NEW MEXICO DEPARTMENT OF HEALTH STRATEGIC PLAN

2014 - 2016

New Mexico Department of Health

"A healthy New Mexico"

New Mexico Department of Health Vision Statement

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New Mexico Department of Health Strategic Plan

A MESSAGE FROM THE CABINET SECRETARY

It's a great honor to serve the people of New Mexico. We are a population of over 2 million residents and 6.4 million visitors each year. With over 3,200 staff members and a budget of $540 million dollars, the Department of Health delivers essential public health and health services to frontier, rural and urban communities and 22 sovereign tribal nations. Our facilities serve as a safety net for people who require long term care, rehabilitation and behavioral health treatment. NMDOH programs work with providers to support people with disabilities and their families. It is also our role to ensure an effective and timely response to public health emergencies. These are among the many ways we serve the people of New Mexico.

The Department of Health's 2014 – 2016 Strategic Plan is a roadmap for the agency on how to remain a vital part of an effective health system today and into the future. In order to achieve this purpose, we must commit to doing all we can to ensure that there is an adequate and competent workforce, and that we are collaborating with our partners to create community environments that promote healthy lifestyles and the prevention of injury and disease.

This Plan outlines our mission, values, vision, and organizational priorities for the coming years. During the Strategic Planning process, we reviewed statewide priorities and carefully considered how these align with national *Healthy People 2020* objectives and acknowledge current health status reports. By working with key community partners in the public and private sectors, we will continue to prioritize our efforts in order to meet the many health challenges we face.

In 2012, we began a pursuit of Public Health Accreditation for the NMDOH. The goal of Accreditation is to improve and protect public health by advancing the quality of all our services, and to strengthen collaborative efforts with state and local partners. By accomplishing Accreditation, the delivery of public health essential services by the NMDOH will be evaluated according to a set of national standards.

This NMDOH Strategic Plan is intended to be a practical, descriptive document designed to reflect our priorities and demonstrate how we are applying our resources to improve the public's health. This is a "living document" intended to change as necessary to ensure the well-being of the people we serve.

I commend our diverse and competent NMDOH professionals for their dedication to improving the quality of our work in order to achieve the shared vision of *A HEALTHY NEW MEXICO!*

Retta Ward

Cabinet Secretary
New Mexico Department of Health

THE FUNCTIONS OF A STATE HEALTH DEPARTMENT

Public health encompasses three core functions:

- ***assessment*** of information on the health of the community
- comprehensive public health ***policy and plan development***
- ***assurance*** that public health services that work are provided to the community

At the state level, each community has a unique "public health system" (figure 1) comprised of individuals, and public and private entities that are engaged in activities that affect the public's health. Public health is most successful when communities are working together and partnerships are strong. State health departments play a pivotal role in assuring the health of communities, and everyone should reasonably expect the state health department to fulfill certain functions.

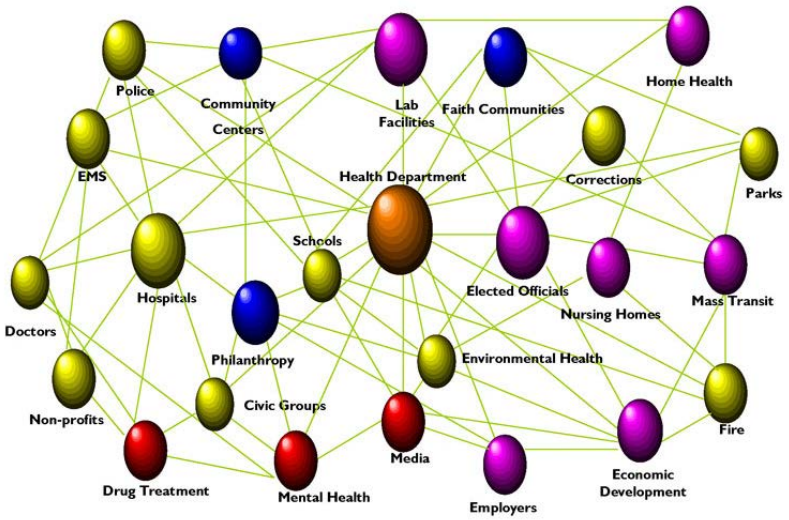


FIGURE 1: AN OVERVIEW OF THE PUBLIC HEALTH SYSTEM

The National Association of County and City Health Officials (NACCHO) has developed standards which provide a framework by which health departments are accountable to the public they serve, and the governing bodies (e.g., local boards of health, county commissioners, and mayors) to which they report. These standards also help us to measure our health department's performance against established, evidenced-based business practices. These standards serve as the basis for national voluntary Public Health Accreditation. Ten Essential Public Health Services provide a working definition of public health and a guiding framework for the responsibilities of local public health systems.

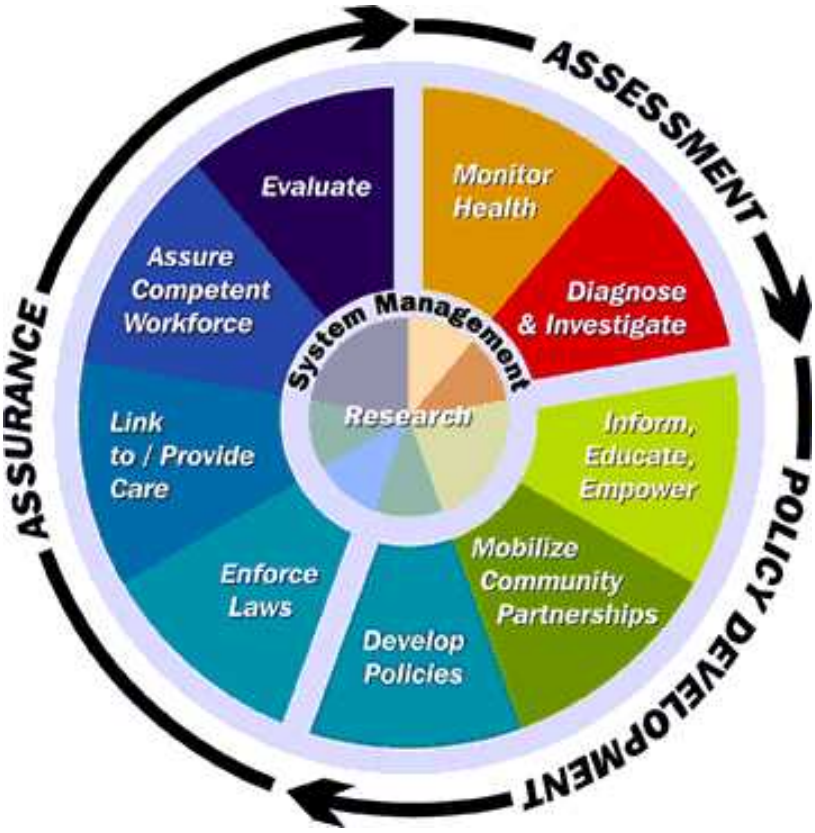


FIGURE 2: 10 ESSENTIAL PUBLIC HEALTH SERVICES

The Ten Essential Services are independent yet complimentary goals for communities to work toward.

- ***Monitor*** *health status to identify and solve community health problems.*
- ***Diagnose and investigate*** *health problems and health hazards in the community.*
- ***Inform, educate****, and empower people about health issues.*
- ***Mobilize*** *community partnerships and action to identify and solve health problems.*
- ***Develop policies and plans*** *that support individual and community health efforts.*
- ***Enforce*** *laws and regulations that protect health and ensure safety.*
- ***Link*** *people to needed personal health services and assure the provision of health care when otherwise unavailable.*
- ***Assure*** *competent public and personal health care workforce.*
- ***Evaluate*** *effectiveness, accessibility, and quality of personal and population-based health services.*
- ***Research*** *for new insights and innovative solutions*

DEPARTMENT OVERVIEW

In 1919, the first meeting of the State Board of Health of New Mexico was held during the administration of Governor Larrazolo and the Division of Public Health Nursing was created. The Board's budget for fiscal year 1921 was $16, 700.16. From the very beginning, public health nursing with its emphasis on providing health care and health education was seen as the most effective means of lowering the state's high infant mortality rate, improving hygiene, and preventing the spread of communicable diseases.

Like most states, New Mexico's health system is comprised of multiple components across many different organizations, all which contribute to assessing, maintaining and improving health in our state. Broadly, the components in New Mexico include: state agencies such as NMDOH, NM Environment Department, NM Human Services Department, NM Children, Youth and Families Department and Aging and Long-Term Services Department; tribal entities; Indian Health Services; hospitals; managed care organizations; universities; advocacy groups; and county and local government. State agencies have worked together for many years to produce the New Mexico Children's Cabinet Report Card and Budget Report.

The New Mexico Department of Health (NMDOH) is a centralized system of health services. A Cabinet Secretary, appointed by the Governor, oversees the NMDOH. New Mexico has 33 counties and 22 sovereign tribes, which are organized into five public health regions. Governance for these regions is provided by NMDOH, a state agency. Local public health offices are not governed by local boards of health or county officials. Public Health Regions have staff resources in all counties to locally assess and address public health needs. Recently, Public Health regions were realigned to better correspond geographically with patterns of public health services and to promote collaboration among local resources and other state agencies.

NMDOH is the lead entity in New Mexico providing core public health functions and essential services. The NMDOH main campus is located in Santa Fe and the agency employs approximately 3,250 people in more than 60 locations around the state and administers an annual budget in excess of $540 million. The NMDOH is divided into 7 divisions (Administrative Services, Information Technology, Public Health, Epidemiology and Response, Scientific Laboratory, Developmental Disabilities Support, and Division of Health Improvement).

In addition there are several offices which engage in cross-departmental efforts and supports (Office of General Counsel, Public Information Office, Office of Internal Audit, and the Office of Policy and Accountability, which includes the Office of Health Equity and the Office of Border Health). Finally, the NMDOH operates 7 facilities providing behavioral health, long term care and rehabilitative services overseen by the Office of Facility Management. New Mexico also has legalized medical cannabis and the Medical Cannabis program was created as an independent self-supporting entity in 2012.

Although the NMDOH has many duties, three divisions perform most of the core public health essential services: the Public Health, the Emergency and Response and the Scientific Laboratory Divisions. However, other offices provide coordination, oversight and enabling services that make the delivery of these services possible and ensure adherence to policy compliance, as well as to quality and performance improvement practices.

- The Public Health Division provides a coordinated system of community-based public health services focusing on disease prevention and health promotion in order to improve health status, reduce disparities and ensure timely access to quality, culturally competent health care. It consists of seven bureaus and five regions: Director's Office/Program Support, Pharmacy, Family Health, Infectious Disease, Chronic Disease Prevention and Control and Health Systems Bureaus and the Northeast, Northwest, Metro, Southeast and Southwest Regions.
- The Epidemiology and Response Division: tracks health and disease; monitors health status to identify community health problems; diagnoses, investigates, and controls outbreaks and health problems in communities; prevents and controls injuries; provides vital registration services; provides health information; improves the EMS system; improves the trauma care system; and prepares and responds to health emergencies. It is organized into seven bureaus and one program: Director's Office/Program Support, Vital Records and Health Statistics, Infectious Disease Epidemiology, Emergency Medical Services, Health Emergency Management, Injury and Behavioral Health, and Environmental Health Epidemiology Bureaus and the Community Health Assessment Program.
- The Scientific Laboratory Division provides clinical testing for infectious disease agents in support of public health programs operated by the Department of Health; veterinary, food, and dairy testing for the Department of Agriculture; forensic toxicology (drug) testing in support of the Department of Public Safety and local law enforcement agencies for the Implied Consent Act and for autopsy investigation performed by the Office of the Medical Investigator; and chemical testing for environmental monitoring and enforcement of law and environmental regulations for the Environment Department. The Scientific Laboratory also provides clinical testing for State operated and local hospitals for infectious diseases that are rare or novel in New Mexico, such as SARS, West Nile virus, avian influenza, and pandemic swine flu, and provides training and certification of law enforcement officers to perform breath alcohol testing within the state. The Scientific Laboratory is organized into one office and four bureaus: Director's Office/Office of Quality, Security, Safety and Emergency Preparedness and the bureaus of Biological Sciences, Chemistry, Toxicology and Program Support.
- Office of General Counsel ensures that public health laws, regulations, and policies are enforced.
- Administrative Services Division provides administrative and management services to internal and external customers: professional services agreements, procurement and grant management processes, and budget related support.
- Office of Policy and Accountability (OPA) coordinates the Public Health Accreditation program; provides leadership, workforce development and coaching in quality and performance improvement; and coordinates the policy and legislative activities in the NMDOH.
- Office of Health Equity coordinates programmatic efforts to address health disparities, including collaboration with OPA to release health disparity reports; delivers targeted health promotion services to target populations, and provides Cultural and Linguistic training.

MISSION, VISION AND VALUES

The vision, mission and core values are the foundation for our strategic plan. Together, they identify why an organization exists, where it wants to go, and how it wants to perform.

OUR MISSION

Promote health and wellness, improve health outcomes, and assure safety net services for all people in New Mexico.

OUR CORE VALES IN FULFILLING OUR MISSION

Accountability → honesty, integrity, and honor commitments made

Communication → promote trust through mutual, honest, and open dialogue

Teamwork → share expertise and ideas through creative collaboration to work toward common goals

Respect → appreciation for the dignity, knowledge, and contributions of all persons

Leadership → promote growth and lead by example throughout the organization and in communities

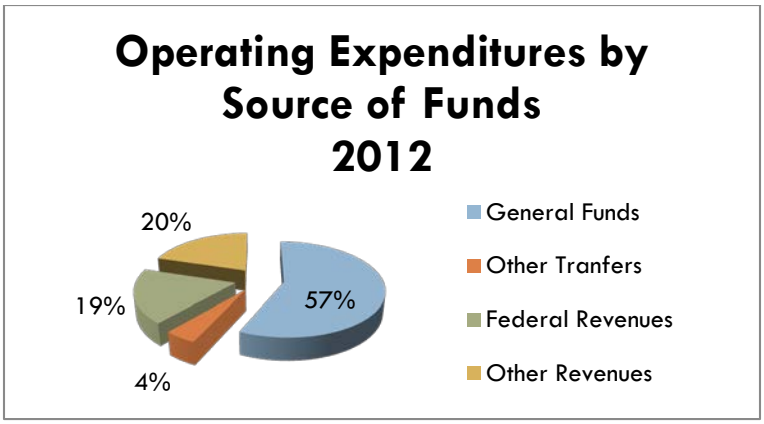
Customer Service → placing internal and external customers first, assure that their needs are met

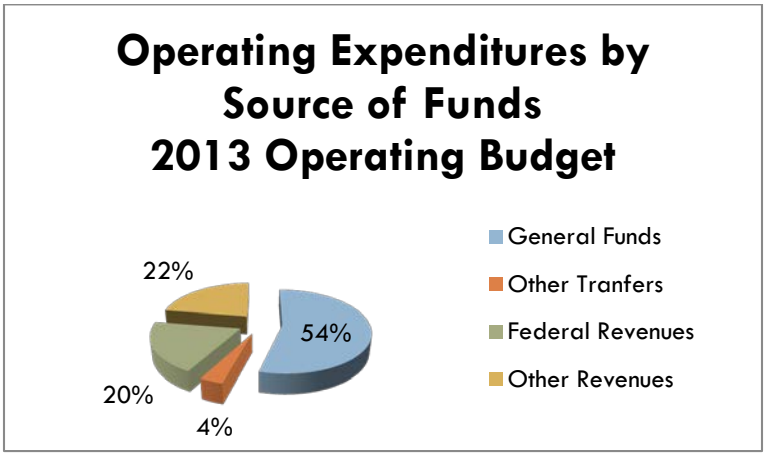
OUR VISION

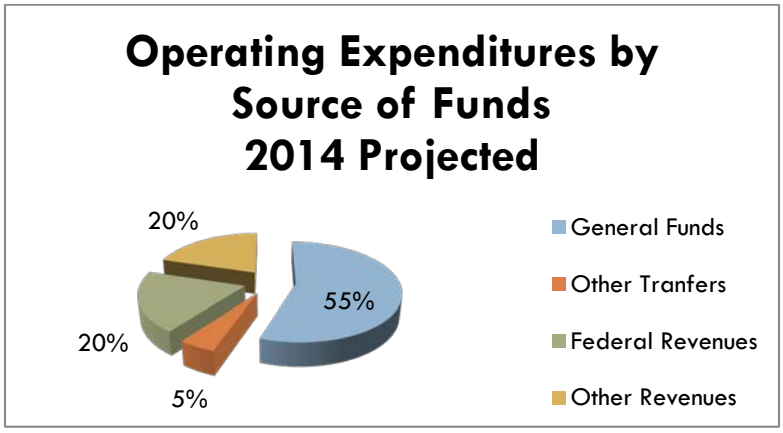
A healthier New Mexico!

OUR RESOURCES→ BUDGET, RESOURCES, FUTURE OUTLOOK

A variety of federal, dedicated revenue streams, state general funds, and fees support our budget. Given the current economic conditions, we recognize the likely funding reductions in federally supported programs. We also recognize that, in order to continue providing basic public health services under these circumstances requires creative thinking about the entire capacity of the public health system. It will also demand that we develop new strategies to use existing sources of flexible funding.







HEALTHY DISPARITY AND HEALTH EQUITY

"Health disparities" was first officially defined as "differences in the incidence, prevalence, mortality and burden of disease and other adverse health conditions that exist among specific population groups in the United States." Health disparities are relative and they are identified by comparing the health status, access to services and/or health outcomes of population groups. Characteristics such as race or ethnicity, limited English proficiency, disabilities, sexual orientation, gender identity, economic status and geographic location may affect one's ability to achieve good health. Although there have been national efforts to reduce health disparities and achieve health equity during the past two decades (Healthy People 2000, 2010, 2020 and the National Partnership for Action to End Health Disparities), these efforts have been hampered by a lack of consistency in collecting and reporting health data.

The Patient Protection and Affordable Care Act passed in 2010 not only addresses access to care, it also addresses the need for improved data to identify significant health differences that often exist between segments of the population. As a result the Office of Minority Health in the United States Department of Health and Human Services has released new minimum data standards for Race and Ethnicity, Sex, Primary Language and Disability Status. Improved data will assist in efforts to target affected populations and monitor efforts to reduce health disparities and move the United States to a status of health equity — "the attainment of the highest level of health for all people".

According to 2011 state population estimates, 43.1% of New Mexicans were Hispanic and 41.5 % were White (Figure P-3). The Hispanic category does not include Black, American Indian, or Asian or Pacific Islander populations. The American Indian or Alaska Native population comprised 10.7% of New Mexico's population; the Black or African American population made up 2.8%; and the Asian or Pacific Islander population constituted another 1.9%.

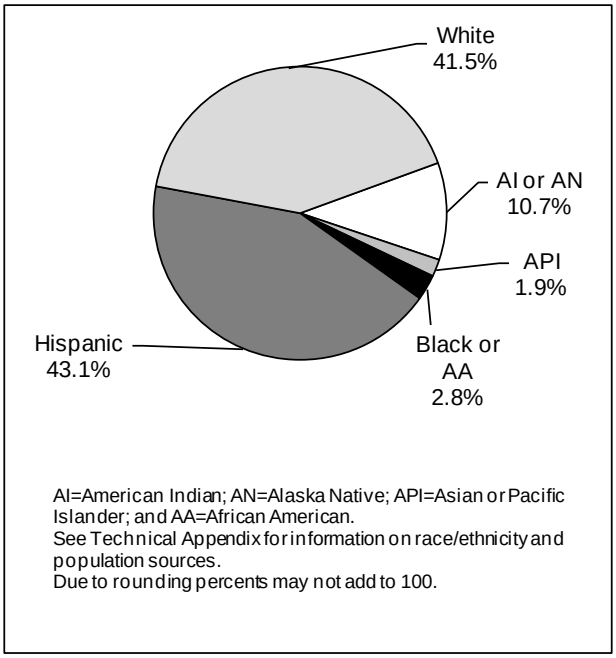


Figure 3, Population Distribution by Race/Ethnicity, New Mexico, 2011

Each of these racial and ethnic groups faces its own health challenges. Differences or disparities in health status and the impact of diseases have been tracked. These disparities are based on comparisons of the health status, access to services, and/or health outcomes of population groups. The disparities are relative since the racial and ethnic groups are being compared to one another.

American Indian	African-Americans/Blacks	Hispanics	Asian/Pacific Islanders	Whites
Adult Obesity Homicide Diabetes Deaths Alcohol-Related Deaths Motor Vehicle Deaths Pneumonia & Influenza Deaths Youth Obesity Late Prenatal Care Youth Suicide	HIV Infections Infant Mortality Adult Smoking	Chlamydia Teen Births Pertussis Adults with Diabetes Not Receiving Recommended Services Adults 65+ Not Ever Receiving Pneumonia Vaccinations	Acute and Chronic Hepatitis B	Suicide Drug Overdose Deaths Fall Related Deaths

Between 2007 and 2011, 9.8% report themselves as being foreign born. This is less than the national statistic of 12.7%. However, the percentage of residents over 5 years of age who speak a language other than English at home is 36.2%, a much higher percentage than the U.S. as a whole, 20.1%.

New Mexico has 22 federally recognized American Indian tribes. There are 19 Indian pueblos (Acoma, Cochiti, Isleta, Jemez, Laguna, Nambé, Okay Owingeh, Picuris, Pojoaque, Sandia, San Felipe, San Ildefonso, Santa Ana, Santa Clara, Santa Domingo, Taos, Tesuque, Zia, and Zuni) and three Indian reservations in the state (Jicarilla Apache nation, Mescalero Apache reservation, and Navajo Nation). New Mexico is home to 6.2% of the total American Indian population.


New Mexico's
Pueblos and Reservations
AZTEC
FARMINGTON
Navajo
CHAMA
Jicarilla
Apache
TAOS
Taos
Picuris
San Juan
ESPAÑOLA
Nambe
Santa Clara
Pojoaque
San Ildefonso
Tesuque
Jemez
Cochiti
SANTA FE
Zia
Santa Ana
Santo Domingo
Sandia
San Felipe
GALLUP
40
Laguna
Zuni
GRANTS
Acoma
ALBUQUERQUE
Isleta
25
ALBUQUERQUE
25
40
54
25
Mescalero
Apache
82
ALAMOGORDO
10
Pueblos
Indian Reservations
Cities
25
Interstate Highways
54
State Highways

EMERGING THREATS AND CLIMATE CHANGE

Forecasts for the climate of New Mexico, with its diverse topography and multiple climatic zones, predict temperature increases in most of the geographical areas of the state (Agency Technical Work Group 2005). By the mid- to late-21st Century in New Mexico there are predicted to be more episodes of extreme heat, heat waves and fewer episodes of extreme cold as well as more extreme drought events (Diffenbaugh et al., 2005, Meehl and Tebaldi 2004, IPCC 2007).

Water resources are vital to the Southwest and New Mexico and many areas of the state are already facing shortages in meeting the needs of growing cities, agriculture and manufacturing industries (Agency Technical Work Group, 2005). Warmer temperatures will reduce mountain snowpack's, and peak spring runoff from snowmelt will shift to earlier in the season. Relatively longer and hotter seasons will likely result in longer periods of extremely low flow and lower minimum flows in late summer. Water supply systems which have no storage (e.g., 'acequia' water delivery systems) or limited storage capacity (e.g., small municipal reservoirs) will suffer seasonal shortages in summer. Large reservoir systems may also suffer shortages from a reduction in average runoff.

Drought can increase the occurrence and severity of dust storms, increase the susceptibility to occurrence of wildfires and flash-floods. Drought can also diminish both water qualities. Current ongoing drought conditions and aquifer mining have already raised the concern that increases in contaminant concentrations may occur in the absence of significant ground water recharge events.

Excess heat events can result in heat exhaustion, heat stroke, and death. A recent analysis of heat stress in New Mexico concluded that residents of the Southeast and Southwest regions of the state had the highest burden of heat stress, based on emergency department visits. This suggests that residents in this part of the state may not be fully aware of the high risk of heat stress, especially in June and July. Therefore, increased education and outreach efforts are warranted.

Recurrence of a multiyear severe drought like that in the 1950s would have greater impacts on the water resources, the health of New Mexicans, and the economy of the state than in the 1950s because of the warmer temperatures, as well as the great increases in population growth and demand for water since the 1950s.

The Environmental Public Health Tracking Program, we conduct surveillance of climate change related indicators, such as heat stress. We also have a page on our website which addresses a lot of the variables associated with climate change (dust, air quality, smoke and fires): https://nmtracking.org/en/eh_alerts/)

THE HEALTH SYSTEM IN NEW MEXICO

New Mexico has had 94 primary health professional shortage areas (HPSA) identified. In New Mexico, 40.5% of the population is living in a primary health professional shortage area as compared to 19.1% of the US population as a whole. An estimated 26.6% of New Mexico's population is underserved compared to 11.4% of the U.S. population. An estimated 125 additional practitioners are needed in New Mexico to remove the HPSA designations and 254 more practitioners are needed to achieve the target population-to-practitioner rate. "In New Mexico only Los Alamos County does not contain a health professional shortage area." New Mexico has 770.5 R.N.s per 100,000 populations compared to the US rate of 920.9. This ranks New Mexico as 44th in the nation. Additionally, New Mexico has 125.4 LPNs per 100,000 population compared to the U.S. rate of 225. This ranks New Mexico as 42nd in the nation.

Community Health Centers are a significant source of care in New Mexico addressing the needs of the HPSAs. There is also a network of 95 medical sites and 40 dental sites of "federally qualified health centers" that are the backbone of New Mexico's health care safety net. These centers provide services to underserved communities, providing access to high quality, family oriented, and comprehensive primary and preventive health care for people who are low-income, uninsured or face other obstacles to getting health care. New Mexico has a total of 36 hospitals. This makes the beds per 1,000 population 1.9 as compared to the U.S. average of 2.6.

QUALITY IMPROVEMENT AND PERFORMANCE MANAGEMENT MODEL

The Results-Based Accountability (RBA) model focuses on population health improvement as the end goal, with program performance as a means to that end. The usefulness of the RBA approach is that it starts with the desired outcome and develops a set of evidence-based and evaluated strategies to attain the outcome. Also, RBA is the framework used for *Turning the Curve*, a process of changing positively the course of unwanted health trends through the development of performance standards and measures, progress reports, and ongoing quality improvement.

The RBA approach and adverse health conditions have been discussed at collaborative meetings attended by stakeholders from across New Mexico. Subsequently, stakeholders developed a scorecard (Appendix B) to feature: data regarding the indicator for each of the health priorities; indicator data trends; high-risk populations and/or geographical areas of the state; evidence-based and promising practice interventions; current partners; and the development of an activity plan by the NMDOH and its accountable partners. These activities are based on no cost/low cost concepts and on collaborative efforts to improve community health.

Thus, RBA is the model, *Turning the Curve* is the process, and the "Results for People Scorecard" is the tool to track population health and program performance improvement. Our novel approach addresses how the NMDOH, in coordination and collaboration with state, community and tribal partners, improves priority health issues in order to alleviate and prevent disease and injury burden in New Mexico.

OUR STRENGTHS AND WEAKNESSES

The establishment of the strategic planning council (SPC) in December of 2012 provided a historic opportunity to re-examine priorities and business practices, and to include input from staff at all levels in NMDOH. In 2013, the SPC conducted a strength, weaknesses, opportunities, and threats (SWOT) analysis soliciting input from staff to identify the strategic issues NMDOH should address. The strategic issues are the challenges or opportunities the organization wants to improve in a specified time period.

The SPC sent the first in a series of employee engagement surveys to all employees in February 2013 and 1,403 or 43% of the workforce completed the survey, out of a total of 3,269 employees. The text analysis tool in survey monkey was utilized to identify key words which appeared in the qualitative answers. The areas identified for improvement are addressed in the quality improvement plan.

Identified strengths, areas in which NMDOH excels, were:

- Customer service (We provide services which are timely and tailored to our customers).
- Teamwork (My colleagues and I hold each other accountable and contribute to achieve results).
- Quality (I understand how success is measured and can contribute to ensuring quality service).

Identified weaknesses, areas which NMDOH will pursue for improvement, were:

- Opportunities for growth (I have the tools I need to learn, do my job better and have career advancement within the NMDOH).
- Training (I have the training needed to accomplish my work successfully and in compliance with rules and regulations).
- Communication (I receive the information I need to do my job effectively).

The identified weaknesses informed the development of the NMDOH Quality Improvement Plan by the Strategic Planning Council. (Attachment A)

STRATEGIC PRIORITIES AND MEASURES

The process of selecting health priority areas began in the spring of 2011 when the NMDOH reviewed national publications comparing states on health issues. The publications reviewed included the Agency for Healthcare Research and Quality (AHRQ) State Snapshot, the Commonwealth Fund State Scorecard, America's Health Rankings, Kaiser State Health Facts and the Annie Casey Foundation Kids Count Data Book. The rankings New Mexico received ranged from 33 (of 50) for America's Health Rankings to 46 (of 50) in the Kids Count Data Book. Each of these publications contains multiple indicators; therefore, it was decided to concentrate on the indicators where New Mexico was ranked in the bottom 10 of the states.

When this list was compiled, indicators were compared to the Centers for Disease Control and Prevention (CDC) "Winnable battles" and the Healthy People 2020 list of leading indicators, as well as *The State of Health in New Mexico* Report and the New Mexico Racial and Ethnic Health Disparities Report Card. A matrix was developed listing the indicators appearing in more than one publication leading to a final list of indicators for which New Mexico ranks poorly. This list was presented to the steering committee. Priorities were selected based on whether New Mexico had a high rate and was ranked in the bottom 10 of the 50 states, a large number of people affected, and disparities existed. In addition to the criteria listed above, there was an attempt to represent all age groups. When New Mexico was awarded a Community Transformation Grant (CTG) by CDC, tobacco was added as a priority area so that all CTG focus areas would be included.

NMDOH also partners with community stakeholders in order to enable us to holistically meet the needs of our customers. We use a series of community health promotion events to learn about our customer/client requirements and support mechanisms. These events provide for communication opportunities between community stakeholders and Health Department staff. They also serve to educate the staff about community concerns/needs, and to inform stakeholders about pertinent Public Health issues. Examples include: meetings regarding environmental public health issues (e.g. sewer/septic tanks wastes); focus groups for community assessment purposes; Tribal health promotion and health literacy events; activities that focus on health weight and nutrition related issues; and tobacco use prevention activities. Information learned from these activities is used to inform strategic planning in conjunction with health assessment activities.

GOALS AND OBJECTIVES

The SPC developed one goal for the NMDOH and this goal addresses strategic issues. The SPC understands the priorities of public health are numerous, with numerous challenges; SPC narrowed its goals to areas of public health that require additional immediate attention while remaining achievable with limited or no additional resources. Our goal addresses issues identified by the U.S. Department of Health and Human Services (HHS) Healthy People 2020 and the extensive analysis process developed by NMDOH senior management.

After identifying goals, the SPC has begun to develop relevant performance measures and confirmed the relevance of these performance measures with our staff. These performance measures will help refine and focus the goals by identifying a measurable activity that determines progress in attaining the goal. The SPC will identify targets and deadlines for achieving stated goals.

In sum, each performance measure when combined with its target and its deadline will become an objective. There will be several objectives for each goal. The goal and objectives developed by the SPC are described in the following pages.

Goal 1: Improved health outcomes for the people of New Mexico

Objective 1: reduce obesity in children and youth.

Relates to the national objective for improving health, Healthy people 2020 - Nutrition and Weight Status Objectives 9 and 10.4

Story behind the Data

Obesity is a growing problem and occurs at very young ages. In 2011, 15% of kindergarten and 22% of third grade students were obese. American Indians have the highest rate of obesity among all age groups in New Mexico. By third grade one in two American Indian students are obese or overweight. Obese children are more likely to be obese adults and suffer from heart disease and diabetes. Healthy eating and active living are two lifestyle choices that can prevent obesity but social and environmental factors make it difficult for many to eat healthy or be physically active. Kids no longer want to play outside. Rather they want to sit and play video games or watch TV. Increased access to inexpensive high fat, high calorie and high sodium foods make healthy eating more difficult.

Strategies:

1: Open outdoor school space for community use during non-school hours

2: Build walking and biking trails that connect neighborhoods to schools and promote community usage

3: Implement the New Mexico Centennial 5.2.1.O Challenge in elementary schools across the state

4: Support childcare providers make healthy eating and physical activity a part of their daily routine

Baseline: 12.8% (percent of obese youth)

Objective 2: Reduce hospitalization due to diabetes

Relates to the national objective for improving health, Healthy people 2020 - Diabetes Objectives 3-12

Story behind the Data

Hospitalization represents the most severe cases of disease and indicates that the disease is not well-controlled. Lack of follow-up on A1C results or the importance of monitoring A1c. Language and cultural barriers exist between patients and providers. Patient denial or fear can lead to non-compliance with medication and treatment plan and poor eating habits because of a lack of knowledge on adapting cultural/traditional foods. Lack of resources affects both access to care and ability to make lifestyle changes. Inadequate links between healthcare and community programs affect care.

Strategies

1: Work with NMPCA and health care organizations to improve tracking and use of A1c results to improve care and clinical outcomes for patients

2: Expand linkages between diabetes and NMDOH Chronic Disease Self-Management Program

3: Disease management, by health care organizations, of their entire patient populations with diabetes

4: Case management of individuals with diabetes who meet specific risk criteria

5: Produce consistent guidelines for appropriate diabetes care and for interpretation of clinical lab information

6: Develop treatment plans; provide patient education at the inpatient and outpatient levels, including use of group education

Baseline: 13.7 Diabetes Hospitalizations per 10,000 (2011)

Objective 3: Reduce tobacco use

Relates to the national objective for improving health-Healthy people 2020 - Tobacco Use Objectives 1 and 13.10

Story behind the Data

Despite decreases in overall adult smoking in NM, rates are still significantly higher among adults who have lower education, lower income, are unemployed, or uninsured. Smoking initiation begins in middle and high schools. Especially high smoking rates are seen among youth with poor academic grades, American Indian youth, and youth experiencing food insecurity. About 92% of New Mexicans are protected from secondhand smoke exposure by the 2007 Dee Johnson Clean Indoor Air Act. Access to services, exposure to media messages, and cultural differences related to use of tobacco may vary in rural compared to urban areas.

Strategies

1: Provide QUIT NOW telephone- and web based cessation services supported by media, training, and community outreach designed to increase tobacco cessation awareness and referrals.

2: Expand linkages between Tobacco Use Prevention and Control (TUPAC) Program and other NMDOH programs (e.g., WIC, Children's Medical Services, PRAMS, etc.) and community organizations (e.g., nonprofits, health councils, tribal groups, priority population networks, etc.) to promote QUIT NOW cessation services.

3: Support smoke-free multi-unit housing community secondhand smoke education and voluntary policy efforts through use of data, strategic partnerships (CTG, TUPAC grantees and new community partners) and training statewide.

Performance Measure: Percentage of QUIT NOW enrollees who successfully quit using tobacco at 7-month follow-up.

Baseline: 21.5% of adults smoke (2011)

Objective 4: Reduce teen births

Relates to the national objective for improving health, Healthy people 2020 - Family Planning Objectives 8 and 9

Story behind the Data

The birth rate for teens ages 15-17 has declined, but it is nearly 30% higher than the national rate. NM is ranked as the 3rd poorest state in the nation. Poverty is a cause as well as a consequence of early childbearing. Hispanics have the highest rate among all populations in NM accounting for 69% of all births to teen girls age 15-17. Sexually active Hispanic teens are less likely to use contraception than other teens. Many NM teens do not have immediate access to family planning or birth control services. Barriers include socioeconomic status, clinic location and transportation. Services at community clinics are often not available at teen friendly hours, e.g. after- school. Increased awareness and accountability for a male's role in birth control and teen pregnancy is needed. Parents often find it difficult to talk with teens about sensitive issues such as sex and reproductive health. Parents may not communicate their values to their children and in some families the stigma of teens having children isn't as powerful. There is a lack of support services and systems for youth such as prevention services and early intervention to prevent unintended and unplanned pregnancies

Strategies

1: Expand Title X family planning services at school based health centers (SBHCs) that have local school board approval to dispense contraceptives, to assist the SBHCs with confidential family planning services on-site.

2: Expand comprehensive sex education programs through local advocacy at individual schools and school districts.

3: Incorporate service learning programs into higher education opportunities through pipeline programs and college credits.

4: Increase adult-teen communication programs on teen pregnancy prevention through the provision of resources and materials to local communities

Performance Measure: Number of pregnancies prevented among 15-17 females seen in department funded clinics.

Baseline: 25.5 Teen (females age 15-17) birth rate per 1,000 (2011)

Objective 5: Increase adult immunizations (Adults 65 and older Pneumococcal Vaccination, 2011)

Relates to the national objective for improving health, Healthy people 2020 - Immunization and Infectious Disease Objectives 12.5-12.10 and 13.1-13.3

Story behind the Data

Pneumococcal Pneumonia (Pneumonia)

• 40,000 cases of invasive pneumonia each year and one-third occur in people 65 and older. Over half of the 5,000 annual deaths occur in persons 65 years and older. Medicare pays for one pneumonia vaccination and one vaccination at age 65 generally provides coverage for a lifetime. High risk persons should receive a booster, which is also covered by Medicare (for high risk persons, if 5 years has passed)

Strategies

1: Collaborate with community services to increase access points to immunizations

2: Educate providers to use reminder recall, IIS tracking

3: Educate public about elder adult immunization needs

Baseline: 69.2% Adult Immunization Rate (Adults 65 and older Pneumococcal Vaccination, 2011)

Objective 6: Increase access to preventive and dental care services

Relates to the national objective for improving health-Healthy people 2020-Oral Health Objective 12

Story behind the Data

Hispanics and American Indians have the higher rates of tooth decay among all populations. Hispanic and American Indian adults are less likely than Whites to have a dental visit within the past year. Less than half of adults with an annual income below $15,000 have had a dental visit within the past year 61% of children are enrolled in Medicaid but undocumented children are not eligible

Strategies

1: Increase Policymakers' Awareness of the Importance of Expanding Adult Medicaid Services.

2: Implement a Culturally Appropriate and Bilingual Prevention Campaign (PSA) to promote Oral Health.

3: Develop a NM Oral Health Surveillance System.

4: Increase Access to Oral Health Care for Those Living in Long-term Care Facilities and Nursing Homes.

5: Develop an Oral Health Strategic Plan.

Baseline: 67.2% Percent of adults with dental visit in the past year (2010)

Objective 7: Reduce elderly falls

Relates to the national objective for improving health, Healthy people 2020 - Injury and Violence Prevention Objective 23.2

Story behind the Data

In NM, falls are the leading cause of injury-related death and hospitalizations among adults 65 years and older. NM had the sixth-highest fall-related death rate among states in 2010. NM's fall-related death rate was 1.6 times higher than the national rate in 2010. NM's fall-related death rate among people 65+ years of age and over increased 115% from 1999 to 2008, and decreased 22% from 2008-2010 but increased again in 2011. Over 2,700 unintentional fall-related hospitalizations occurred among adults 65+ in 2011.

Strategies

1: Provide the Tai Chi: Moving for Better Balance evidence based exercise program to people interested in implementing this program to older adults within their communities.

2: Expand linkages between Office of Injury Prevention Older Adult Fall Prevention program and the Aging and Long Term Services Department and the NMDOH Chronic Disease Self-Management Program to promote older adult fall prevention.

3: Build Partnerships to address fall prevention.

Baseline: 88.0 Fall-related death rate among older (65+) adults per 100,000 (2011)

Objective 8: Reduce drug overdose deaths

Relates to the national objective for improving health, Healthy people 2020 - Substance Abuse Objective 12

Story behind the Data

In 2010, New Mexico had the second highest drug overdose death rate in the nation. The consequences of drug use continue to burden New Mexico communities. Drug use can result in overdose death and is also associated with other societal problems including crime, violence, homelessness, loss of productivity and spread of blood-borne disease. Unintentional overdose, or poisoning, accounts for 80-85% of drug-induced deaths in New Mexico. High rates among Hispanic males drive the overall high state rates. A primary risk factor is excessive prescription drug misuse. Prescription drug-associated overdose death rate has been higher than illicit (i.e. heroin) associated death rate since 2007. Poisoning from drug overdoses has surpassed motor vehicle deaths as the major cause of unintentional injury in New Mexico.

Strategies

1: Increase access to overdose prevention education and naloxone for persons at risk of misuse or overdose of their prescribed pain medication (Co-prescription Pilots)

2: Increase reach and access to public health overdose prevention and naloxone services

3: Expand protocol/service scope of Basic Emergency Responders to include administration of naloxone.

4: Expand professional education to healthcare providers on the role of overdose prevention education and naloxone for high risk patients receiving opioid pain medication.

Baseline: 25.9 Drug Overdose Death Rate per 100,000 (2011)

Objective 9: Reduce alcohol related deaths/reduce abuse of alcohol

Relates to the national objective for improving health-Healthy people 2020-Substance Abuse Objective 20 and 14.3

Story behind the Data

New Mexico had the highest alcohol-related (AR) death rate in the nation from 1997 through 2007 (most recent year available). From 1990-2007, NM's AR chronic disease death rate was 1.5 to 2 times US rate; the US rate declined 16%, but NM's rate remained high and unchanged. From 1990-2007, NM's AR injury death rate was 1.4 to 1.8 times US rate; and increased by 18% while the US rate decreased 3%. Male AR death rates are > 2x female rates. More than 75% of AR deaths in NM occur before age 65. High rates among American Indian males and females and Hispanic males drive the overall high state rates. Excessive alcohol consumption (binge and heavy drinking) is primary risk factor.

Strategies

1 (CG-EAC): Reduce excessive alcohol consumption using strategies recommended by the Community Guide.

2 (CG-AID): Reduce alcohol-impaired driving using strategies recommended by the Community Guide.

3 (ASBI): Implement Alcohol Screening and Brief Intervention (ASBI) more broadly in New Mexico.

Baseline: 53.7 Alcohol-related deaths rate per 100,000 (2011)

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Appendices

Appendix A
Quality Improvement Plan

Quality Improvement Plan

Provides a basic guidance document about how the New Mexico Department of Health will manage, deploy, and review quality throughout the organization. It describes the processes and activities that will be put into place to ensure that quality deliverables are produced consistently.

The NMDOH Quality Improvement Program is a disciplined approach to performance management using the Results-Based Accountability model, which includes organizational strategic planning, performance management and accountability, operational/business planning and performance and focused quality improvement efforts.

Leadership and Strategic Planning

The Strategic Planning Council (SPC) with guidance from NMDOH senior leadership (Cabinet Secretary, Deputy Secretaries, Division and Office Directors, General Counsel) sets direction for the organization through strategic planning. This plan provides a vision of the NMDOH as it sees itself in the future; a clearly stated mission which expresses the reason(s) the NMDOH exists and for whom; and, goals, objectives, strategies, and performance measures which will move the NMDOH toward its vision in incremental, achievable steps.

Quality

Quality in public health is the degree to which policies, programs, services and research for the population increase desired health outcomes and conditions in which the population can be healthy. The U.S. Department of Health & Human Services vision for public health quality, as defined by the Assistant Secretary for Health, is to build better systems to give all people what they need to reach their full potential for health

- Quality Improvement (QI) is an integrative process which links knowledge, structures, processes and outcomes to enhance quality throughout the organization. The purpose of the 2013 New Mexico Department of Health (NMDOH) Quality Improvement Plan (QIP) is to provide the context, framework and processes for the ongoing continuous improvement of services provided throughout the NMDOH to its customers/stakeholders (internal and external).

Quality Improvement Principles

Quality Improvement is a systematically approaches to assessing services, identifying opportunities for improvement and implementing improvements on a priority basis. Quality Improvement is a continuing cycle of measurement, analysis, action and progress. The NMDOH approach to quality improvement is based on the following principles:

- Focusing on the needs of our customers/stakeholders (internal and external);
- Using data to analyze problems and performance concerns and to evaluate improvements;
- Involving employees who know and are impacted by the improvement opportunity;
- Developing and implementing improvements based on data and analysis;

- Engaging customers and stakeholders;
- Monitoring and evaluating performance; and
- Continually making improvements over time on an ongoing basis.

Quality Improvement Council

The Quality Improvement Council (QIC) was established to oversee the quality improvement process, including the development of strategic plans. The QIC has representation from all divisions and facilities in the Department of Health. QIC members work with senior managers to offer NMDOH employees a chance to assist in forging the NMDOH's future. The QI Council is responsible for conducting QI efforts and for promoting, training, challenging, and empowering NMDOH employees to participate in the ongoing process of QI

The responsibilities of the Council include:

- Developing and approving the Quality Improvement Plan;
- Assuring that the review functions outlined in the plan are completed;
- Prioritizing issues referred to the QI Committee for review;
- Assuring the data obtained through QI activities are analyzed,
- Recommending appropriate follow up and problem resolution;
- Identifying educational needs and assuring that staff education for quality improvement takes place;
- Appointing sub committees or teams to work on specific issues, as necessary;
- Assuring that resources are properly allocated through the establishment of priorities for planning, implementing and evaluating improvements;
- Monitoring Division improvement efforts which directly support NMDOH priority measures;
- Ensuring the organization sustains the gains of its improvement effort;
- Leading NMDOH culture shift toward customer-focused, evidence-based, continuous improvement practices;
- Reviewing selected program evaluation reports and making recommendations on program improvements;
- Reviewing after-action reports and making recommendations to the appropriate division; and
- Reviewing and revising Quality Improvement Plan on an annual basis

The QI Council meets once a month for 90 minutes and maintains records and minutes of all meetings. Quarterly the QI Council will provide a report of the QI program to the Cabinet Secretary.

Quality Improvement Activities

The Quality Improvement Council identifies and defines goals and specific objectives to be accomplished each year. These goals include training of NMDOH employees on the results-based accountability process. Quality improvement tools and techniques applied in a variety of group and team situations enable the important data collection, problem analysis, and employee involvement which are keys to

improving performance. Progress in meeting these goals and objectives is an important part of the annual evaluation of quality improvement activities. The following criteria were developed by the members of the Strategic Planning Council in regards to selecting which NMDOH level Quality Improvement projects to focus on:

Scope

While a potential QI project does not have to impact the entire NMDOH, it should not just affect one narrow program or area. We want to maximize the reach. This can include doing a project in just one division, if there is potential to identify best practices that can be shared and replicated in other areas.

Customers

A potential QI project does not have to immediately impact external customers in the community, but rather can focus on internal processes and customers. All internal work will ultimately help the communities we serve by helping NMDOH to function more effectively.

Number of projects

The SPC will pick only one project at a time from each of the three QI focus areas. While there are many quality projects that are not selected, these can continue within their divisions. The OPA will provide training and support on RBA to these as well; to the extent they have the time and resources.

Other Agency QI Projects

Divisions and programs are encouraged to initiate their own quality improvement projects. These projects should follow Results-Based Accountability principles and apply common quality improvement tools and techniques to help teams achieve their desired results. Divisions and programs desiring to pursue quality improvement efforts are encouraged to coordinate with Office of Policy and Accountability (OPA) for advice and assistance. All employees within the NMDOH are encouraged to seek areas/programs which could benefit from a QI process. Individuals wishing to submit an idea/process need to complete a QI Project Submission Form to the Strategic Planning Council.

Monitoring and Oversight

NMDOH staff are encouraged to conduct ongoing quality improvement analysis as a part of their overall job responsibilities. This involves continually evaluating processes and results in order to improve them. Concerns or issues can be brought to the attention of division staff, management, or the Quality Improvement Council via the attached Quality Improvement Submission Form.

Monitoring and oversight activities can take place at several levels throughout the NMDOH. For those quality improvement efforts that do not rise to the level of the Quality Improvement Council monitoring and oversight, it is the expectation that divisional managers oversee such efforts and report quarterly to the Council the efforts engaged at the division level. The Quality Improvement Council will sponsor, monitor, and oversee quality improvement efforts that are accepted by the Council. Quality improvement efforts sponsored by the Council will be initiated through the use of a formal quality improvement project form.

From Talk to Action

Quality improvement activities emerge from a systematic and organized framework for improvement. This framework, adopted by the Cabinet Secretary, is understood, accepted and utilized throughout the NMDOH, as a result of continuous education and involvement of staff at all levels in population or performance activities.

Results-Based Accountability (RBA) is a disciplined way of thinking and taking action those communities can use to improve the lives of children, families and the community as a whole. RBA can be used by agencies to improve the performance of their programs. RBA can be adapted to fit the unique needs and circumstances of different communities and programs.

RBA starts with ends and works backwards, step by step, to means. For programs, the ends are how customers are better off when the program works the way it should. RBA is a process that gets you and your partners from talk to action quickly. It uses plain language and common sense methods that everyone can understand. RBA is an inclusive process where diversity is an asset and everyone in the NMDOH can contribute. Like all good processes, RBA is hard work. But it is work that you control and that makes a real difference in people's lives.

The RBA model is applied in two ways:

Population Accountability → about the well-being of WHOLE POPULATIONS

- Communities, Cities, Counties, States, Nations

Performance Accountability → about the well-being of CLIENT POPULATIONS

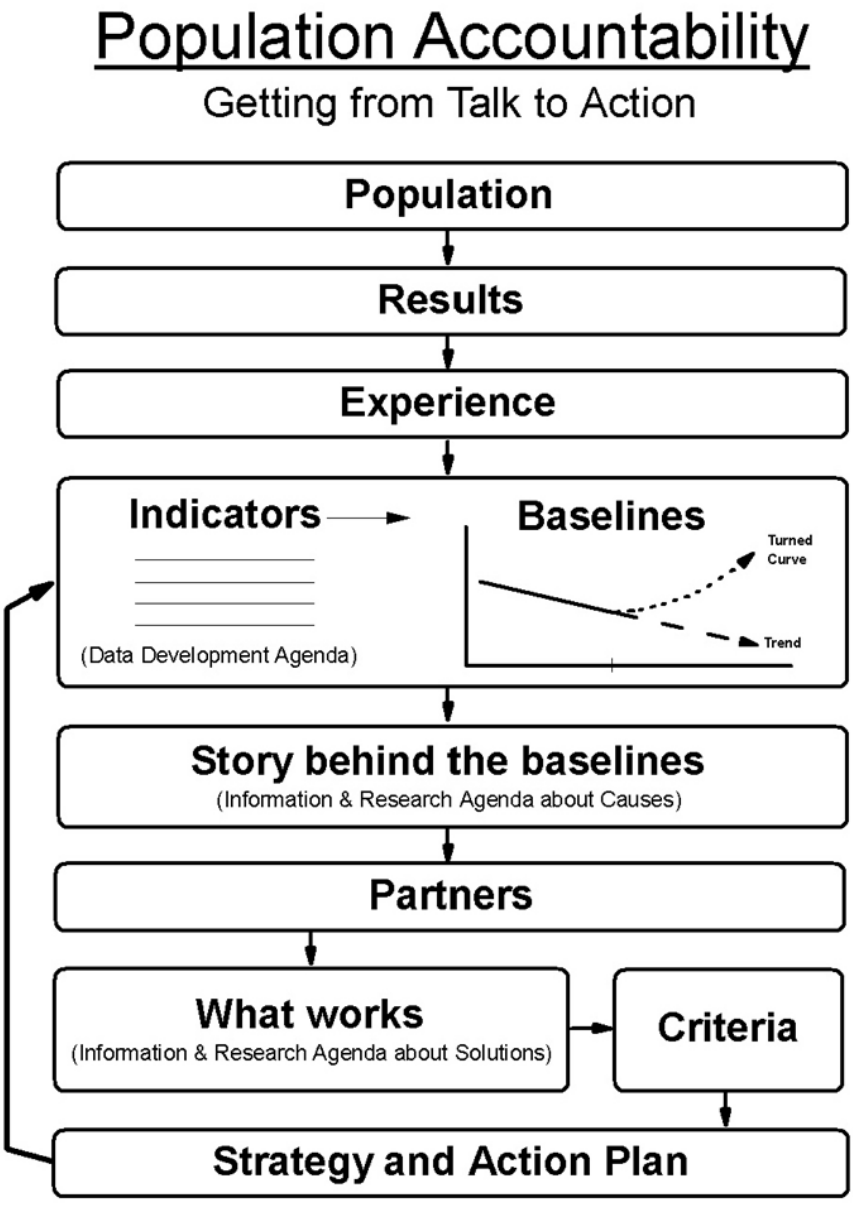
- Programs, Agencies, Service Systems

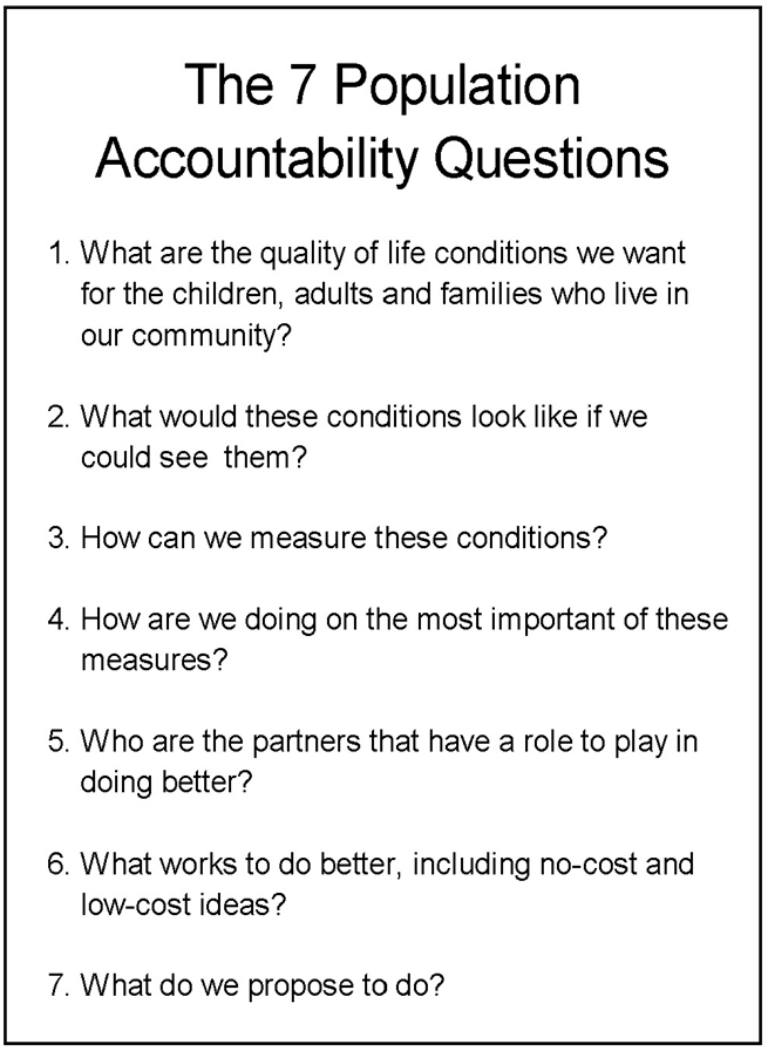
Population Accountability – for the well-being of whole populations in a community, city, county, state or nation

- Population: identify a population; whole or subpopulation in a geographic area (world, nation, state, region, county, city or neighborhood)
- Results: what do we want for this population?
- Experience: How to we understand the results we want? How do we see, hear or feel them? This is the bridge between results and indicators. Each experience is a pointer to a potential indicator. Experience can be a temporary substitute for data when there is no data.

- Indicators: look for data that tells us if we are getting results or not
    - Communication Power: Does the indicator communicate to a broad and diverse audience?
    - Proxy Power (Representative Power): Does the indicator say something of central importance about the result? Can the measure stand as a proxy or representative for the plain language statement of well-being?
    - Data Power: Do we have quality data on a timely basis? Is the data reliable and consistent? To what extent do we have the data at the state, county, city and community levels?
    - Data Development Agenda: prioritized lost of where we need new or improved data
- Baselines: must be developed for each indicator, allow us to define success as turning the curve away from the baseline or beating the baseline
- Historical: tells where we have been
- Forecast: says where we are headed if we do not do anything differently
- Story behind the baselines: understanding what is causing the behavior, which in-turn will help us decide what actions to take that will best address these causes
- Information and research agenda about causes: disciplined way of pursuing unanswered questions about causes.
- Partners: Who are the partners who have a role to play in doing better? Public? Private? Across communities? Fiscal people?
- What works: What works to do better? Look at the research for what has worked in other places including best and promising practice.
    - Each part of the story behind the curve points to an action
    - Each partner and potential partner has something important to contribute to turning the curve
    - No-cost and Low-cost ideas
    - Information and research agenda about solutions: what has worked in other and the success stories where people have tackled similar challenges

- Strategy and Action Plan: set of criteria to set priorities, create an action plan and budget, and get started
    - Priority setting is always based on criteria (explicit or implicit)
    - Four criteria to be used for selecting the most powerful actions:
        - Specificity: Is the idea specific enough to be implemented? Can it actually be done?
        - Leverage: How much difference will the proposed action make on results, indicators, and turning the curve?
        - Values: Is it consistent with our personal and community values?
        - Reach: Is it feasible and affordable? Can it actually be done and when?


Population Accountability
Getting from Talk to Action
Population
Results
Experience
Indicators
(Data Development Agenda)
Baselines
Turned Curve
Trend
Story behind the baselines
(Information & Research Agenda about Causes)
Partners
What works
(Information & Research Agenda about Solutions)
Criteria
Strategy and Action Plan



Performance Accountability – for Programs, Agencies and Service Systems

- Customers: Who are our customers? Whole lives are affected, for better or worse, by the actions of the program.
- Performance measures:
  - Quantity → How much did we do?
  - Quality → how well did we do it?
  - Effort → how hard did we work?
  - Effect → what change did we produce?
- Story behind the baselines: understanding what is causing the behavior, which in-turn will help us decide what actions to take that will best address these causes
  - Information and research agenda about causes: disciplined way of pursuing unanswered questions about causes.

- Partners: Who are the partners who have a role to play in doing better? Public? Private? Across communities? Fiscal people?
- What works: What works to do better? Look at the research for what has worked in other places including best and promising practice.
    - Each part of the story behind the curve points to an action
        - Each partner and potential partner has something important to contribute to turning the curve
        - No-cost and Low-cost ideas
        - Information and research agenda about solutions: what has worked in other and the success stories where people have tackled similar challenges
- Strategy and Action Plan: set of criteria to set priorities, create an action plan and budget, and get started
- Priority setting is always based on criteria (explicit or implicit)
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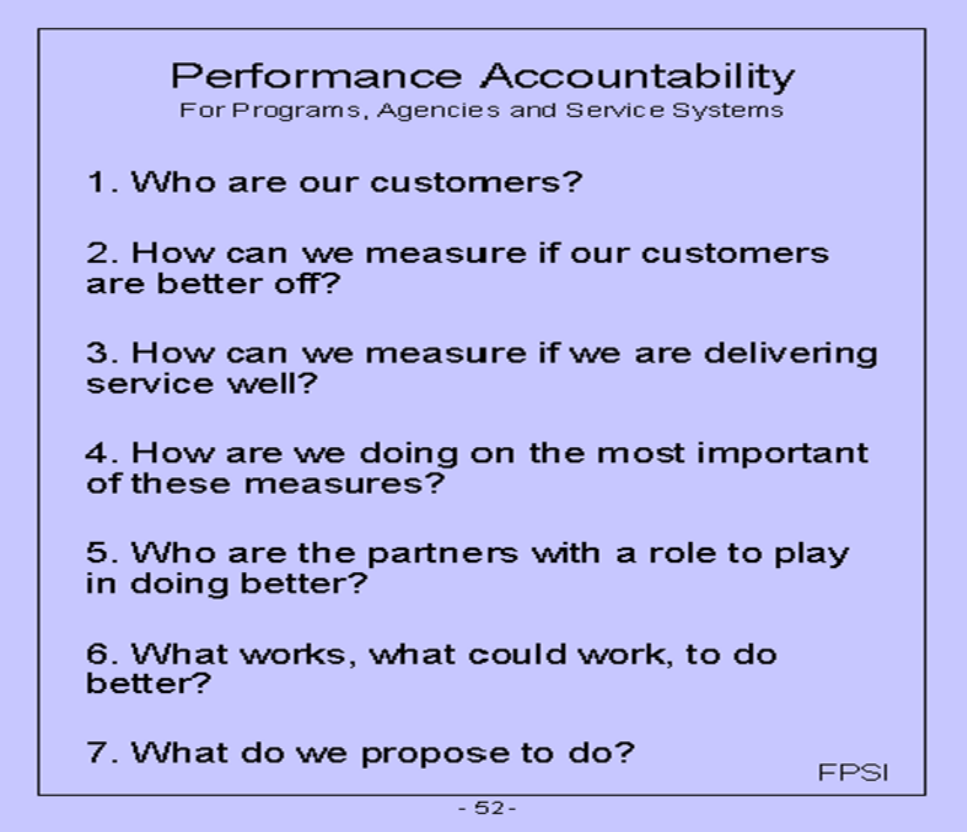
    - Values: Is it consistent with our personal and community values?
    - Reach: Is it feasible and affordable? Can it actually be done and when?



PROJECT SELECTION

The NMDOH conducted an Employee Engagement Survey in 2013 which asked employees to identify areas for team improvement. The top three selected areas were:

- 67.5% Opportunities for Growth (I have the tools I need to learn, do my job better and have career advancement within the NMDOH.)
- 51.0% Training (I have the training needed to accomplish my work successfully and in compliance with rules and regulations.)
- 49.7% Communication (I receive the information I need to do my job effectively.)

Using the text analysis tool within Survey Monkey the top five most common words identified within the qualitative text were:

- 19% Opportunities
- 17% Employees
- 15% Staff
- 13% Improve
- 8% Teamwork

A search within the qualitative data was then conducted, specifically searching for the identified key words. The results of the aforementioned review were summarized and presented to the Quality Improvement Council. The council chose three focus areas:

Communications → the activity of conveying information through the exchange of thoughts, messages, or information, as by speech, visuals, signals, writing, or behavior. It is the meaningful exchange of information between two or more people. Any act by which one person gives to or receives information from another person about that person's needs, desires, perceptions, knowledge, or affective states.

Training and Workforce Development → Through workforce development, individuals can receive training that increases their competency and makes them a greater asset in the workforce. The National Governors' Association defines workforce development as the education, employment, and job-training efforts designed to help employers get a skilled workforce as well as to help individuals to succeed in the workplace.

Health and Safety → is an area concerned with protecting the safety, health and welfare of people engaged in work or employment. The goals of occupational safety and health programs include fostering a safe and healthy work environment.

Council members were tasked with seeking, within their division, examples of QI projects which aligned with our three focus areas. The members presented their examples to the QI Council and using the previously mentioned criteria selected one project for each of our focus areas.

Sub-committees will be formed and will be chaired by a member of the Office of Policy and Accountability (OPA) as well as contain two members of the Strategic Planning Council. Other personal with expertise in area(s) will be recruited and invited to be a participant in sub-committee.

QUALITY IMPROVEMENT PROJECTS

Communication

Objective: Redesign the NMDOH's external website

Training and Workforce Development

Objective: Review gaps in NMDOH-wide employee training and develop tools for e-tracking to ensure completion

Health and Safety

Objective: Improve health and safety of NMDOH workforce

The chair of each sub-committee will submit a monthly progress report to the Quality Improvement Council regarding the progress of said committee.

ANNUAL EVALUATION

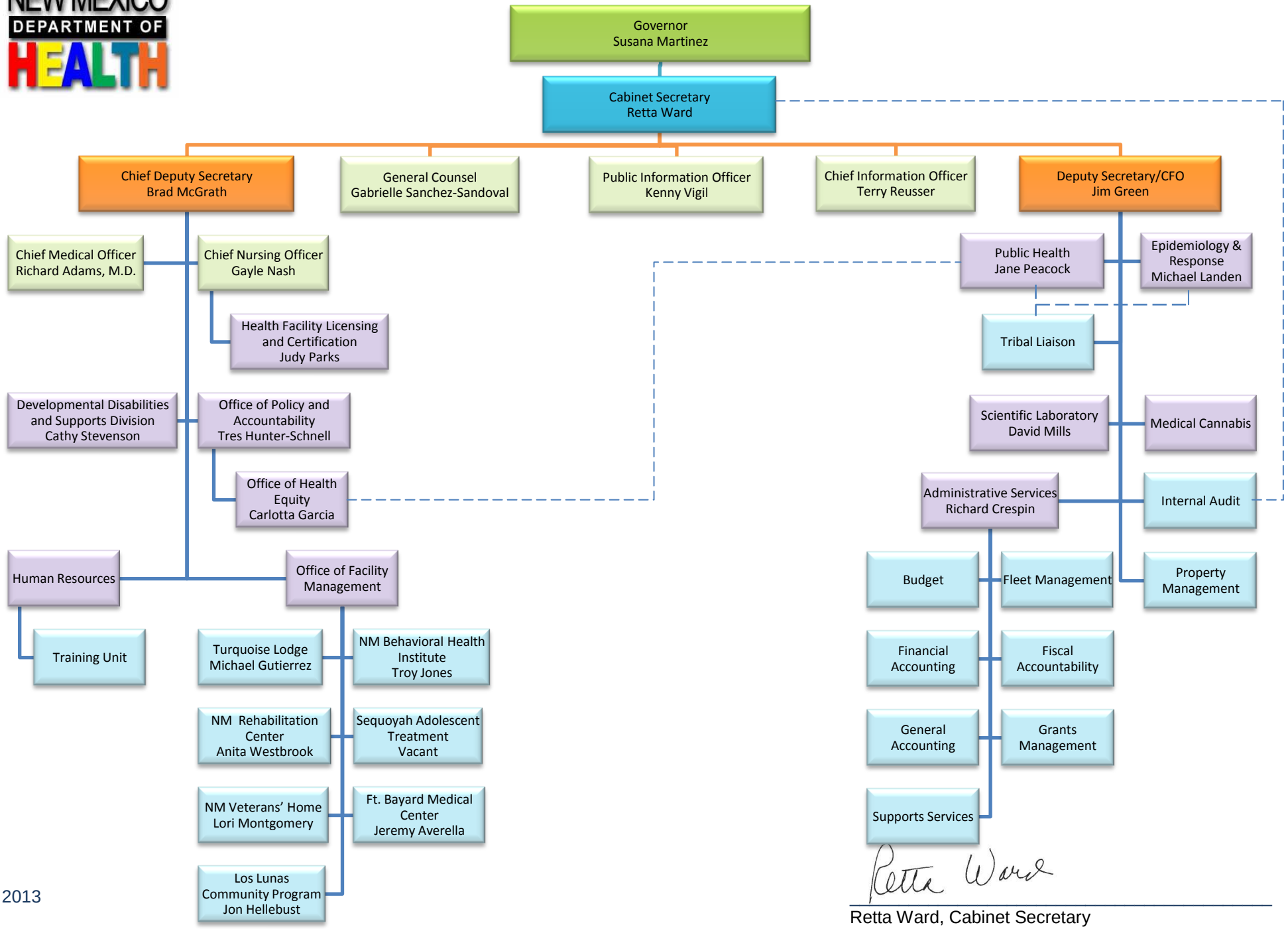
Our QI Plan will be evaluated on an annual basis for effectiveness in achieving the goal of assuring that the most appropriate quality of care was provided to our customers. A summary of activities, improvements made, care delivery processes modified, projects in progress, and recommendations for changes to this QI Plan, will be compiled and forwarded to the Strategic Planning Council.

Appendix B
"Results for People Scorecard"


https://hosted.resultsscorecard.com/NMHealth/portal.aspx?Novel=y
Roundhouse | New Mexico Tel...
New Mexico Department of...
IBIS-PH Indicator Profile View ...
Timesheet
File Edit View Favorites Tools Help
Compose Topic Details Joint Com... County Results (2) County Results http--www.nmlegis.gov-S...
Page Safety Tools
Results Scorecard
Welcome, Kelly Gallagher | Help | Logout | Change Password
Home Start Again
Scoreboard Data Driven Decisions
Reports Data & Projects
Scorecard Builder Organize Data
Administration Users, Data Import, Set up
NEW MEXICO DEPARTMENT OF HEALTH
Welcome to the
New Mexico Department of Health
"Results for People" Scorecard
Building a Healthy New Mexico
Right click for Edit & Print options.
Featured Data Tablet
Print
Select
Adult Immunization Rate (Adults 65 and older Pneumoccocal Vaccination)
2011
69.2%
Story Behind the Curve
Pneumococcal Pneumonia (Pneumonia) 40,000 cases of invasive pneumonia each year One-third occur in people 65 a...
Alcohol-related deaths rate per 100,000
2011
53.7
Story Behind the Curve
New Mexico had the highest alcohol-related (AR) death rate in the nation from 1997 through 2007 (most recent year ...
CTG: # of children with access to physical activity opportunities
No Graph Available
N/A
N/A
Story Behind the Curve
While the majority of the largest NM school districts have formal joint use agreements between the school district...
N/A
Diabetes Hospitalizations per 10,000
2011
Drug Overdose Death Rate per 100,000
2011
Fall-related death rate among older (65+) adults per 100,000
2011
100%

Appendix C
NMDOH Organizational Chart

NEW MEXICO DEPARTMENT OF HEALTH



May, 2013

Retta Ward

Retta Ward, Cabinet Secretary