians
Jacqueline W. Fincher, MD, MACP, President
Darilyn V. Moyer, MD, FACP, FRCP, FIDSA, Executive Vice President and CEO

Society of General Internal Medicine
Jean S. Kutner, MD, MSPH; President
Eric B. Bass, MD, MPH, CEO

[1] National Ambulatory Medical Care Survey: 2016 Summary Tables. Accessed November 23, 2020.
[2] Martin S, Phillips RL, Petterson S, Levin Z, Bazemore AW. Primary Care Spending in the United States, 2002-2016. JAMA Intern Med. 2020;180(7):1019–1020. doi:10.1001/jamainternmed.2020.1360

www.newprimarycareparadigm.org

HUMAN SERVICES DEPARTMENT

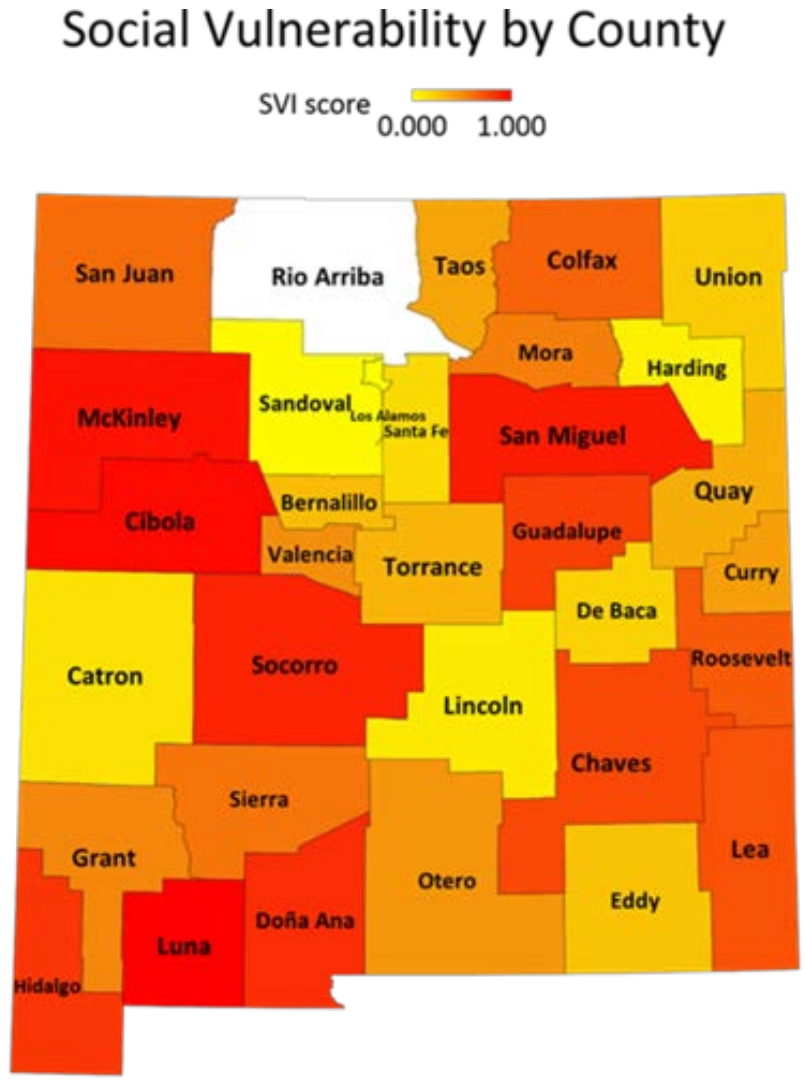
NM PRIMARY CARE COUNCIL GOALS, OBJECTIVES & TACTICS

INVESTING FOR TOMORROW, DELIVERING TODAY.

PRIMARY CARE COUNCIL GOAL 1: EQUITY

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

- Objective 1: Develop NM incentivized model of integrated public health, primary care, and behavioral health integration.
- Objective 2: Create meaningful partnership between governmental agencies, non-profit organizations, businesses, and academic centers to support health equity.
- Objective 3: Increase sustained investment in historically marginalized and divested populations.



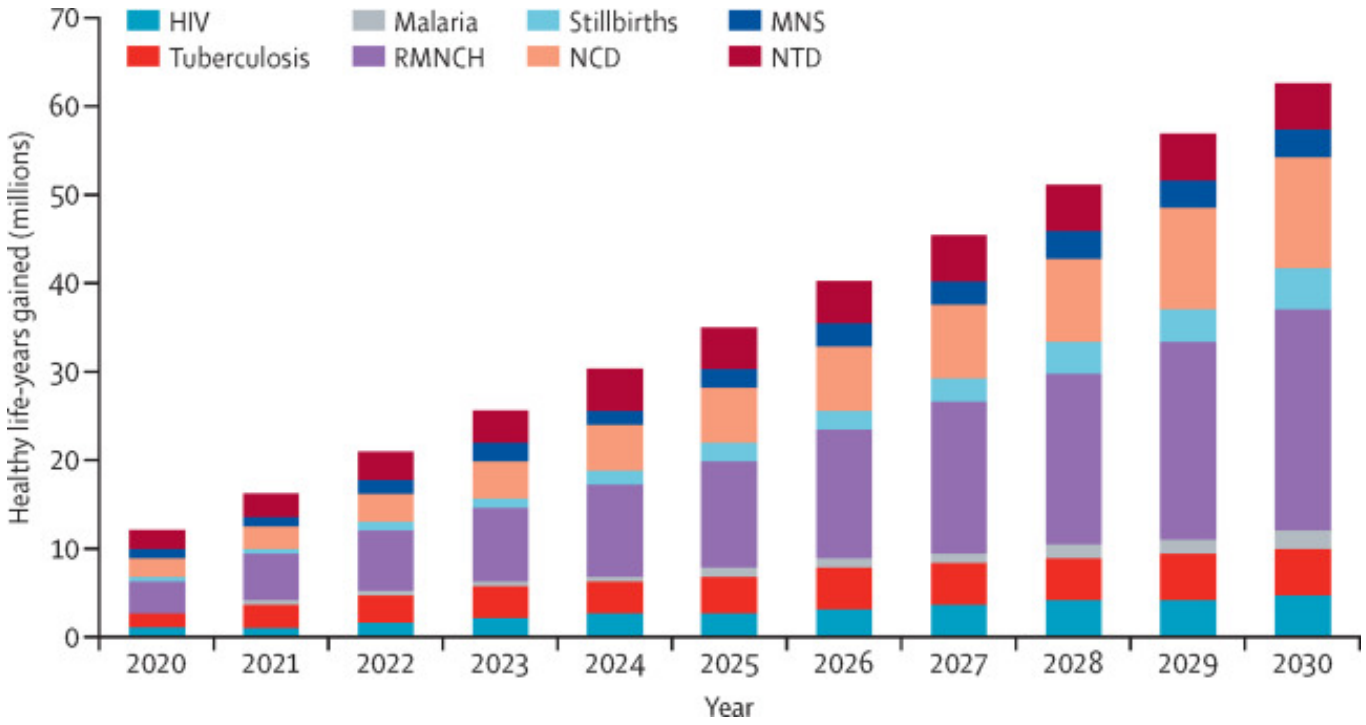
Source: U.S. Centers for Disease Control Social Vulnerability Index, 2018 data. No data available for Rio Arriba County.
https://www.atsdr.cdc.gov/placeandhealth/svi/documentation/SVI_documentation_2018.html February 25, 2021.

PRIMARY CARE COUNCIL GOAL 1: EQUITY

Objective 1: Develop a New Mexico incentivized model of public health, primary care, and behavioral health integration.

- Tactic 1: Inventory NMDOH services across NM primary care settings including staff presence, grants, and contracts for services.
- Tactic 2: Conduct needs and assets assessment for public health services in primary care settings across NM.
- Tactic 3: Develop NM models of public health, primary care, and behavioral health integration.

Healthy life-years gained by investments in primary health care (measure 1), by disease area (2020–30)



Source: The Lancet, 2020. MNS=mental, neurological, and substance use disorders. NCD=non-communicable disease. NTD=neglected tropical disease. RMNCH=reproductive, maternal, neonatal, and child health.

HUMAN SERVICES DEPARTMENT

PRIMARY CARE COUNCIL GOAL 1: EQUITY

Objective 2: Create meaningful partnership between governmental agencies, non-profit organizations, businesses, and academic centers to support health equity.

- Tactic 1: Inventory existing linkages across key state agencies, non-profits organizations, businesses, and academic centers that support health equity.
- Tactic 2: Determine resource allocation priorities within the NMDOH State Health Improvement Plan through a comprehensive literature review of the NMDOH State Health Assessments with Community Health and State agency assessments.
- Tactic 3: Create an integrated network of community health workers to address population and behavioral health needs and link primary care to public health services.

2020-2022 STATE HEALTH IMPROVEMENT PLAN FOR SELECTED PRIORITIES

ACCESS TO PRIMARY CARE

HEALTH STATUS INDICATOR: AMBULATORY CARE SENSITIVE CONDITIONS HOSPITALIZATION RATE

Background

Health Professional Shortage Areas are locations, designated by the Federal government, with critical shortages of key primary care services – defined as having less than half the services needed by the population of the area. Shortage of primary care results from an inadequate supply/distribution of health professionals as well as an inadequate safety net infrastructure for employing health professionals to deliver care. The primary care safety net infrastructure consists of community-based primary care centers and rural health clinics. Safety net agencies address barriers to care, including accessibility, affordability and acceptability.

The percent of New Mexico's population in Health Professional Shortage Areas is among the highest in the nation. Thirty-two of the state's 33 counties are primary medical care, dental, and primary mental Health Professional Shortage Areas, representing 50.0%, 42.6%, and 59.7% of the total population of the state, respectively.

Many states have demonstrated the effectiveness of incentive programs on the improved placement of health professionals and continued health professional retention in shortage areas. Incentive programs include health professional education loan repayment programs and obligated scholarship programs. With the existence of multiple Federal, State and local incentive programs, there could be a diffusion of impact unless the programs are well coordinated. When programs are coordinated around a unified set of priorities, they are more effective in meeting State health policy targets.

Other states and the Federal government have recognized that supply and demand in the primary care marketplace, by itself, is not enough to assure that needed health services are available in all communities. Under current healthcare reimbursement systems, communities with a large proportion of low-income residents and rural communities may not generate sufficient paying demand to assure that private providers will practice in these locations. A primary care safety net of health centers has been developed to assure the infrastructure needed to address needs in these communities. This infrastructure is supported by both Federal and State funds.

VICES

2020 -2022 New Mexico State Health Improvement Plan | December 2018 11

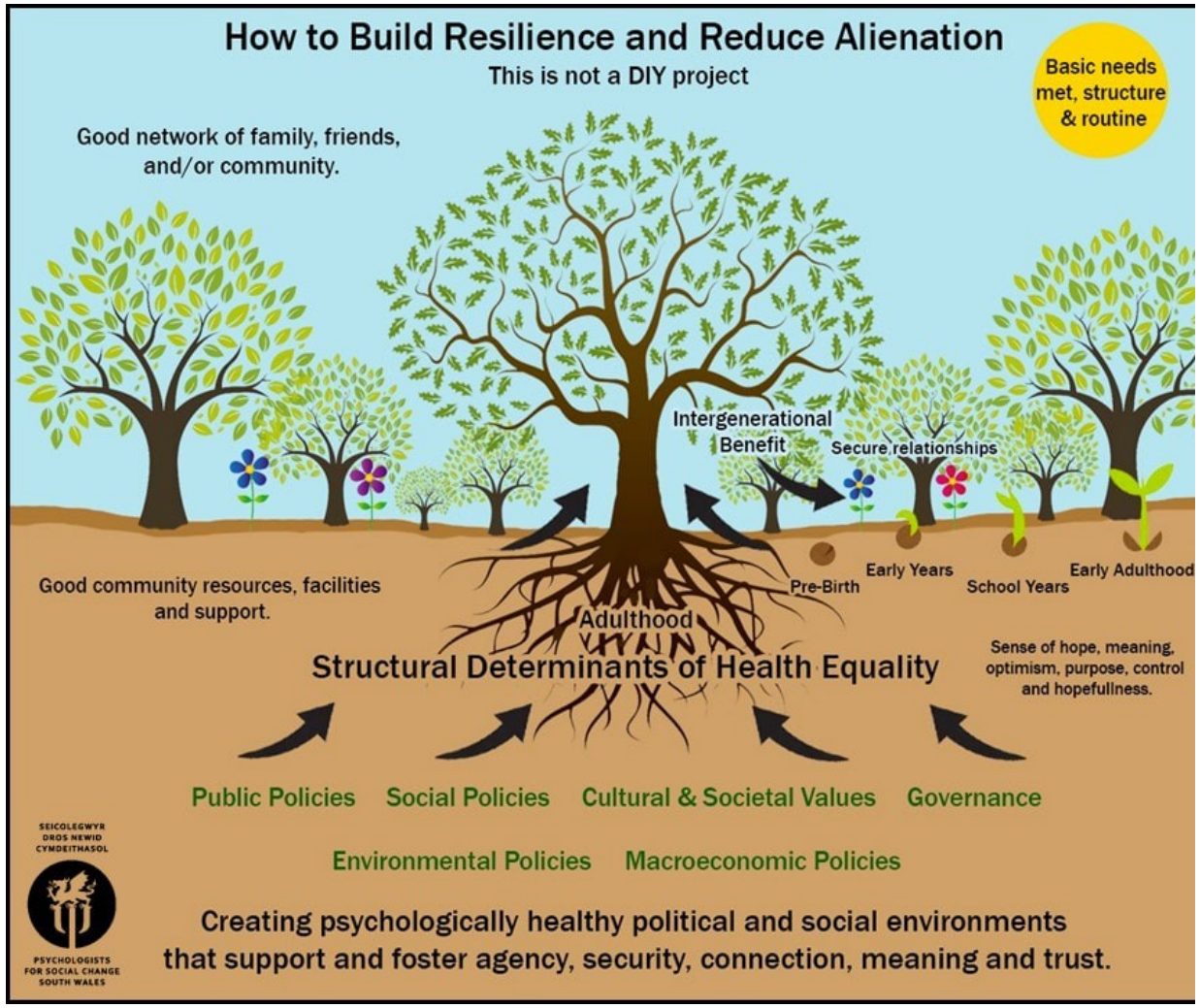
PRIMARY CARE COUNCIL GOAL 1: EQUITY

Objective 3: Increase sustained investment in historically marginalized and divested populations.

- Tactic 1: Conduct cross-sectional assessment of key state agencies, municipal, county, tribal, as well as private and non-profit entities focused on investment in historically marginalized and divested populations.

- Tactic 2: Employing national, state, and local standards, embed equity metrics across Primary Care Council workgroups to ensure sustained investment in historically marginalized and divested populations.

- Tactic 3: Develop and implement state-led community engagement process with historically marginalized and divested communities to co-learn about institutional and structural determinants of health and promote community led solutions.



Link: http://www.psychchange.org/building-resilience-and-community-wellbeing.html

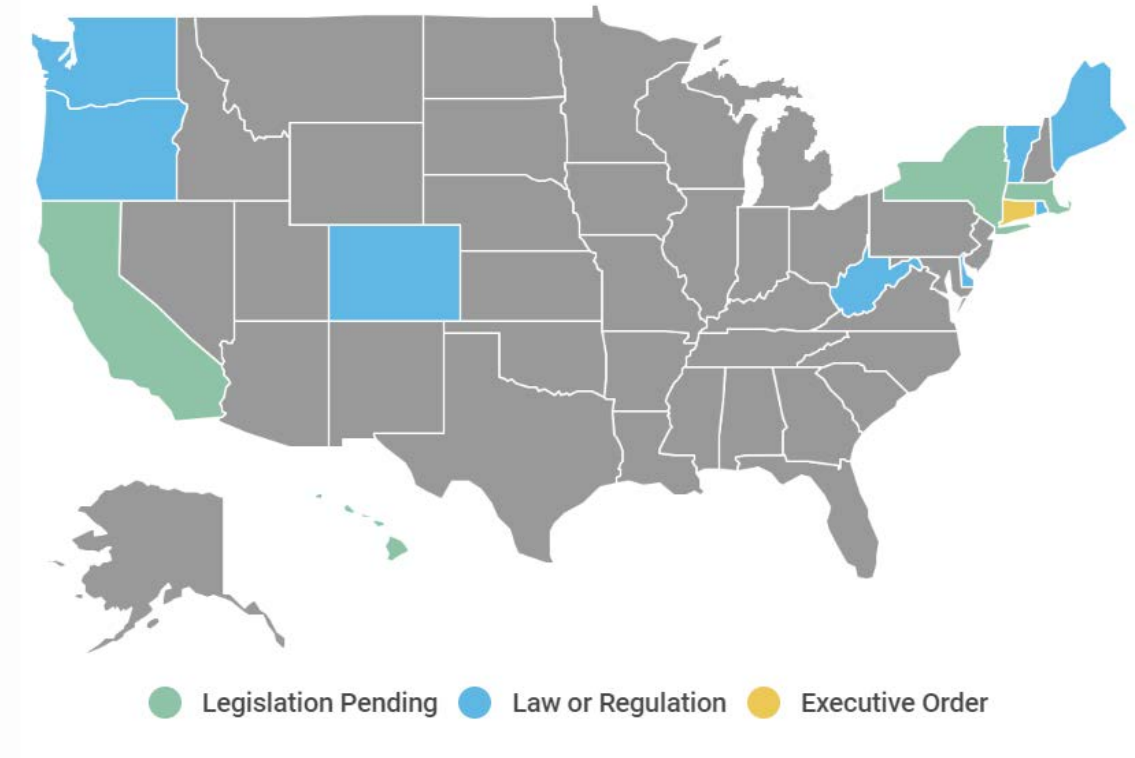
PRIMARY CARE COUNCIL GOAL 2: PAYMENT STRATEGIES

Goal 2: Develop and recommend sustainable payment models and strategies to achieve high quality and equitable primary care for all New Mexicans.

- **Objective 1:** Recommend state policies to establish primary care delivery investments required to achieve high-quality, equitable primary care for all New Mexicans.

- **Objective 2: Implement** Medicaid care investment and payment strategies aligned with NM Primary Care Council Mission and Vision.

State Legislative Activity to Measure or Increase Primary Care Spending



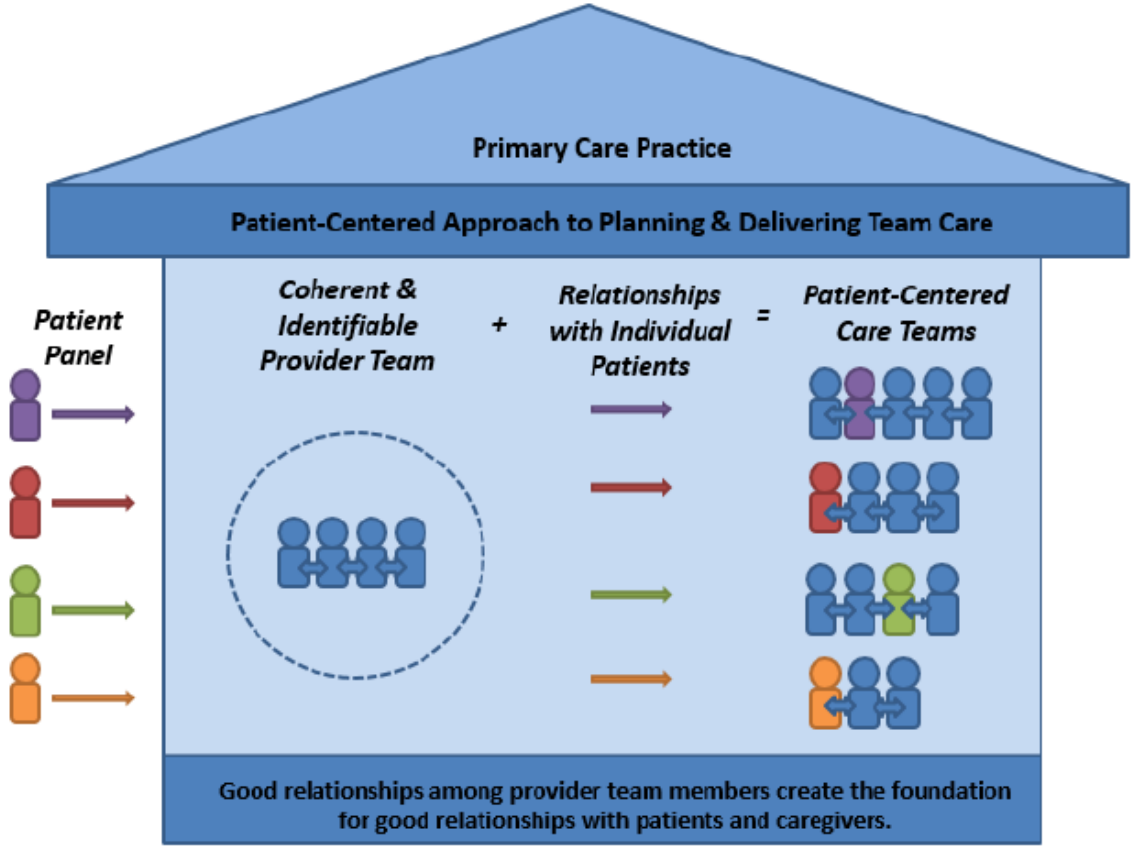
Link: https://www.pcpcc.org/primary-care-investment

PRIMARY CARE COUNCIL GOAL 2: PAYMENT STRATEGIES

Objective 1: Recommend state policies to establish primary care delivery investments required to achieve high-quality, equitable primary care for all New Mexicans.

- Tactic 1. Review national and state models of optimal primary care investment, and make recommendations to inform stakeholders.
- Tactic 2. Develop shared description of primary care practitioners and services, and develop standardized processes for measuring the volume and cost of primary care provided in NM.
- Tactic 3. Upon availability of state's All Payer Claims Database (APCD), determine statewide primary care expenditure. In the interim, determine primary care expenditure for Medicaid and other available payers.

Conceptual blueprint for the provision of patient-centered team-based care



Link: https://pcmh.ahrq.gov/page/creating-patient-centered-team-based-primary-care

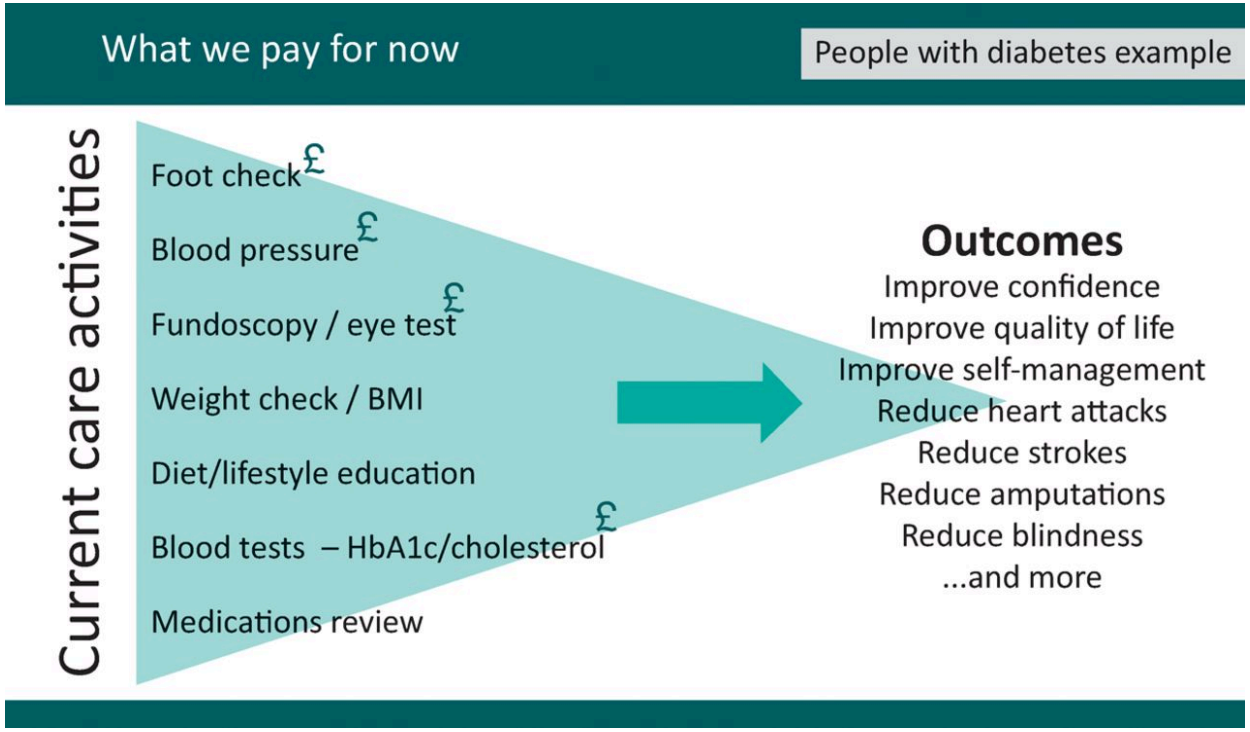
PRIMARY CARE COUNCIL GOAL 2: PAYMENT STRATEGIES

Objective 2: Medicaid implements primary care investment and payment strategies aligned with our Primary Care Mission and Vision.

- Tactic 1. Incentivize Medicaid primary care access, quality, and patient experience to begin the transition from volume-based reimbursement to paying for outcomes.

- Tactic 2. Establish Medicaid payment models that incentivize Interprofessional Primary Care Teams and community partners to provide high-quality primary care; pay for outcomes, not volume.

Outcomes Based Health Care



Link: https://www.rcpjournals.org/content/futurehosp/5/2/98

PRIMARY CARE COUNCIL GOAL 3: HEALTH IT

Goal 3: Develop and drive health information technology improvements and investments that make high quality primary care seamless and easy for Interprofessional Primary Care Teams, patients, families, and communities.

- Objective 1: Work to ensure NM Health Information Exchange is seamless and easy for Interprofessional Primary Care Teams, provides pragmatic comprehensive aggregate patient data to enable Interprofessional Primary Care Teams to provide high-quality care and facilitates high-quality continuity of care.
- Objective 2: Ensure online, comprehensive high-quality primary care educational and training resources are available to NM Interprofessional Primary Care Team members.

Link: https://www.healthaffairs.org/do/10.1377/hblog20190807.475758/full/

Health Information Exchange After 10 Years: Time For A More Assertive, National Approach

Michael Hochman, Judith Garber, Edmondo J. Robinson

AUGUST 14, 2019 10.1377/hblog20190807.475758

HealthAffairs

Although most transactions in our modern world are electronic and automated, many health care professionals still exchange patient information through inefficient manual processes. In much of the US, health information exchange (HIE) requires a complex series of handwritten signatures and faxed requests, resulting in lengthy delays. The net result is frustration for clinicians and patients, as well as repetition of services and even medical errors.

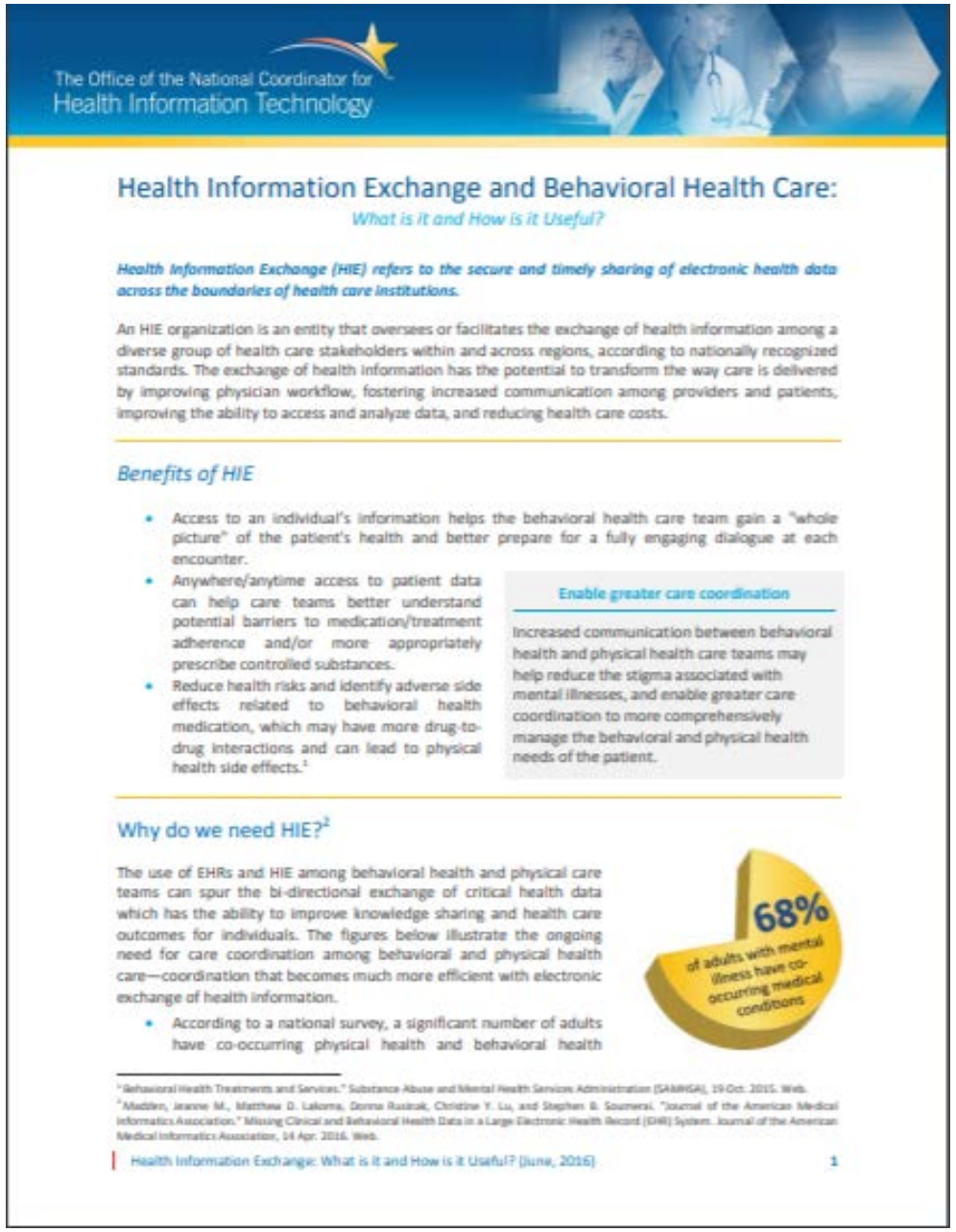
In 2009, Congress attempted to modernize HIE processes by passing the HITECH Act, offering grants and incentives to states and municipalities for developing regional HIE initiatives. Although there has been some progress toward effective mechanisms for data exchange, in many regions of the country it is no easier to share medical information than it was a decade ago. According to a 2018 report, fewer than half of office-based physicians can exchange patient health information outside their organization electronically, and less than a third can automatically integrate this information into their electronic health record (EHR).

PRIMARY CARE COUNCIL GOAL 3: HEALTH IT

Objective 1: Work to ensure NM Health Information Exchange is seamless and easy for Interprofessional Primary Care Teams, provides pragmatic comprehensive aggregate patient data to enable Interprofessional Primary Care Teams to provide high-quality care and facilitates high-quality continuity of care.

- Tactic 1. Develop means to assess, track, and improve the Interprofessional Team's use of New Mexico's Health Information Exchange in providing high-quality primary care and in achieving quantifiable patient and system outcomes.
- Tactic 2. Develop a summary of interoperability requirements that allow the HIE to meet or exceed all federal requirements for interoperability, which is the extent to which health systems and devices can exchange data and interpret that shared data.

Link: https://www.healthit.gov/sites/default/files/playbook/pdf/behavioral-health-care-fact-sheet.pdf



The Office of the National Coordinator for Health Information Technology

Health Information Exchange and Behavioral Health Care:

What is it and How is it Useful?

Health Information Exchange (HIE) refers to the secure and timely sharing of electronic health data across the boundaries of health care institutions.

An HIE organization is an entity that oversees or facilitates the exchange of health information among a diverse group of health care stakeholders within and across regions, according to nationally recognized standards. The exchange of health information has the potential to transform the way care is delivered by improving physician workflow, fostering increased communication among providers and patients, improving the ability to access and analyze data, and reducing health care costs.

Benefits of HIE

- Access to an individual's information helps the behavioral health care team gain a "whole picture" of the patient's health and better prepare for a fully engaging dialogue at each encounter.
- Anywhere/anytime access to patient data can help care teams better understand potential barriers to medication/treatment adherence and/or more appropriately prescribe controlled substances.
- Reduce health risks and identify adverse side effects related to behavioral health medication, which may have more drug-to-drug interactions and can lead to physical health side effects.[1]

Enable greater care coordination

Increased communication between behavioral health and physical health care teams may help reduce the stigma associated with mental illnesses, and enable greater care coordination to more comprehensively manage the behavioral and physical health needs of the patient.

Why do we need HIE?[2]

The use of EHRs and HIE among behavioral health and physical care teams can spur the bi-directional exchange of critical health data which has the ability to improve knowledge sharing and health care outcomes for individuals. The figures below illustrate the ongoing need for care coordination among behavioral and physical health care—coordination that becomes much more efficient with electronic exchange of health information.

- According to a national survey, a significant number of adults have co-occurring physical health and behavioral health

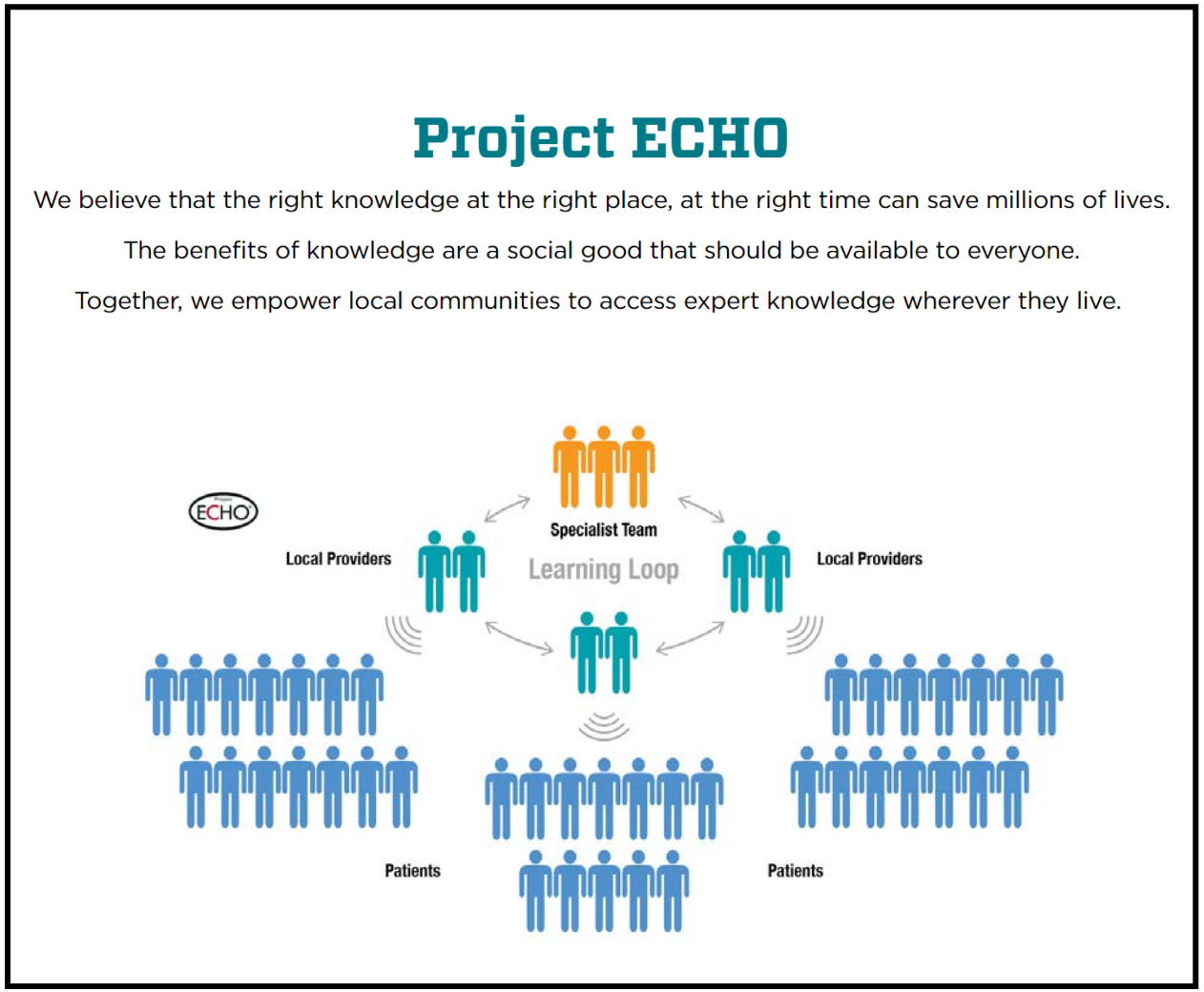
"Behavioral Health Treatments and Services." Substance Abuse and Mental Health Services Administration (SAMHSA), 19 Oct. 2015. Web.
"Madden, Jeanne M., Matthew D. Lakoma, Donna Rusinak, Christine Y. Lu, and Stephen B. Soumerai. "Journal of the American Medical Informatics Association." Missing Clinical and Behavioral Health Data in a Large Electronic Health Record (EHR) System. Journal of the American Medical Informatics Association, 14 Apr. 2016. Web.

NM PRIMARY CARE COUNCIL GOAL 3: HEALTH IT

Objective 2: Ensure online, comprehensive high-quality primary care educational and training resources are available to NM Interprofessional Primary Care Team members.

- Tactic 1. Complete an assessment of the core educational and training assets and needs of the members of the Interprofessional Primary Care Team.

- Tactic 2. Coordinate with Project ECHO on Interprofessional Primary Care Team education and training.



NM PRIMARY CARE COUNCIL GOAL 4: WORKFORCE SUSTAINABILITY

Goal 4: Create a sustainable workforce, financial model, and budget to support our mission and secure necessary state and federal funding.

- **Objective 1:** Develop a statewide full-time equivalent (FTE) benchmark analysis of Interprofessional Primary Care Team members in NM to determine Primary Care service sufficiency standards.
- **Objective 2:** Recommend comprehensive statewide plan to recruit and retain a diverse primary care workforce throughout NM that reflects the communities they serve.
- **Objective 3:** Develop statewide FTE metrics to address the unique health and social vulnerability of New Mexicans.

Link: https://pubmed.ncbi.nlm.nih.gov/33165609/

JAMA Network | Open

Original Investigation | Health Policy

Association of Racial/Ethnic and Gender Concordance Between Patients and Physicians With Patient Experience Ratings

Junko Takeshita, MD, PhD, MSCE; Shiyu Wang, MS; Alison W. Loren, MD, MSCE; Nandita Mitra, PhD; Justine Shults, PhD; Daniel B. Shin, PhD; Deirdre L. Sawinski, MD

Abstract

IMPORTANCE The Press Ganey Outpatient Medical Practice Survey is used to measure the patient experience. An understanding of the patient- and physician-related determinants of the patient experience may help identify opportunities to improve health care delivery and physician ratings.

OBJECTIVE To evaluate the associations between the patient experience as measured by scores on the Press Ganey survey and patient-physician racial/ethnic and gender concordance.

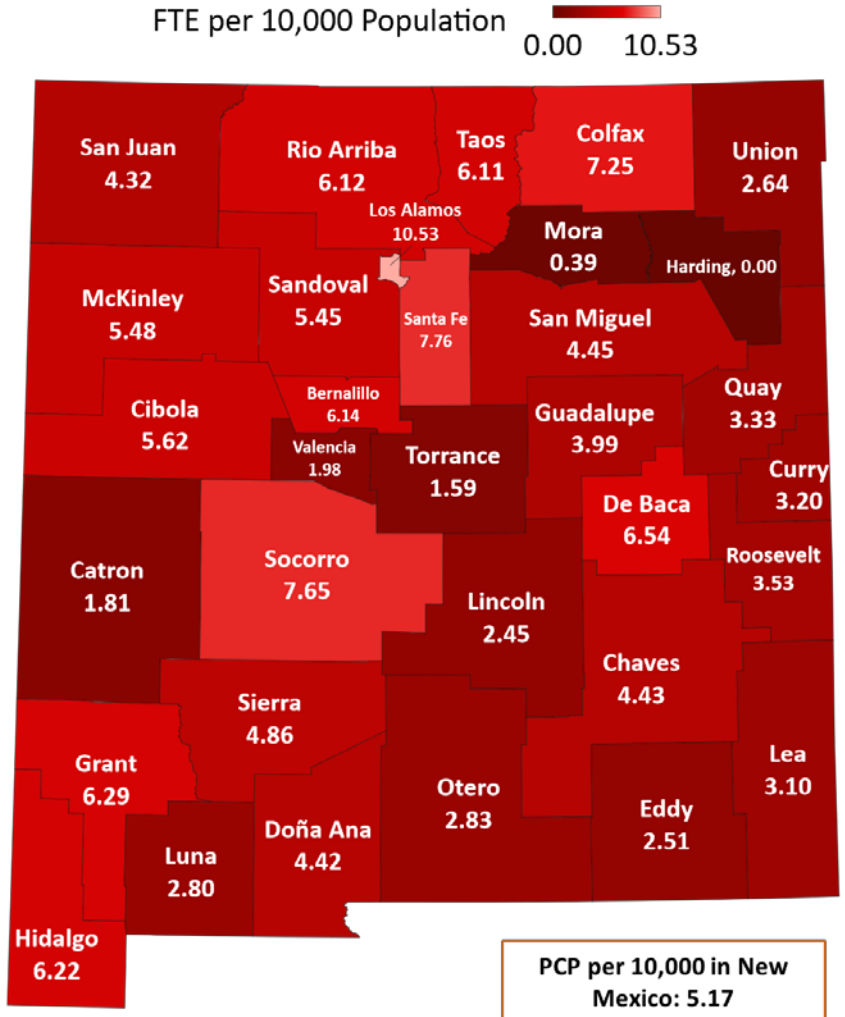
DESIGN, SETTING, AND PARTICIPANTS A cross-sectional analysis of Press Ganey surveys returned for outpatient visits within the University of Pennsylvania Health System between 2014 and 2017 was performed. Participants included adult patient and physician dyads for whom surveys were returned. Data analysis was performed from January to June 2019

NM PRIMARY CARE COUNCIL GOAL 4: WORKFORCE SUSTAINABILITY

Objective 1: Develop a statewide full-time equivalent (FTE) benchmark analysis of Interprofessional Primary Care Team members in NM to determine Primary Care service sufficiency standards.

- Tactic 1. Upon reviewing the literature, determine the members of the Interprofessional Primary Care Team that reflect the specific professional composition in New Mexico.
- Tactic 2. Conduct an FTE primary care healthcare workforce analysis.

Primary Care Physicians FTE by County per 10,000 Population, 2020



HUMAN SERVICES DEPARTMENT

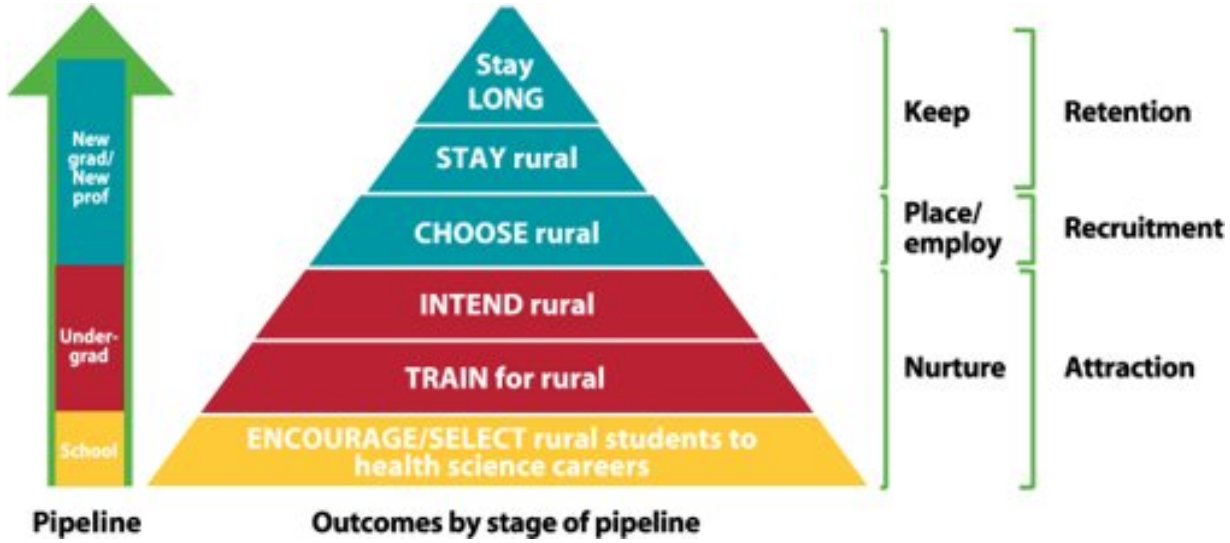
Investing for tomorrow, delivering today.

NM PRIMARY CARE COUNCIL GOAL 4: WORKFORCE SUSTAINABILITY

Objective 2: Recommend a comprehensive statewide plan to recruit and retain a diverse primary care workforce throughout NM that reflects the communities they serve.

- Tactic 1. Develop a comprehensive inventory and analysis of public-sponsored primary care recruitment/retention programs that will inform a plan to improve Interprofessional Primary Care Team workforce.
- Tactic 2. Coordinate with the NM Graduate Medical Education Expansion Review Board and Advisory Group to determine metrics for medical resident recruitment and retention effectiveness.
- Tactic 3. Develop cost-effective recruitment and retainment strategy to provide and sustain the Interprofessional Primary Care Team required to provide high-quality primary care for every community in NM.

Health Workforce Rural Pipeline Pathway



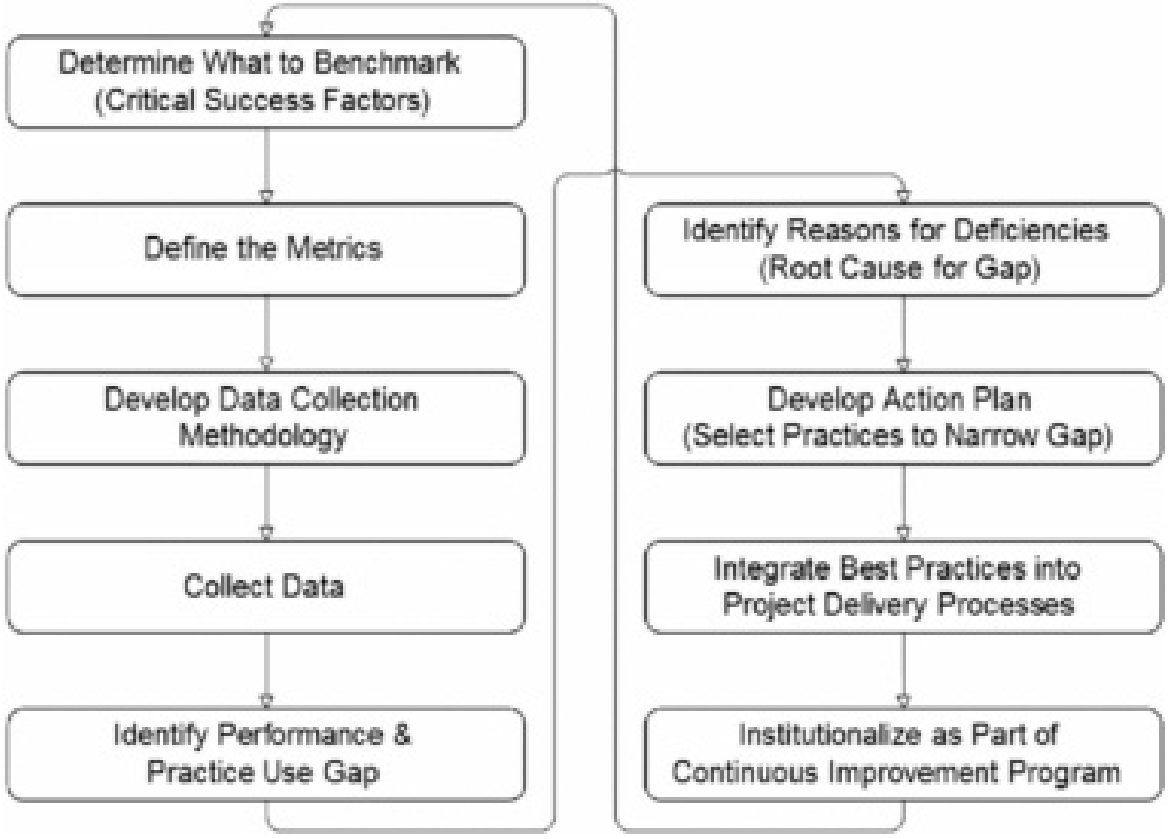
Link: https://www.semanticscholar.org/paper/Critical-success-factors-for-recruiting-and-health-Katzenellenbogen-Durey/b660b35940ab436f3c96724241bc209920157613

NM PRIMARY CARE COUNCIL GOAL 4: WORKFORCE SUSTAINABILITY

Objective 3: Develop statewide FTE metrics to address the unique health and social vulnerability of New Mexicans.

- Tactic 1. Research national and state models for FTE benchmark metrics, equity adjustments, and factoring complex care needs to assess health system optimal staffing; coordinate research with state and local health policy experts in university and government settings.
- Tactic 2. Make recommendations statewide FTE benchmark metrics.
- Tactic 3. Report on statewide FTE benchmarks based on recommendations and research.

Example Benchmark Framework



Link: https://www.nap.edu/read/11344/chapter/5