NEW MEXICO
DEPARTMENT OF
HEALTH

Department of Health

Date:
10/31/2019

Reporting Period:
FY20 Q1

Agency Mission:

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

Agency Goals:

Community Engagement – to Improve Organizational Communication & Collaboration
Data & Evaluation – to Provide Benchmarks for Practice Improvements & Monitor State Health Status
Effective Business Practices – to Develop Policies & Plans that Support Agency-Wide Health Efforts
Employee Competence – to Assure a Competent Public Health Workforce
Healthy New Mexico – to Improve the Health Status of All New Mexicans

Key Strategic Plan Initiatives:

Track and support existing public health measures and priorities, while continuing to improve data collection activities

- Push performance measure orientation toward more outcome and output measures
- Focus explanatory population-based indicators toward the SHIP, since they require long-range, cross agency influence

Publish updated NM-IBIS Community Health Status Indicators (CHSIs) annually

- Involve community and tribal stakeholders in defining priority indicators for community health assessment
- Engage NMDOH program and epidemiologist staff in defining/operationalizing measures appropriately
- Ensure NMDOH program and epidemiologist staff maintain data and narrative context for NM-IBIS CHSIs annually appropriately

Redesign waivers to eliminate the DDW waitlist

- Design and implement three phased plan to eliminate wait list
- Create and implement a Supports Waiver
- Secure Rate increase for providers
- Disengage seven remaining requirements in the Jackson Settlement

Implement the State Health Improvement Plan (SHIP) priorities

- Identify NMDOH leads
- Involve and engage stakeholder groups and other state health-oriented agencies
- Determine best implementation practices in concert with external stakeholders
- Involve pertinent state partners in state health priority setting and implementation efforts
- Determine cross-agency strategies for collective statewide action

Promote effective substance use disorder treatment

- Map existing substance use treatment facilities, include tribal locations, and identify gaps
- Institute evaluation tools, with Behavioral Health Supports Division, and apply to known programs
- Expand Medical Assisted Treatment in Public Health Clinics and Primary Care Facilities
- Identify effective interventions for alcohol and methamphetamine abuse

Agency Programs		
1	Public Health Division	P002
2	Epidemiology and Response Division	P003
3	Scientific Laboratory Division	P004
4	Facilities Management Division	P006
5	Developmental Disabilities Supports Division	P007
6	Health Certification Licensing and Oversight	P008
7	Medical Cannabis Program	P787

New Mexico Department of Health

Public Health Division

P002

Program Description and Purpose

The Public Health Division (PHD) fulfills the New Mexico Department of Health's mission by working with individual families, communities and partners to improve health, eliminate disparities, and ensure timely access to quality, culturally competent health care.

Program Budget (in thousands):

FY19	General Fund	Other State Funds	Federal Funds	Other Transfers	TOTAL	FTE
200	$ 21,658.50	$ 3,396.70	$ 23,947.10	$ 3,017.90	$ 52,020.20	820.5
300	$ 15,367.10	$ 5,049.50	$ 10,538.80	$ 11,401.50	$ 42,356.90	
400	$ 12,287.40	$ 32,902.90	$ 35,318.50	$ 245.10	$ 80,753.90	
TOTAL	$ 49,313.00	$ 41,349.10	$ 69,804.40	$ 14,664.50	$ 175,131.00	

FY20	General Fund	Other State Funds	Federal Funds	Other Transfers	TOTAL	FTE
200	$ 22,374.90	$ 3,189.80	$ 25,107.10	$ 3,144.00	$ 53,815.80	816.5
300	$ 15,367.10	$ 4,950.50	$ 10,760.00	$ 12,086.70	$ 43,164.30	
400	$ 12,259.10	$ 33,401.20	$ 34,888.80	$ 305.90	$ 80,855.00	
TOTAL	$ 50,001.10	$ 41,541.50	$ 70,755.90	$ 15,536.60	$ 177,835.10	

* These figures do not include the Other Financing Uses General Fund amount of $462.3 thousand

Program Objective 1: Link people to needed personal health services and assure the provision of health care when otherwise unavailable

Measure	Description
1.1	Percent of participants in the National Diabetes Prevention Program that were referred by a health care provider through the agency-sponsored referral system
1.2	Percent of New Mexico adult cigerette smokers who access cessation services
1.3	Percent of QUIT NOW enrollees who successfully quit using tobacco by 7-month follow-up
1.4	Number of successful overdose reversals per client enrolled in the NMDOH Harm Reduction Program (**FY20 KEY MEASURE**)
1.5	Percent of female clients ages 15-19 seen in NMDOH public health offices who are provided most or moderately effective contraceptives (**FY20 KEY MEASURE**)

Program Objective 2: Work with health system and surveillance partners to monitor health status to identify community problems

Measure	Description
2.1	Percent of third grade children who are considered obese
2.2	Percent of adolescents who smoke
2.3	Percent of adults who smoke
2.4	Percent of preschoolers (19-35 months) who are indicated as being fully immunized

2.5	Percent of older adults who have ever been vaccinated against pneumococcal disease

Program Objective 3: Work with community partners to inform, educate and empower people about health issues	
Measure	Description
3.1	Number of teens that successfully complete teen pregnancy prevention programming (**FY20 KEY MEASURE**)
3.2	Number of high school youth trained in the Evolvement youth engagement program to implement tobacco projects in their school/community
3.3	Number of WIC clients participating in food tastings and/or cooking demonstrations in WIC clinics with kitchens

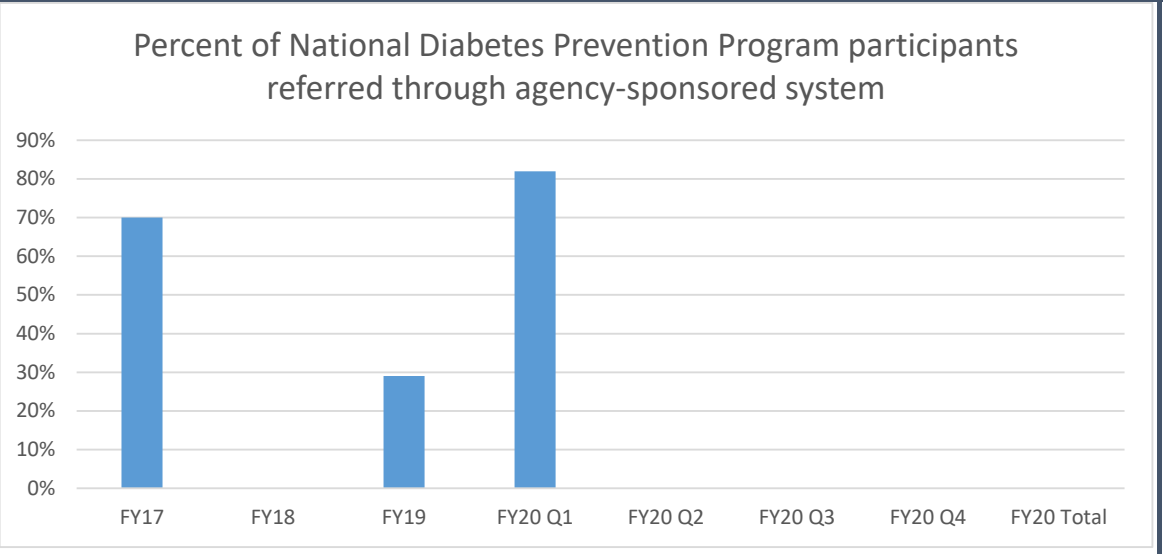
Program Objective 4: Work with communities to develop policies and plans that support individual and community health efforts	
Measure	Description
4.1	Percent of children in Healthy Kids, Healthy Communities with increased opportunities for healthy eating in public elementary schools
4.2	Percent of adults who are considered obese

Program Objective 5: Work with health care delivery systems to evaluate effectiveness, accessibility and quality of personal and population-based health services	
Measure	Description
5.1	Percent of NMDOH funded school-based health centers that demonstrate improvement in their primary care or behavioral health care focus area
5.2	Rate of diabetes hospitalization per 1,000 diagnosed persons
5.3	Rate of births to teens per 1,000 females aged 15-19

Program Objective 1: Link people to needed personal health services and assure the provision of health care when otherwise unavailable

Measure 1.1

Percent of participants in the National Diabetes Prevention Program that were referred by a health care provider through the agency-sponsored referral system



FY17	FY18	FY19	FY20 Q1	FY20 Q2	FY20 Q3	FY20 Q4	FY20 Total	FY20 Target
70%	0%	29%	82%					≥25%

Measure Description

Numerator: Number of participants in the NDPP that were referred by a healthcare provider through the agency-sponsored referral system.
Denominator: Total number of participants in the NDPP that were registered in the agency-sponsored referral system.

Data Source/Methodology

Data Source: DPCP's centralized referral and data system, accessed through Paths to Health NM: Tools for Healthier Living, and data from the referral and data management system service software Workshop Wizard

Story Behind The Data

Prediabetes, a precursor to diabetes, is when blood sugar levels are higher than normal, but not high enough to be diagnosed as diabetes. There may be no external symptoms of disease. In 2018, an estimated 567,000 New Mexican adults had prediabetes and only 3 out of 10 with the condition were aware of it. Unrecognized and untreated, prediabetes can progress to diabetes and lead to serious and costly health complications. Older adults, African Americans, and American Indians are at higher risk for prediabetes. The Centers for Disease Control and Prevention (CDC) states without weight loss and physical activity, 15-30% of people with prediabetes will develop diabetes within 5 years. Increasing access to a proven, structured lifestyle change program, such as the National Diabetes Prevention Program (NDPP), can cut an adults risk of getting type 2 diabetes in half by losing weight, eating healthy, and being more active.

Improvement Action Plan

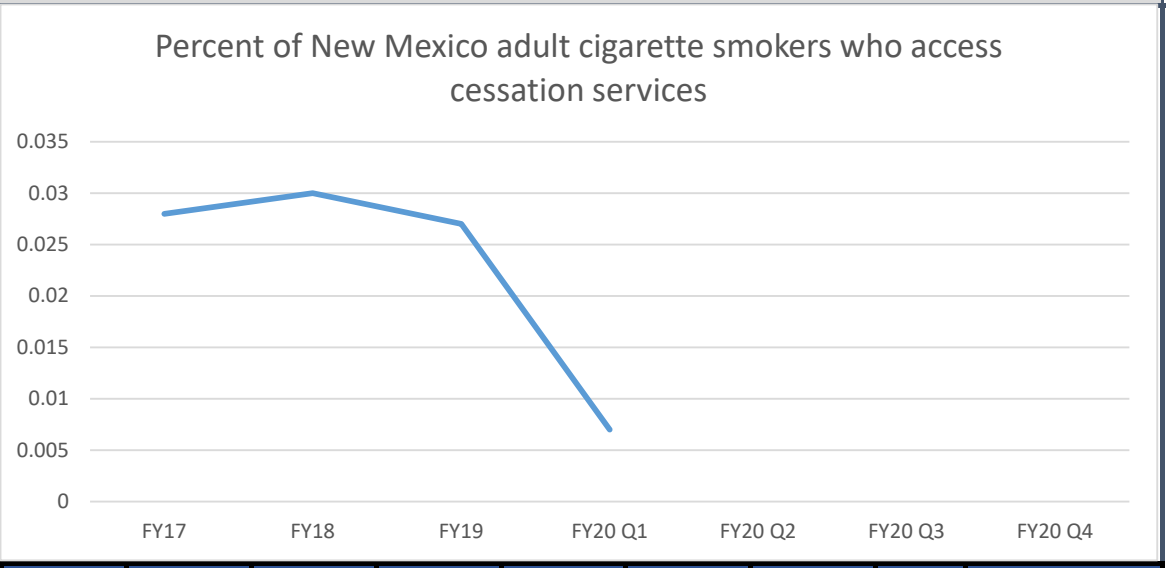
During this quarter, 9 referrals were received from healthcare providers. The Diabetes Prevention and Control Program (DPCP) will continue to promote its HIPAA compliant, referral and data management system service software, Workshop Wizard™ (NMDOH-sponsored referral system) as an available resource for healthcare systems and providers to refer their patients, with prediabetes or at risk for type 2 diabetes, to in-person or online National Diabetes Prevention Programs (NDPP). Technical assistance efforts will also focus on working with existing healthcare systems delivering the National DPP to incorporate Workshop Wizard™, as part of their screening, testing and referral workflow processes. The DPCP's Diabetes Prevention Coordinator will also continue to identify

	healthcare professional venues to share information on the Prevent Diabetes STAT Toolkit, Workshop Wizard™, and Paths to Health NM: Tools for Healthier Living website. In addition, ongoing efforts between the New Mexico Primary Care Association and PAC Software, NMDOH-sponsored referral system contractor, to generate referrals through EClinicalWorks electronic health record system and connect those referrals to Workshop Wizard™ are close to being finalized. PAC Software is now a member of the EClinicalWorks Provider-To-Provider Network and pilot tests will begin in fall, 2019. Last, the DPCP and its partners will continue to disseminate branded Paths to Health NM: Tools for Health Living "Rack Cards" to healthcare providers in areas with existing National DPP's to promote referrals through the NMDOH-sponsored referral system.

Program Objective 1: Link people to needed personal health services and assure the provision of health care when otherwise unavailable

Measure 1.2

Percent of New Mexico adult cigerette smokers who access cessation services



FY17	FY18	FY19	FY20 Q1	FY20 Q2	FY20 Q3	FY20 Q4	FY20 Total	FY20 Target
2.80%	3.00%	2.70%	0.70%					≥2.5%

Measure Description

Numerator: Number of adult cigarette smokers who access NMDOH Cessation Services.

Denominator:
Total estimated number of adult cigarette smokers in NM.

Data Source/Methodology

Annual QUIT NOW and DEJELO YA Cessation Services utilization and enrollment reports; Behavioral Risk Factor Surveillance System (BRFSS); UNM Geospatial and Population Studies population estimates as reported in NM IBIS.

Story Behind The Data

The New Mexico Department of Health's (NMDOH's) Tobacco Use Prevention and Control Program successfully reached 0.7% of adult smokers through its QUIT NOW and DEJELO YA tobacco cessation services in Q1 of FY20, aiming toward an annual target of 2.5% or higher. Although cigarette smoking continues to decline in the state, there are still about 246,000 adult cigarette smokers and users of other types of tobacco. Of the remaining smokers, about 2 in 3 have attempted to quit in the past year and 8 in 10 say that they plan to quit in the next 6-months. The strong interest in smoking cessation among remaining smokers points to a continued need and opportunity to reach and serve additional people through QUIT NOW and DEJELO YA.

Improvement Action Plan

Activities in FY20 will include consistent availability of cessation services through the entire fiscal year, mass media and targeted media to promote use of the services, training of health care providers, and the ongoing monitoring, evaluation, and tailoring of services. NMDOH Tobacco Cessation Services include quit coaching/counseling, free nicotine medications, phone- and web-based support, as well as services in Spanish. Enrollment and follow-up data are evaluated on a monthly basis in order to adjust promotion efforts and service delivery.

Program Objective 1: Link people to needed personal health services and assure the provision of health care when otherwise unavailable

Measure 1.3

Percent of QUIT NOW enrollees who successfully quit using tobacco by 7-month follow-up

FY17	FY18	FY19	FY20 Q1	FY20 Q2	FY20 Q3	FY20 Q4	FY20 Total	FY20 Target
32.00%	30.00%	32.15%	32.20%					≥30.0%

Measure Description

A sample of QUIT NOW enrollees is contacted 7-months after enrollment to determine whether they still had not been using tobacco for the previous month. The measure represents the percentage of those people reached at follow-up who responded that they are still done using tobacco.

Data Source/Methodology

New Mexico QUIT NOW Cessation Services Quarterly Evaluation Report compiled by TUPAC's contracted program evaluation team.

Story Behind The Data

The New Mexico Department of Health's (NMDOH's) Tobacco Use Prevention and Control Program reached QUIT NOW enrollees for a 7-month follow-up and found that 32.2% remained quit in Q1 of FY20, slightly better than the target of 30%. New Mexico's 7-month quit rate for QUIT NOW enrollees continues to track slightly above the 28.7% seen across 37 other state quitlines in the U.S. About two in three adult tobacco users want to quit, which translates into about 150,000 New Mexican adults who are potentially interested or actively trying to quit tobacco. QUIT NOW provides the quit coaching and FDA-approved medications to help these tobacco users accomplish their goal of quitting tobacco.

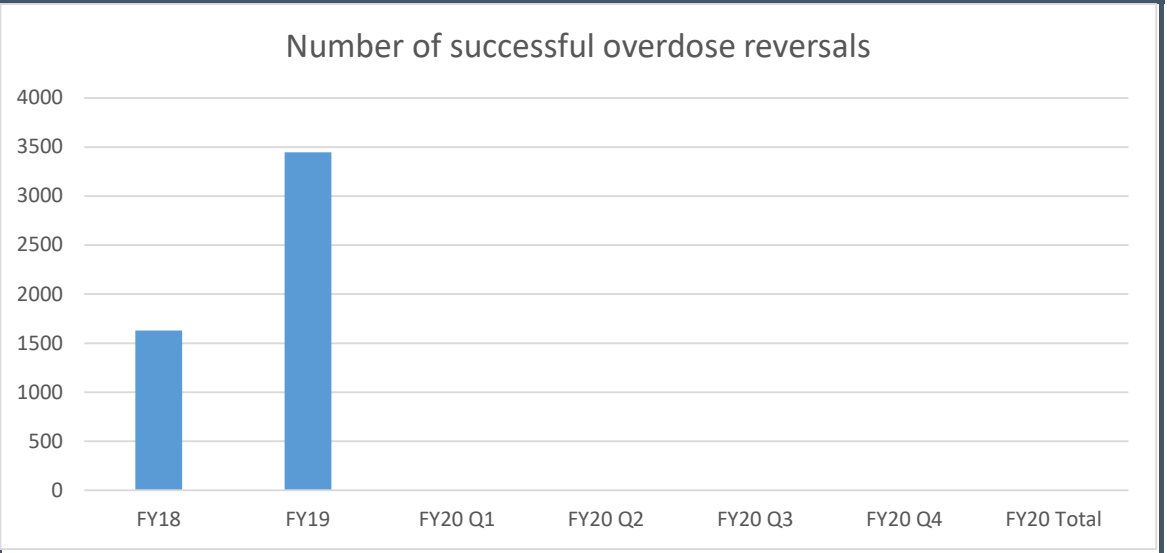
Improvement Action Plan

The Tobacco Program continues to train health care providers and health centers on tobacco use screening and referral to quitting services. Online trainings and in-person outreach to providers continues to be an effective way of increasing awareness, and the trainings continue to be updated to reflect the current tobacco landscape for nicotine addiction (i.e., e-cigarette use). A new online training geared toward behavioral health providers will be finalized and made available soon, which will then be promoted to this audience who serves patients who smoke at significantly higher rates than the general population.

Program Objective 1: Link people to needed personal health services and assure the provision of health care when otherwise unavailable

Measure 1.4

Number of successful overdose reversals per client enrolled in the NMDOH Harm Reduction Program (FY20 KEY MEASURE)



FY17	FY18	FY19	FY20 Q1	FY20 Q2	FY20 Q3	FY20 Q4	FY20 Total	FY20 Target
	1629	3446						

Measure Description

This measure is the number of successful reversals per number of overdose prevention compared to the number of naloxone distribution and education sessions.

Data Source/Methodology

NMDOH's Hepatitis and Harm Reduction Naloxone Distribution Database as complied by the Hepatitis and Harm Reduction Program with the support of Substance Use Epidemiology staff from the Epidemiology and Response Division.

Story Behind The Data

The New Mexico Department of Health Hepatitis and Harm Reduction Program has one of the nation's longest standing overdose prevention education and naloxone distribution programs. In Q3 of FY2016, the New Mexico Legislature passed legislation that reduced barriers to providing naloxone to individuals at highest risk of experiencing an opioid overdose and those around them. This allowed the program to rapidly increase the number of individuals reached. This data shows that the number of individuals who reported that they had successfully utilized naloxone to reverse an opioid overdose has remained steady. It is important to note that this number is likely an undercount of those that utilized naloxone to reverse an opioid overdose as this is based on self-reporting when individuals return to receive a refill.

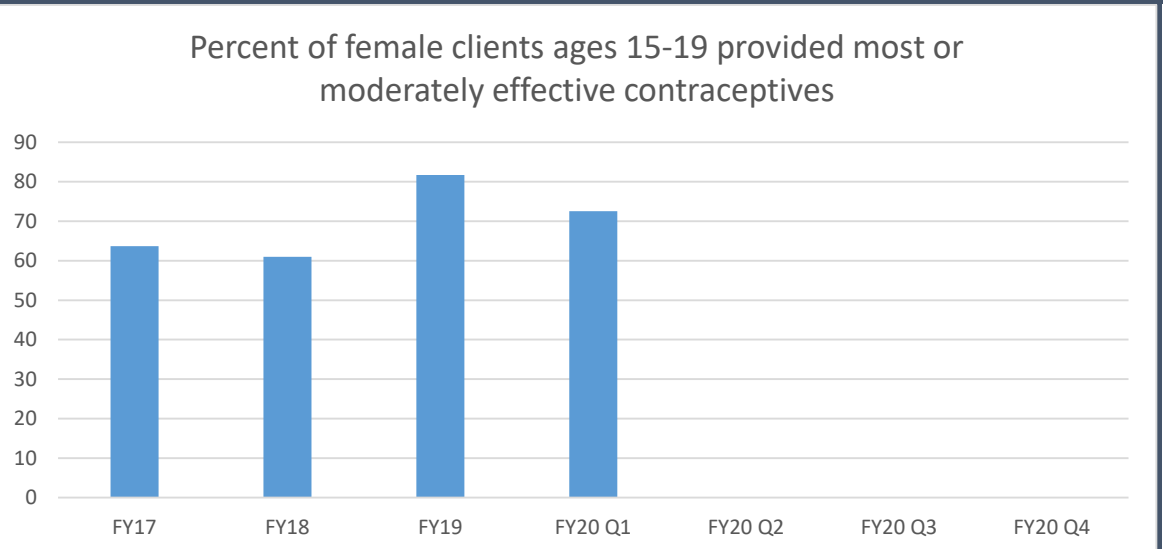
Improvement Action Plan

The Hepatitis and Harm Reduction Program continues to meet the objectives that have been set. The program will continue to work towards reducing stigma and encouraging individuals to report when they have utilized naloxone, as the program continues to grow each year, and it is anticipated that the objective will continue to be met in future fiscal years.

Program Objective 1: Link people to needed personal health services and assure the provision of health care when otherwise unavailable

Measure 1.5

Percent of female clients ages 15-19 seen in NMDOH public health offices who are provided most or moderately effective contraceptives (FY20 KEY MEASURE)



FY17	FY18	FY19	FY20 Q1	FY20 Q2	FY20 Q3	FY20 Q4	FY20 Total	FY20 Target
63.7	61	81.7	72.5					62.5

Measure Description

This is a measure of the percentage of family planning teen clients who receive an implant, IUD, pill, ring, or shot as their method of birth control during a specific quarter.

Data Source/Methodology

The NM Family Planning Annual Report; reports are generated on a quarterly basis to determine the percentage of teens who report using most- or moderately-effective contraception during a given timeframe.

Story Behind The Data

Access to and availability of effective contraceptive methods contribute to the steady decrease in New Mexico's teen birth rate. The broad range of contraceptive methods (including IUDs and implants [most-effective] and pills, injectables, and rings [moderately-effective]) is available at 39 of the 44 public health offices that offer family planning services. In Q1, almost 73% of the contraceptives that were dispensed to teens aged 15-19 years old in local public health offices were most- or moderately-effective contraceptive methods. Since 2013, the teen birth rate among 15-to-19-year-olds in New Mexico has declined by 41.3% to 25.2 per 1,000 in 2016 (NM-IBIS) and is the sixth highest in the nation (National Center for Health Statistics). Teens who drop out of school are more likely to become pregnant and have a child, than peers who graduate. Seventy-one percent of teen mothers report that their pregnancy was unintended or mistimed, compared to 44% of all mothers (NM Indicator-Based Information System, 2018). Some reasons for higher teen parenthood in mixed urban/rural areas include lack of health insurance, increased poverty, transportation barriers, and less access to services. In NM, teen birth rates are highest for American Indians and Hispanics (at almost double the reference rate).

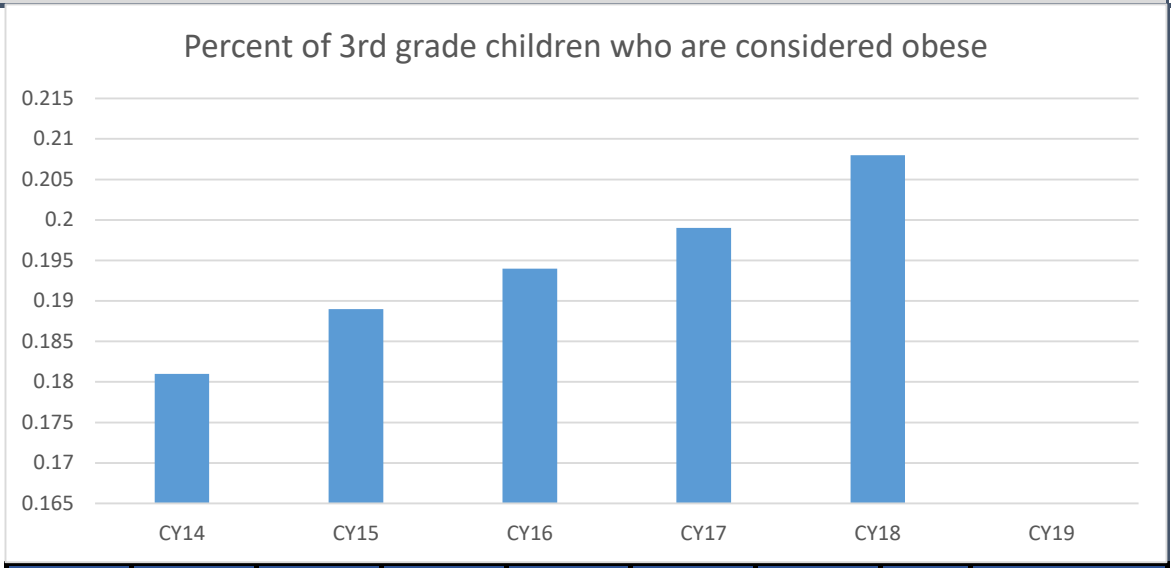
Improvement Action Plan

The New Mexico Family Planning Program is dedicated to continuing the provision of family planning clinical services and telemedicine services for reproductive health. NM FPP will also continue to fund staff in public health offices to provide the broad range of contraceptive methods and confidential family planning services throughout the state. The Q1 percentage is higher than the FY20 target; FPP will continue to ensure that most- and moderately-effective contraception are available on the formulary for clients to select.

Program Objective 2: Work with health system and surveillance partners to monitor health status to identify community problems

Measure 2.1

Percent of third grade children who are considered obese



CY14	CY15	CY16	CY17	CY18	CY19	CY20		CY20 Target
18.10%	18.90%	19.40%	19.90%	20.80%				Explanatory

Measure Description

Annual calendar year explanatory measure. Obesity is defined as Body Mass Index (BMI) at or above the 95th percentile for children of the same age and sex.

Data Source/Methodology

In the fall of 2018, the Obesity, Nutrition, and Physical Activity Program (ONAPA) and its partners, completed statewide childhood obesity surveillance by measuring 6,604 kindergarten and third grade students in 56 randomly-selected public elementary schools, and in March 2019, published its New Mexico

Story Behind The Data

Childhood obesity occurs when a child is well above the healthy weight for his/her age and height. Obese children are more likely to become obese adults with increased risk of chronic conditions, including heart disease and type 2 diabetes. American Indian children have the highest rates among all racial/ethnic groups, by third grade nearly one-in-two (42.3%) American Indian students are overweight or obese, followed by Hispanics at 37.7%

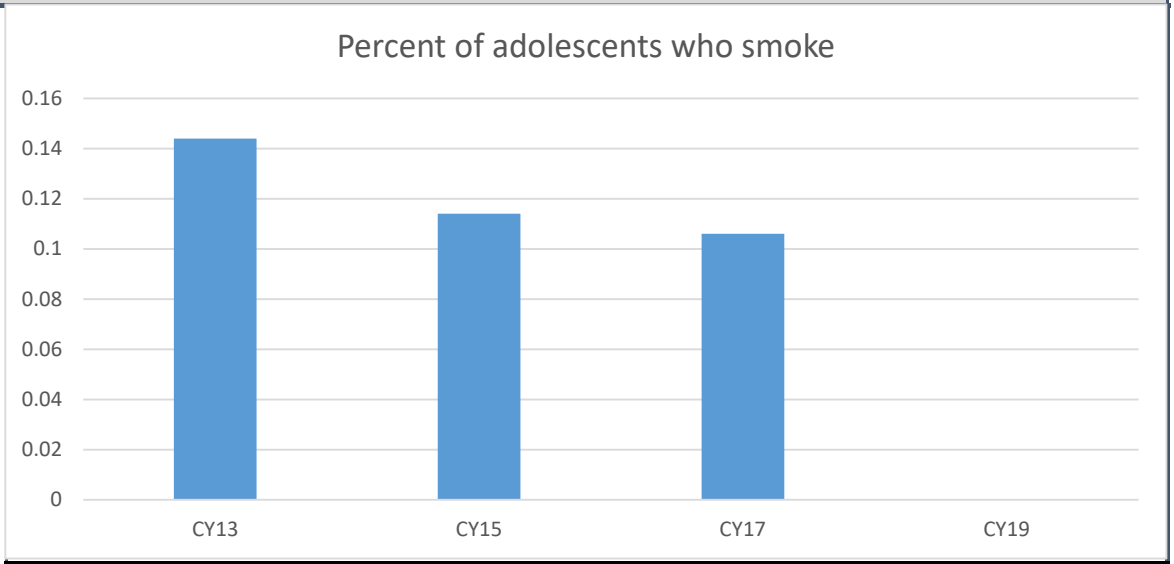
Improvement Action Plan

Childhood Obesity 2018 update. ONAPA and its partners also built support for measuring an additional 3,000 students in 31 HKHC schools, so these communities would have more comprehensive childhood obesity data.	

Program Objective 2: Work with health system and surveillance partners to monitor health status to identify community problems

Measure 2.2

Percent of adolescents who smoke



CY13	CY15	CY17	CY19					
14.40%	11.40%	10.60%	n/a					Explanatory

Measure Description

Annual calendar year explanatory measure

Data Source/Methodology

New Mexico youth smoking data for 2019 will not be available until early 2010. The Youth Risk and Resiliency Survey (YRRS) is conducted every two years and is currently in the field (Fall 2019).

Story Behind The Data

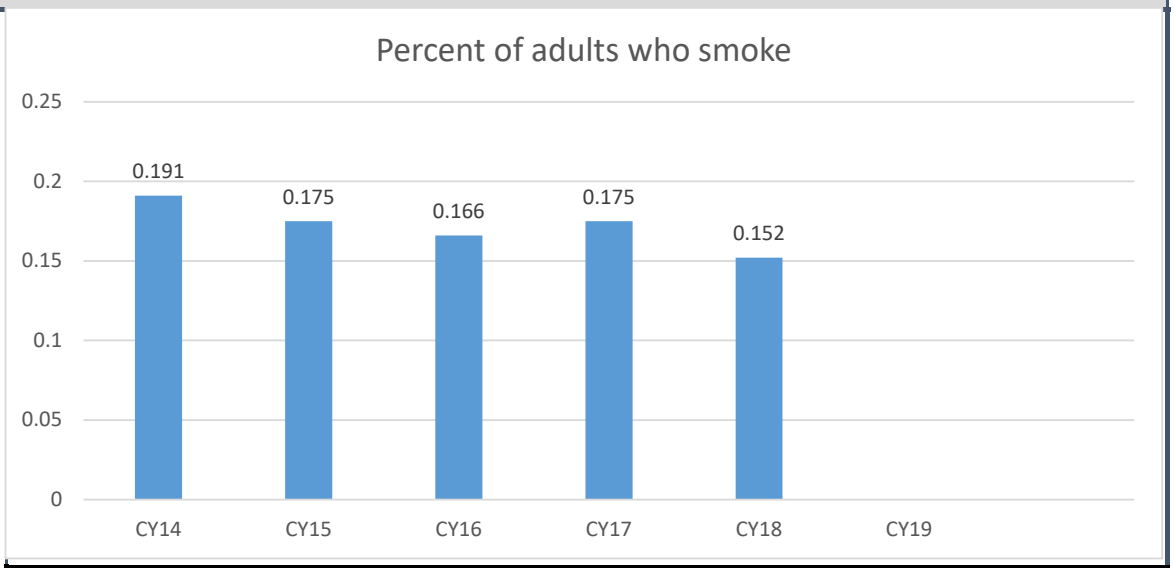
The most recent youth smoking rate was 10.6% and comes from the 2017 YRRS. New national data showed a significant decline in youth smoking between 2018 (8.1%) and 2019 (5.8%), and while New Mexico youth smoking trends typically mirror those in the U.S., we will have to wait until early 2020 to determine if this holds true for 2019 results.

Improvement Action Plan

Program Objective 2: Work with health system and surveillance partners to monitor health status to identify community problems

Measure 2.3

Percent of adults who smoke



CY14	CY15	CY16	CY17	CY18	CY19	CY20		CY20 Target
19.10%	17.50%	16.60%	17.50%	15.20%				Explanatory

Measure Description

Annual calendar year explanatory measure

Data Source/Methodology

Behavioral Risk Factor Surveillance System (BRFSS) data via New Mexico Internet Based Information System (NM IBIS)

Story Behind The Data

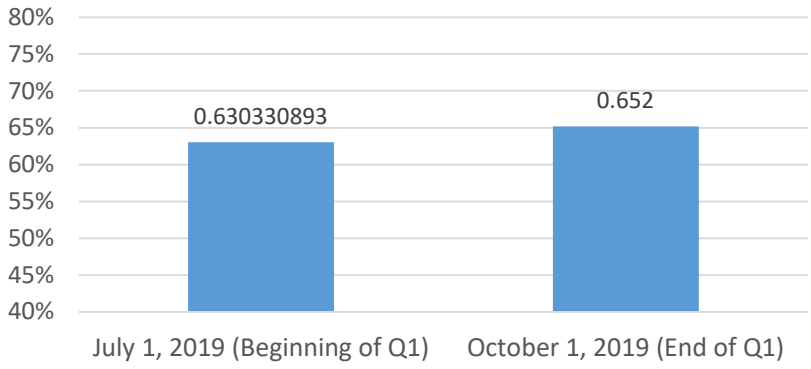
Cigarette smoking is the leading preventable cause of disease, disability, and death in the U.S. and in New Mexico. Cigarette use kills over 2,800 New Mexicans and afflicts 84,000 people with tobacco-related diseases. Smoking also costs New Mexico about $844 million annually in healthcare-related costs. Smoking among New Mexicans has reached an all-time low of 15.2% and has declined by 30% among adults since 2011, which translates into about 100,000 fewer smokers in 2018. However, smoking rates have stagnated or not declined as quickly among certain supgroups, including low-income, uninsured, Medicaid-insured and lesbian/gay New Mexicans.

Improvement Action Plan

Program Objective 2: Work with health system and surveillance partners to monitor health status to identify community problems

Measure 2.4

Percent of preschoolers (19-35 months) who are indicated as being fully immunized



FY17	FY18	FY19	FY20 Q1	FY20 Q2	FY20 Q3	FY20 Q4	FY20 Total	FY20 Target
n/a	61.80%	63.85%	65.20%					≥65%

Measure Description

Percentage of preschoolers ages 19-35 months who are fully immunized.

Data Source/Methodology

The data source is New Mexico Vital Records Bureau and the New Mexico Statewide Immunization Information System (NMSIIS). Reports were generated from NMSIIS to determine the percentage of preschoolers (age 19-35 months) who are fully immunized factoring in the total reported births during this timeframe from Vital Records.

Story Behind The Data

1. In Q1 FY20 (As of October 1, 2019), New Mexico's vaccine coverage for children aged 19-35 months old was 65.2%, according to data from the New Mexico Statewide Immunization Information System and NM Vital Records. The 4:3:1:3:3:1:4 (4 DTaP, 3 Polio, I MMR, 3 HepB, 3 HIB, 1 Varicella, and 4 Pneumococcal) series is the nationally-accepted 'gold standard' for childhood immunization coverage.
2. The Healthy People 2020 objective is 80%, and is a realistic target for New Mexico as well.
3. In FY17, New Mexico focused on the roll-out of its new, state-of-the-art immunization registry that has improved ordering, reporting, data quality and data exchange. In FY18 and FY19, ongoing efforts to improve registry data continued. The current 2020 goal is to reduce the number of duplicate records for clients in the registry to improve data quality. The NMSIIS team is working on implementing their Data Quality Improvement Plan and will hire contractual staff to assist with onboarding, data exchange and quality improvement intiatives. The Immunization Program continues revenue collection for the Vaccines Purchase Act (VPA) for vaccines administered to privately-insured clients, which assures the continued supply of vaccines for this group.
4. In the first quarter of FY19, regulations for the registry were promulgated and they went into effect October 16, 2018. The regulations work to enforce statutory reporting requirements, which should also contribute to the overall data quality and completeness of patient immunization records.
5. In the second quarter of FY20, New Mexico will continue its vaccine revenue collection to support future vaccine purchases, and expand upon the capacity of its immunization registry (NMSIIS) to support enhanced tracking of program objectives.

Improvement Action Plan

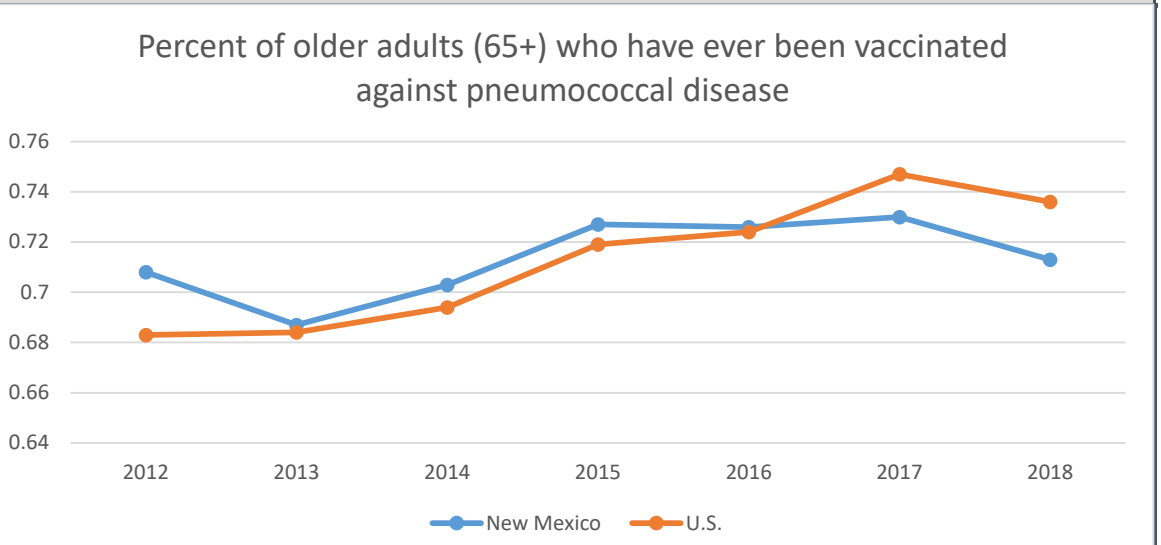
Immunization Quality Improvement for Providers (IQIP) visits focus on practices to help practices improve immunization coverage of their childhood and adolescent populations. Having providers routinely measure their clinics' pediatric immunization coverage levels and share the results with their staff can increase their practices' effectiveness in bringing all their patients up-to-date for immunizations. Finally, having a practice immunization champion focused on quality improvement,

	reducing barriers to immunization, and improving coverage levels is a key evidence-based strategy. A strongly recommended evidence-based strategy is reminder-recall notices to families whose children are due or late for a vaccine. Effective reminder-recall notices and provider feedback are dependent upon complete and accurate immunization records in NMSIIS. A primary Immunization Program goal is to improve registry data quality by continuing to increase electronic data exchange, train providers statewide, and assure that all Vaccines for Children providers are entering immunizations timely into the registry. The Immunization Program sends out monthly reminder-recall notices statewide for preschoolers that are not up-to-date. NMSIIS also has the functionality that allows providers to generate coverage reports for their own practices. Providers are trained on how to produce these reports as part of their IQIP visit. The Immunization Program supports the recognition of the immunization champions through its support of the NM Immunization Coalition's annual "Immunization Champion" award, and through incentives for staff who participate in IQIP reviews. Action Plan/Milestones: Q.1: Reduce the number of duplicate records that exist for the 0-3 year-old age group in the Immunization registry to improve data quality. Status: Completed

Program Objective 2: Work with health system and surveillance partners to monitor health status to identify community problems

Measure 2.5

Percent of older adults who have ever been vaccinated against pneumococcal disease



FY17	FY18	FY19	FY20 Q1	FY20 Q2	FY20 Q3	FY20 Q4	FY20 Total	FY20 Target
73.0%	71.3%	n/a	n/a					≥75%

Measure Description

Numerator: Number of survey respondents age 65 and older who have ever had a pneumonia immunization. Data are weighted to adjust for effects of sample design and to represent the population distribution of adults by sex, age group, and area of residence.
Denominator: Total number of survey respondents age 65 and older, excluding missing, "Don't Know" and "Refused" responses.

Data Source/Methodology

Data for this indicator report are from the Behavioral Risk Factor Surveillance System (BRFSS), an ongoing survey of adults regarding their health-related behaviors, health conditions, and preventive services. Data are collected in all 50 states, D.C., and U.S. territories. Responses have been weighted to reflect the

Story Behind The Data

Recommended immunizations for adults, aged 65 years and older, include a yearly immunization against influenza (flu) and a one-time immunization against pneumococcal disease: pneumococcal polysaccharide 23-valent vaccine (PPSV23). Adults 65 and over may also benefit from pneumococcal conjugate 13-valent vaccine, which protects against an additional 13 strains of pneumococcal bacteria and is recommended based on shared clinical decision-making between an individual and their provider. CDC estimates that influenza has resulted in between 9.3 million – 49.0 million illnesses, between 140,000 – 960,000 hospitalizations, and between 12,000 – 79,000 deaths annually since 2010. Pneumococcal disease, which is caused by infection with *Streptococcus pneumoniae* bacteria, can cause serious illness and death due to pneumonia, bloodstream infections, meningitis, and other types of infection. Most of the deaths and serious illnesses caused by influenza and pneumococcal disease occur in older adults and others at increased risk for complications of these diseases because of other risk factors or medical conditions.

Improvement Action Plan

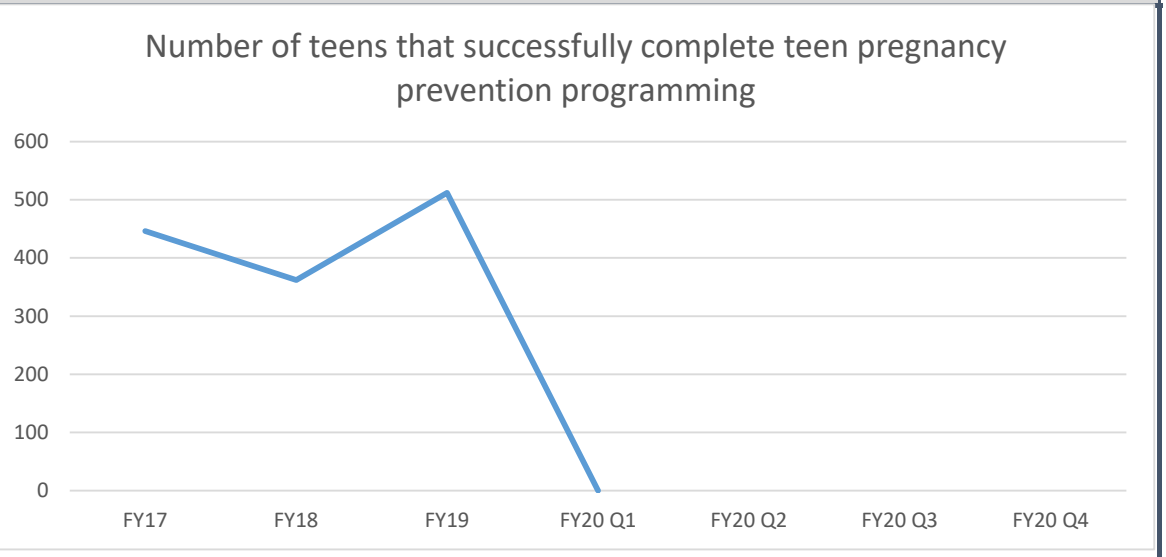
In FY20, the Immunization Program will continue to ensure that public health offices and partner organizations have access to PCV13 and PPSV23 for their uninsured patients.
The program will also continue to promote pneumococcal vaccination at community events serving older adults. In Q1, the program conducted outreach at the New Mexico Conference on Aging and a screening event hosted by the New Mexico Adult Falls Prevention Coalition, interacting with approximately 600 older adults. The program will also continue its immunization registry reminder/recall project; all people over 65 with registry records receive postcards reminding them

New Mexico adult population by age, sex, ethnicity, geographic region, marital status, education level, home ownership and type of phone ownership. The US Healthy People 2020 Target for this measure is 90%.	that their annual wellness visit is due and that they may need certain vaccines. Also in FY20, the program will expand its Community Health Worker curriculum statewide, including a train-the-trainer session planned for Q2.

Program Objective 3: Work with community partners to inform, educate and empower people about health issues

Measure 3.1

Number of teens that successfully complete teen pregnancy prevention programming (FY20 KEY MEASURE)



FY17	FY18	FY19	FY20 Q1	FY20 Q2	FY20 Q3	FY20 Q4	FY20 Total	FY20 Target
446	362	512	0					232

Measure Description

This is a measure of the count of students who successfully complete a specific teen pregnancy prevention program over a 12-month period.

Data Source/Methodology

Curriculum specific data analysis by monitoring and auditing of Master Lists, Attendance Lists, and the Wyman Connect website for data collection. Reports are generated when programming is complete.

Story Behind The Data

Service-learning, positive youth development, and comprehensive sex education programming are all protective factors for teens to reduce risky sexual behaviors. Since 2013, the teen birth rate among 15-to-19-year-olds in New Mexico (NM) has declined by 41.3% to 25.2 per 1,000 in 2016 (NM-IBIS) and is the sixth highest in the nation (National Center for Health Statistics). Teens who drop out of school are more likely to become pregnant and have a child than peers who graduate. Seventy-one percent of teen mothers report that their pregnancy was unintended or mistimed, compared to 44% of all mothers (NM Indicator-Based Information System, 2018). Some reasons for higher teen parenthood in mixed urban/rural areas include lack of health insurance, increased poverty, transportation barriers, and less access to services.

In NM, teen birth rates are highest for American Indians and Hispanics (at almost double the reference rate). Proactive service-learning, positive youth development, and comprehensive sex education programming are all protective factors for teens to reduce risky sexual behaviors. NM Family Planning Program continues to contract with schools and community organizations to provide both TOP and Project AIM.

FY20 Q1 has zero pregnancy prevention programming to report because school was not in session during this period.

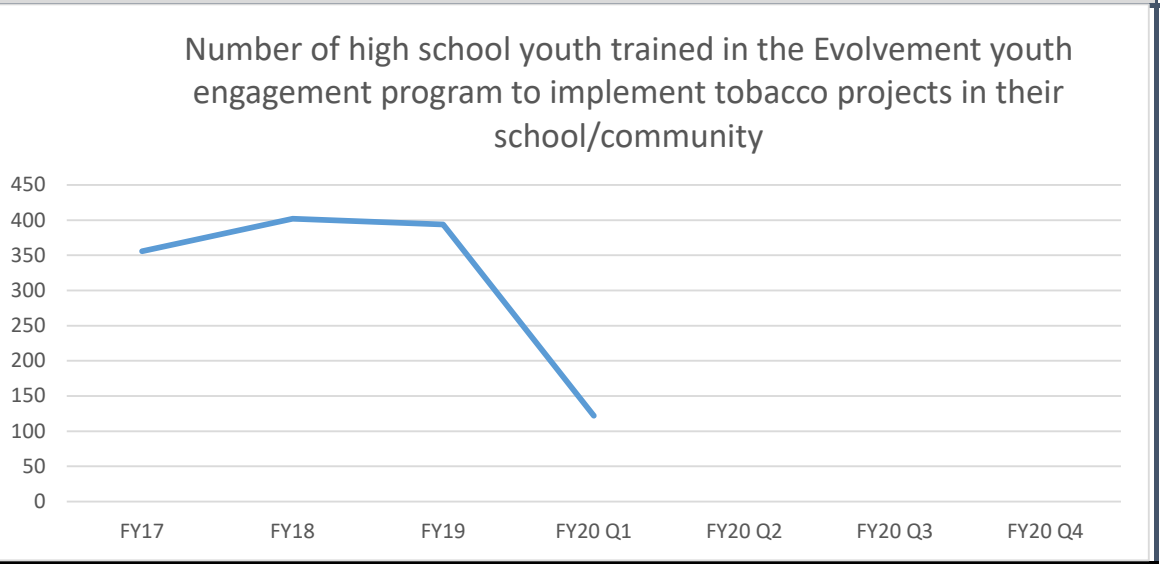
Improvement Action Plan

Focus in Q1 is on recruitment and collaboration with our partners, and the FY20 teen pregnancy prevention programming will begin with all cohorts. The Family Planning Program's health educators will be gathering client data.

Program Objective 3: Work with community partners to inform, educate and empower people about health issues

Measure 3.2

Number of high school youth trained in the Evolvement youth engagement program to implement tobacco projects in their school/community



FY17	FY18	FY19	FY20 Q1	FY20 Q2	FY20 Q3	FY20 Q4	FY20 Total	FY20 Target
356	402	394	122					≥375

Measure Description

This measure includes youth who are enrolled in a high school that has been officially recruited and selected for participation in the Evolvement youth engagement program. Youth also need to have undergone approved training in the program and engaged in the development and implementation of one or more tobacco prevention projects in their school or community during the school year.

Data Source/Methodology

Youth enrolled in a high school that has been recruited and selected for participation in the Evolvement youth engagement program. Data from TUPAC Contractor Annual Report and online electronic evaluation reporting system.

Story Behind The Data

Training youth in the Evolvement youth engagement program is a key strategy in implementing tobacco prevention campaigns in schools and communities across New Mexico. Increasing awareness and education on the harms of tobacco use and nicotine addiction through prevention campaigns, along with other interventions, can help reduce youth tobacco use prevalence. Campaigns implemented by trained Evolvement youth are designed to address topics such as emerging tobacco products, as well as restrict youth access to tobacco by educating New Mexico communities, parents, and retailers to help prevent illegal tobacco sales to minors. In Q1 of FY20, 122 youth were trained on youth engagement strategies across four different school trainings in different parts of the state.

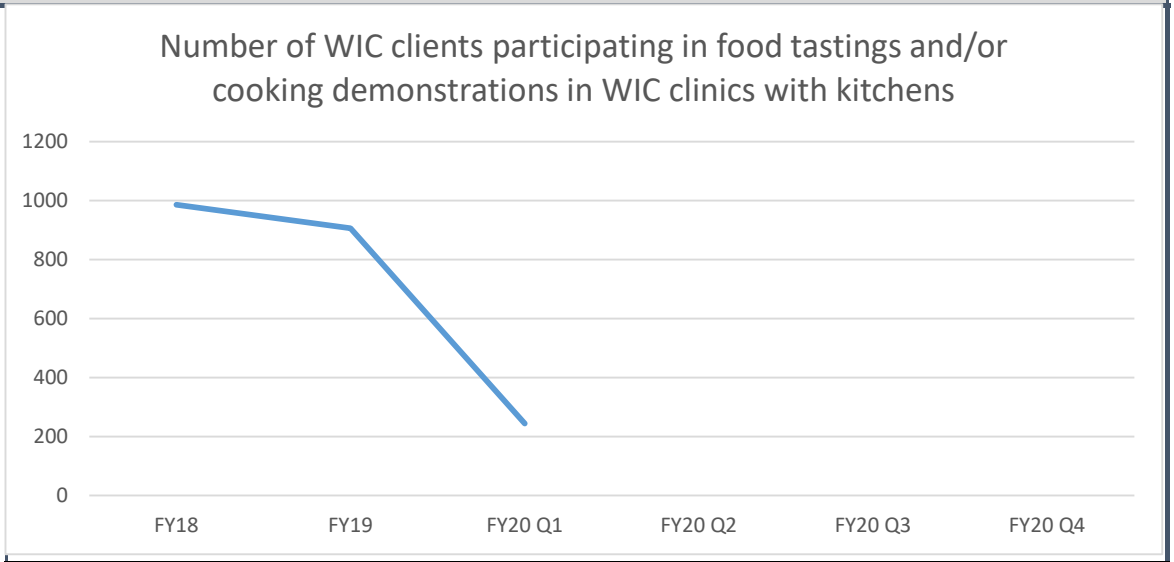
Improvement Action Plan

At the end of Q1 in FY20, there are already 17 schools that have expressed interest in joining the Evolvement youth engagement program, and 14 have already signed memoranda of understanding for FY20. An additional 12 trainings are being coordinated for Q2, with an estimated reach of at least 240 youth statewide. Careful attention is being paid to ensuring that the recruited schools are geographically spread out and demographically diverse to have the greatest impact in tobacco prevention efforts.

Program Objective 3: Work with community partners to inform, educate and empower people about health issues

Measure 3.3

Number of WIC clients participating in food tastings and/or cooking demonstrations in WIC clinics with kitchens



FY17	FY18	FY19	FY20 Q1	FY20 Q2	FY20 Q3	FY20 Q4	FY20 Total	FY20 Target
N/A	986	906	244					>1,232

Measure Description

This measure is intended to provide information on the low-income adult population in New Mexico, specifically WIC clients. The Obesity, Nutrition and Physical Activity Program (ONAPA) is currently working with WIC and New Mexico State University Cooperative Extension Services (CES) to implement nutrition education using WIC approved foods in WIC clinics with kitchens.

Data Source/Methodology

ONAPA works closely with WIC clinics and NMSU CES (as appropriate) to collect information on the number of WIC clients who participate in food tastings.

Story Behind The Data

Between 2016 and 2018, 66.2.7% of New Mexico's adults were overweight or obese. Adults with lower socioeconomic status are more likely to practice unhealthy lifestyle behaviors, be overweight or obese, and suffer from chronic conditions. Women, Infants, and Children (WIC) clients (women and their children under the age of 5) are considered low-income and at risk for food insecurity.

The ONAPA, WIC, and NM State University are coordinating efforts to provide nutrition education through the implementation of food tastings and cooking demos for WIC recipients using WIC eligible foods - primarily fruits, vegetables, and whole grains. With the addition of federal Supplemental Nutrition Assistance Program Education (SNAP-Ed) funding in fiscal year 2016, the ONAPA program expanded its reach to the low-income adult population for the first time, specifically those participating in food assistance programs within tribal communities and high-poverty counties. The SNAP-Ed program has the greatest potential impact on nutrition and physical activity behaviors with interventions and strategies geared towards low-income women and children.

Improvement Action Plan

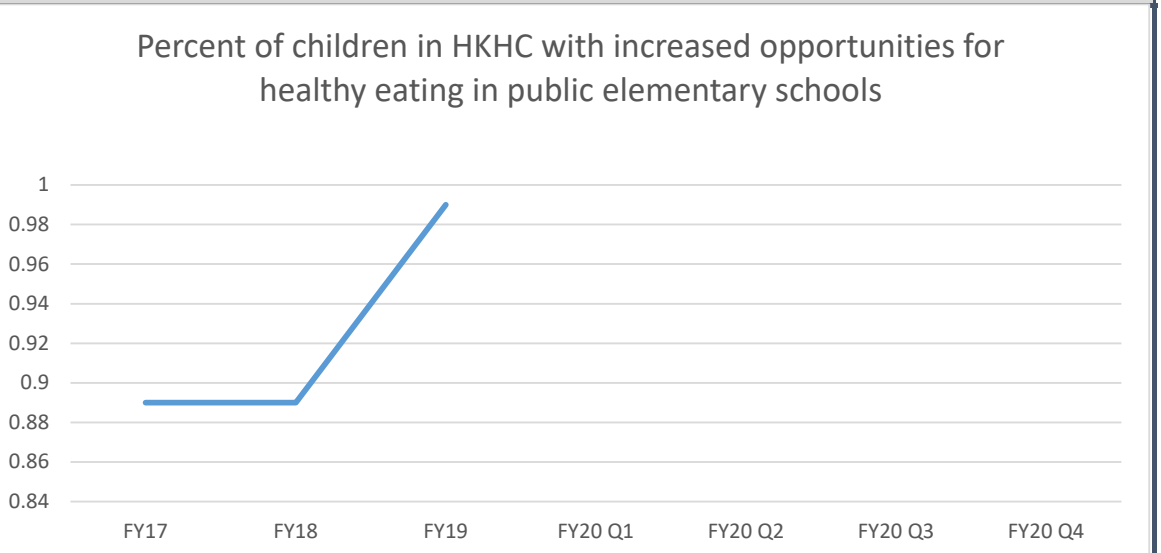
In Q1, WIC recipient attendance at WIC clinic food demos is increasing after the implementation of the MOSAIC data collection system within WIC. ONAPA is working on strengthening our partnership with WIC to expand food demos in WIC clinics without kitchens to reach more WIC recipients. Supplies and equipment needed to conduct mobile food demos have been identified and both programs are exploring options for purchase because two additional WIC clinics without kitchens (Alamo Band of Navajo Nation in Socorro County and the Chaparral WIC clinic in Dona Ana County) began participating in food tastings in collaboration with NMSU. The WIC State Nutritionist has identified WIC staff interested in participating in training to conduct food tastings and cooking

	demos in WIC clinics without kitchens. WIC will identify a nutrition education curriculum that uses WIC foods. Once the curriculum is determined, training for WIC staff will begin.

Program Objective 4: Work with communities to develop policies and plans that support individual and community health efforts

Measure 4.1

Percent of children in Healthy Kids, Healthy Communities with increased opportunities for healthy eating in public elementary schools



FY17	FY18	FY19	FY20 Q1	FY20 Q2	FY20 Q3	FY20 Q4	FY20 Total	FY20 Target
89%	89%	99%						>89%

Measure Description

This measure represents elementary-school age children in schools with increased opportunities for healthy eating during the school day on an ongoing and regular basis; the denominator is total elementary school population of schools within HKHC communities.

Data Source/Methodology

Data on healthy eating is collected annually at the end of the school year by HKHC coordinators in local elementary schools. Our program aggregates, analyzes, and reports results by the end of the summer to assess environmental, policy, and systems changes over time.

Story Behind The Data

Increasing healthy eating and physical activity opportunities in schools is a best practice for preventing obesity, by exposing children to healthy lifestyle behaviors at an early age. In 2018, 13.3% of kindergarten and 20.8% of third grade students in New Mexico were obese; obese children are more likely to become obese adults with an increased risk of chronic health conditions. Healthy eating and physical activity are two lifestyle behaviors that can help prevent obesity.

As it relates to this measure, the Obesity, Nutrition, and Physical Activity Program (ONAPA) works closely with local coordinators in 13 Healthy Kids Healthy Communities (HKHC) to:
1) Engage partners and build school system support for establishing and implementing strong wellness policies to improve the school nutrition environment.
2) Implement sustainable healthy eating interventions coupled with nutrition education, e.g., the Healthy Kids 521O Challenge (a 21-day educational campaign motivating children to eat at least 5 fruits or vegetables each day, limit screen time to 2 hours or less each day, get at least 1-hour of physical activity each day, and drink lots of water (H2O) every day), classroom fruit and vegetable tastings, salad bars, farm to cafeteria, healthy snacks, and edible gardens.

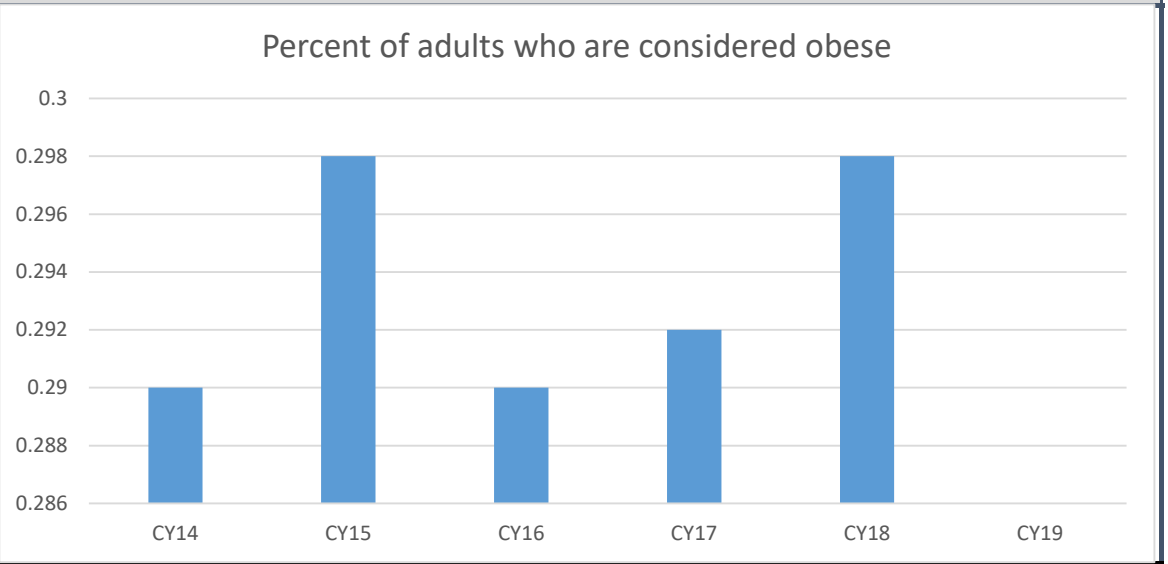
Improvement Action Plan

In Q1, Healthy Kids Healthy Communities (HKHC) coordinators worked with local schools to create a plan for participating in and promoting New Mexico Grown Week, Farm to School Month, and International Walk and Roll to School Day. In partnership with schools, they also began implementing the Healthy Kids 521O Challenge and BMI surveillance. Nearly every elementary school in a HKHC school district, implements at least one healthy eating initiative. While HKHC is effectively increasing opportunities for healthy eating in schools in 13 communities, more resources are needed to expand efforts into additional communities across the state to improve healthy lifestyle behaviors and increase the likelihood of childhood obesity prevalence rates trending downwards.

Program Objective 4: Work with communities to develop policies and plans that support individual and community health efforts

Measure 4.2

Percent of adults who are considered obese



CY14	CY15	CY16	CY17	CY18	CY19	CY20		FY20 Target
29%	29.80%	29%	29.20%	29.80%	n/a			Explanatory

Measure Description

The percent of respondents whose self-reported height and weight corresponds to a Body Mass Index (BMI) equal to or greater than 30.0.

Data Source/Methodology

Data for this indicator report are from the Behavioral Risk Factor Surveillance System (BRFSS), an ongoing survey of adults regarding their health-related behaviors, health conditions, and preventive services. Data are collected in all 50 states, D.C., and U.S. territories. Responses have been weighted to reflect the New Mexico adult population by age, sex, ethnicity, geographic region, marital status, education level, home ownership and type of phone ownership.

Story Behind The Data

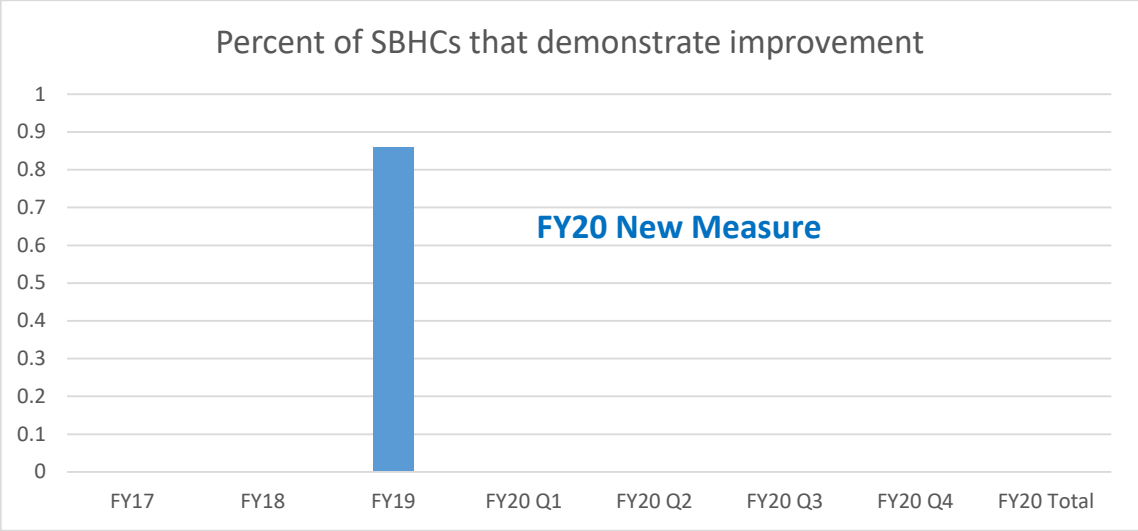
Among New Mexico's adults, 65.7% are overweight or obese (American Indians have the highest rate at 75%). Similarly, over one-in-four adults, ages 45 years old and older, have been diagnosed with two or more chronic diseases. Adults with lower socioeconomic status are at greater risk for adopting unhealthy lifestyle behaviors, becoming overweight or obese, and developing chronic disease.

Improvement Action Plan

Program Objective 5: Work with health care delivery systems to evaluate effectiveness, accessibility and quality of personal and population-based health services

Measure 5.1

Percent of NMDOH funded school-based health centers that demonstrate improvement in their primary care or behavioral health care focus area



FY17	FY18	FY19	FY20 Q1	FY20 Q2	FY20 Q3	FY20 Q4	FY20 Total	FY20 Target
		86%	0%					95%

Measure Description

NMDOH funded school based health centers are required to complete a Quality Improvement initiative as part of their contract. This annual measure reports the number of school based health centers that meet their year-long QI goal.

Data Source/Methodology

School based health centers report to OSAH in their operational plan their annual QI goal, as well as their mid-year progress and end of year progress toward those goals.

Story Behind The Data

Engaging clinical care practices in quality improvement (QI) activities is essential to achieving the triple aim of improving the health of the population, enhancing patient experiences and outcomes, and reducing the per capita cost of care, as well as improving provider experience. School based health centers are no exception to these goals. To that end, DOH funded school based health centers are required to complete a pediatric, QI initiative annually. OSAH includes 12 different QI focus areas including primary and behavioral health care, and admistrative processes. FY19 was the first year for this performance measure.

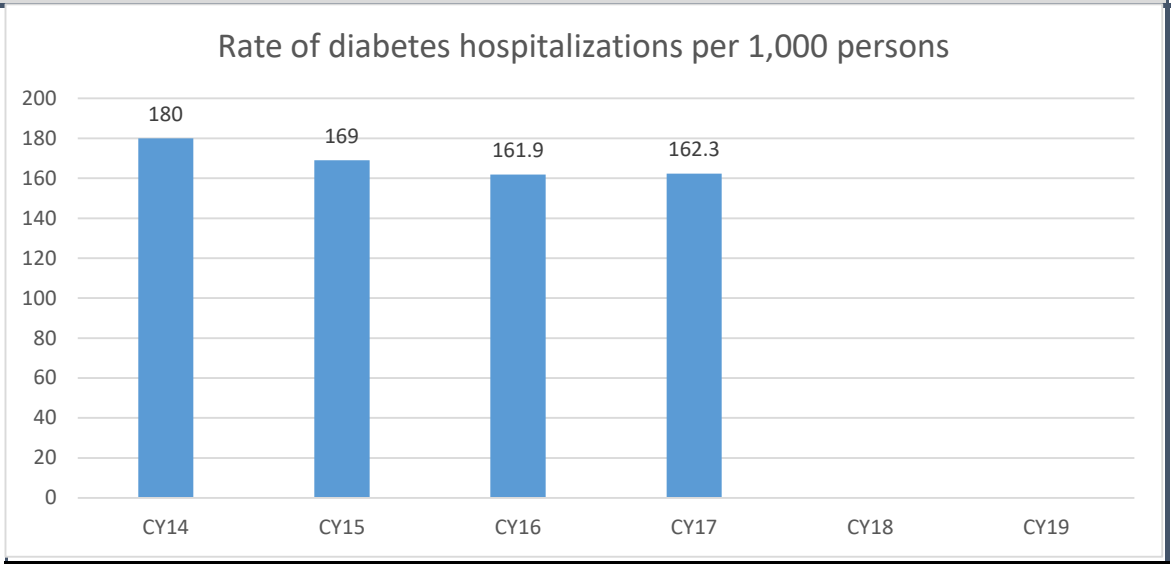
Improvement Action Plan

School based health centers report to OSAH in their operational plan their annual QI goal, their mid-year progress, and their end of year progress toward those goals.

Program Objective 5: Work with health care delivery systems to evaluate effectiveness, accessibility and quality of personal and population-based health services

Measure 5.2

Rate of diabetes hospitalization per 1,000 diagnosed persons



CY14	CY15	CY16	CY17	CY18	CY19	CY20		FY20 Target
180	169	161.9	162.3					Explanatory

Measure Description

Annual population-based explanatory measure.

Data Source/Methodology

Hospital Inpatient Discharge data, Behavioral Risk Factor Surveillance System, and inter-census data are utilized to estimate the age-adjusted rate of diabetes hospitalization.

Story Behind The Data

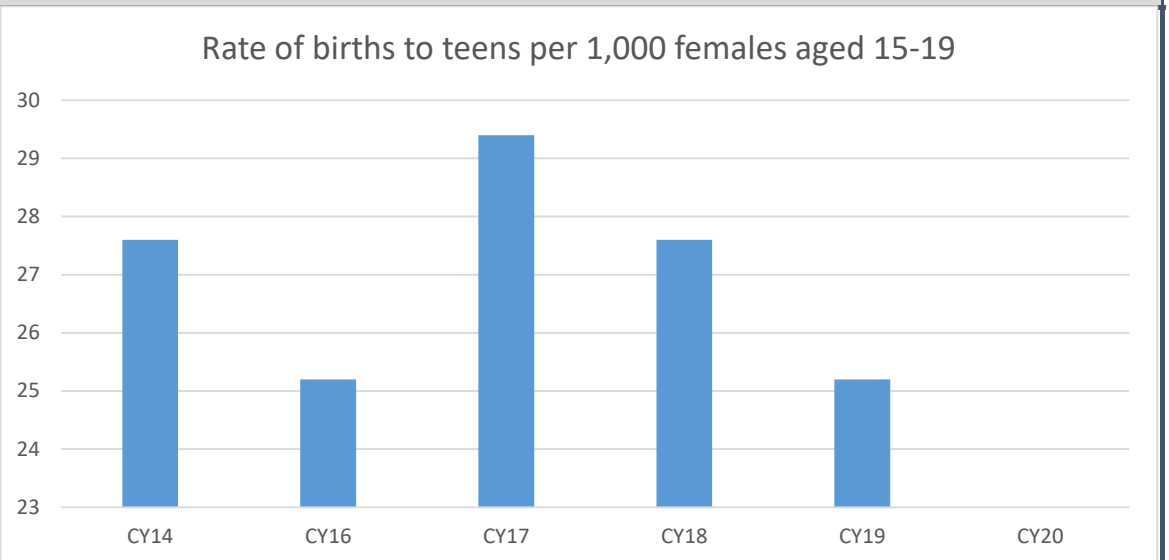
Diabetes, one of the leading causes of death and disability in the U.S., is the sixth leading cause of death in New Mexico. In 2017, an estimated 220,039 NM adults, ages 18 and older (13.7%) had diabetes, and only 7 in 10 with the condition were aware of it. For people with diagnosed diabetes, the condition can be managed and complications can be prevented or reduced through improved quality of clinical care and increased access to sustainable self-management and support services. The hospitalization rate among adults with diagnosed diabetes has been declining over the past five years because of several factors, like disease management programs provided by health care organizations and diabetes self-management eduction.

Improvement Action Plan

Program Objective 5: Work with health care delivery systems to evaluate effectiveness, accessibility and quality of personal and population-based health services

Measure 5.3

Rate of births to teens per 1,000 females aged 15-19



CY14	CY15	CY16	CY17	CY18	CY19	CY20		FY20 Target
27.6	25.2	29.4	27.6	25.2	n/a			Explanatory

Measure Description

This measure is a count of births to females aged 15-19 over the total population of females aged 15-19

Data Source/Methodology

NM-IBIS

Story Behind The Data

Increased access to and availability of most- and moderately-effective contraception and evidence-based unintended teen pregnancy prevention programming can be directly linked to a decrease in the teen birth rate. Since 2013, the teen birth rate among 15-to-19-year-olds in New Mexico (NM) has declined by 41.3% to 25.2 per 1,000 in 2018 (NM-Indicator-Based Information System) and is the sixth highest in the nation (National Center for Health Statistics).

Improvement Action Plan

This data is collected on a calendar year and the Family Planning Bureau calculates an estimated decrease of 10% per year.

New Mexico Department of Health

Epidemiology and Response Division

P003

Program Description and Purpose

The Epidemiology and Response Division (ERD) monitors health, provides health information, prevents disease and injury, promotes health and health behaviors, responds to public health events, prepares for health emergencies, and provides emergency medical, trauma and vital records to New Mexicans. ERD provides services through six bureaus: Emergency Medical Systems (EMS), Environmental Health Epidemiology (EHEB), Health Emergency Management (BHEM), Infectious Disease Epidemiology (IDEB), Injury and Behavioral Epidemiology (IBEB), and Vital Records and Health Statistics (BVRHS).

Program Budget (in thousands):

FY19	General Fund	Other State Funds	Federal Funds	Other Transfers	TOTAL	FTE
200	4,199,400	463,600	9,093,000	406,700	14,162,700	203
300	1,226,900	78,100	5,073,400	133,000	6,511,400	
400	4,489,400	72,500	1,785,100	298,000	6,645,000	
TOTAL	9,915,700	614,200	15,951,500	837,700	27,319,100	

FY20	General Fund	Other State Funds	Federal Funds	Other Transfers	TOTAL	FTE
200	4,200,300	450,100	9,245,400	266,900	14,162,700	204
300	1,173,600	84,900	5,003,000	249,900	6,511,400	
400	4,541,800	79,200	1,703,100	108,300	6,432,400	
TOTAL	9,915,700	614,200	15,951,500	625,100	27,106,500	

Program Objective 1: Improve Health Status of New Mexico

Measure	Description
1.1	Percent of self-reported sexual assaults per 100,000 population
1.2	Number of youth who have completed an evidence-based or evidence-supported sexual assault primary prevention program
1.3	Rate of suicide per 100,000 population
1.4	Percent of hospitals with emergency department based self-harm secondary prevention program
1.5	Number of community members trained in evidence-based suicide prevention programs

Program Objective 2: Reduce substance use deaths

Measure	Description
2.1	Rate of alcohol-related deaths per 100,000 population
2.2	Percent of county and tribal health councils that include in their plans evidence-based strategies to reduce alcohol-related harms
2.3	Percent of persons receiving alcohol screening and brief intervention (a-SBI) services

2.4	Percent of retail pharmacies that dispense naloxone (**FY20 KEY MEASURE**)
2.5	Percent of opioid patients also prescribed benzodiazepines (**FY20 KEY MEASURE**)

Program Objective 3: Reduce deaths among older populations	
Measure	Description
3.1	Rate of heat related illness hospitalizations per 100,000 population
3.2	Rate of cardiovascular disease (heart disease & stroke) deaths per 100,000 population
3.3	Percent of NM hospitals certified for stroke care (**FY20 KEY MEASURE**)
3.4	Rate of fall-related deaths per 100,000 adults, aged 65 years or older
3.5	Percent of emergency department based secondary prevention of older adult fractures due to falls programs

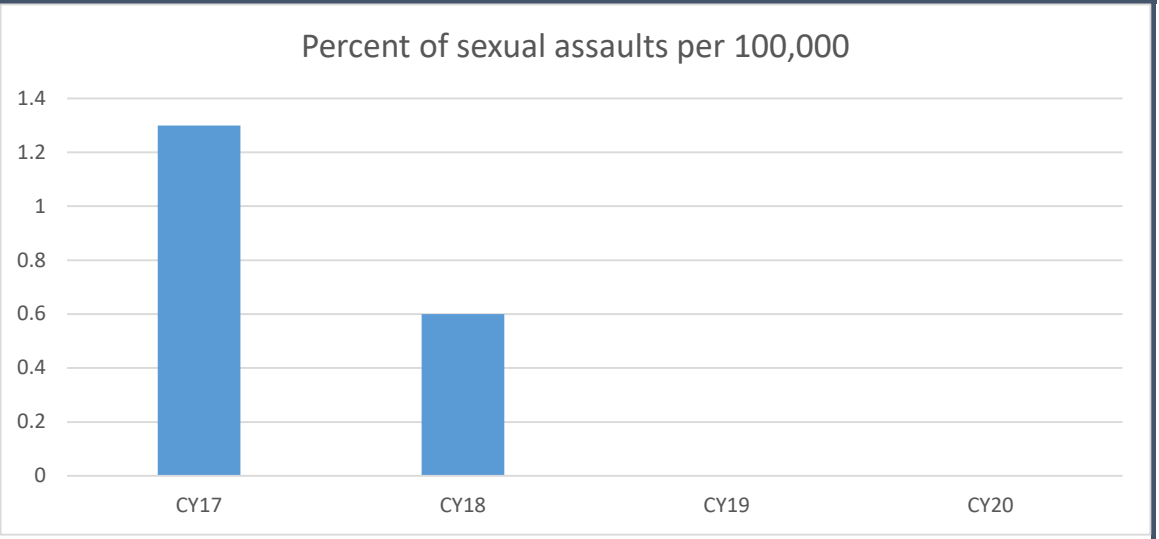
Program Objective 4: Reduce pneumonia and influenza deaths	
	Description
4.1	Percent of the New Mexico population served during mass distribution of antibiotics and/or vaccinations through public/private partnerships in the event of a public health emergency
4.2	Rate of pneumonia and influenza death rate per 100,000 population

Program Objective 5: Monitor health status and provide health information	
Measure	Description
5.1	Rate of drug overdose deaths per 100,000 population
5.2	Rate of avoidable hospitalizations per 100,000 population
5.3	Percent of vital records front counter customers who are satisfied with the service they received

Program Objective 1: Improve Health Status of New Mexico

Measure 1.1

Percent of self-reported sexual assaults per 100,000 population



CY17	CY18	CY19	CY20					FY20 Target
1.3	0.6							Explanatory

Measure Description

Numerator: Those who answered 'Yes' to the question, "In the past 12 months, has anyone HAD SEX with you after you said or showed that you didn't want to or without your consent?"

Denominator: Number of NM residents who completed the BRFSS for the year indicated, and who answered the question above.

Data Source/Methodology

Questions were added to the Behavior Risk Factor Surveillance System for a period of three years to establish a baseline percentage of completed sexual assaults in New Mexico for 2016, 2017, and 2018. Data are weighted to reflect the demographic population parameters of all NM residents.

Story Behind The Data

According to the 2015 National Intimate Partner and Sexual Violence Survey (NIPSVS), 19.5% of women in New Mexico have been raped during their lifetime, and 34.4% have been victims of rape, physical violence, and/or stalking by an intimate partner. NIPSVS data shows that sexual violence in youth, without appropriate trauma-informed interventions, can result in immediate and lifelong consequences. Certain populations are at greater risk for sexual violence, including LGBTQ, American Indians, people living with disabilities, African Americans, immigrants, children, and women.
The Epidemiology and Response Division's Sexual Violence Prevention Program (SVPP) addresses the issue through a social-ecological approach where prevention is addressed through individual, relationship, community, and societal approaches, with many focused on the individual and relationship level. For this, sexual violence prevention partners deliver primary prevention at the school level.
Because the data is collected from state-level survey data, there is a delay in data acquisition. The percentage increased from CY16 to CY17 then decreased again in CY18. Because this is an explanatory measure, it is unclear how much affect SVPP efforts had on this measure. This measure will not be collected on an annual basis due to cost of collection, therefore analysis of this measure will need to continue on a long-term basis.

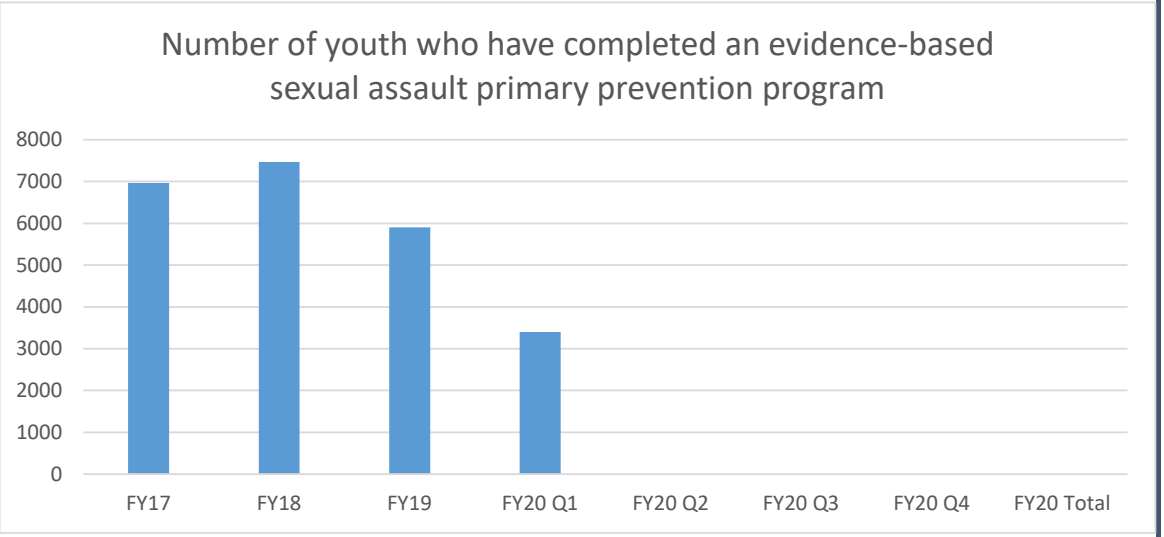
Improvement Action Plan

The Epidemiology and Response Division's Sexual Violence Prevention Program (SVPP) intends to affect long-term change by supporting partners and contractors to implement more community level and policy based interventions with broader and more systemic reach and increasing use of localized data to inform contractors of priority populations in their regions to deliver tailored prevention strategies.

Program Objective 1: Improve Health Status of New Mexico

Measure 1.2

Number of youth who have completed an evidence-based or evidence-supported sexual assault primary prevention program



FY17	FY18	FY19	FY20 Q1	FY20 Q2	FY20 Q3	FY20 Q4	FY20 Total	FY20 Target
6962	7470	5905	3400					≥7000

Measure Description

This output measure focuses on students and youth who have completed primary prevention programs.

Data Source/Methodology

This information comes from data from contractors showing participant counts.
Data are weighted to reflect the demographic population parameters of all NM public high school students.

Story Behind The Data

According to the 2015 National Intimate Partner and Sexual Violence Survey (NIPSVS), 19.5% of women in New Mexico (NM) have been raped during their lifetime, and 34.4% of those have been victims of rape, physical violence, and/or stalking by an intimate partner. NIPSVS data show that sexual violence in youth, without appropriate trauma-informed interventions, can result in immediate and lifelong consequences. Certain populations are at greater risk for sexual violence, including people living with disabilities, LGBTQ+, indigenous/tribal women, adults living in poverty, and youth who have unstable housing or are foreign-born.

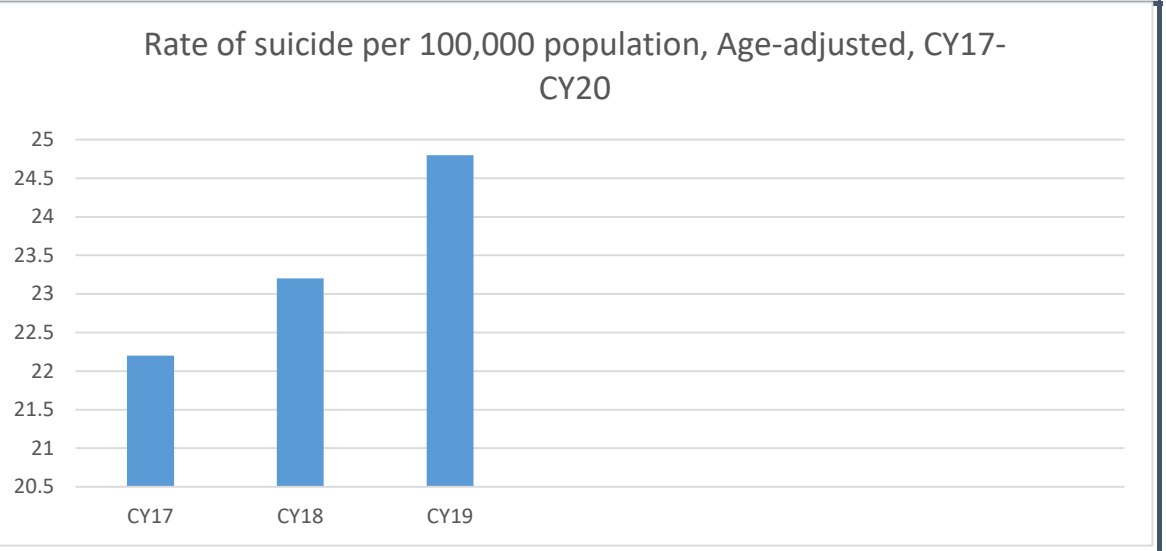
Improvement Action Plan

The Office of Injury Prevention (OIP) works with partners around the state to provide education to youth and adults who work with youth for the primary prevention of sexual violence. The OIP will increase the number of New Mexicans who have completed an evidence-based sexual assault primary prevention program and the Sexual Violence Prevention Program (SVPP) will move toward community and societal level interventions and establish performance measures reflecting this shift.
Q1: Train 2,000 youth in an evidence-based or evidence-supported sexual assault primary prevention program.
Q2: Train 2,500 youth in an evidence-based or evidence-supported sexual assault primary prevention program.
Q3: Train 2,500 youth in an evidence-based or evidence-supported sexual assault primary prevention program.
Q4: Gather and analyze evaluation data from youth that completed an evidence-based or evidence-supported sexual assault primary prevention program.

Program Objective 1: Improve Health Status of New Mexico

Measure 1.3

Rate of suicide per 100,000 population



CY17	CY18	CY19	CY20				CY20 Total	CY20 Target
22.2	23.2	24.8						Explanatory

Measure Description

Numerator: Count of deaths in 2018
Denominator: Mid-year population estimate from UNM, Geospatial and Population Studies Program. Rate is per 100,000 population, age-adjusted to U.S. 2000 population.

Data Source/Methodology

Data Source: New Mexico Death Data: Bureau of Vital Records and Health Statistics (BVRHS), New Mexico Department of Health; New Mexico Population Estimates: University of New Mexico, Geospatial and Population Studies (GPS) Program, http://gps.unm.edu/; Centers for Disease Control and Prevention, National Center for Health Statistics, CDC WONDER Online Database (http://wonder.cdc.gov).

Story Behind The Data

The suicide rate in New Mexico have consistently been more than 50% higher than national rates. In 2017, New Mexico had the fourth highest suicide rate in the country. From 2009-2017, deaths by suicide in New Mexico increased by 28% compared to 19% for the U.S. In 2018, state data shows that suicide was the ninth leading cause of death in New Mexicans across all ages and the second leading cause of death for those ages 5 - 34 years. Among residents 15 - 17 years, suicide was the leading cause of death. In addition, suicide was the third leading cause of death for individuals 35 - 44 years. The past decade saw an increase in suicide for all age groups, with the largest rate increases found in children 10-14 years and adults 65-74 years, a tripling and doubling, respectively, of the rates of suicide.

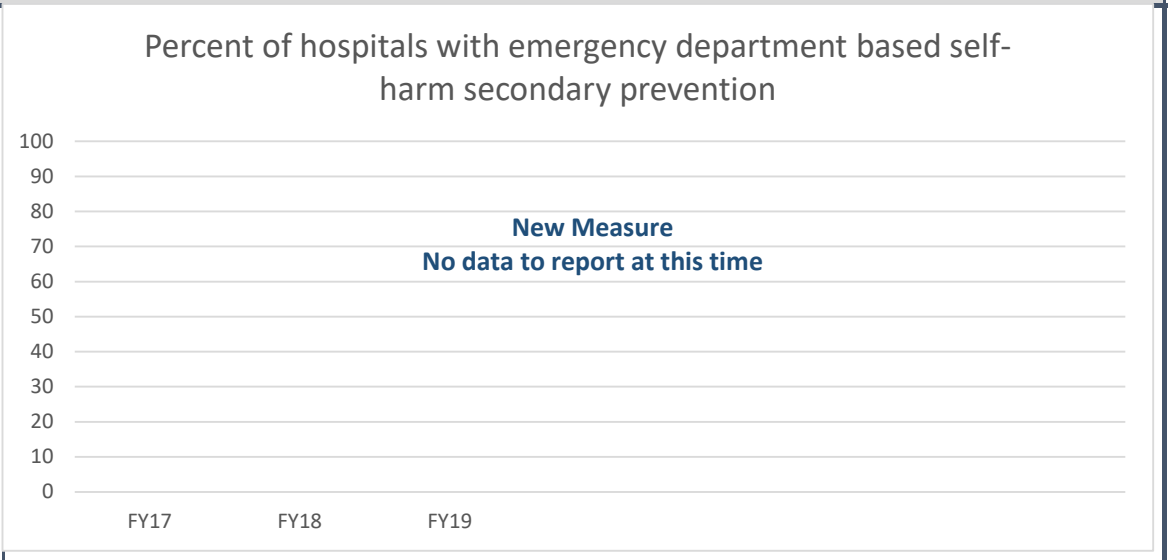
Improvement Action Plan

The DOH's Epidemiology and Response Division's Office of Injury Prevention (OIP) is convening the statewide New Mexico Suicide Prevention Coalition to build New Mexico's Strategic Plan for Suicide Prevention. Specific strategies and activities are being written to meet the major suicide prevention strategic goals identified by a group representative of the state's population. OIP is working to establish a Secondary Prevention of Suicide Program in two regional hospital Emergency Departments. This will help to address the state's high rate of suicide by preventing suicide in individuals at particularly high risk, such as those seen for suicide attempts and then discharged from the Emergency Department. OIP's Suicide Prevention Program continues serving as a resource for data and resource sharing and collaborates with the Office of School and Adolescent Health to offer suicide gatekeeper trainings across the state.

Program Objective 1: Improve Health Status of New Mexico

Measure 1.4

Percent of hospitals with emergency department based self-harm secondary prevention program



FY17	FY18	FY19	FY20 Q1	FY20 Q2	FY20 Q3	FY20 Q4	FY20 Total	FY20 Target
n/a	n/a	n/a	n/a					5% (n=2/37)

Measure Description

Numerator: The number of emergency departments with self-harm secondary prevention programs.
Denominator: The number of emergency departments in NM (*n* =37).

Data Source/Methodology

Data Source: Emergency Department data reports with information linked to New Mexico's suicide rate with data sources as described above.

Story Behind The Data

Reducing the high rate of suicide in New Mexico requires a comprehensive and multi-faceted approach involving both primary and secondary prevention. Individuals discharged from an emergency department following a suicide attempt are documented to have higher rates of suicide within the first 6-12 months following discharge. Thus, to address this concern, an evidence-based program to prevent subsequent suicide is being developed. This program involves educating emergency department staff about suicide and how to approach individuals presenting with suicide attempts to help reduce stigma, instill hope and promote help-seeking. In addition, the program requires use of a patient-centered, personalized Safety Intervention Plan (SIP), a quick referral for follow-up care, and a series of caring contacts reflecting compassion and concern during the first 6-12 months following the patient's discharge.

Improvement Action Plan

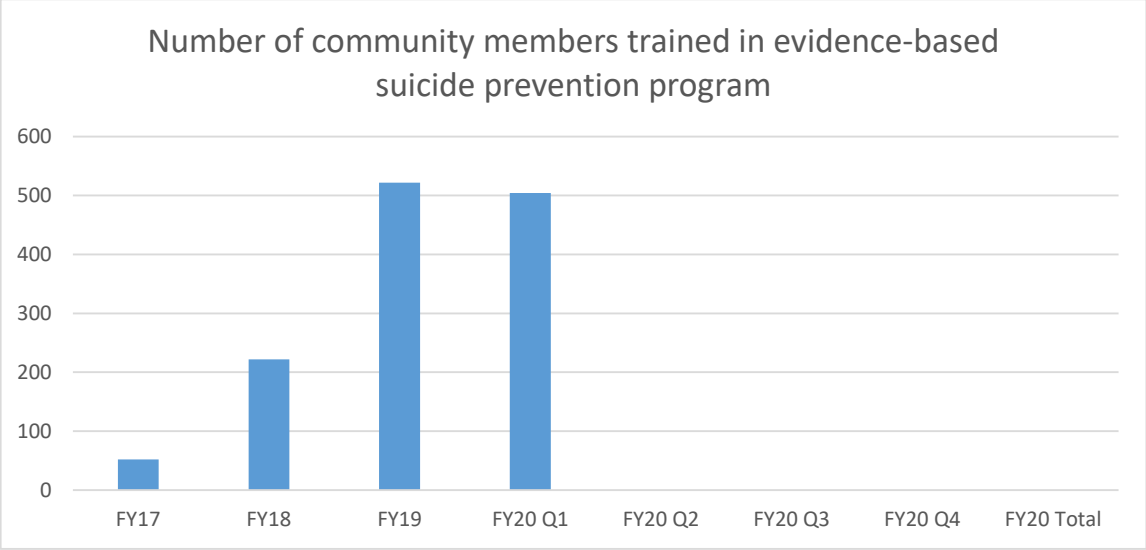
An evidence-based secondary prevention of suicide program will be conducted, evaluated, and revised as needed in two emergency departments in New Mexico in FY20. This program will subsequently be established in other emergency departments within the state in the following years.

Q1: Plan and research with an initial emergency department to implement an evidence-based self-harm secondary prevention program.
Q2: a) Provide training for the initial emergency department to implement a self-harm secondary prevention program; and b) Identify a second emergency department to implement a self-harm secondary prevention program.
Q3: a) Implement the self-harm secondary prevention program with the initial emergency department; and b) Plan and research with the second emergency department to implement a self-harm secondary prevention program.
Q4: a) Continue to support and evaluate the self-harm secondary prevention program with the initial emergency department; and b) Operate a self-harm secondary prevention program with the second emergency department.

Program Objective 1: Improve Health Status of New Mexico

Measure 1.5

Number of community members trained in evidence-based suicide prevention programs



FY17	FY18	FY19	FY20 Q1	FY20 Q2	FY20 Q3	FY20 Q4	FY20 Total	FY20 Target
52	222	522	504					600

Measure Description

Numerator: n/a
Denominator: n/a The measure is a count of community members trained in suicide gatekeeper programs.

Data Source/Methodology

Data Source: Office of Injury Suicide Prevention Program and Office of School and Adolescent Health (OSAH) participant records of suicide gatekeeper trainings offered, type of trainings, number of participants, and types of participants (e.g., students, Juvenile Justice staff, parents, health care providers)

Story Behind The Data

Evidence-based suicide gatekeeper trainings, such as the Question, Persuade, Refer program, have been shown to be effective in reducing suicide and are an important aspect of suicide prevention in the state. The suicide rate in New Mexico has consistently been more than 50% higher than the national rate over the past decade, and the state rate increased between 2009 and 2017 by 28% compared to an increase of 19% for the U.S. Thus, continuing to increase awareness of suicide by educating community members about risk factors and warning signs is one component of a comprehensive approach to effectively address suicide. However, suicide gatekeeper training is an aspect of prevention that needs to be paired with other prevention, intervention, postvention, crisis response, and community building initiatives to address the many root causes of suicide in the state.

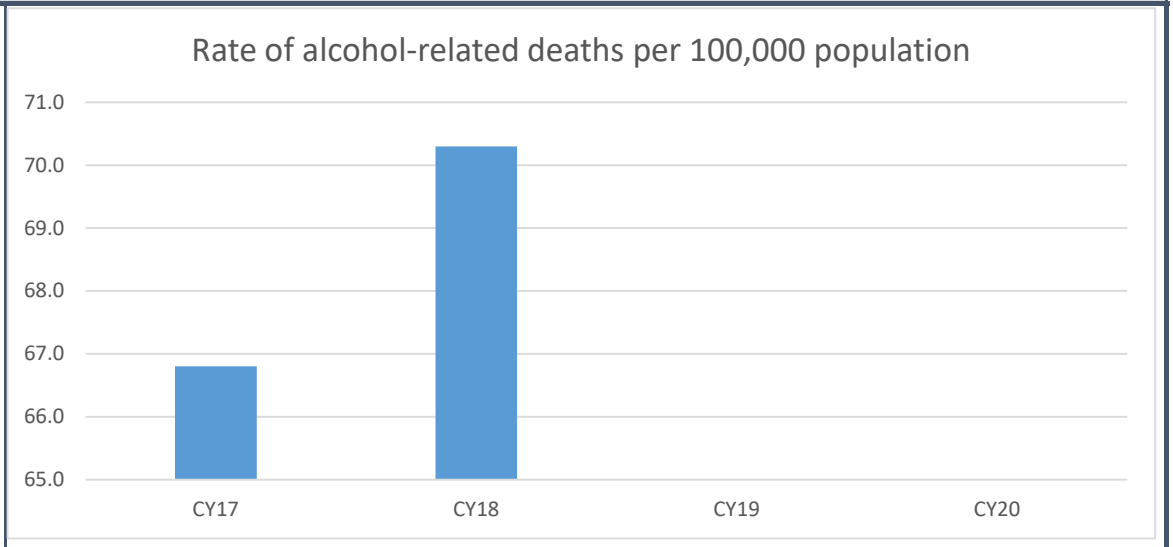
Improvement Action Plan

Gatekeeper trainings will continue to be offered to community members across the state by the Department of Health's Ofice of Injury Prevention and OSAH. There is an increased emphasis on building the capacity for training within regions around the state by increasing the number of local gatekeeper trainers and trainings. OSAH has established an improved system to identify gatekeeper trainers and the number of evidence-based trainings being offered across the state each quarter.
FY20 Quarterly Targets:
Q1: Train 350 community members in an evidence-based suicide prevention program.
Q2: Train 50 community members in an evidence-based suicide prevention program.
Q3: Train 50 community members in an evidence-based suicide prevention program.
Q4: Train 150 community members in an evidence-based suicide prevention program.

Program Objective 2: Reduce substance use deaths

Measure 2.1

Rate of alcohol-related deaths per 100,000 population



CY17	CY18	CY19	CY20					CY20 Target
66.8	70.3							Explanatory

Measure Description

Numerator: Number of alcohol-related deaths.
Denominator: New Mexico population. This rate is age-adjusted to the standard 2000 US population.

Data Source/Methodology

Death data are from NMDOH Bureau of Vital Records and Health Statistics. Population data are from UNM/GPS. Estimates of alcohol-related deaths are based on CDC ARDI.

Story Behind The Data

New Mexico has the highest alcohol-related death rate in the US. New Mexico's CY18 alcohol-related death rate is twice the US 2017 death rate (70.3 compared to 35.0). The alcohol-related death rate in New Mexico increased 5% between 2017 and 2018.

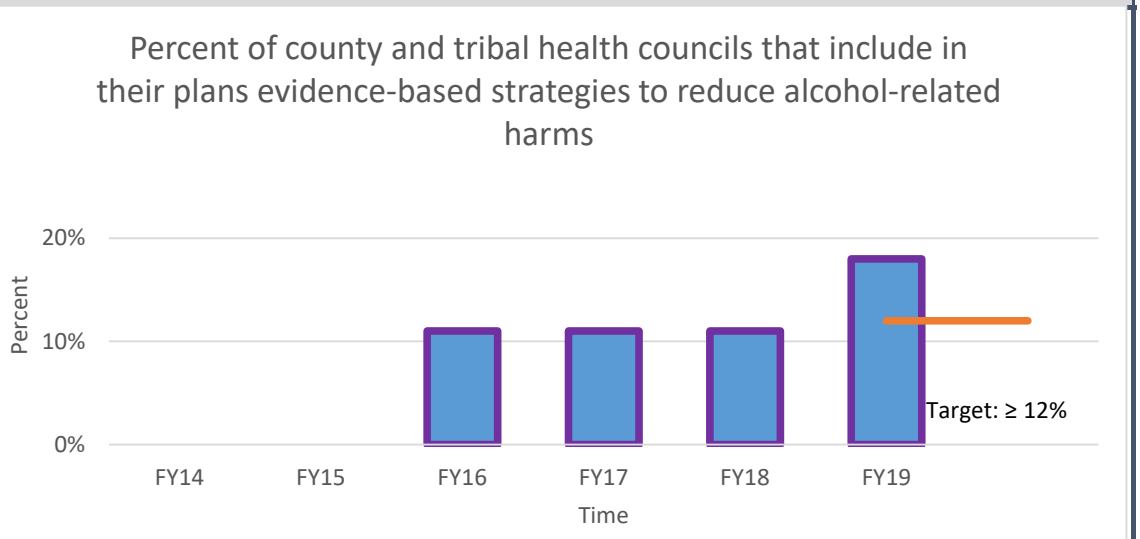
Improvement Action Plan

NMDOH ERD staff reach out to local (county/tribal/pueblo/national) health councils about the importance of including alcohol-related strategies. Data, presentations, and support are offered to the health councils. NMDOH ERD staff are also working with HSD to get data on Medicaid paid alcohol Screening and Brief Intervention (a-SBI) services. NMDOH has requested funding to establish an office of Alcohol in ERD as more than one staff person is needed to adequately address this problem in New Mexico.

Program Objective 2: Reduce substance use deaths

Measure 2.2

Percent of county and tribal health councils that include in their plans evidence-based strategies to reduce alcohol-related harms



FY17	FY18	FY19	FY20 Q1	FY20 Q2	FY20 Q3	FY20 Q4	FY20 Total	FY20 Target
11%	11%	18%	21%					20%

Measure Description

Numerator: Number of health councils that report evidence-based alcohol prevention strategies.
Denominator: Total number of health councils.

Data Source/Methodology

Data for this measure comes from a survey and phone calls.

Story Behind The Data

The county and tribal/national/pueblo health councils, impact health outcomes in their service areas through interventions and programs. Health councils are encouraged to implement evidence-based strategies to prevent excessive alcohol consumption. NMDOH reaches out to at least two health councils per quarter to enquire about evidence-based excessive alcohol strategies and offer data and support.

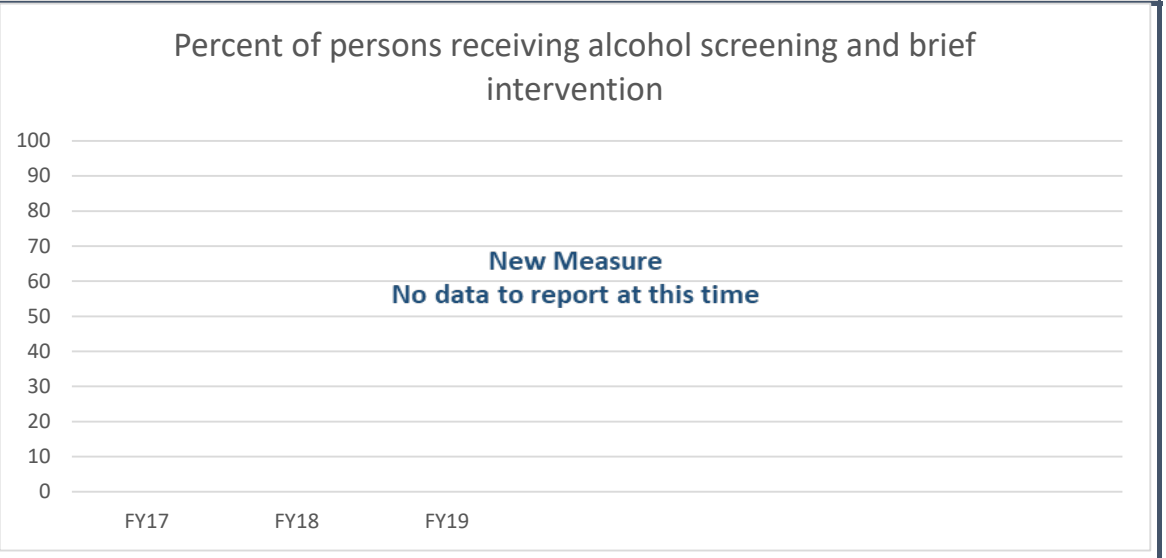
Improvement Action Plan

The alcohol epidemiologist continues to call at least two health councils about the importance of strategies to prevent excessive alcohol use. The alcohol epidemiologist offers data and support for evidence-based prevention strategies.

Program Objective 2: Reduce substance use deaths

Measure 2.3

Percent of persons receiving alcohol screening and brief intervention (a-SBI) services



FY17	FY18	FY19	FY20 Q1	FY20 Q2	FY20 Q3	FY20 Q4	FY20 Total	FY20 Target
								≤ 5%

Measure Description

This is a proposed as a population-based explanatory rate. **Numerator**: Number of persons receiving SBI services. **Denominator**: Total number of persons 15 and up.

Data Source/Methodology

Data is form HSD's Medicaid database.

Story Behind The Data

Alcohol Screening and Brief intervention (a-SBI) is a clinical intervention to address excessive alcohol consumption. Particularly when combined with referral to treatment, a-SBI is an impactful strategy that can decrease excessive alcohol consumption.

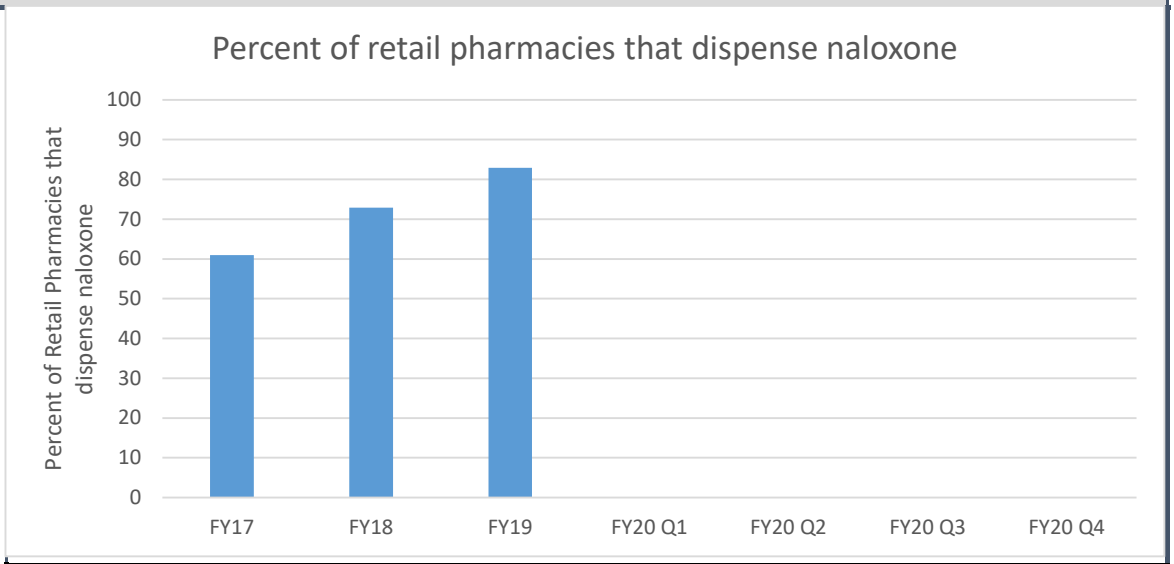
Improvement Action Plan

NMDOH is working with HDS to obtain counts of Medicaid payments for SBI services. This will be used as a proxy for SBI service provision. **The goal for this measure will be determined once baseline data (FY17-FY19) is established.**

Program Objective 2: Reduce substance use deaths

Measure 2.4

Percent of retail pharmacies that dispense naloxone (FY20 KEY MEASURE)



FY17	FY18	FY19	FY20 Q1	FY20 Q2	FY20 Q3	FY20 Q4	FY20 Total	FY20 Target
61%	72.90%	82.90%	n/a					≥ 80%

Measure Description

Numerator: Number of retail pharmacies with a Medicaid claim for naloxone.
Denominator: Total number of retail pharmacies in New Mexico.

Data Source/Methodology

Data Source: NM Human Services Department Medicaid Claims Data; NM Board of Pharmacy

Story Behind The Data

The percent of retail pharmacies dispensing naloxone has continuously improved over the past few years. The purpose of this measure is to ensure that all New Mexicans have access to naloxone at their local pharmacy. Naloxone is the opioid overdose reversal drug and increasing the distribution of naloxone in New Mexico is important to enable more laypersons to respond to opioid overdoses. In FY19, DOH worked to identify retail pharmacies that had not submitted Medicaid claims for naloxone, collaborated with the Board of Pharmacy to narrow down the list, and contracted with the University of New Mexico College of Pharmacy for pharmacy training of the identified pharmacies. This work is continuing in FY2020.

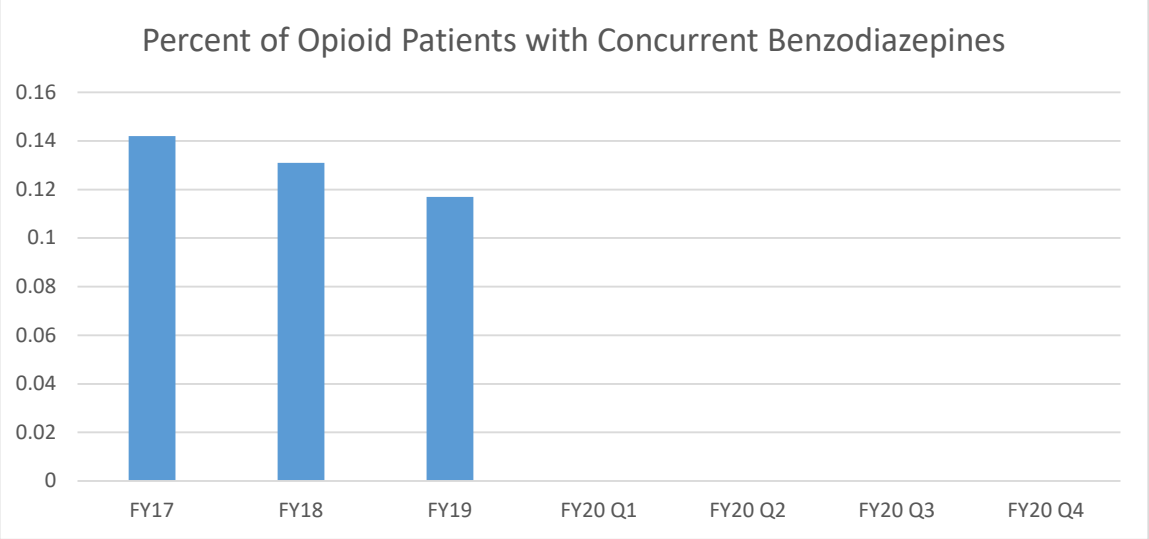
Improvement Action Plan

UNM College of Pharmacy has been contracted to do pharmacy training on naloxone and the applicable laws with an emphasis on training retail pharmacies that do not currently dispense naloxone based on Medicaid claims data. Senate Bill 221 was enacted in June 2019 which requires the co-prescription of naloxone with any opioid prescription with a supply of five or more days.

Program Objective 2: Reduce substance use deaths

Measure 2.5

Percent of opioid patients also prescribed benzodiazepines (FY20 KEY MEASURE)



FY17	FY18	FY19	FY20 Q1	FY20 Q2	FY20 Q3	FY20 Q4	FY20 Total	FY20 Target
14%	13%	12%	n/a					≤ 5%

Measure Description

Numerator: Number of retail pharmacy patients with concurrent prescriptions for opioids and benzodiazepines with at least 10 days of overlap. **Denominator:** Number of retail pharmacy patients with any opioid prescription.

Data Source/Methodology

Data Source: New Mexico Board of Pharmacy Prescription Monitoring Program (PMP) data.

Story Behind The Data

Opioids and benzodiazepines both depress respiration. The risk of death increases when benzodiazepines are taken along with opioids. Prescription opioids as a drug-type are involved in more drug overdose deaths than any other drug-type, however in 2017, for the first time, a benzodiazepine drug (alprazolam) was the most common prescription drug involved in overdose deaths in New Mexico. Alprazolam remains the most common prescription drug involved in drug overdose deaths in 2018. A benzodiazepine prescribers guide was produced with the support of the Overdose Prevention and Pain Management Advisory Council. The Council includes voting representatives from several state agencies and stakeholder groups. The guide was distributed by the NM provider licensing boards to their licensees.

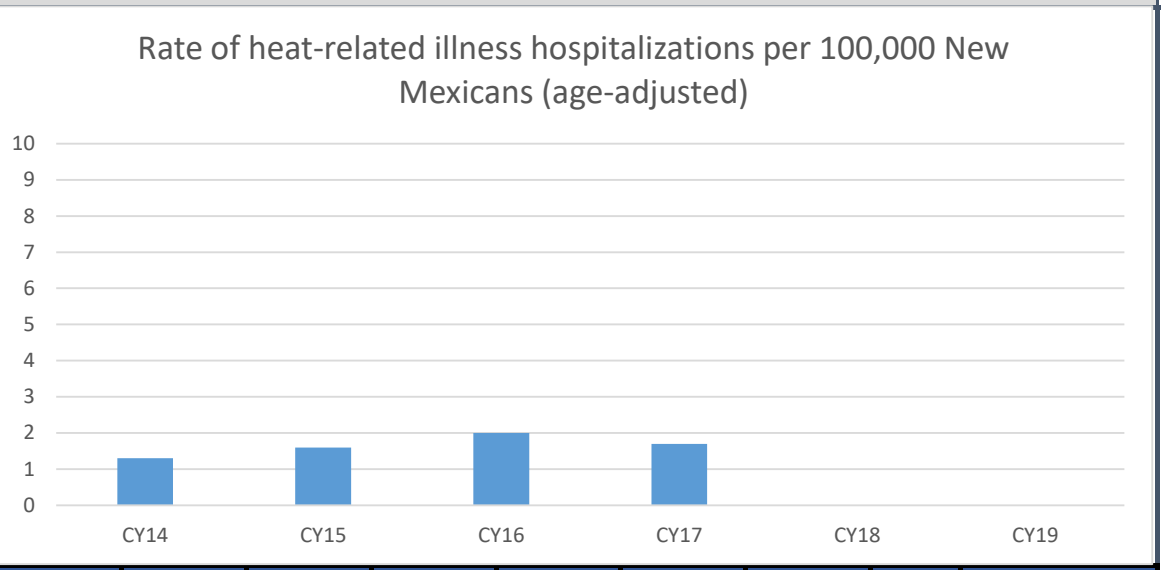
Improvement Action Plan

ERD will follow-up with the licensing boards on feedback they have received on the benzodiazepine prescribing guide. They will also continue to include co-prescription rates on reports to licensing boards, and on the Quarterly Measures Report. CY19 Q1 prescribing reports were delayed due to change in vendor reporting options but were sent to the licensing boards on 8/5/2019. CY19 Q2 reports were sent to the licensing boards on 10/10/19.

Program Objective 3: Reduce deaths among older populations

Measure 3.1

Rate of heat related illness hospitalizations per 100,000 population



CY14	CY15	CY16	CY17	CY18	CY19	CY20		FY20 Target
1.3	1.6	2	1.7					Explanatory

Measure Description

Heat-related Illness (HRI) is defined as a constellation of explicit effects of hot weather on the body, including heat stroke, and sunstroke (hyperthermia), heat syncope or collapse, heat exhaustion, heat cramps, heat fatigue, heat edema, and other unspecified clinical effects attributed to excessive heat exposure. The HRI hospitalization rate is defined as the number of admissions to an acute care in-state hospital that occurs per 100,000 New Mexico residents.

Numerator: Number of inpatients (NM residents) treated each year, where HRI is any primary or other diagnosis.

Denominator: Midyear New Mexico resident population.

Data Source/Methodology

Hospital Inpatient Discharge

Story Behind The Data

No National benchmarks were identified and our definitions for HRI are not consistent among states. The goal is to keep the rate of HRI hospitalizations at or below the average rate for the past four years. Therefore, the target was calculated by averaging 2014 – 2017 data = age adjusted rate of 1.7 HRI admissions per 100,000 NM residents.

According to the Healthy People 2020 Social Determinants of Health, the topic area is organized into 5 place-based domains:

1. Economic Stability
2. Education
3. Health and Health Care
4. Neighborhood and Built Environment
5. Social and Community Context

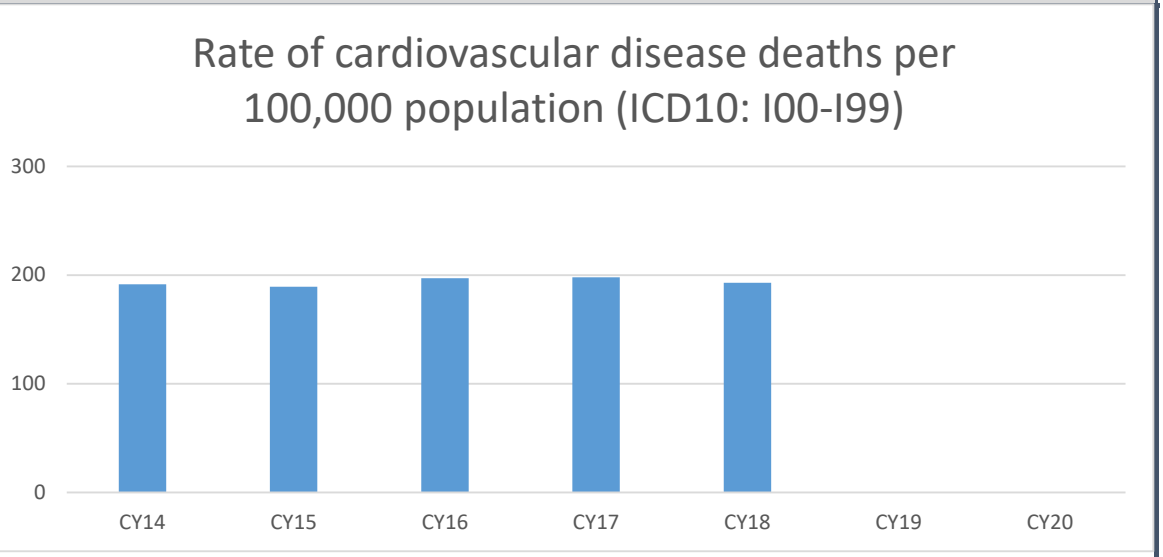
Under the Neighborhood and Built Environment domain, Environmental Conditions are a key issue. Air temperature is one of the environmental conditions that can impact health. It is known from the recent reports from the National Oceanic and Atmospheric Administration (NOAA) that many of the hottest years on record have occurred in the past decade. Older adults and children are at increased risk for heat-related disease and death. In addition, racial and ethnic minorities have higher rates of heat-related disease and death. This association may be due to factors such as living in urban areas, lacking air conditioners, and working in agriculture. The measure tracks hospitalization trends over time for heat-related illness as an emerging health effect of climate change.

Data, made available by the Health Systems Epidemiology Program, Epidemiology and Response Division, New Mexico Department of Health.	
	Improvement Action Plan
	The Epidemiology and Response Division's Environmental Health Epidemiology Bureau is committed to developing a plan using the Building Resiliency Against Climate Effects (BRACE) framework to enhance the resiliency of New Mexicans and visitors to the health effects caused by climate change, in this case the effect of high ambient temperatures. The Building Resilience Against Climate Effects (BRACE) framework is a five-step process that allows health officials to develop strategies and programs to help communities prepare for the health effects of climate change. Part of this effort involves incorporating complex atmospheric data and both short and long-range climate projections into public health planning and response activities. Combining atmospheric data and projections with epidemiologic analysis allows health officials to more effectively anticipate, prepare for, and respond to a range of climate sensitive health impacts.

Program Objective 3: Reduce deaths among older populations

Measure 3.2

Rate of cardiovascular disease (heart disease & stroke) deaths per 100,000 population



CY14	CY15	CY16	CY17	CY18	CY19	CY20		CY20 Target
191.4	189.3	197.2	198.1	193				Explanatory

Measure Description

Numerator: Annual number of NM residents whose recorded primary cause of death was one of the following ICD-10 Cardiovascular disease codes.
Denominator: Number of NM residents for the corresponding year.

Age-adjustment: Standardized to the distribution of 5-year age groups for NM residents.

Data Source/Methodology

New Mexico's Indicator-Based Information System (NM-IBIS): https://ibis.health.state.nm.us/

Story Behind The Data

In 2018, NM stroke care hospitals treated >85% of patients who arrived at the hospital within 2 hours and were treated within 3 hours, an improvement from 2017 and Q1 of 2018 where the 85% goal was not met.Plus in 2018, NM stroke care hospitals administered IV alteplase in 19.4% of patients who arrived at the hospital within the appropriate time window. This is above the national average and is increased from 16.9% in 2017.

- The peak time to alteplase administration in 2018 has decreased slightly from 2017 showing us that alteplase is being given faster in NM overall.
- Heart Disease & Stroke Prevention Program (HDSPP) continues to support the Million Hearts workshops, where attendees are educated about the Million Hearts Initiative.
- Continue to collect PM2.5 and Ozone data from the monitor in Portales.

Improvement Action Plan

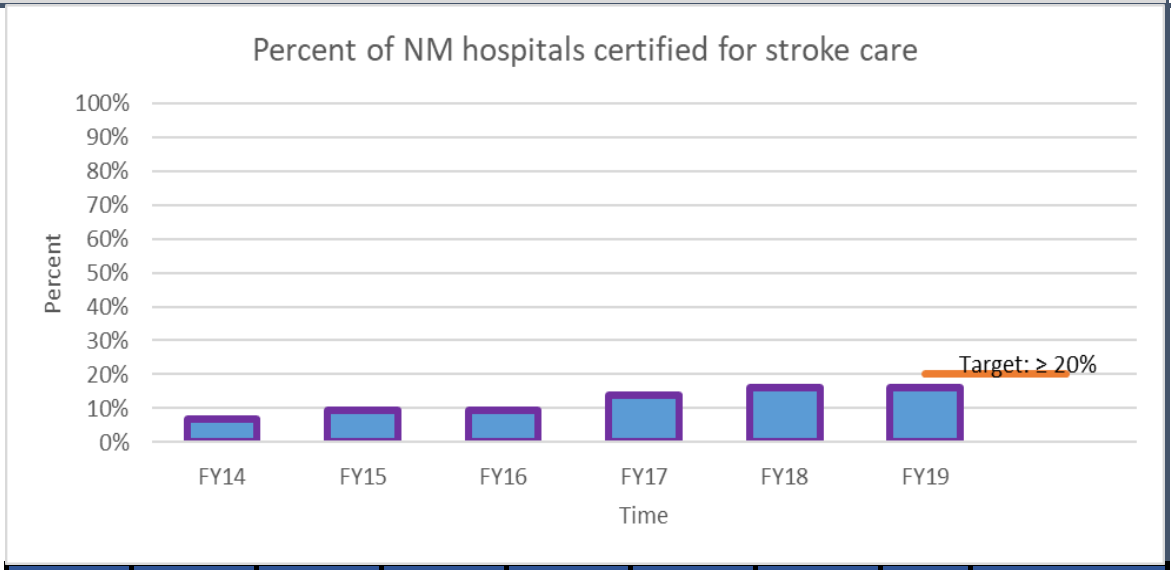
- Distribute recently purchased blood pressure cuffs to HDSPP partners: the Office of Community Health Workers for use in their clinical support trainings, Presbyterian Healthcare Services Center for Community Health, FQHCs throughout NM, and the YMCA in order to promote the importance of self-measured blood pressure monitoring.
- Hold classes starting in July, at the YMCA of Central NM in Albuquerque for their Y-BPSM program, an evidence-based program focused on self-measured blood pressure and education about nutrition and physical health to make lifestyle changes. HDSPP is supporting the program and helping with start-up. The goal is to have 25 individuals in the initial cohort and expand from there.

	• Look in to strategies on implementing interventions recommended by The Community Guide Task Force. • Review the new recommendations made by American Stroke Association for all categories found in the establishment of stroke systems of care for implementation.

Program Objective 3: Reduce deaths among older populations

Measure 3.3

Percent of NM hospitals certified for stroke care (FY20 KEY MEASURE)



FY17	FY18	FY19	FY20 Q1	FY20 Q2	FY20 Q3	FY20 Q4	FY20 Total	FY20 Target
14%	16.2%	16.2%	n/a					≥20%

Measure Description

Numerator: Number of hospitals in NM certified for stroke care.
Denominator: Number of acute care hospitals in NM.

Data Source/Methodology

The Joint Commission's list of certified stroke care centers, as well as Det Norske Veritas' list of certified stroke care centers.

Story Behind The Data

In the US and New Mexico (NM), stroke is the fifth leading cause of death and a leading cause of adult disability. In order to reduce the impact that strokes have on New Mexicans, hospital stroke centers have been developed. Hospitals with these certifications will have a dedicated stroke-focused program, staffed by qualified medical professionals with specific stroke care education. Seven out of 43 acute care hospitals in NM are certified for stroke care. Currently, six (14%) are designated as primary stroke centers, and one is designated as acute stroke ready. A total of 16% of hospitals in New Mexico are designated to provide stroke specific care to patients.

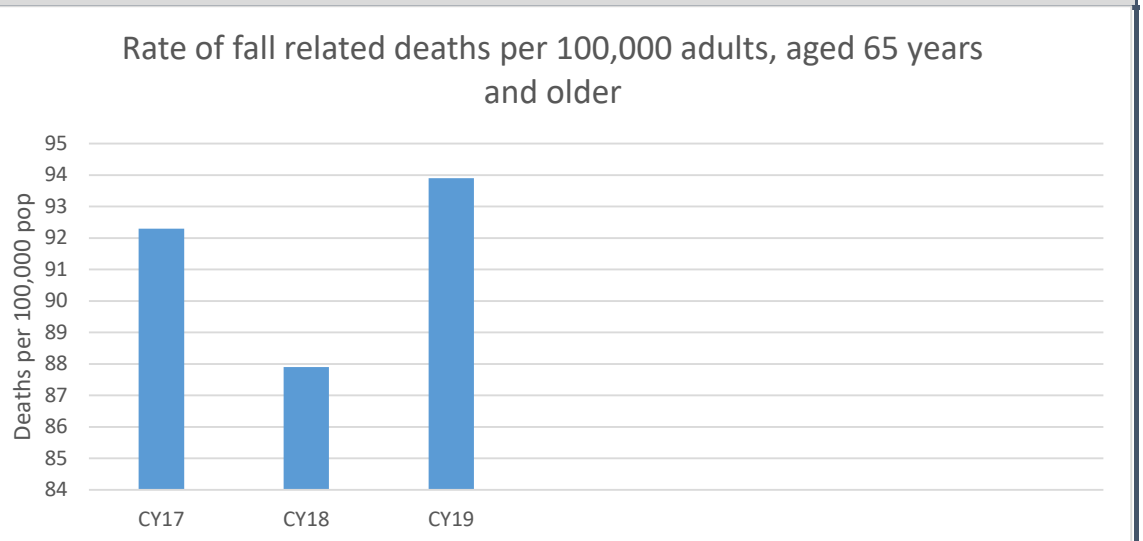
Improvement Action Plan

The NMDOH Epidemiology and Response Division's EMS Bureau's Stroke Program will work with the current hospitals to maintain or elevate their current accreditation and certification level. The EMS Bureau will also continue to seek new hospitals who want to participate as certified stroke care facilities in New Mexico.
Q1: Send award letters to stroke care hospitals to help with the cost of the stroke data registry.
Q2: Pursue obtaining access to the American Heart Association's stroke data registry to facilitate system improvement.
Q3: Survey hospitals throughout the state to inform the EMS Bureau of reasons hospitals do not pursue stroke certification. Information will also be gathered on the abilities of hospitals to perform procedures related to stroke care.
Q4: Survey the utilization of the Stroke Care Card to assess its usage and effectiveness in decreasing the time to stroke care.

Program Objective 3: Reduce deaths among older populations

Measure 3.4

Rate of fall-related deaths per 100,000 adults, aged 65 years or older



CY17	CY18	CY19	CY20					FY20 Target
92.3	87.9	93.9						Explanatory

Measure Description

Age-adjustment: Age-adjusted to the U.S. Standard Population.
Numerator: Number of fall-related deaths of people aged 65 and older.
Denominator: Number of NM residents aged 65 and older.

Data Source/Methodology

Data Source: New Mexico's Indicator-Based Information System (NM-IBIS).

Story Behind The Data

Unintentional falls are the leading cause of injury in adults older than 64. In 2018, there were 5,829 hospital visits in those 65 and older, as a result of falls. This is up from 5,515 visits in 2017, an increase of over 5%. Intervention for patients admitted to emergency departments for a fall can be an effective tool in preventing subsequent falls. Between 36% and 50% of patients have an adverse event, such as a recurrent fall, emergency department revisit, or death within 1 year after a fall. This is a new performance measure.

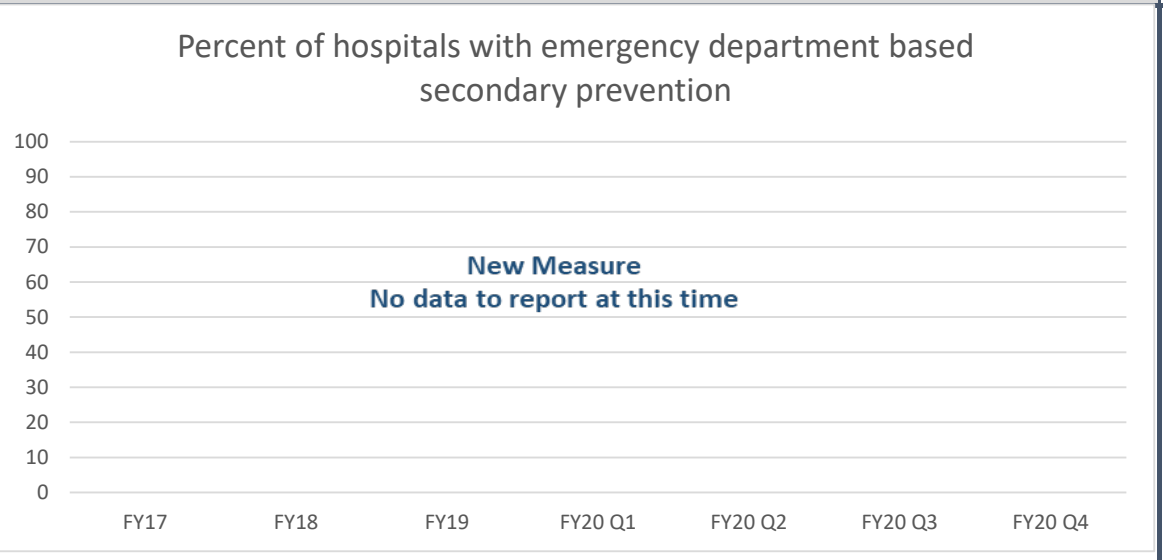
Improvement Action Plan

- Expand the network of instructors available statewide to implement evidence-based falls prevention interventions.
- Increase the number of professionals trained on the use of the STEADI Falls Prevention Toolkit to assess for fall-risk.
- Provide education on falls prevention, encourage older adults to exercise, and refer older adults to evidence-based interventions.

Program Objective 3: Reduce deaths among older populations

Measure 3.5

Percent of emergency department based secondary prevention of older adult fractures due to falls programs



FY17	FY18	FY19	FY20 Q1	FY20 Q2	FY20 Q3	FY20 Q4	FY20 Total	FY20 Target
n/a	n/a	n/a						5.41%

Measure Description

Age adjusted: Applies only to adults 65 years and older. **Numerator:** Number of hospitals with emergency department based secondary prevention of older adult fractures due to falls programs**.** **Denominator:** 37 NM hospitals with emergency departments.

Data Source/Methodology

Data Source: New Mexico Department of Health Syndromic Surveillance System and Hospital reports**.**

Story Behind The Data

Unintentional falls are the leading cause of fatal and non-fatal injury in adults older than 64. New Mexico's fall-related death rate was 1.5 times greater than the U.S. rate in 2017. NMDOH offers evidence-based interventions proven by the Centers for Disease Control and Prevention (CDC) to prevent older adult falls: A Matter of Balance, Tai Chi for Arthritis, Tai Ji Quan: Moving for Better Balance, STEADI Falls Prevention Toolkit and Otago. There are currently over 400 evidence-based falls prevention instructors in 22 New Mexico counties. Over 1,600 older adults in New Mexico have completed an evidence-based intervention.

Improvement Action Plan

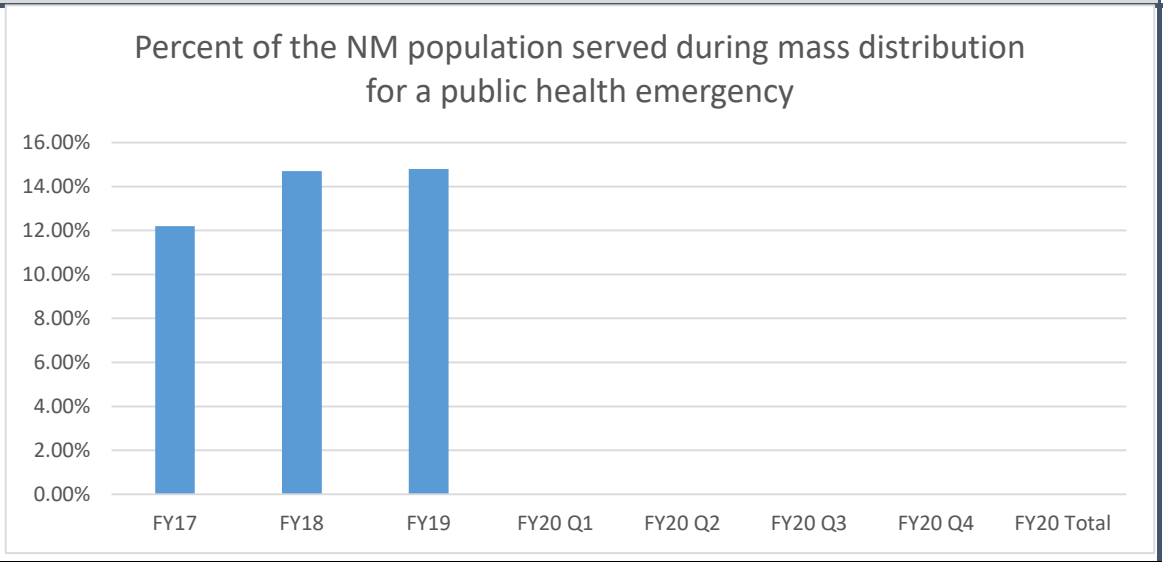
Establish emergency department based secondary prevention programs for older adult fractures caused by falls.
Q1: Plan and research with an initial emergency department to implement an evidence-based falls prevention program.
Q2: a) Provide training for the initial emergency department to implement a secondary falls prevention program; and b) Identify a second emergency department to implement a secondary falls prevention program.
Q3: a) Implement the secondary falls prevention program with the initial emergency department;

	and b) Plan and research with the second emergency department to implement a secondary falls prevention program. Q4: a) Continue to support and evaluate the secondary falls prevention program with the initial emergency department; and b) Operate a secondary falls prevention program with the second emergency department.

Program Objective 4: Reduce pneumonia and influenza deaths

Measure 4.1

Percent of the New Mexico population served during mass distribution of antibiotics and/or vaccinations through public/private partnerships in the event of a public health emergency



FY17	FY18	FY19	FY20 Q1	FY20 Q2	FY20 Q3	FY20 Q4	FY20 Total	FY20 Target
12.20%	14.70%	14.80%						≥ 19%

Measure Description

The number of new closed PODs each year.

Data Source/Methodology

Crimson Contagion August 2019.

Story Behind The Data

New Mexico and its citizens must be provided with primary and alternate methods to receive antibiotics and or vaccinations during a pandemic. New Mexico's primary strategy for mass prophylaxis is through Open (Public) Points of Dispensing (PODs) with existing plans to serve 100% of the population. The alternate strategy that this measure aims to achieve is that of Closed POD partnering. Closed POD partnering is achieved through rigorous research and time-intensive planning efforts that identify agencies, entities, and organizations that employ and/or serve a significant number of individuals and possess the internal resources to provide prophylaxis to their employees, family members and critical contactors.

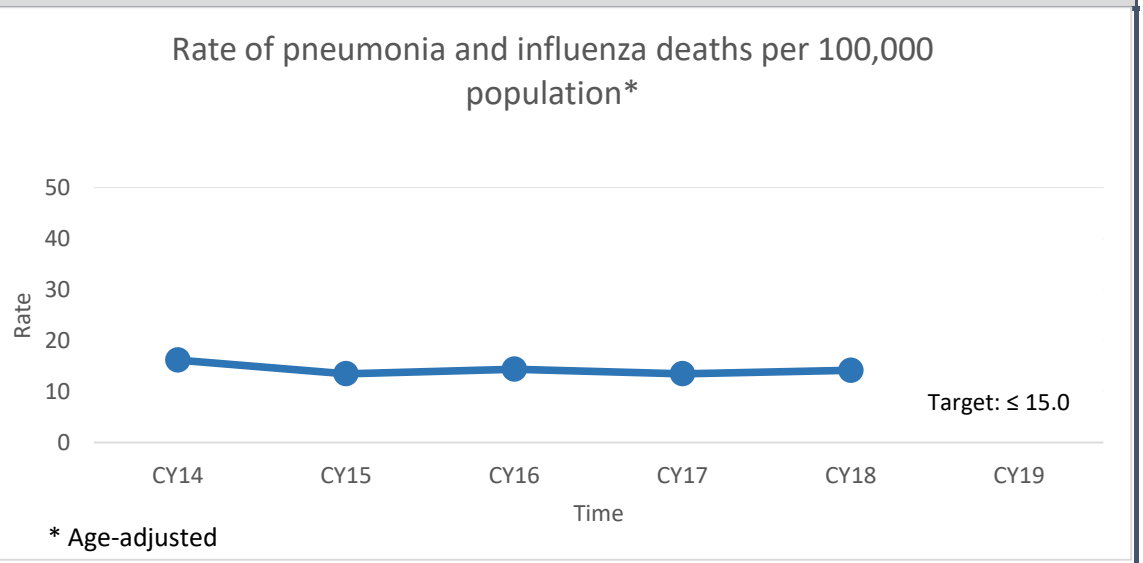
Improvement Action Plan

Q1: Continue ongoing closed POD planning, by meeting with state agencies and other organizations.
Q2: Review Open and Closed POD plans for cold chain details.
Q3: Suggest POD plan revisions and edits to improve their cold chain planning.
Q4: Query POD locations to gather information on their total cold chain capacity.

Program Objective 4: Reduce pneumonia and influenza deaths

Measure 4.2

Rate of pneumonia and influenza death rate per 100,000 population



* Age-adjusted

CY17	CY18	CY19						CY20 Target
13.5	14.5							Explanatory

Measure Description

Criteria for Eligibility: Inclusion is based on death certificate data with a cause-of-death code J09-J18 (influenza death codes include J09-J11; Pneumonia death codes are J12-18).

Numerator: Number of cases with a pneumonia or influenza cause of death.
Denominator: Population estimates provided by the University of New Mexico, Geospatial and Population Studies (GPS) program.

Interpretation: The influenza and pneumonia age-adjusted death rate was xx per 100,000 population.

Data Source/Methodology

• New Mexico Death Data: Bureau of Vital Records and Health Statistics (BVRHS)
• New Mexico Population Estimates: University of New Mexico, Geospatial and

Story Behind The Data

Pneumonia and influenza (P&I) infections are the eighth leading cause of death in the US and 10th in New Mexico. Between 2010 and 2018, influenza causes an estimated 190,000 - 960,000 hospitalizations and 12,000 - 79,000 deaths nationally each year. P&I death rates have decreased over the last 10 years. Recognizing the importance of influenza antiviral medications in preventing influenza-related deaths has increased their use among hospitalized influenza patients and during influenza outbreaks in healthcare facilities.
NMDOH promotes and assures the use and availability of influenza and pneumococcal vaccines. Surveillance for influenza-like illness, influenza hospitalizations, and pneumonia and influenza related deaths will continue to inform influenza vaccination policy and recommendations.

Improvement Action Plan

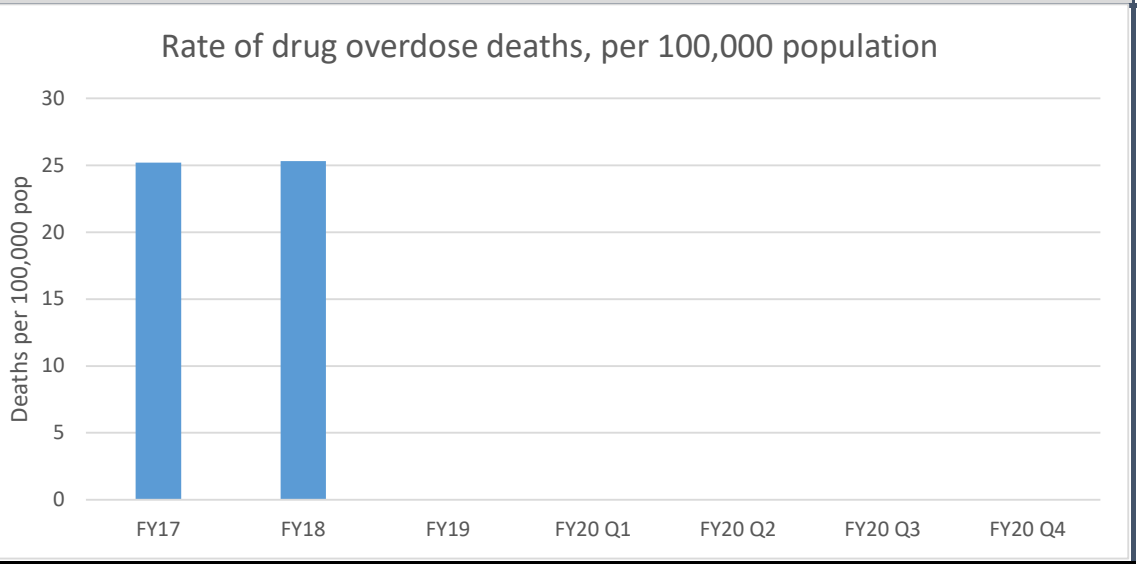
• Measure the percent of adults ≥65 years of age who receive pneumococcal vaccine.
• Measure the rates of pneumococcal vaccine uptake among children.

Population Studies (GPS) Program, http://gps.unm.edu/	• Measure the percent of the population ≥6 months of age who receive influenza vaccine. • Measure P&I death and hospitalization rates through existing surveillance systems to detect changes in morbidity and mortality. • Conduct viral isolation of specimens to detect changes in circulating viral strains and to compare what is circulating with vaccine strains. • Measure the use of anti-viral medications among hospitalized cases and attributed to influenza. • Convene a Quarterly Health Status Indicator meeting to interact with and engage stakeholders involved in P&I related activities.

Program Objective 5: Monitor health status and provide health information

Measure 5.1

Rate of drug overdose deaths per 100,000 population



FY17	FY18	FY19	FY20 Q1	FY20 Q2	FY20 Q3	FY20 Q4	FY20 Total	FY20 Target
24.6	26.6	n/a	n/a					Explanatory

Measure Description

Numerator: The number of drug overdose deaths as defined by underlying cause of death ICD-10 codes X40-X44, X60-X64, X85, Y10-Y14.
Denominator: New Mexico Population (UNM/GPS estimates).
Age adjustment to the US 2000 standard population.

Data Source/Methodology

Data Source: NMDOH Bureau of Vital Records and Health Statistics death data; UNM/GPS population estimates.

Story Behind The Data

New Mexico long had one of the highest rates of drug overdose deaths in the US. Between 2015 and 2017 NM reported small small decreases in the number of drug overdose deaths. However, the number increased in 2018. For the last few years, New Mexico has aggressively addressed opioid overdose deaths, including making naloxone more available, mandating use of the PMP, increasing the number of healthcare providers who can prescribe medication assisted treatment (MAT), paying for screening and brief intervention (SBI) services through Medicaid, increasing support for harm reduction, and including syringe services. During this time, the non-fentanyl opioid-involved death rates have been decreasing while methamphetamine-involved and fentanyl-involved death rates have increased.

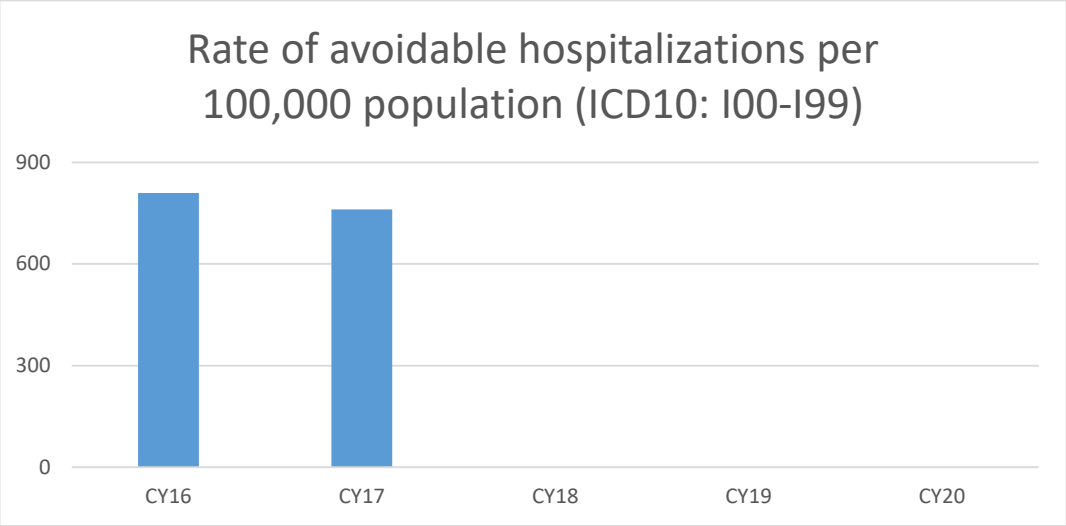
Improvement Action Plan

The Epidemiology and Response Division is working with the Behavioral Health Services Division (BHSD) in the Human Services Department (HSD) on a plan to decrease methamphetamine-involved deaths. The draft plan includes prevention, criminal justice, treatment, surveillance components and will be carried out in collaboration with DOH's sister agencies to maximize impact with limited resources. Opioid-related work (as described above) will continue.

Program Objective 5: Monitor health status and provide health information

Measure 5.2

Rate of avoidable hospitalizations per 100,000 population



CY16	CY17	CY18	CY19	CY20				CY20 Target
809.3	760.9							Explanatory

Measure Description

Numerator: Ambulatory Care Sensitive Condition-related hospitalizations, D**enominator**: All hospitalizations, age-specific rates (by gender, county, and race). The calculation method will follow the Agency for Healthcare Research and Quality (AHRQ) protocols for calculating ACSC hospitalization rates in their Prevention Quality Indicators (PQIs), exclusions include hospitalizations provided to NMDOH with missing values for clinical documentation/discharge diagnosis, county, or race.

Data Source/Methodology

New Mexico's Hospital Inpatient Discharge Dataset (https://nmhealth.org/about/erd/hsep/hidd/).

Story Behind The Data

Avoidable hospitalizations initially began being analyzed in NM for the 2016 calendar year beginning with the implementation of ICD-10-CM coding of discharge diagnosis. The initial analysis has provided a baseline of descriptive statistics to support identification of the NM population by demographics, including age, gender, race, and geographics that is most impacted by avoidable hospitalizations. These particular hospitalizations are avoidable with proper control and management of various conditions, adequate access to primary care, and with preventative public health measures.

Improvement Action Plan

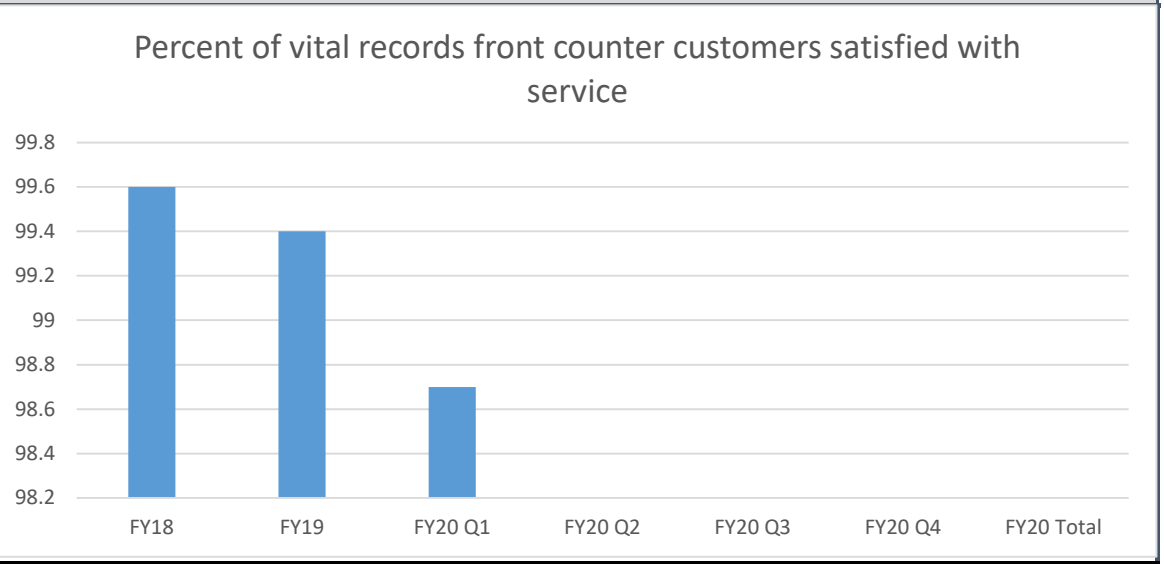
The Epidemiology and Response Division's Health Systems Epidemiology Program, currently analyzes avoidable hospitalization data annually upon collection of the annual hospital inpatient discharge dataset and disseminates these data via various methods, e.g., epidemiology reports, press reports, etc. The intention is to develop a communication plan that provides proper structure to the

message, audience, communication channels, follow-up, and maintenance protocols.

Program Objective 5: Monitor health status and provide health information

Measure 5.3

Percent of vital records front counter customers who are satisfied with the service they received



FY17	FY18	FY19	FY20 Q1	FY20 Q2	FY20 Q3	FY20 Q4	FY20 Total	FY20 Target
n/a	99.6	99.4	98.7					95

Measure Description

Numerator: Number of customers that marked excellent or good.
Denominator: Total number of customer who filled out the customer survey. Exclusions would be those customers who refused to complete a survey.

Data Source/Methodology

Counter customer survey.

Story Behind The Data

Vital records are important legal documents and are key to many essential activities, so having satisfied customers who use Vital Records' service reflects positively on the state. Due to the implementation of the Real ID driver's license, the number of customers and the services they need have changed drastically, thus the amount of time needed to serve a customer has increased by up to five times the old rate due to the complexity of the services now needed.
The Bureau reviewed four different software options that electronically capture customer satisfaction. Some of these platforms were stand-alone systems that allowed only for the customer satisfaction survey, while others combined with customer queuing software, which can be used for other purposes.

Improvement Action Plan

The Epidemiology and Response Division's Bureau of Vital Records and Health Statistics (BVRHS) will work to maintain customer satisfaction to the FY19 target of 95.0% by achieving the following quarterly milestones:

- Q1: Conduct customer satisfaction surveys to verify that the 95% goal is maintained.
- Q2: Develop recommendations for choice of customer satisfaction survey.
- Q3: Develop electronic versions of survey using computer tables.
- Q4: Modify approach to customer service as needed, based on new process.

New Mexico Department of Health

Scientific Laboratory Division

P004

Program Description and Purpose

The Scientific Laboratory Division (SLD), provides clinical testing for infectious disease agents in support of public health programs operated by the Department of Health and the Office of the Medical Investigator; veterinary, food and dairy testing for the Department of Agriculture and; forensic toxicology (drug) testing in support of the Department of Public Safety, Department of Transportation and local law enforcement agencies for the Implied Consent Act and the Office of the Medical Investigator; and chemical testing for environmental monitoring and enforcement of law and environmental regulations for the Environment Department. SLD also provides clinical testing for State operated clinics and local hospitals for infectious diseases that are rare or novel in New Mexico (e.g. Zika, Ebola, West Nile virus, avian influenza, Chikungunya, Dengue, etc.) and provides training and certification of law enforcement officers to perform breath alcohol testing within the state. The activities of SLD in support of these State agencies are all mandated in statute, and are essential for the successful mission of the programs it supports in these numerous agencies.

Program Budget (in thousands):

FY19	General Fund	Other State Funds	Federal Funds	Other Transfers	TOTAL	FTE
200	$ 5,070,800.00	$ 1,227,000.00	$ 1,372,400.00	$ 118,800.00	$ 7,789,000.00	134
300	$ 380,400.00	$ 61,600.00	$ 48,100.00	$ -	$ 490,100.00	
400	$ 2,126,000.00	$ 642,100.00	$ 1,447,800.00	$ 689,200.00	$ 4,905,900.00	
TOTAL	$ 7,577,200.00	$ 1,930,700.00	$ 2,868,300.00	$ 808,000.00	$ 13,185,000.00	

FY20	General Fund	Other State Funds	Federal Funds	Other Transfers	TOTAL	FTE
200	$ 5,379,000.00	$ 1,272,500.00	$ 1,543,000.00	$ 119,100.00	$ 8,313,600.00	134
300	$ 170,600.00	$ 33,500.00	$ 61,200.00	$ 34,500.00	$ 299,800.00	
400	$ 2,193,800.00	$ 593,900.00	$ 1,551,300.00	$ 628,100.00	$ 4,967,100.00	
TOTAL	$ 7,743,400.00	$ 1,899,900.00	$ 3,155,500.00	$ 781,700.00	$ 13,580,500.00	

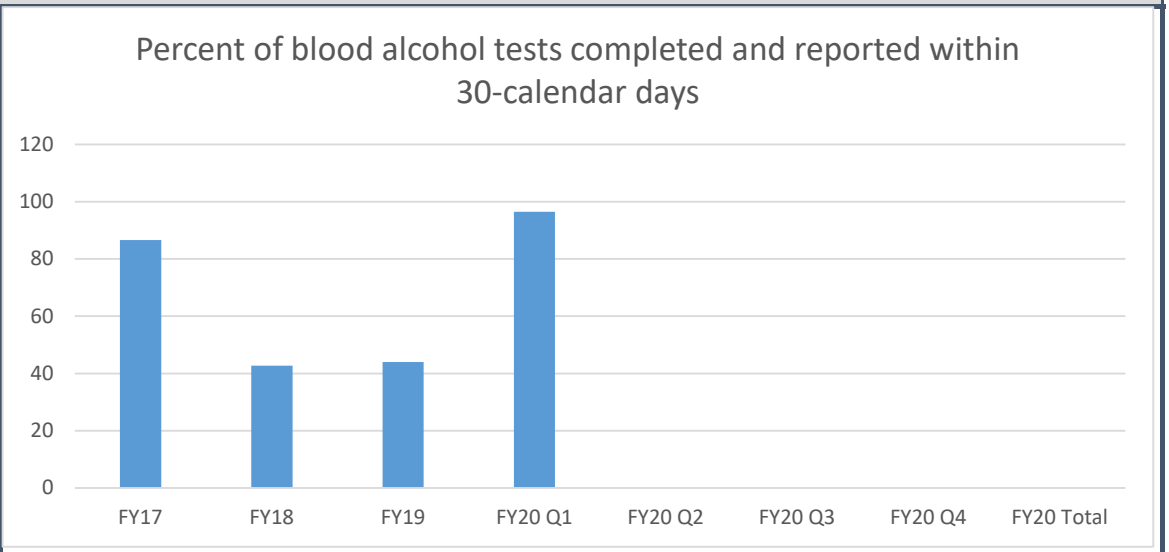
Program Objective 1: Provide laboratory analyses within established timeframes

Measure	Description
1.1	Percent of blood alcohol tests from driving-while-intoxicated cases that are completed and reported to law enforcement within 30-calendar days (**FY20 KEY MEASURE**)
1.2	Percent of environmental samples for chemical contamination that are completed and reported to the submitting agency within 60-business days
1.3	Percent of public health threat samples for communicable diseases and other threatening illnesses that are completed and reported to the submitting agency within published turnaround times

Program Objective 1: Provide laboratory analyses within established timeframes

Measure 1.1

Percent of blood alcohol tests from driving-while-intoxicated cases that are completed and reported to law enforcement within 30-calendar days (FY20 KEY MEASURE)



FY17	FY18	FY19	FY20 Q1	FY20 Q2	FY20 Q3	FY20 Q4	FY20 Total	FY20 Target
86.58	42.78	44	96.52					90%

Measure Description

Denominator: Number of cases reported out during the quarter/year.
Numerator: Number of cases reported out within 30 calendar days of receipt.
(Note: Measure previously specified reporting in 15 days and changed to 30-days in FY19-Q4).

Data Source/Methodology

Data Source is the Laboratory Information Management System (LIMS). The LIMS is a secure integrated IT system that tracks samples, results, quality control, and collects audit reasons for changes.

Story Behind The Data

Nationally, New Mexico has had the highest alcohol-related death rate since 1997. New Mexico's rate has consistently been nearly twice the national rate and has been increasing more rapidly than the national rate. According to the Centers for Disease Control and Prevention, alcohol is a contributing factor in up to 49% of motor vehicle crashes.
The Scientific Laboratory Division (SLD) Toxicology staff analyze samples for blood alcohol concentration (BAC) and drugs to determine cause of impairment in drivers, as well as Office of Medical Investigator (OMI) samples for cause of death. They also serve as expert witnesses in court cases where alcohol or drugs are involved.
Duplicate testing of each specimen is performed per accreditation requirements, which doubles testing time (started FY16-Q3). This measure was revised to extend results reporting from 15 calendar days to 30 calendar days. The target of 90% was exceeded in FY20-Q1, with 96.52% of results reported within the new 30-day turnaround time.

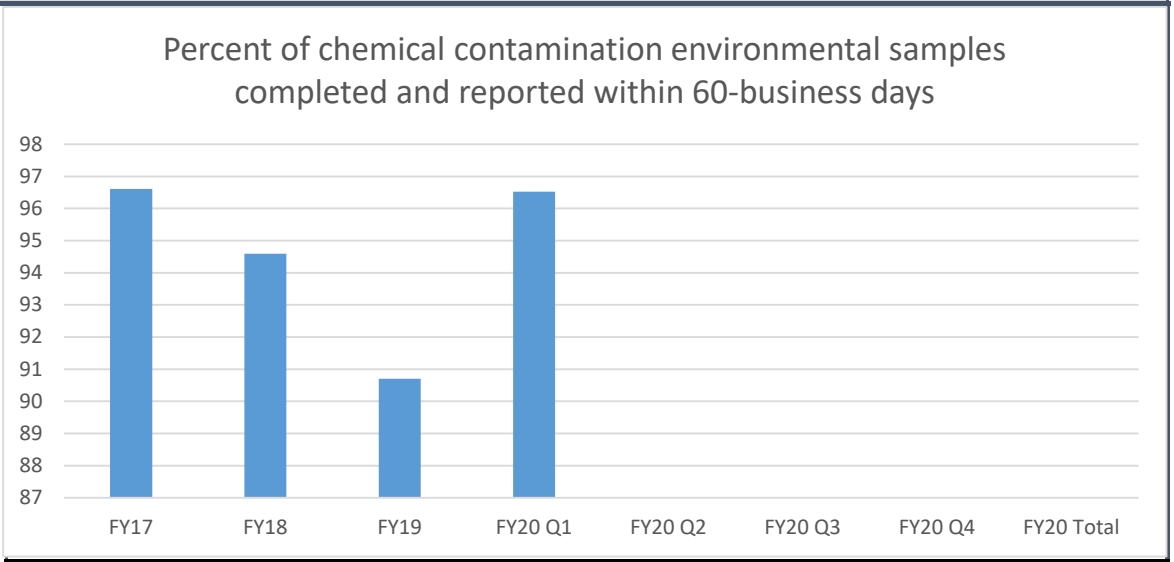
Improvement Action Plan

- Continue to recruit and hire qualified staff.
- Continue training of newly-hired staff.
- Continue to monitor and maintain equipment.

Program Objective 1: Provide laboratory analyses within established timeframes

Measure 1.2

Percent of environmental samples for chemical contamination that are completed and reported to the submitting agency within 60-business days



FY17	FY18	FY19	FY20 Q1	FY20 Q2	FY20 Q3	FY20 Q4	FY20 Total	FY20 Target
96.61	94.59	90.7	96.52					90%

Measure Description

Denominator: Number of samples reported out during the quarter/year. These samples include chemical, radiological, and air particulate contaminants.
Numerator: Number of samples in the denominator that are reported out within 60 calendar days of receipt.

Data Source/Methodology

Data Source is the Laboratory Information Management System (LIMS). The LIMS is a secure integrated IT system that tracks samples, results, quality control, and collects audit reasons for changes.

Story Behind The Data

This performance measure is new for FY20. The Scientific Laboratory Division (SLD) is certified by the Environmental Protection Agency to analyze the primary regulated contaminants in water, air, and soil samples under the New Mexico Environment Department regulations. The laboratory performs analyses for organic and inorganic materials, radioactive materials, and heavy metals for tax-supported governmental agencies and municipalities to ensure that contamination by potentially toxic compounds is detected and measured. Turn-around times are based on the needs of the New Mexico Environment Department. The Chemistry Bureau exceeded the FY20 target of 90% by reporting 96.52% of results within 60 calendar days of sample receipt.

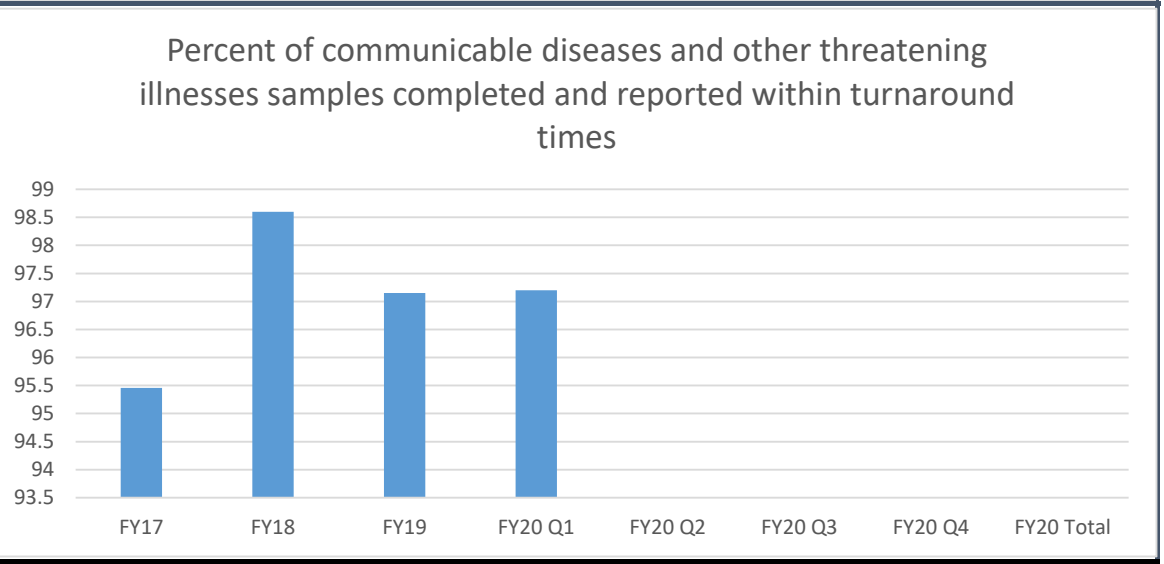
Improvement Action Plan

The laboratory will seek to obtain replacement equipment for both the Metals and Organics testing sections. Much of the analytical equipment is old and no longer supported by the manufacturers. Continued use of old equipment can lead to poor test performance and result in re-running samples, which increases timeline for results reporting.

Program Objective 1: Provide laboratory analyses within established timeframes

Measure 1.3

Percent of public health threat samples for communicable diseases and other threatening illnesses that are completed and reported to the submitting agency within published turnaround times



FY17	FY18	FY19	FY20 Q1	FY20 Q2	FY20 Q3	FY20 Q4	FY20 Total	FY20 Target
95.46	98.6	97.15	97.2					90%

Measure Description

Denominator: Number of samples reported out during the quarter/year. These samples include animal and human diagnostic samples, as well as reference samples, food, dairy and water samples.
Numerator: Number of samples reported out within turn-around times for tests listed in SLD's DIRECTORY OF SERVICES.

Data Source/Methodology

Data Source is the Laboratory Information Management System (LIMS). The LIMS is a secure integrated IT system that tracks samples, results, quality control, and collects audit reasons for changes.

Story Behind The Data

This performance measure is new for FY20. The Biological Sciences Bureau of the Scientific Laboratory Division (SLD) tests for commonly occuring and exotic infectious diseases of public health significance. The laboratory receives human and animal diagnostic specimens as well as food, dairy, and water samples for routine testing, surveillance testing, and outbreak investigation. The Bureau partners with national, state, and local agencies such as the Centers for Disease Control & Prevention, Food & Drug Aministration, Veterinary Diagnostic Services, city and county agencies, epidemiologists, hospitals, and patient testing laboratories to detect and confirm bacterial and viral causes for infectious disease. Each test performed is described in SLD's Directory of Services and has a defined turnaround time for reporting results. The laboratory exceeded the target of 90%, reporting 97.2% of results within specified turnaround times.

Improvement Action Plan

Prepare for and pass upcoming inspections by the Environmental Protection Agency and College of American Pathologists. Train the newly-hired General Microbiology section line supervisor and additional staff to perform clinical testing at capacity. Complete validation studies to update six testing platforms for detecting human exposure infectious viruses and one molecular method for identifying antibiotic resistance. Complete training for the transition to Whole Genome Sequencing for bacteria and streamline internal processes to reach the turnaround time expectations of the Epidemiology & Response Division.

New Mexico Department of Health

Facilities Management Division

P006

Program Description and Purpose

The Facilities Management Division (FMD) fulfills the NMDOH mission by providing:

- Programs in mental health, substance abuse, long-term care, and physical rehabilitation in both facility and community-based settings; and
- Safety net services throughout New Mexico.

FMD consists of six healthcare facilities and one community program. Most individuals served by NMDOH facilities have either complex medical conditions or psychiatric disorders that manifest in violent behaviors, and private sector providers are either unable or unwilling to serve these complex individuals, many of whom are restricted to NMDOH facilities by court order. The FMD Facility and Community Program staff cares for both New Mexico adult and adolescent residents, who need continuous care 24 hours/day, 365 days/year as well as provision of a variety of behavioral health outpatient services.

Program Budget (in thousands):

FY19	General Fund	Other State Funds	Federal Funds	Other Transfers	TOTAL	FTE
200	45,029.0	44,805.6	4,834.5	736.6	95,405.7	1,793
300	4,213.3	6,248.0	119.0	734.5	11,314.8	
400	* 10,353.2	7,677.8	104.8	2,960.7	21,096.5	
TOTAL	59,595.5	58,731.4	5,058.3	4,431.8	127,817.0	

*4,050.0 is for the Fort Bayard Medical Center building lease purchase

FY20	General Fund	Other State Funds	Federal Funds	Other Transfers	TOTAL	FTE
200	46,093.3	54,175.4	7,588.5	738.6	108,595.8	2,003
300	5,221.3	6,652.9	308.8	734.5	12,917.5	
400	* 10,854.1	11,991.4	1,184.8	2,981.3	27,011.6	
TOTAL	62,168.7	72,819.7	9,082.1	4,454.4	148,524.9	

*4,050.0 is for the Fort Bayard Medical Center building lease purchase

Program Objective 1: Improve quality of care

Measure	Description
1.1	Percent of long-term care residents experiencing facility acquired pressure injuries (Veterans' Home)
1.2	Customer Overall satisfaction (Veterans' Home)
1.3	Number of residents requiring re-hospitalization within 30-days of admission (Veterans' Home)
1.4	Number of significant medication errors per 100 patients (**FY20 KEY MEASURE**)
1.5	Percent of long-term care residents experiencing one or more falls with major injury (**FY20 KEY MEASURE**)

Program Objective 2: Assure safety net services

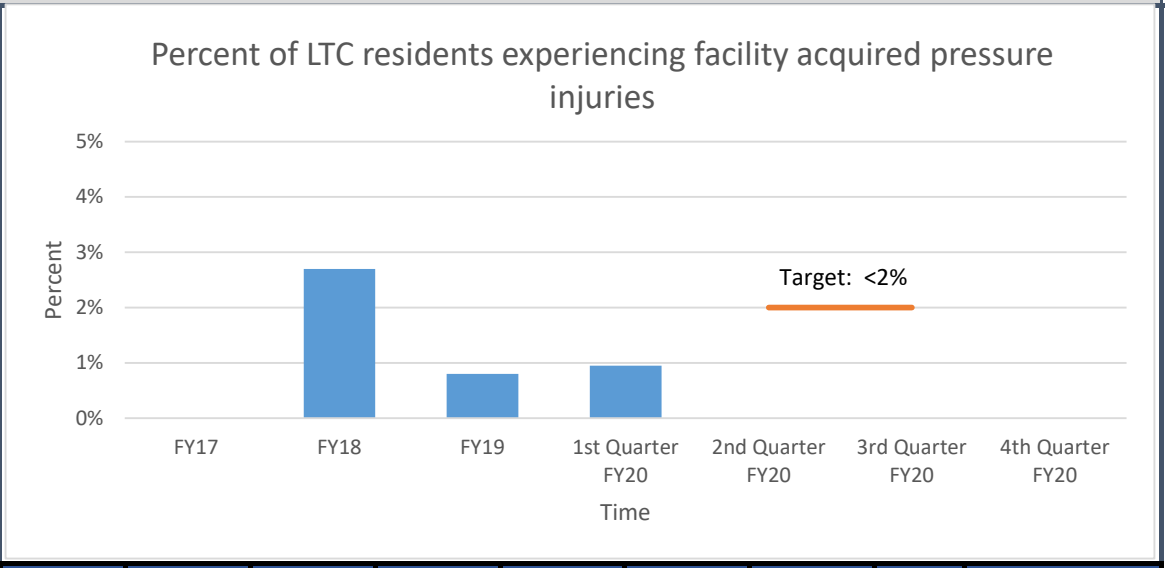
Measure	Description
2.1	Percent of adolescent residents (SATC & NMBHI Care Unit) who are successfully discharged

2.2	Percent of priority Request for Treatment clients who are admitted to the program (TLH)
2.3	Rate of medical detox occupancy at Turqoise Lodge Hospital
2.4	Percent of eligible third-party revenue collected at all agency facilities (**FY20 KEY MEASURE**)

Program Objective 1: Improve quality of care

Measure 1.1

Percent of long-term care residents experiencing facility acquired pressure injuries (Veterans' Home)



FY17	FY18	FY19	FY20 Q1	FY20 Q2	FY20 Q3	FY20 Q4	FY20 Total	FY20 Target
	2.70%	0.80%	0.63%					<2%

Measure Description

New Mexico State Veterans' Home (NMVH) facility acquired pressure injuries are tracked monthly. The calculated rate is based on the total number of LTC residents with facility acquired pressure injuries for the quarter.

Numerator: Total number of LTC residents with pressure injuries acquired in-house for the quarter.

Denominator: Total number of LTC residents served for the quarter.

Data Source/Methodology

Pressure injury data is compiled and reported on the facility Monthly Pressure Injury Report. The facility acquired pressure injury data is taken from the Monthly Pressure Injury Report and calculated into a facility acquired pressure injury rate by using the total number of residents served for the month.

Story Behind The Data

History: A performance action team (PAT) was developed to improve NMVH pressure injury rates. The team implemented actions to lower the facility pressure injury rate, with oversight by the Quality Assurance Performance Improvement (QAPI) Committee. Supporting performance measures were developed to monitor processes identified for pressure injury prevention. These processes include: Braden Scale, care plan updates, physical therapy assessment for redistribution devices, repositioning based on schedule clocks, and nutritional assessments. NMVH facility acquired pressure injury rates decreased over FY19.

FY20 Q1: In August 2019, the pressure injury PAT reviewed current measures for pressure injury prevention and revised the repositioning measure. The NMVH facility acquired pressure injury rate is below the established target.

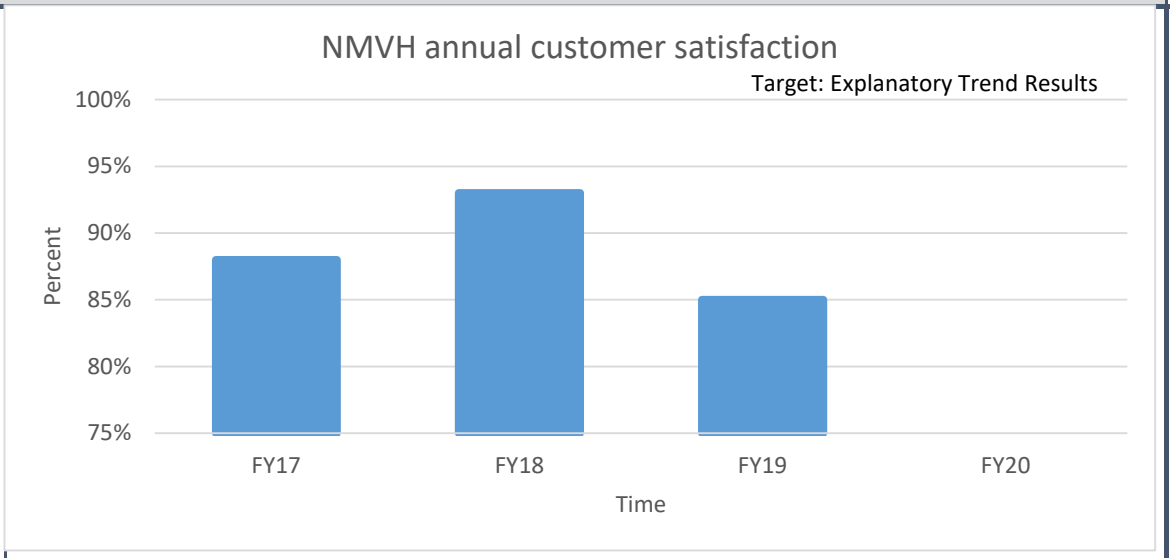
Improvement Action Plan

NMVH QAPI Committee reviews facility acquired pressure injury rates monthly and makes recommendations, as needed. The Skin Focus Team (team includes the dietician, medical provider, and nursing) goes around weekly to address and/or prevent skin issues related to individual resident needs. Revision of the performance measures will be implemented by October 31, 2019 and reported to the QAPI Committee monthly.

Program Objective 1: Improve quality of care

Measure 1.2

Customer Overall satisfaction (Veterans' Home)



FY17	FY18	FY19	FY20 Q1	FY20 Q2	FY20 Q3	FY20 Q4	FY20 Total	FY20 Target
88%	93%	85%						Explanatory

Measure Description

Annual surveys are available to NMVH residents and resident families/POAs with results based on returned surveys.
Numerator: Total number of positive survey results answering most of the time, always, and yes for the fiscal year.
Denominator: Total number of survey results answering most of the time, always, yes, no, sometimes, and never for the fiscal year.

Data Source/Methodology

Satisfaction survey results are calculated from an internal survey tool and include residents and resident families/POA survey results.

Story Behind The Data

History: FY17 and FY18 survey results were calculated through an external vendor. The survey process changed for FY19 to an annual survey utilizing NMVH's internal survey tools. Residents and/or resident families/POAs were surveyed at the end of FY19 with 65 surveys returned.

FY20 Q1: Survey results were calculated based on three (3) categories: Medical Staff - 88%, Nursing - 86%, Other - 85%, for an Overall Satisfaction Rate of 86%.

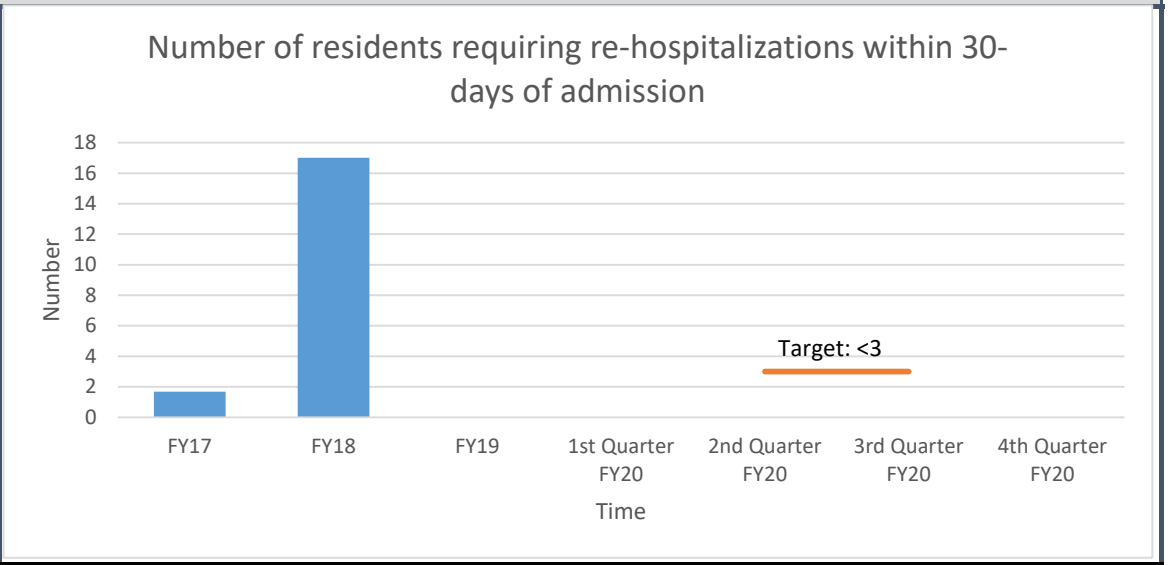
Improvement Action Plan

A Performance Action Team (PAT) will be developed by October 31, 2019. The purpose of the PAT is to review survey responses and make recommendations for improvement of customer satisfaction to the Quality Assurance Performance Improvement (QAPI) Committee by November 27, 2019.

Program Objective 1: Improve quality of care

Measure 1.3

Number of residents requiring re-hospitalization within 30-days of admission (Veterans' Home)



FY17	FY18	FY19	FY20 Q1	FY20 Q2	FY20 Q3	FY20 Q4	FY20 Total	FY20 Target
1.7	17	0	0				0	<3 Quarter/ <12 Annual

Measure Description

The performance measure is the total number of LTC residents sent back to any acute care hospital from NMVH within 30-days of admission/readmission for the quarter.

Data Source/Methodology

NMHV uses data from the Point Click Care (PCC) Rehospitalization Report - All Payer 30-Day Rehospitalization Rate for the total number of rehospitalizations for the quarter.

Story Behind The Data

FY20 Q1: No residents were sent back to an acute care hospital within 30-days of admission or readmission.

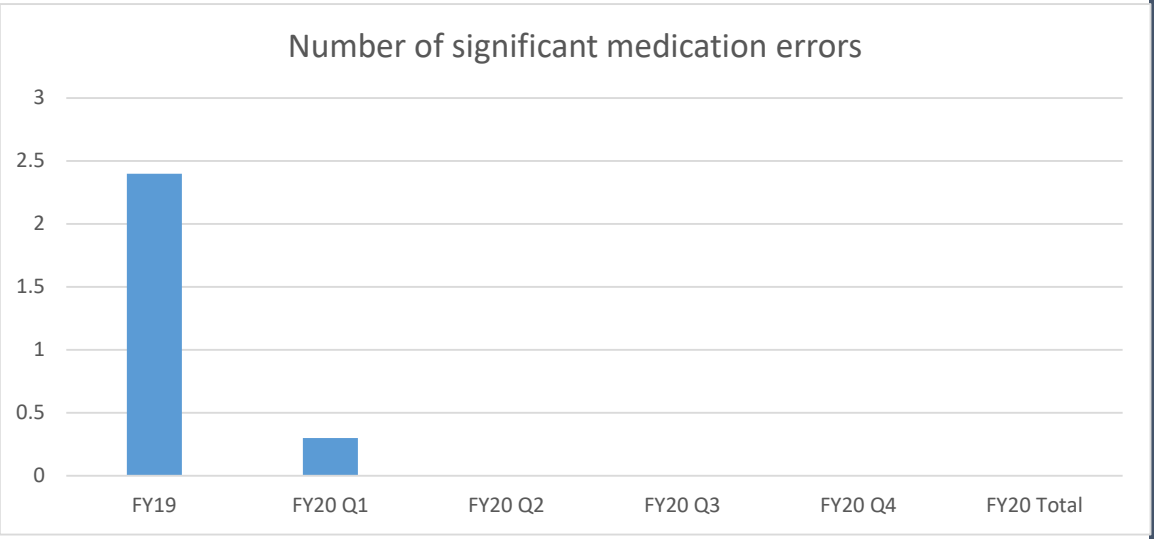
Improvement Action Plan

Review of the NMVH PCC Rehospitalization Report will be done monthly to identify any change in the current trend. Findings will be reported to the QAPI Committee for oversight and recommendations/action, as appropriate.

Program Objective 1: Improve quality of care

Measure 1.4

Number of significant medication errors per 100 patients (FY20 KEY MEASURE)



FY17	FY18	FY19	FY20 Q1	FY20 Q2	FY20 Q3	FY20 Q4	FY20 Total	FY20 Target
		2.4	0.3					≤ 2.0

Measure Description

This measure reports on the quality of patient care by measuring the accuracy of medication administration within each facility and the entire program area. Medication administration is a consistent and standard practice at each facility. **Numerator**: Total number of inpatient days (for all facilities). **Denominator**: Total number of days/month to determine an inpatient average daily census. This average daily census is then divided by 100 to determine the denominator.

Data Source/Methodology

Data will be provided by each facility following their determination of whether a medication error is considered "Significant", which is defined as a level D or higher according to the NCC MERP Index for Categorizing Medication Errors. This will be

Story Behind The Data

In 1999, the Institute of Medicine published To Err Is Human: Building a Safer Health System, in which they stated that between 44,000-98,000 people die in hospitals each year as a result of preventable medication errors and laid out a strategy for reducing these errors.
The DOH Facilities, of which each serve a distinct population, monitor and report the rate of significant Category D or higher medications errors, according to the National Coordinating Council for Medication Error Reporting and Prevention (NCC MERP) Index for Categorizing Medication Errors. The NCC MERP addresses interdisciplinary causes of errors and promotes safe use of medications to prevent errors. A Category D or higher is an error that reaches the patient, resulting in increased patient monitoring or treatment intervention and corrective actions taken to prevent recurrence and harm.

Improvement Action Plan

The DOH Facilities continue to work to:

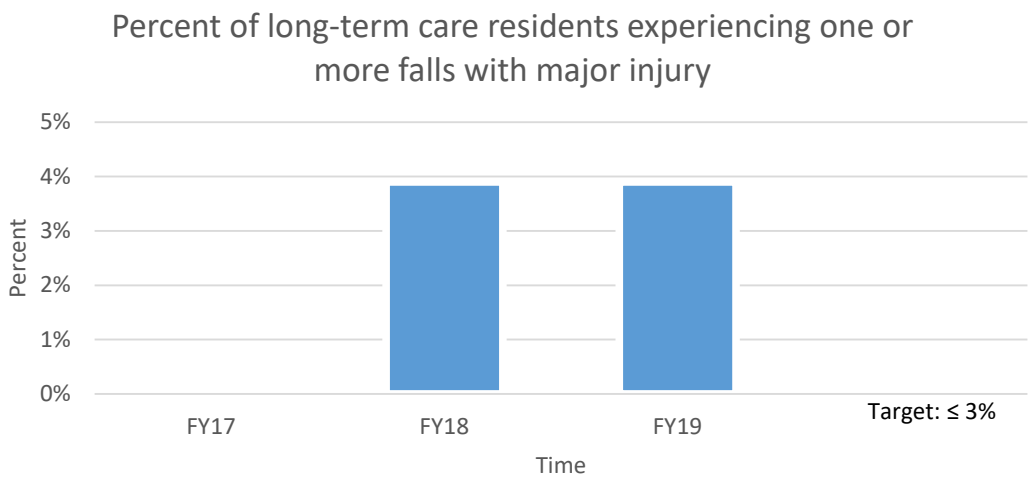
- Foster a culture of patient safety that focuses on medication error prevention, minimizes at-risk

the numerator.	provider behavior, and supports medication error reporting within a non-punitive, continuous quality improvement framework; • Monitor actual and potential medication errors that occur/may occur, including near misses, and investigate the root causes; and • Identify ways, establish goals, adopt best practices and provide training to continually improve the medication use system to prevent medication errors.

Program Objective 1: Improve quality of care

Measure 1.5

Percent of long-term care residents experiencing one or more falls with major injury (FY20 KEY MEASURE)



FY17	FY18	FY19	FY20 Q1	FY20 Q2	FY20 Q3	FY20 Q4	FY20 Total	FY20 Target
	3.9%	3.9%	5.5%					≤ 3%

Measure Description

This measure reports the percentage of residents within long term care facilities who have fallen with a major injury as a result of the fall. The DOH long term care facilities are the New Mexico Behavioral Health Institute, New Mexico Veterans' Home and the Fort Bayard Medical Center.

Data Source/Methodology

Certification And Survey Provider Enhanced Reports, also known as CASPER Reports, are generated from the Centers of Medicare and Medicaid Services (CMS). All Nursing Facilities who receive any payment from Medicare or Medicaid are required to complete this process. This data collection will utilize the measure of "Falls with Major

Story Behind The Data

Falls are common and are a major safety concern for long-term care facilities. While not all falls and injuries can be prevented, it is critical to have a systematic process of assessment, intervention, and monitoring to minimize fall risk and prevent major injuries resulting from falls.
Every new long-term care resident is assessed for fall risk. This assessment is then included in each individual resident's care plan, contributing to the success of this measure. It is, however, a significant challenge to balance each resident's need for independence with the inherent risk for falls.

Improvement Action Plan

Facilities will continue to work on strategies that help protect residents from falls in nursing home settings which include:

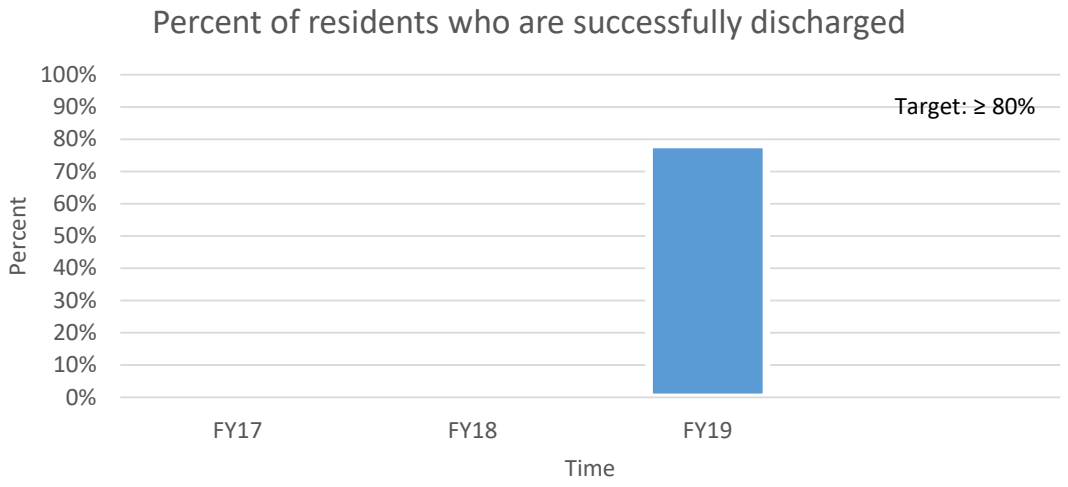
- Education of employees, residents, and family members;
- Close observation;
- Therapy services that focus on strengthening and improving balance and mobility;
- Individualized resident treatment planning following a fall; and
- Active Falls Prevention Committee, which analyzes tracks and reports on causes of falls.

Injury" which is reported as a numerator and a denominator along with the Facility Observed Percent. The report also provides comparative data for State Average and National Average. Each Department of Health facility reports individually, so the combined outcome is an average of these facilities and this is consistent with the comparative data which is also an average.	

Program Objective 2: Assure safety net services

Measure 2.1

Percent of adolescent residents (SATC & NMBHI Care Unit) who are successfully discharged



FY17	FY18	FY19	FY20 Q1	FY20 Q2	FY20 Q3	FY20 Q4	FY20 Total	FY20 Target
		78.4%	75.0%					≥ 80%

Measure Description

This measure will assess and evaluate how well the adolescent residents met their treatment goals while in treatment, resulting in successful discharges. The DOH facilities with adolescent programs are the New Mexico Behavioral Health Institute (CARE Unit) and the Sequoyah Adolescent Treatment Center.
Numerator: Total number of successful discharges for the reporting period.
Denominator: Total number of discharges for the reporting period.

Data Source/Methodology

AVATAR, which is an electronic healthcare record system.

Story Behind The Data

According to the June 7, 2017 Results First report presented to NM Legislative Finance Committee:
▪"Behavioral health problems affect 1 out of 5 children nationally";
▪"New Mexico has a higher rate of individuals living at or below the poverty line than the rest of the country, putting the state at higher risk for individuals developing behavioral health problems"; and
▪"In New Mexico, 14% of youth experienced 3 or more adverse childhood experiences, higher than the national average of 11%".
The DOH has youth Residential Treatment programs which provide intensive services for adolescents with serious emotional and behavioral problems and this performance measure reports on the programs meeting their goal for successful discharges from the programs. A successful discharge is a resident discharged to a lower level of care or to the recommended level of care at the time of admission. An unsuccessful discharge includes a discharge to the juvenile justice system.

Improvement Action Plan

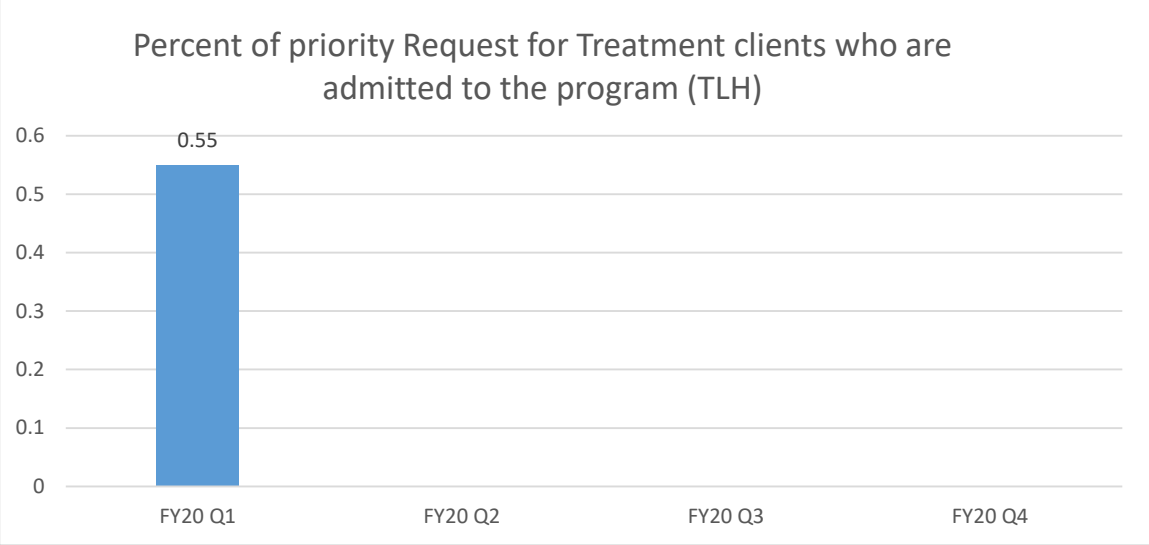
The DOH programs continue to provide individualized treatment and services that meet the needs of each resident, to include group therapy, positive group experiences, living skills, and fostering a positive culture of support. It is important, firstly, that resident recruitment fit the criteria of the program to ensure the availability of appropriate treatment services and specialized staff to meet treatment needs. Treatment teams continue to work on appropriate interventions and services to

	best meet each resident's needs for a successful discharge. Ongoing reviews and development of program strategies are required to meet the goal.

Program Objective 2: Assure safety net services

Measure 2.2

Percent of priority Request for Treatment clients who are admitted to the program (TLH)



FY17	FY18	FY19	FY20 Q1	FY20 Q2	FY20 Q3	FY20 Q4	FY20 Total	FY20 Target
43%	59%	68%	55%					50% of Approvals

Measure Description

Numerator: Number of admitted Priority Patients per month.
Denominator: Total number of Approved Priority Patients per month.

Data Source/Methodology

AVATAR EMR, an enterprise behavioral health software program for electronic medical records and practice management.

Story Behind The Data

In 2016, New Mexico had the twelfth highest total drug overdose death rate in the nation, down from second in 2014. Turquoise Lodge Hospital (TLH) provides safety net services for consumers in New Mexico who are seeking detoxification from drugs and/or alcohol. TLH prioritizes admission for pregnant injecting drug users, pregnant substance users, other injecting drug users, women with dependent children, parenting women, and men and women seeking to regain custody of children. TLH has the potential to impact New Mexico's drug overdose and alcohol death rate through active engagement of priority populations.

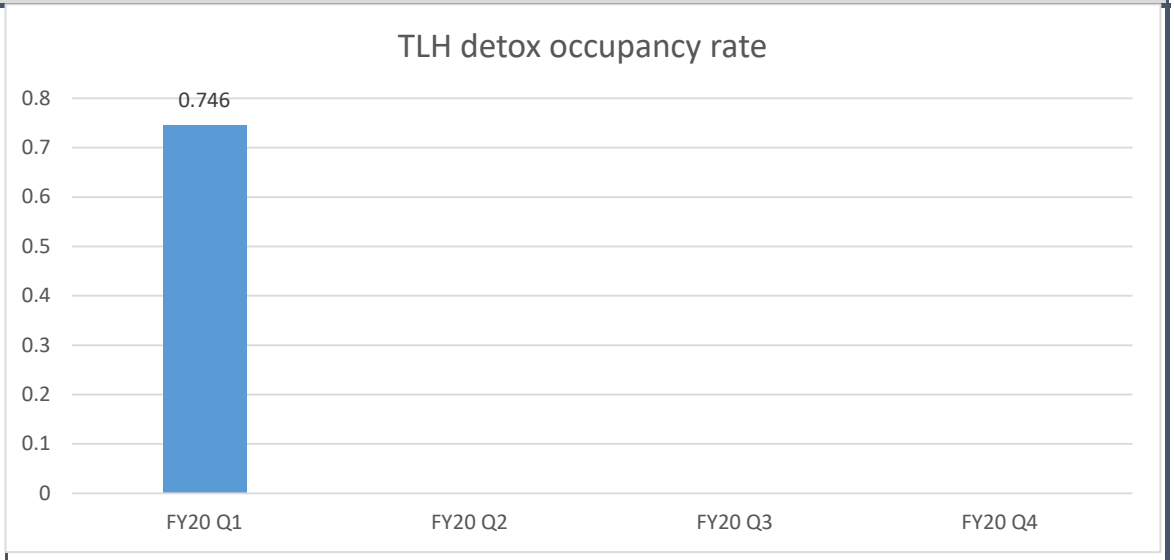
Improvement Action Plan

In FY17, TLH modified their electronic call system to flag priority populations and implemented an engaging pre-scheduling telephone call that occurs within one business day of approval for treatment. This intervention moved the timeliness of first contacting a consumer from an average of 4.96 days in FY17 Q1-2 to an average of 1.4 days in FY18. To determine whether increased contact was effective in increasing engagement, TLH evaluated the historical baseline of priority individuals who were admitted: FY15: 26%, FY16: 41%, and FY17: 43%. In FY18, we exceeded our target with 59% of approved priority patients admitted to the hospital.
TLH will continue to utilize the Crystal Report implemented in the First Quarter to more quickly see the outcomes of our interventions.

Program Objective 2: Assure safety net services

Measure 2.3

Rate of medical detox occupancy at Turqoise Lodge Hospital



FY17	FY18	FY19	FY20 Q1	FY20 Q2	FY20 Q3	FY20 Q4	FY20 Total	FY20 Target
93.4	86.3	83.3	74.6%					75%

Measure Description

Numerator: Total number of detox patients in hospital per day, monthly (Patient Days).
Denominator: Number of detox admissions per month. Quarterly Data is serviced from the 3-month average of monthly data.

Data Source/Methodology

Hospital Census Data

Story Behind The Data

As of 2016, New Mexico has the twelfth highest drug overdose death rate in the nation. The consequences of substance use are not limited to death, but include many medical and social consequences, including poverty and lack of adequate insurance. Turquoise Lodge Hospital (TLH) is a specialty hospital that provides safety net services for New Mexican adults with substance use disorders. Occupancy rate, or the percentage of staffed beds that are occupied, measures access to these safety net services. TLH does not make admission decisions based on an individual's insurance, the lack of insurance or the ability to pay. According to the U.S. Centers of Disease Control and Prevention (CDC), for the year 2013, the average specialty hospital occupancy rate in the United States was 63.0% and in New Mexico the average rate was 56.0%.

Improvement Action Plan

Maintain call management and assessment system for receiving inflow of Requests for Treatment within the Access Department.

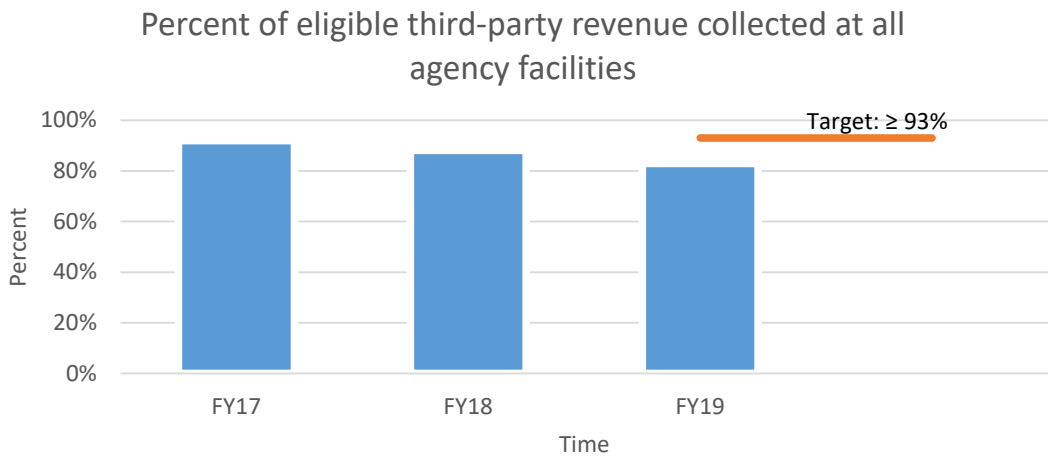
- Schedule three to five admissions per day, five days per week.
- Monitor processes and occupancy rate and implement changes as necessary.
- Increase nursing resources to complete the pre-admission assessment, more quickly, which would allow for patients to be approved for admission in a more efficient way.

Q1. Analyze Detox Occupancy Rate against workflow of Access Department, staffing patterns and scheduling patterns. TLH relocated our facility in June 2019, which resulted in decreasing our daily census to accommodate an occupied relocation process. Therefore, the number of daily admissions decreased for approximately 4-6 weeks.

Program Objective 2: Assure safety net services

Measure 2.4

Percent of eligible third-party revenue collected at all agency facilities (FY20 KEY MEASURE)



FY17	FY18	FY19	FY20 Q1	FY20 Q2	FY20 Q3	FY20 Q4	FY20 Total	FY20 Target
92.0%	88.1%	83.0%	84.1%					≥ 93%

Measure Description

This measure reports the percent of payments received based on the amount billed by the facilities.
Numerator: Amount of revenue collected in the reporting period.
Denominator: Amount billed in the reporting period.
Equals the percent of third-party revenue collected.

Data Source/Methodology

The information is obtained from the Electronic Healthcare Record systems used by each Facility. Earned income (revenue) in the reporting period less adjustments for uncompensated/non-recoverable care equals the amount billed.

Story Behind The Data

The collection of revenue is important to maintain services across the state. Greater revenue collection allows DOH to provide an enhanced level of care to our patients. The state's revenue fluctuates each year, and as a result the amount of General Fund appropriated to NMDOH, is directly affected.

Improvement Action Plan

There are many challenges with collecting revenue timely and efficiently at each facility. DOH continues working on the following strategies to improve revenue collection:

- Addressing billing transmission system issues, timely;
- Filling vacated billing positions (high turnover positions) and training staff to handle both current and aged accounts, quickly;
- Ensuring proper Managed Care Organization (MCO) protocols (i.e. obtaining prior authorizations) are being followed for reimbursement eligibility;
- Keeping engaged with MCO representatives, the NM Human Services Department and/or other

	third-party, on unresolved claims; • Reviewing services to ensure that they are billable under contracts and/or negotiating new service rates as necessary; • Improving data entry accuracy during claims processing; and • Sharing best practices among the Facilities.

New Mexico Department of Health

Developmental Disabilities Supports Division

P007

Program Description and Purpose

The Developmental Disabilities Supports Division (DDSD) effectively administers a system of person-centered community supports and services that promotes positive outcomes for all stakeholders. DDSD is the primary state agency that funds community services and supports for people with disabilities and their families in New Mexico. DDSD's primary focus is on assisting individuals with developmental disabilities and their families in exercising their right to make choices, grow and contribute to their community. The Developmental Disabilities Supports Division (DDSD) oversees home and community based Medicaid waiver programs. These include the Developmental Disabilities Waiver (Traditional Waiver), the Medically Fragile Waiver (Traditional Waiver), the Mi Via Self-Directed Waiver and the Supports Waiver. The DDSD Intake and Eligibility Bureau manages the Central Registry for individuals waiting for services. DDSD also provides several State General Funded Services. For all programs DDSD's vision is for people with intellectual and developmental disabilities and their families to excercise their right to make choices and grow and contribute to their community.

Program Budget (in thousands):

FY19	General Fund	Other State Funds	Federal Funds	Other Transfers	TOTAL	FTE
200	7,311.1	6,214.1	588.9	0.0	14,114.1	189
300	8,425.2	1,254.3	2,158.3	207.9	12,045.7	
400	21,679.6	1,685.6	83.6	1,177.1	24,625.9	
500	117,294.3	0.0	0.0	0.0	117,294.3	
TOTAL	154,710.2	9,154.0	2,830.8	1,385.0	168,080.0	

* 500s are waiver payments

FY20	General Fund	Other State Funds	Federal Funds	Other Transfers	TOTAL	FTE
200	7,657.1	6,413.0	607.6	0.0	14,677.7	188
300	8,675.2	1,454.3	2,158.3	207.9	12,495.7	
400	26,882.6	1,663.4	83.6	1,177.1	29,806.7	
500	131,944.3	19.2	0.0	0.0	131,963.5	
TOTAL	175,159.2	9,549.9	2,849.5	1,385.0	188,943.6	

Program Objective 1: Redesign waivers to eliminate the DDW waitlist

Measure	Description
1.1	Number of individuals on the developmental disabilties waiver waiting list
1.2	Number of individuals receiving developmental disability waiver services
1.3	Percent of developmental disabilities waiver applicants who have a service and budget in place within 90 days of income and clinical eligibility (**FY20 KEY MEASURE**)

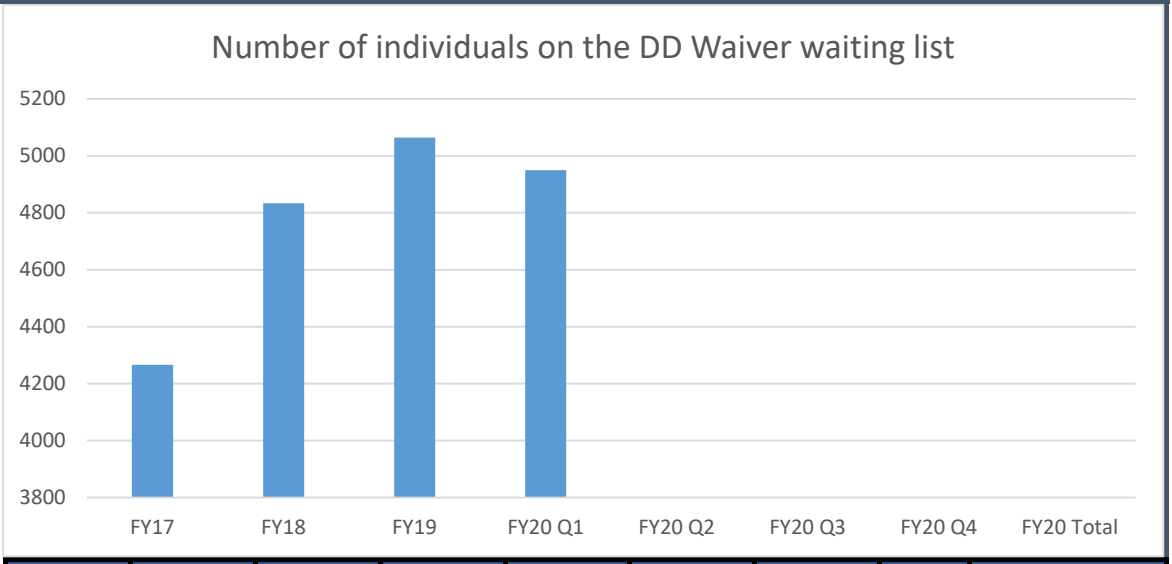
Program Objective 2: Become a data driven decision-making organization

Measure	Description
2.1	Percent of DD Waiver providers in compliance with General Events timely reporting requirements (2-day rule) (**FY20 KEY MEASURE**)
2.2	Percent of adults on the DD Waiver who receive employment supports (**FY20 KEY MEASURE**)

Program Objective 1: Redesign waivers to eliminate the DDW waitlist

Measure 1.1

Number of individuals on the developmental disabilties waiver waiting list



FY17	FY18	FY19	FY20 Q1	FY20 Q2	FY20 Q3	FY20 Q4	FY20 Total	FY20 Target
4266	4834	5064	4950					Explanatory

Measure Description

This explanatory measure indicates the number of individuals waiting for services.

Data Source/Methodology

New Mexico Department of Health, Developmental Disabilities Supports Division, Central Registry.

Story Behind The Data

The wait time for Home and Community-Based Services (HCBS) Waivers varies widely by state. In New Mexico, the HCBS Waivers with a waiting list include the Developmental Disabilities (DD) and Mi Via Waivers. Individuals are offered waiver services as funding for allocation slots becomes available. Persons that meet the requirements can receive standard Medicaid benefits and other services while on the waiting list. As of September 30, 2019, there were 4,950 individuals on the waiting list for HCBS Waivers. These individuals have been determined to meet the definition of developmental disability. Of those individuals, 405 have placed their allocation on hold. This means these individuals were offered waiver services and have chosen to continue on the waiting list, for now. The number of individuals on the wait list decreased slightly from the end of FY19, as there was a large allocation group with the FY20 appropriation. The FY20 appropriation creates 355 waiver slots for individuals on the wait list and as of September 30, 2019, 220 of those slots have been filled. The remaining 125 will be filled throughout this fiscal year.

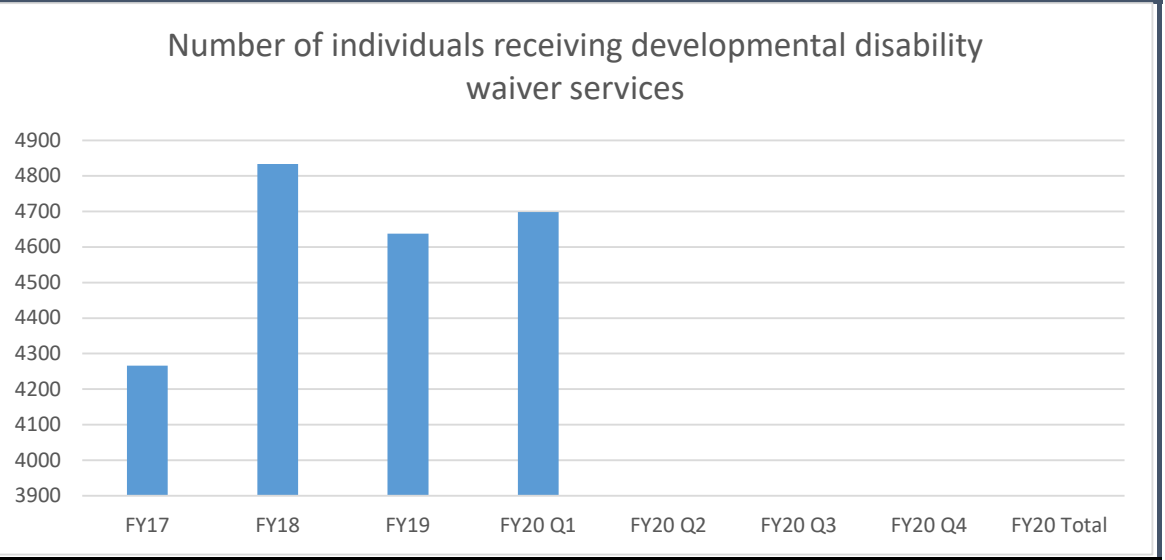
Improvement Action Plan

Increase applicant awareness of services that are available to them while they are on the wait list such as Medicaid, State General Fund, and community-based service options.

Program Objective 1: Redesign waivers to eliminate the DDW waitlist

Measure 1.2

Number of individuals receiving developmental disability waiver services



FY17	FY18	FY19	FY20 Q1	FY20 Q2	FY20 Q3	FY20 Q4	FY20 Total	FY20 Target
4266	4834	4638	4698					Explanatory

Measure Description

This explanatory measure indicates the number of individuals receiving waiver services (Traditional or Mi Via).

Data Source/Methodology

New Mexico Human Services Department, Client Counts and Expense Report, October 7, 2019.

Story Behind The Data

Every state in the nation has the option to provide home and community-based services with approval from the Centers for Medicare and Medicaid Services (CMS). Nationwide, over 44 states, and the District of Columbia, provide home and community-based Medicaid waiver services to people with Intellectual or Developmental Disabilities (I/DD).
The Developmental Disabilities Waiver program (DDW) serves as an alternative to institutional care. DDW provides a variety of services for people with I/DD to support them in living independently and participating actively in their communities.

In FY20-Q1, the Developmental Disabilities Supports Division (DDSD) had 4698 (Human Services Department 10/7/19 Developmental Disabilities Waiver and Mi Via Waiver unduplicated count) persons receiving Developmental Disability Waiver services. The Intake and Eligibility Bureau (IEB) has developed an allocation plan for the FY19 allocations. FY19 allocation batch allows for 80 slots, with 10 reserved for expedited allocations. The IEB completes replacement and attrition allocations, with replacement as applicable, e.g., hold, no response, refuse altogether, and approximately six attrition slots each month.

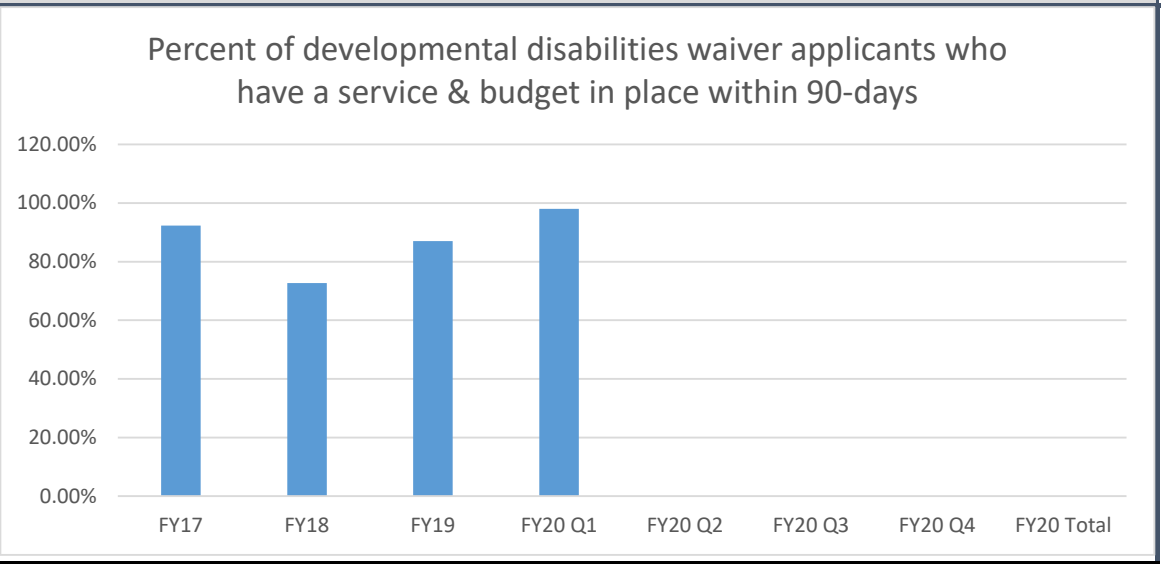
Improvement Action Plan

Monitor allocation process to ensure people receive timely DD Waiver services as allocation slots become available.

Program Objective 1: Redesign waivers to eliminate the DDW waitlist

Measure 1.3

Percent of developmental disabilities waiver applicants who have a service and budget in place within 90 days of income and clinical eligibility (FY20 KEY MEASURE)



FY17	FY18	FY19	FY20 Q1	FY20 Q2	FY20 Q3	FY20 Q4	FY20 Total	FY20 Target
92.30%	72.70%	87.00%	98.00%					90.00%

Measure Description

This indicator measures the percentage of newly allocated indiviudals receiving initial services in a timely manner.

Data Source/Methodology

New Mexico Department of Health, Developmental Disabilities Supports Division, Central Registry

Story Behind The Data

This performance measure is in response to Lewis v. New Mexico Department of Health. It is important in ensuring allocated individuals have a service plan in place within 90-days of income and clinical eligibility. The Developmental Disabilities Supports Division (DDSD) Intake and Eligibility Bureau (IEB) works closely with internal and external partners to ensure that individuals with developmental disabilities receive waiver services in a timely manner by completing the necessary application requirements.

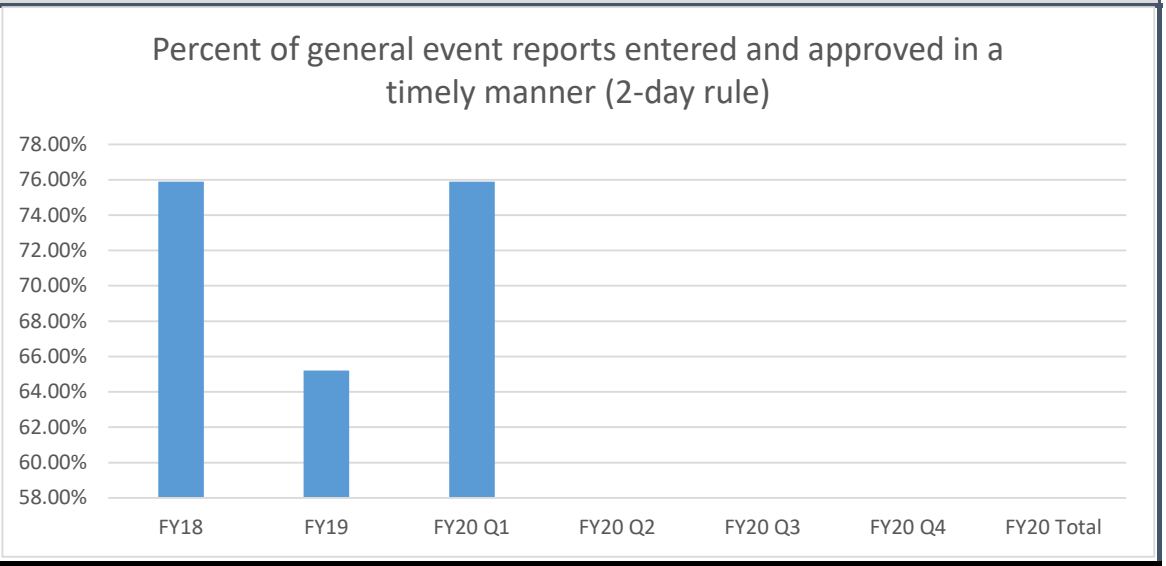
Improvement Action Plan

- Review, continuously, the Central Registry status reports to determine if systemic or case-specific problems exist during the eligibility determination process.
- Communicate with registrants/applicants to ensure contact information is current and accurate.
- Increase applicant awareness of Medicaid, State General Fund, and community-based service options.

Program Objective 2: Become a data driven decision-making organization

Measure 2.1

Percent of DD Waiver providers in compliance with General Events timely reporting requirements (2-day rule) (FY20 KEY MEASURE)



FY17	FY18	FY19	FY20 Q1	FY20 Q2	FY20 Q3	FY20 Q4	FY20 Total	FY20 Target
not available	75.90%	65.20%	75.90%					86%

Measure Description

This measure indicates the degree to which General Events Reports are addressed in a timely manner.

Data Source/Methodology

New Mexico Department of Health, DDSD, Therapy Database, October 2019.

Story Behind The Data

The timely submission and approval of General Events Reports is critical to DDSD's mission of ensuring the safety and wellbeing of the individuals on the traditional Developmental Disabilities Waiver (DDW). The purpose of General Events Reporting (GER) is to report, track and analyze events, which a pose a risk to adults in the DDW program, but do not meet criteria for ANE or other reportable incidents as defined by the Incident Management Bureau. According to DDSD requirements providers must enter and approve GERs within two (2) business days, with the exception of medication errors, of the event date.

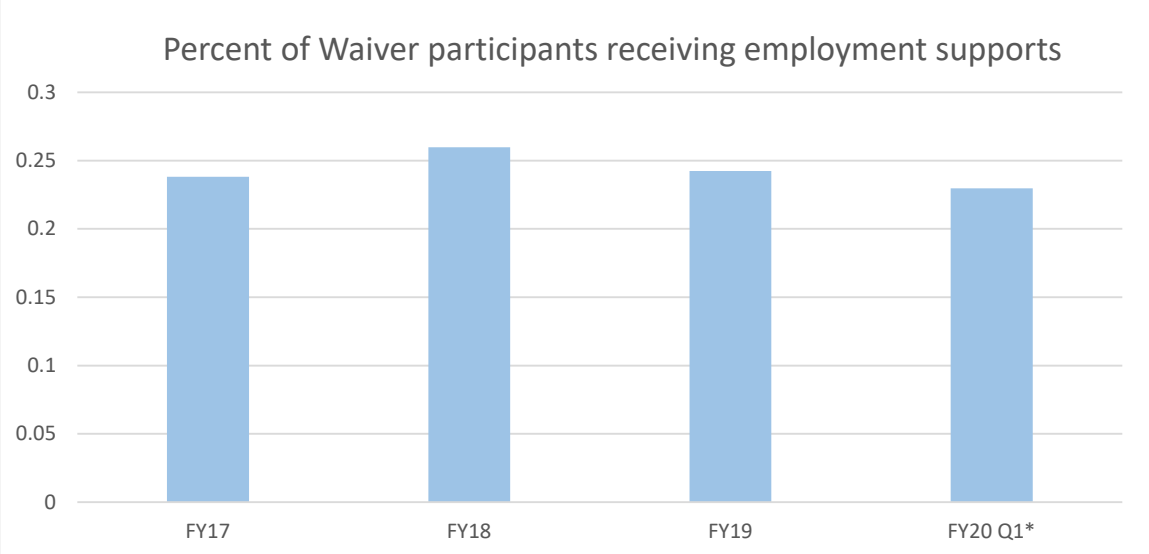
Improvement Action Plan

A review is conducted of cases and providers who are not adhering to General Events Reporting Requirements. Provider agencies not adhering to requirements are subject to a variety of interventions intiated by regional offices.

Program Objective 2: Become a data driven decision-making organization

Measure 2.2

Percent of adults on the DD Waiver who receive employment supports (FY20 KEY MEASURE)



FY17	FY18	FY19	FY20 Q1	FY20 Q2	FY20 Q3	FY20 Q4	FY20 Total	FY20 Target
23.8%	26.0%	24.2%	23.0%					34%

Measure Description

This indicator measures the percentage of waiver participants who receive employment-related services.

Data Source/Methodology

New Mexico Department of Health, Omnicaid Database. *All figures are derived from claims paid during the period 10.1.2018 through 9.30.2019. The one-year time period (ending with FY20 Q1) is utilized to provide both recent and reliable data. This one-year time period aligns with the performance measure target (34%), which is

Story Behind The Data

Nationally, individuals with intellectual/developmental disabilities ⟨I/DD⟩ experience greater levels of unemployment, underemployment, low wages, and poverty compared to those without disabilities. New Mexico has made steady progress toward increasing community-integrated outcomes and performs above the national average of 18.6%. Community Integrated Employment ⟨CIE⟩ includes job development, so individuals with developmental disabilities may participate as active community members and realize the benefits of employment. In FY20-Q1, 20.7% of eligible adults received employment services. Throughout FY17, FY18 and continuing in FY19, the Developmental Disabilities Supports Division ⟨DDSD⟩ conducted presentations for Employment First ⟨E1st⟩, which was incorporated into the DD Waiver Standards in March, 2018. E1st sets the expectation that individuals with I/DD, who are of working age, should be given the opportunity to work in the community. Paid staff are responsible to help remove barriers to work. To date, DDSD has conducted over 100 presentations, including two train-the-trainer sessions to approximately 1438 people.

Improvement Action Plan

Partners for Employment (PFE), a collaborative effort between DDSD, NM Division of Vocational Rehabilitation (DVR) and the University of New Mexico/Center for Development and Disability (UNM/CDD) continues to host College of Employment Services Training statewide with 3 new cohorts that began in September in Albuquerque, Las Cruces and Santa Fe/Las Vegas. PFE has hosted 11 CES cohorts throughout the state of New Mexico since its inception in July, 2018. CES is a nationally recognized Association for Rehabilitation Educators (ACRE) certified training that teaches best practice in supported employment and follows a 13-week curriculum that includes both web based and face to face sessions.

measured over a period of one year. All figures provided are subject to revision as additional claims, are processed and adjusted. Individuals of working age include all waiver participants (both Traditional and Mi Via) between the age of 22 to 64 years inclusive.	

New Mexico Department of Health

Health Certification Licensing and Oversight

P008

Program Description and Purpose

The Division of Health Improvement (DHI) ensures that healthcare facilities, community-based Medicaid waiver providers and community support services deliver safe and effective healthcare and community services in accordance with laws, regulations, and standards of practice. DHI works closely with key stakeholders to promote and protect the health, safety, and quality of life of New Mexicans. Key DHI enforcement activities include:

- Conducting various health and safety surveys for both facilities and community-based programs;
- Conducting investigations of alleged abuse, neglect, exploitation, death or environmental hazards; and
- Processing over 44,000 caregiver criminal history screenings annually.

Program Budget (in thousands):

FY19	General Fund	Other State Funds	Federal Funds	Other Transfers	TOTAL	FTE
200	4,461.30	1,514.60	1,821.70	3,621.00	11,418.60	173
300	85	330.4	82.7	311.2	809.3	
400	463.7	116.7	518.4	471.8	1,570.60	
TOTAL	5,010.00	1,961.70	2,422.80	4,404.00	13,798.50	

FY20	General Fund	Other State Funds	Federal Funds	Other Transfers	TOTAL	FTE
200	4,271.60	1,699.60	2,076.40	4,350.60	12,398.20	183
300	609.5	139.1	96	170.5	1,015.10	
400	510.2	208	584.2	452	1,754.40	
TOTAL	5,391.30	2,046.70	2,756.60	4,973.10	15,167.70	

Program Objective 1: Ensure safe healthcare services

Measure	Description
1.1	Percent of Caregiver Criminal History Screening (CCHS) Appeal Clearance recidivism/re-offense (conviction) after a successful appeal
1.2	Percent of improved accuracy in nursing home Incident Reports (IRs) submitted following participation in a DHI quality training on reporting requirements
1.3	Percent of Assisted Living Facilities (ALF's) compliance with background checks
1.4	Rate of abuse for developmental disability waiver and mi via waiver clients
1.5	Rate of re-abuse for developmental disability waiver and mi via waiver clients

Program Objective 2: Provide timely completion of oversight activities

Measure	Description
2.1	Percent of health facility survey statement of deficiencies (CMS form 2567/state form) distributed to the facility within 10 days of survey exit (DOB-LTC)
2.2	Percent of health facility survey statement of deficiencies (CMS form 2567/state form) distributed to the facility within 10 days of survey exit (POB-NLTC)
2.3	Percent of abuse, neglect and exploitation investigations completed within required timeframes (**FY20 KEY MEASURE**)

2.4	Percent of Quality Management Bureau (QMB) 1915c Home and Community-Based Service Waiver (HCBS - DDW, Mi Via, and Med Frag.) report of findings distributed within 21 working days from end of survey

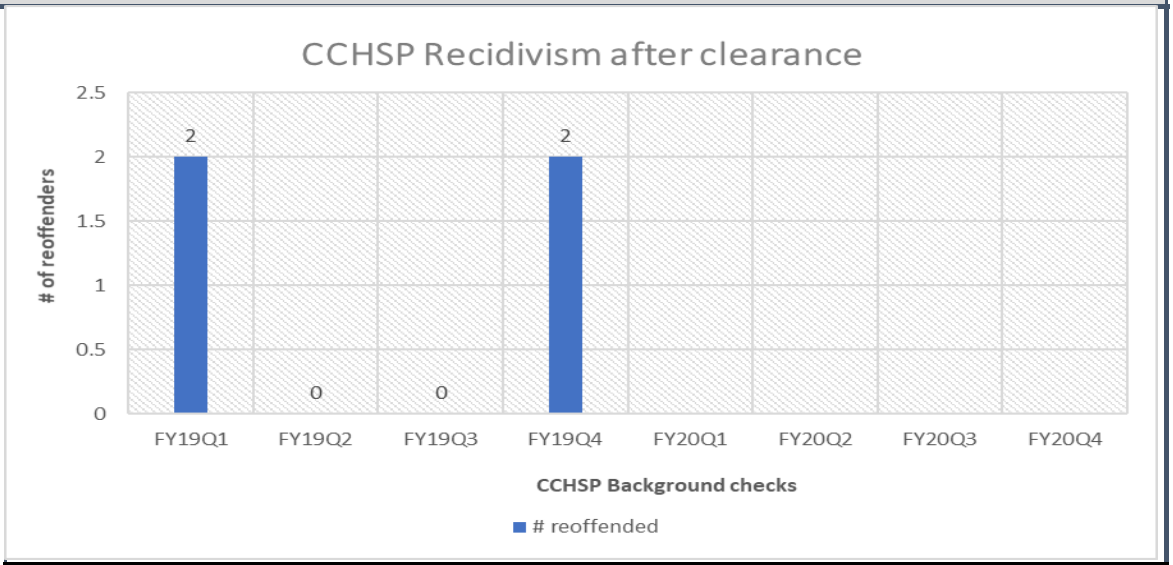
Program Objective 3: Provide timely initiation of oversight activities	
Measure	Description
3.1	Percent of (IMB) assigned investigations initiated within required timelines
3.2	Percent of Assisted Living Facilities (ALF) complaint surveys initiated within timeframes

Program Objective 4: Pursue organization excellence	
Measure	Description
4.1	Percent of Nursing Home (NH) survey citation(s) upheld as valid when reviewed by the Centers of Medicare and Medicaid Services (CMS) and through Informal Dispute Resolution (IDR)

Program Objective 1: Ensure safe healthcare services

Measure 1.1

Percent of Caregiver Criminal History Screening (CCHS) Appeal Clearance recidivism/re-offense (conviction) after a successful appeal



FY17	FY18	FY19	FY20 Q1	FY20 Q2	FY20 Q3	FY20 Q4	FY20 Total	FY20 Target
		4						<12 annually

Measure Description

This measure applies to "Employee Caregivers" as defined by NMAC 7.1.9. The CCHS database collects and records the date a background check is received (start date) and the date the background check is completed and closed (completion date).

Data Source/Methodology

This data is collected and tracked using the CCHSP database which is linked to various state and federal public safety data bases, (i.e. FBI, HLS, Sex offenders, etc.) at:

Story Behind The Data

When a caregiver is disqualified at screening they can appeal for reconsideration, this performance measure looks at those individuals who reoffend after being cleared following an appeal. This measure counts the individuals who are currently employed and offend or reoffend resulting in a disqualification event, regardless of the date of their original clearance.

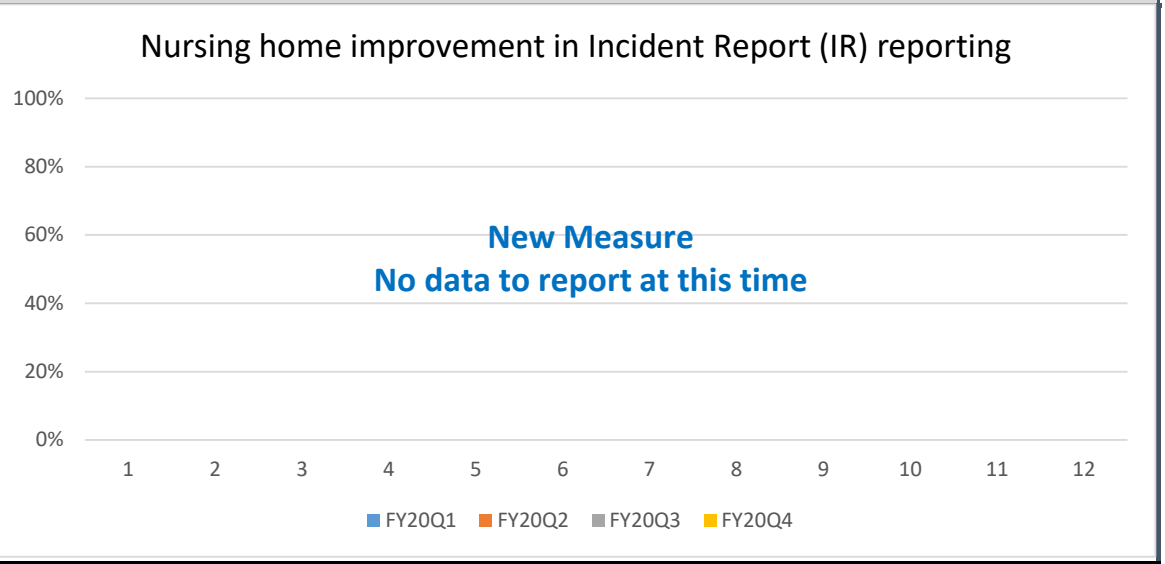
Improvement Action Plan

Continue monitoring, no actions required.

Program Objective 1: Ensure safe healthcare services

Measure 1.2

Percent of improved accuracy in nursing home Incident Reports (IRs) submitted following participation in a DHI quality training on reporting requirements



FY17	FY18	FY19	FY20 Q1	FY20 Q2	FY20 Q3	FY20 Q4	FY20 Total	FY20 Target
			n/a					85%

Measure Description

Numerator: Total number of IR components that meet criteria per incident.
Denominator: Total number of IR components per incident.

Data Source/Methodology

This data is collected and tracked by the complaints unit on an excel spreadsheet. **Part 1**: Baseline prior to training. **Part 2**: Change post training. **Part 3**: Percent of change (improvement) in IR accuracy and quality.
Percent of accurate IR components post DHI training Minus (-) Percent of accurate IR components prior to DHI training Equals (=) percent of change (improvement) in IR accuracy and quality.

Story Behind The Data

Receiving an accurate and complete incident report (IR) and 5-day (calendar days) follow-up investigation summary from a licensed nursing home health facility is a state and federal requirement. This information is an important first step in triaging an incident to determine potential assignment for onsite survey. When incomplete IRs are submitted it can delay the triage process while additional information is requested and collected. This adds additional staff time to process each IR received. This performance measure looks at the impact (outcome) of quality training that DHI provides to nursing homes to improve the accuracy and quality of their IRs and follow-up investigations. The data compares the quality and accuracy of a nursing home against itself over time, following participation in a DHI training on improving IR reporting, as well as their follow-up investigations and summary of corrective and preventive actions taken. There are 25 components to a complete IR and each IR is scored for completeness.

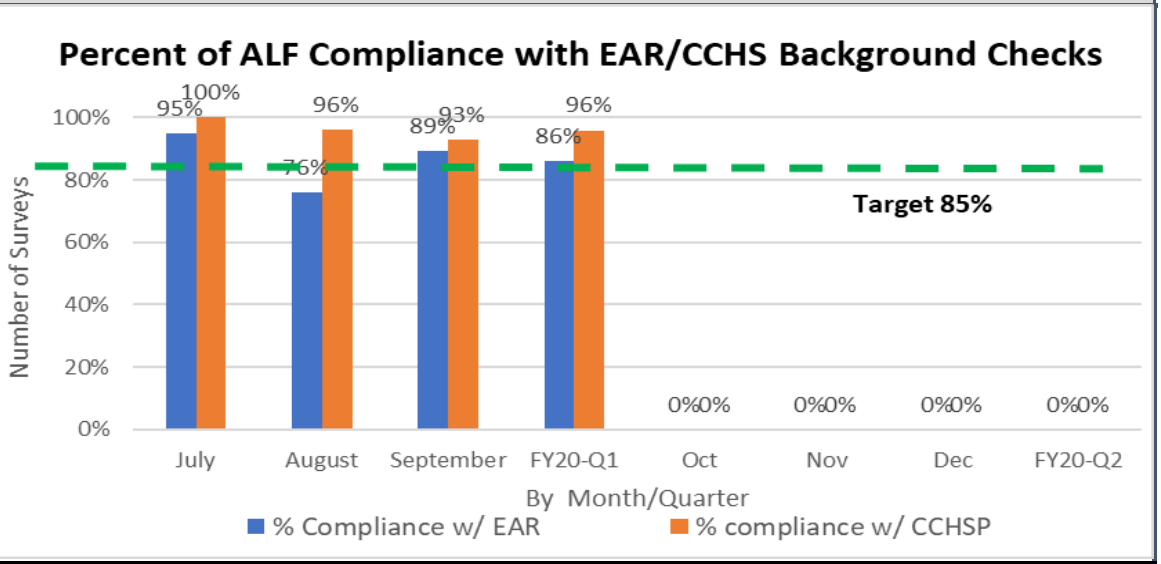
Improvement Action Plan

To date four trainings have been completed, DHI will monitor future IRs for improvement.

Program Objective 1: Ensure safe healthcare services

Measure 1.3

Percent of Assisted Living Facilities (ALF's) compliance with background checks



FY17	FY18	FY19	FY20 Q1	FY20 Q2	FY20 Q3	FY20 Q4	FY20 Total	FY20 Target
			86.2% EAR 96% CCHS					85%

Measure Description

This measure monitors the compliance of Assisted Living Facilities (ALF's) with completing background checks for all caregivers with the Employee Abuse Registry (EAR) and Caregiver Criminal History Screening Program (CCHSP).
Numerator: Number of ALFs cited for CCHS in a survey.
Denominator: Number of ALFs surveyed.

Data Source/Methodology

Data is collected from survey findings and is tracked on a spreadsheet at: HTTPS://HFLCShared (\\dhirndcolm002)H:\Review Office\Reviewer\LTC TRACKING LOG\Licensed Only

Story Behind The Data

This performance measure reports on the compliance of assisted living facilities with caregiver criminal history screening requirements. Historical compliance has been poor due to limited oversight by DHI. Improved compliance is expected with increased oversight from new DHI survey teams.

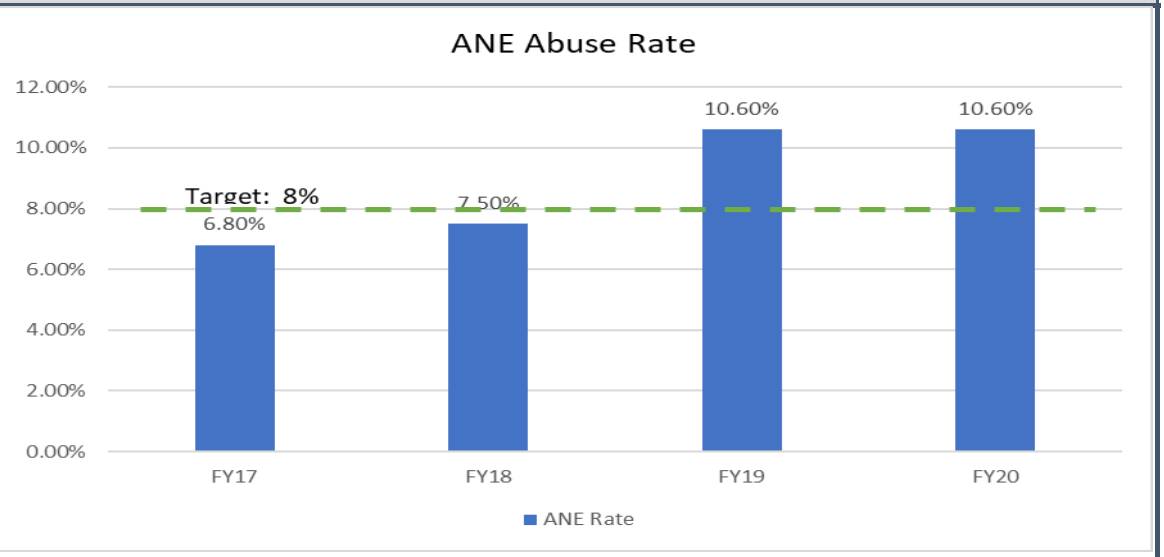
Improvement Action Plan

- Hire and train additional ALF surveyors.
- Complete all ALF complaint surveys within timeframes.
- Complete all ALF annual survey.

Program Objective 1: Ensure safe healthcare services

Measure 1.4

Rate of abuse for developmental disability waiver and mi via waiver clients



FY17	FY18	FY19	FY20 Q1	FY20 Q2	FY20 Q3	FY20 Q4	FY20 Total	FY20 Target
6.80%	7.50%	10.60%	10.60%					≤ 7%

Measure Description

Numerator: Number of persons who have had one or more substantiated allegations of abuse, neglect or exploitation (ANE) within a twelve-month (calendar year) period as tracked by the IMB database.
Denominator: Total individuals served by the New Mexico traditional Developmentally Disabled Waiver (DDW), Medically Fragile Waiver (MFW) (adults only) and Mi Via waiver.

Data Source/Methodology

This data comes from the IMB computer database. The four quarterly reports are summed and divided by 4 to reach an average population for the 12-month period.
Eligibility: Individuals eligible for the DDW, MFW (adult only) and Mi Via waivers, calculated from quarterly reports of populations from

Story Behind The Data

Abuse, neglect, and exploitation (ANE) of individuals with intellectual/developmental disabilities (I/DD) has a direct impact on their quality of life and results in increased emergency room visits, additional medications, and related medical treatment. Neglect is the most common allegation. Lack of adequate supervision, failure to follow health care plans, and insufficient staff training are the most common reasons for substantiated neglect.
Many adults with I/DD are unable to recognize danger, understand their rights, and protect themselves, and neglect is the leading cause of premature death for this population. The current increase in the abuse rate to 10.6% is a direct reflection of the increase and completion of backlogged cases. **As of September 30, 2019, all backlog cases were completed and closed.**

Improvement Action Plan

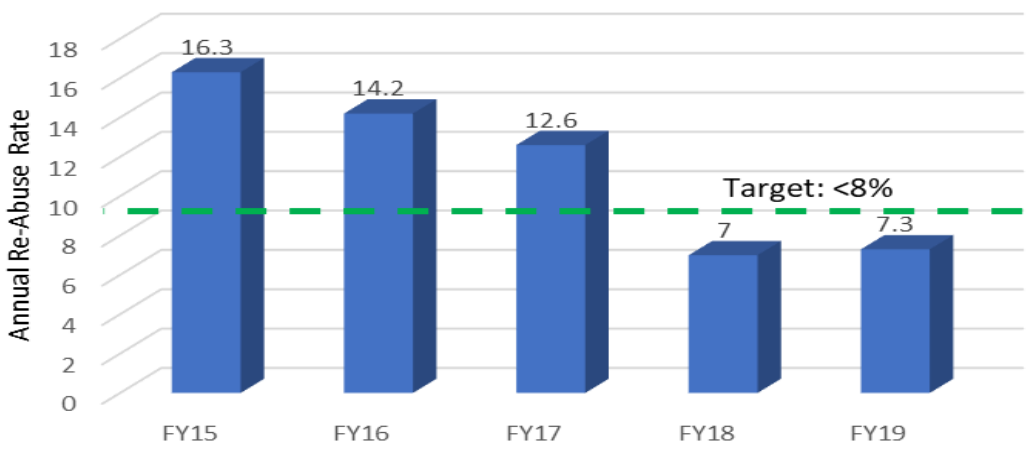
As of September 30th, 2019, the backlog of cases no longer exists.

DDSD at the end of each quarter, as tracked by the UNM Continuum of Care database. The four quarterly reports are summed and divided by 4 to reach an average population for the 12-month period. Time Period: Due to the length of investigations, the quarterly data will always be presented from the previous quarter.	

Program Objective 1: Ensure safe healthcare services

Measure 1.5

Rate of re-abuse for developmental disability waiver and mi via waiver clients



FY17	FY18	FY19	FY20 Q1	FY20 Q2	FY20 Q3	FY20 Q4	FY20 Total	FY20 Target
	7.00%	7.30%	7.30%					≤ 6%

Measure Description

Numerator: Number of repeat substantiated cases involving the same consumer over a 12-month period.
Denominator: Total number of substantiated cases.

Data Source/Methodology

The data comes from the IMB Database. This data measures the number of repeat substantiated cases involving the same consumer over a 12-month period.

Story Behind The Data

It is important to measure repeat abuse, neglect, and exploitation (ANE) because many individuals are unable to recognize danger, understand their rights, and protect themselves.
Repeat ANE of individuals with Intellectual/Developmental Disabilities I/DD has a direct impact on their quality of life resulting in increased emergency room visits, additional medications, and related medical treatment. Neglect is the most common allegation. Lack of adequate supervision, failure to follow health care plans, and staff training are the most common reasons for substantiated neglect. Incidents are tracked through the Incident Management Bureau (IMB) incident management data system. By tracking the Re-Abuse rate, (which includes ANE), IMB can determine the effectiveness of Corrective and Preventive Action Plans and strategies intended to reduce the rate of abuse. IMB continues to make improvements to its database functionality to improve the quality of the data. Data prior to 2016 has limitations and does not represent the current level of detail for comparison.

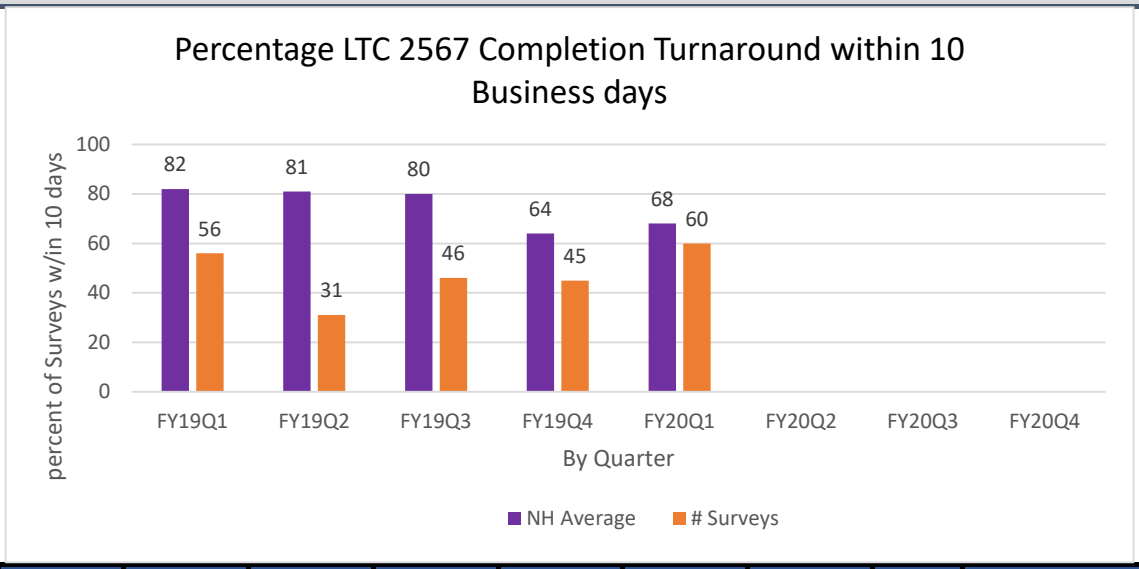
Improvement Action Plan

Ongoing monitoring.

Program Objective 2: Provide timely completion of oversight activities

Measure 2.1

Percent of health facility survey statement of deficiencies (CMS form 2567/state form) distributed to the facility within 10 days of survey exit (DOB-LTC)



FY17	FY18	FY19	FY20 Q1	FY20 Q2	FY20 Q3	FY20 Q4	FY20 Total	FY20 Target
89%	89%							85%

Measure Description

Numerator: Number of health facilities receiving a CMS form 2567 and/or state form (statement of deficiencies), within 10 business days of survey exit.
Denominator: Number of long-term care, non-long-term care, and licensed only health facilities receiving a CMS form 2567 and/or state form (statement of deficiencies).

Data Source/Methodology

DHI management manually tracks this data using three spreadsheets: "The Long Term Care Tracking log", "The Non-Long Term Care Tracking Log" and "The Licensed Only Tracking Log"

Story Behind The Data

Providing regulatory oversight to health facilities is key to the mission of DHI to ensure that safe healthcare services are being provided to all New Mexican's. Timely feedback following a survey is critical to ensure health facilities make necessary corrections and improvements to ensure safe healthcare services are being provided. DHI has a federal requirement to issue 2567s within 10-days. A high vacancy rate has impacted DHI's timeliness of reports and DHI has experienced a significant increase in survey workload and complaint surveys. During FY19 Q4, there was a delay in sending compliance letters for deficiency free surveys.

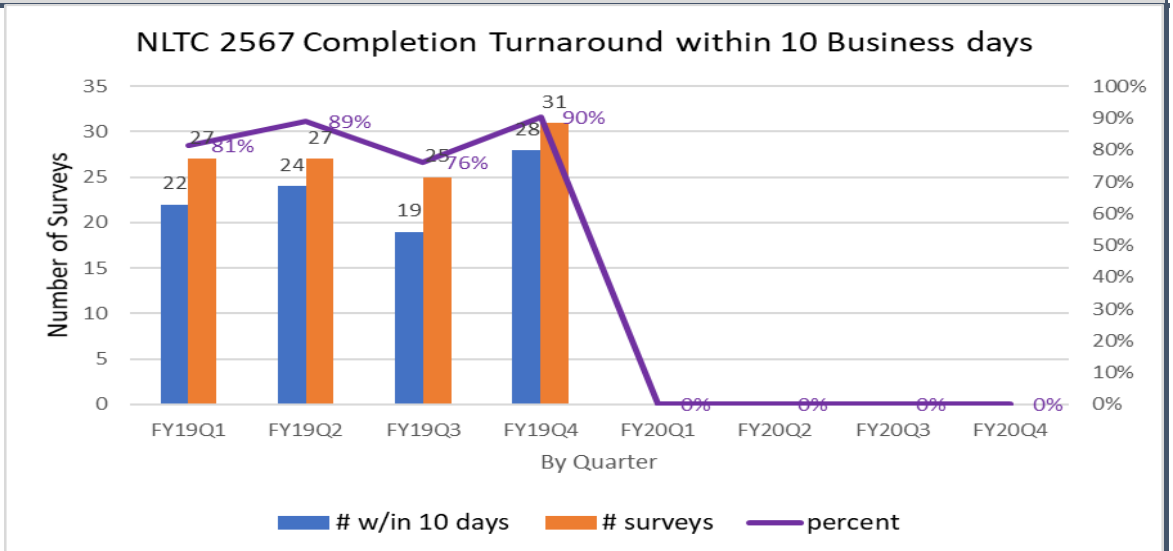
Improvement Action Plan

- Recruit and train vacant surveyor positions.
- Implement workflow management improvements.

Program Objective 2: Provide timely completion of oversight activities

Measure 2.2

Percent of health facility survey statement of deficiencies (CMS form 2567/state form) distributed to the facility within 10 days of survey exit (POB-NLTC)



FY17	FY18	FY19	FY20 Q1	FY20 Q2	FY20 Q3	FY20 Q4	FY20 Total	FY20 Target
		84.50%						90%

Measure Description

Numerator: Number of health facilities receiving a CMS form 2567 and/or state form (statement of deficiencies) within 10 days.
Denominator: Total number of surveys.

Data Source/Methodology

Data Source: HTTPS://HFLCShared (\\dhirndcolm002)(H:)\Review Office\Reviewer\NLTC TRACKING LOGH:\Review Office\Reviewer\NLTC TRACKING LOG

Story Behind The Data

Providing regulatory oversight to health facilities is key to mission of DHI to ensure that safe healthcare services are provided to all New Mexican's. Timely feedback following a survey is critical to ensure health facilities make necessary corrections and improves to ensure safe healthcare services are being provided. DHI has a federal requirement to issue 2567s within 10-days. A high vacancy rate has impacted DHI's timeliness of reports and DHI has experienced a significant increase in survey workload and complaint surveys. During FY19 Q4, there was a delay in sending compliance letters for deficiency free surveys. The change in the complaint process has created an influx of assigned surveys.

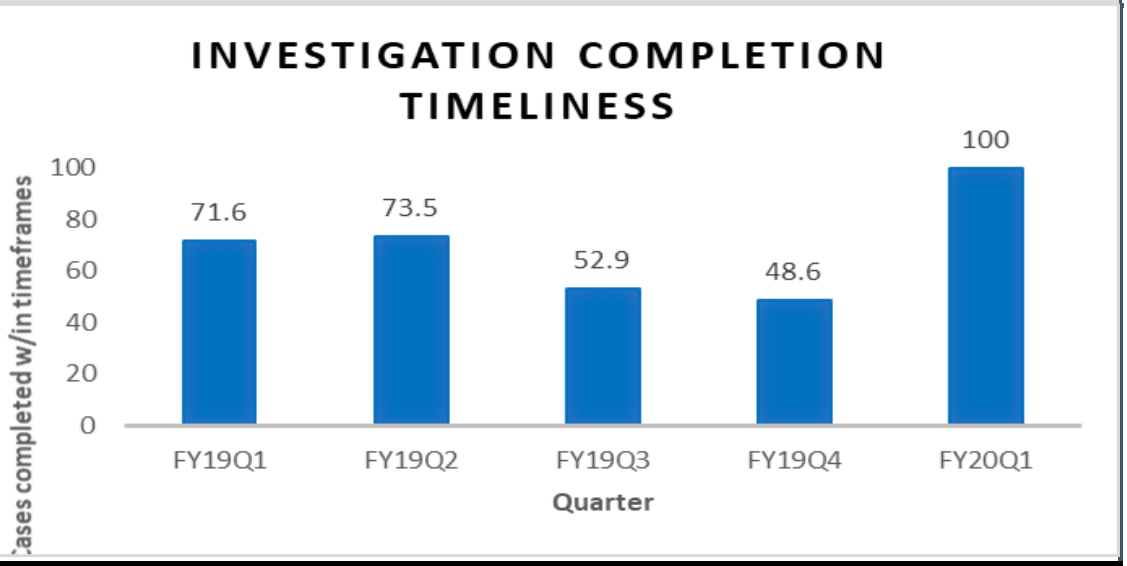
Improvement Action Plan

- Recruit and train vacant surveyor positions.
- Implement workflow management improvements.
- Meet with CMS consultants to review and improve the complaint triage process.

Program Objective 2: Provide timely completion of oversight activities

Measure 2.3

Percent of abuse, neglect and exploitation investigations completed within required timeframes (FY20 KEY MEASURE)



FY17	FY18	FY19	FY20 Q1	FY20 Q2	FY20 Q3	FY20 Q4	FY20 Total	FY20 Target
		48.60%	100%					90%

Measure Description

Completing investigations within the prescribed 45-day timeline is important to ensure the health and safety of the consumer we serve. Therefore, this is a high priority.
Numerator: Number of IMB investigations completed within 45-days or less, or with an approved extension.
Denominator: Total number of investigations completed in the Quarter.

Data Source/Methodology

Data Source: This data comes from the IMB database.

Story Behind The Data

Abuse, neglect, and exploitation (ANE) of individuals with intellectual/developmental disabilities (I/DD) has a direct impact on their quality of life and results in increased emergency room visits, additional medications, and related medical treatment. Neglect is the most common allegation. Lack of adequate supervision, failure to follow health care plans, and insufficient staff training are the most common reasons for substantiated neglect. Completing investigations within the prescribed 45-day timeline is important to ensure the health and safety of the consumer we serve. The decrease at the end of FY19 was a result of completing and closing the backlog of old cases.

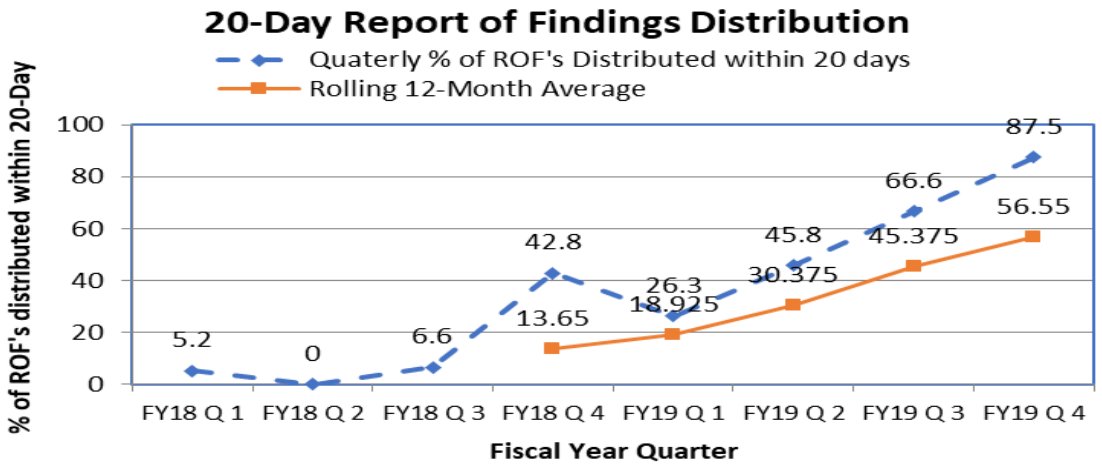
Improvement Action Plan

DHI's Investigation Management Bureau will be reviewing employee productivity and retention, as well as evaluating the need for additional resources, 5 additional investigator positions have been added.

Program Objective 2: Provide timely completion of oversight activities

Measure 2.4

Percent of Quality Management Bureau (QMB) 1915c Home and Community-Based Service Waiver (HCBS - DDW, Mi Via, and Med Frag.) report of findings distributed within 21 working days from end of survey



FY17	FY18	FY19	FY20 Q1	FY20 Q2	FY20 Q3	FY20 Q4	FY20 Total	FY20 Target
54.90%	12.50%	49.20%	87.50%					86%

Measure Description

This measure assesses the 20-day distribution time, which begins one-working day following the HCBS waiver survey exit. This PM measures how quickly the surveyed provider receives formal notice of a deficiency.
Numerator: Total number of survey reports completed and distributed within 20-day working days.
Denominator: Total number of surveys reports completed and distributed in a quarter.

Data Source/Methodology

Data Source: QMB Output Indicator Report. QMB manually collects data from each completed survey using an excel spreadsheet. This data source is then used to create the monthly "Output Indicator Report." Data is compiled and reported quarterly. QMB will measure

Story Behind The Data

A high vacancy rate has impacted DHI's timeliness of reports and the Quality Management Bureau (QMB) has experienced a 100% turnover in surveyor staff during the past 24 months. The resulting vacancies required survey teams to schedule back to back provider surveys, which was further complicated by a prohibition to use overtime for report writing, causing a significant backlog of survey reports pending completion. Turnover in 2 program manager positions who are responsible for editing reports was an additional factor as well, delaying the completion of reports.
An additional factor impacting report writing has been ongoing technical issues with the development of the QMB database and e-survey tools. This project has now been transitioned into the MMISR project.
At this time, QMB has an 11% vacancy rate and is working to get new surveyors and managers fully trained.

Improvement Action Plan

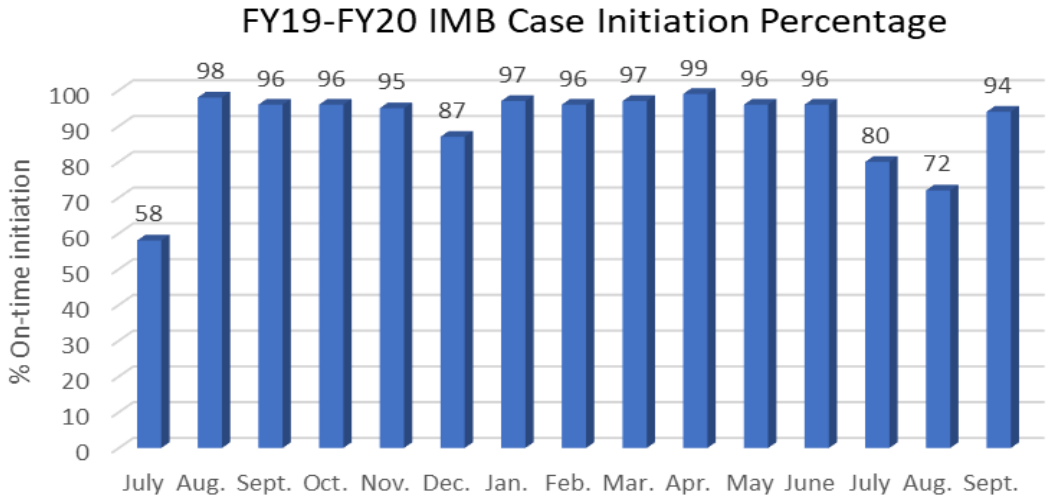
Recruit and train vacant surveyor positions.

the percentage of compliance with this internal requirement	

Program Objective 3: Provide timely initiation of oversight activities

Measure 3.1

Percent of (IMB) assigned investigations initiated within required timelines



FY17	FY18	FY19	FY20 Q1	FY20 Q2	FY20 Q3	FY20 Q4	FY20 Total	FY20 Target
								86%

Measure Description

The number of investigations that were initiated on time, consistent with the identified priority level.
Numerator: Number of investigations that were initiated on time, consistent with the identified priority level.
Denominator: Total number of investigations initiated.

Data Source/Methodology

Data Source: This data comes from the IMB Database.

Story Behind The Data

A critical component of keeping individuals safe is the timely initiation of investigations of ANE. Case initiation is defined as the Investigator making direct contact with someone identified in the case (i.e, Reporter, Alleged Victim, Case Manager, Incident Coordinator, etc.). IMB uses the same case initiation priority levels as Adult Protective Service and the Children, Youth and Families Department An Emergency Priority requires initiation within three hours, a Priority One requires initiation within 24-hours and a Priority Two requires initiation within five-days.

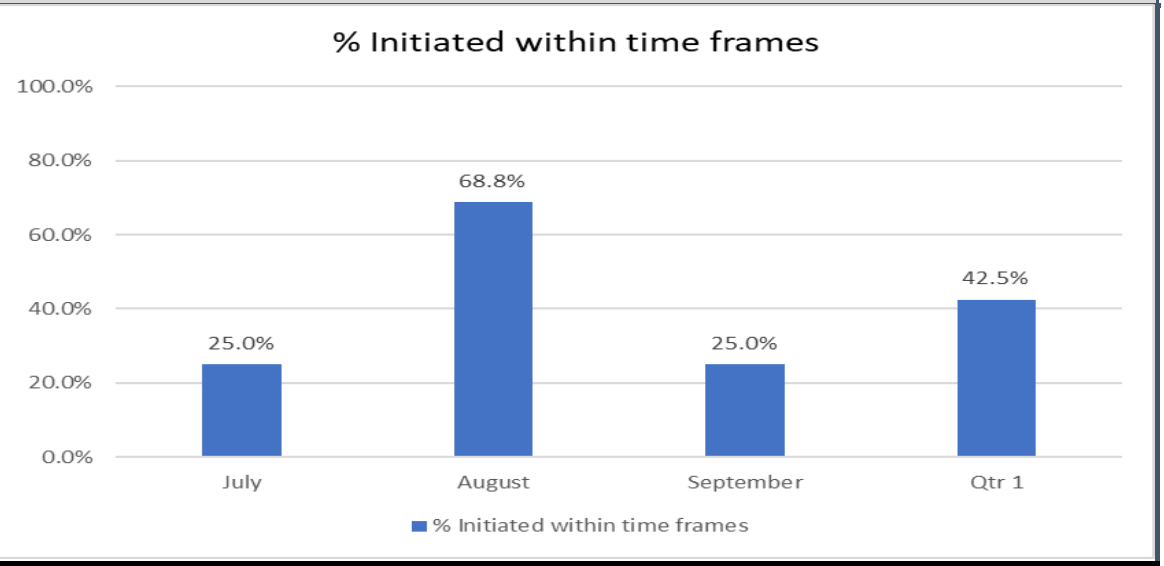
Improvement Action Plan

Additional staffing will allow Investigators more time to spend on individual cases.

Program Objective 3: Provide timely initiation of oversight activities

Measure 3.2

Percent of Assisted Living Facilities (ALF) complaint surveys initiated within timeframes



FY17	FY18	FY19	FY20 Q1	FY20 Q2	FY20 Q3	FY20 Q4	FY20 Total	FY20 Target
			42.50%					85%

Measure Description

This performance measure reports on the percent of asisted living facilities complaints initiated within timeframes.

Data Source/Methodology

This ALF survey data is collected and tracked by the ALF program manager using a spreadsheet at: HTTPS://HFLCShared (\\dhirndcolm002)H:\Review Office\Reviewer\LTC TRACKING LOG\Licensed Only

Story Behind The Data

This performance measure reports on the percent of Assisted Living Facilities (ALF) complaints initiated within timeframes. Improved compliance is expected with increased new DHI ALF survey teams. There has been a historical backlog of complaints pending a survey review, with the addition of new surveyor staff, old complaints have been completed and the teams are now current with workload.

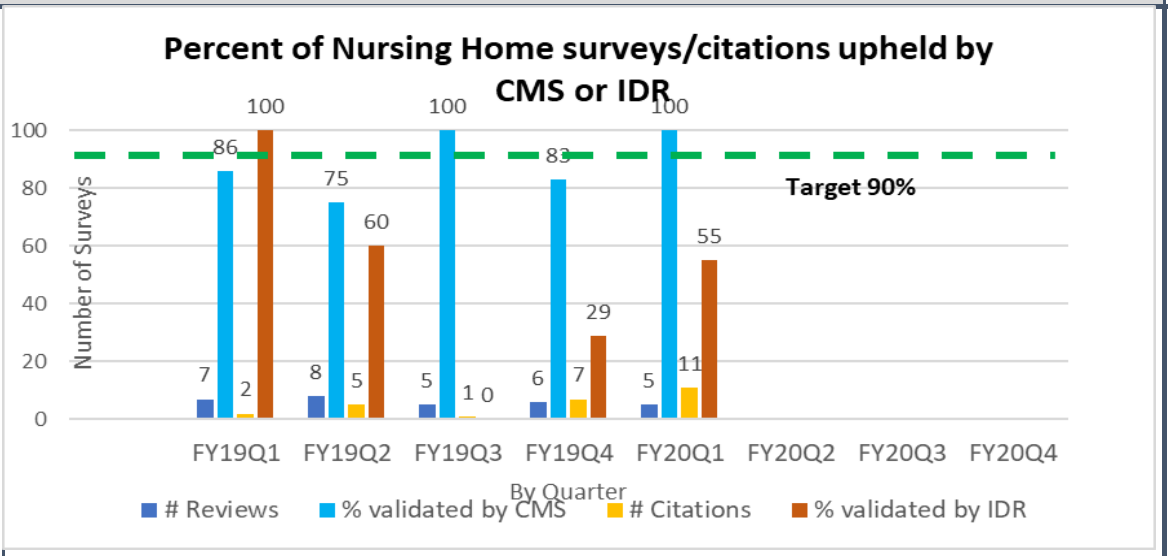
Improvement Action Plan

Ongoing monitoring.

Program Objective 4: Pursue organization excellence

Measure 4.1

Percent of Nursing Home (NH) survey citation(s) upheld as valid when reviewed by the Centers of Medicare and Medicaid Services (CMS) and through Informal Dispute Resolution (IDR)



FY17	FY18	FY19	FY20 Q1	FY20 Q2	FY20 Q3	FY20 Q4	FY20 Total	FY20 Target
		85% CMS 47% IDR						90%

Measure Description

This performance measure reports on the validity and defensibility of the evidence to support non-compliance with federal regulations when DHI has recommended a remedy or sanction which triggers a review of the citation by CMS or when a nursing home requests an Informal Dispute Resolution (IDR) of deficiencies cited. IDRs can be requested when no remedy/sanction has been imposed.
Numerator: Number of Citations validated
Denominator: Number of citations under review (date of CMS review/IDR).

Data Source/Methodology

This data is collected and tracked by the bureau chief using a spreadsheet at: HTTPS://HFLCShared (\\dhirndcolm002)(H:)\NHquality (Quality Indicator)

Story Behind The Data

Writing valid and defensible citations is critical to the survey process. This includes the evidence to support non-compliance with federal regulations when DHI has recommended a remedy or sanction which triggers a review of the citation by CMS or when a nursing home requests an Informal Dispute Resolution (IDR) of deficiencies cited. IDRs can be requested when no remedy/sanction has been imposed. The measure is a useful quality improvement tool to improve the writing of citations that are supportable when challenged.

Improvement Action Plan

New measure - ongoing monitoring.

New Mexico Department of Health

Medical Cannabis Program

P787

Program Description and Purpose

The Medical Cannabis Program (MCP) was created in 2007 under the Lynn and Erin Compassionate Use Act (the Act). The purpose of this Act is to allow the beneficial use of medical cannabis in a regulated system for alleviating symptoms caused by debilitating medical conditions. The Program enables the provision of compassionate care for people that have certain illnesses who prefer to use cannabis to alleviate symptoms related to their diagnosis. The Program serves New Mexicans with qualifying medical conditions diagnosed by a health care provider. There are currently 28 qualifying medical conditions.

Program Budget (in thousands):

FY19	General Fund	Other State Funds	Federal Funds	Other Transfers	TOTAL	FTE
200				$1,949,700.00	$1,949,700.00	28
300				$793,500.00	$793,500.00	
400				$586,800.00	$586,800.00	
TOTAL				$3,330,000.00	$3,330,000.00	

FY20	General Fund	Other State Funds	Federal Funds	Other Transfers	TOTAL	FTE
200				$1,747,200.00	$1,747,200.00	28
300				$503,500.00	$503,500.00	
400				$973,200.00	$973,200.00	
TOTAL				$3,223,900.00	$3,223,900.00	

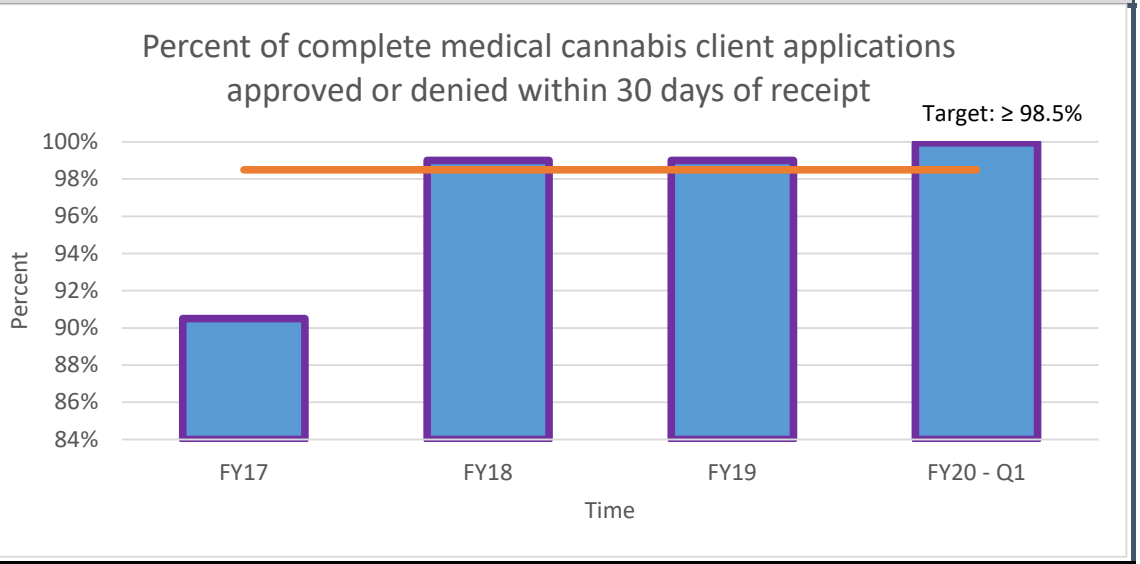
Program Objective 1: Allow the beneficial use of medical cannabis to New Mexicans

Measure	Description
1.1	Percent of complete medical cannabis client applications approved or denied within thirty calendar days of receipt
1.2	Percent of registry identification cards issues within 5 business days of application approval

Program Objective 1: Allow the beneficial use of medical cannabis to New Mexicans

Measure 1.1

Percent of complete medical cannabis client applications approved or denied within thirty calendar days of receipt



FY17	FY18	FY19	FY20 Q1	FY20 Q2	FY20 Q3	FY20 Q4	FY20 Total	FY20 Target
90.50%	99.00%	99.00%	99.96%					≥99%

Measure Description

Percent of complete Medical Cannabis client applications approved or denied within 30 calendar days of receipt.

Data Source/Methodology

The data is obtained through the electronic records system used by the Medical Cannabis Program - Bio-Track. This program allows the gathering of data based on date completed application is received by the program, entry date, approval date, and card print date.

Story Behind The Data

Proccessing applications in a timely manner helps ensure medical cannabis patients have safe access to safe medicine and protections offered under the Lynn and Erin Compassionate Use Act. In FY19-Q4, 99 percent of completed patient applications were processed in 30-days.

Improvement Action Plan

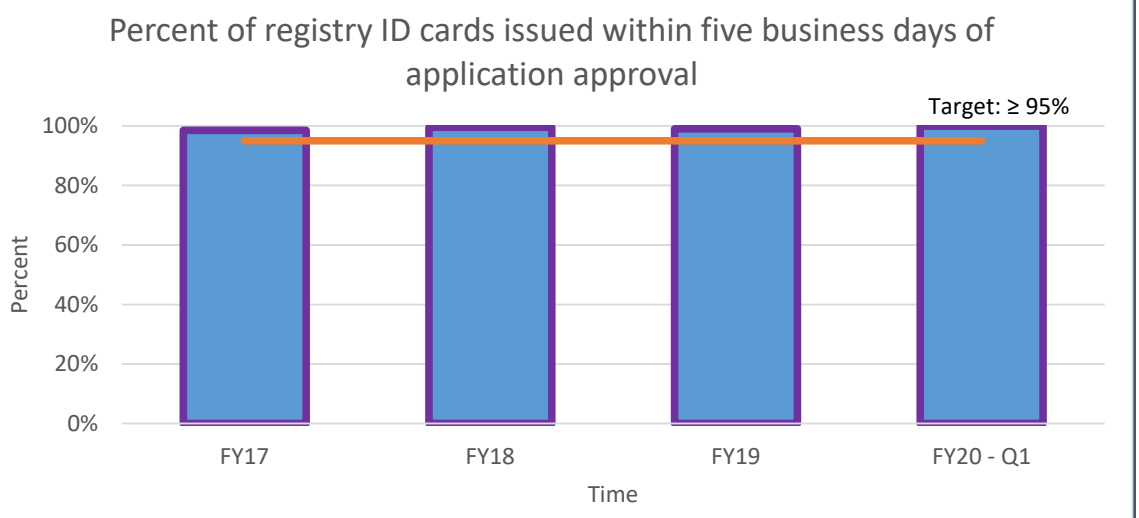
As enrollment in the Medical Cannabis Program accelerates, the Program has worked to streamline patient applications by making forms clearer and easier to read, implementing operational changes, and revising letters for deficient applications. The review process for applications has also been streamlined including changing the process for when community partner organizations bring large quantities of applications to the program so that the applications receive an initial review for missing items. This helps to reduce the wait time for patients in the event an application is not complete.

The Medical Cannabis Program is also in the process to either change or upgrade existing software systems to allow patients and licensed medical providers to submit applications electronically.

Program Objective 1: Allow the beneficial use of medical cannabis to New Mexicans

Measure 1.2

Percent of registry identification cards issues within 5 business days of application approval



FY17	FY18	FY19	FY20 Q1	FY20 Q2	FY20 Q3	FY20 Q4	FY20 Total	FY20 Target
98.50%	99.50%	99%	99.98					≥95%

Measure Description

This measure provides the percentage of Medical Cannabis Program Patient Registry Identification cards, which have been issued within five business days of the approval of a completed application to the program.

Data Source/Methodology

The data is obtained through the electronic records system used by the Medical Cannabis Program - Bio-Track. This program allows the gathering of data based on date completed application is received by the program, entry date, approval date, and card print date.

Story Behind The Data

Mailing patient registry ID cards in a timely manner helps ensure medical cannabis patients have access to safe medicine and protections offered under the Lynn and Erin Compassionate Use Act. In FY19-Q4, the Medical Cannabis Program exceeded its target by printing and mailing 99 percent of patient registry ID cards within 5-days of application approval.

Improvement Action Plan

As enrollment in the Medical Cannabis Program accelerates, the Program has worked to streamline patient applications by making forms clearer and easier to read, implementing operational changes, and revising letters for deficient applications.

The Medical Cannabis Program is also in the process to either change or upgrade existing software systems to allow patients and licensed medical providers to submit applications electronically.