HUMAN SERVICES DEPARTMENT

PRIMARY CARE COUNCIL INAUGURAL MEETING

JULY 24, 2021

INVESTING FOR TOMORROW, DELIVERING TODAY.

BEFORE WE START...

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

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

PHOTO COURTESY: HSD Employee

HUMAN SERVICES DEPARTMENT

MISSION

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

GOALS

We help NEW MEXICANS

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

We communicate EFFECTIVELY

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

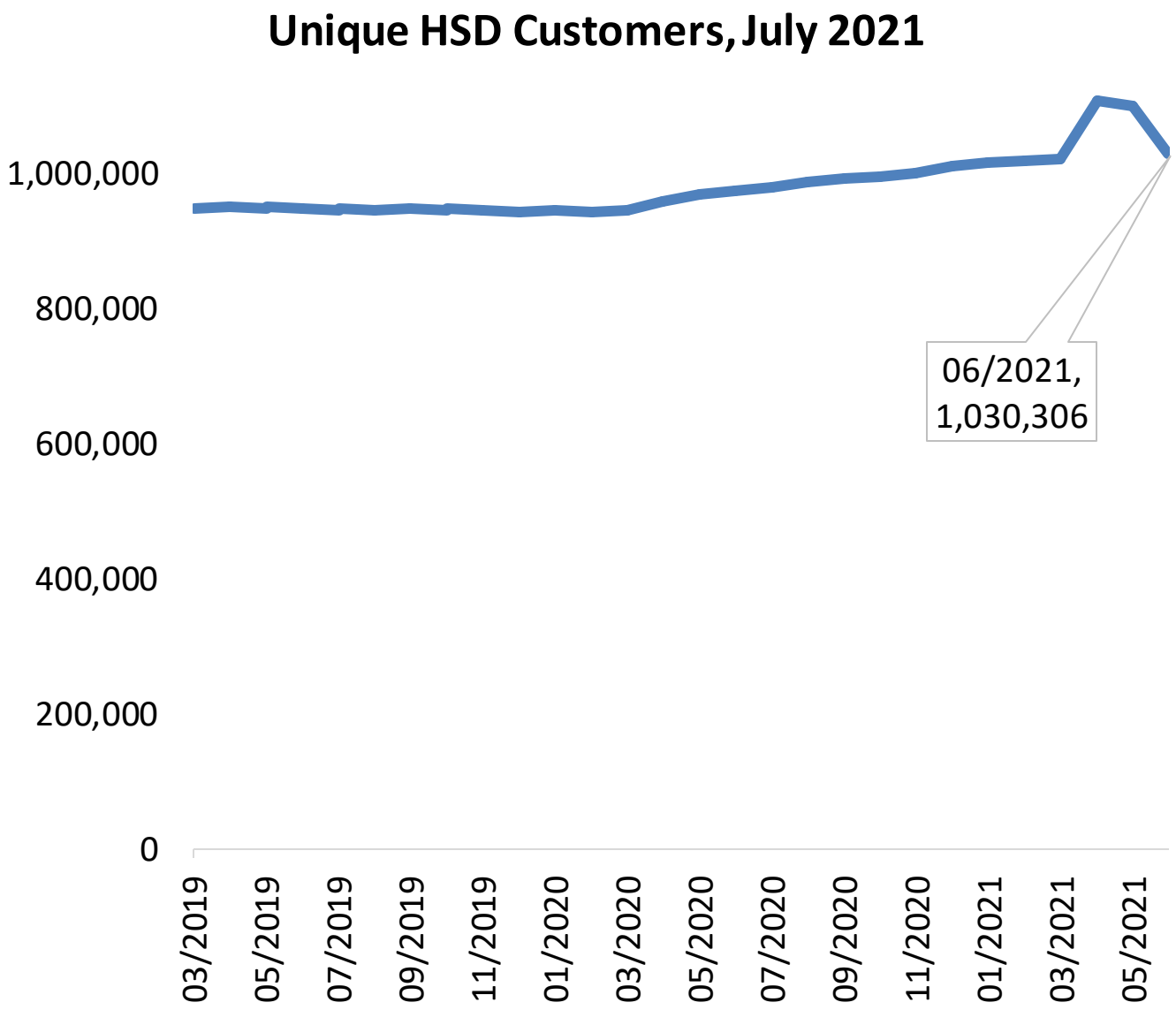
We make access EASIER

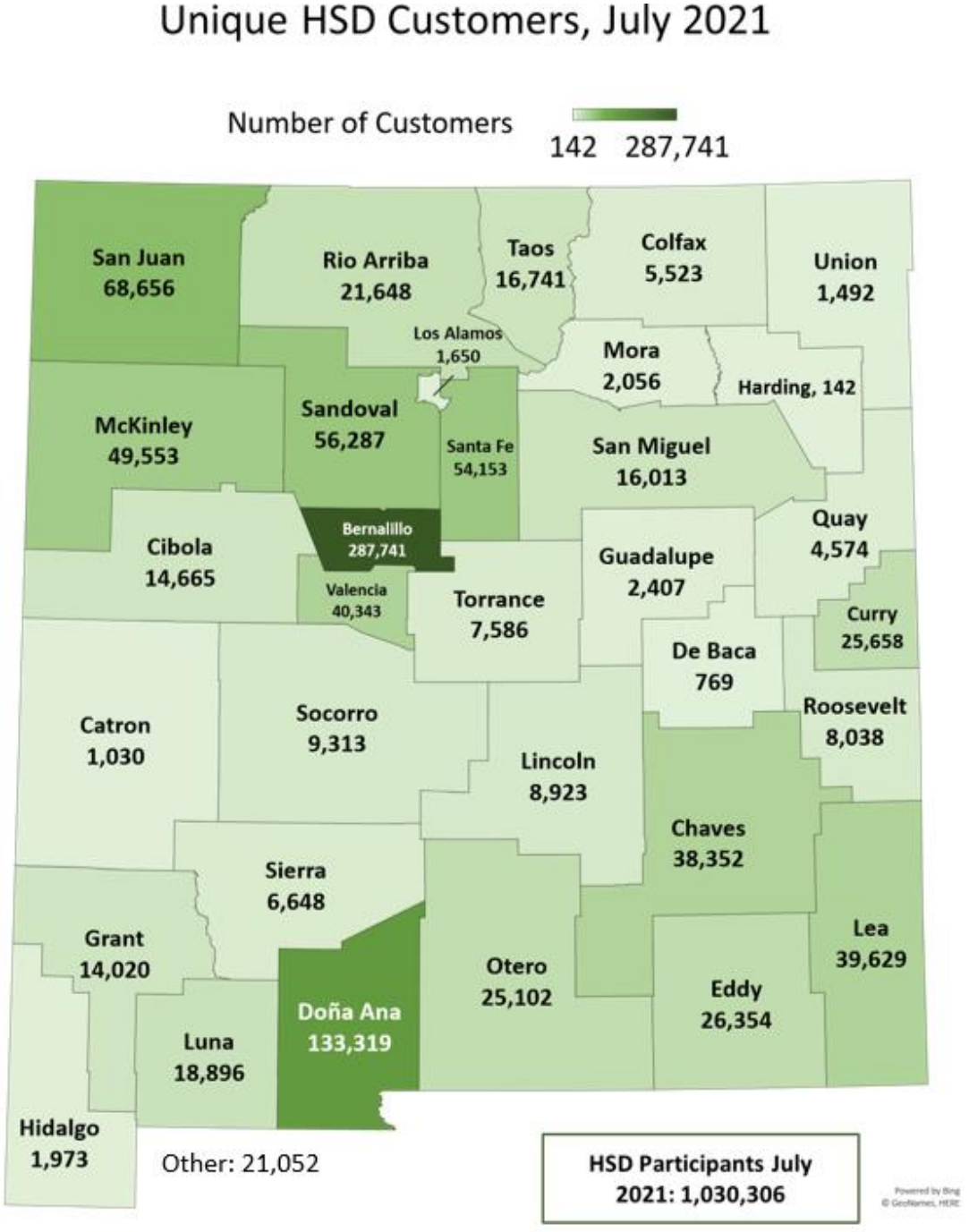
3. Successfully implement technology to give customers and staff the best and most convenient access to services and information.

We support EACH OTHER

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

WE'VE BEEN BUSY





HSD'S SOCIAL IMPACT: NM BENEFITS FROM MODERN AND RESPONSIVE SOCIAL SAFETY NET (AS OF 7/16/21)

HSD's Programs have had the following social impact:

249,503,289 meals provided to New Mexicans through Supplemental Nutrition Assistance Program (SNAP) **since January 2021**

932,606 individuals provided the ability to visit a doctor, afford medication and immunizations through Medicaid **in June 2021**

20,523 homes heated and cooled for New Mexico families through Low Income Energy Assistance Program (LIHEAP) **in Federal Fiscal Year 2021**

12,166 families provided shelter and necessities through Temporary Assistance for Needy Families (TANF) Program **in June 2021**

$135.79 collected per child* per month on average through child support to help kids be happy and healthy **over the last 12 months**

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

MEETING AGENDA – 1ST HALF

Meeting Section	Time	Presenter	Agenda Item
Welcome	9:00AM - 9:30AM	Sec. David Scrase & Nicole Comeaux	Opening Comments & Zoom Tutorial
Introductions & Icebreaker	9:30AM – 10:30AM		Introduce the Council & Share Goals
Part 1 – Sunshine Laws	10:30AM – 10:40AM	Alex Castillo Smith	Open Meetings Act Overview
			Open Meetings Resolution Highlights
			Vote to Adopt Resolution
Short Break	10:40AM – 10:50AM	-	Break
Part 2 – Background & Council Overview	10:50AM – 11:00AM	Sarah Criscuolo	HB 67 Overview
	11:00AM – 11:15AM	Hala Reeder	New Mexico Healthcare Workforce Analysis
	11:15AM – 11:40AM	Jeff Clark	Overview of Readings
	11:40AM – 11:50AM	Sarah Criscuolo	Defining Primary Care
Public Comment	11:50AM – 12:00PM	Alex Castillo Smith	Feedback, Comments, & Questions

MEETING AGENDA – 2ND HALF

Meeting Section	Time	Presenter	Agenda Item
Lunch Break	12:00PM – 1:00PM	-	Break
Part 3 – Strategic Planning	1:00PM – 1:10PM	Alex Castillo Smith	Strategic Planning Overview
	1:10PM – 1:30PM	Sarah Criscuolo	Review Survey Results & Determine Mission
	1:30PM – 1:40PM		Review Survey Results & Determine Vision
	1:40PM – 2:15PM		Review Survey Results & Identify Goals
Short Break	2:15PM – 2:25PM	-	Break
Part 4 – Council Plans and Expectations Moving Forward	2:25PM – 2:30PM	Sec. David Scrase	Review Second Meeting Agenda
	2:30PM – 3:10PM	Sarah Criscuolo	Identify Workgroups & Accountability Measures
Public Comment	3:10PM – 3:25PM	Alex Castillo Smith	Public Feedback, Comments, and Questions
Reflection	3:25PM – 4:00PM	Jeff Clark	Council Feedback, Comments, and Questions

OPENING COMMENTS

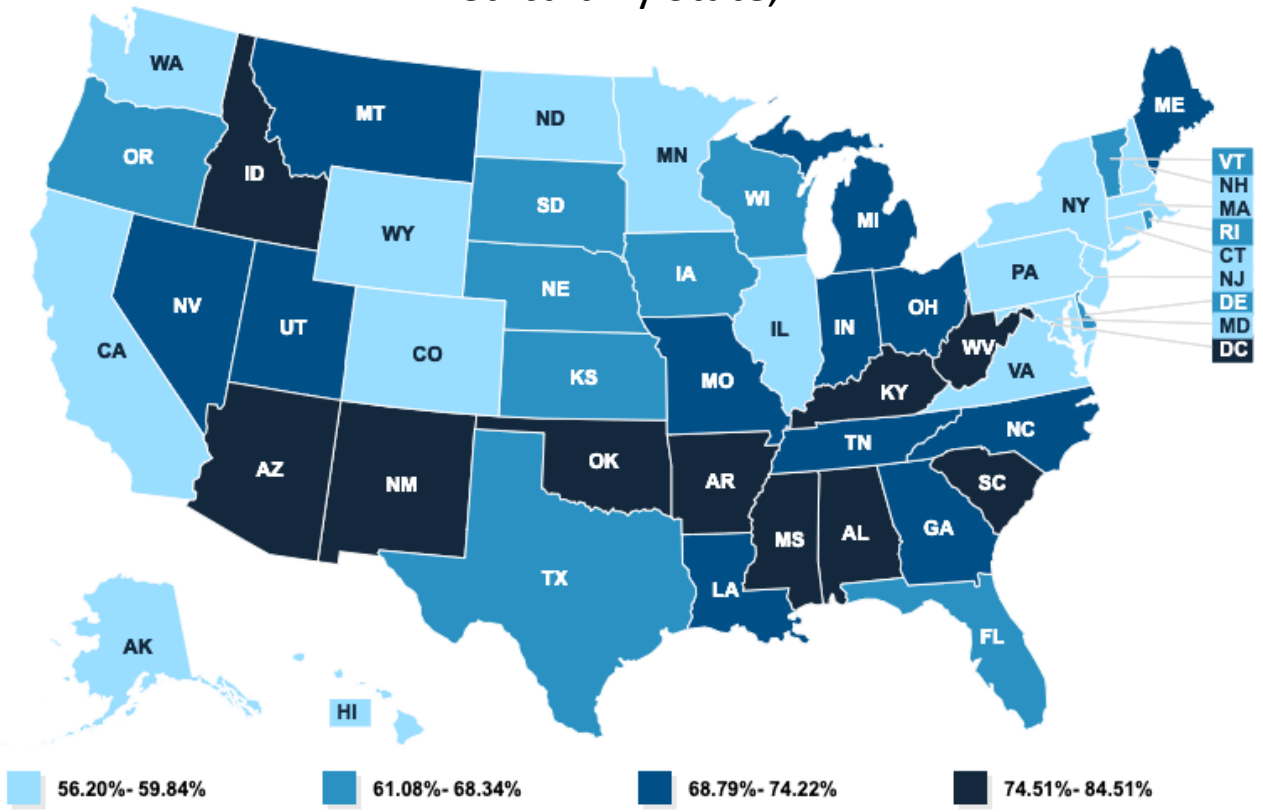
David R. Scrase, M.D.
Cabinet Secretary

Deborah A. Armstrong
State Representative

Patricia Roybal Caballero
State Representative

Nicole Comeaux
Medicaid Director

Federal Medical Assistance Percentage (FMAP) For Medicaid By State, FY22



NM FMAP 3rd highest in the country (79.9%), meaning Federal share of most Medicaid expenditures 79.9% (remainder State share).

Source: https://www.kff.org/medicaid/state-indicator/federal-matching-rate-and-multiplier/?activeTab=map&currentTimeframe=0&selectedDistributions=fmap-percentage&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D

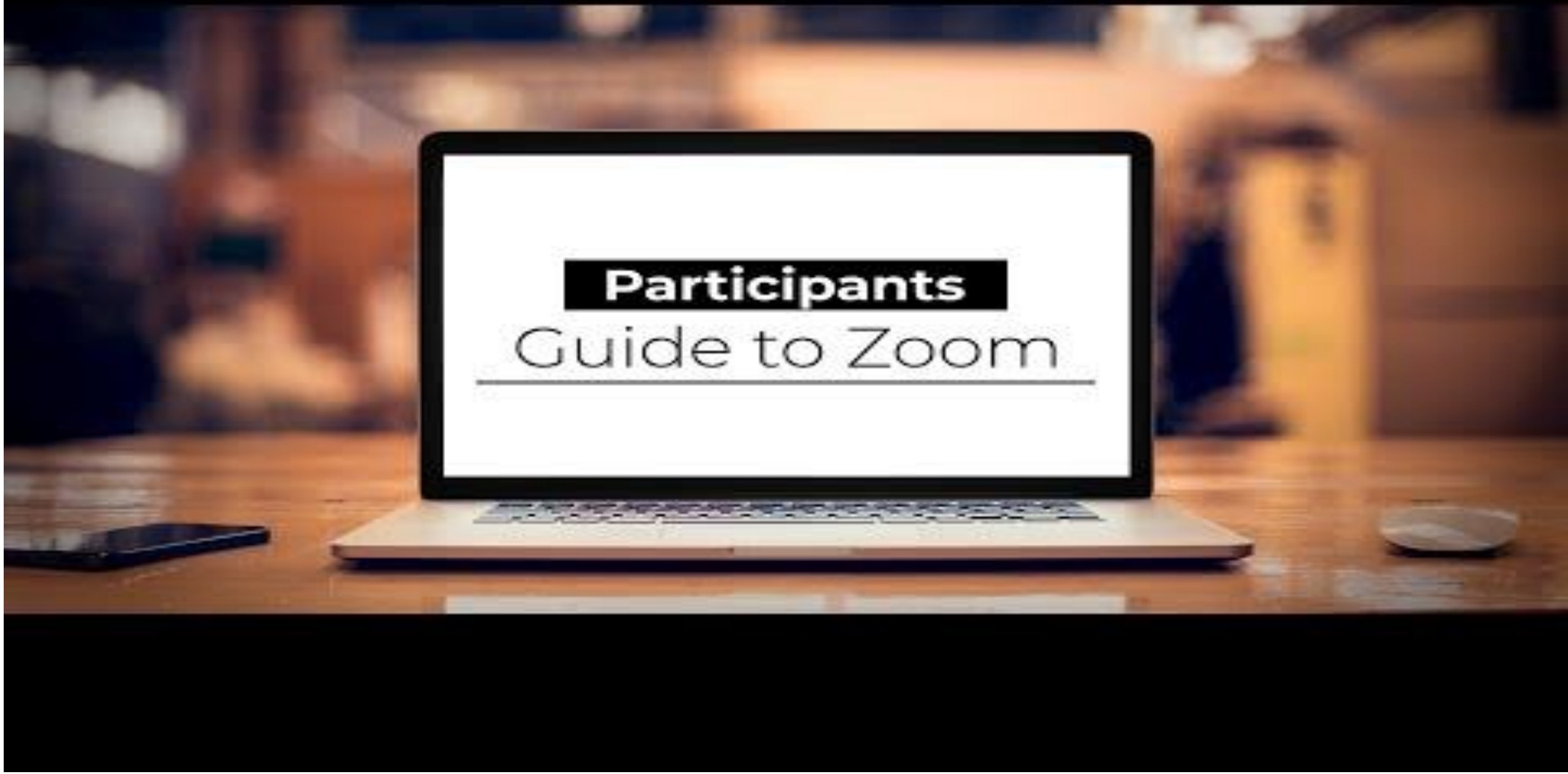
PROPORTION OF NM'S 2018 MEDICAID MANAGED CARE EXPENDITURE SPENT ON PRIMARY CARE

- NM MEDICAID = 6.6% OF TOTAL HEALTH CARE EXPENDITURE SPENT ON PRIMARY CARE
- NATIONAL AVG = 11.2%

- Numerator: $201,065,345
  - Primary Care Expenditure: All billed expenditures toward office-based outpatient visits to primary care practitioners and providers
- Denominator: $3,052,309,843
  - Total Health Care Expenditures
    - Primary Care, In-Patient Care, Nursing Home, Physician Services, Specialty Care, Pharmacy, Dental, Behavioral Health, Outpatient Clinics, Home Services, and Community Services

Primary Care Practitioners and Providers Used to Determine NM's Primary Care Expenditure

Practitioners	Providers
• Family Medicine • General Practice • General Internal Medicine • General Pediatrics • Geriatrics • Nurse Practitioners • Physician Assistants	• Federally Qualified Health Clinics • Indian Health Service/ Tribal Health Providers/ Urban Indian Providers • Primary Care • Rural Medicine


Participants
Guide to Zoom

NM PRIMARY CARE COUNCIL MEMBERS

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

EILEEN GOODE, RN

- CEO, NM Primary Care Association
- Contribution/Strength: Eileen Goode, representing the state's Federally Qualified Health Centers, is a native New Mexican with rural roots, is an RN with 40+ years' experience, in primary care and community health.
- Personal Goal: I hope to contribute to the team and as a result, have a clear definition of team-based primary care and discover ways to increase access and improve the health of New Mexicans.

JENNIFER K. PHILLIPS, M.D.

- Professor & Associate Chair, Family Medicine, UNM School of Medicine
- Contribution/Strength: I am a family doctor at UNM with a large panel of patients that I have cared for more than 15 years. I have also been a medical director for 15 years and have been in multiple leadership roles in the UNM health system. Now I am interim CMO for the UNM medical group.
- Personal Goal: Help improve the health of New Mexico, connect my work to improve and expand primary care in the UNM Health system with state efforts, address health equity and the social determinants of health/health related social needs for our state to improve health and as part of 'advanced primary care', include integrative medicine in primary care as 'advanced primary care.'

KATHY R. FRESQUEZ-CHAVEZ, NP

- CEO, Bella Vida Healthcare
- Contribution/Strength: I am an enthusiastic, dedicated, Doctor of Nursing Practice (DNP) and Family Nurse Practitioner who owns a small healthcare clinic in a rural community. As a strong Hispanic woman, working through my own trials and tribulations in life, have learned the importance of kindness, and teamwork to achieve momentous goals.
- Personal Goal: My goal is to improve healthcare in New Mexico by providing better access and affordability to the people of New Mexico. Bringing my experience as a Nurse Practitioner and a small business owner I will bring my unique perspectives to meet the challenges of healthcare in New Mexico.

LORI ZINK, M.D.

- Physician, BCA Pediatrics
- Contribution/Strength: I bring the first-person perspective of a primary care pediatrician in private practice in rural New Mexico.
- Personal Goal: Help expand primary care in New Mexico and add a clinician's perspective to the council.

MATTHEW PROBST, PA

- Chief Quality Officer, El Centro Family Health
- Contribution/Strength: My strength is strategic vision with action to force multiply limited resources in the power of “we.”
- Personal Goal: Reshaping primary care in NM to lead the US into implementation of a high-quality primary healthcare system which puts people before profit to provide accessibility to everyone as a human right.

VALORY WANGLER, M.D.

- Family Medicine Program Director, Rehoboth McKinley Christian Health Care Services
- Contribution/Strength: As a family physician working in rural Northwest New Mexico for the last decade in hospital leadership in both the governmental (IHS) and non-profit sectors, I bring extensive knowledge of the regional primary care environment, and I lead efforts to increase primary care medical student and graduate medical education in the Four Corners.
- Personal Goal: Provide valuable input to the future of primary care in NM.

LAURA PARAJON, M.D.

- Deputy Secretary, NM Department of Health
- Contribution/Strength: I am bringing my experience working in community based primary health care with the WHO Collaborating Center for Human Resources in Health where public health and primary health care services are closely linked.
- Personal Goal: To contribute to the community engagement, public health and partnership component of integration of these elements with primary care, as well as learn from my colleagues.

JEFFREY B. CLARK, M.D.,MPH, MSS, FAAFP (JEFF)

- Human Services Department/Medicaid Assistance Division
- Contribution/Strength: I served with Army for 35 years in operational and garrison assignments ranging from direct patient care to leadership at the clinic, department, hospital, academic medical center, health system, region, and enterprise levels; our Team developed and executed policy at each level.
- Personal Goal: Professional and personal growth via working with a diverse Team of professionals with myriad experiences, insights, and perspectives dedicated to an important and challenging mission; guiding and leading change.

JULIE WEINBERG

- Director, Life and Health Division, NM Office of Superintendent of Insurance
- Contribution/Strength: My 32 years of experience and work in government-sponsored health coverage program policy, funding and operations, including more than 4 years as NM Medicaid Director and 6 years working in Medicaid and Medicare health plans, plus my passion for health system innovation and reform, and genuine health equity will allow me to contribute a unique, collegial and productive perspective to the Primary Care Council's mission.
- Personal Goal: Personal satisfaction that the work will help to improve the lives of my neighbors, people in my immediate community and all New Mexicans.

ALISHA PARADA, M.D.

- Chief, Division of General Internal Medicine, Geriatrics and Integrative Medicine, UNM Health Sciences Center
- Contribution/Strength: I have experience on several boards and medical societies which give me insight to various challenges that our state faces regarding our primary care work force.
- Personal Goal: I want to serve our state and learn more about how to Improve Primary care for our community and be a part of a group that can direct and implement changes for the greater good.

ANJALI TANEJA, M.D.

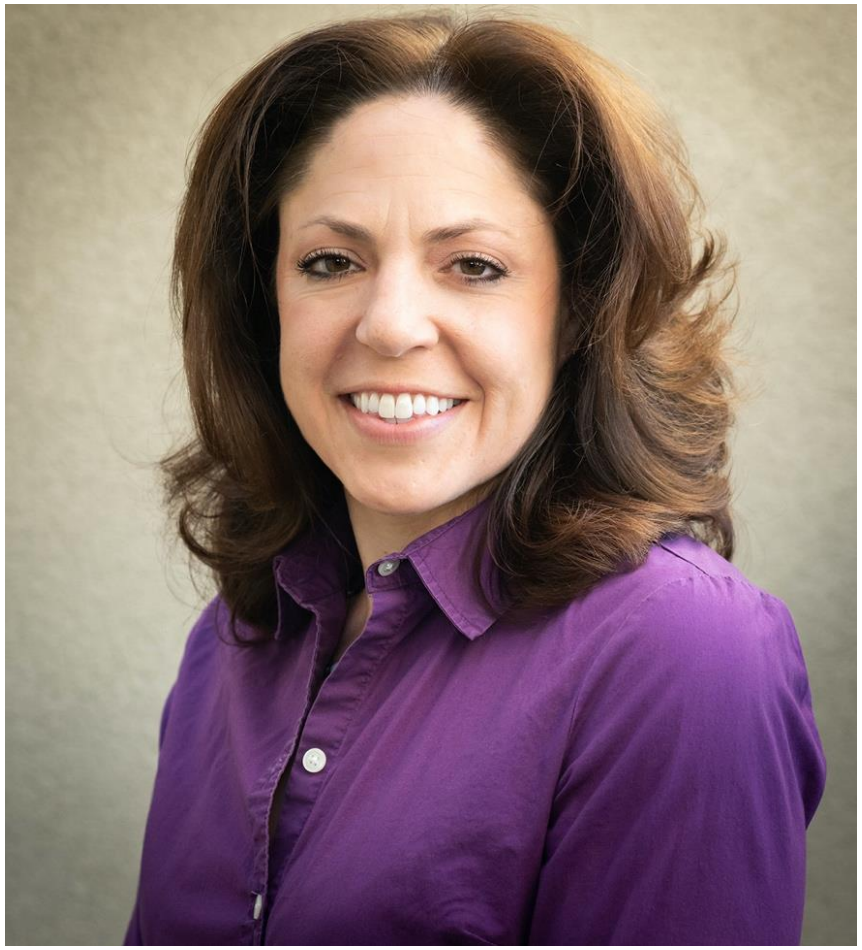
- Executive Director, Casa de Salud
- Contribution/Strength: Bring prior expertise in curating online networks of healthcare workers, in serving on the board of national physician's organization, directing out of state value based intensive ambulatory model of care and brings current expertise in building local innovative healthcare and healing spaces and in visioning a successful anti-racist healthcare workforce development program here in New Mexico.
- Personal Goal: I'm hopeful to be engaged with an amazing group of innovators across various sectors, and to dream towards a (radically) new way of doing primary care in NM, one that would best serve our communities and that would recruit and retain healthcare providers and health workers (CHWs, coaches, MAs, etc).

CINDY BROWNING

- CEO, Cañoncito Band of Navajo Health Center
- Contribution/Strength: I have over 30 years of diverse financial accounting background, a solid understanding of rural patient accessibility needs, and experience identifying measurable outcomes of meeting objectives and goals.
- Personal Goal: Improve access, increase quality, and decrease cost of primary care throughout the state.

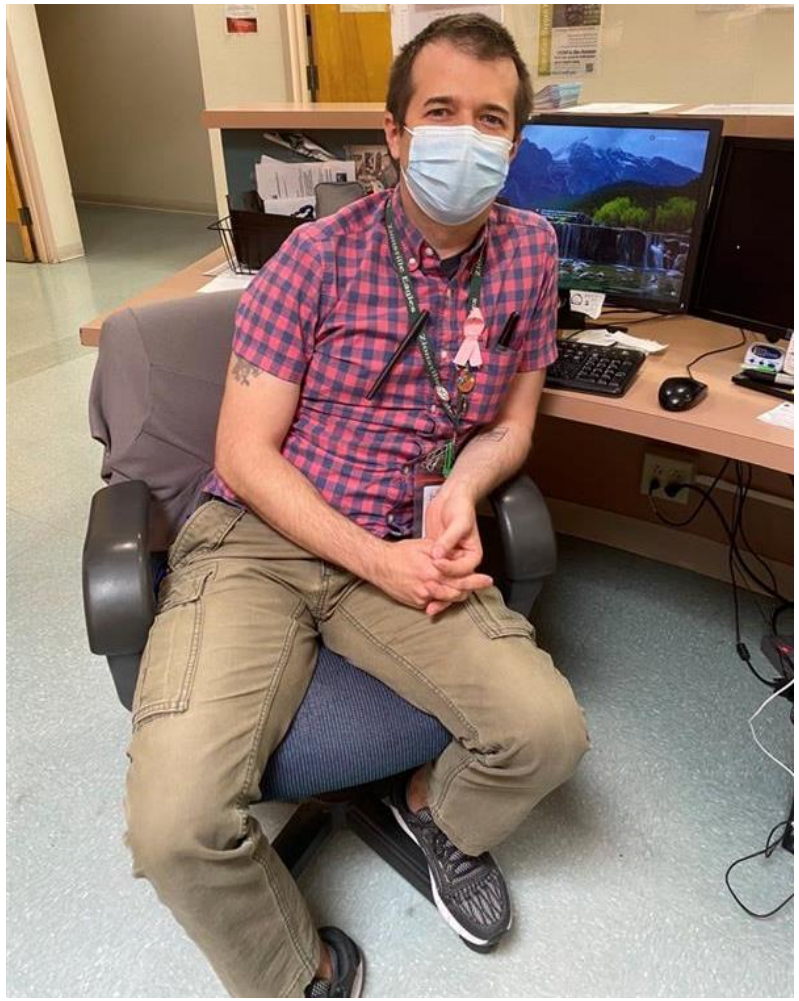
GRETCHEN RAY, PHARMD.

- Assoc. Professor pf Pharmacy Practice, UNM College of Pharmacy
- Contribution/Strength: As a pharmacist clinician (PhC) I provide focused diabetes and cardiovascular risk reduction medication management to patients within two primary care clinics, and I hope to provide insight to the team as to how pharmacists and PhCs can contribute to the primary care model.
- Personal Goal: Assist the council by providing insight to the group as to how pharmacist clinicians can enhance and grow the inter professional primary care model.



JON HELM, RN

- Nurse Flow Manager, First Choice Community Healthcare
- Contribution/Strength: The strength I bring is that I work in a clinic 40 hours per week and train new nurses to primary care. I listen to patients and providers needs all day and have a unique perspective about what our future shall be.
- Personal Goal: A health care delivery system that works for the citizens of New Mexico.



MAGGIE MCCOWEN, LISW

- Executive Director, NM Behavioral Health Provider Association
- Contribution/Strength: As a lifelong social worker and mental health professional I bring a strong commitment to the contribution behavioral health care can make to strengthening the primary care system in New Mexico.
- Personal Goal: I would like to lend expertise and perspective to the integration of existing behavioral health services into existing primary care practices.

ROHINI MCKEE, M.D.

- Chief Quality & Safety Officer, UNM Hospital
- Contribution/Strength: I bring the perspective of a procedural specialist to the importance of primary care. I am comfortable using data to evaluate outcomes and process in my role as Chief Quality and Safety Office of UNM Hospital and will bring those skills to this group.
- Personal Goal: I am honored to serve and look forward to learning from my colleagues and thinking through the issue of how we change the incentive structure of healthcare in NM to provide high quality primary care to all. Having worked as a specialist surgeon for 13 years, I have seen firsthand the perils of the current system, which has no broad safety net for our patients, and I will find it very fulfilling if I can be a part of a group that changes the infrastructure of health care delivery in our state.

RUBY ANN ESQUIBEL

- Health Policy Coordinator, NM Legislative Finance Committee
- Contribution/Strength: Years of policy and funding experience collaborating to enhance New Mexico's healthcare workforce.
- Personal Goal: Expand PC services across state and payment models.

SCOTT FLURY

- Patient Advocate, La Clínica del Pueblo de Rio Arriba
- Contribution/Strength: Spent the past 20 years working to expand rural healthcare services in the Chama Valley.
- Personal Goal: Ways to assure comprehensive healthcare in all parts of New Mexico looking at a team approach and assuring funding is available now in the long term for those services.

SUSAN WILSON

- Executive Director, NM Coalition for Healthcare Value
- Contribution/Strength: I represent the New Mexico Coalition for Healthcare Value. I bring to the Task Force an understanding of how employers view the healthcare system, how they pay for the healthcare system and how they measure the healthcare system.
- Personal Goal: Creating a high-quality primary care system for all New Mexicans.

TROY CLARK

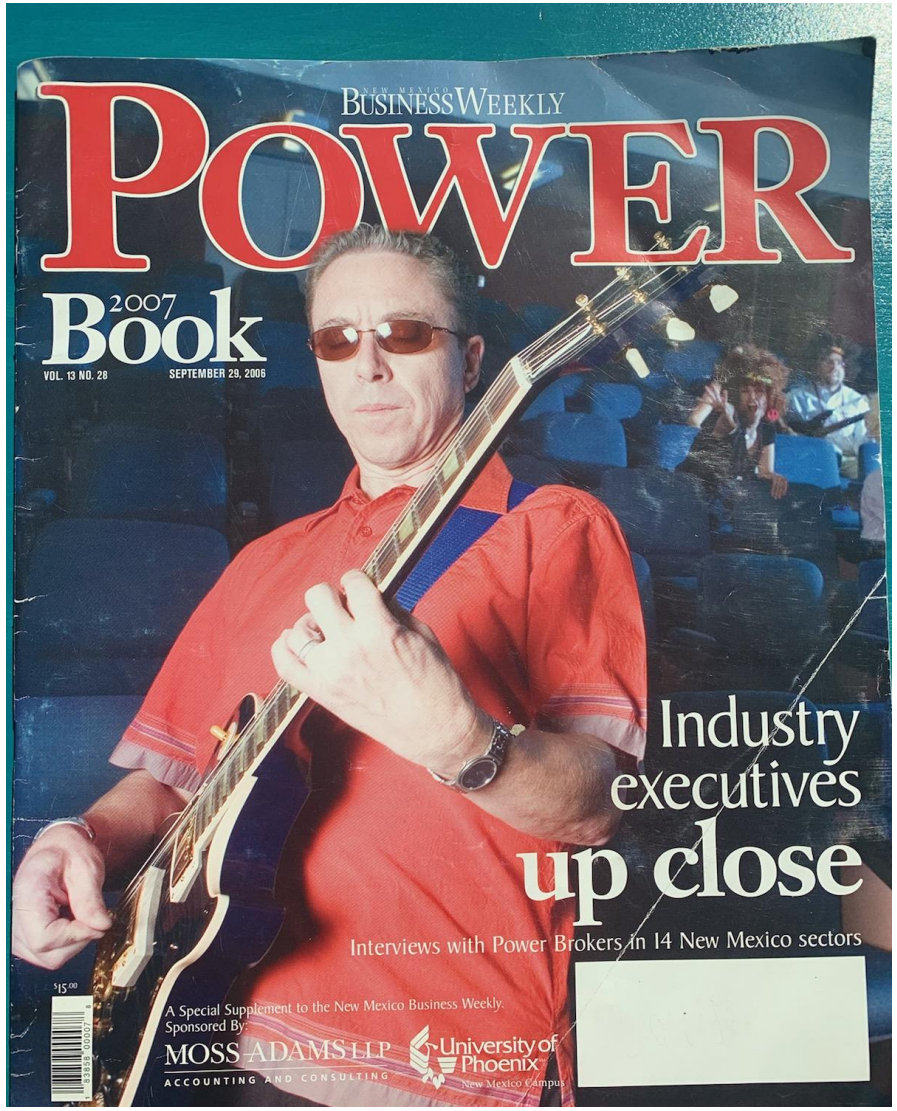
- President & CEO, NM Hospital Association
- Contribution/Strength: A strength I bring is my background and experience with population health and managing large physician practice groups with a large contingent of Primary Care.
- Personal Goal: Provide perspective of achieving something realistic and attainable for the primary care needs of New Mexicans.

WEI-ANN BAY, M.D.

- Chief Medical Officer, Blue Cross and Blue Shield of NM
- Contribution/Strength: I hope to contribute a payer's perspective as well as my experience in the practice of primary care.
- Personal Goal: Knowledge about primary care spending in general and in New Mexico, understand and learn where NM's primary care providers are on the issue, their readiness to transform from quantity to quality, what their needs are in practice transformation, understand how payers can impact primary care spend - using the knowledge learned from serving on the council, engage discussions with other payers in the state in a multi-payer strategy to implement high quality primary care.

DAVID R. SCRASE, M.D.

- Cabinet Secretary for NM Health and Human Services Department; Acting Secretary, NM Department of Health
- Strength/Contribution: Ability to bring diverse people together to achieve a common goal; math.
- Personal Goal: To ensure every New Mexican can be seen by their primary care team within 48 hours.



ALEX CASTILLO SMITH

- HSD Manager, Strategic Planning & Special Projects
- Strength/Contribution: cat-herder in-chief; like to ask wow (not how); focused on justice
- Personal Goal: New Mexicans to have the ability to see Primary Care teams who they can relate to when needed and at low-cost.

AUDREY COOPER

- Soon-to-be HSD Project Manager, Food Security & Primary Care
- Strength/Contribution: justice-minded; belief in possibility of big ideas.
- Personal Goal: New Mexicans have accessible and equitable partnerships with the system of primary care resulting in ubiquitous health and wellbeing of both clients and clinical personnel.

SARAH CRISCUOLO

- HSD Policy Fellow
- Strength/Contribution: Wide eyes and enthusiastic to learn.
- Personal Goal: Help foster avenues of communication between clinical professionals, those that receive primary care in New Mexico, and state government employees to facilitate conversations that enact macro-level policy change.

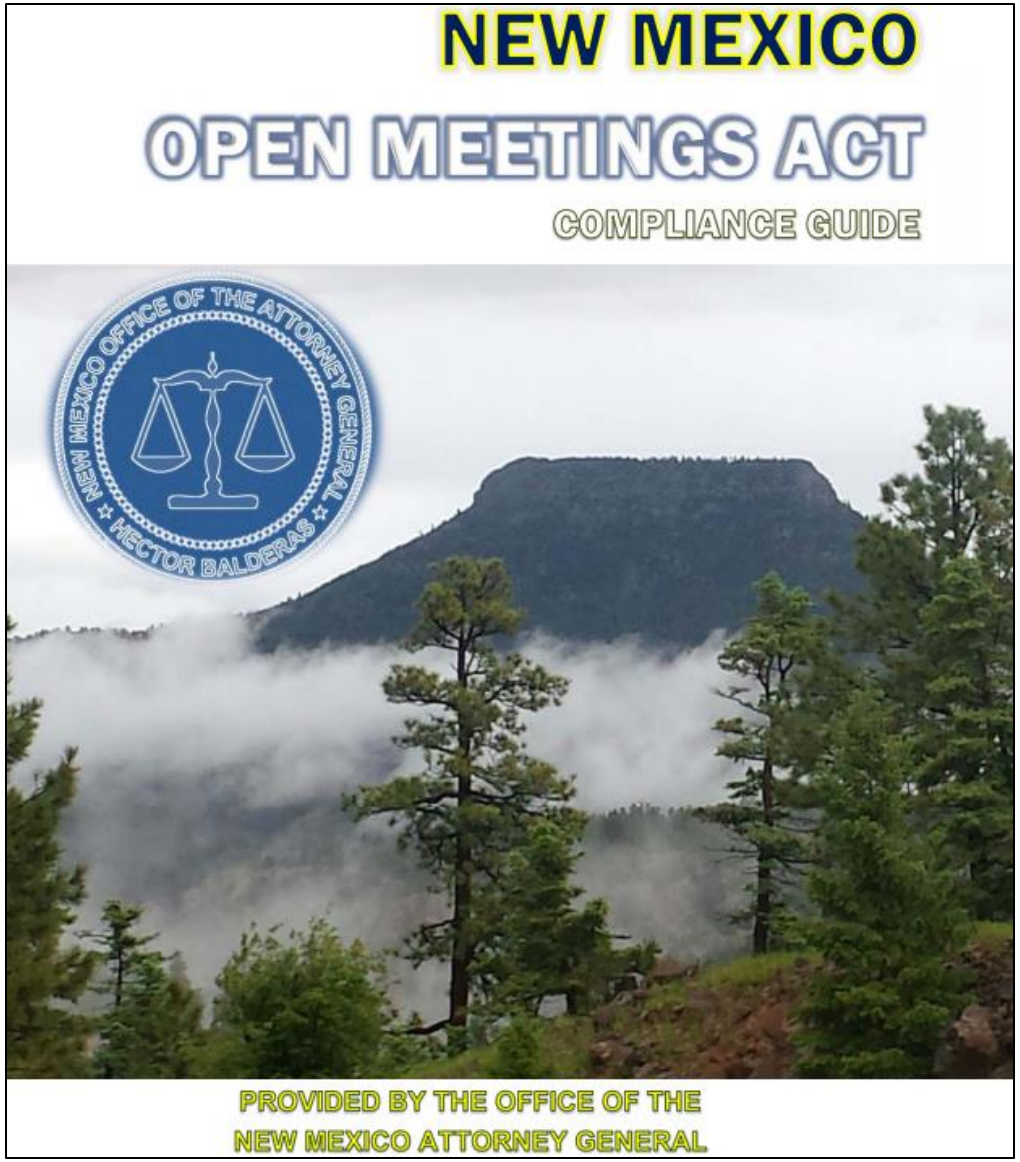
HUMAN SERVICES DEPARTMENT

OPEN MEETINGS ACT OVERVIEW & RESOLUTION ADOPTION

INVESTING FOR TOMORROW, DELIVERING TODAY.

SUNSHINE LAWS

- Require public business be conducted in full public view, actions of public bodies be taken openly, and deliberations of public bodies be open to the public.
- **Open Meetings Act** is a NM law pertinent to our work.



OPEN MEETINGS ACT

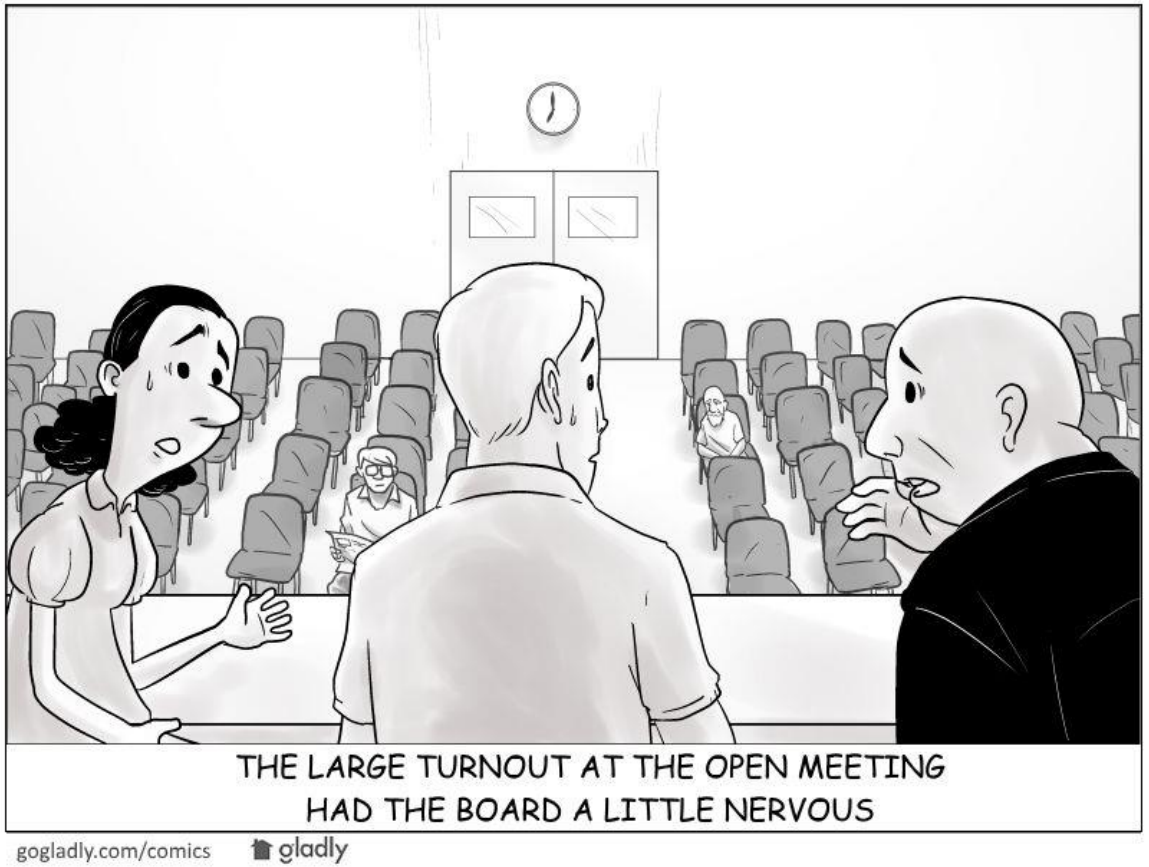
- **All meetings** of a public body that formulate public policy, discuss public business, or take any action within the authority of body **are open to the public at all times**.*
- Any meetings that discuss/adopt any proposed resolution, rule, regulation or action at which a majority or quorum of the body is in present- including any closed meetings- shall be held only after **reasonable notice** to the public.
- The body shall keep **written minutes** of all meetings, including date, time and place, attendee names and absent members, substance of discussions, and record of any decisions and votes.

*closed meetings or other instances allowed under the NM Constitution or Open Meetings Act

OPEN MEETINGS ACT

Subsection H of the Open Meetings Act permits closed meetings in few instances.

- During open meeting: Moving to closed meeting shall be approved by majority of quorum; vote shall be taken in open meeting; and vote of each individual member shall be recorded in minutes.
- Outside of open meeting: Closed meeting shall not be held until public notice stating specific provision of law authorizing closed meeting and stating with reasonable specificity subject to be discussed is published.



OPEN MEETINGS RESOLUTION ADOPTION (VOTING MEMBERS)

- Declares Council adhere to Act
- Proposes posting notices on HSD's website not less than 72 hours prior to meeting
- Identifies when Council will meet: 3rd Wednesday of 1st month of each state fiscal year quarter (July, October, January, and April)

HUMAN SERVICES DEPARTMENT

STATE OF NEW MEXICO
Michelle Lujan Grisham, Governor
David R. Scrase, M.D., Secretary for Human Services Department
Kari Armijo, Deputy Cabinet Secretary
Angela Medrano, Deputy Cabinet Secretary
Nicole Comeaux, JD, MPH, New Mexico State Medicaid Director

New Mexico Primary Care Council
OPEN MEETINGS RESOLUTION – July 24, 2021

WHEREAS, House Bill 67 (HB67) seeks to increase access to primary care, improve the quality of primary care services, lower the cost of primary care delivery, address the shortage of primary care providers, and overall reduce the health care costs throughout the state.

WHEREAS members of the Council will do this work in collaboration and consultation with HSD; and,

WHEREAS the Primary Care Council is required to follow the Open Meetings Act (NMSA 1978, Sections 10-15-1 to 4); and

WHEREAS Sections 10-15-1(B) of the Open Meetings Act states that, except except as may be otherwise provided for in the New Mexico Constitution or the provisions of the Open Meetings Act, all meetings of a quorum of members of any board, commission, administrative adjudicatory body or other policymaking body of any state agency, any agency or authority of any county, municipality, district or any political subdivision held for the purpose of formulating public policy, discussing public business, or for the purpose of taking any action within the authority of or the delegated authority of such body, are declared to be public meetings open to the public at all times; and

WHEREAS Section 10-15-1(D) of the Open Meetings Act states that any meeting subject to the Open Meetings Act at which the discussion or adoption of any proposed resolution, rule, regulation, or formal action occurs shall be held only after reasonable notice to the public; and

WHEREAS Section 10-15-1 (D) of the Open Meetings Act requires the Primary Care Council to determine annually what constitutes reasonable notice of its public meetings.

NOW, THEREFORE, BE IT RESOLVED:

The Primary Care Council shall hold its regular meetings on the third Wednesday of the first month of each state fiscal year quarter (July, October, January, and April) at a location that will be determined for each meeting and be named in the public notice for that meeting.

Established meeting dates, times and locations shall be subject to change on the order of the Secretary of the Human Services Department or in the absence of the Secretary, the Board Chairperson.

HUMAN SERVICES DEPARTMENT

RESOLUTION ADOPTION

INVESTING FOR TOMORROW, DELIVERING TODAY.

HUMAN SERVICES DEPARTMENT

BREAK

10 MINUTES

INVESTING FOR TOMORROW, DELIVERING TODAY.

HUMAN SERVICES DEPARTMENT

BACKGROUND & COUNCIL OVERVIEW

INVESTING FOR TOMORROW, DELIVERING TODAY.

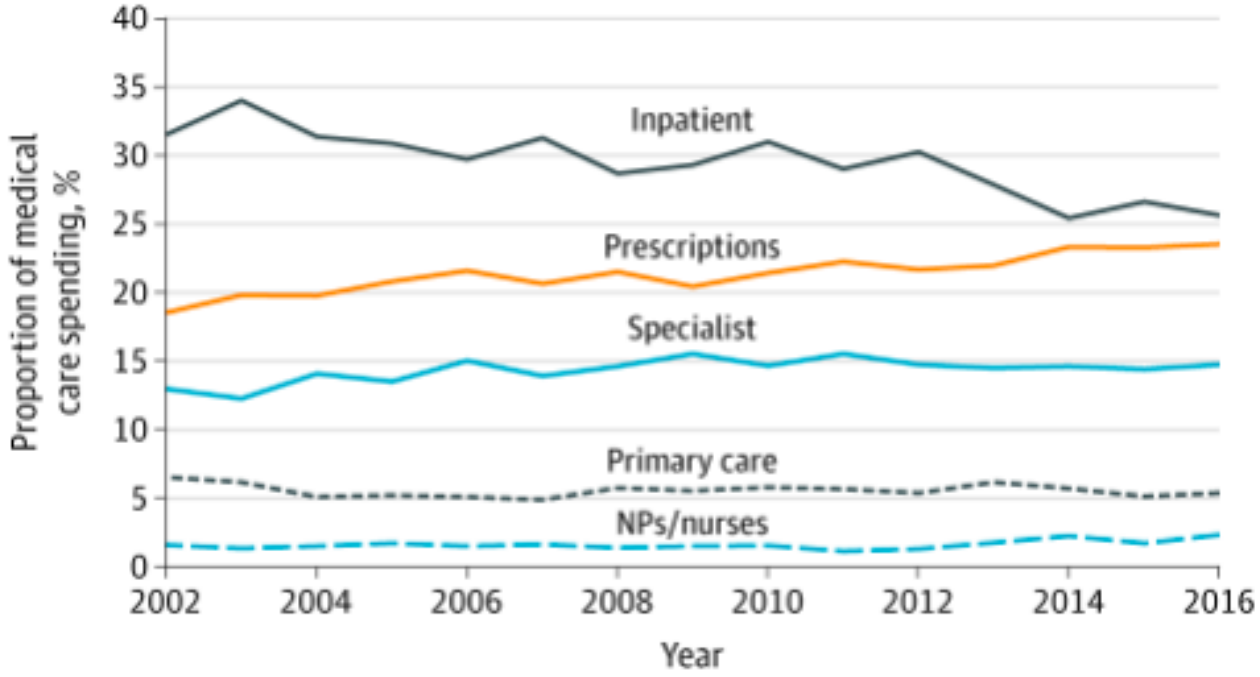
SESSION OVERVIEW

- House Bill 67 Overview
- Healthcare FTE Analysis Presentation
- Summary of Readings
- Defining Primary Care

NEW MEXICO PRIMARY CARE COUNCIL

- House Bill 67 enacted during 2021 legislative session, established Council to:
- "Increase access to primary care, improve the quality of primary care services, lower the cost of primary care delivery, address the shortage of primary care providers and reduce overall health care costs" statewide.
- Council consist of 22 members representing state agencies, Federally Qualified Health Centers, providers, and other healthcare stakeholders.
- Among other duties, Council will "coordinate efforts with GME Expansion Board and other… initiatives to devise a plan that addresses primary care workfare shortages within the State."

Trends in Spending for Select Types of Medical Care, U.S.



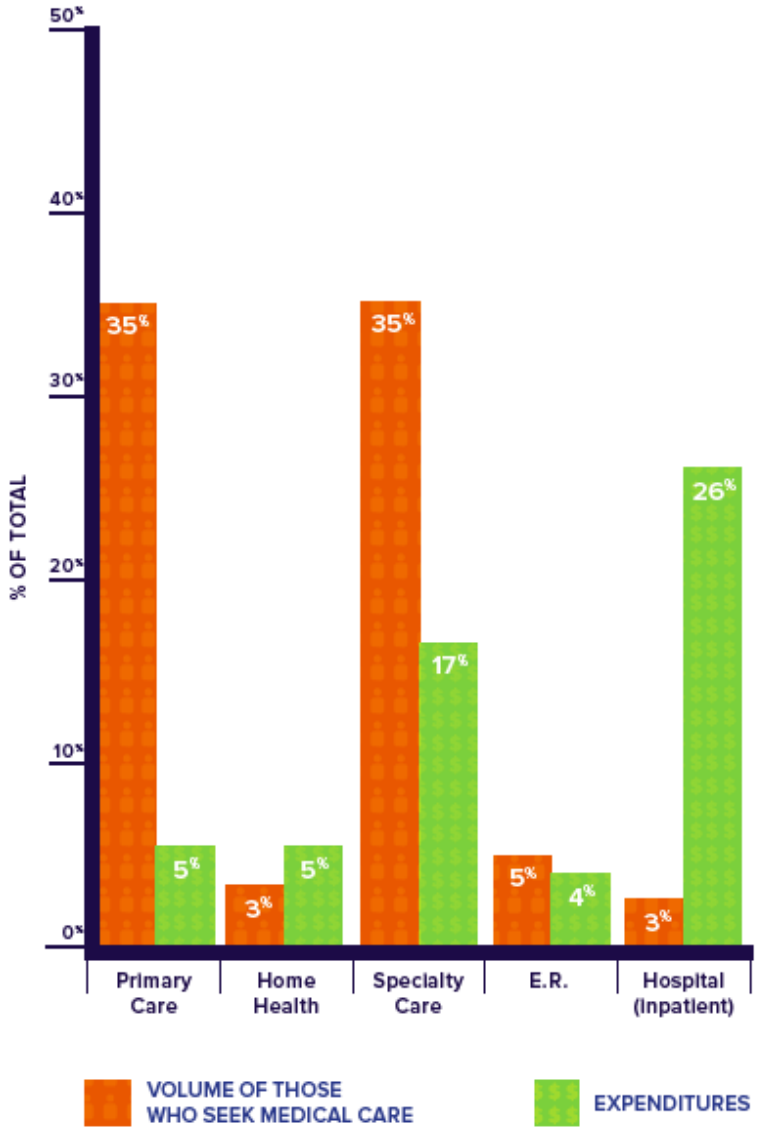
Source: JAMA. NP indicates nurse practitioner. Data from Medical Expenditure Panel Survey.

HOUSE BILL 67: PRIMARY CARE COUNCIL ACT

Council Specified Duties

1. Develop a shared description of primary care practitioners and services.
2. Analyze annually the proportion of health care delivery expenditures allocated to primary care statewide.
3. Review national and state models of optimal primary care investment with the objectives of:
   - Increasing access to primary care.
   - Improving the quality of primary care services.
   - Lowering the cost of primary care delivery statewide.
4. Review New Mexico state and county data and information about barriers to accessing primary care services faced by New Mexico residents.
5. Recommend policies, regulations and legislation.

Medical Care Visits Versus Expenditures Using Panel Survey Data



Source: https://www.nap.edu/catalog/25983/implementing-high-quality-primary-care-rebuilding-the-foundation-of-health

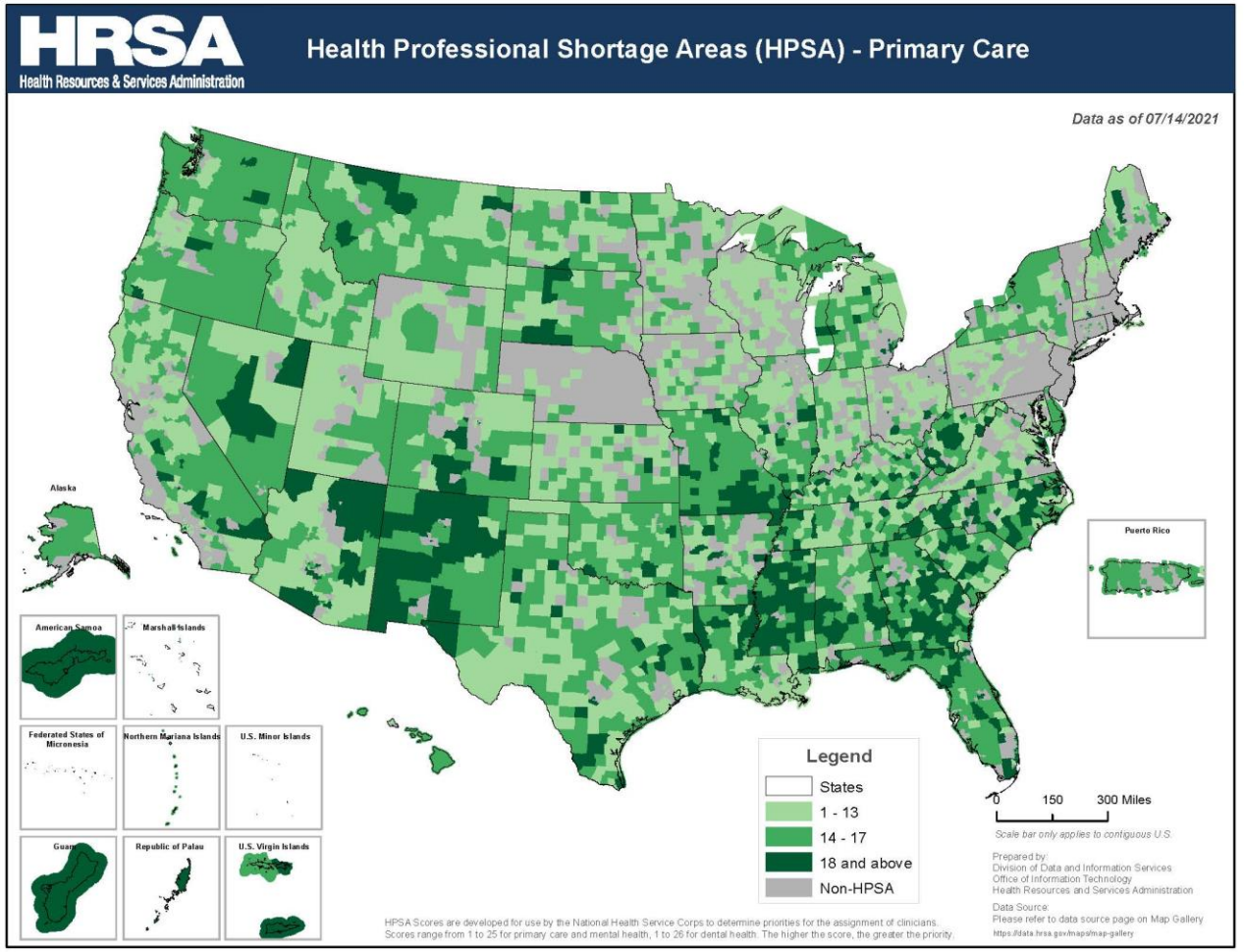
HOUSE BILL 67: PRIMARY CARE COUNCIL ACT

Council Specified Duties

6. Coordinate efforts with the Graduate Medical Education Expansion Review Board and other primary care workforce development initiatives to devise a plan that addresses primary care workforce shortages within the state

7. Report annually to the Interim Legislative Health and Human Services Committee and the Legislative Finance Committee

8. Develop and present to the Secretary a five-year strategic plan to determine how primary care investment could:
   - Increase access to primary care
   - Improve the quality of primary care services
   - Lower the cost of primary care delivery
   - Address the shortage of primary care providers
   - Reduce overall health care costs

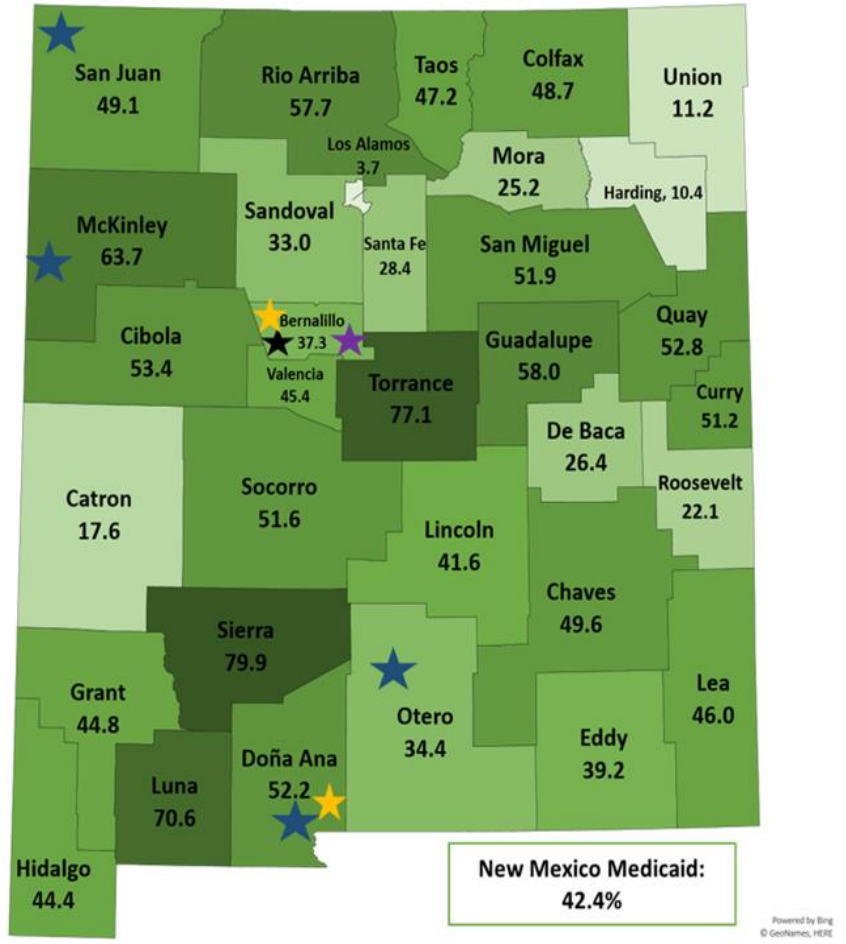


Source: https://data.hrsa.gov/ExportedMaps/MapGallery/HPSAPC.pdf

PRIMARY CARE GRADUATE MEDICAL EDUCATION EXPANSION

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

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



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

HUMAN SERVICES DEPARTMENT

QUESTIONS AND COMMENTS?

INVESTING FOR TOMORROW, DELIVERING TODAY.

HUMAN SERVICES DEPARTMENT

OVERVIEW OF READINGS

INVESTING FOR TOMORROW, DELIVERING TODAY.

OVERVIEW OF READINGS

Pages xi-xiii, 3-18, and other sections based on your interest

40-page state-level analysis from the Patient-Centered Primary Care Collaborative

Unified Voice, Unified Vision, Changing Primary Care Finance

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

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

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

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

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

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

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

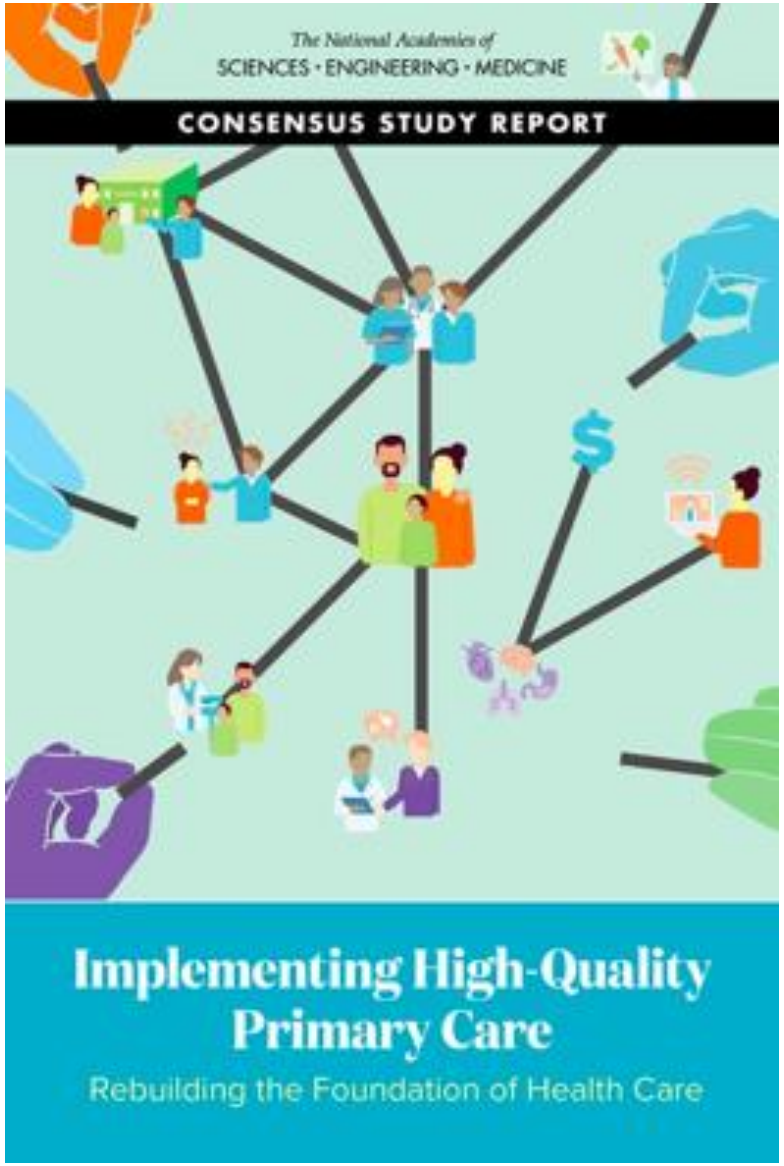
www.newprimarycareparadigm.org

1-page call-to-action piece from the New Primary Care Paradigm

THE NATIONAL ACADEMIES OF SCIENCES, ENGINEERING, & MEDICINE (NASEM)

Implementation Goals ("Objectives")

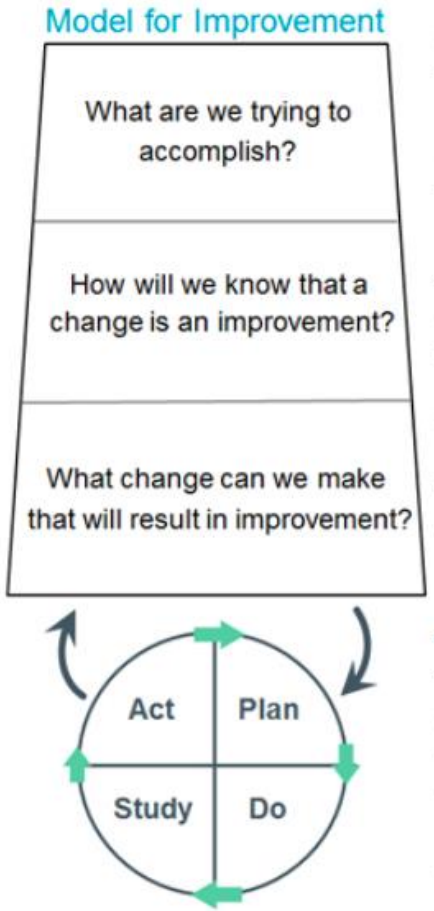
1. Pay for primary care teams to care for people, not doctors to deliver services.
2. Ensure high-quality primary care is available to every individual and family in every community.
3. Train primary care teams where people live and work.
4. Design information technology that serves patient, family,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



Source: https://www.nap.edu/catalog/25983/implementing-high-quality-primary-care-rebuilding-the-foundation-of-health

MODEL FOR IMPROVEMENT: RECOMMENDATIONS TO IMPROVE PRIMARY CARE

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



HUMAN SERVICES DEPARTMENT

Investing for tomorrow, delivering today.

IMPLEMENTING HIGH-QUALITY PRIMARY CARE (NASEM)

- Primary Care associated with better population health and equitable outcomes. Primary care is a common good, making strength and quality of U.S. primary care services public concern.
- Facilitators of High-Quality Primary Care:
  - Payment Models
  - Accountability and Improving Quality
  - Digital Health Care
  - Interprofessional Care Teams
  - Research
  - Leadership
  - Policy, Laws, and Regulations

Why the 1996 Recommendations Failed to Gain Traction
1. Lack of Centralized Accountability
2. Demise of Health Care Reform
3. Limited Implementation of Newer Models of Care Delivery
4. Lack of Collaboration to Improve Education and Training
5. Erosion of Primary Care Workforce
6. Lack of Primary Care Research Agenda
7. Misaligned Payment Models
8. Fragmentation of U.S. Healthcare System

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

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

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

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

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QUESTIONS AND COMMENTS?

INVESTING FOR TOMORROW, DELIVERING TODAY.

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DEFINING PRIMARY CARE

INVESTING FOR TOMORROW, DELIVERING TODAY.

HOW DO WE WANT TO DEFINE PRIMARY CARE?

DEFINITION INCLUDED IN SURVEY

Primary care is the provision of integrated, accessible, health care services by clinicians who are accountable for addressing a large majority of person health care needs, developing a sustained partnership with patients, and practicing in the context of the family and the community.

NEW & PROPOSED DEFINITION

High-quality primary care is the provision of whole-person, integrated, accessible, and equitable healthcare by interprofessional teams who are accountable for addressing majority of an individual's health and well-being across settings and through sustained relationships with patients, families, and communities. (NASEM, June 2021)

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QUESTIONS AND COMMENTS?

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PUBLIC COMMENT

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LUNCH

INVESTING FOR TOMORROW, DELIVERING TODAY.

MEETING AGENDA – 2ND HALF

Meeting Section	Time	Presenter	Agenda Item
Lunch Break	12:00PM – 1:00PM	-	Break
Part 3 – Strategic Planning	1:00PM – 1:10PM	Alex Castillo Smith	Strategic Planning Overview
	1:10PM – 1:30PM	Sarah Criscuolo	Review Survey Results & Determine Mission
	1:30PM – 1:40PM		Review Survey Results & Determine Vision
	1:40PM – 2:15PM		Review Survey Results & Identify Goals
Short Break	2:15PM – 2:25PM	-	Break
Part 4 – Council Plans and Expectations Moving Forward	2:25PM – 2:30PM	Sec. David Scrase	Review Second Meeting Agenda
	2:30PM – 3:10PM	Sarah Criscuolo	Identify Workgroups & Accountability Measures
Public Comment	3:10PM – 3:25PM	Alex Castillo Smith	Public Feedback, Comments, and Questions
Reflection	3:25PM – 4:00PM	Jeff Clark	Council Feedback, Comments, and Questions

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STRATEGIC PLANNING

INVESTING FOR TOMORROW, DELIVERING TODAY.

SESSION OVERVIEW

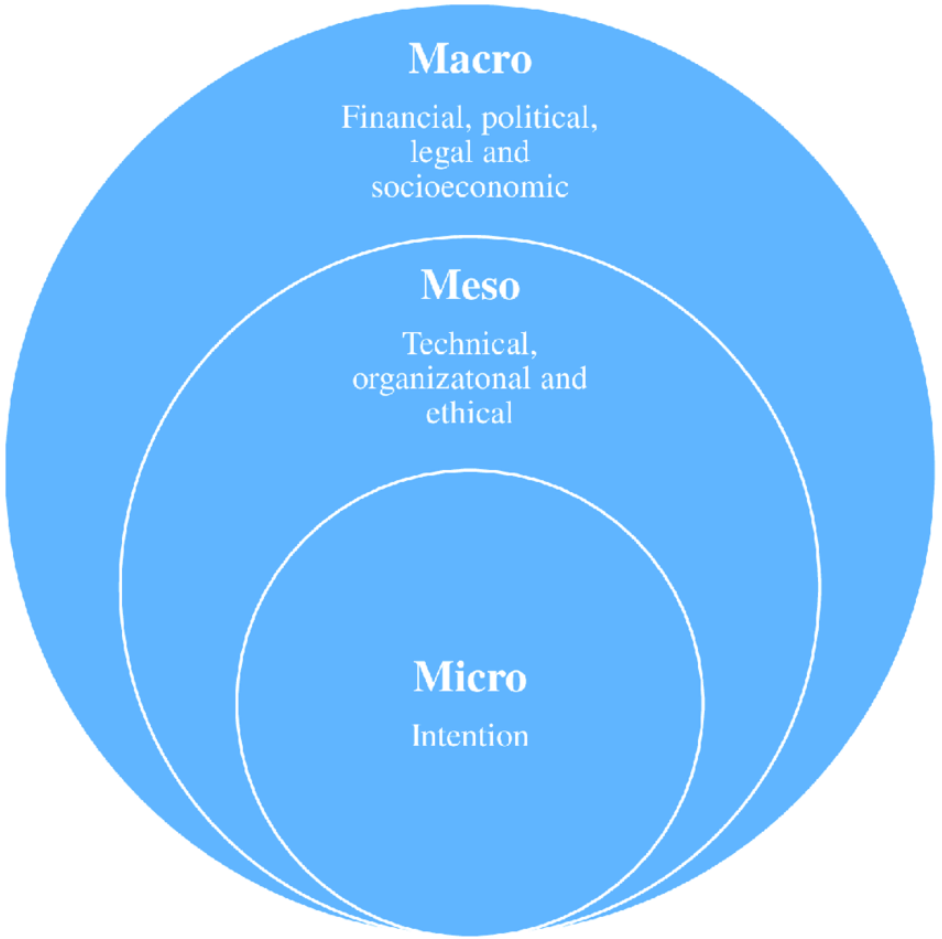
- Strategic Planning Overview
  - **Mission**
  - **Vision**
  - **Goals**
  - Objectives & Tactics
- Review Survey Results
- Determine Mission & Vision
- Identify Goals

PRIMARY CARE IMPLEMENTATION STRATEGY (NASEM)

1. Framework with 3 levels of change (micro, meso, and macro) accounting for complexity of U.S. health care system and its public- and private-sector actors.

2. Accountability framework establishing structure and process for assessing adequacy and completeness of activities.

3. Public policy framework develops government policy to implement high-quality primary care, consistent with its status as a common good.



MISSION: WHAT IS OUR PURPOSE?

- Written declaration of an organization's core purpose and focus that normally remains unchanged over time.
- Properly crafted mission statements:
  - serve as filters to separate what is important from what is not,
  - clearly state which markets will be served and how,
  - communicate a sense of intended direction, and
  - Should be 25 words or less.

VISION: WHAT DO WE WANT THE FUTURE LOOK LIKE?

- Aspirational description of what an organization would like to achieve or accomplish in mid-term or long-term future.
- Intended to serves as clear guide for choosing current and future courses of action.

GOALS: WHAT ARE OUR DESIRED OUTCOMES?

- Goals are broad and highest-level outcomes towards which effort and actions are directed.
- They are "what's", not "how's" and we might have multiple goals to achieve.
- Normally contain a verb.
- There is no measurement, instead provides general direction of the work.
- Time frame: 2-5 years

OBJECTIVES: PLAN THAT TURNS WHAT WE *HAVE* INTO WHAT WE *WANT* TO GET WHAT WE *NEED*.

- Objectives differs from goals in that they are measurable and specific.
- Quantify and set target so strategy can be planned around it.
- For example, “increase the number of primary care practitioners by 15% in 2 years” or “develop a succession plan for retiring physicians” would be objectives.
- Time frame: 1-2 years.

TACTICS: TRANSLATE STRATEGY INTO ACTIONS THAT ARE LEARNED FROM AND BUILT UPON

- Tactics are actions or tools a work group takes to achieve their objectives.
- They are "how's," not "what's."
- Goals, objectives, and tactics must work in tandem.
  - Without tactics you're left with big thinking and no action.
- We need both big wings (strategies/goals) and feet (tactics).
- Time frame: 3-12 months.

WHAT FIVE KEY WORDS/CONCEPTS COME TO MIND WHEN YOU ENVISION THE MISSION OF THE COUNCIL?

- Accessible (15)
- Quality (12)
- Health Equity (8)
- Affordability (7)
- Sustainability (7)
- Collaborative, team-based (6)
- Recommend Policies (5)
- Incentivize Primary Care (4)
- Primary care (3)
- Promote health and well-being (3)
- Consistent (2)
- Data to inform improvement (2)
- Define primary care (2)
- Fund primary care (2)
- Innovation (2)
- Integrated (2)
- Patient/person focused (2)
- Payment equity (2)
- Preventative (2)

KEY IDEAS FOR MISSION

COUNCIL IDEAS

1. Draw from the Primary Care Definition
2. Accessible, access to care
3. High-quality, high-value
4. Health equity
5. Affordability
6. Sustainability
7. Collaborative, team-based

STATUTE (HB 67)

1. Increase access to primary care.
2. Improve quality of primary care services.
3. Lower cost of primary care delivery.
4. Address shortage of primary care providers.
5. Reduce health care costs throughout the state.

PROPOSED MISSION STATEMENT

The Mission of the Primary Care Council is:

- To ensure interprofessional, primary care teams deliver high-quality health care across New Mexico through sustained relationships with patients, families, and communities.

(22 words)

WHAT FIVE KEY WORDS/CONCEPTS COME TO MIND WHEN YOU ENVISION THE VISION OF THE COUNCIL?

- Community-based (11)
- Equitable (8)
- Connected care (6)
- Expansion of GME in PC (6)
- Fiscal responsibilities (6)
- Improved access to care (6)
- Improved provider experience (6)
- High-quality (5)
- Improve the health of NM by 2030 (5)
- Affordable (4)
- Nationally excellent outcomes (4)
- Outstanding care (4)
- Transformative recommendations (4)
- Chronic disease management (3)
- Sustainable Change (3)
- Wellness (3)
- Adopt other models (2)
- Comprehensive (2)
- Cultural values (2)
- Improved patient experience (2)
- Increase PC workers (2)
- Innovation (2)

KEY IDEAS FOR VISION

1. Community-based, partnering with community, community-level: Fully integrated, collaborative teamwork
2. Improved population health throughout New Mexico
3. High-quality primary care is available to every individual and family in every New Mexican community
4. Equitable primary care for all New Mexicans – no matter where they live, work, and play.

PROPOSED VISION STATEMENT

The Vision of the Primary Care Council is:

- By 2026, every New Mexican can receive high-quality, equitable, affordable care from their primary care team, and within 48 hours when needed.

(23 words)

REFLECTING ON HB67 AND THE COUNCIL'S CHARGE, PLEASE OUTLINE 3-5 GOALS OF THE COUNCIL

- Determine/Address shortages of PC providers (10)
- Improve PC IT and interoperability (8)
- Value-based payment model (7)
- Increase high-quality primary care (6)
- Determine/Address shortages of PC locations (5)
- Improve access in rural areas (5)
- Compensate PC providers (4)
- Illustrate savings of health care dollars (4)
- Increase funding for PC provider training (4)
- PC teams (4)
- Create PC provider pipeline (3)
- Develop PC strategic plan (3)
- Improve health equity (3)
- Community educational opportunity in healthcare (2)
- Determine definition of PC (2)
- Develop baseline understanding of PC system and costs (2)
- Improve healthcare outcomes (2)
- Integrate Behavioral Health (2)
- Invest in NM health (2)
- PC is available to all (2)
- Recommend policy change (2)
- Safeguards for patients (2)
- Support PC providers in rural/remote locations (2)

KEY IDEAS FOR GOALS

COUNCIL IDEAS

1. Determine and address PC provider shortages
2. Use telehealth, Improve IT and interoperability
3. Shift healthcare financing to value-based payment model
4. Increase high-quality PC
5. Improve access for rural/underserved communities

STATUTE (HB 67)

1. Analyze health care delivery expenditures allocated to PC.
2. Review national and state models of optimal PC investment.
3. Review NM data about barriers to accessing PC.
4. Recommend policies, regulations, and legislation.
5. Coordinate efforts with GME.
6. Report to Interim LHHS Committee and LFC.

PROPOSED GOALS

1. Strategic Plan
Create a 5-year strategic plan that improves access, quality, and lowers the cost of primary care delivery.

2. Payment Strategies
Develop and make recommendations regarding new primary care payment strategies to support sufficient growth and meet needs of New Mexicans.

3. Information Technology
Develop and make recommendations regarding information technology improvements and investments to increase healthcare experience.

4. Sustainability
Work with legislature and other partners to create a sustainable financial model to support our mission.

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

PICK YOUR WORKGROUP!

Goal 1: Strategic Plan	Goal 2: Payment strategies	Goal 3: Information Technology	Goal 4: Sustainability

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QUESTIONS AND COMMENTS?

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BREAK

10 MINUTES

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COUNCIL PLANS & EXPECTATIONS MOVING FORWARD

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SECOND MEETING AGENDA

- October 27, 2021
- Email David if you'd like to be Council Chair
- Present Final Mission, Vision, and Goals
- Review and Ratify Council Objectives and Tactics
- Review Preliminary Strategic Plan (Workgroup 1)

WORKGROUPS & ACCOUNTABILITY MEASURES

- We will now breakout into workgroups (25 mins), with HSD facilitating group discussion as you all:
  - Select a chairperson for workgroup;
  - Agree on date(s) and time(s) for workgroup meeting(s);
  - Decide on amount of time you want to meet between now and **October 27th** to bring substantive recommendations back to the Council; and,
  - Discuss processes and responsibilities for creating workgroup objectives and tactics.

Workgroup	Facilitator
Goal 1	Alex Castillo Smith
Goal 2	Sarah Criscuolo
Goal 3	Jeff Clark
Goal 4	Sec. David Scrase

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GROUP DISCUSSION & REPORT-OUT

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PUBLIC COMMENT

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REFLECTION

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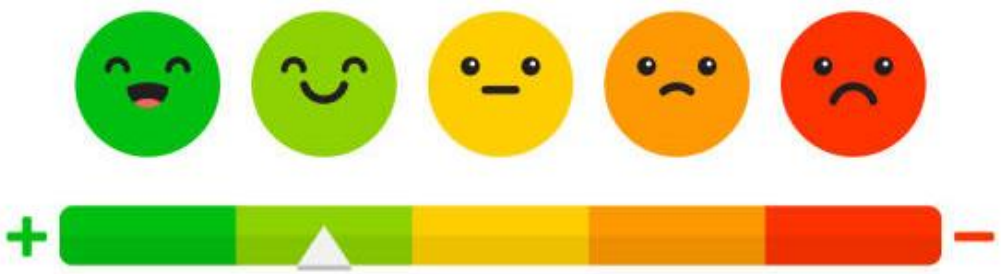
YOUR FEEDBACK IS IMPORTANT TO US

MEETING CONTENT

- How would you describe our progress today?
- What topics would you like to see covered in future meetings?



MEETING DELIVERY

- What worked well? What didn't?
- In what areas can we improve facilitation?
- Do you have any other feedback or suggestions?

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APPENDIX

INVESTING FOR TOMORROW, DELIVERING TODAY.

JASON MITCHELL, M.D.

- Senior Vice President, Chief Medical and Clinical Transformation Officer, Presbyterian Healthcare Services
- Contribution/Strength: I look forward to sharing skills in designing value-based care models and improving the clinician experience.
- Personal Goal: I want to contribute to building a sustainable primary care workforce in NM.

1. PAY FOR PRIMARY CARE TEAMS TO CARE FOR PEOPLE, NOT DOCTORS TO DELIVER SERVICES.

- Implementing high-quality primary care requires committing to pay primary care more and differently given its capacity to improve population health and health equity for all society, not because it generates short-term returns on investment for payers.
- High-quality primary care is not a commodity service whose value needs to be demonstrated in a competitive marketplace but a common good promoted by responsible public policy and supported by private-sector action.
- Implementation of primary care spending policies should attend to the characteristics and practice of what constitutes high-quality primary care in accordance with the committee's definition

2. ENSURE THAT HIGH-QUALITY PRIMARY CARE IS AVAILABLE TO EVERY INDIVIDUAL AND FAMILY IN EVERY COMMUNITY.

- Successfully implementing high-quality primary care means everyone should have access to the "sustained relationships" primary care offers.
- While private primary care practices are not obligated to treat the uninsured, those that do and are able should assume an ongoing clinical relationship with them.
- Primary care accessibility should not be limited by the walls of the practice.
- Finally, much of what improves health has little to do with medical care, and efforts by primary care teams to build relationships with community organizations and public health agencies should be fostered.

3. TRAIN PRIMARY CARE TEAMS WHERE PEOPLE LIVE AND WORK.

- Black, Hispanic, American Indian and Alaska Native, and Native Hawaiian and other Pacific Islander people are currently under-represented in nearly every clinical health care occupation. For care teams to address race- and ethnicity-based treatment disparities, their members should reflect the lived experience of the people and families they serve.
- Developing a workforce to deliver the committee's definition of primary care requires reshaping training program expectations and the clinical settings in which that training occurs. Training primary care clinicians individually in inpatient settings will not accomplish this.

4. DESIGN INFORMATION TECHNOLOGY THAT SERVES THE PATIENT, FAMILY, AND INTERPROFESSIONAL CARE TEAM.

- Digital health, including electronic health records, create opportunities for improving care coordination and person-centeredness. However, digital health is a major source of professional dissatisfaction and clinician burnout.
- The experience of local and regional health information exchanges can inform this effort.
- Creating and implementing these changes requires innovation by vendors and state and national support agencies and accomplishing these goals will not be easy to ascertain.

5. ENSURE THAT HIGH-QUALITY PRIMARY CARE IS IMPLEMENTED IN THE UNITED STATES

- Successfully implementing recommendations rests in part on clear accountability.
- Lack of accountability hampered efforts to implement many recommendations in the 1996 IOM report. Thus, the committee's task would be incomplete without recommending an accountability system.
- . Evidence abounds for what is needed to achieve high-quality primary care for all, but organized support for this work is lacking. The professional diversity of high-quality primary care teams is their clinical strength but political and economic weakness, for while other health care services have a single voice advocating for public policy change, primary care lacks a similar voice