NEW MEXICO PRIMARY CARE ALTERNATIVE PAYMENT MODEL PROVIDER READINESS ASSESSMENT

November 2022

Prepared by Health Management Associates

Contents

Executive Summary

Introduction

The New Mexico Human Services Department (HSD) engaged Health Management Associates (HMA) to assess clinical organizations' capacity for a risk/reward payment model as well as barriers and facilitators to primary care alternative payment model (APM) implementation. The purpose of the assessment is to give HSD and primary care stakeholders actionable information on primary care providers' readiness to succeed in APMs and to identify critical gaps that need to be addressed via the development of the APM and training and technical assistance activities.

Methodology

HMA developed and administered a provider readiness survey between September 6 and September 30, 2022 and received 70 responses. The survey instrument (Appendix A: Provider Readiness Survey) asked about six topics: (1) care delivery; (2) health information technology (HIT) and health information exchange (HIE) readiness; (3) partnership readiness; (4) financial and operational readiness; (5) board, leadership, and strategic readiness; and (6) primary concerns.

HMA also conducted focus groups between October 21 and November 8, 2022, with the following four types of clinical organizations: federally qualified health centers (FQHCs), small- and medium-sized practices, hospitals, and interprofessional teams (behavioral health, oral health, and pharmacies). The focus group discussion guides are shared in Appendix C: Focus Group Discussion Guides.

Findings

Based on the findings highlighted in the executive summary and detailed in the report and given the current plan for initial implementation in January 2024 with an additional year to prepare for accountability for results in January 2025, the New Mexico primary care system appears ready for a new value-based payment model. However, large providers and FQHCs collectively have greater levels of readiness than small and individual practices, and these providers will need additional support to prepare for and succeed in a new payment model.

I. Care delivery

- There is a correlation between provision of care management services and provider size; larger practices are more likely to provide care management services.
- There is a correlation between electronic care management systems and provider size; usage is higher among FQHCs and larger practices.
- Fifty-five percent of providers are screening for social determinants of health or health-related social needs (SDoH/HRSNs) and 41% conduct risk stratification.
- Sixty-four percent of providers track which external provider a patient is referred to; this figure is higher for FQHCs (81%).
- Very few providers have oral health/dental (16%), or vision care/eye doctor (7%) services on site; however, these figures are higher for FQHCs (60% and 13%, respectively).

- There is a correlation between practice size and patient-centered medical home or health home status; larger practices are more likely to be recognized as patient-centered medical homes or health homes.
- Sixty-seven percent of providers conduct linguistic needs assessments of their patient population and 61% conduct cultural needs assessments.
- Thirty-seven percent of providers have behavioral health staff onsite; however, this figure varies significantly among practice size (from 7% for individual providers to 57% for practices with more than 100 providers) and type (63% of FQHCs compared to 30% of non-FQHCs).

II. HIT/HIE

- Fifty-one percent of practices have systems for quality improvement and data reporting, 30% have decision support or registry capabilities, and 25% participate in health information exchange (HIE).
- Twenty-one percent of providers maintain actionable lists of "super utilizers"[1] and 19% maintain lists of other patients at-risk for hospitalization.
- Having access to a database or data warehouse is correlated with practice size; larger practices and FQHCs are more likely to have access than smaller practices.

III. Partnership Readiness

- Fifty-one percent of practices report having social service sector partnerships and 67% report having partnerships with medical providers.
- Thirty percent of practices have performed an analysis of available community partners; there is wide variation across categories of providers.

IV. Financial and Operational Readiness

- Forty-eight percent of practices report that they meet the Health Resources and Services Administration (HRSA) standard for working capital (>30 days), 37% do not know whether they meet the standard, and the remaining 15% report that they do not meet the standard.
- Fifty-five percent of practices have not evaluated the upfront costs of participating in an APM.

V. Board, Leadership, and Strategic Readiness

- Forty-three percent of practices report their boards are engaged in value-based payment initiatives.
- Forty-nine percent of practices report their staff are ready for an APM; this varies little across practice sizes.

VI. Areas of Concern When Preparing for APMs

- The most significant areas of concern are time and staffing needed to implement an APM, impact on fiscal workflow, meeting clinical targets, and impact on operational workflow.

[1] The Robert Wood Johnson Foundation describes super-utilizers as "individuals whose complex physical, behavioral, and social needs are not well met through the current fragmented health care system. As a results, these individuals often bounce from emergency department to emergency department, from inpatient admission to readmission or institutionalization – all costly, chaotic, and ineffective ways to provide care and improve patient outcomes."

Recommendations

Recommendations fall into three categories: training and technical assistance, APM development, and other recommendations.

Training and Technical Assistance Recommendations

Deploy members of the Primary Care Council and the Transformation Collaborative to champion the APM. Messaging should include communication regarding how the APM will reduce provider burden and that the payment model is not just about cutting spending.

Develop a training curriculum that includes strategies for data collection, sharing, analysis, and reporting; risk assessment and SDoH/HRSN screening tools; creating partnerships with social service organizations; race, ethnicity, language and cultural competency data; partnerships with interprofessional teams; collecting, tracking, and reporting quality measure information; and best practices for risk/reward-sharing and financial modeling for APM arrangements.

APM Development Recommendations

Design the APM to reduce provider burden. In addition, the structure of the APM should enable providers to participate at levels of risk they can tolerate, with a glide path to increasing levels of risk and reward over time, and the APM should allow for non-clinical patient supports. Lastly, the APM should incorporate SDoH/HRSN data into the structure of the APM's quality and performance outcome measures.

Other Recommendations

Align quality measures and incentives across Medicaid managed care organizations, and possibly other payers. Address provider concerns regarding workforce capacity and financial barriers to participating in health information exchange. Support practices lacking sufficient data and IT infrastructure to succeed under the APM.

Introduction and Background

The 2021 New Mexico House Bill 67 (Primary Care Council Act) charges the Human Services Department (HSD) with establishing a statewide Primary Care Council (PCC) to identify ways primary care investment can increase access to primary care, improve the quality of primary care services, address the shortage of primary care providers, and reduce overall health care costs. The mission of the PCC is to revolutionize primary care into interprofessional, sustainable teams delivering high-quality, accessible, equitable health care across New Mexico through partnerships with patients, families, and communities. The PCC has a goal to develop and make recommendations regarding sustainable payment models and strategies to achieve high quality and equitable primary care for all New Mexicans. In support of this goal, the PCC and HSD are pursuing a primary care alternative payment model (APM) that will address health equity, workforce sustainability, and health technology. APMs are payment approaches that incentivize high-quality, cost-efficient, and coordinated care[2]. While the term "APM" is used throughout this report, this terminology will not be used in the broader payment reform messaging throughout New Mexico.

To advance primary care payment reform in New Mexico, HSD engaged Health Management Associates (HMA) to assess clinical organizations' capacity to participate in a risk/reward payment model and to identify barriers and facilitators to primary care APM implementation. The purpose of the assessment is to give HSD and primary care stakeholders actionable information on primary care providers' readiness to succeed in APMs and to identify critical gaps that need to be addressed. Findings from the assessment will be used to inform the development of training and technical assistance (TA) resources to help providers and payers succeed in the new APM environment.

Methodology

The readiness assessment used a mixed-methods research design. The data collection included a statewide readiness survey and four focus groups to assess primary care practices' needs and identify potential barriers and challenges to APM implementation. In addition, ongoing conversations have been held with various primary care stakeholders, including the PCC, two of its workgroups (Payment Strategies and Health Data Equity), the Native American Technical Advisory Committee, New Mexico Medical Society, and SYNCRONYS (New Mexico's health information exchange) users. While those meetings are not summarized in this report, they have provided useful information about providers' and communities' needs, and this type of engagement will continue throughout the APM development process.

The readiness assessment had the following three learning objectives:

1. To assess provider knowledge of and readiness for various elements needed to implement and succeed under a primary care APM.
2. To identify gaps in provider readiness and areas where support and technical assistance are needed to mitigate these gaps.

[2] Alternative Payment Models (APMs), CMS Innovation Center.

3. To guide strategy around training, technical assistance, and other supports for primary care practices to increase provider readiness and confidence prior to and throughout the APM implementation process.

Provider Readiness Survey

The purpose of the survey was to collect quantitative data from as many primary care practices across New Mexico as possible. The survey was based on a validated tool used by HMA in other states and tailored to New Mexico's unique primary care landscape with input from HSD and the PCC. The full survey can be viewed in Appendix A: Provider Readiness Survey. It was administered via Qualtrics on September 6, 2022, and disseminated by HSD, PCC members, and various provider associations. HMA received a total of 70 responses by the deadline of September 30, 2022.

Table 1 shows the distribution of survey respondents by practice size and Table 2 shows the distribution by FQHC status (self-reported).

TABLE 1

Number and Percent of Survey Respondents by Practice Size		
	Number	Percent
Individual provider	14	20%
2-20 providers	40	57%
21-100 providers	9	13%
More than 100 providers	7	10%

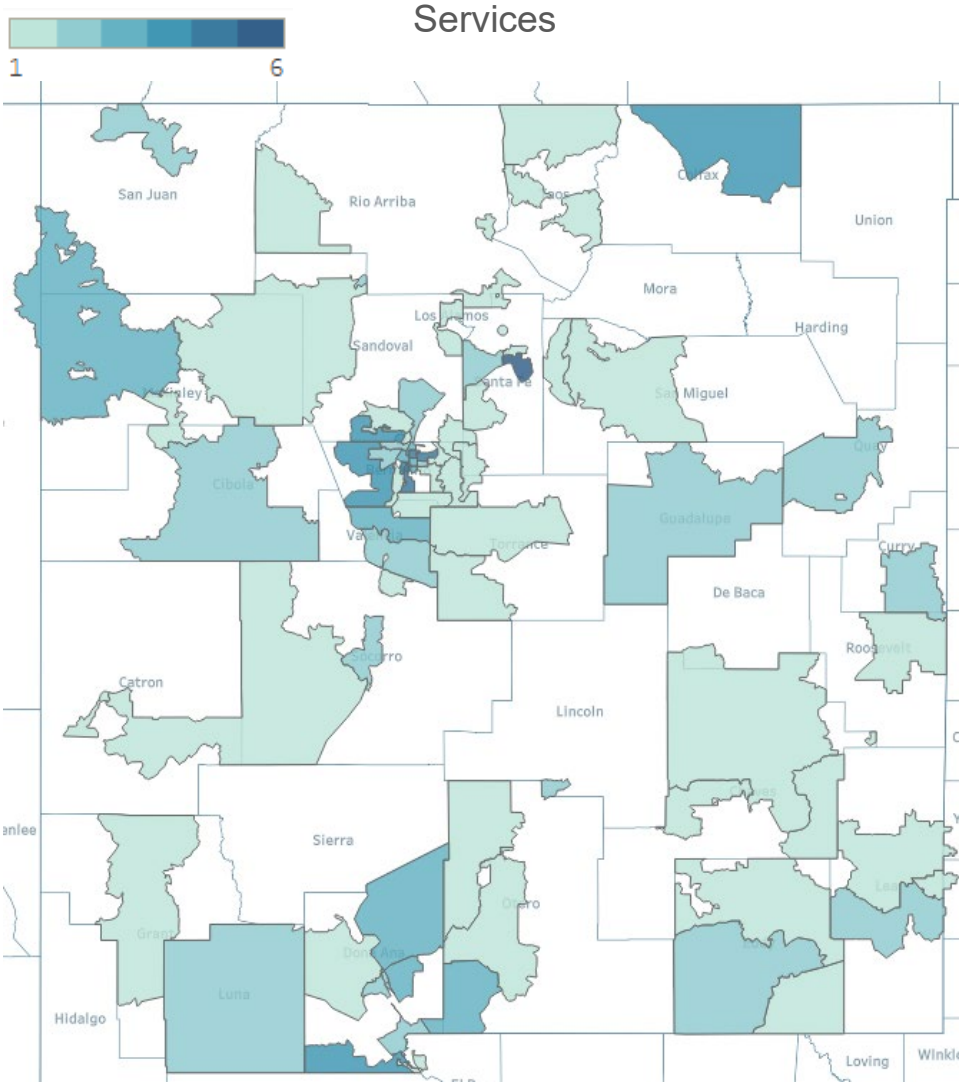
TABLE 2

Number and Percent of Survey Respondents by FQHC Status		
	Number	Percent
FQHC	16	23%
Non-FQHC	54	77%

Figure 1 shows the distribution of ZIP codes where survey respondents report providing primary care services. Respondents could choose more than one ZIP code. A darker color indicates a higher number of respondents provide services in the ZIP code (range: 1 respondent to 6 respondents). Tables containing a detailed distribution of survey respondents by county and ZIP code can be viewed in Appendix B: Distribution of Survey Respondents by County and ZIP Code.

FIGURE 1

Number of Survey Respondents by ZIP Code in Which They Report Providing Primary Care Services



Focus Groups

The purpose of the focus groups was to obtain more detailed and nuanced qualitative information than is available from a survey. The focus group discussion guides were developed based on a preliminary analysis of survey findings (Appendix C: Focus Group Discussion Guides). Four virtual focus groups occurred between October 21 and November 8, 2022, with representatives from federally qualified health centers (FQHCs), hospitals, small- and medium-sized practices, and interprofessional teams (behavioral health, oral health, and pharmacies). Discussion guides were tailored as appropriate for each group. Participants were recruited by HSD and various clinical professional organizations. Table 3 shows the number of individual participants in each group.

TABLE 3

	Number of Participants per Focus Group
FQHCs	18
Hospitals	9
Small- and Medium-Size Practices	8
Interprofessional Teams	13

About the Report

This report is a summary of findings from the readiness assessment survey and focus groups. The report describes primary care practices' current state regarding various elements of APM readiness, barriers preventing APM participation, and mitigation strategies designed to increase support and participation.

The report is divided into five sections covering topics regarding clinical organizational capacity and readiness for APM implementation: (1) care delivery; (2) health information technology (HIT) and health information exchange (HIE) readiness; (3) partnership readiness; (4) financial and operational readiness; and (5) board, leadership, and strategic readiness. The intended audience for the report includes the Office of Governor Michelle Lujan Grisham, HSD, the PCC, other stakeholders involved in APM development and provider training, and the broader New Mexico primary care community.

Key Focus Group and Survey Takeaways

Focus group participants were asked what their organizations need to succeed in an alternative payment model, and their responses provide a useful overview of elements that excite them, their concerns, and the supports they believe are needed to succeed.

Excitement

Focus group participants expressed optimism about the possibilities raised by the APM. One clinician proposed using APM development as an opportunity to envision what an ideal modern primary care practice should look like – including who is in the care team, what types of supports are built in, and how workload is managed – and then developing a model that supports this vision.

An FQHC participant noted that their practice has been monitoring quality and striving to improve the health of populations with greatest need in anticipation of APMs. In their experience, having quality drive operations and payment greatly benefits patients.

Another pracitioner noted their excitement about the opportunity to provide better and more innovative care for patients. They noted that, with sufficient investment, support, and a ramp up period, primary care practices will be able to leverage interprofessional, collaborative teams and use creative and out of the box strategies to meet patients' unique and holistic needs.

For me the APM is really exciting. As a physician I want to focus on the things that are going to help my patients. It's challenging to get there, but at the end of the day I'd rather be compensated for getting someone's A1C under control than for a procedure that isn't going to have a long-term impact. – Small/medium practice focus group participant

Concerns

Some components of APM implementation raised concerns among focus groups participants. One recurring area of concern is provider administrative burden. Participants reported that a critical consideration in ensuring success under the APM is aligning quality metrics and incentives across Medicaid managed care organizations. Additionally, minimizing complexity in billing systems, claims management, and denials management would alleviate provider burden and help practices receive reimbursements in a timelier manner.

Another challenge mentioned across focus group participants is lack of primary care workforce capacity. This concern was particularly salient among small and rural practices. Rural hospitals reported they do not have enough primary care physicians to meet the demand of the population in their service area, and as a result patients wait months for an initial primary care appointment. Small rural primary care practices shared that they currently operate with very limited staffing, often with overlapping responsibilities and all team members pitching in to support operations. While additional care team members would be valuable for patient care, practices reported lacking resources to hire any additional staff. Additionally, providers across various focus groups shared challenges with recruiting practitioners to New Mexico and to their practices.

Lastly, a consistent theme from all focus groups was concern about the rising cost of healthcare and reimbursements that do not keep up with these costs. Practices worry that the APM may result in additional financial burden or that they could be penalized with reduced reimbursements for not meeting quality standards that may be out of their control (e.g., rural providers cannot refer to certain specialists because they do not operate in their service area).

Key factors to success

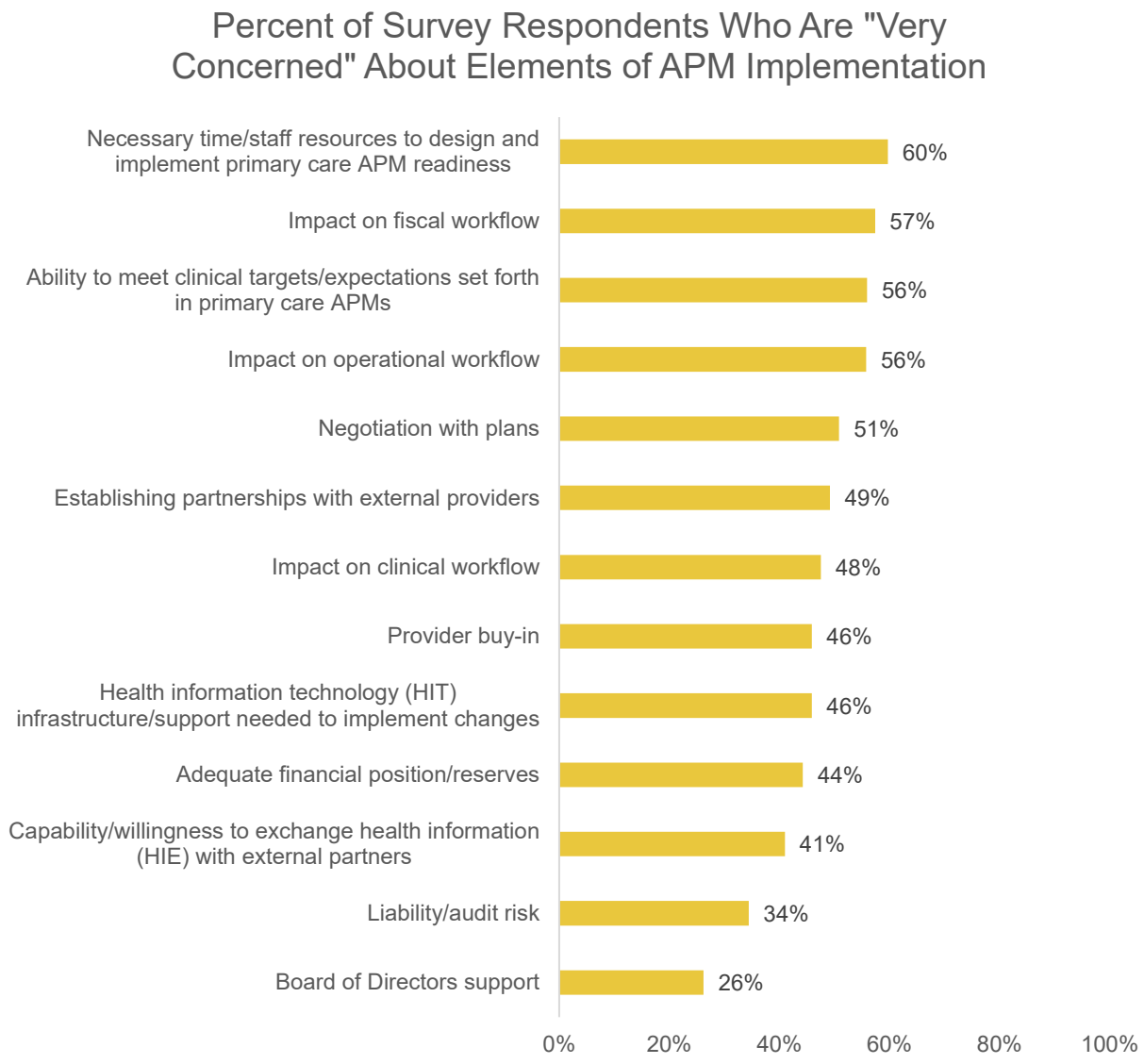
Some hospitals and FQHCs that participated in focus groups have experience with alternative payment models and shared key factors to success under these models, including:

- **Access to data and infrastructure to support data sharing.** It is critical for practices to have access to reliable and actionable information about patients to empower care teams to provide preventive care and chronic care management. This was cited as an early challenge for hospitals and FQHCs that have adopted APMs, and a critical consideration in the development of the primary care APM.
- **Financial resources.** Primary care practices, especially smaller practices, need financial investment to develop robust infrastructure and support systems to succeed under APMs.
- **Ramp up period or "glide path" model.** Practices need time to adjust to alternative APMs and feel comfortable bearing more risk. Both FQHCs and hospitals shared positive experiences with models that began with an upside-only option such as shared savings and only transitioned to downside risk over time, once they had adjusted to the APM.

- **Auxiliary supports and tools.** A hospital that has succeeded under an accountable care organization (ACO) model noted that success was dependent on tools, services, and resources provided by an organization that oversees the ACO.

One question on the provider readiness survey asked respondents to rate their level of concern on 13 elements related to APM preparation and implementation on a scale of "not a concern," "concerned," and "very concerned." More than half of survey respondents report they were "very concerned" about having necessary time and staff resources to design and implement a primary care APM, the impact on fiscal workflow, the ability to meet clinical targets and expectations for primary care APMs, the impact on operational workflows, and negotiation with plans (Figure 2).

FIGURE 2



Survey respondents (n=70)

The biggest concerns vary among practice sizes (Table 4). Individual providers are more likely to be very concerned with the APM's impact on fiscal workflow (80%, n=7) and negotiations with plans (80%, n=7). Larger organizations' (more than 100 providers) primary concerns are necessary time and staff resources to design and implement an APM (71%, n=5), the APM's impact on operational workflow (71%, n=5), and provider buy-in (71%, n=5).

TABLE 4

Percent of Survey Respondents Who Were "Very Concerned" by Practice Size					
	All Respondents	Individual Provider	2-20 Providers	21-100 Providers	More than 100 Providers
Necessary time/staff resources to design and implement primary care APM readiness	60%	70%	53%	67%	71%
Impact on fiscal workflow	57%	80%	54%	44%	57%
Impact on operational workflow	56%	70%	51%	44%	71%
Ability to meet clinical targets/expectations set forth in primary care APMs	56%	70%	54%	44%	57%
Negotiation with plans	51%	80%	43%	44%	57%
Establishing partnerships with external providers	49%	70%	43%	44%	57%
Impact on clinical workflow	48%	70%	46%	56%	14%
Health information technology (HIT) infrastructure/support needed to implement changes	46%	70%	34%	56%	57%
Provider buy-in	46%	60%	43%	22%	71%
Adequate financial position/reserves	44%	70%	43%	11%	57%
Capability/willingness to exchange health information (HIE) with external partners	41%	70%	34%	22%	57%
Liability/audit risk	34%	60%	37%	11%	14%
Board of Directors support	26%	60%	23%	0%	29%

Note: Orange fill indicates the top two (or three if tied) primary concerns for each respondent type (read by column).

FQHCs are less concerned about an APM's impact on their organization for every one of these considerations compared to non-FQHCs, as shown in Table 5.

TABLE 5

Percent of Survey Respondents Who Were "Very Concerned" by FQHC Status			
	All Respondents	FQHCs	Non-FQHCs
Necessary time/staff resources to design and implement primary care APM readiness	60%	27%	70%
Impact on fiscal workflow	57%	33%	65%
Impact on operational workflow	56%	33%	63%
Ability to meet clinical targets/expectations set forth in primary care APMs	56%	33%	63%
Negotiation with plans	51%	13%	63%
Establishing partnerships with external providers	49%	20%	59%
Impact on clinical workflow	48%	33%	52%
Health information technology (HIT) infrastructure/support needed to implement changes	46%	33%	54%
Provider buy-in	46%	20%	50%
Adequate financial position/reserves	44%	20%	52%
Capability/willingness to exchange health information (HIE) with external partners	41%	13%	50%
Liability/audit risk	34%	27%	37%
Board of Directors support	26%	20%	28%

Note: Orange fill indicates the top two (or more if tied) primary concerns for each respondent type (read by column).

Section 1: Care Delivery

This section describes readiness related to care delivery among primary care practices and contains three topics:

- Care Management, Care Planning, and Referrals
- Patient and Family-Centeredness
- Behavioral Health and Primary Care Integration of Services

WHY THIS MATTERS

A high functioning care team uses all members of the team in specific roles and at the top of their skill set and training. Because payment under an APM is based on value rather than volume of services rendered, all team members work directly with patients in identifying needed services and coordinating their care. Patients are assessed for physical, behavioral, and social needs, and a care plan is developed and shared with all members of the care team. Patients and their caregivers are active participants in developing the care plan and setting improvement goals. [3]

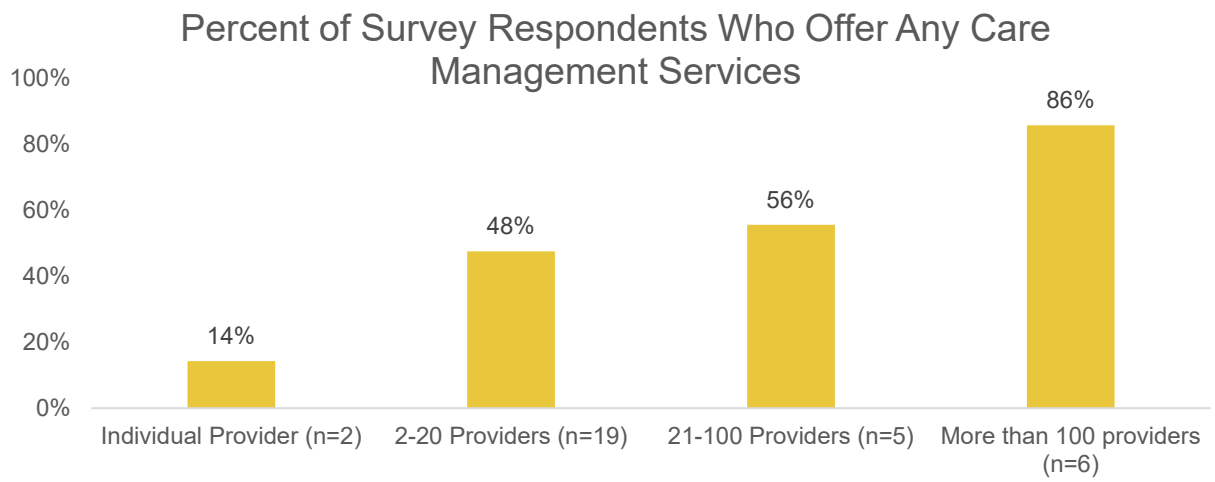
[3] Sullivan, Erin E. PhD; Ibrahim, Zara; Ellner, Andrew L. MD; Giesen, Lindsay J. Management Lessons for High-Functioning Primary Care Teams. Journal of Healthcare Management 61(6):p 449-465, November 2016.

Care Management, Care Planning, and Referrals

Care Management

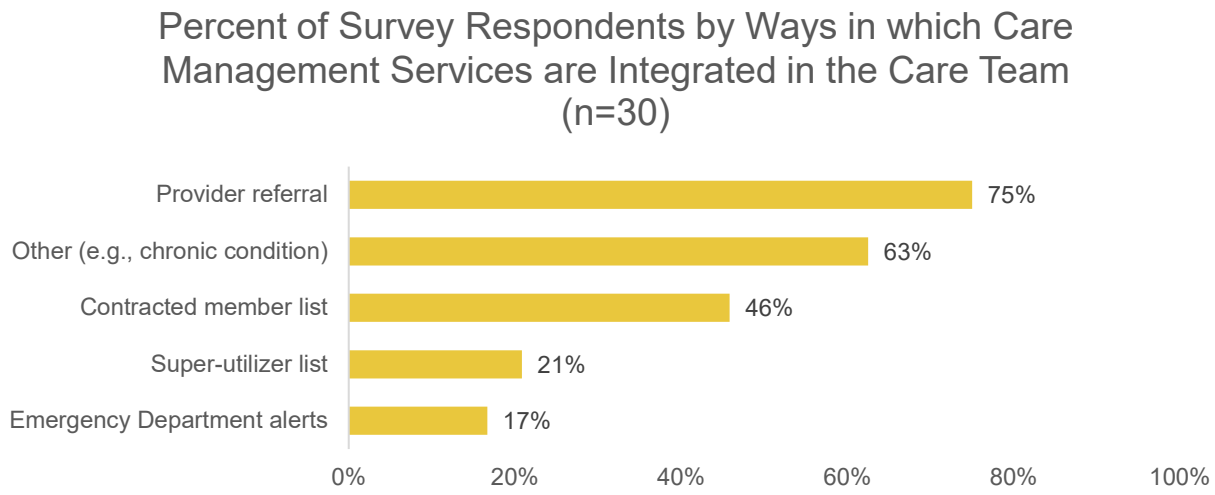
The readiness survey examined the extent to which primary care practices have care management services in place. Forty-six percent (n=32) of survey respondents offer care management services at their health center/practice and the remaining 54% (n=38) do not offer care management services. FQHCs are no more likely to report offering care management services than non-FQHCs. The size of the organization has a strong correlation with the extent to which care management services are offered (Figure 3). Nearly all (86%, n=6) of survey respondents with more than 100 providers offer care management services compared to just 14% of individual providers.

FIGURE 3



The average number of FTEs dedicated to care management activities is 8.5 and the median number is 3.0. Among respondents who offer care management services, about three in four (78%, n=25) organizations agree or strongly agree that their care management services are integrated into the care team. Among practices/clinics that integrate care management services into the care team, provider referral is the most common way in which these services are integrated (Figure 4).

FIGURE 4



A theme across all focus groups is that care management is most successful with interdisciplinary care teams that can support both the social and medical needs of patients. Focus group participants emphasized the importance of developing an APM that incentivizes and facilitates non-clinical patient supports. One clinic described having nurses or other care team members devoted specifically to managing the holistic needs of their clinic's Medicaid patient population, for example, medication adherence, transportation, diet and nutrition, and scheduling procedures and appointments. However, for this model to be feasible they needed to devote staff specifically to this type of care management; they had previously tried to have clinicians do these tasks in addition to clinical work and it was not successful.

It is important to note that focus group participants from small and rural practices expressed concern about their ability to hire this type of interdisciplinary care team. They lack the financial resources to recruit and hire non-clinical staff, and struggle with getting reimbursed for non-clinical services.

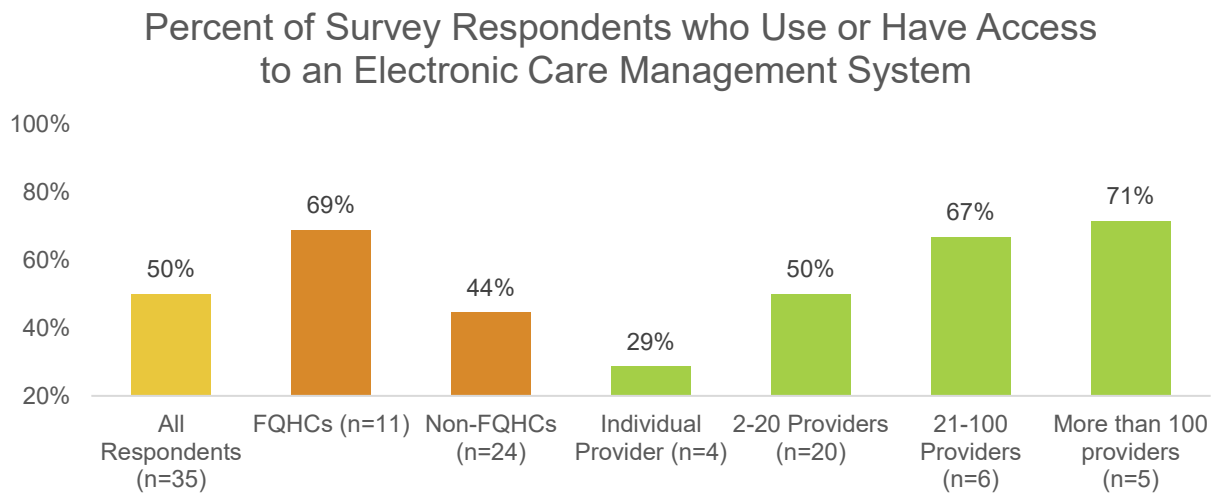
Focus group participants that are already dedicating resources to care coordination and patient outreach shared that a potential benefit of the APM would be allowing them to continue expanding and improving those services. One clinic that currently provides care coordination services across multiple clinical sites reported that it has already improved care quality and would likely continue to improve if further supported by the APM. An FQHC shared their experience rolling out a multidisciplinary team-based care model, in which care teams composed of medical providers, behavioral health workers, community health workers, care coordinators, operations and front desk staff, and billing staff work together to take care of their patient populations. A key to the success of this model is access to data. The care delivery teams use data to see how they are performing on quality measures, to guide their work, and to improve patient outcomes.

Care Plans

Nearly half of survey respondents (47%, n=33) use a care plan as a source for care management, and these are more likely to be larger organizations (14 percent, n=2, of individual providers reported using a care plan as a source of care management). There was little difference in use of care planning as a source of care management if an organization was an FQHC. Fifty percent (n=8) of FQHCs compared to 46% (n=25) of non-FQHCs use a care plan as a source for care management.

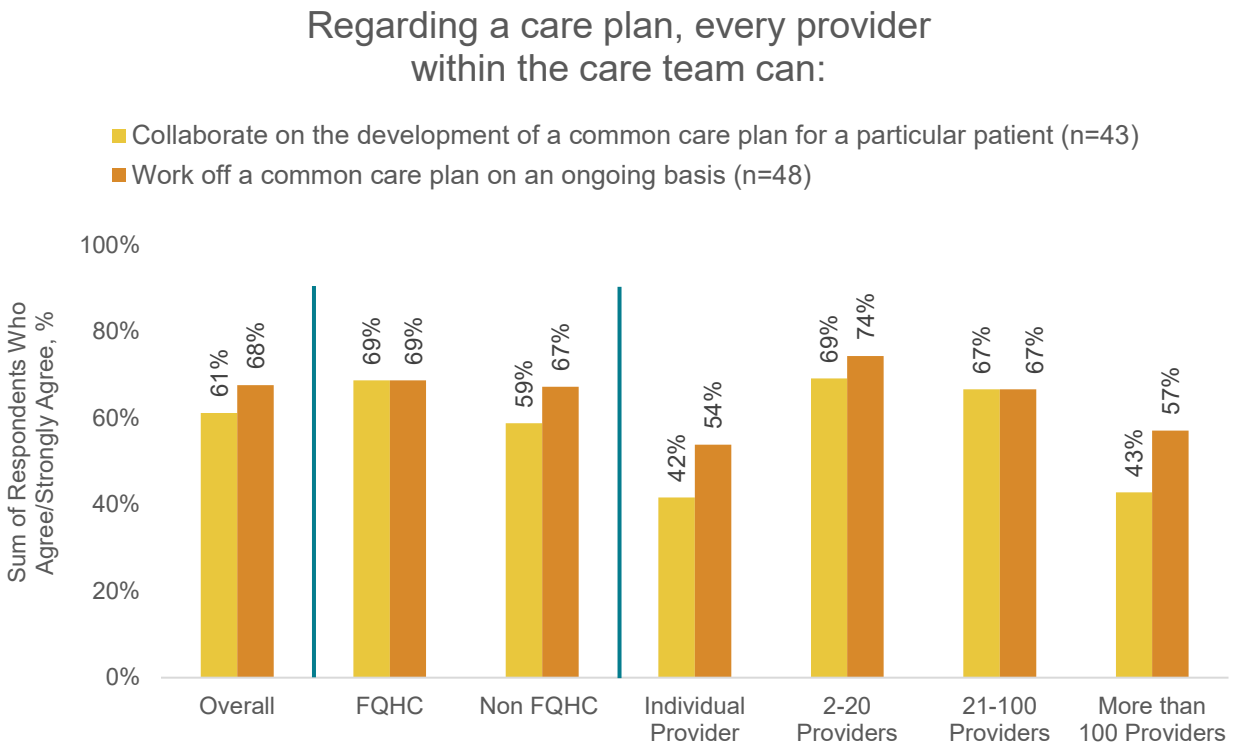
Fifty percent of respondents (n=35) use or have access to an electronic care management system for their care plan and related services (Figure 5). FQHCs and larger organizations (21 or more providers) are more likely to use or have access to an electronic care management system for their care plan and related services.

FIGURE 5



Survey respondents were more likely to report that every provider within the care team can work off a common care plan on an ongoing basis (e.g., read each other's notes and collaborate in maintenance and updates to the plan) and less likely to report that collaboration occurs on the development of a common care plan for a particular patient (Figure 6). However, for FQHCs and mid-size organizations (2 to 100 providers), the likelihood of collaborating to develop a common care plan while also working off a common care plan is higher compared to all respondents.

FIGURE 6



Approximately two in three survey respondents (65%, n=45) have care plans informed by real-time intelligence about a patient's status (e.g., potential allergies, evidence gathered from patients with similar conditions, adverse drug reactions and/or drug-to-drug interactions). FQHCs are more likely than non-FQHCs to have care plans informed by real-time intelligence about a patient's status, 81% (n=13) and 59% (n=32), respectively.

Initial screening assessments and health/functional assessments are the most common regularly conducted assessment among survey respondents (Table 6). This prevalence is shared regardless of FHQC status or organizational size. Risk assessments (74%, n=50) are the third most common, followed by health-related social needs (HRSN) or social determinants of health (SDoH) (55%, N=37), and risk stratification assessments (41%, n=28).

TABLE 6

Percent of Survey Respondents who Regularly Conduct the Following Assessments by FQHC Status and Practice Size							
	All Respondents	FQHC	Non-FQHC	Individual Provider	2-20 Providers	21-100 Providers	More than 100 Providers
Initial Screenings (n=62)	90%	94%	89%	100%	85%	89%	100%
Health/functional assessments (n=59)	87%	100%	83%	85%	87%	89%	86%
Risk assessments (n=50)	74%	63%	77%	77%	72%	89%	57%
HRSN or SDoH (n=37)	55%	56%	55%	46%	61%	56%	43%
Risk stratification (n=28)	41%	44%	40%	38%	41%	44%	43%

Note: Green fill indicates the top two (or three if tied) assessment types regularly conducted for each respondent type (read by column).

As shown in Table 7, survey respondents who conduct assessments are most likely to capture initial screenings, health/functional assessments, and risk assessments as structured data in their care plan, EHR or another database images, paper, or PDF do not qualify). This is regardless of FQHC status or size, except for mid-size organizations (21-100 providers). Survey respondents with 21-100 providers are more likely to collect structured data for HRSN or SDoH (80%, n=4) and risk stratification (75%, n=3).

TABLE 7

Among Survey Respondents who Regularly Conduct the Following Assessments, Percent who Capture the Assessment as Structured Data in their Care Plan, EHR, or Another Database							
	All Respondents	FQHC	Non-FQHC	Individual Provider	2-20 Providers	21-100 Providers	More than 100 providers
Initial Screenings (n=45)	75%	87%	71%	75%	79%	63%	71%
Health/functional assessments (n=37)	62%	88%	56%	55%	75%	63%	33%
Risk assessments (n=36)	60%	90%	69%	70%	74%	63%	100%
HRSN or SDoH (n=24)	40%	78%	63%	40%	74%	80%	33%
Risk stratification (n=14)	23%	67%	48%	60%	53%	75%	0%

Note: Green fill indicates the top two assessment types for which structured data are collected for each respondent type (read by column).

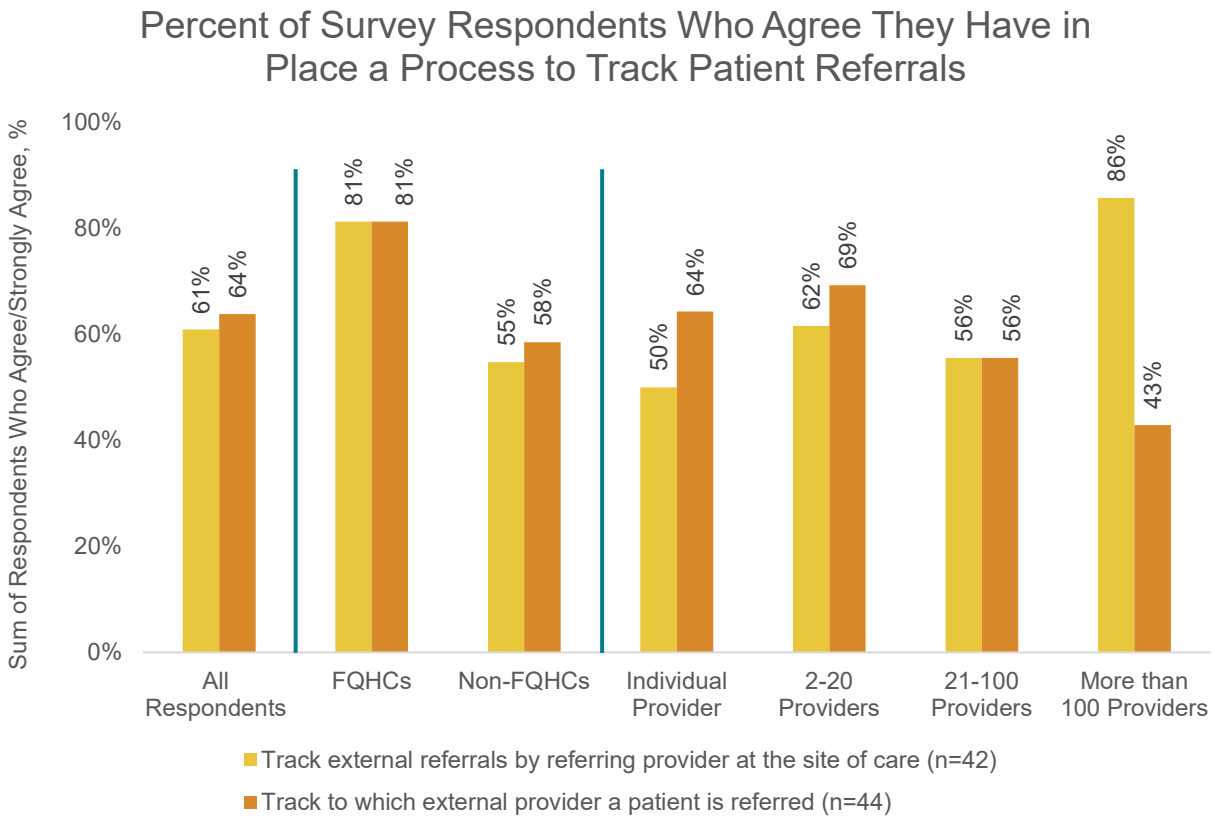
Focus group participants were also asked whether they collect SDoH data and/or integrate health-related social needs into their workflows. FQHCs are required to complete a psychosocial history for patients and during the FQHC focus group, participants shared several strategies they are currently using to collect SDoH data. One FQHC integrated the PRAPARE validated tool into their electronic health record, and it is currently being used by their chronic care management team. This is a fillable form that is simple to complete and easy to create a report. The tool is used to identify patient needs for housing, food insecurity, health literacy, education level, employment, domestic violence, and behavioral health services. Other FQHCs use third-party software such as One Degree and Unite US to collect SDoH data.

Among hospital focus group participants, only a few collect these data, and they are not yet used to inform care or support provided to patients. Small- and medium-sized practice focus group participants similarly reported that they do not regularly collect this information, although most did note that they do their best to support patients with health-related social needs. One clinician shared that they have incorporated more health literacy and patient education into their workflows to help patients understand their medical conditions and treatment plans. Another shared an anecdote about helping a patient arrange transportation for cancer treatment several hours away. A common theme was that these needs are not preemptively screened, but when they arise small and medium practices do their best to support patients. Rural providers reported that they are uniquely positioned to provide these supports because they are very integrated in their communities and familiar with patients' non-clinical needs.

Referral Tracking

As shown in Figure 7, approximately two-thirds of survey respondents have in place a process to track patient referrals, including tracking external referrals by referring provider at the site of care (61%) and tracking to which external provider a patient is referred (64%).

FIGURE 7

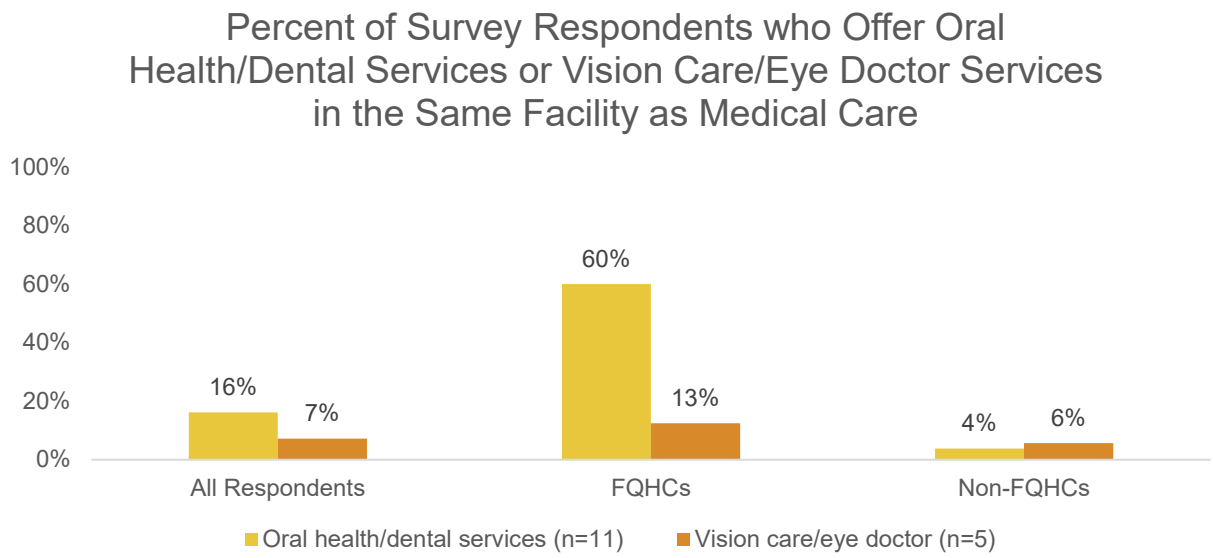


About three in 10 survey respondents (30%, n=20 and 3 respondents didn't answer) have a strategy in place to outreach to and engage managed care members who are assigned to their organization but have never been seen by their organization. FQHCs and large organizations (more than 100 providers) are the most likely to have such a strategy, at 47% (n=7) and 57% (n=4), respectively.

Just under half (46%, n=31) of respondents agree or strongly agree they have established routine communication and handoff processes with hospitals that are used by their patients. This reduces to just one in five (21%, n=3) for individual provider respondents.

Except for FQHCs, respondents are not likely to offer oral health/dental services or vision care/eye doctor services to their patients in the same physical facility that they offer medical care (Figure 8).

FIGURE 8



Note: Oral health/dental services were reported by 11 survey respondents, including 9 FQHCs, and 2 Non-FQHCS. Vision/eye doctor services were reported by 5 survey respondents, including 2 FQHCs, and 3 non-FQHCS.

This is consistent with focus group findings. Because of their care model, FQHCs were far more likely to report integration of oral health/dental and vision services with medical services. All 19 FQHCs in New Mexico either provide dental services on site (n=15) or contract with nearby FQHCs, non-profit dental providers, or dental offices that provide services on a sliding scale. Out of a total of 186 FQHC sites, 61 provide dental services on site or contract for local services. Only two or three FQHCs in New Mexico provide vision services, although this is a service that the Health Resources and Services Administration (HRSA) is encouraging FQHCs to expand.

One focus group participant, a representative of a medical home, reports that their greatest strength is embedding and being able to provide dental, primary care, and behavioral healthcare all at one location. These services are embedded within their primary care model, and providers from each of these specialties can work together to coordinate care. Several hospital focus group participants report limited dental and vision services and most hospital participants noted this as a gap.

During the interprofessional team focus group, dental, behavioral health, and pharmacy providers shared their experiences and input on integrating with primary care. No pharmacists reported formal integration with a primary care practice, and one pharmacy representative noted that most of their referrals come from word of mouth rather than medical providers. Several dentists shared that outside of FQHC-affiliated dental clinics, most dentists are not currently integrated with primary care. They noted that moving to an integrated model could be difficult due to this lack of infrastructure for relationships and data sharing with medical offices and could result in decreased access unless significant support is provided to develop such infrastructure. Additionally, dental and pharmacy representatives reported that they do not currently collect or report on quality measures, and do not have the IT system or processes in place to do so.

A current challenge for both dental and pharmacy providers is their level of reimbursement, which providers report is too low to be sustainable. Both provider types also described challenges with their current payment models and describe not getting reimbursed for the full scope of services they provide. Focus group participants were interested in the APM, but unsure how it would affect these challenges. (Input on behavioral health and primary care integration is discussed later in this report.)

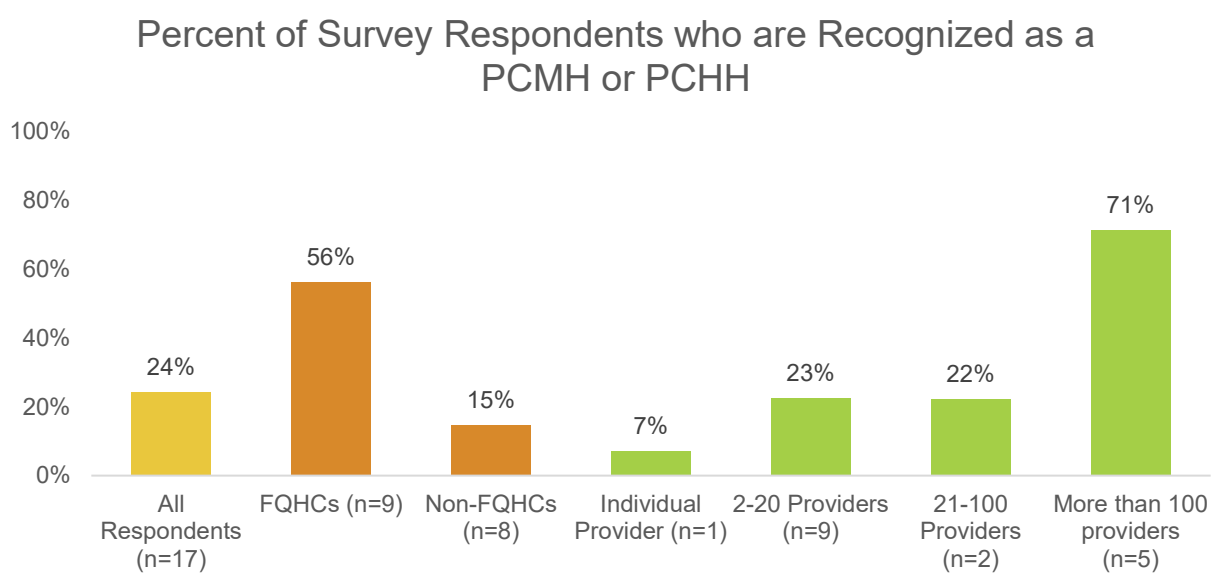
Patient and Family-Centeredness

This section explores the extent to which a health center/practice provides patient and family-centered care. About one in four survey respondents (24%, n=17) are recognized as a patient-centered medical home (PCMH)/patient-centered health home (PCHH)[6]. Being an FQHC or a larger organization (100 or more providers) increases the likelihood of being recognized as a PCMH/PCHH (Figure 9).

WHY THIS MATTERS

The care team must have a thorough understanding of its population, including the language, cultural, and social environments, to provide meaningful care that will help implement improvements in health status. Along with understanding the global population the team serves, each patient should be at the center of their care and should be an active contributor to their care plan. Access to services should be available during and outside traditional business hours to effectively manage urgent concerns and avoid unnecessary ED visits. Experienced nursing staff can assess the urgency of medical complaints and work with another provider, when necessary, to accommodate the appropriate level of care needed.[4,5]

FIGURE 9



[4] Christine A. Sinsky, Rachel Willard-Grace, Andrew M. Schutzbank, Thomas A. Sinsky, David Margoulius, Thomas Bodenheimer. In Search of Joy in Practice: A Report of 23 High-Functioning Primary Care Practice. The Annals of Family Medicine. May 2013, 11 (3) 272-278; DOI: 10.1370/afm.1531

[5] Sevin, Cory MSN, RN, NP; Moore, Gordon MD; Shepherd, John MD; Jacobs, Tracy BSN, RN; Hupke, Cindy RN. Transforming Care Teams to Provide the Best Possible Patient-Centered, Collaborative Care. Journal of Ambulatory Care Management 32(1):p 24-31, January 2009. DOI: 10.1097/01.JAC.0000343121.07844.e0

[6] The Agency for Healthcare Research and Quality defines patient-centered medical homes, sometimes known as patient-centered health homes, as "a model of the organization of primary care that delivers the core functions of primary health care." The five functions and attributes encompassed by medical homes are comprehensive care, patient-centered, coordinated care, accessible services, and quality and safety.

Empaneled Patients

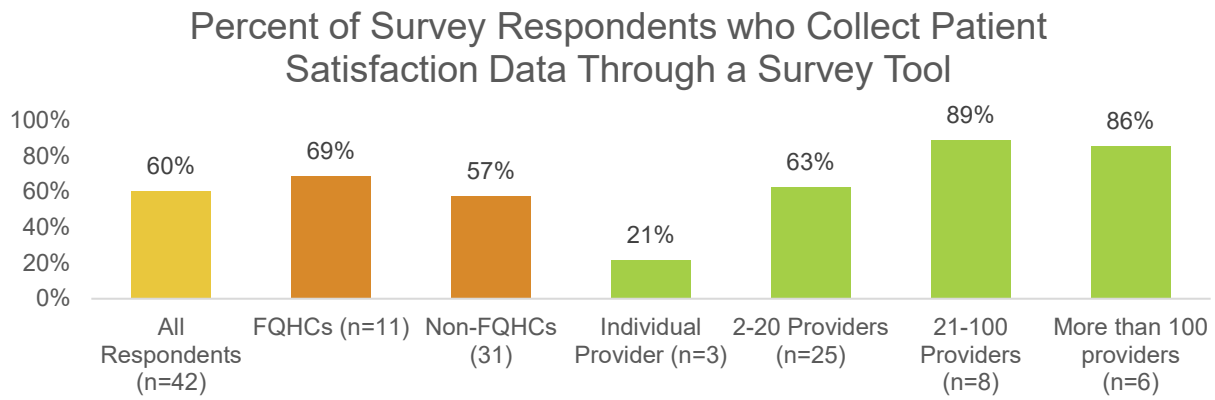
More than half of respondents (56%, n=39) have patients empaneled to a particular primary care provider. There is little variation across the different survey respondent types.

Providing Patient-Centered Care

Patient Satisfaction Data Collection

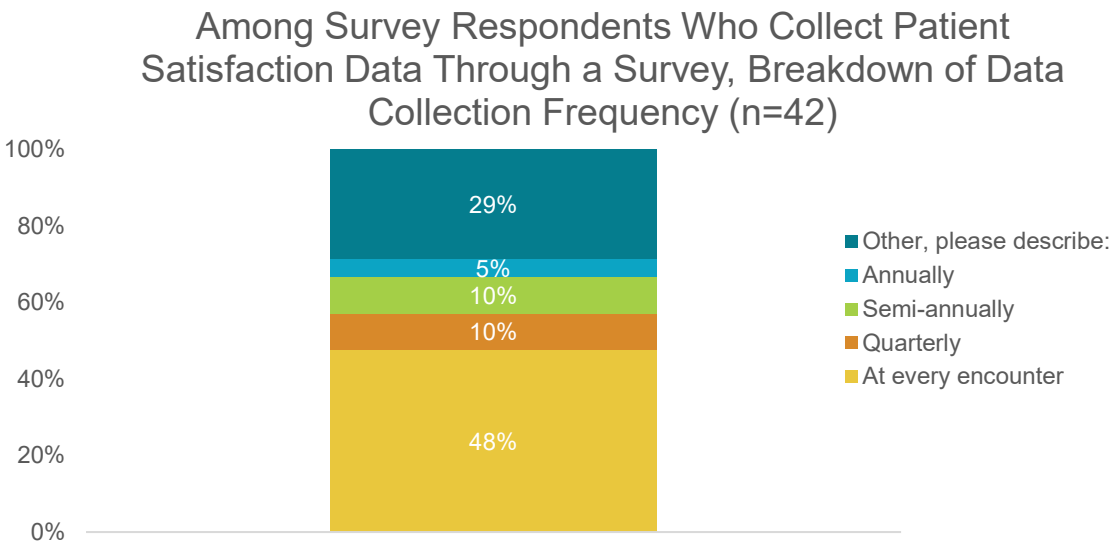
Patient satisfaction data is collected through a survey tool by 60% (n=42) of survey respondents (Figure 10). FQHCs and mid-size to large organizations (2 or more providers) are more likely to collect patient satisfaction data. Hospital focus group participants were asked how they collect patient satisfaction information and share it with providers, and most reported that they use the Press Ganey survey to gather information from patients.

FIGURE 10



Among these respondents who collect patient satisfaction data, 48% (n=20) collect at every encounter (Figure 11). Others reported they collect patient satisfaction randomly, in the waiting room prior to visit, or post encounter.

FIGURE 11

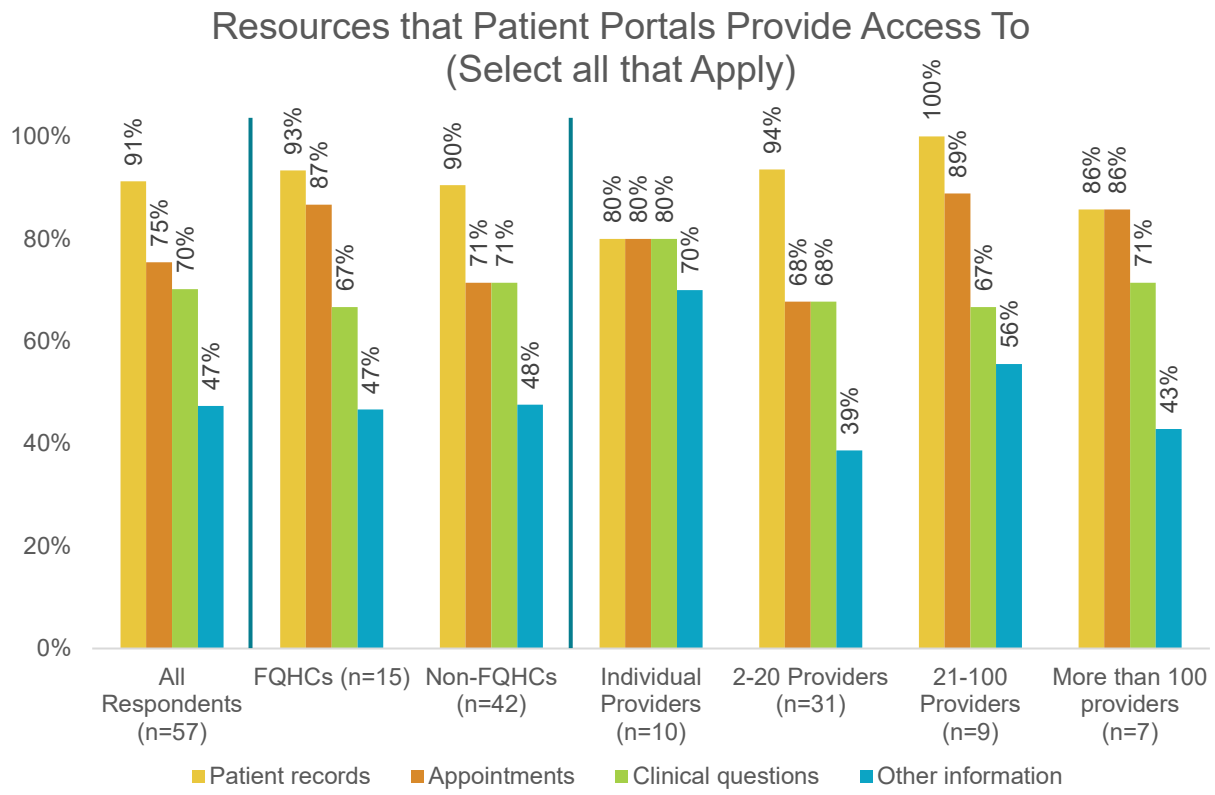


Electronic Patient Portal Utilization

Nearly all survey respondents (84%, n=57) provide use of an electronic patient portal for patient access. Respondents who do not provide use of an electronic patient portal are more likely to be smaller organizations (less than 20 providers) and non-FQHCs.

Resources provided to patients via patient portals is predominately patient records (91%), followed by appointments (75%), clinical questions (70%), and other information (47%) (Figure 12). This trend is similar across all provider types. Despite the reported availability of patient portals, it is less likely for survey respondents to report that more than 50% of patients use the portal. Nineteen percent (n=11) of survey respondents who provide use of a portal report that more than 50% of patients use the portal for any reason, 56% (n=32) report that less than 50% of patients use the portal, and 25% (n=14) report they do not know how many patients used the portal.

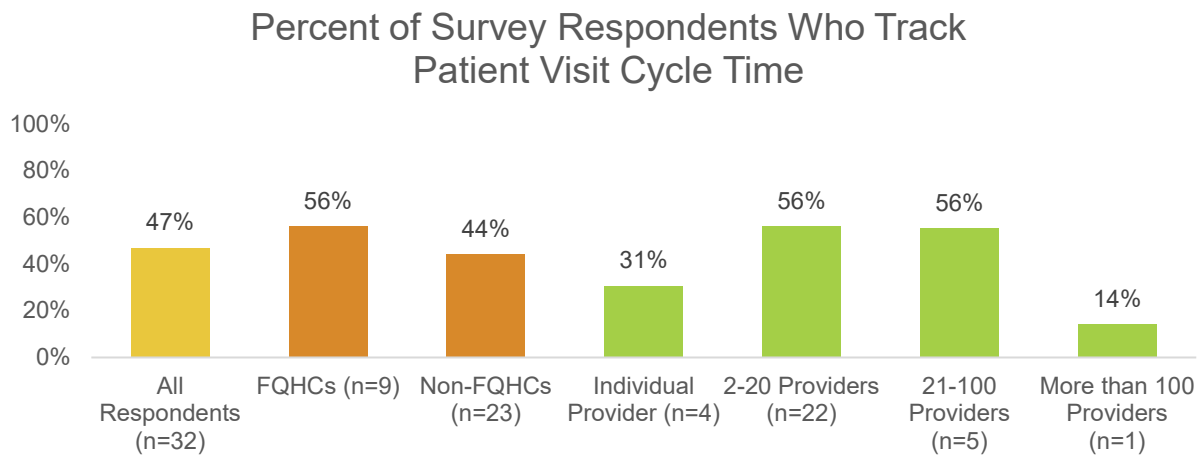
FIGURE 12



One in four survey respondents (24%, n=17) report use of any patient-centered tools such as shared decision-making or decision support tools. Individual providers (43%, n=6) are most likely to report that they use such tools.

Tracking patient visit cycle time is important because patient-centered care values the importance of a patient's time and this type of tracking can help identify bottlenecks in the practice's workflow. Nearly half of survey respondents (46%, n=32) report they track patient visit cycle time (i.e., the amount of time it takes a patient from the time they enter the door to exit after a completed visit) (Figure 13). Tracking is most common among FQHCs and mid-size practices (2 to 100 providers).

FIGURE 13



Enhanced Care

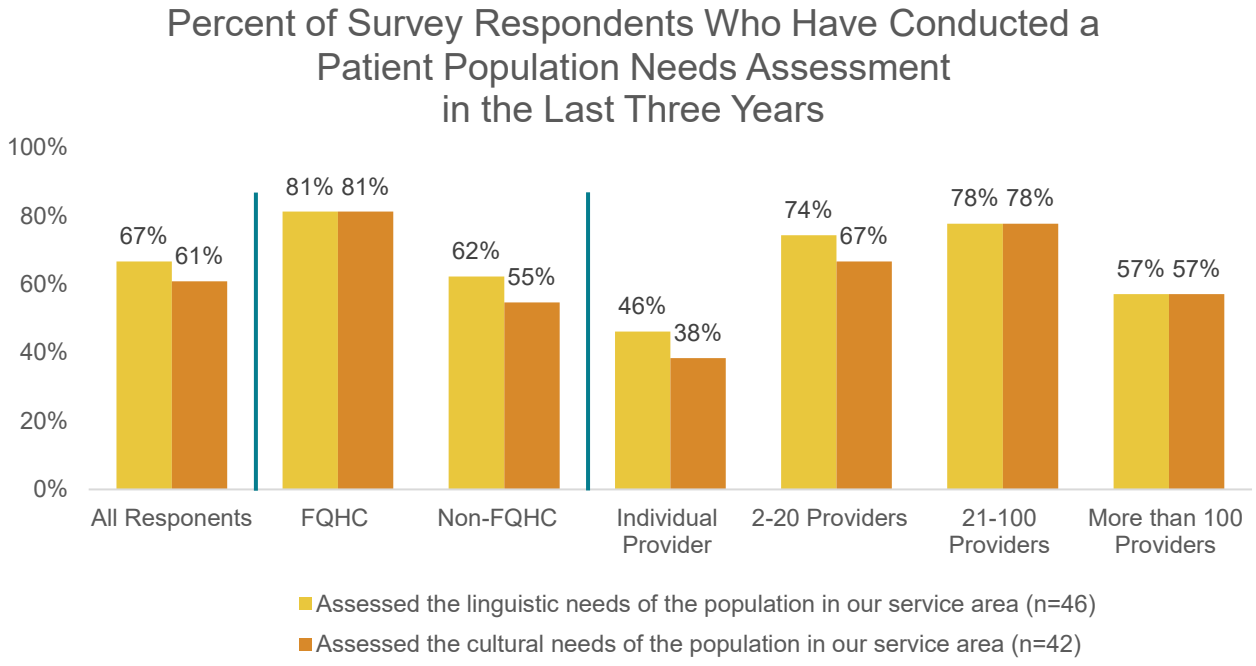
Half of the survey respondents (50%, n=34) have an individual engaged full time in clinical nursing for triage, care coordination, and/or telephone consultation services (less than 20% administrative office work). This is similar across all provider categories.

Linguistic and Cultural Competency

Patient Population Needs Assessment

Survey respondents are slightly more likely to assess for linguistic needs (67%, n=46) versus cultural needs (61%, n=42) of the population in their service area in the last three years (Figure 14). FQHCs and medium to large practices (2 or more providers) are more likely to conduct these assessments.

FIGURE 14

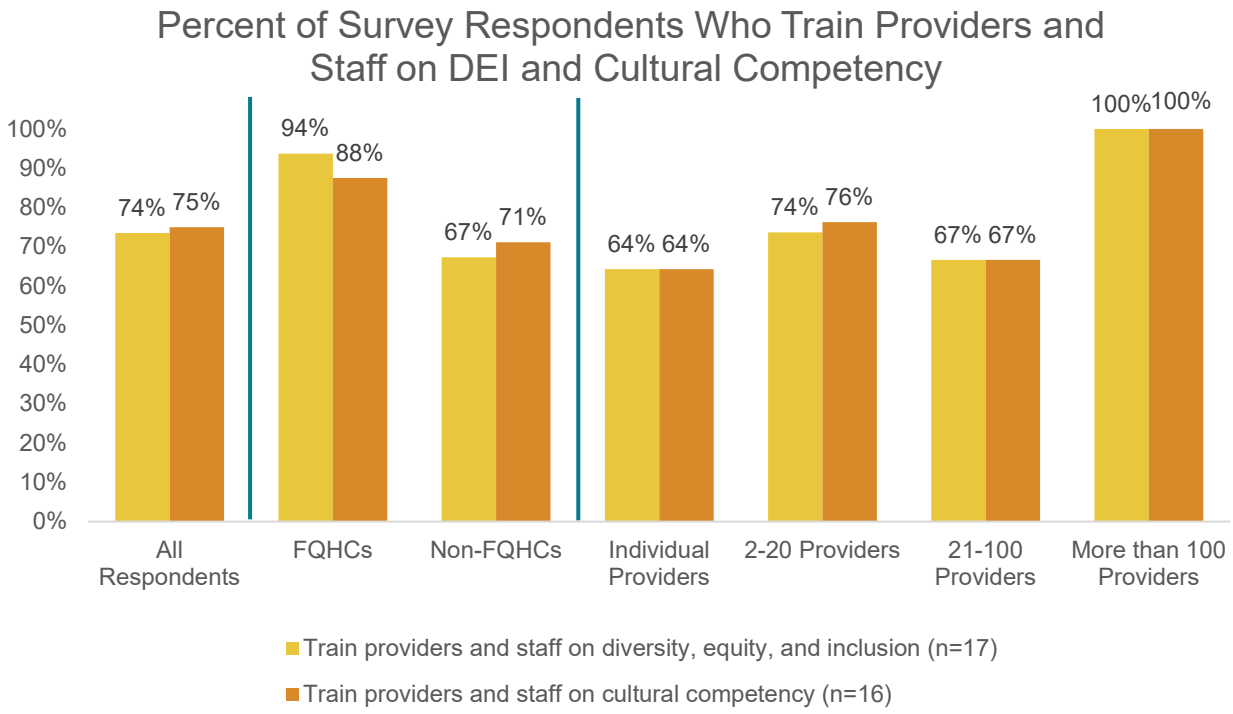


Regarding accessibility of translation and interpretation services, individual providers are less likely to report that such services are easily accessible for all patients: 43% (n=6) of individual providers compared to 92% (n=36) of respondents with 2-20 providers, 89% (n=8) of survey respondents with 21-100 providers, and 100% (n=7) of respondents with more than 100 providers.

Provider and Staff Training

Approximately three in four survey respondents train providers and staff on diversity, equity, and inclusion (DEI) or cultural competency (Figure 15). Non-FQHCs are less likely to offer training compared with FQHCs. Small to mid-size organizations (1 to 99 providers) are less likely than large organizations (100 or more providers) to offer training.

FIGURE 15



Survey respondents were asked how often they train their providers and staff on cultural competency and DEI. With the option to select more than one frequency, annual training is the most common frequency at which survey respondents offer both DEI (40%, n=27) and cultural competency (46%, n=31) training. Orientation is the second most common time at which DEI (34%, n=23) and cultural competency training (37%, n=25) is offered. Others reported that they train regularly scheduled meetings or when the need or opportunity arises.

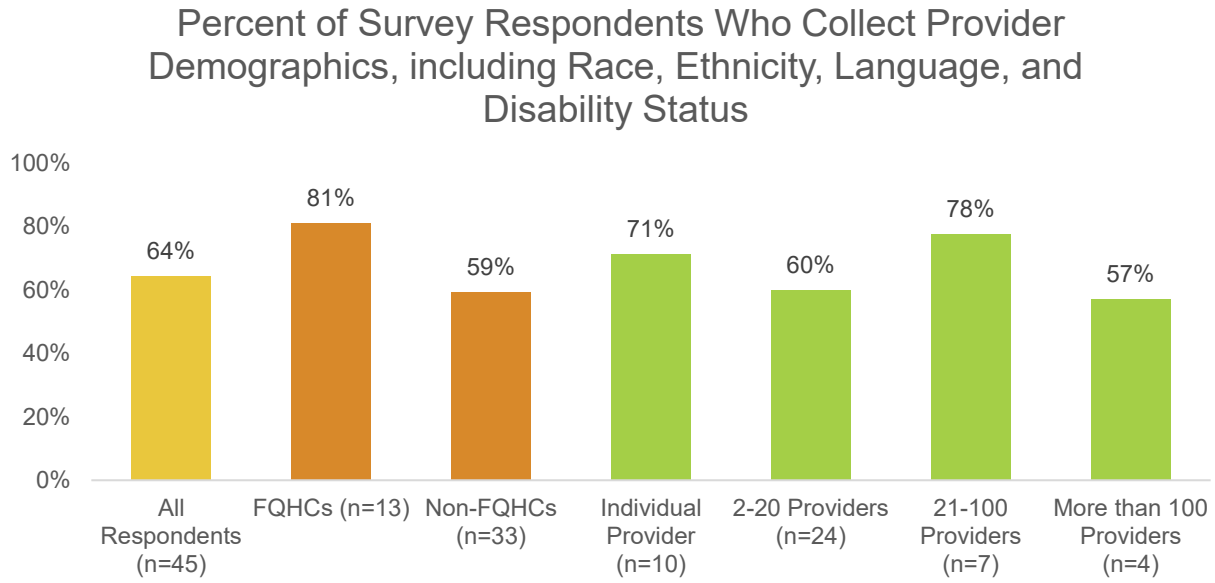
Provider Demographic Data Collection

Sixty-four percent (n=45) of survey respondents collect provider demographics, including race, ethnicity, language, and disability status (Figure 16). FQHCs are more likely than non-FQHCs to collect provider demographic data, 81% (n=13) and 59% (n=32), respectively. The influence of provider size on whether provider demographics is unclear. Survey respondents with 2-20 providers and respondents with more than 100 providers are less likely to collect provider demographics. However, survey respondents with 21-100 providers are more likely to do so: 78% (n=7) of respondents.

WHY THIS MATTERS

Nationally, non-white people are less likely than white patients to report being the same race as their healthcare providers[7]. This misalignment may lead to strained patient-provider relationships and is thought to contribute to disparities in health outcomes. Historical medical mistreatment of patients of color in the United States has contributed to a mistrust of healthcare providers within these groups. According to research conducted by The Urban Institute and Robert Wood Johnson Foundation, racial alignment between patient and provider is associated with greater likelihood of patients agreeing to and receiving preventive care, better patient experience ratings, and higher ratings on patient-reported measures of care quality.[7]

FIGURE 16



Two thirds (64%, n=45) of survey respondents report that the provider demographics and/or experiences are reflective of the community in their service area. Similarly, two thirds (66%, n=46) of survey respondents have developed patient education materials and information on tests and procedures in multiple languages and at appropriate health literacy levels.

[7] Gonzalez, Kenney, McDaniel, & O'Brien, 2022

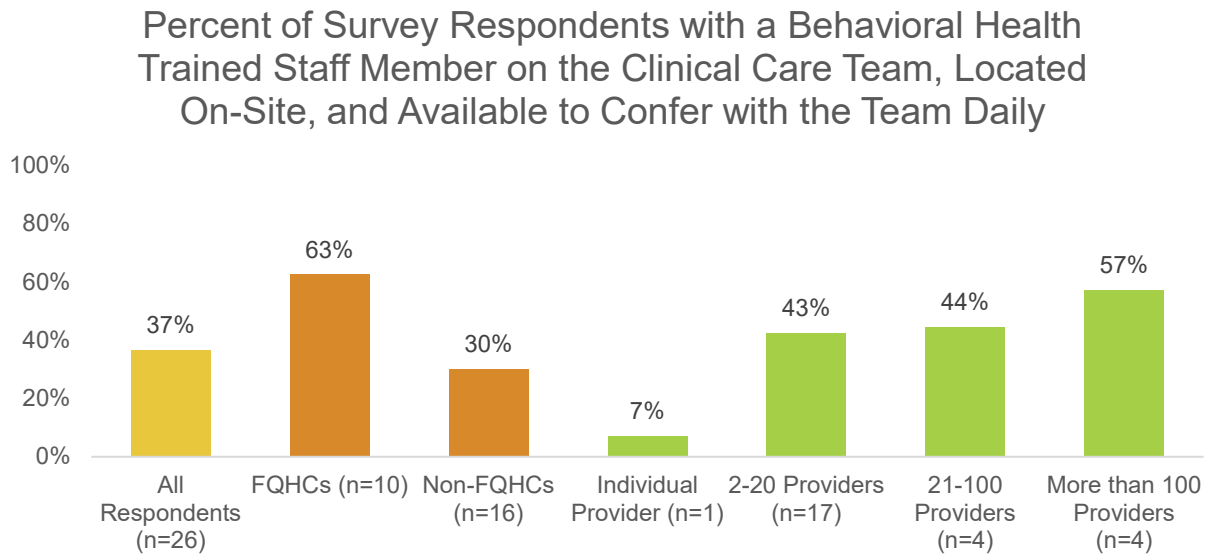
Behavioral Health and Primary Care Integration of Services

This section of the survey explored the extent to which health centers/practices integrate behavioral health and primary care. Thirty-seven percent (n=26) of respondents have a behavioral health trained staff member as part of the clinical care team, located on-site, and available to confer with the team throughout the day. FQHCs (63%, n=10) and larger organizations (2 or more providers) are more likely to integrate behavioral health and primary care (Figure 17). Most respondents with integrated behavioral health and primary care report that the behavioral health trained staff member(s) are available to confer with the clinical care team 50% or more of the time.

WHY THIS MATTERS

Nearly half of patients with one or more of the top five chronic medical conditions treated in primary care also suffer from a co-existing behavioral health issue. Providing primary and behavioral health care in one location by an integrated care team leads to improved outcomes (clinical and financial) for both medical and behavioral health issues as well as significantly lower long-term health care costs. The behavioral health staff should function as a core team member, not ancillary staff.[8,9]

FIGURE 17



Similarly, one third (33%, n=23) of survey respondents report that behavioral health services are available to their patients in the same physical facility as medical care services. FQHCs (63%, n=10) and larger organizations (2 or more providers) are more likely to offer behavioral health services in the same physical facility as medical care.

[8] Chapman DP, Perry GS, Strine TW. The vital link between chronic disease and depressive disorders. Prev Chronic Dis. 2005 Jan;2(1):A14. Epub 2004 Dec 15. PMID: 15670467; PMCID: PMC1323317

[9] Margaret Brown, Catherine A. Moore, Jill MacGregor, Jason R. Lucey, Primary Care and Mental Health: Overview of Integrated Care Models, The Journal for Nurse Practitioners, Volume 17, Issue 1, 2021, Pages 10-14, ISSN 1555-4155, https://doi.org/10.1016/j.nurpra.2020.07.005

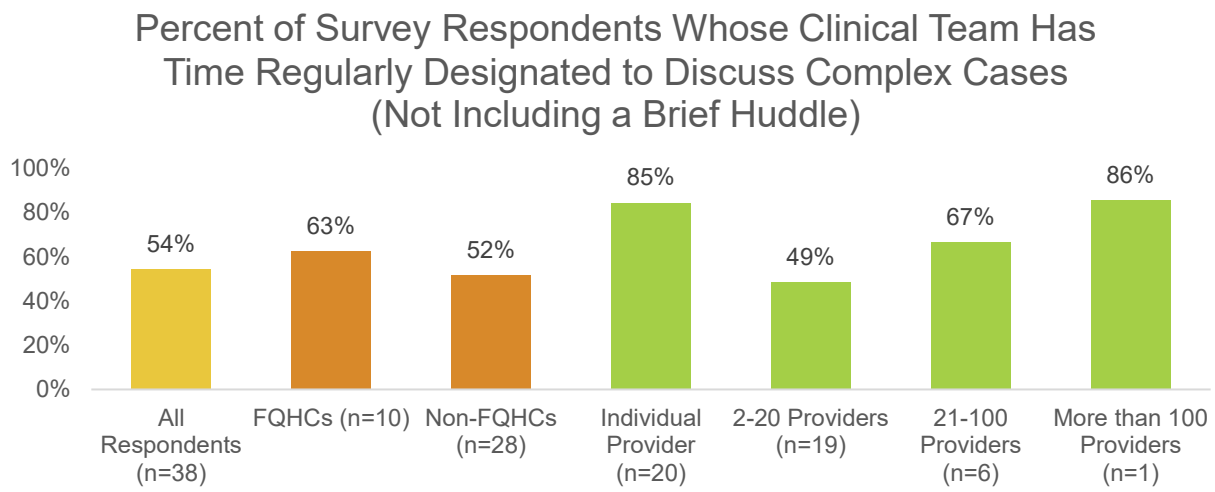
Among respondents with behavioral health services in the same physical facility as medical care:

- Seven in 10 survey respondents (70%, n=16) with a medical provider who refers a patient for on-site behavioral health services (non-urgent) always/sometimes can have the patient be seen the same day for behavioral health care.
- Almost eight in 10 survey respondents (78%, n=18) have primary care and behavioral health staff document in a shared medical record.
- One survey respondent reported being able to view access in each other's records.

Among survey respondents with behavioral health services *not* located in the same physical facility as medical care services, barriers that prevent offering behavioral health services to patients include cost, lack of providers available, or not enough space in their practice to add an additional provider. These barriers are exacerbated in rural areas.

More than half (54%, n=37) of survey respondents' clinical teams have time regularly designated to discuss complex cases (not including a brief huddle) (Figure 18). This is more common among FQHCs (63%, n=10) and individual providers (8%, n=11).

FIGURE 18



Many focus group participants are currently integrating behavioral health with primary care to some extent. Several hospital representatives shared their models of behavioral health integration, including having counselors and psychiatrists as members of their primary care teams, collecting data and doing behavioral health assessments during primary care visits, and embedding primary care providers into behavioral health clinics. One hospital noted that they built a behavioral health screening into their electronic health record, and if patients screen positive, local referrals are automatically included on their discharge papers.

A participant in the small and medium practice focus group shared an innovative behavioral health intervention, in which they partnered with a local hospital to identify the 10 patients who most frequently came to the ED for behavioral health needs. The primary care practice hired a social worker to engage those 10 patients, connecting them to primary care and behavioral health services.

The following year, the patients' ED visits were drastically reduced and an estimated $400,000 of medical spending was saved.

All 19 FQHCs in New Mexico provide some level of behavioral health services, often a social worker, therapist, and/or family counselor. Four FQHCs provide a higher intensity of behavioral health services and support for people with serious mental illness. Some FQHCs have been providing behavioral health services onsite for 20-30 years, while most have started to integrate these services in the last five to six years. Several FQHC representatives noted the importance of telehealth in their behavioral health integration, and encouraged this model be leveraged more widely.

However, focus group participants also reported needs regarding increasing behavioral health integration with primary care. Nearly all hospitals reported this is a gap in their services. Rural practices also noted a lack of behavioral health resources, both within their clinics and their communities. A rural participant shared that their local ED does not have psychiatric or social work services, so they have nowhere to refer patients with acute behavioral health needs. Focus group participants noted that it is challenging for them to expand behavioral health services, for reasons including financial barriers, low reimbursement, physical space limitations, recruitment and salary competition, and lack of internal and/or local expertise to stand up or expand behavioral health services. Participants across all practice types expressed an interest in expanding their behavioral health service offerings if the necessary support were provided.

Section 2: Health Information Technology and Health Information Exchange Readiness

This section explores survey respondents' readiness to succeed under a primary care APM in terms of health information technology (HIT) and health information exchange (HIE) participation. It included three topics:

- Quality Improvement and Data Monitoring
- Provider Alerts, Decision Support Tools, and Registries
- Health Information Exchange

WHY THIS MATTERS

Effectively managing patient populations requires health centers to have accurate and comprehensive data about those populations, and those data must be collected and reported in a timely, often real-time, manner. The care team must have actionable data at the point of care to make appropriate clinical decisions and avoid duplication or unnecessary tests and services. Transitions of care can be costly, but if managed appropriately with real-time data, they can be an opportunity to control costs and improve outcomes. Providers practicing without this information will be unable to fully contribute to the success of a primary care APM.[10,11]

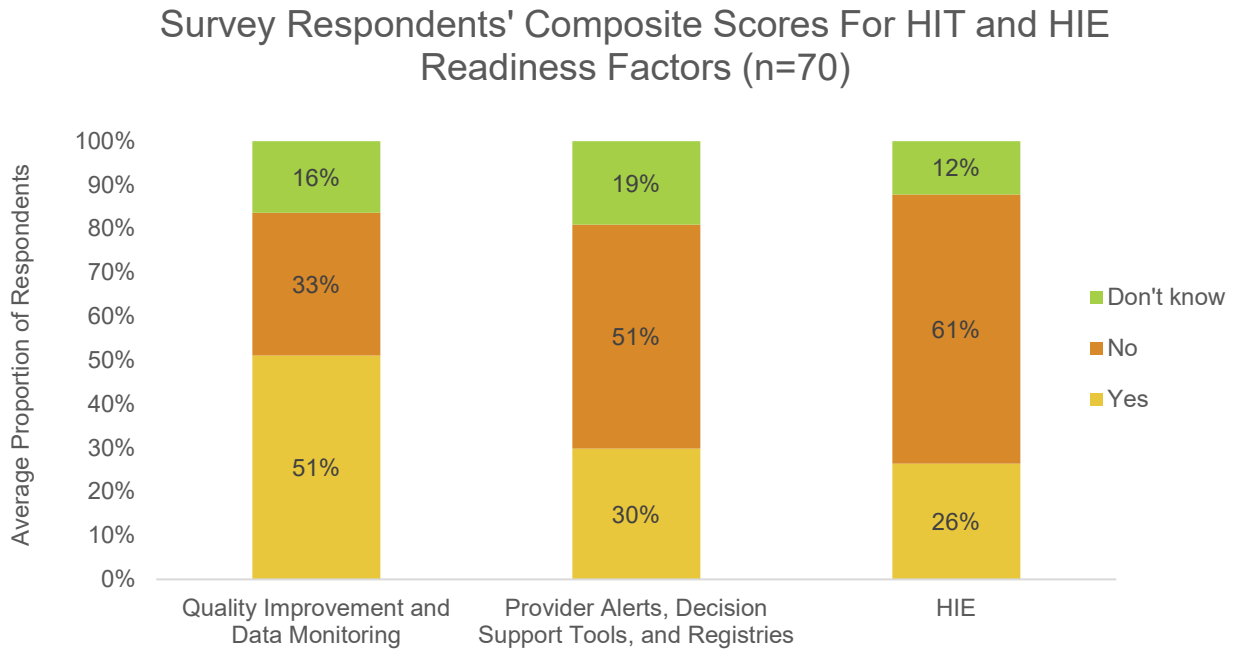
[10] Macias, C.G., Carberry, K.E. (2021). Data Analytics for the Improvement of Healthcare Quality. In: Giardino, A., Riesenberg, L., Varkey, P. (eds) Medical Quality Management. Springer, Cham. https://doi.org/10.1007/978-3-030-48080-6_6

[11] Zachary Predmore, Elham Hatef, and Jonathan P. Weiner.Integrating Social and Behavioral Determinants of Health into Population Health Analytics: A Conceptual Framework and Suggested Road Map.Population Health Management.Dec 2019.488-494. http://doi.org/10.1089/pop.2018.0151

A composite score for each topic was calculated. The score is the average of the percent of respondents who reported yes, no, or I don't know for each survey item within a topic. This composite score method is used several times throughout the remainder of the report.

Survey responses regarding whether there are resources and protocols in place for the necessary HIT and HIE for an APM suggests more readiness related to quality improvement and data monitoring (51%), followed by provider alerts, decision support tools and registries (30%), and HIE (26%) (Figure 19).

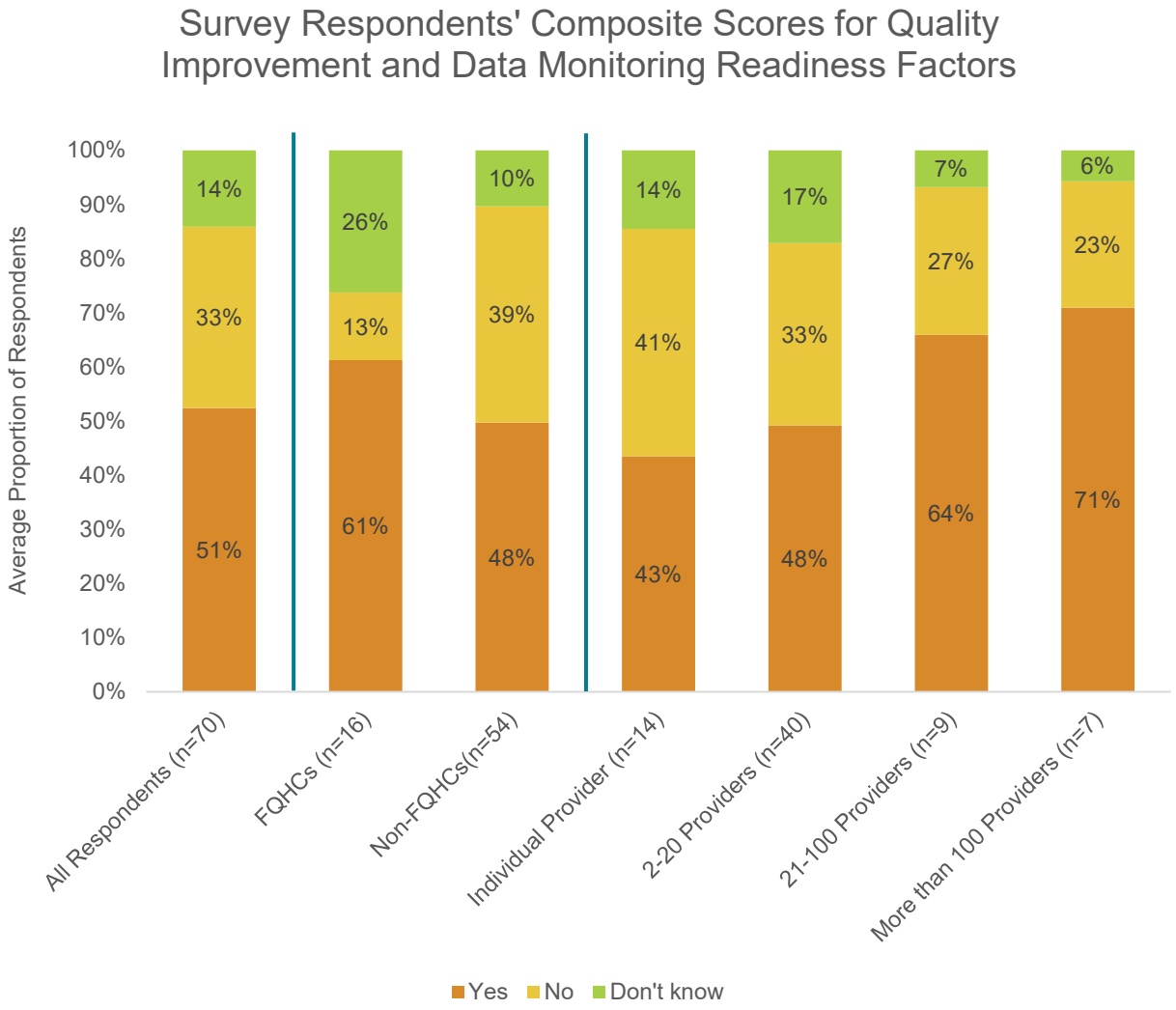
FIGURE 19



Quality Improvement and Data Monitoring

FQHCs (61%) compared with non-FQHCs (48%) are more likely to report they have the factors (e.g., resources, protocols) regarding quality improvement and data monitoring readiness (Figure 20). Similarly, larger organizations, including organizations with 21-100 providers (64%) and organizations with more than 100 providers (71%), report greater readiness.

FIGURE 20



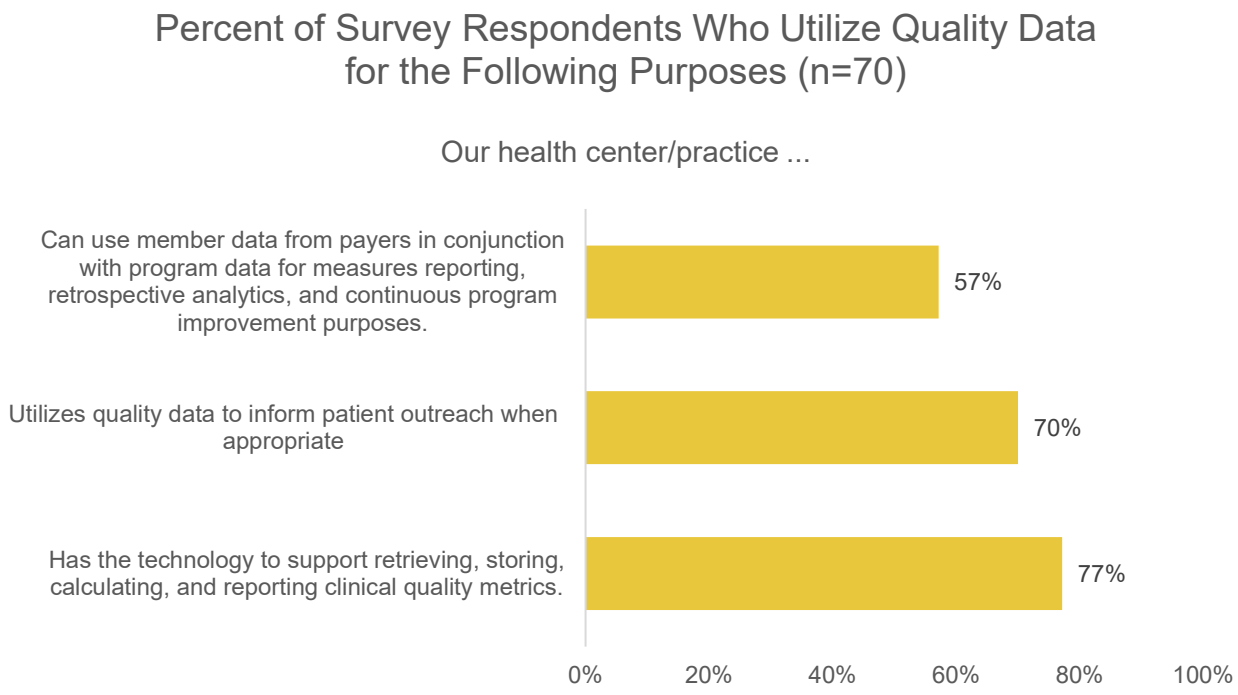
Forty-one percent (n=29) of respondents have undertaken major chronic disease-specific quality improvement initiatives in the past three years (e.g., participated in a learning collaborative, pursued NCQA Diabetes Center of Excellence recognition). Chronic disease-specific quality improvement initiatives that are underway include improving overall measurement processes; performance improvement projects; and diabetes, colon, asthma, and ADHD screening and follow-up initiatives.

Seventy-seven percent (n=54) of survey respondents have the technology to support retrieving, storing, calculating, and reporting clinical quality metrics (Figure 21). Individual providers (36%, n=5) are least likely to report having this technology. As part of reporting, 39% (n=27) of survey respondents specifically measure and monitor quality incentive payment provisions of third-party payer contracts and 26% (n=18) measure and monitor test utilization. Quality and outcome measures are commonly reviewed by clinical leadership (76%, n=53) and providers (74%, n=51).

Regarding the utilization of quality data:

- 70% (n=49) of survey respondents utilize quality data to inform patient outreach when appropriate. Individual providers (29%, n=4) are least likely to use quality data for this purpose.
- 57% (n=40) of survey respondents can use member data from payers in conjunction with program data for measures reporting, retrospective analytics, and continuous program improvement purposes.

FIGURE 21



Small and medium practice focus group participants were asked how they establish quality metric targets, measure their progress, and address shortcomings. Practices noted that information technology is necessary to be able to collect and monitor quality data. One practice, a member of an ACO, shared that their quality standards are defined by the ACO's medical director and implemented across the ACO. This is only possible because they have the technology to gather and monitor quality information for a patient across the ACO system. Another practice, a member of a clinically integrated network (CIN), shared that their quality metrics are established by the medical directors of the participating clinics. This collaborative approach to defining quality metrics, standards of care, training, and other elements of quality has been effective.

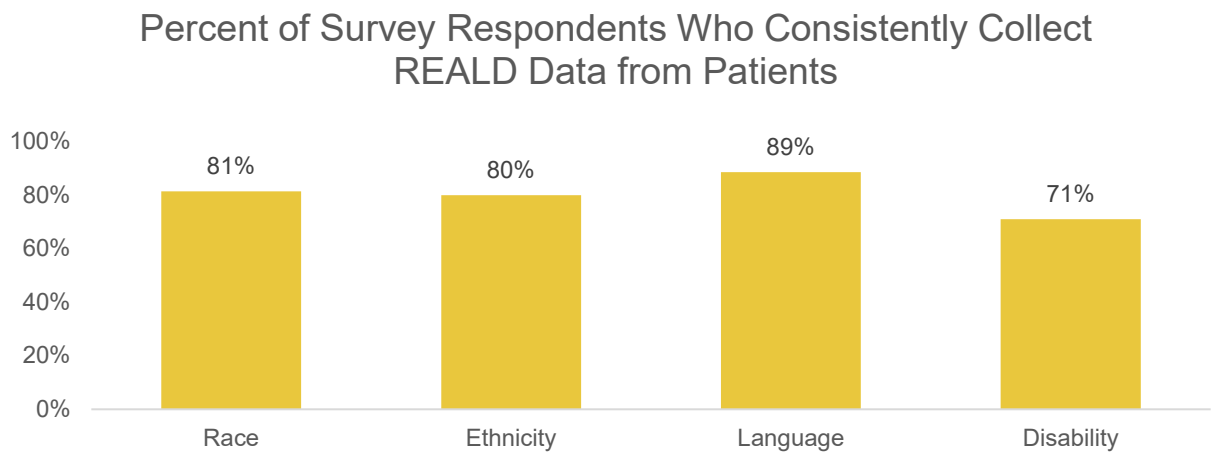
FQHC focus group participants described a similar collaborative approach to determining quality metrics with their payers and noted that this process has led to more ownership and accountability over metrics among providers and practices. While the exact metrics vary by plan, FQHCs are primarily tracking the 10 Healthcare Effectiveness Data and Information Set (HEDIS) measures plus 16 metrics that HRSA requires all FQHCs to monitor. However, several focus group participants

noted that if given the choice, they would select metrics they have more control over, and for which they can receive timely and accurate data, rather than the 10 HEDIS measures. For example, one practice noted that they do not receive hospital data quickly enough to follow up within the timeframe required by the HEDIS measure.

APMs offer an opportunity to close longstanding disparities in healthcare and health outcomes based on factors including race, ethnicity, language, and disability status (REALD). The Health Care Payment Learning and Action Network (HCP LAN) recently released a guidance document on how APMs can drive increased accessibility, health equity, and better health outcomes by including two specific design elements: providing person-centered, culturally and linguistically appropriate care, and using payment incentives to reduce health disparities in quality of care, outcomes, and patient experience.[12] To meaningfully incorporate these elements, primary care practices must be able to accurately and consistently collect REALD data from patients. This will allow them to stratify data and performance measures by race, ethnicity, language, and disability to identify any disparities, and it will support practices in ensuring their services are person-centered, and culturally and linguistically appropriate for their patient population.

Survey respondents are most likely to collect language data consistently for all patients (89%, n=62), followed by race (81%, n=57) and ethnicity (80%, n=56) (Figure 22). Disability status was the least commonly collected demographic, reported by 71% (n=49) of survey respondents.

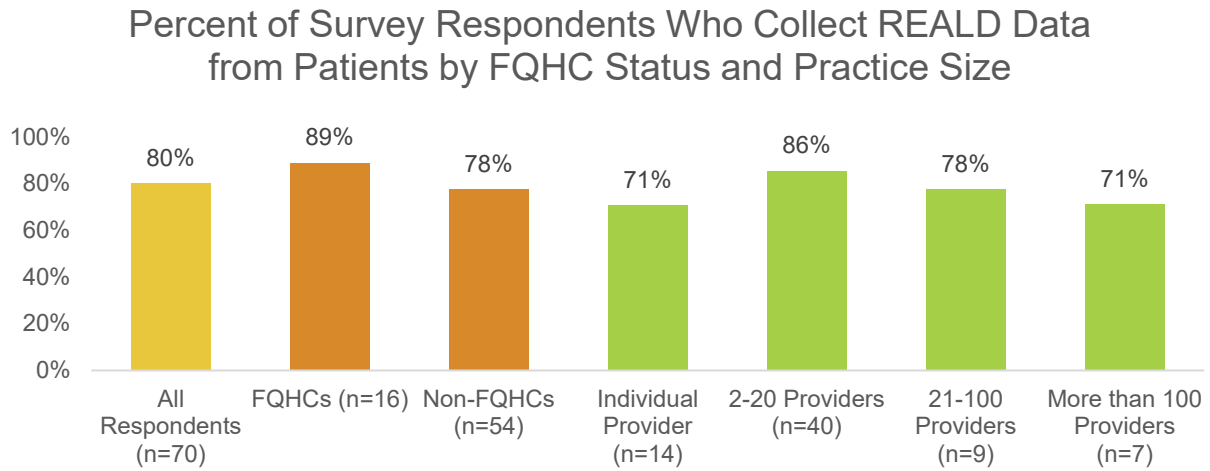
FIGURE 22



Some variation existed in the extent to which REALD data are collected consistently for all patients by provider type (Figure 23). FQHCs (89%) are more likely than non-FQHCs (78%) to consistently collect REALD data from patients. Mid-size organizations (e.g., 2-20 providers at 89%; 21-100 providers at 78%) are more likely to do so than individual providers (71%) and large organizations (more than 100 providers, 71%).

[12] McGinnis, Smithey, & Patel, 2022

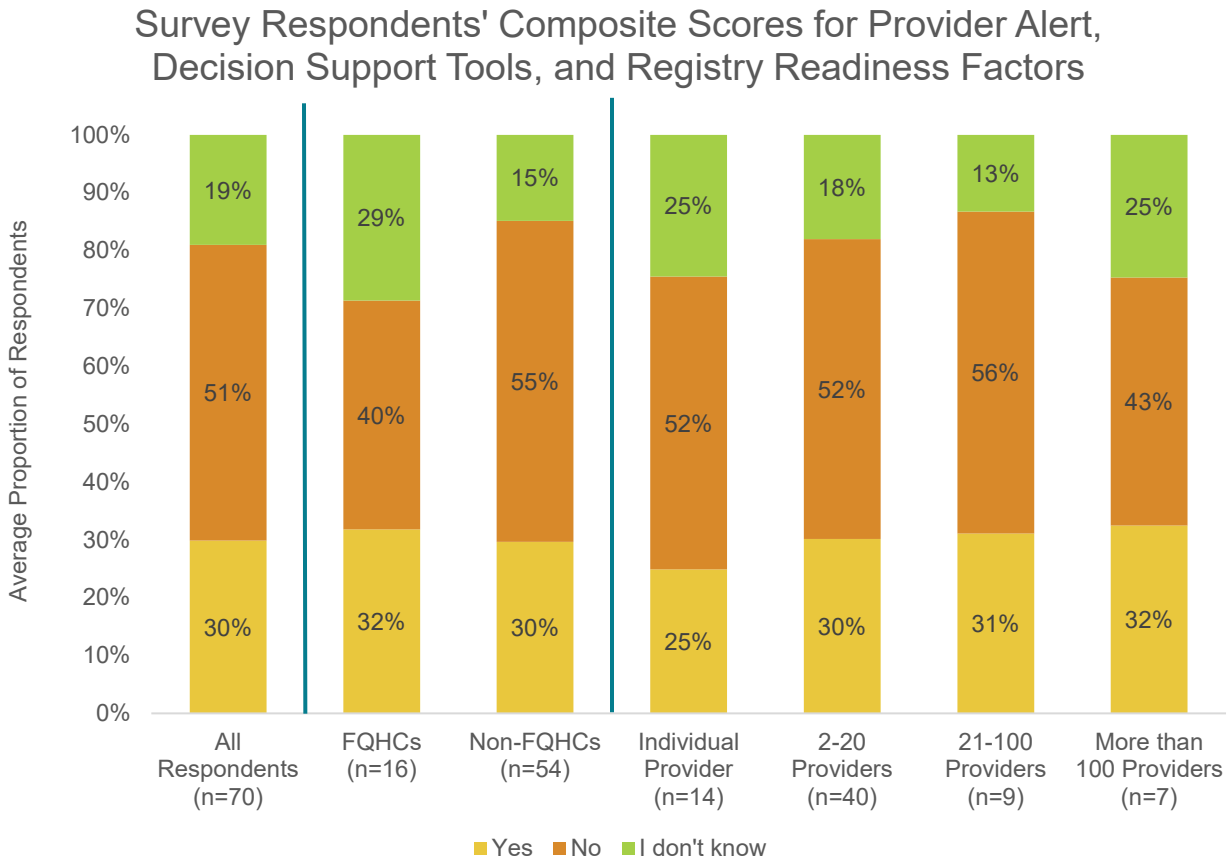
FIGURE 23



Provider Alerts, Decision Support Tools, and Registries

FQHC status and organization size do not appear to be correlated with respondents' readiness around provider alerts, decision support tools, and registries (Figure 24).

FIGURE 24



Sixty-seven percent (n=47) of respondents have evidence-based clinical protocols and decision support tools embedded in their EHRs to aid in point-of-service decision-making. The percent of survey respondents report using the following automatic prompts in their EHR are:

- 74% (n=52) for reminders for preventive services to be ordered
- 66% (n=46) for reminders for tests or services that have been ordered but remain incomplete

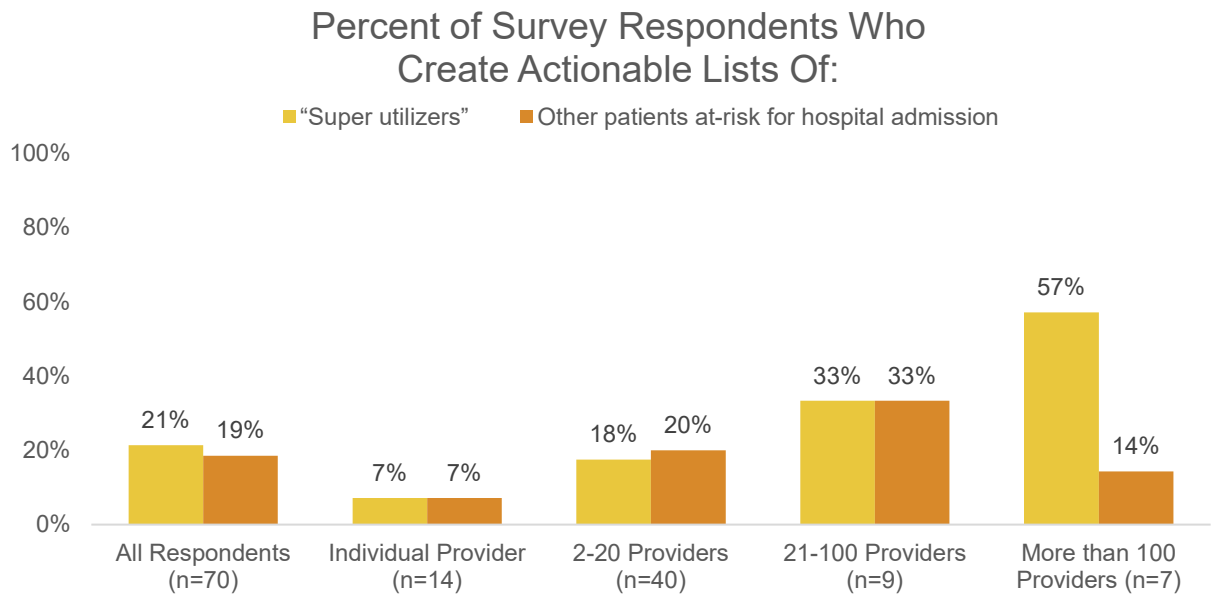
The percent of survey respondents whose providers and care team members receive proactive alerts in EHRs are as follows:

- 42% (n=29) for automatic ordering of generic prescription drugs
- 29% (n=20) for emergency room utilization
- 29% (n=20) for inpatient hospitalization

Twenty six percent (n=18) of survey respondents have a workflow in place to quickly act on real-time admission, discharge, and transfer (ADT) alerts received when their patients are registered or discharged from the hospital and the emergency room. FQHC status and organizational size do not appear to drive to what extent respondents have this workflow in place.

Survey respondents do not commonly create an actionable list of "super utilizers"[13] (21%, n=15) or other patients at-risk for hospital admission (e.g., recently discharged, children with uncontrolled asthma) (19%, n=13). Large organizations (more than 100 providers) are more likely to create an actionable list of "super utilizers" compared to small and medium organizations (Figure 25).

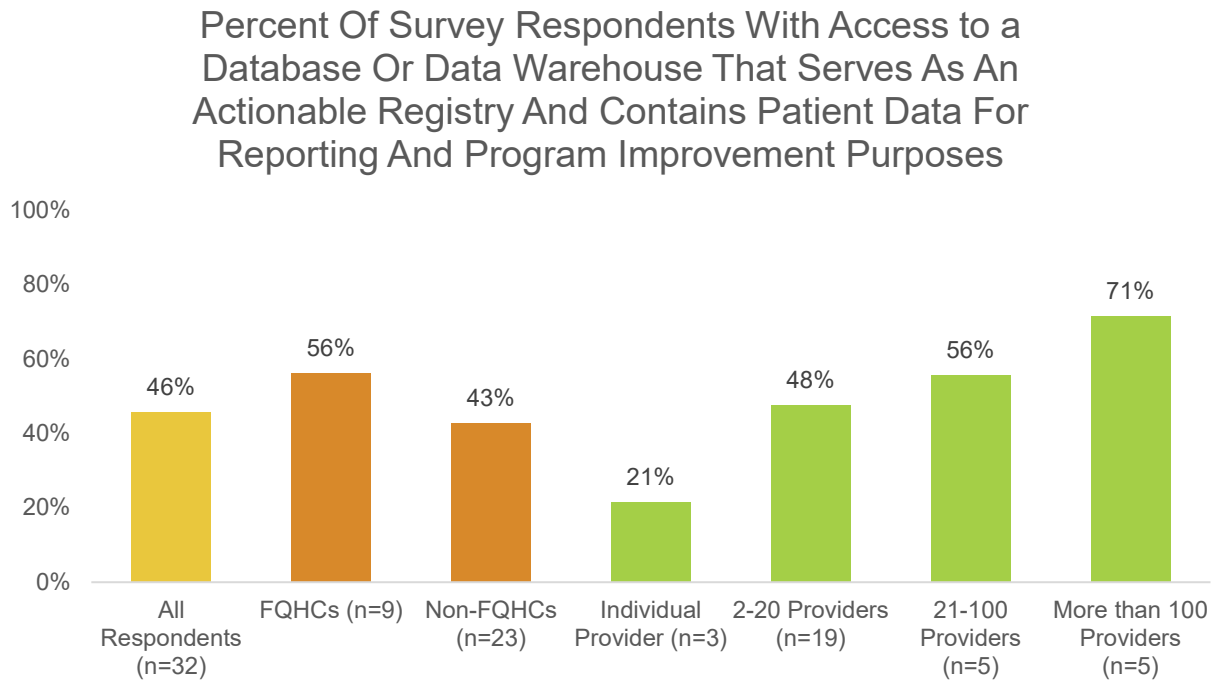
FIGURE 25



[13] The Robert Wood Johnson Foundation describes super-utilizers as "individuals whose complex physical, behavioral, and social needs are not well met through the current fragmented health care system. As a results, these individuals often bounce from emergency department to emergency department, from inpatient admission to readmission or institutionalization – all costly, chaotic, and ineffective ways to provide care and improve patient outcomes."

Nearly half (46%, n=32) of respondents have access to a database or data warehouse that serves as an actionable registry and contains patient data for reporting and program improvement purposes (Figure 26). FQHC status and organizational size appear to influence the extent to which there is access to a database or data warehouse. Fifty-six percent of FQHCs report access to a database or data warehouse compared to 46% of non-FQHCs. Similarly, as the organization size increases, so does the percent of survey respondents who report access to a database or data warehouse.

FIGURE 26

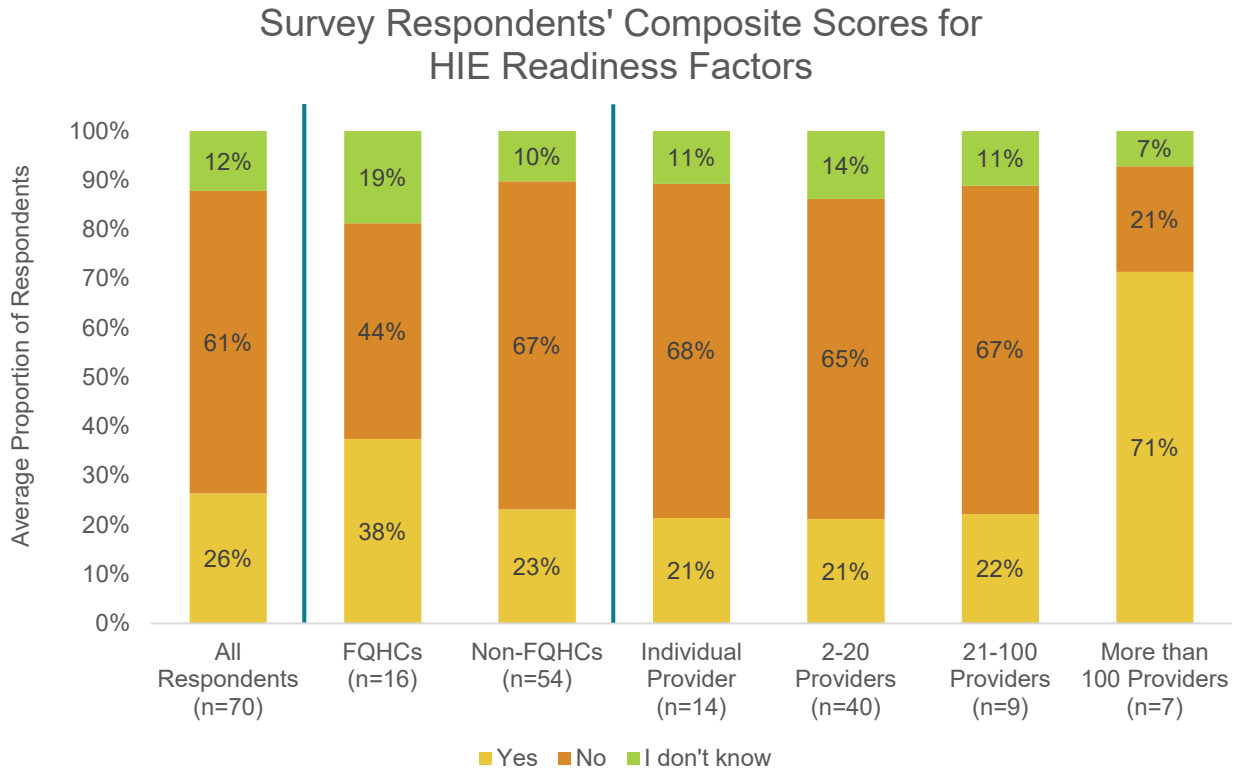


Among survey respondents who have access to a database or data warehouse, 75% (n=24) utilize actionable registries to monitor patients (e.g., list of all patients with diabetes, date of their last appointment, or date and result of their last HbA1c test).

Health Information Exchange

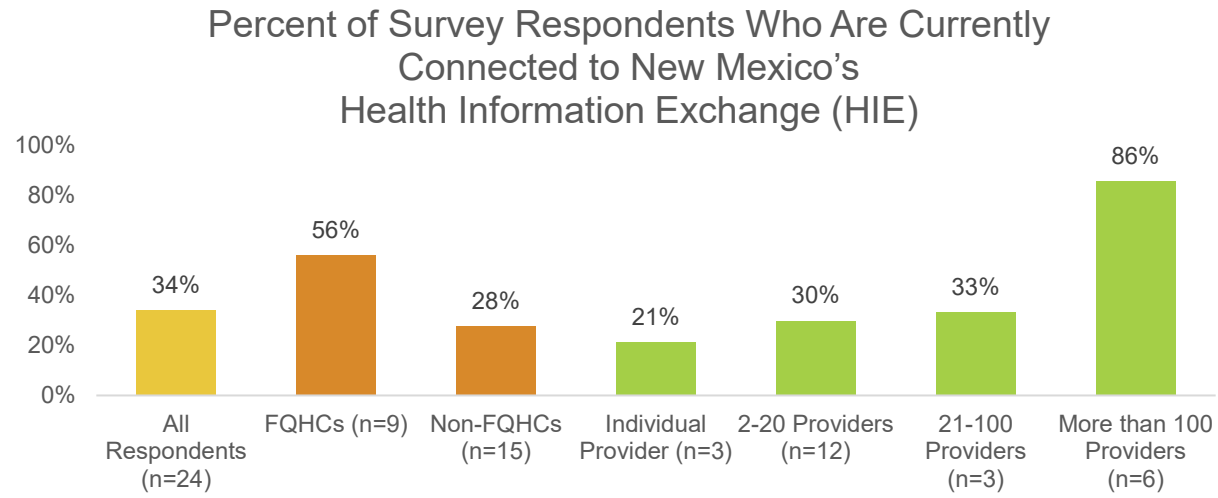
FQHCs (38%) are more likely to report HIE readiness compared to non-FQHCs (23%) (Figure 27). Large organizations (more than 100 providers) report greater readiness than small and medium practices.

FIGURE 27



One in three (34%, n=24) survey respondents report being currently connected to New Mexico's HIE (Figure 28). FQHCs (56%, n=9) are more likely to report being connected compared to non-FQHCs (28%, n=15). Large organizations (more than 100 providers) are more likely to be connected, with 86% (n=6) of respondents with more than 100 providers being connected compared to 21% (n=3) of individual providers, 30% (n=12) of respondents with 2-20 providers, and 33% (n=3) of respondents with 21-100 providers.

FIGURE 28



Nineteen percent (n=13) of survey respondents use an HIE service offered by another HIE service provider (such as a query based HIE) to communicate with external providers. Among respondents connected to New Mexico's HIE, 50% (n=12) report it is challenging to pay for the annual fees and respondents also note that startup costs are a barrier (48%, n=22). Among respondents not connected to the HIE, the biggest barriers vary among different provider types (Table 8). For example, individual providers are more likely to cite lack of administrative support as a barrier (64%, n=7). Other barriers include not knowing the HIE was an option available to them, difficulty connecting and staying connected with the HIE, and needing training.

TABLE 8

Percent of Respondents Reporting Barrier(s) Preventing Them from Connecting to New Mexico's HIE by FQHC Status and Practice Size							
	All Respondents (n=46)	FQHCs (n=7)	Non-FQHCs (n=39)	Individual Provider (n=11)	2-20 Providers (n=28)	21-100 Providers (n=6)	More than 100 Providers (n=1)
Financial – start-up costs	48%	29%	51%	64%	36%	67%	100%
Financial – annual fees	41%	29%	44%	55%	32%	67%	0%
Other, please describe.	35%	43%	33%	18%	43%	33%	0%
Difficult to assess value	35%	14%	38%	45%	32%	33%	0%
Lack of administrative support	35%	14%	38%	64%	25%	33%	0%
Lack of technological support	30%	14%	33%	55%	25%	17%	0%
Security/privacy concerns	15%	14%	15%	18%	14%	17%	0%

Note: Green fill indicates the top two (three if tied) primary barriers for connecting to New Mexico's HIE for each respondent type (read by column).

Participants in all four focus groups noted that being able to easily access and exchange actionable data is critical to their success under an APM. Hospital and FQHC focus group participants that already operate under APMs noted that a key to their success is being able to access patient data, both internal data and information about care that patients receive outside their four walls. One small/medium practice focus group participant noted that different payers use different technology platforms, so integration is a challenge. A hospital focus group participant noted that they share patient records for internal referrals but do not have a mechanism in place to support closed-loop referrals to external providers.

Among focus group participants, hospitals are most prepared in terms of data and IT infrastructure and the ability to aggregate data, perform analytics, and provide actionable reports to their providers. Most hospital focus group participants reported that they are able to customize and generate reports

through their EHR or another platform. Small/medium practice focus groups reported feeling much less prepared in this area. Across all practice types, even those already plugged into the HIE and other data sharing infrastructure, a common concern expressed is the challenge of receiving accurate data quickly enough to act on it. Data exchange, aggregation, and analysis was commonly raised as an area of need among focus group participants. Lastly, focus group participants expressed interest in working collaboratively with the state, payers, and the HIE to improve data exchange processes and infrastructure.

Section 3: Partnership Readiness

The section explores survey respondents' partnership readiness, including the extent to which practices have partnerships with social service and medical providers.

WHY THIS MATTERS

Partnerships with other health care and social service providers along the entire continuum of care are critical to ensuring practices can effectively coordinate and manage health care and costs for patients.[14]

Social Service Sector Partnerships

Half (51%, n=36) of respondents report having a social service sector partnership, defined in the survey as a formal arrangement through a memorandum of understanding or contract. The education/schools sector and food and nutrition services are the most common partnership among survey respondents. FQHC status and organization size appear to influence the extent to which survey respondents have social service partners (Table 9). Nearly all (88%, n=14) FQHCs have social service partnerships compared to 39% (n=21) of non-FQHCs. Just 14% (n=2) of individual providers have social service partnerships compared to 100% (n=7) of respondents with more than 100 providers.

TABLE 9

Percent of Respondents Who Have Agreements (Formal Arrangements Through a Memorandum of Understanding or Contract) With the Following Types of Social Service Providers by FQHC Status and Practice Size

	All Respondents (51%, n=36)	FQHCs (88%, n=14)	Non-FQHCs (39%, n=21)	Individual Provider (14%, n=2)	2-20 Providers (53%, n=21)	21-100 Providers (56%, n=5)	More than 100 Providers (100%, n=7)
Education/ schools	50%	71%	38%	50%	33%	80%	86%
Food and nutrition services	44%	50%	43%	0%	43%	40%	71%
Transportation	36%	43%	33%	0%	48%	40%	14%
Child welfare	31%	43%	24%	0%	24%	40%	57%
Supported employment agencies	31%	36%	29%	50%	19%	60%	43%

[14] Hughes, G., Shaw, S.E. and Greenhalgh, T. (2020), Rethinking Integrated Care: A Systematic Hermeneutic Review of the Literature on Integrated Care Strategies and Concepts. The Milbank Quarterly, 98: 446-492. https://doi.org/10.1111/1468-0009.12459

Housing	25%	36%	19%	0%	24%	40%	29%
Disability services	19%	36%	10%	50%	14%	20%	29%
Legal services	17%	14%	19%	0%	14%	60%	0%
Tribal services	14%	0%	24%	0%	5%	20%	43%
Other	3%	0%	5%	0%	5%	0%	0%

Note: Green fill indicates the top two (three if tied) primary social service providers with memoranda of understanding (MOUs) for each respondent type (read by column).

Medical Provider Partnerships

Two thirds (67%, n=47) of survey respondents report having partnerships with medical providers, including hospitals, home health, skilled nursing/long term care, and crisis services. Partnerships are defined in the survey as formal arrangements through a memorandum of understanding or contract and they support referrals and coordination of care following transfer to or provision of additional services by the partner. FQHC status and organization size appear to influence the extent to which survey respondents have medical provider partners (Table 10). Eighty-one percent (n=13) of FQHCs have a medical provider partnership compared to 63% (n=34) of non-FQHCs. Nearly half (46%, n=6) of individual providers have medical provider partnerships compared to 100% (n=7) of survey respondents with more than 100 providers. Hospitals and home health are the two most common medical provider partnerships among survey respondents.

TABLE 10

Percent of Respondents Who Have Agreements (Formal Arrangements Through a Memorandum of Understanding or Contract) With the Following Types of Medical Providers by FQHC Status and Practice Size

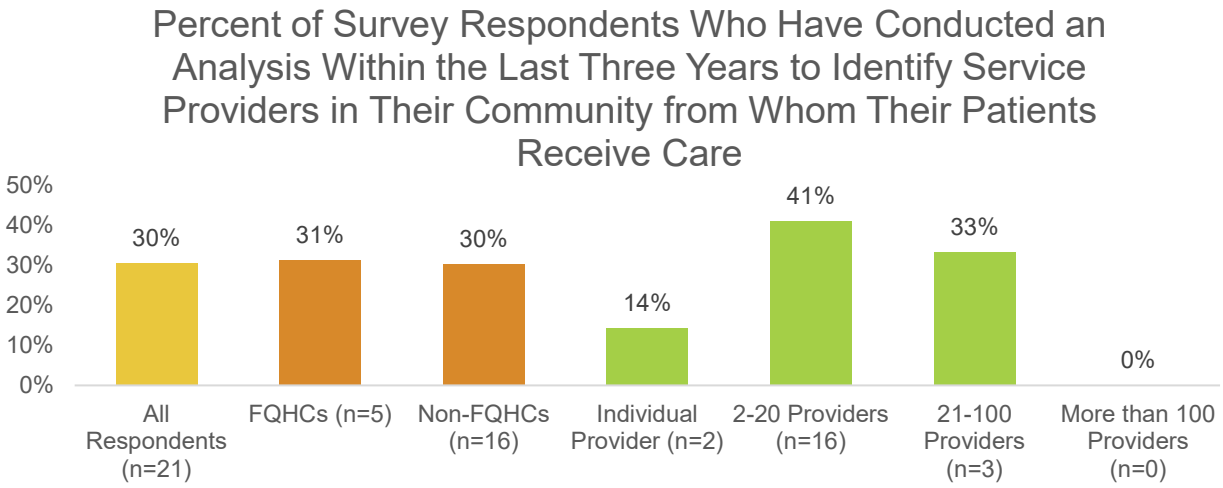
	All Respondents (67%, n=47)	FQHCs (81%, n=13)	Non-FQHCs (63%, n=34)	Individual Provider (46%, n=6)	2-20 Providers (68%, n=27)	21-100 Providers (67%, n=6)	More than 100 providers (100%, n=7)
Hospitals	91%	100%	88%	83%	96%	83%	100%
Home health	34%	23%	38%	17%	33%	33%	57%
Crisis services	30%	23%	32%	17%	26%	50%	43%
Skilled nursing/long-term care	28%	23%	29%	0%	22%	67%	43%
Other	6%	0%	9%	17%	4%	17%	0%

Note: Green fill indicates the top two (more if tied) primary medical providers with MOUs for each respondent type (read by column).

Community Partner Landscape Analysis

Thirty percent (n=21) of survey respondents report having conducted an analysis within the last three years to identify other service providers in their community from whom their patients receive care (Figure 29). FQHC status does not appear to affect the likelihood of such an analysis. Individual providers and large organizations (more than 100 providers) appear to be less likely to have conducted such an analysis.

FIGURE 29



The percent of survey respondents who reported having agreements in place that enable it to serve individuals with the following needs are as follows:

- 53% (n=33) for mental health
- 49% (n=30) for substance use
- 34% (n=19) for intellectual and developmental disabilities (IDD)

FQHCs and large practices (more than 100 providers) are more likely to have agreements in place that enable it to serve individuals with mental health, substance use, and IDD needs (Table 11).

TABLE 11

Percent of Respondents Who Have Agreements (Formal Arrangements Through a Memorandum of Understanding or Contract) With the Following Types of Providers by FQHC Status and Practice Size

	All Respondents (n=70)	FQHCs (n=16)	Non-FQHCs (n=54)	Individual Provider (n=14)	2-20 Providers (n=40)	21-100 Providers (n=9)	More than 100 providers (n=7)
Mental health	53%	79%	46%	40%	51%	56%	83%
Substance use	49%	79%	40%	30%	49%	50%	83%
Intellectual and developmental disabilities	34%	50%	30%	30%	30%	29%	67%

Note: Green fill indicates the provider types who are more likely than all respondents to have agreements in place that enable it to serve individuals.

Partnership readiness was reported to be a significant area of need for small/medium practice focus group participants. Small/medium practices repeatedly noted that there are insufficient services in their communities to meet demand, and that they have very limited options for referring patients to social services, behavioral health, dental, and vision.

In our community we have one dentist who accepts Medicaid and one eye doctor who's here two days per week. We don't have these services available to us and we think we'll be punished for not meeting referral expectations under the APM. – Small/medium practice focus group participant

This group also expressed concern about the cost of care in rural communities and how this may affect their performance under an APM. One practice noted that they only have one option for referrals to laboratory services and radiology, and both are expensive. The practice worried they would be penalized for referring patients to high-cost services but reiterated that there are no lower cost alternatives in their community.

Challenges around referrals to community social services partners were echoed by FQHC and hospital participants, particularly those who operate in smaller or more rural communities. This was identified as an area of need across all focus groups.

Section 4: Financial/Operational Readiness

This section explores the survey respondents' financial operational readiness for success under a primary care APM.

WHY THIS MATTERS

Success in APM arrangements is grounded in improving health outcomes and realizing cost efficiencies, thereby reducing the total healthcare spend. To realize these desired behaviors, alternative payment incorporates various payment models, generally including (1) base compensation (to reimburse for services provided in-house), (2) quality incentive payments, and (3) managing the total cost of care of a patient. As a result, managing and monitoring financial performance will move away from per-visit analyses to quality metrics and patient- and family-centered financial analyses (per patient).

With regards to base compensation, practices will need to become more efficient in the delivery of services so increased emphasis will be placed on managing productivity and capacity levels of provider and non-provider staff, as well as improving business processes with the goal of reducing the average cost per unit (visits and procedures). In addition, centers will need to better understand the utilization of services by patient for both services provided in-house as well as outside its four walls as the underpinning of managing the overall cost per patient. An additional complexity is that patient utilization patterns often vary based on the health and social risk status of a patient and therefore payment is also varied by risk status. Therefore, coding will become even more important for a practice to manage a patient's health status, utilization patterns, cost of care, and to access quality incentive payments.

Accordingly, the foundation for success in primary care APMs includes the appropriate coding for services, improvement in cost efficiencies for services provided in-house, management of utilization, and the ensuing overall cost of care by patient while improving health outcomes and quality.[15,16]

[15] Kissam, S.M., Beil, H., Cousart, C., Greenwald, L.M. and Lloyd, J.T. (2019), States Encouraging Value-Based Payment: Lessons From CMS's State Innovation Models Initiative. The Milbank Quarterly, 97: 506-542. https://doi.org/10.1111/1468-0009.12380

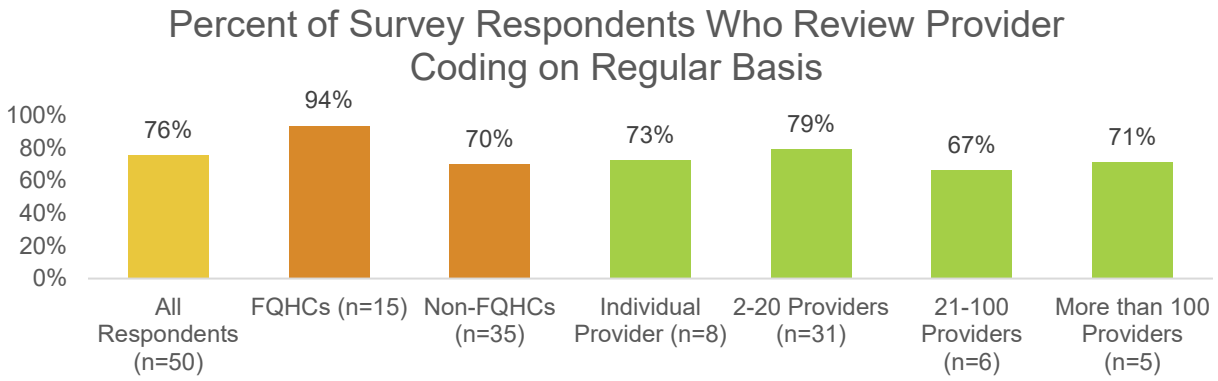
[16] David Grembowski and Miriam Marcus-Smith. The 10 Conditions That Increased Vermont's Readiness to Implement Statewide Health System Transformation. Population Health Management 2018 21:3, 180-187

Proper Coding and Documentation Practices

Eighty-eight percent (n=58) of survey respondents train providers on proper coding and documentation practices. Fewer survey respondents (65%, n=43) have coders on staff. In 2022, survey respondents have an average of 74 FTEs (median of 4) who are physician or mid-level practitioners, followed by 10 FTEs (median of 3) who are billing staff, and 4 FTEs (median of 1) who are coders.

Three in four survey respondents (76%, n=50) review provider coding on a regular basis (Figure 30). FQHCs (94%, n=15) are more likely to review provider coding on a regular basis compared to non-FQHCs (70%, n=35).

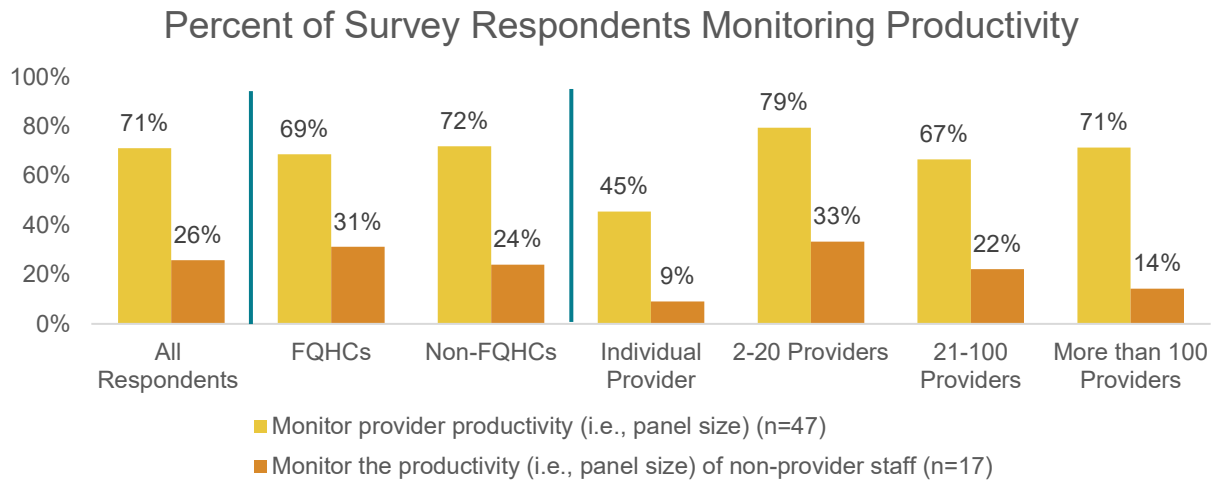
FIGURE 30



Incentive Compensation Program for Providers

Nearly half (47%, n=31) of survey respondents have an incentive compensation program for providers. Among these survey respondents, more than half (52%, n=16) report their incentive program is aligned with existing quality incentive programs in payer contracts. More survey respondents are likely to monitor provider productivity (i.e., panel size) than they are to monitor the productivity (i.e., panel size) of non-provider staff (Figure 31). This may be because provider productivity is more likely to drive quality metrics under value-based care and be tied to incentives.

FIGURE 31



One FQHC focus group participant that has already been operating under an APM shared that an early step they took was ensuring all providers had their own clinical quality targets, knew where they stood compared to their peers and where their gaps were, and, importantly, had access to resources needed to close their gaps (e.g., technology supports, workflow changes). The practice reported that sharing these data and supports with providers has helped them improve care quality and patient outcomes.

As described above, most hospital focus group participants noted they use the Press Ganey survey to collect information about patient satisfaction and to monitor provider performance. Hospitals reported that patient satisfaction data are used to incentivize improved provider performance, and that providers are eligible for additional compensation if they meet or exceed their targets.

Roster of Attributed Members

One third (33%, n=22) of survey respondents report they have a roster of attributed members. The larger the organization the more likely they are to maintain a roster, ranging from 18% (n=2) of individual providers to 71% (n=5) of survey respondents with more than 100 providers. FQHC status does not appear to be an influential factor, with 38% (n=6) of FQHCs maintaining a roster of attributed members compared to 32% (n=16) of non-FQHCs. A roster of attributed members is most commonly at the physician level (86%, n=18) compared to the practice level (14%, n=3).

Patient attribution was raised as a concern in the FQHC and hospital focus groups. An FQHC participant noted that they serve small rural communities and worry about having enough patients attributed to be able to succeed in a risk/reward APM. This concern was shared by hospital focus group participants who worry it could be amplified if additional MCOs are added in New Mexico.

Cost Structure and Fee Schedules

The following describes various aspects of survey respondents' cost structure and fee schedules:

- Forty-one percent (n=27) of survey respondents analyze cost per visit on a regular basis to identify cost efficiencies.
- About one third (32%, n=21) of survey respondents utilize a cost-based charge structure, meaning the practice has calculated its costs per procedure or service and based its fee schedule on this analysis.
- Survey respondents are more likely to update fee schedules on an annual basis (59%, n=39) versus not on an annual basis (29%, n=19).

Social Determinants of Health Assessment

Fifty-five percent of survey respondents (n=37) regularly conduct a HRSN or SDoH assessment (as described in the case planning section) and 40% of these respondents capture the assessment as structured data in their care plan, EHR, or another database. Fifty-three percent of survey respondents' fee schedules (n=37) include ICD-10 Z codes. Large organizations (100 or more providers) are the least likely to include ICD-10 Z codes at 14% (n=1). Among respondents who collect structured SDoH data in their care plan, EHR, or another database, 65% include ICD-10 Z codes in their fee schedules (Table 12). This suggests that ICD-10 Z codes may be a useful way by which to collect structured data, and there is an opportunity to learn best practices and approaches to expanding the accurate use of ICD-10 Z codes.

TABLE 12

Percent of Survey Respondents Whose Fee Schedule Includes ICD-10 Z Codes Among Respondents Who Capture HSRN or SDoH Assessment as Structured Data in their Care Plan, EHR, or Another Database			
		Fee Schedule Includes ICD-10 Z Codes	
		Yes (n=18)	No (n=5)
Capture HSRN or SDoH Assessments as Structured Data in Their Care Plan, EHR, or Another Database	No (n=6)	13%	13%
	Yes (n=17)	65%	9%

More than half (52%, n=34) of respondents agree/strongly agree they have a strategy in place for assessing the needs of patients regarding SDoH. Forty percent (n=20) of survey respondents include ICD-10 Z codes in their fee schedule *and* report they have a strategy for assessing the needs of patients regarding SDoH (Table 13). Another 26% (n=13) of survey respondents indicate they have a strategy for assessing the needs of patients regarding SDoH but do not include ICD-10 Z codes on their fee schedules. This suggests a positive relationship between the utilization of ICD-10 Z codes and having a strategy for assessing the SDoH need of patients.

TABLE 13

Percent of Survey Respondents Whose Fee Schedule Includes ICD-10 Z Codes Among Respondents Who Have a Strategy for Assessing the Needs of Patients Regarding SDoH			
		Fee schedule includes ICD-10 Z codes	
		Yes (n=28)	No (n=22)
Have a strategy for assessing the needs of patients regarding SDoH	Disagree/Strongly Disagree (n=17)	16%	18%
	Agree/Strongly Agree (n=33)	40%	26%

In-House Services

Thirty percent (n=20) of survey respondents calculate and monitor the total annual cost per patient for in-house services, with over half (56%) of FQHCs doing so (compared to 22% of non-FQHCs).

- One quarter of respondents (24%, n=16) monitor the utilization of specific services by patient for in-house services.
- Fifteen percent (n=10) have partial capitation agreements with MCOs for in-house services (e.g., primary care).

Third Party Agreements

Quality Incentive Payments

Forty-one percent (n=27) of respondents have agreements with third party payers that include quality incentive payments. For example, during the focus groups some practices reported participating in Medicare ACOs. Among respondents with quality incentive payments, 44% (n=12) have been successful in fully accessing quality incentive payments.

Surplus Sharing Arrangements and Risk Sharing Agreements

Few respondents have surplus sharing agreements (20%, n=13) or risk sharing agreements (15%, n=10) with third party payers. This indicates that most practices who completed the survey do not have experience with shared savings (upside risk only) or risk sharing (upside and downside) and therefore may not yet have the systems or processes in place to manage these types of contracts.

Agreements with Independent Physician Association or Accountable Care Organization

One in four (24%, n=16) survey respondents have a participation agreement with an independent physician association (IPA) or ACO. Among these respondents, 56% (n=9) have a surplus sharing agreement and 38% (n=6) have a risk sharing agreement with the IPA or ACO.

Thirty-nine percent of survey respondents (n=13) involved in surplus sharing or risk sharing arrangements report being "not at all engaged" in monitoring performance. Another 30% (n=10) of these respondents report being "very engaged." The larger the organization, the more likely the respondent is to be engaged in monitoring performance.

Table 14 illustrates the relationship between engagement in monitoring performance and success with receiving payments among survey respondents involved in surplus sharing or risk sharing arrangements. Nearly half of respondents (46%) who report being somewhat/very engaged in monitoring performance also report being somewhat/very successful with receiving payments. Conversely, 42% of respondents who reported being not at all/minimally engaged in monitoring performance reported feeling not at all/minimally successful financially with receiving payments.

TABLE 14

Percent of Survey Respondents Successfully Receiving Payments Among Respondents Engaging in Monitoring Performance			
		Success with receiving payments	
		Not at all/Minimally Successful (n=11)	Somewhat/Very Successful (n=16)
Engagement in monitoring performance	Not at all/Minimally Engaged (n=14)	42%	12%
	Somewhat/Very Engaged (n=12)	0%	46%

High Cost/High Utilizing Patients and Providers

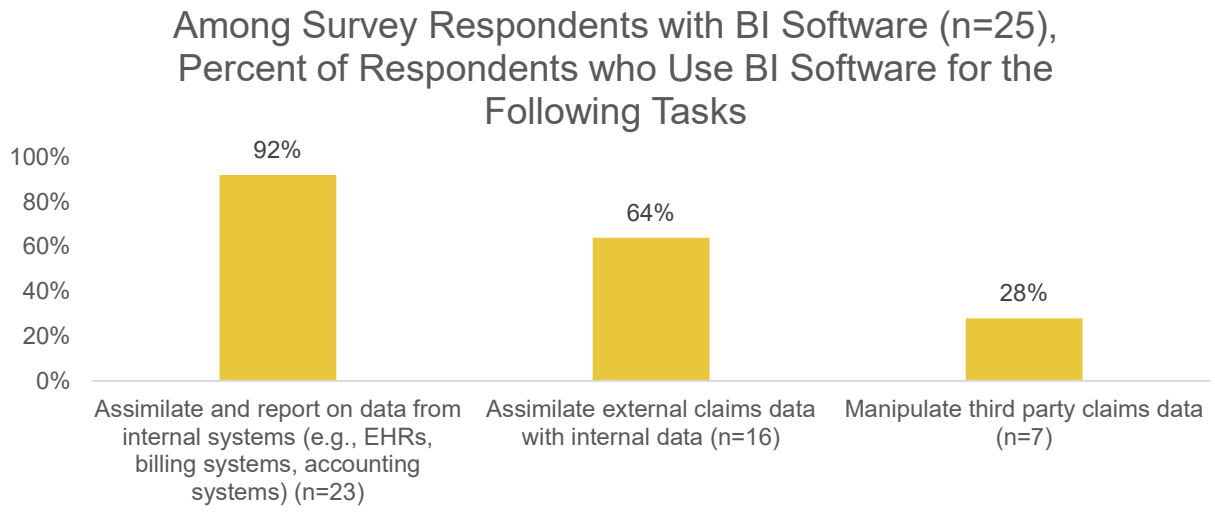
The percent of respondents who actively identify high-cost/high-utilizing patients is 26% (n=17). Among those 17 who answered affirmatively, 29% also identify and monitor high-cost providers. Under value-based care, there is a return on investment in focusing on high-cost/high-utilizing patients and the providers that disproportionately care for these patients.

Business Intelligence (BI) Software Utilization

Thirty-six percent (n=25) of survey respondents report using business intelligence (BI) software for some purpose. Among these respondents, survey respondents most commonly use BI software to assimilate and report on data from internal systems (e.g., EHRs, billing systems, accounting

systems) (35%, n=23) (Figure 32). This is followed by the assimilation of external claims data with internal data (25%, n=16) and the manipulation of third-party claims data (11%, n=7). Nearly half (48%, n=12) of survey respondents using BI software have a flexible architecture that allows for ad hoc reporting (e.g., to respond to reporting requests and requirements from different payers).

FIGURE 32



Working Capital

The HRSA standard for working capital (>30 days) is used as a solvency metric; with more days of working capital, there is a smaller risk of bankruptcy. Nearly half (48%, n=31) of survey respondents meet the HRSA standard for working capital. Another 37% (n=24) of respondents do not know and 15% (n=10) said they do not meet this HRSA standard. Among survey respondents who meet the HRSA standard:

- Nearly all (87%, n=27) of respondents can maintain cash for more than 30 days. Two respondents do not, and two respondents do not know.
- Eighty one percent (n=25) of respondents met this working capital metric for the past three fiscal years. Two respondents did not, and four respondents do not know.

Thirty-eight percent (n=25) have a positive unrestricted net asset position and 17% (n=11) do not (the remaining 45% do not know). Among survey respondents who have positive net assets:

- Nearly all (92%, n=23) have positive net assets available for operations.
- Respondents (n=17) report the net assets represent an average of 132 days of operation (median of 99 days).

Just under half (43%, n=28) of survey respondents generated a positive margin for the three most recent completed fiscal years, and 26% (n=17) report they did not. Thirty-one percent (n=20) of survey respondents report they do not know.

The percent of respondents who generated a positive operating margin (operating revenue less expenses before depreciation and non-operating revenues and expenses) for the three most recent

completed fiscal years was 32% (n=21). The remaining two thirds either did not (32%, n=21) or do not know (35%, n=23).

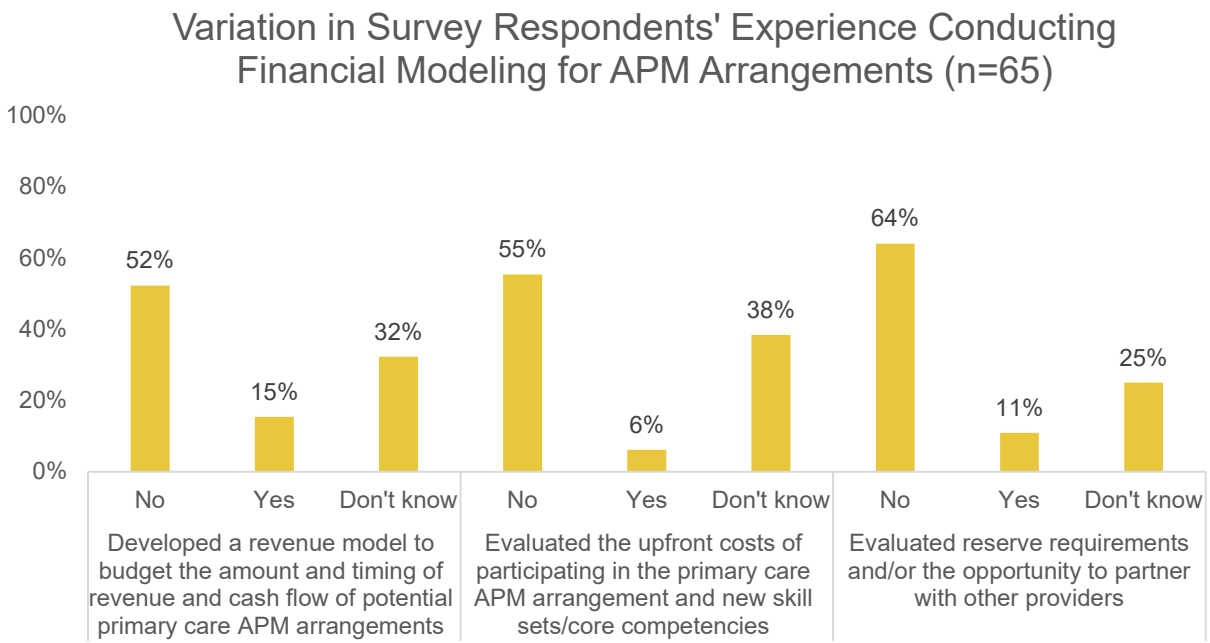
Financial Modeling for APM Arrangements

More than half of survey respondents report not conducting the kinds of financial modeling needed to anticipate in APM arrangements. There is some variation in the financial modeling preparation (Figure 33):

- 64% (n=41) have not evaluated reserve requirements and/or the opportunity to partner with other providers.
- 55% (n=36) have not evaluated the upfront costs of participating in the primary care APM arrangement and new skill sets/core competencies.
- 52% (n=34) have not developed a revenue model to budget the amount and timing of revenue and cash flow of a potential primary care APM arrangement.

The percent of respondents who did not know about their financial modeling activity in these three areas is worth noting. This may be a function of who within each organization responded to the survey. However, it may also be indicative of the low visibility in the organizations of any financial preparation for APM arrangements.

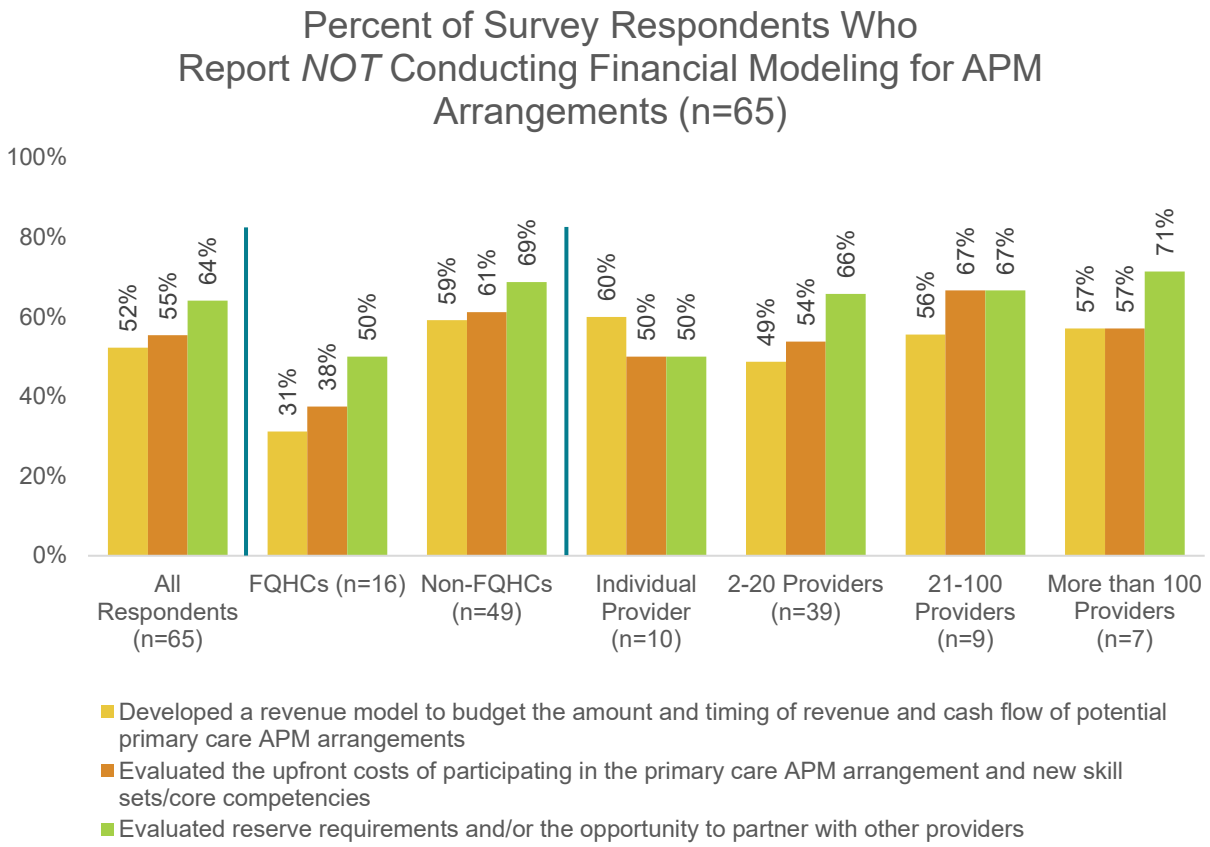
FIGURE 33



There is some variation in the financial modeling preparation by provider type (Figure 34):

- Non-FQHCs are more likely than FQHCs to report they have not participated in or conducted any financial modeling for APM arrangements.
- Larger organizations are slightly more likely to report not having participated in or conducted any financial modeling for APM arrangements.

FIGURE 34



Practices across all focus groups raised concerns about financial readiness for participating in an APM. Specific concerns shared include the inability to hire staff to support the interprofessional, team-based care that is the goal of the APM, recruitment challenges and workforce shortages caused by the inability to offer competitive salaries, potential for increased complexity in billing systems and claims management under an APM, and how the timing of APM implementation and rollout could affect or cause delays in reimbursements.

> *We're an extremely rural practice, a "mom and pop" business. We have a front desk clerk, a medical assistant, and a phone support medical assistant. We can't afford to hire any additional staff. If we don't get paid for a service, we're not making money.* – Small/medium practice focus group participant

Small/medium practice participants in particular noted that up-front financial support is needed to allow them to hire staff, provide training and technical assistance to staff, and invest in IT and other infrastructure needed to succeed.

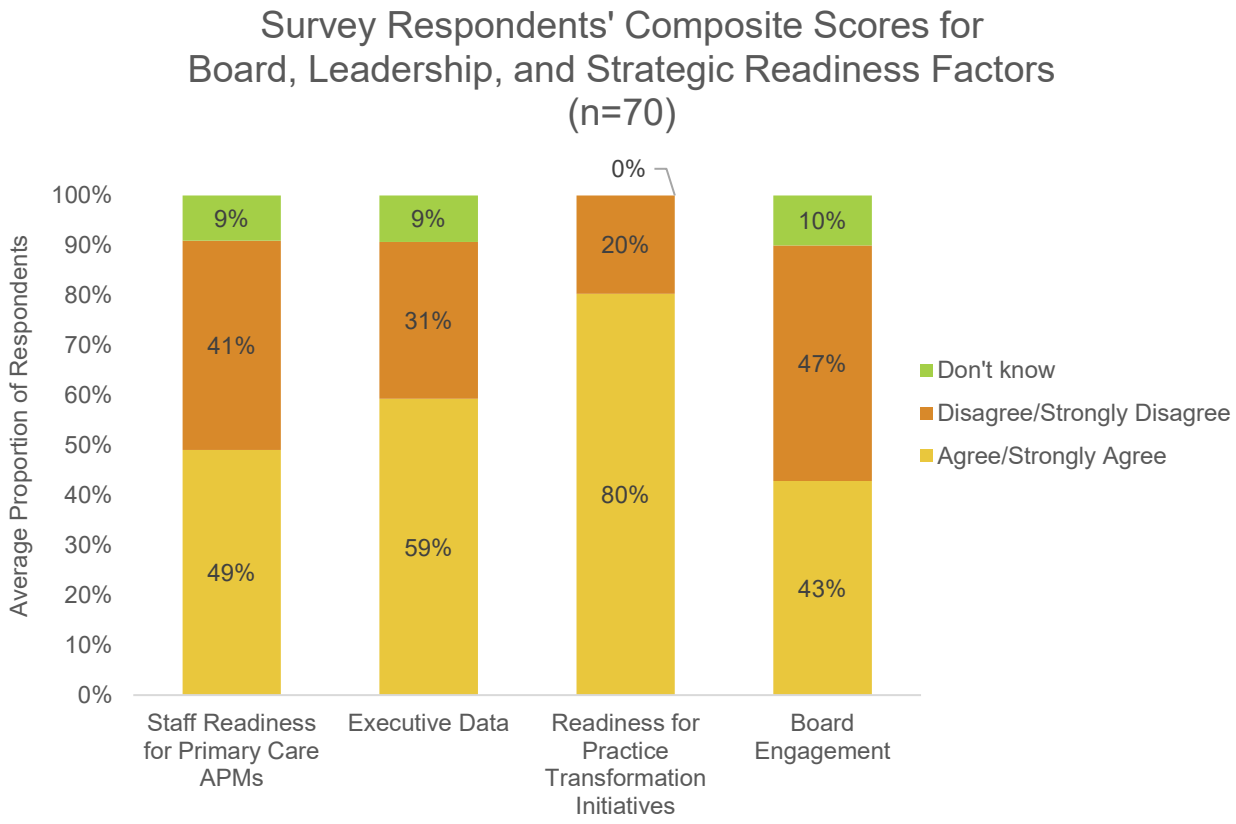
Section 5: Board, Leadership, and Strategic Readiness

This section reports on survey findings related to organizations' board, leadership, and strategic readiness to succeed under a primary care APM. Responses suggest the area of highest readiness is practice transformation initiatives (80%), followed by executive data (59%), staff readiness for primary care APMs (49%), and board engagement (43%) (Figure 35).

WHY THIS MATTERS

Moving to a primary care APM will likely be a significant shift in the way services have traditionally been developed and delivered. Therefore, it is important that the Boards and all staff—leadership, frontline clinical and non-clinical staff, and other support staff— of primary care organizations understand the reason for change and are willing and able to participate in the planning and execution of strategies that enable a health center to succeed under a primary care APM. In particular, the role of the Board and leadership in supporting the changes is critical as is the need for a performance dashboard that enables an organization to track and respond to key metrics.

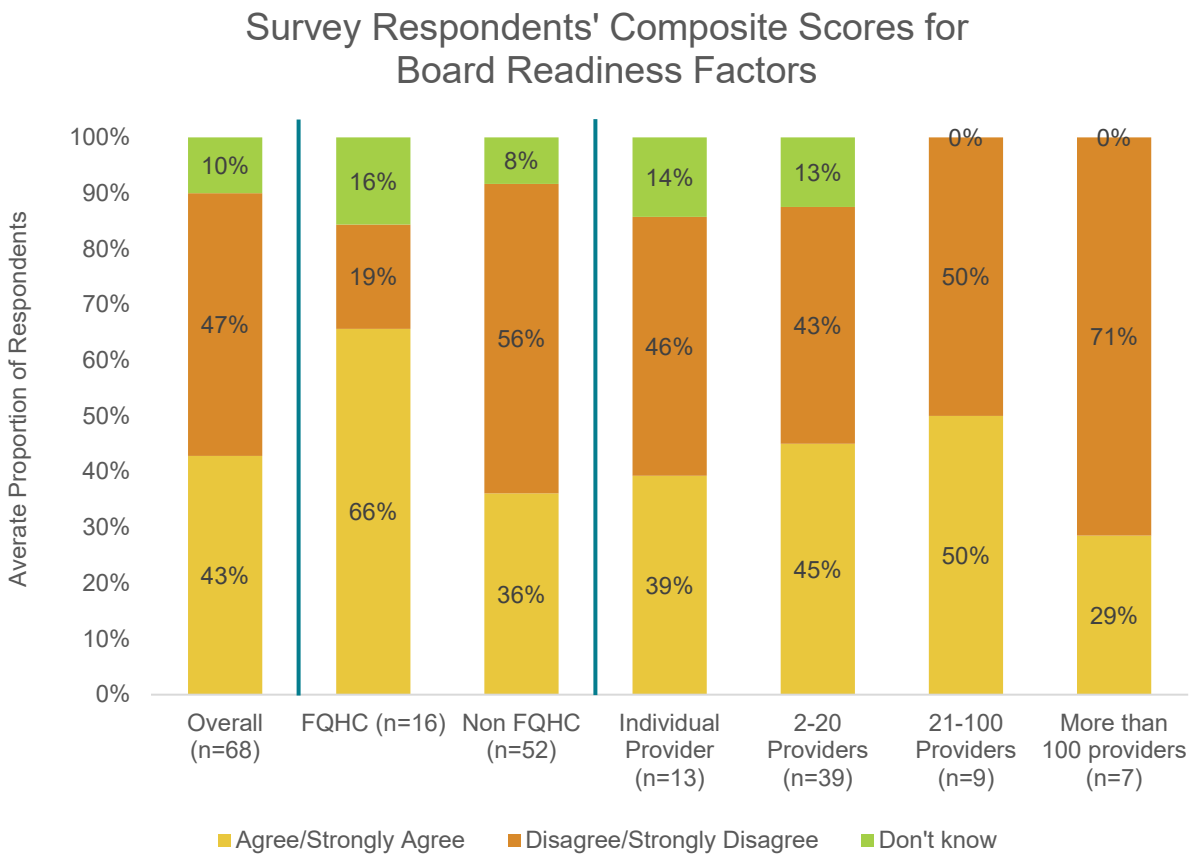
FIGURE 35



Board Engagement

FQHCs (66%) are more likely to report Board engagement readiness compared to non-FQHCs (36%) (Figure 36). Large organizations (more than 100 providers) are the least likely to report this readiness at just 29% of survey respondents in this group.

FIGURE 36



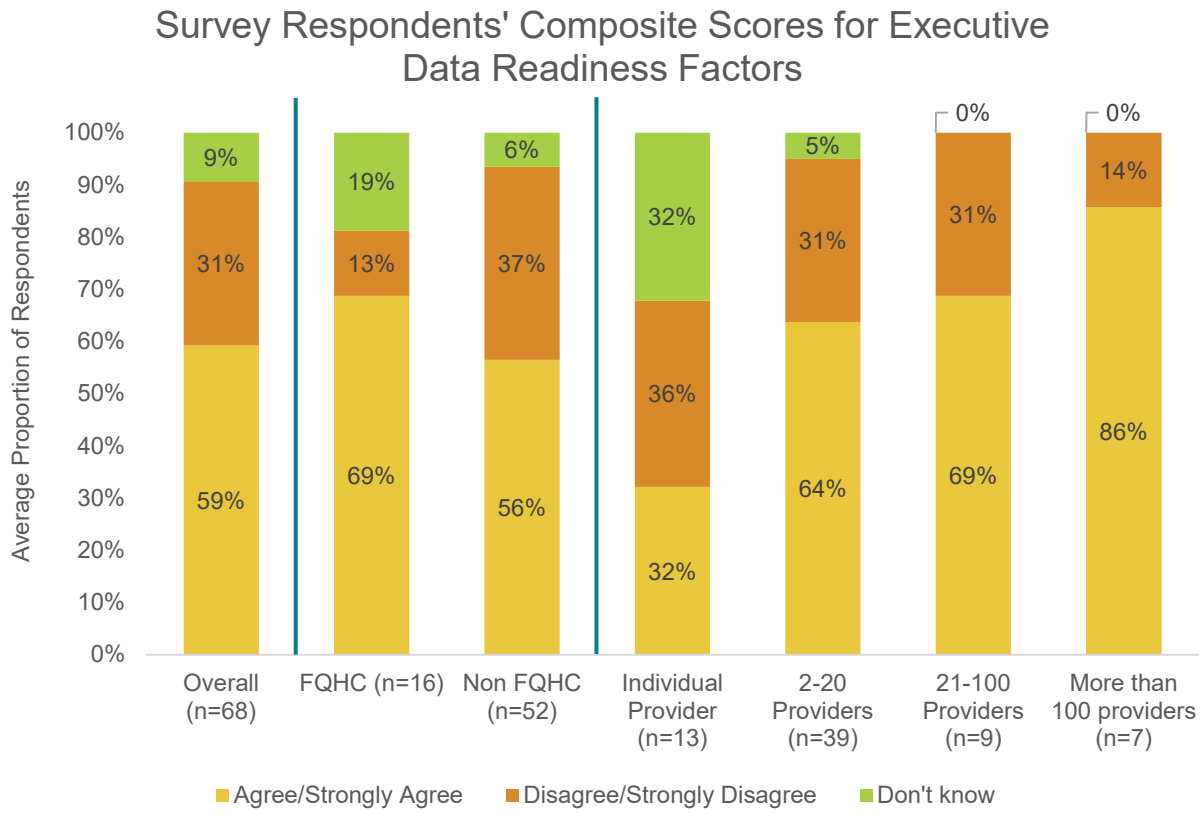
Specifically:

- More than half (51%, n=36) agree/strongly agree that their organization has engaged in a comprehensive strategic planning process with their Board and other key stakeholders that prepares them for the transition to value-based care while maintaining fidelity to their organization's mission, vision, and values within the last three years.
- One in three (34%, n=24) agree/strongly agree that their organization has determined the level of risk they are willing to take in relation to primary care APMs through a process that included executive leadership and members of the governing Board.

Executive Data

FQHCs (69%) are more likely to report executive data readiness compared to non-FQHCs (32%) (Figure 37). Large organizations (more than 100 providers) are more likely to report this readiness (86%) compared to individual providers (32%), organizations with 2-20 providers (64%) and organizations with 21-100 provider (61%).

FIGURE 37



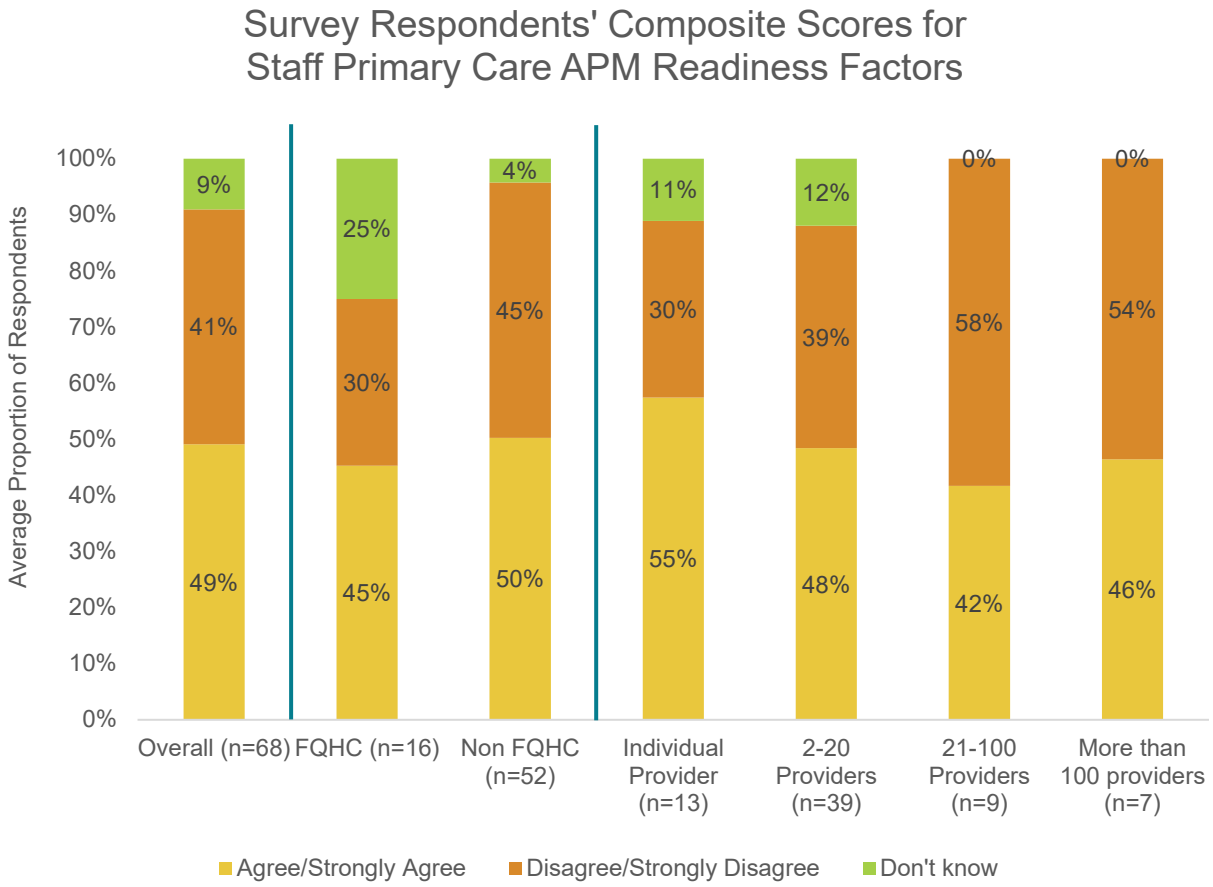
Specifically:

- More than half (57%, n=40) agree/strongly agree that their organization's leadership team has access to a performance management dashboard that enables it to monitor and respond to critical organizational indicators in real time.
- Sixty-one percent (n=43) agree/strongly agree that their organization's management team regularly tracks the results of a patient experience survey.

Staff Readiness for Primary Care APMs

There was little variation across practice sizes or types in the extent to which survey respondents agree/strongly agree that staff are ready for primary care APMs (Figure 38).

FIGURE 38



Broken down by type of staff:

- 57% of respondents agree/strongly agree that **administrative leadership** are ready for an APM
- 56% of respondents agree/strongly agree that **clinical leadership** are ready for an APM
- 47% of respondents agree/strongly agree that **providers** are ready for an APM
- 34% of respondents agree/strongly agree that **staff** are ready for an APM

Participants across focus groups noted that staff may be ready for some elements of APM implementation, but that a gradual rollout is needed to ensure success. An FQHC participant shared that staff are familiar with tracking quality metrics and implementing population health initiatives; but worried that transitioning to an APM for all of their Medicaid patients would be challenging. One hospital participant noted that staff are familiar with requirements such as annual wellness visits and preventive care, while another hospital shared that these will be entirely new concepts for their providers and significant education and support will be necessary to help them feel comfortable. Small/medium practice focus group participants expressed the most concern regarding staff readiness, noting that their employees are often already balancing the responsibilities of multiple positions and that they lack financial resources to hire additional staff for activities such as care coordination and billing.

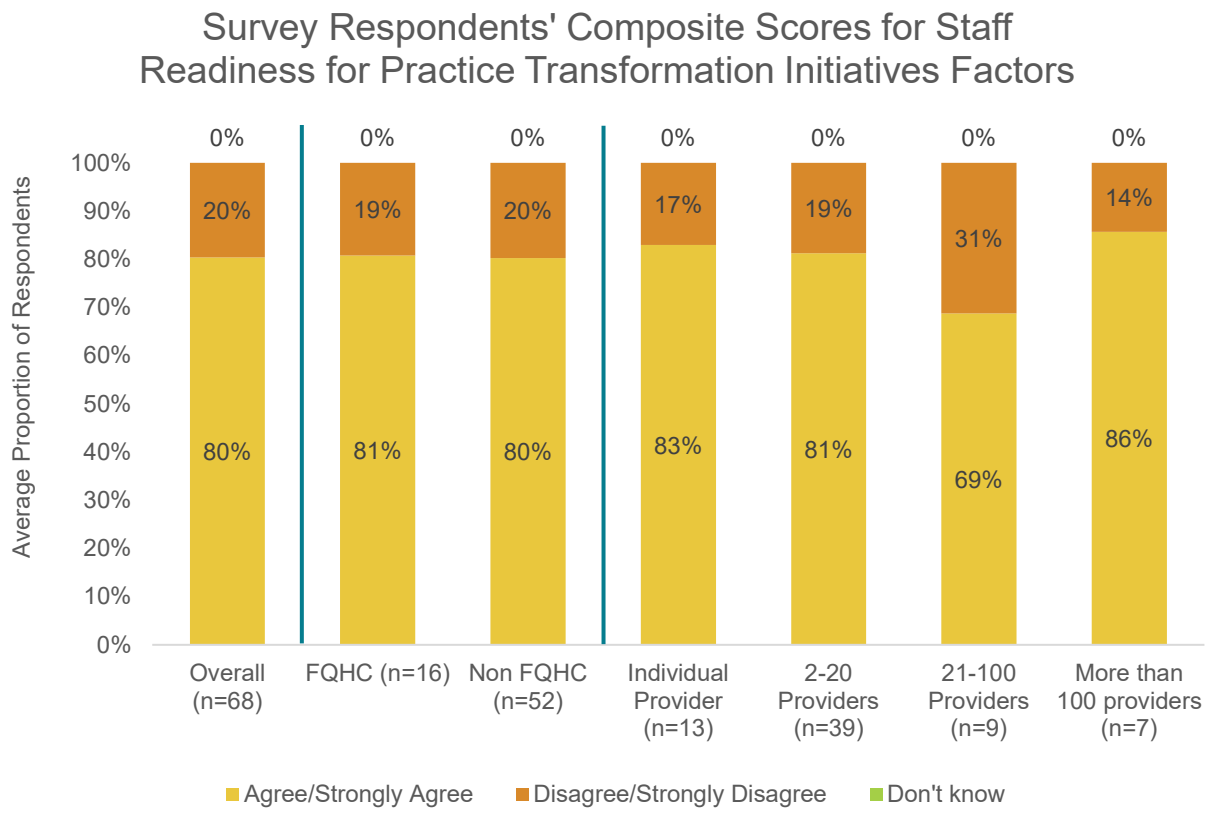
> *We've been striving to work with target populations and improving quality measures in preparation for these types of models. Having quality drive the model will benefit the patients. Starting with a smaller group instead of our whole population of Medicaid patients may help; implementing gradually and using lessons learned.* – FQHC focus group participant

A theme echoed among focus group participants is the need for clear information and support from the state and payers to effectively prepare staff. An FQHC participant expressed the need for quality metric definitions well in advance of APM launch so practices can adjust workflows. Another participant emphasized the importance of offering training and technical assistance in a way that does not decrease patient access; for example, holding live trainings *and* sharing recorded versions. A hospital focus group participant shared that longer regional in-person trainings would be beneficial and requested an email address or phone number where providers can send APM questions.

Staff Readiness for Practice Transformation Initiatives

Eighty percent of survey respondents agree or strongly agree that staff are active in or willing to participate in practice transformation initiatives (Figure 39). Mid-size organizations (21-100 providers) were the least likely to report "agree/strongly agree" regarding staff readiness for practice transformation initiatives factors.

FIGURE 39



Summary and Recommendations

The readiness assessment survey and the four focus group sessions offer rich information about New Mexico providers' concerns and needs regarding implementation of a primary care APM. For example, the top four concerns across respondents in survey Section VI: Areas of Concern When Preparing for APMs (i.e., items for which 55-60% of respondents reported they are very concerned) are (1) resources, (2) impact on fiscal workflow, (3) meeting clinical targets, and (4) impact on operational workflows. Drilling down on these results, individual providers were very concerned about negotiations with health plans, medium-sized practices were very concerned about health IT, and larger organizations were concerned about provider buy-in. The following recommendations are based on these findings, presented in the categories of Training and Technical Assistance, APM Development, and Other Recommendations.

Training and Technical Assistance Recommendations

Qualitative data from the survey and focus groups indicate multiple needs and concerns and therefore topics for training and technical assistance activities in 2023, whether via webinar or regional in-person learning collaboratives. Recommendations are organized into sub-categories of Messaging and Curriculum Content, and the first recommendation applies to virtual and in-person events and to one-on-one interactions with clinical organizations that are hesitant about engaging in APM efforts.

Messaging

- Deploy members of the Primary Care Council and the Transformation Collaborative to champion the APM and generate enthusiasm among their peers.
- Communicate how the APM will reduce provider burden.
- Communicate that the APM is as much about quality improvement and increasing access to primary care as controlling costs.

Curriculum Content

- Strategies for data collection, sharing, reporting, and analysis.
- Risk assessment and social determinants of health/health-related social needs screening tools. This could involve developing a standardized tool(s), sharing tools validated by other organizations (e.g., NCQA or CMS), discussion of what to do with the data once it is captured (i.e., referrals to the appropriate community-based organizations), and using Z codes to receive appropriate reimbursement.
- Data aggregation, risk stratification, population attribution, care gaps, and clinical workflow framework alignment.
- Creating partnerships with social service sector organizations and developing directories of such organizations for referral purposes.
- REALD and cultural competency data collection and strategies for applying the data.
- Partnerships with interprofessional teams. This could include providing examples of innovative approaches and types of partnership arrangements. Emphasize the role of behavioral health in interprofessional teams as this was identified as a significant concern in the survey and focus groups.

- Collecting, tracking, and reporting quality measure information. Based on the qualitative research findings, it may be worthwhile to tailor this topic towards smaller practices and provider organizations new to value-based care.
- Best practices for risk sharing, surplus sharing, and financial modeling for APM arrangements. In developing such a session, exercise caution to ensure HSD is not providing financial or legal advice.
- Achieving better outcomes, including health and clinical, financial, quality of life, and psychosocial.

APM Development Recommendations

The findings from the survey and focus groups communicated several concerns that should be addressed as the APM is developed and refined:

- Design the APM to reduce provider burden.
- Structure the APM to enable providers to participate at levels of risk they can tolerate, with a "glide path" to increasing levels of risk and reward over time.
- Include and encourage non-clinical patient supports in the APM design.
- Incorporate SDoH/HRSN data into the structure of the APM's quality and performance outcome measures.

Other Recommendations

There were several findings from the survey and focus groups that HSD and the PCC may consider addressing that do not fall under the categories of training and TA or APM development:

- Align quality measures and incentives across Medicaid managed care organizations, and possibly other payers.
- Address provider concerns regarding workforce. Possible solutions include expanded telehealth support, mini-grants to fund additional staff, and partnerships with payers to leverage resources across providers (e.g., a payer-based care manager could support several clinical organizations).
- Address practices' concerns regarding the financial barriers to participating in health information exchange, both start-up costs and annual fees. This could involve use of mini-grant funds or discussions with SYNCRONYS regarding how the organization can create a sustainable business model while enabling participation by lower resourced organizations.
- Address provider concerns regarding insufficient infrastructure through mini-grants, partnerships with MCOs, and alliances across providers (e.g., group purchasing, shared resources such as a community health worker).

For questions about this report or New Mexico's primary care payment reforms, please contact Elisa Wrede at elisa.wrede@hsd.nm.gov.

Appendix A: Provider Readiness Survey

New Mexico Primary Care Alternative Payment Model Readiness Survey

Introduction and Purpose

Welcome to the Primary Care Alternative Payment Model (APM) Readiness Survey. This tool was developed by the New Mexico Primary Care Council (PCC), the New Mexico Human Services Department (HSD), and the State's national partner, Health Management Associates.

The 2021 New Mexico House Bill 67 (Primary Care Council Act) charges HSD to establish a statewide PCC to identify ways primary care investment could increase access to primary care, improve the quality of primary care services, address the shortage of primary care providers, and reduce overall health care costs.

The mission of the PCC is to revolutionize primary care into interprofessional, sustainable teams delivering high-quality, accessible, equitable health care across New Mexico through partnerships with patients, families, and communities.

To advance primary care payment reform in New Mexico, the state would like to know about clinical organizations' capacity to accept risk, and barriers and facilitators to primary care APM implementation. This survey is developed to give New Mexico policymakers and primary care leaders actionable information on primary care providers' readiness to succeed in APMs and to identify critical gaps that need to be addressed. We appreciate your time and cooperation in completing this survey and helping develop the payment model and strategies to support you throughout implementation.

Completing the Survey

We encourage you to work as a team to complete the survey. Working as a team will allow you to explore primary care APM readiness elements together and agree on the status of each element, thereby reducing the likelihood of answers being based on a single person's perceptions.

We recommend reviewing the survey questions and gathering responses before beginning to complete the survey online. A PDF of the survey was provided in the distribution email for your reference. Once responses are gathered, we anticipate the survey will take approximately 20 minutes to complete.

Throughout the survey you will see references to your "health center/practice." For the purposes of the survey, health center/practice means any provider type, including hospitals, ancillary providers, etc. If you are completing the survey on behalf of a primary care practice with multiple locations, please consider all locations when responding.

If you have questions about any of the content or language in the survey and need support, please contact Alex Castillo Smith (alex.castillosmith@state.nm.us) and Elisa Wrede (elisa.wrede@state.nm.us). If you have any technical challenges completing the survey and need support, please contact Margot Swift (mswift@healthmanagement.com).

The survey includes six sections:

Section I: Board, Leadership, and Strategic Readiness
Section II: Health Information Technology and Health Information Exchange Readiness
Section III: Care Delivery
- *Part I: Care Management*
- *Part II: Patient and Family-Centeredness*
- *Part III: Behavioral Health and Primary Care Integration of Services*

Section IV: Partnership Readiness
Section V: Financial/Operational Readiness
Section VI: Areas of Concern when Preparing for Primary Care Alternative Payment Models

Health Center/Primary Care Practice Information

Name of Person Completing Survey: [open text]
We are asking for a contact name and email address in case we have follow-up questions about survey responses. If you prefer not to be contacted with follow-up questions, you may leave these fields blank.

Email Address of Person Completing Survey: [open text]
We are asking for a contact name and email address in case we have follow-up questions about survey responses. If you prefer not to be contacted with follow-up questions, you may leave these fields blank.

Health Center/Primary Care Practice Name: [open text]

Health Center/Primary Care Practice County:
If you are completing the survey on behalf of a health center/practice that operates in multiple counties, please select all that apply.

Bernalillo County	Harding County	Roosevelt County
Catron County	Hidalgo County	Sandoval County
Chaves County	Lea County	San Juan County
Cibola County	Lincoln County	San Miguel County
Colfax County	Los Alamos County	Santa Fe County
Curry County	Luna County	Sierra County
De Baca County	McKinley County	Socorro County
Doña Ana County	Mora County	Taos County
Eddy County	Otero County	Torrance County
Grant County	Quay County	Union County
Guadalupe County	Rio Arriba County	Valencia County

Health Center/Primary Care Practice ZIP Code: [open text]
If you are completing the survey on behalf of a health center/practice that operates in multiple ZIP codes, please list all ZIP codes separated by a comma.

Health Center/Primary Care Practice Size:
- Individual provider
- 2-20 providers
- 21-100 providers
- More than 100 providers

Is your health center/primary care practice a Federally Qualified Health Center (FQHC)?
More information about FQHCs, including certification requirements, can be found here.
- No
- Yes

Section I: Board, Leadership, and Strategic Readiness

Context

Moving to a primary care APM will likely be a significant shift in the way services have traditionally been developed and delivered. Therefore, it is important that your Board and all staff—leadership, frontline clinical and non-clinical staff, and other support staff—understand the reason for change and are willing and able to participate in the planning and execution of strategies that enable your health center to succeed under a primary care APM. In particular, the role of the Board and leadership in supporting the changes is critical as is the need for a performance dashboard that enables you

to track and respond to key metrics.

This set of survey questions explores your board, leadership, and strategic readiness to succeed under a primary care APM.

Board Engagement

Our health center/practice has engaged in a comprehensive strategic planning process with our Board and other key stakeholders within the last three years that prepares us for the transition to value-based care while maintaining fidelity to our organization's mission, vision, and values.

- Strongly disagree
- Disagree
- Agree
- Strongly agree
- Don't know

Our health center/practice has determined the level of risk our organization is willing to take in relation to primary care APMs through a process that included executive leadership and members of the governing Board.

- Strongly disagree
- Disagree
- Agree
- Strongly agree
- Don't know

Executive Data

Our health center/practice's leadership team has access to a performance management dashboard that enables it to monitor and respond to critical organizational indicators in real time.

- Strongly disagree
- Disagree
- Agree
- Strongly agree
- Don't know

Our health center/practice's management team regularly tracks the results of a patient experience survey.

- Strongly disagree
- Disagree
- Agree
- Strongly agree
- Don't know

Staff Readiness

In general, the following groups are knowledgeable about and on board with participation in primary care APMs.	Strongly disagree	Disagree	Agree	Strongly agree	Don't know
Providers					
Staff					
Administrative leadership					
Clinical leadership					

In general, the following groups are active in or willing to participate in practice transformation initiatives. *Practice transformation initiatives are those that improve health outcomes, create a closer patient-provider relationship, and help replace costly acute care episodes with preventive care.*	Strongly disagree	Disagree	Agree	Strongly agree	Don't know
Providers					
Staff					

Section II: Health Information Technology and Health Information Exchange Readiness

Context

Effectively managing patient populations requires health centers to have accurate and comprehensive data about those populations, and those data must be collected and reported in a timely, often real-time, manner. The care team must have actionable data at the point of care in order to make appropriate clinical decisions and avoid duplication or unnecessary tests and services. Transitions of care can be costly, but if managed appropriately with real-time data, they can be an opportunity to control costs and improve outcomes. Providers practicing without this information will be unable to fully contribute to the success of a primary care APM.

This set of survey questions explores your readiness to success under a primary care APM in terms of health information technology and health information exchange participation.

Quality Improvement and Data Monitoring

Has your health center/practice undertaken any major chronic disease-specific quality improvement initiatives in the past 3 years (e.g., participated in a learning collaborative, pursued NCQA Diabetes Center of Excellence recognition, etc.)?

- No
- Yes
- Don't know

(If yes) Briefly describe the major chronic disease-specific quality improvement initiatives your health center/practice has undertaken in the past 3 years. [open text]

Our health center/practice has the technology to support retrieving, storing, calculating, and reporting clinical quality metrics.

- Strongly disagree
- Disagree
- Agree
- Strongly agree
- Don't know

As part of your reporting, do you specifically measure and monitor the following?	No	Yes	Don't know
Quality incentive payment provisions of third-party payer contracts			
Test utilization			

Are quality and outcome measures reviewed with the following groups?	No	Yes	Don't know
Clinical leadership			

Providers			

Our health center/practice utilizes quality data to inform patient outreach when appropriate (e.g., monitors colorectal cancer screening and outreaches to patients who are overdue).

Strongly disagree
Disagree
Agree
Strongly agree
Don't know

Our health center/practice collects race, ethnicity, language, and disability (REALD) data consistently for all patients.	Strongly disagree	Disagree	Agree	Strongly agree	Don't know
Race					
Ethnicity					
Language					
Disability					

Our health center/practice can use member data from payers in conjunction with program data for measures reporting, retrospective analytics, and continuous program improvement purposes.

This capability is usually found in so-called "business intelligence/decision support/data analytics" applications that work off large, multi-dimensional databases or warehouses.

Strongly disagree
Disagree
Agree
Strongly agree
Don't know

Provider Alerts, Decision Support Tools, and Registries

Our health center/practice has evidence-based clinical protocols and decision support tools embedded electronically in our EHR to aid in point-of-service decision-making.

Strongly disagree
Disagree
Agree
Strongly agree
Don't know

In general, providers use the following automatic prompts about services in our EHR:

Reminders for preventative services to be ordered

Strongly disagree
Disagree
Agree
Strongly agree
Don't know

Reminders for tests or services that have been ordered but remain incomplete

Strongly disagree
Disagree
Agree

Strongly agree
Don't know

Do providers and care team members receive proactive alerts in your EHR for:	No	Yes	Don't know
Emergency room utilization			
Inpatient hospitalization			
Automatic ordering of generic prescription drugs			
Other, please describe: [open text]			

Does your health center/practice have a workflow in place to quickly act on real-time admission, discharge, and transfer (ADT) alerts received when your patients are registered or discharged from:	No	Yes	Don't know
The hospital			
The emergency room			
Other, please describe: [open text]			

Does your health center/practice create an actionable list of:	No	Yes	Don't know
"Super utilizers" (e.g., patients who have frequent ED use or hospital readmissions)			
Other patients at-risk for hospital admission (e.g., recently discharged, children with uncontrolled asthma)			

Does your health center/practice have a workflow in place to reach out to patients for ongoing follow-up?
No
Yes
Don't know

Does your health center/practice have access to a database or data warehouse that serves as an actionable registry and contains patient data for reporting and program improvement purposes?
No
Yes
Don't know

(If yes) Our health center/practice utilizes actionable registries to monitor patients (e.g., list of all patients with diabetes, date of their last appointment, and date and result of their last HbA1c test).
Strongly disagree
Disagree
Agree
Strongly agree
Don't know

Health Information Exchange

Is your health center/practice currently connected to New Mexico's health information exchange (HIE)?
No
Yes

(If no) What barrier(s) prevent your health center/practice from connecting to New Mexico's HIE? Select all that apply.

Financial – start-up costs
Financial – annual fees
Lack of administrative support
Lack of technological support
Security/privacy concerns
Difficult to assess value
Other, please describe: [open text]

(If yes to connected to HIE) Is it challenging for your health center/practice to pay for the annual fees to connect to New Mexico's HIE?
No
Yes

Is your health center/practice using any HIE service offered by another HIE service provider (such as a query based HIE) to communicate with external providers?
No
Yes
Don't know

Section III: Care Delivery

Section III, Part I: Care Management

Context

A high functioning care team uses all members of the team in specific roles and at the top of their skill set and training. Because payment is based on value rather than provider volume, all team members work directly with patients in identifying needed services and coordinating the care. Patients are assessed for physical, behavioral, and social needs, and a care plan is developed and shared with all members of the care team. Patients and their caregivers are active participants in developing the care plan and setting goals for improvement.

This set of survey questions explores your care management services.

Care Management

Do you offer any care management services at your health center/practice?
No
Yes

(If yes) How many FTEs on staff are dedicated to care management activities? Number of FTEs: [open text]

(If yes) Care management services are integrated into the care team.
Strongly disagree
Disagree
Agree
Strongly agree
Don't know

(If agree or strongly agree) How are care management services integrated into the care team? Select all that apply.
Provider referral

ED alerts
Super-utilizer list
Contracted member list
Other (e.g., chronic condition)

Our health center/practice uses a care plan as a source for care management.
Strongly disagree
Disagree
Agree
Strongly agree
Don't know

Does your health center/practice use or have access to an electronic care management system for your care plan and related services?
No
Yes

Regarding a care plan, every provider within the care team can:

Collaborate on the development of a common care plan for a particular patient
Strongly disagree
Disagree
Agree
Strongly agree
Don't know

Work off a common care plan on an ongoing basis (e.g., read each other's notes and collaborate in maintenance and updates to plan)
Strongly disagree
Disagree
Agree
Strongly agree
Don't know

Care plans are informed by real-time intelligence about a patient's status (e.g., potential allergies, evidence gathered from patients with similar conditions, adverse drug reactions and/or drug-to-drug interactions).
Strongly disagree
Disagree
Agree
Strongly agree
Don't know

Does your health center/practice regularly conduct the following types of assessments?	No	Yes
Initial screenings		
Health/functional assessments		
Risk assessments		
Risk stratification		
Health related social needs (HRSN) or social determinants of health		

(If yes to any item) Does your health center capture the assessment as structured data in your care plan, EHR, or another database (images/paper/PDF do not qualify) for the following types for assessments? *Structured data are data entered into a specific field that can be used to generate statistics, reports, or other information. Information entered as free text in a chart note, contained in images such as PDFs, or otherwise unsearchable information does not qualify as structured data.*	**No**	**Yes**	**Don't know**
Initial screenings			
Health-functional assessments			
Risk assessments			
Risk stratification			
Health related social needs (HRSN) or social determinants of health			

Does your health center/practice track external referrals by referring provider at the health center?

- No
- Yes
- Don't know

Does your health center/practice track to which external provider a patient is referred?

- No
- Yes
- Don't know

Our health center/practice has established relationships and processes with hospitals utilized by our patients for routine communication and handoffs (e.g., with hospital ED care navigators, discharge planners, coordinators).

- Strongly disagree
- Disagree
- Agree
- Strongly agree
- Don't know

Do you have a strategy in place to outreach to and engage any managed care members who are assigned to you but have never been seen in your health center/practice?

- No
- Yes
- Don't know

Are oral health/dental services available to your patients in the same physical facility as the medical care?

- No
- Yes

(If no) How do you refer patients for dental treatment? [open text]

Are vision care/eye doctor services available to your patients in the same physical facility as the medical care?

- No
- Yes

(If no) How do you refer patients for vision care? [open text]

Section III, Part II: Patient and Family-Centeredness

Context

The care team must have a thorough understanding of their population, including the language, cultural, and social environments, to provide meaningful care that will help implement improvements in health status. Along with understanding the global population the team serves, each patient should be the center of their care and should be an active contributor to their care plan.

Access to services should be available during and outside traditional business hours to effectively manage urgent concerns and avoid unnecessary ED visits. Experienced nursing staff can assess the urgency of medical complaints and work with another provider, when necessary, to accommodate the appropriate level of care needed.

This set of survey questions explores the extent to which your health center/practice provides patient and family-centered care.

Patient-Centered Medical Home (PCMH)/Patient-Centered Health Home (PCHH)

Are you currently recognized as a PCMH or PCHH by an authorizing agency such as NCQA or URAC?

- No
- Yes

Are patients empaneled to a particular primary care provider?

- No
- Yes

Providing Patient-Centered Care

Do you collect patient satisfaction data through a survey tool?

- No
- Yes

(If yes) Select the frequency with which you survey patients for satisfaction.

- At every encounter
- Quarterly
- Semi-annually
- Annually
- Other, please describe: [open text]

Do you provide use of an electronic patient portal for patient access?

A patient portal is a secure online website that gives patients convenient 24-hour access to personal health information and other related services from anywhere with an Internet connection.

- No
- Yes

(If yes) Which of the following resources does the patient portal provide access to? Select all the apply.

- Patient records
- Appointments
- Clinical questions
- Other information

(If yes) Do more than 50% of patients use the portal for any reason?

No
Yes
Don't know

Do you use any patient-centered tools such as shared decision-making or decision support tools?
No
Yes
Don't know

Do you track patient visit cycle time (i.e., the amount of time it takes a patient from the time they enter the door to exit with a completed visit)?
No
Yes
Don't know

Enhanced Access

Does your health center/practice have an individual engaged full time in clinical nursing for triage, care coordination, and/or telephone consultation services (less than 20% administrative office work)?
No
Yes

Linguistic and Cultural Competency

Our health center/practice has assessed the linguistic needs of the population in our service area within the last three years.
Strongly disagree
Disagree
Agree
Strongly agree
Don't know

Our health center/practice has assessed the cultural needs of the population in our service area within the last three years.
Strongly disagree
Disagree
Agree
Strongly agree
Don't know

Language translation and interpretation services are easily accessible for all patients.
Strongly disagree
Disagree
Agree
Strongly agree
Don't know

How often does your health center/practice train providers and staff on cultural competency? Select all that apply.
No training is provided
During orientation

Annually
Other, please describe: [open text]

How often does your health center/practice train providers and staff on diversity, equity, and inclusion? For example, trainings that explore the role of racism, colonialism, and other forms of oppression in healthcare, bias, privilege, etc. Select all that apply.
No training is provided
During orientation
Annually
Other, please describe: [open text]

Does your health center/practice collect provider demographics, including race, ethnicity, language, and disability status?
No
Yes
Don't know

Provider demographics and/or experiences are reflective of the community in our service area.
Strongly disagree
Disagree
Agree
Strongly agree
Don't know

Our health center/practice has developed patient education materials and information on tests and procedures in multiple languages and at appropriate health literacy levels.
Strongly disagree
Disagree
Agree
Strongly agree
Don't know

Section III, Part III: Behavioral Health and Primary Care Integration of Services

Context

Nearly half of patients with one or more of the top five chronic medical conditions treated in primary care also suffer from a co-existing behavioral health issue. Providing primary and behavioral health care in one location by an integrated care team leads to improved outcomes (clinical and financial) for both medical and behavioral health issues as well as significantly lower long-term health care costs. The behavioral health staff should function as a core team member, not ancillary staff.

This set of survey questions explores the extent to which your health center/practice integrates behavioral health and primary care.

Behavioral Health and Primary Care Integration of Services

Is a behavioral health trained staff member part of the clinical care team, located on-site, and available to confer with the team throughout the day?
No
Yes

(If yes) How often are they available to confer with the team?
- 0%-25% of the time
- 26%-50% of the time
- 51%-75% of the time
- 76%-100% of the time

Are behavioral health services available to your patients in the same physical facility as the medical care?
- No
- Yes

(If yes) If a medical provider refers a patient for onsite behavioral health services (non-urgent), how often can the patient be seen the same day for behavioral health?
- Never
- Rarely
- Sometimes
- Always
- Don't know

(If yes to BH available in same facility) Do primary care and behavioral health staff document in a shared medical record?
- No
- Yes
- Don't know

(If no) Do they have, at minimum, viewing access in each other's records?
- No
- Yes
- Don't know

(If no to BH available in the same facility) How do you refer patients for behavioral health care? [open text]

(If no to BH available in the same facility) What barriers prevent you from offering behavioral health services to your patients in the same physical facility as the medical care? [open text]

Does your clinical team have time regularly designated to discuss complicated or difficult cases (not including a brief huddle)?
- No
- Yes

Section IV: Partnership Readiness

Context

Partnerships with other health care providers along the entire continuum of care are also critical to ensuring that your health center can effectively coordinate and manage health care and costs for the patients for whom you will be responsible.

Partnership Agreements

Does your health center/practice have agreements (formal arrangements through a memorandum of understanding or contract) in place with the following types of social service providers?	No	Yes	Don't know

Housing			
Food and nutrition services			
Tribal services			
Disability services			
Education/schools			
Child welfare			
Legal services			
Supported employment agencies			
Transportation			
Other, please describe: [open text]			

Does your health center/practice have agreements in place with the following types of medical providers?	No	Yes	Don't know
Hospitals			
Home health			
Skilled nursing/long-term care			
Crisis services			
Other, please describe: [open text]			

Has your health center/practice conducted an analysis within the last three years to identify the other service providers in your community from whom your patients receive care?

No
Yes
Don't know

Our health center/practice has agreements in place that enable it to serve individuals with the following needs:	Strongly disagree	Disagree	Agree	Strongly agree	Don't know
Mental health					
Substance use					
Intellectual and developmental disabilities					

Section V: Financial Operational Readiness

Context

Success in APM arrangements is grounded in improving health outcomes and realizing cost efficiencies, thereby reducing the total healthcare spend. To realize these desired behaviors, alternative payment incorporates various payment models, generally including (1) base compensation (to reimburse for services provided in-house), (2) quality incentive payments, and (3) managing the total cost of care of a patient. As a result, managing and monitoring financial performance will move away from per-visit analyses to quality metrics and patient- and family-centered financial analyses (per patient).

With regards to base compensation, centers will need to become more efficient in the delivery of services so increased emphasis will be placed on managing productivity and capacity levels of provider and non-provider staff, as well as improving business processes with the goal of reducing the average cost per unit (visits and procedures). In addition, centers will need to better understand the utilization of services by patient for both services provided in-house as well as outside its four walls as the underpinning of managing the overall cost per patient. An additional complexity is that patient utilization patterns often vary based on the health (risk) status of a patient and therefore payment is also varied

by risk status. Therefore, coding will become even more important for a center to manage a patient's health status, utilization patterns, cost of care, and to access quality incentive payments.

Accordingly, the foundation for success in primary care APMs includes the appropriate coding for services, improvement in cost efficiencies for services provided in-house, management of utilization, and the ensuing overall cost of care by patient while improving health outcomes and quality.

This set of survey questions explores your health center/practice's financial operational readiness for success under a primary care APM.

Financial Operational Readiness

Does your health center/practice train providers on proper coding and documentation practices?
- No
- Yes

Does your health center/practice have coders on staff?
- No
- Yes

Please provide the following information for 2022:
- Number of physician or mid-level practitioner (e.g., nurse practitioner or physician assistant) FTEs on staff: [open text]
- Number of coder FTEs on staff: [open text]
- Number of billing staff (excluding coders and front desk) FTEs on staff: [open text]

Does your health center/practice review provider coding on a regular basis?
- No
- Yes
- Don't know

Does your health center/practice have an incentive compensation program for providers?
- No
- Yes
- Don't know

(If yes) Is the program aligned with existing quality incentive programs in payer contracts?
- No
- Yes
- Don't know

Does your health center/practice monitor provider productivity (i.e., panel size)?
- No
- Yes
- Don't know

Does your health center/practice monitor the productivity (i.e., panel size) of non-provider staff?
- No
- Yes
- Don't know

Does your health center/practice have a roster of attributed members?

No
Yes
Don't know

(If yes) Is the member attribution at the physician or practice level?
Physician
Practice

Does your health center/practice analyze cost per visit on a regular basis to identify cost efficiencies?
No
Yes
Don't know

Does your health center/practice utilize a cost-based charge structure?
No
Yes
Don't know

Does your health center/practice update its fee schedule on an annual basis?
No
Yes
Don't know

Does your fee schedule include ICD-10 Z codes?
Z codes are the encounter reason codes used to describe factors influencing health status, e.g., Z56 – problems related to employment and unemployment or Z59 – problems related to housing and economic circumstances.
No
Yes
Don't know

Does your health center/practice calculate and monitor the total, annual cost per patient for in-house services?
No
Yes
Don't know

Does your health center/practice monitor the utilization of specific services by patient for in-house services?
No
Yes
Don't know

Does your health center/practice have partial capitation agreements with MCOs for in-house services (e.g., primary care)?
Capitation is a payment arrangement in which a provider is paid a set amount for each enrolled person assigned to them, per period of time (e.g., per member per month, or PMPM), whether or not that person seeks care.
No
Yes
Don't know

Our health center/practice has a strategy for assessing the needs of patients regarding social determinants of health,
Strongly disagree
Disagree
Agree
Strongly agree

Don't know

Does your health center/practice have agreements with third party payers that include quality incentive payments?
No
Yes
Don't know

(If yes) Have you been successful in fully accessing quality incentive payments?
No
Yes
Don't know

Does your health center/practice have surplus-sharing arrangements with third party payers?
This means a payment arrangement in which the provider can share with the payer in the surpluses (savings) of overall healthcare expenditures for members assigned to the provider.
No
Yes
Don't know

Does your health center/practice have risk-sharing arrangements with third party payers?
This means a payment arrangement in which the provider can share with the payer in the losses (shortfalls) of overall healthcare expenditures for members assigned to the provider.
No
Yes
Don't know

Does your health center/practice have participation agreements with an independent physician association (IPA) or accountable care organization (ACO)?
No
Yes
Don't know

(If yes) Do you have any surplus sharing agreements with those entities?
No
Yes
Don't know

(If yes to agreements with IPA/ACO) Do you have any risk sharing agreements with those entities?
No
Yes
Don't know

If your health center/practice is involved in surplus-sharing or risk- sharing arrangements:

How engaged is your health center/practice in monitoring performance?
Not at all engaged
Minimally engaged
Somewhat engaged
Very engaged
Not applicable

How successful has your health center/practice been, financially, with receiving payments?

Not at all successful
Minimally successful
Somewhat successful
Very successful
Not applicable

Does your health center/practice actively identify high-cost/high-utilizing patients?
No
Yes
Don't know

(If yes) Does your health center/practice identify and monitor high-cost providers?
No
Yes
Don't know

Does your health center/practice utilize Business Intelligence (BI) software to:	No	Yes	Don't know
Assimilate and report on data from internal systems (e.g., EHRs, billing systems, accounting systems)?			
Assimilate external claims data with internal data?			
Manipulate third party claims data?			

(If yes to any items) Does the BI software have a flexible architecture that allows for ad hoc reporting, e.g., to respond to reporting requests and requirements from different payers?
No
Yes
Don't know

Does your health center/practice meet the HRSA standard for working capital (>30 days)?
HRSA definition: Days in Working Capital = (Current Assets – Current Liabilities)/(Total Annual Operating Expenses/365 days)
No
Yes
Don't know

(If yes) Does your health center/practice maintain cash > 30 days?
No
Yes
Don't know

(If yes to meeting HRSA standard) Has your center/practice met this working capital metric for the past three fiscal years?
No
Yes
Don't know

Does your health center/practice have a positive unrestricted net asset position?
No
Yes
Don't know

(If yes) Do you have positive net assets, available for operations?

Positive Net Assets, Available for Operations = Unrestricted Net Assets – (Net Fixed Assets – Capital, Long-term Debt)

No
Yes
Don't know

(If yes to positive unrestricted net asset position) How many days of operation does your health center/practice's net asset position represent? [open text]

Did your health center/practice generate a positive margin for the three most recent completed fiscal years?

No
Yes
Don't know

Did your health center/practice generate a positive operating margin (operating revenue less expenses before depreciation and non-operating revenues and expenses) for the three most recent completed fiscal years?

No
Yes
Don't know

Has your health center/practice developed a revenue model to budget the amount and timing of revenue and cash flow of potential primary care APM arrangements?

No
Yes
Don't know

Has your health center/practice evaluated the upfront costs of participating in the primary care APM arrangement and new skill sets/core competencies?

No
Yes
Don't know

Has your health center/practice evaluated reserve requirements and/or the opportunity to partner with other providers?

No
Yes
Don't know

Section VI: Areas of Concern when Preparing for Alternative Payment Models

Context

The table below captures broad categories that can influence success in primary care APM adoption. Please indicate your health center/practice's level of concern for each item.

	Very Concerned	Concerned	Not a Concern
Necessary time/staff resources to design and implement primary care APM readiness			
Adequate financial position/reserves			
Establishing partnerships with external providers			
Negotiation with plans			
HIT infrastructure/support needed to implement changes			
Capability/willingness to exchange health information (HIE) with external partners			
Liability/audit risk			
Provider buy-in			
Board of Directors support			
Impact on clinical workflow			
Impact on fiscal workflow			
Impact on operational workflow			
Ability to meet clinical targets/expectations set forth in primary care APMs			

Appendix B: Distribution of Survey Respondents by County and ZIP Code

Note: Survey respondents could select more than one county and ZIP code where they provide services, so numbers total more than 70.

Number of Survey Respondents by County	
	Number
Bernalillo County	27
Catron County	1
Chaves County	2
Cibola County	2
Colfax County	6
Curry County	6
De Baca County	0
Doña Ana County	11
Eddy County	2
Grant County	2
Guadalupe County	3
Harding County	1
Hidalgo County	1
Lea County	5
Lincoln County	3
Los Alamos County	2
Luna County	2
McKinley County	2
Mora County	2
Otero County	2
Quay County	2
Rio Arriba County	4
Roosevelt County	1
Sandoval County	6
San Juan County	2
San Miguel County	2
Santa Fe County	10
Sierra County	0
Socorro County	2
Taos County	2
Torrance County	1
Union County	0
Valencia County	3

Number of Survey Respondents by ZIP Code	
	Number
87505	6
87111	5
87106	5
87109	5
87740	4
88008	4
87102	4
87121	4
87124	4
88012	3
87107	3
87108	3
87110	3
88011	3
87113	3
88081	3
87031	3
87301	3
88435	2
87114	2
88005	2
88021	2
88030	2
88101	2
88001	2
88220	2

87018	2
88345	2
87120	2
87112	2
87020	2
87004	2
87801	2
88240	2
87401	2
88401	2
87002	2
87174	2
87131	2
87507	2
87501	1
88352	1
88256	1
11216	1
79912	1
87059	1
87701	1
87062	1
88310	1
87825	1
87544	1
87830	1
88061	1
87068	1

88063	1
88003	1
87036	1
87016	1
88260	1
88007	1
87047	1
87105	1
87048	1
87123	1
87539	1
87008	1
87015	1
87010	1
87504	1
87144	1
88203	1
87013	1
88242	1
88210	1
76323	1
87323	1
88130	1
87532	1
88201	1
87552	1
87556	1
87571	1

Appendix C: Focus Group Discussion Guides

FQHC Discussion Questions

Introductory questions:

- What do you think your organization needs to succeed in an alternative payment model?
- Share how you feel an APM can improve the health and wellbeing of New Mexicans.

Care delivery and clinical expectations:

- Please describe the care management processes in your organization.
- Which screening tools do you use?
- How – and to what extent – do you integrate behavioral health, oral health, and vision services into your care plans? Are there any successes or promising strategies that you'd like to share?
- How do you establish quality measure targets, measure your progress, and address shortcomings?

Staff and provider readiness:

- What is your biggest concern(s) regarding clinical staff being ready for APMs? What supports (e.g., education, resources, technical assistance) would providers at your organization need to improve their readiness for APM implementation?
- What is your biggest concern(s) regarding non-clinical staff being ready for APMs? What supports would non-clinical staff at your organization need to improve their readiness for APM implementation?

Diversity, equity, inclusion, and social determinants of health:

- How do you integrate SDoH and health-related social needs into your workflows?

Financial operations readiness:

- What experience does your organization have in value-based payment and bearing risk?
- How do you handle different reimbursement procedures and incentive payments from different payers?
- How do you communicate payment incentives to your front-line clinicians and measure their progress?

Hospital Discussion Questions

Introductory questions:

- What do you think your organization needs to succeed in an alternative payment model?
- Share how you feel an APM can improve the health and wellbeing of New Mexicans.

Leadership, provider, and staff readiness:

- To what extent is your organizational leadership committed to value-based payment? Do you think your board is in alignment with your staff leadership?

- What is your biggest concern(s) regarding clinical staff being ready for APMs? What supports (e.g., education, resources, technical assistance) would providers at your organization need to improve their readiness for APM implementation?
- What is your biggest concern(s) regarding non-clinical staff being ready for APMs? What supports would non-clinical staff at your organization need to improve their readiness for APM implementation?

Care delivery and clinical expectations:

- Please describe the care management processes in your organization.
- Which screening tools do you use?
- How – and to what extent – do you integrate behavioral health, oral health, and vision services into your care plans?
- Describe your partnerships with community-based and social service organizations and how you communicate patient needs with them.

Health IT and health information exchange:

- How do you provide performance reports to your front-line clinicians?
- To what extent can you share data with other clinical organizations?
- How do you produce quality and cost reports for state and federal agencies, commercial payers, and/or accreditation organizations?

Diversity, equity, inclusion, and social determinants of health:

- How do you integrate SDoH and health-related social needs into your workflows?

Financial operations readiness:

- What experience does your organization have in value-based payment and bearing risk?
- How do you handle different reimbursement procedures and incentive payments from different payers?
- How do you communicate payment incentives to your clinicians and measure their progress?

Small and Medium Practice Discussion Questions

Introductory questions:

- What do you think your organization needs to succeed in an alternative payment model?
- Share how you feel an APM can improve the health and wellbeing of New Mexicans.

Leadership, provider, and staff readiness:

- Do you have an understanding of the implications of the movement toward value-based payment? What do you think the effects will be on your practice?
- What is your biggest concern(s) regarding clinical staff being ready for APMs? What supports (e.g., education, resources, technical assistance) would providers at your organization need to improve their readiness for APM implementation?
- What is your biggest concern(s) regarding non-clinical staff being ready for APMs? What supports would non-clinical staff at your organization need to improve their readiness for APM implementation?

Care delivery and clinical expectations:

- Please describe the care management processes in your organization.
- How – and to what extent – do you integrate behavioral health, oral health, and vision services into your care plans?
- How do you establish quality measure targets, measure your progress, and address shortcomings?

Health IT and health information exchange:

- How do you provide performance reports to your front-line clinicians?
- To what extent can you share data with other clinical organizations?
- How do you produce quality and cost reports for state and federal agencies, commercial payers, and/or accreditation organizations?

Diversity, equity, inclusion, and social determinants of health:

- How do you integrate SDoH and health-related social needs into your workflows?

Financial operations readiness:

- What experience does your organization have in value-based payment and bearing risk?
- How do you address different reimbursement procedures and incentive payments from different payers?
- How do you communicate payment incentives to your front-line clinicians and measure their progress?

Interprofessional Team Discussion Questions

- What do you think your organization needs to succeed in an alternative payment model?
- What do you think are your greatest assets and strengths?
- What are the biggest challenges?
- Please describe your existing partnerships with primary care clinical organizations.
- Do you collect social determinants of health/health-related social needs information, and if so, how?
- What quality measures do you use? How would you suggest that they be integrated into the APM?
- What types of care management services does your organization have available?
- What training and technical assistance would be useful in helping you participate and succeed in the primary care APM?
- Before we close, is there anything we did not ask that you would like to make sure we include, or that you think it is very important for us to capture?