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FY21 QUARTER 4 PERFORMANCE REPORT

DEPARTMENT OF HEALTH

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DEPARTMENT OF HEALTH OVERVIEW

Agency Mission:

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

Agency Goals/Objectives:

- Expand access to services
- Improve health status for all New Mexicans
- Ensure safe healthcare environment statewide
- Pursue organizational excellence

Key Strategic Plan Initiatives:

Operationalize COVID-19 response

- Draft a plan for COVID-19 vaccine promotion and rollout.
- Assure optimal case investigation and contact tracing.
- Track COVID-19 throughout the state and in special populations.

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.

Decrease diseases of despair (suicide & drug and alcohol related deaths), decrease mortality rates and thereby reduce SHIP priorities by 5%

- Integrate behavioral health services in healthcare settings.
- Improve access to mental health in schools.
- Increase engagement treatment (AOD).
- Increase harm reduction activities and naloxone dispersion.

Improve NMDOH Facilities by implementing Economic Feasibility report suggestions

- Share tools and processes to improve efficiency and standardize practices (EHR, TJC reviews, P&Ps, training & education, billing, teleconferencing capabilities, etc.).
- Identify public and private partners with similar services and establish relationships with partners to form continuum of care models.
- Develop a unified vision & mission statement for the integrated NMDOH facilities system and create a unified operational strategic plan.

Maintain accreditation and health standards

- Conduct skills assessments for both licensed and certified staff to ensure quality of care for all residents/patients.
- Enhance infection control protocols in the era of COVID.
- Add internal tracer/audit/survey activities.
- Collect and coordinate data, narratives and documents necessary for public health reaccreditation.
- Seek public health reaccreditation.

AGENCY PROGRAMS

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FY21 COVID-19 Performance Measures

Beginning in early March 2020, managing COVID-19 became NMDOH's first priority, and remains so as of this report cycle. Currently, most agency resources are dedicated to the pandemic response. The Public Health Division (PHD) and the Department's Operations Center (DOC) both activated their incident command systems when the pandemic began and have been operating at level one (the highest level) for the majority of that time. Level one ensures that staff and resources are available to respond to health emergencies 24 hours per day, seven days per week.

NMDOH's regular programs and services continue to function with many employees teleworking to ensure COVID-safe workplace practices. Teleworking employees regularly take on COVID-19 response work, and they as well as all front-line response staff often work outside of usual business hours to manage the pandemic. Because of this, the department may not be able to achieve its performance measures in the ways it originally anticipated. Conversely, responding to the COVID-19 pandemic has significantly strengthened the department's community partnerships, intra-departmental and inter-divisional collaborations, and has provided an excellent opportunity to better understand the state's health and emergency response infrastructure. Both the COVID-19 response and NMDOH's regular operations depend on successfully performing the three core public health functions (Assessment, Assurance and Policy Development) and on achieving NMDOH's four strategic plan goals:

- To expand access to services
- To improve health status for all New Mexicans
- To ensure a safe healthcare environment statewide
- To pursue organizational excellence

NMDOH needs to be vigilant and flexible in order to maintain its usual operations while simultaneously managing the COVID-19 pandemic. By doing that, all COVID related repercussions will reflect our commitment to our vision of creating a Healthier New Mexico.

COVID-19 Performance Measures:

1. Number of COVID-19 swab tests performed.
2. Number of hours between the time a case is identified and when the case is contacted by Epidemiology and Response Division to isolate.
3. Number of hours between the time a case contact is identified and when the case contact is contacted by Epidemiology and Response Division to quarantine.
4. Percent of facility admissions (and hospital readmissions) having two verified COVID-19 negative tests.
5. Percent of staff tested for COVID-19.
6. Percent of patients/residents tested for COVID-19.
7. Number and percent of individuals receiving Home and Community Based Services (HCBS) who have received a COVID-19 test.
8. Number and percent of individuals receiving Home and Community Based Services (HCBS) who are confirmed positive for COVID-19.
9. Percent of providers who submitted or approved GERs in a timely manner related to COVID.
10. Percent and number of individuals who have been fully vaccinated.
11. Percent of COVID-19 tests resulted within 48 hours of receipt in the laboratory.

IMPROVEMENT ACTION PLAN Key:

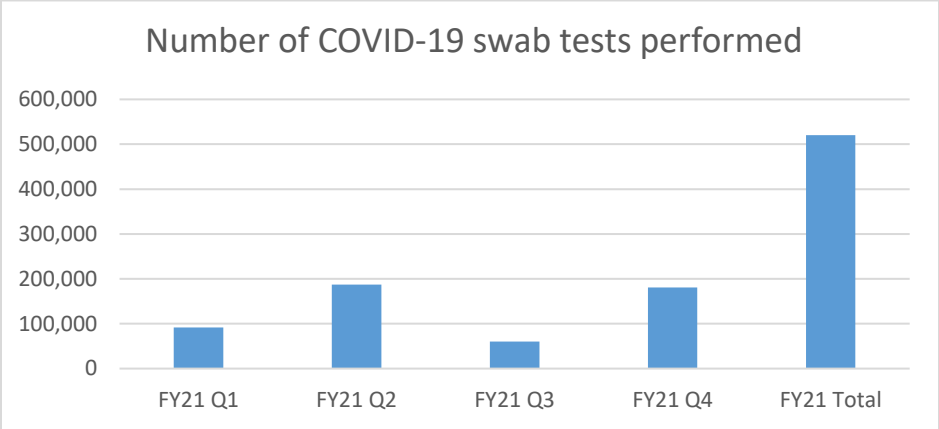
Major Quarterly Action Steps:	**Goal Completion Date**				
	Q1	**Q2**	**Q3**	**Q4**	**Target**
1) **X** denotes quarter(s) the action step was accomplished	X	X	X	X	
2) **-** denotes no action step was accomplished in that quarter	-	-	-	-	
3) **n/a** means the action step was not applicable during that quarter	n/a	n/a	n/a	n/a	
4) **P** denotes partial completed action	P	P	P	P	

COVID-19 PERFORMANCE MEASURE #1

Number of COVID-19 swab tests performed (PHD)

Results

FY21 Q1	FY21 Q2	FY21 Q3	FY21 Q4	FY21 Total	FY21 Target
91,568	186,924	60,269	181,125	519,886	Explanatory



MEASURE DESCRIPTION:
Numerator: N/A
Denominator: N/A

DATA SOURCE/METHODOLOGY:
For Q1-Q3, numbers of samples collected are recorded by PHD staff at sample collection sites and reported to the PHD director's office. The Public Health Division shifted its focus to providing vaccines throughout New Mexico early in 2021.
For Q4, the number of tests performed is tracked through the online registration application. The total includes tests that were provided by entities and agencies other than the Public Health Division. For Q4, 181,125 tests were conducted as recorded by the application. For Q3 the number recorded was 60,269, For Q2 it was 186,924, and for Q1 it was 91,568. For the first two quarters of FY21, the numbers are likely under-recorded because not all who were getting tested registered for their tests through the registration application.

STORY BEHIND THE DATA:
Public Health Division field offices throughout the state conduct COVID-19 sample collection daily either in the public health offices, or at community partner sites. This is a count of the total number of swabs collected by the Public Health Division during the quarter. In the third quarter of 2021, testing numbers decreased due to Public Health Division redirecting their efforts toward vaccination. As of June 30th, the Public Health Division has administered 376,571 vaccines and has led the coordination of vaccine rollout for the entire state.

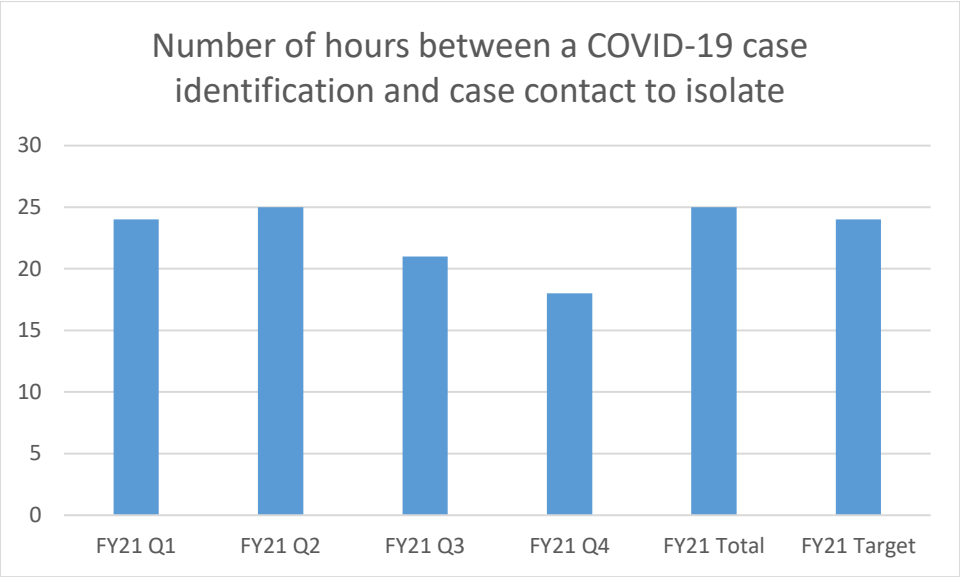
IMPROVEMENT ACTION PLAN:
No improvement plan needed for explanatory measure.

COVID-19 PERFORMANCE MEASURE #2

Number of hours between the time a case is identified and when the case is contacted by Epidemiology and Response Division to isolate (ERD)

Results

FY21 Q1	FY21 Q2	FY21 Q3	FY21 Q4	FY21 Total	FY21 Target
24 hours	25 hours	21 hours	18 hours	25 hours	≤24 hours



MEASURE DESCRIPTION:
The difference in hours between the date/time of the investigation creation date for a confirmed COVID-19 case and the date/time of the first phone interview to provide isolation instructions.

DATA SOURCE/METHODOLOGY:
The investigation creation date/time and patient ID are retrieved from the NM-EDSS database for all COVID-19 cases. The interaction date/time of the first reached interaction for all cases are downloaded via a Salesforce report link. NMEDSS and Salesforce are merged based on patient ID. The elapsed time between the investigation creation date/time and the interaction date/time is calculated in hours for all cases. The mean, median, minimum, and maximum times are summarized by week of investigation creation and excludes out-of-state cases.

STORY BEHIND THE DATA:
The time to isolation for a COVID-19 case is a metric that measures the capacity of the ERD COVID-19 team to quickly respond and provide isolation instructions. This measure is important to provide adequate resources and review statewide policies to slow the spread of COVID-19.

IMPROVEMENT ACTION PLAN:

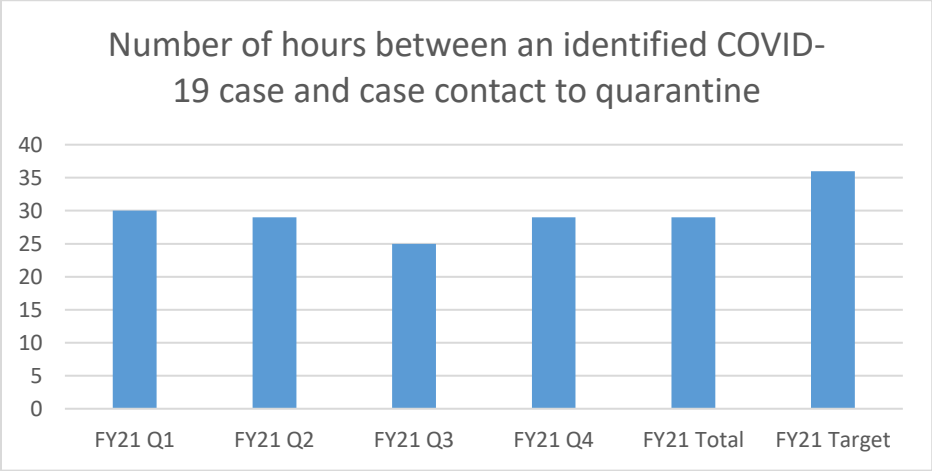
Major Quarterly Action Steps:	Goal Completion Date				
	Q1	Q2	Q3	Q4	Target
1) Report the metric on a weekly basis.	X	X	X	X	**Q1**
2) Collaborate with Salesforce/MTX to improve the method for determining the metric.	X	n/a	n/a	n/a	**Q2**
3) Automate reporting with Salesforce/MTX.	n/a	X	n/a	n/a	**Q3**

COVID-19 PERFORMANCE MEASURE #3

Number of hours between the time a case contact is identified and when the contact is contacted by Epidemiology and Response Division to quarantine (ERD)

Results

FY21 Q1	FY21 Q2	FY21 Q3	FY21 Q4	FY21 Total	FY21 Target
30 hours	29 hours	25 hours	29 hours	29 hours	≤36 hours



MEASURE DESCRIPTION:
The difference in hours between the date/time of the investigation creation date for a confirmed COVID-19 case and the date/time of the first phone interview with the case's contact to provide quarantine instructions.

DATA SOURCE/METHODOLOGY:
The investigation creation date/time and patient ID are retrieved from the NM-EDSS database for all COVID-19 cases. The interaction date/time of the first reached interaction for all reported contacts for each case are downloaded via a Salesforce report link. NMEDSS and Salesforce are merged based on patient ID. The elapsed time between the investigation creation date/time and the interaction date/time is calculated in hours for all contacts. The mean, median, minimum, and maximum times are summarized by week of investigation creation and excludes out-of-state case contacts.

STORY BEHIND THE DATA:
The time to quarantine for a COVID-19 case contact is a metric that measures the capacity of the ERD COVID-19 team to quickly respond and provide quarantine instructions. This measure is important to provide adequate resources and review statewide policies to slow the spread of COVID-19.

IMPROVEMENT ACTION PLAN:

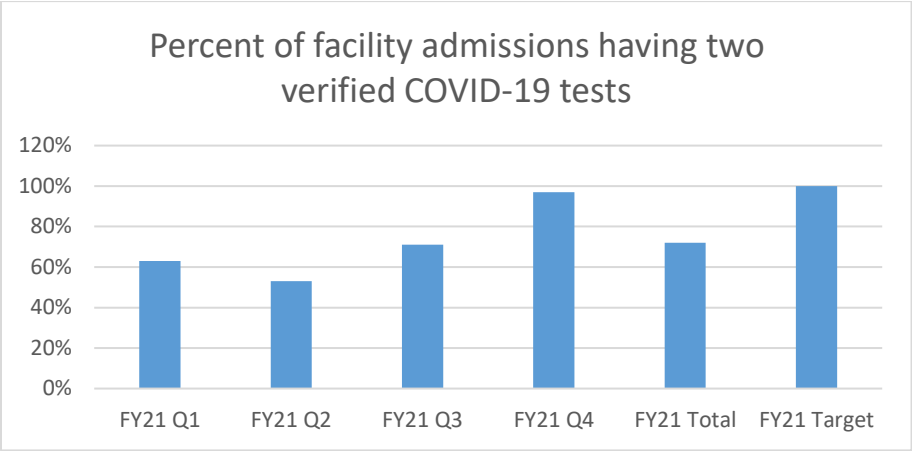
Major Quarterly Action Steps:	Goal Completion Date				
	Q1	Q2	Q3	Q4	Target
1) Report the metric on a weekly basis.	X	X	X	X	**Q1**
2) Collaborate with Salesforce/MTX to improve the method for determining the metric.	X	n/a	n/a	n/a	**Q1**
3) Automate reporting of the metric with Salesforce/MTX.	n/a	X	n/a	n/a	**Q2**

COVID-19 PERFORMANCE MEASURE #4

Percent of facility admissions (and hospital readmissions) having two verified COVID-19 negative tests (FMD)

Results

FY21 Q1	FY21 Q2	FY21 Q3	FY21 Q4	FY21 Total	FY21 Target
63%	53%	71%	97%	72%	100%



MEASURE DESCRIPTION:
This measure reports the percent of admissions having two verified COVID-19 tests.
Numerator: Number of new admissions and hospital readmissions having two verified COVID-19 tests.
Denominator: Number of new admissions and hospital readmissions.

DATA SOURCE/METHODOLOGY:
The information is obtained from tracking logs, lab reports, and electronic healthcare records systems.

STORY BEHIND THE DATA:
To reduce the spread of COVID-19 in our care Facilities and in following CDC guidelines or maintaining regulatory compliance with testing and surveillance, DOH's goal is to obtain two verified COVID-19 negative tests for every new admission and every readmission from a hospital. There is a challenge, however, with meeting the 100% target for the detox programs in our two substance abuse treatment facilities. Patients admitted to a detox program where the stay is only 4-5 days, since it takes 3 days to receive tests back, do not get tested again because they are usually gone already (or some leave prematurely). If tested again within those short-stay days, it would add liability for the facilities as they would need to track patients down to ensure the delivery of results. Those patients that complete the detox program then enter a social rehabilitation program within the facility are tested as a new admission.

IMPROVEMENT ACTION PLAN:

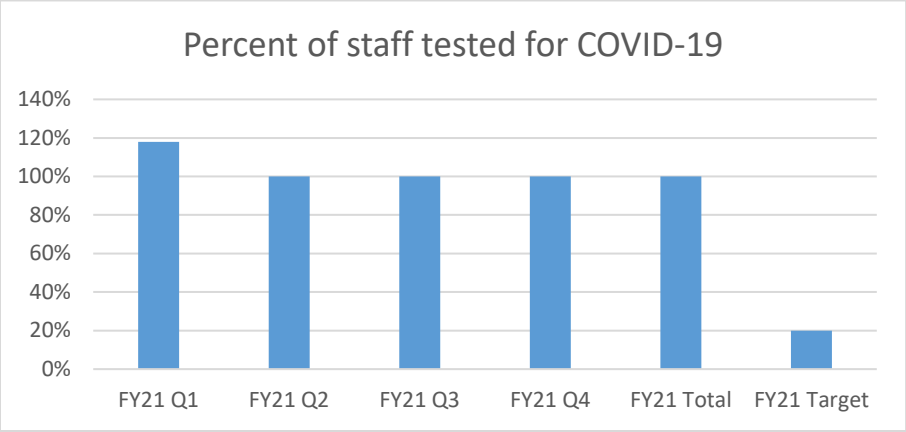
Major Quarterly Action Steps:	Goal Completion Date				
	Q1	Q2	Q3	Q4	Target
1) Test patients/residents admitted and readmitted from hospital and submit to laboratory.	X	X	X	X	
2) Monitor test results, report as necessary, and take appropriate action for positive test results received.	X	X	X	X	

COVID-19 PERFORMANCE MEASURE #5

Percent of staff tested for COVID-19 (FMD)

Results

FY21 Q1	FY21 Q2	FY21 Q3	FY21 Q4	FY21 Total	FY21 Target
118%	100%	100%	100%	100%	20%



MEASURE DESCRIPTION:
This measure reports the percent of staff tested for COVID-19.
Numerator: Number of DOH Facilities staff tested for COVID-19.
Denominator: Number of DOH Facilities staff as of last day of month.

DATA SOURCE/METHODOLOGY:
The information is obtained from tracking logs, lab and Human Resources reports.

STORY BEHIND THE DATA:
To reduce the spread of COVID-19 in DOH care Facilities and in following CDC guidelines or maintaining regulatory compliance with testing and surveillance, DOH's goal is to test at least 20% of its Facilities staff. This measure may be above the target due to rapid responses that occur when a positive test result has been received at a Facility. A rapid response involves testing 100% of staff and residents/patients each week for two weeks where for each week one negative test result is required to get "back to a status of normalcy". Rapid responses occurred frequently in FY21 Q1, Q2 and Q3.

IMPROVEMENT ACTION PLAN:

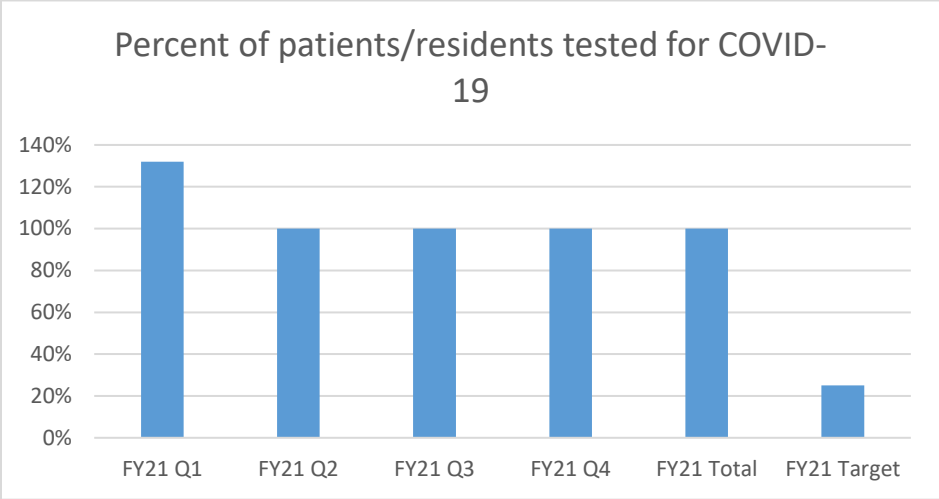
Major Quarterly Action Steps:	Goal Completion Date				
	Q1	Q2	Q3	Q4	Target
3) Test staff and submit to laboratory on a weekly basis.	X	X	X	X	
4) Monitor test results, report as necessary, and take appropriate action for positive test results received.	X	X	X	X	

COVID-19 PERFORMANCE MEASURE #6

Percent of patients/residents tested for COVID-19 (FMD)

Results

FY21 Q1	FY21 Q2	FY21 Q3	FY21 Q4	FY21 Total	FY21 Target
132%	100%	100%	100%	100%	25%



MEASURE DESCRIPTION:
This measure reports the percent of patients/residents tested for COVID-19.
Numerator: Number of patients/residents tested for COVID-19.
Denominator: Inpatient number of patients/residents served.

DATA SOURCE/METHODOLOGY:
The information is obtained from tracking logs, lab reports, and electronic healthcare records systems.

STORY BEHIND THE DATA:
To reduce the spread of COVID-19 in our care Facilities and in following CDC guidelines or maintaining regulatory compliance with testing and surveillance, DOH's goal is to test at least 25% of its patients/residents. This measure may be above the target due to rapid responses that occur when a positive test result has been received at a Facility. A rapid response involves testing 100% of staff and residents/patients each week for two weeks where for each week one negative test result is required to get "back to a status of normalcy". Rapid responses occurred frequently in FY21 Q1, Q2 and Q3. It must be noted, however, that patients/residents have a right to refuse testing.

IMPROVEMENT ACTION PLAN:

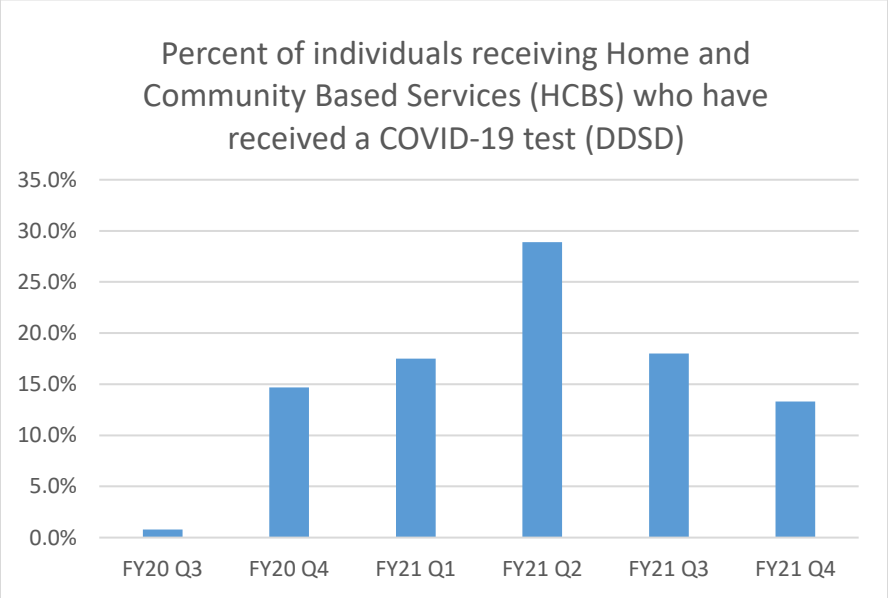
Major Quarterly Action Steps:	**Goal Completion Date**				
	Q1	**Q2**	**Q3**	**Q4**	**Target**
1) Test staff and patients/residents and submit to laboratory on a weekly basis.	X	X	X	X	
2) Monitor test results, report as necessary, and take appropriate action for positive test results received.	X	X	X	X	

COVID-19 PERFORMANCE MEASURE #7

Number and percent of individuals receiving Home and Community Based Services (HCBS) who have received a COVID-19 test (DDSD)

Results

FY20 Q3	FY20 Q4	FY21 Q1	FY21 Q2	FY21 Q3	FY21 Q4	FY21 Total	FY21 Target
41/5,196 (0.8%)	765/5,196 (14.7%)	897/5,134 (17.5%)	1512/5,239 (28.9%)	967/5364 (18.0%)	723/5437 (13.3%)	2561/5437 (47.1%)	Explanatory



MEASURE DESCRIPTION:
Numerator: Number of Individuals with Home and Community Based Services (HCBS) receiving a COVID-19 test in the quarter.
Denominator: Number of individuals receiving HCBS including DD Waiver, Mi Via Waiver, Medically Fragile Waiver and Supports Waiver.

DATA SOURCE/METHODOLOGY:
Number of individuals received a COVID-19 test as reported by NM DOH/ERD. ERD statewide test data are compared to HCBS Waiver census data provided by DDSD and HSD. The information above is based on ERD Data received on 7/8/2021.
Number of individuals receiving Home and Community Based Services (HCBS) is from NM Human Services Department Client Counts and Expense Report 7/9/2021.

STORY BEHIND THE DATA:
The number and percent of individuals on an HCBS receiving a COVID-19 test increased throughout the fiscal year to a high of 28.9% in FY21 Q2. Since then, the percentage of individuals tested decreased quarterly to 13.3% by FY21 Q4. DDSD continues to monitor the testing of individuals receiving services (see COVID-19 Related Activities Section).

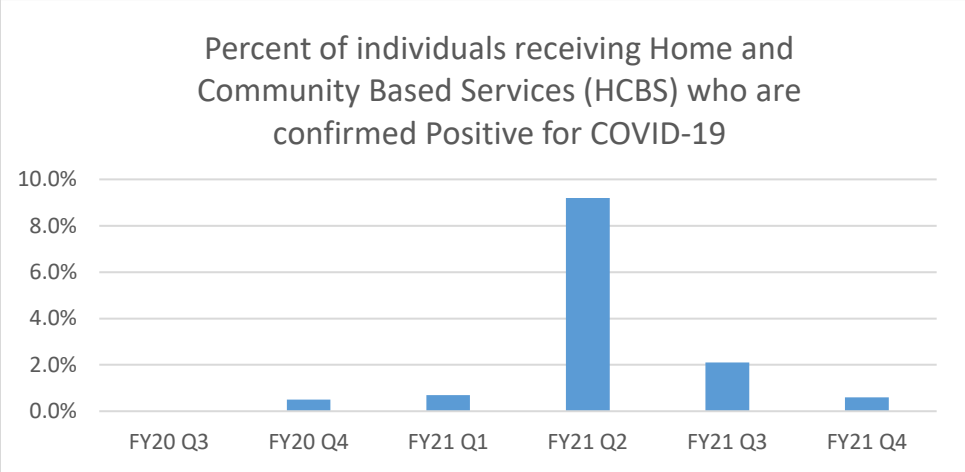
IMPROVEMENT ACTION PLAN:
No improvement plan needed for explanatory measure.

COVID-19 PERFORMANCE MEASURE #8

Number and percent of individuals receiving Home and Community Based Services (HCBS) who are confirmed positive for COVID-19 (DDSD)

Results

FY20 Q4	FY21 Q1	FY21 Q2	FY21 Q3	FY21 Q4	FY21 Total	FY21 Target
25/5,196 (0.5%)	34/5,134 (0.7%)	494/5,239 (9.2%)	115/5,364 (2.1%)	34/5437 (0.6%)	557/5437 (10.2%)	Explanatory



MEASURE DESCRIPTION:
Numerator: The number of individuals receiving Home and Community Based Services with a confirmed positive test for COVID-19 in the quarter.
Denominator: The number of individuals receiving Home and Community Based Services (HCBS) including DD Waiver, Mi Via Waiver, Medically Fragile Waiver and Supports Waiver.

DATA SOURCE/METHODOLOGY:
The number of individuals testing positive for COVID-19 is reported by NM DOH/ERD to DDSD. ERD statewide test data are compared to HCBS Waiver census data provided by DDSD and HSD. The information above is based on ERD Data received on 7/8/2021. The number of individuals receiving Home and Community Based Services (HCBS) is from NM Human Services Department Client Counts and Expense Report 7-9-2021.

STORY BEHIND THE DATA:
The COVID positivity rate for individuals receiving HCBS continued to decrease in FY21Q4 to 0.6% after reaching a high of 9.2% in FY21 Q2. A similar downward trend is observed for the general population in the state. DDSD will continue to monitor COVID-19 related events for all individuals receiving services (see COVID-19 Related Activities Section).

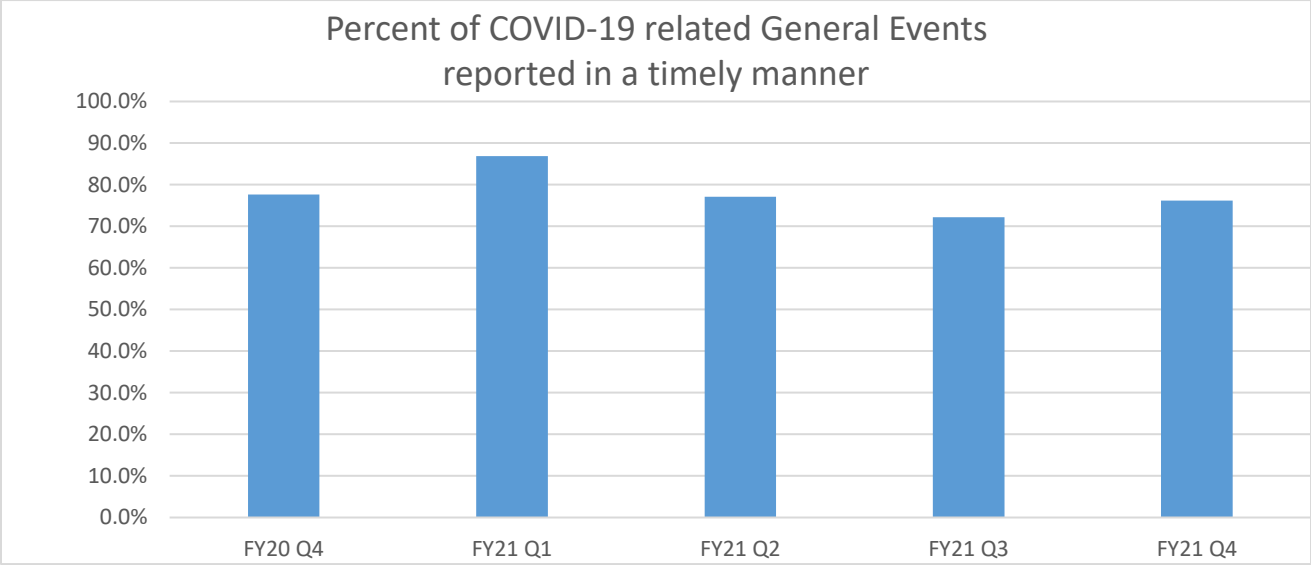
IMPROVEMENT ACTION PLAN:
No improvement plan needed for explanatory measure.

COVID-19 PERFORMANCE MEASURE #9

Percent of providers who submitted or approved GERs in a timely manner related to COVID-19 (DDSD)

Results

FY20 Q4	FY21 Q1	FY21 Q2	FY21 Q3	FY21 Q4	FY21 Total	FY21 Target
440/567 77.6%	518/596 86.9%	1201/1558 77.1%	3363/4657 72.2%	825/1083 76.2%	5907/7894 (74.8%)	Explanatory



MEASURE DESCRIPTION:
Numerator: GERs submitted related to COVID are COVID-19 suspected or known exposure, tests, confirmed test results, hospitalizations, deaths. Timely is defined as within 2 full days of event occurrence. GERs are submitted and reported for DD Waiver recipients only.
Denominator: GERs submitted related to COVID (includes COVID-19 suspected or known exposure, tests, confirmed test results, hospitalizations, deaths). GERs are submitted and reported for DD Waiver recipients only. Recipients for the Medically Fragile Waiver are not included in this measure.

DATA SOURCE/METHODOLOGY:
Effective 3/18/20, DDSD created a General Events Reporting (GER) system specific to COVID-related events (Suspected or Confirmed Exposure, COVID-19 Testing including both positive and negative results, and COVID-19 Related Death). GERs are reported in Therap, a proprietary data system.

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). DDSD is tracking COVID related events to ensure the safety and wellbeing of individuals during the pandemic. In FY21 Q4, 76.2% of all COVID related GERs were submitted and approved in a timely manner. This overall number of COVID-related GERs increased significantly with the onset of COVID vaccination reporting in March 2021.

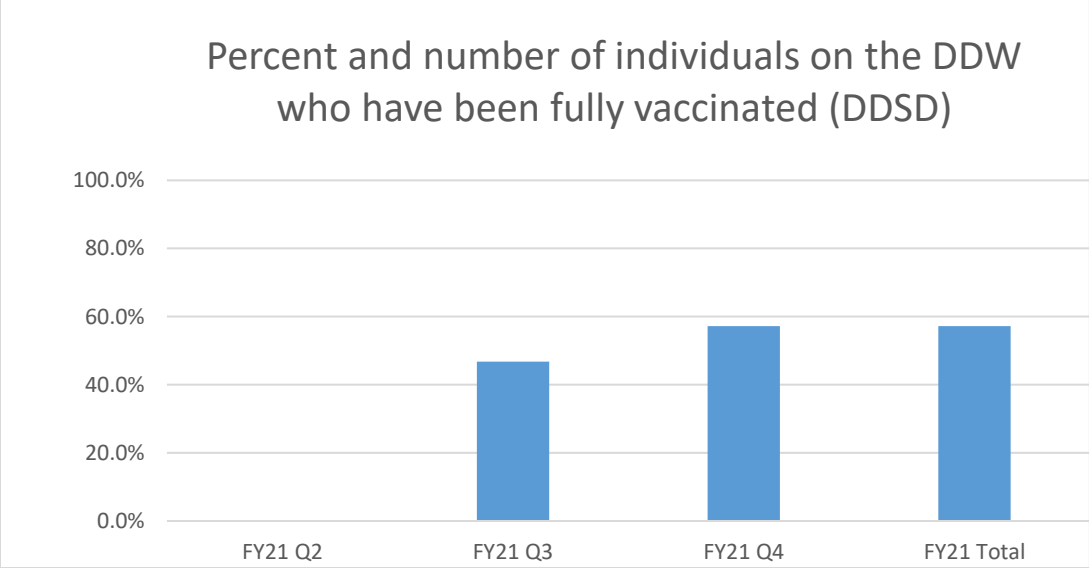
IMPROVEMENT ACTION PLAN:
No improvement plan needed for explanatory measure.

COVID-19 PERFORMANCE MEASURE #10

Percent and number of individuals who have been fully vaccinated (DDSD)

Results

FY21 Q1	FY21 Q2	FY21 Q3	FY21 Q4	FY21 Total	FY21 Target
New Measure	New Measure	1525/3258 (46.8%)	1897/3,319 (57.2 %)	1897/3,319 (57.2%)	Explanatory



MEASURE DESCRIPTION:
Numerator: The number of individuals either having completed a full 2-shot series (Pfizer or Moderna) or having completed a single-dose (J&J) vaccine by the end of Q4.
Denominator: The number of eligible individuals on the Developmental Disabilities Waiver services (HSD Client Count report 7/14/21).

DATA SOURCE/METHODOLOGY:
The data source is the Therap Clinical Database administered by DDSD. The data is based on General Events Reports (GERs) submitted to DDSD from providers for vaccine related events during the quarter. This data source and methodology relies exclusively on General Event Reporting in Therap and therefore differs from the other DDSD COVID Measures (7 and 8) and includes only individuals on the traditional Developmental Disabilities Waiver and does not include individuals on the Mi Via, Medically Fragile or Supports waivers (source: HSD client count report 7.14.21).

STORY BEHIND THE DATA:
COVID vaccines became available starting in mid-December 2020 and were increasingly available through FY21 Q3. Eligibility increased to include individuals with I/DD and their caregivers during FY21 Q3. DOH and DDSD partnered with HCBS agencies and advocacy groups to promote vaccine uptake among eligible populations. During FY21Q4 there were 1,897 individuals who were fully vaccinated, according to GER data. The estimated rate of vaccination was 57.2% for the traditional DDW population by the end of FY21.

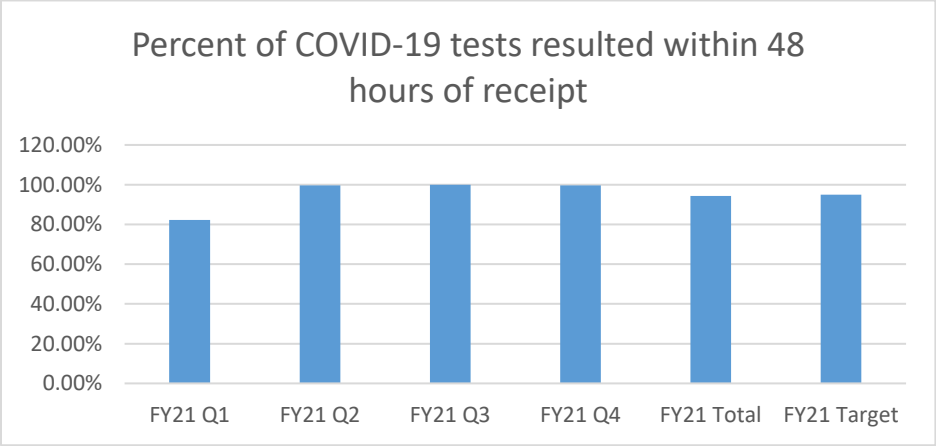
IMPROVEMENT ACTION PLAN:
No improvement plan needed for explanatory measure.

COVID-19 PERFORMANCE MEASURE #11

Percent of COVID-19 tests resulted within 48 hours of receipt in the laboratory (SLD)

Results

FY21 Q1	FY21 Q2	FY21 Q3	FY21 Q4	FY21 Total	FY21 Target
82.3%	99.7%	99.9%	99.7%	94.3%	95%



MEASURE DESCRIPTION:
Denominator: Number of cases reported out during the quarter/year.
Numerator: Number of cases reported out within 48 hours of receipt.

DATA SOURCE/METHODOLOGY:
The Laboratory Information Management System (LIMS). The LIMS is a secure integrated IT system that tracks samples, results, conducts quality control, and collects audit reasons for changes.

STORY BEHIND THE DATA:
SLD provides 24/7 COVID-19 diagnostic testing services for the state of New Mexico. Since the start of the pandemic, SLD has validated and performed high-complexity molecular diagnostic COVID-19 testing for the people of New Mexico. As a public health laboratory, SLD does not historically operate as a high-volume 24/7 testing facility but as of May 2020 was charged with extending COVID-19 testing operations. In FY21 Q4, SLD resulted 99.7% of COVID-19 test results within 48 hours of receipt to exceed the target of 95%. Use of web-based test ordering significantly reduced hand-entry of data, which decreased the turn-around time for releasing results. Non-DOH facilities (prisons, nursing homes, etc.) began utilizing commercial testing laboratories which decreased the number of specimens received. SLD is currently validating the newly released CDC Influenza/COVID-19 combination molecular diagnostic test, as well as validating the use of saliva as a specimen source for the detection of the virus.

IMPROVEMENT ACTION PLAN:

Major Quarterly Action Steps:	Goal Completion Date				
	Q1	Q2	Q3	Q4	Target
1) Hire term staff and supervisors to support COVID-19 laboratory operations.	X				**95%**
2) Complete development of the LIMS web portal for test ordering and reporting results.	P	P	P	X	**95%**
3) Complete validation of the COVID-19 antibody test.		X			**95%**
4) Complete validation of the CDC Influenza/COVID-19 molecular diagnostic test.		P	X		**95%**
5) Complete validation of saliva as a matrix for COVID-19 molecular diagnostic testing		P	P	P	**95%**

PROGRAM P002: Public Health Division (PHD)

Program Description, Purpose and Objectives:
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):

FY20	General Fund	Other State Funds	Federal Funds	Other Transfers	TOTAL	FTE
200	$22,374.9	$3,189.8	$25,107.1	$3,144.0	$53,815.8	820.5
300	$15,367.1	$4,950.5	$10,760.0	$12,086.7	$43,164.3	
400	$12,259.1	$33,401.2	$34,888.8	$305.9	$80,855.0	
TOTAL	$50,001.1	$41,541.5	$70,755.9	$15,536.6	$177,835.1	

FY21	General Fund	Other State Funds	Federal Funds	Other Transfers	TOTAL	FTE
200	$23,041.3	$4,754.8	$26,085.1	$2,689.1	$56,570.3	775.0
300	$18,443.6	$3,783.3	$9,514.6	$12,528.7	$44,270.2	
400	$11,353.3	$31,057.2	$26,714.8	$336.8	$69,462.1	
TOTAL	$52,838.2	$39,595.3	$62,314.5	$15,554.6	$170,302.6	

Program Performance Measures:

1. Percent of adolescents who smoke.
2. Percent of adults who smoke.
3. Percent of New Mexico adult cigarette smokers who access cessation services (FY21 Key Measure).
4. Number of successful overdose reversals per client enrolled in the NMDOH Harm Reduction Program (FY21 Key Measure).
5. Number of births to teens per 1,000 females aged 15-19.
6. Percent of female clients ages 15-19 seen in NMDOH public health offices who are provided most or moderately effective contraceptives (FY21 Key & HB2 Measure).
7. Number of teens that successfully complete teen pregnancy prevention programming.
8. Percent of NMDOH funded school-based health centers that demonstrate improvement in their primary care or behavioral health care focus area (FY21 Key & HB2 Measure).
9. Percent of third grade children who are considered obese.
10. Percent of children in Healthy Kids, Healthy Communities with increased opportunities for healthy eating in public elementary schools.
11. Percent of participants in the National Diabetes Prevention Program that were referred by a health care provider through the agency-sponsored referral system.
12. Percent of preschoolers (19-35 months) who are indicated as being fully immunized (FY21 Key & HB2 Measure).
13. Percent of older adults who have ever been vaccinated against pneumococcal disease.

PHD COVID-19 Related Activities:

The Public Health Division (PHD) has prioritized its COVID-19 response since March 2020. During emergencies like this one, PHD is the “boots on the ground” response system for the Department of Health. Staff have been involved with community education efforts through presentations, media, etc. PHD implemented the Incident Command System (ICS) to organize its response and effectively coordinate operations with other Divisions and responding partners. PHD also continues to provide many of their regular services and programs through the COVID-19 crisis. Staff worked with contractors and employees to continue to provide programs and services in a socially distanced and safe way.

During the fourth quarter of FY21:

- PHD has supported the *Vaccine Mission*, which includes the equitable distribution of the COVID19 Vaccine to decrease morbidity and mortality from COVID19.

- PHD utilized the Incident Command System (ICS) structure for the COVID vaccine and has served in critical ICS roles for the statewide vaccine roll-out.
- PHD staff coordinated and administered vaccine events along with multiple community partners, including mobile events focused on communities of high social vulnerability and those who have been hard hit by COVID.
- PHD assisted with the development of the following vaccine plans: Vaccine Equity Plan, Tribal Vaccine Plan, Congregate Care & Detention Centers, Homebound and Safety Plan.
- PHD has worked closely with mobile vaccine teams comprised of National Guard and FEMA team members.
- PHD continued to provide dedicated case management for pregnant women and infants with COVID and for those needing social service support to be able to isolate or quarantine.
- PHD has been the central point of testing for COVID-19. PHD has provided drive through testing sites since the middle of March 2020, in addition to providing testing at many of the 52 Public Health Offices throughout the state.
- PHD has written or contributed to developing protocols related to testing, PPE conservation, drive-thru screenings, screening at Public Health Offices, the Alternative Care Sites, and the isolation and quarantine sites. Having provided much of the medical expertise related to these test sites and facilities, PHD staff provided support to NMDOH facilities throughout the COVID-19 response, as well as other partners such as CYFD's youth shelter evaluations and detox centers.
- PHD has worked on NMDOH's Office of General Counsel's efforts to implement emergency isolation or quarantine orders for people who pose a risk to the community, including through gathering information and providing testimony.
- PHD personnel have worked to conserve Personal Protective Equipment (PPE) throughout the COVID-19 response.
- PHD continues the billing processes for collecting from insurance companies and Medicaid for COVID-19 testing and vaccine.

IMPROVEMENT ACTION PLAN Key:

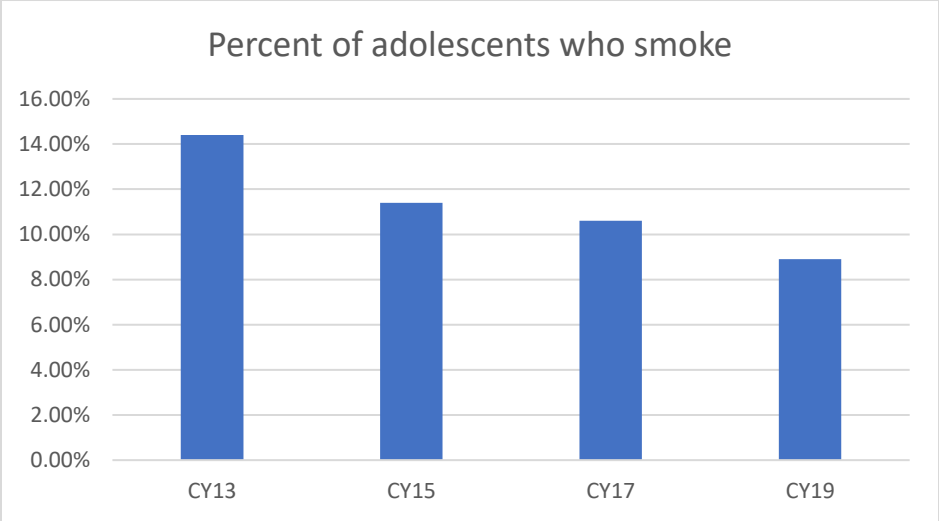
Major Quarterly Action Steps:	**Goal Completion Date**				
	Q1	**Q2**	**Q3**	**Q4**	**Target**
1) **X** denotes quarter(s) the action step was accomplished	X	X	X	X	
2) **-** denotes no action step was accomplished in that quarter	-	-	-	-	
3) **n/a** means the action step was not applicable during that quarter	n/a	n/a	n/a	n/a	
4) **P** denotes partial completed action	P	P	P	P	

PHD PERFORMANCE MEASURE #1

Percent of adolescents who smoke

Results

CY13	CY15	CY17	CY19	CY20	FY21 Target
14.4%	11.4%	10.6%	8.9%	n/a	Explanatory



MEASURE DESCRIPTION:
The percentage of High School youth who report smoking cigarettes on 1 or more of the past 30 days.

DATA SOURCE/METHODOLOGY:
The Youth Risk and Resiliency Survey (YRRS) is conducted every two years (most recent in 2019 and next one in fall 2021).

STORY BEHIND THE DATA:
The most recent (2019) NM youth cigarette smoking prevalence of 8.9% represents a historic low, but it is slightly higher than the national prevalence of 6%. Use of another tobacco product, e-cigarettes, however, increased from 24% (2017) to 34.7% (2019) and accounts for most of the tobacco use among youth. The NMDOH Tobacco Use Prevention and Control Program continues to incorporate e-cigarette use in its tobacco prevention and cessation activities. Plans are also underway to implement a new set of vaping-specific interventions, *Live Vape Free*, expected to launch in early FY22. *Live Vape Free* will support youth vapers with a texting program and multimedia experience tailored to their needs to teach the skills to quit vaping for good. Program will also provide concerned adults with a self-paced, online learning program to support them in their conversations with youth vapers.

Efforts are underway to implement the 2021 Youth Risk and Resiliency Survey in public middle and high schools in September-November 2021. New 2021 YRRS data is expected in Spring 2022.

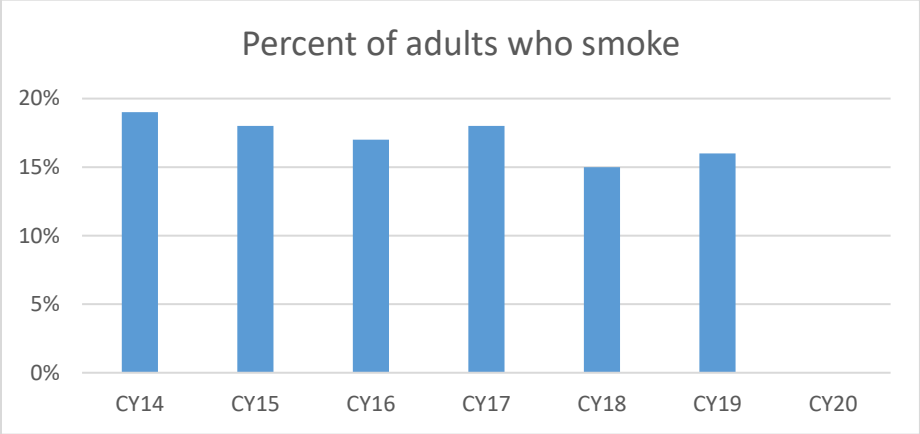
IMPROVEMENT ACTION PLAN:
Annual calendar year explanatory measure, thus no quarterly results required.

PHD PERFORMANCE MEASURE #2

Percent of adults who smoke

Results

CY14	CY15	CY16	CY17	CY18	CY19	CY20	FY21 Target
19.1%	17.5%	16.6%	17.5%	15.2%	16.0%	n/a	Explanatory



MEASURE DESCRIPTION:
The percentage of adults who report smoking every day or some days and have smoked at least 100 cigarettes (5 packs) in their lifetime.

DATA SOURCE/METHODOLOGY:
Behavioral Risk Factor Surveillance System (BRFSS) data via New Mexico Internet Based Information System (NM IBIS). 2020 BRFSS data is expected in late August 2021.

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. In 2019, there are about 88,700 fewer adult smokers than there were in 2011. Although smoking among New Mexicans has declined by about 25% since 2011, data from recent years seems to indicate that smoking rates may be stabilizing generally and remain high among certain subgroups, including low-income, uninsured, Medicaid-insured and lesbian/gay New Mexicans. The upcoming release of 2020 BRFSS data could also reveal any impact of the COVID pandemic on cigarette smoking patterns among NM adults.

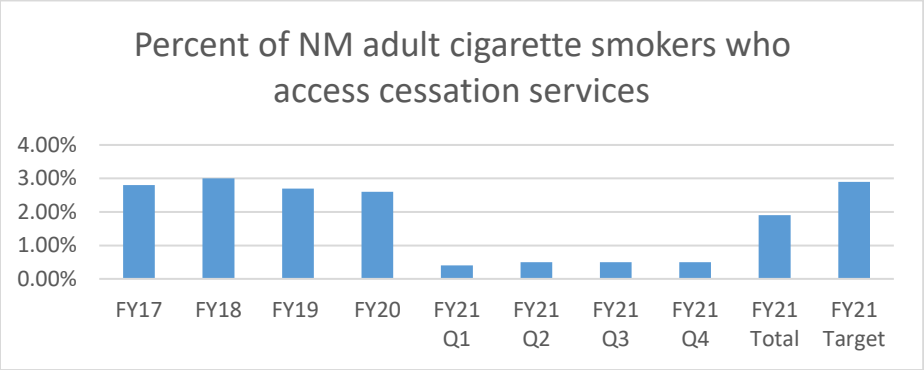
IMPROVEMENT ACTION PLAN:
Annual calendar year explanatory measure, thus no quarterly action plan results.

PHD PERFORMANCE MEASURE #3

Percent of New Mexico adult cigarette smokers who access cessation services

Results

FY17	FY18	FY19	FY20	FY21 Q1	FY21 Q2	FY21 Q3	FY21 Q4	FY21 Total	FY21 Target
2.8%	3.0%	2.7%	2.6%	0.4%	0.5%	0.5%	0.5%	1.9%	≥2. 9%



MEASURE DESCRIPTION:
Numerator: Number of adult cigarette smokers who access NMDOH Cessation Services (QUIT NOW; DEJELO YA).
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 NMDOH Tobacco Use Prevention and Control (TUPAC) Program served 1,235 NM tobacco users in Q4, representing about 0.5% of adult smokers in the state through its QUIT NOW and DEJELO YA tobacco cessation services. Overall, for FY21, NM reached 1.9% of adult smokers in the state with cessation services, far below the annual target of 2.9%. NM and the rest of the country experienced significant declines in use of their tobacco helplines during this past year of the COVID pandemic. NM QUIT NOW enrollments declined by 18% from 2019 to 2020 and calls to quitlines across the US declined by 27% (2019 to 2020). In Q3-Q4, the TUPAC program ran two additional media campaigns promoting the tobacco helpline using lung health/COVID messaging to persuade tobacco users to quit. New data also show that New Mexicans with behavioral health conditions or those experiencing stress increased their tobacco use during the pandemic, requiring new strategies for promoting and providing quit services during this unique time.

IMPROVEMENT ACTION PLAN:

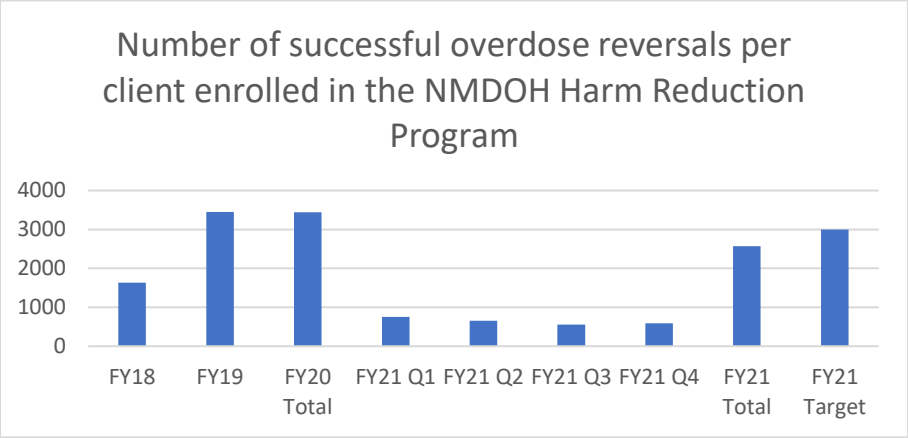
Major Quarterly Action Steps:	Goal Completion Date				
	Q1	Q2	Q3	Q4	Target
1) Maintain phone- and web-based tobacco cessation services with optional supports.	X	X	X	X	
2) Promote QUIT NOW and DEJELO YA services using a variety of methods (TV, online, print, niche marketing) to reach target of 8,000 enrollments in FY21.	X	X	X	X	
3) Train health care providers and clinics on health systems change efforts; adapt to virtual formats to maintain engagement during COVID.	n/a	P	X	X	
4) Continue tobacco and cessation training of health care, social service, and other providers using four existing online training modules.	X	X	X	X	

PHD PERFORMANCE MEASURE #4

Number of successful overdose reversals per client enrolled in the NMDOH Harm Reduction Program

Results

FY18	FY19	FY20	FY21 Q1	FY21 Q2	FY21 Q3	FY21 Q4	FY21 Total	FY21 Target
1,629	3,446	3,444	754	657	552	585	2,572	3,000



MEASURE DESCRIPTION:
This measure is the number of successful self-reported reversals provided to the Hepatitis and Harm Reduction programs.

DATA SOURCE/METHODOLOGY:
NMDOH's Hepatitis and Harm Reduction Naloxone Distribution Database as compiled 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's 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. In FY 21 challenges including federal funding no longer being available to the harm reduction program, changes in the route of consumption of substances, and the COVID-19 pandemic's impact in staffing has led to a decreased program utilization. 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:

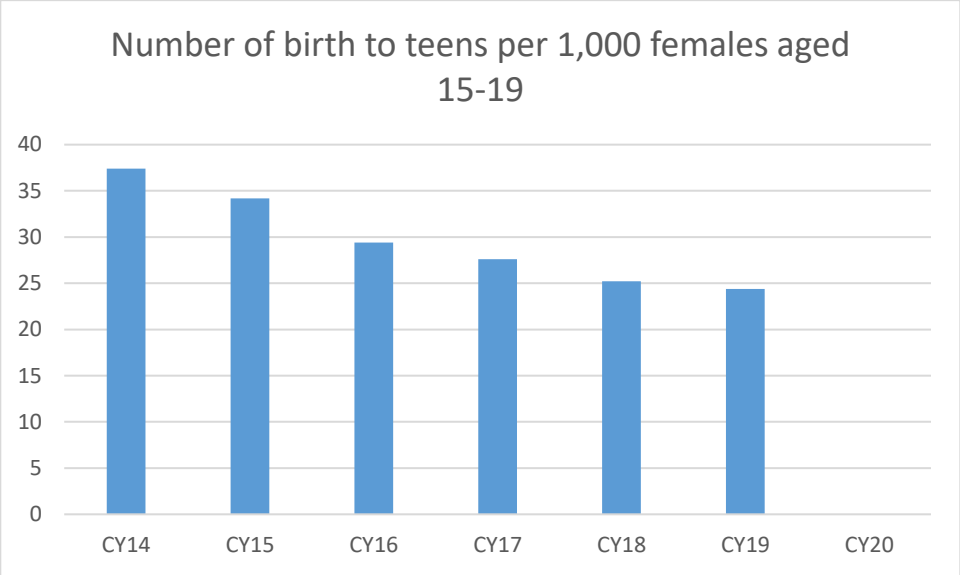
Major Quarterly Action Steps:	Goal Completion Date				
	Q1	Q2	Q3	Q4	Target
1) Provide overdose prevention trainings to service providers at least once per quarter across the state.	X	X	X	X	**4**
2) Have at least 30% ratio of successful reversals to naloxone visits.	38.4%	33.6%	34.5%	30.5%	**30%**

PHD PERFORMANCE MEASURE #5

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

Results

CY14	CY15	CY16	CY17	CY18	CY19	CY20	FY21 Target
37.4	34.2	29.4	27.6	25.2	24.4	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. This data is collected on a calendar year and the Family Planning Program calculates an estimated decrease of 10% per year.

DATA SOURCE/METHODOLOGY:
NM Indicator Based Information System (NM-IBIS, https://ibis.health.state.nm.us/)

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. In particular, New Mexico has prioritized improving and measuring access to Long-Acting Reversible Contraception (LARC) among adolescent women enrolled in the Medicaid program through a set of reimbursement and program initiatives – a central focus of Governor Lujan Grisham's platform to improve women's health. Since 2014, the teen birth rate among 15-to-19-year-olds in New Mexico (NM) has declined by 34.8% to 24.4 per 1,000 in 2019 (NM-IBIS) and is tied in 2018 for the seventh highest in the nation (at 25.2 per 1,000, with Tennessee and Texas) (National Center for Health Statistics).

While this is a DOH performance measure, there are other state agencies providing services and, therefore, impacting the teen birth rate, such as NM Human Services Department, NM Public Education Department, NM Children, Youth, and Families Department, and NM Early Childhood Education and Care Department. The NM Family Planning Program, which reports on this measure, provides services to about 4% of the female teen population (aged 15-19) in the state.

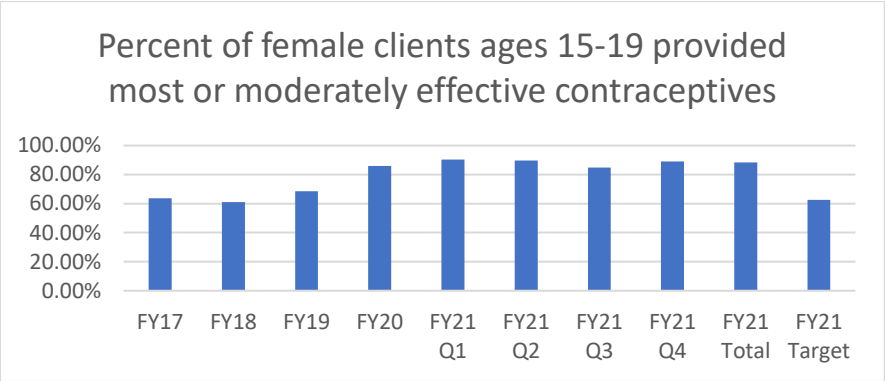
IMPROVEMENT ACTION PLAN:
An annual calendar year explanatory measure, thus no quarterly action plan results.

PHD PERFORMANCE MEASURE #6

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

Results

FY17	FY18	FY19	FY20	FY21 Q1	FY21 Q2	FY21 Q3	FY21 Q4	FY21 Total	FY21 Target
63.7%	61%	68.5%	85.8%	90.3%	89.8%	84.9%	89.0%	88.4%	≥62.5%



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

DATA SOURCE/METHODOLOGY:
The NM Family Planning Annual Report - these 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. Immediate past quarter data is provisional, as data cannot be obtained, reviewed, and verified by the deadline for submission.

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 41 of the 43 public health offices that offer family planning services. In December 2020, 34 Public Health Offices provided family planning services, due to COVID response. Since 2014, the teen birth rate among 15-to-19-year-olds in New Mexico has declined by 34.8% to 24.4 per 1,000 in 2019 (NM IBIS) and is tied in 2018 for the seventh highest in the nation (at 25.2 per 1,000, with Tennessee and Texas) (National Center for Health Statistics).

IMPROVEMENT ACTION PLAN:

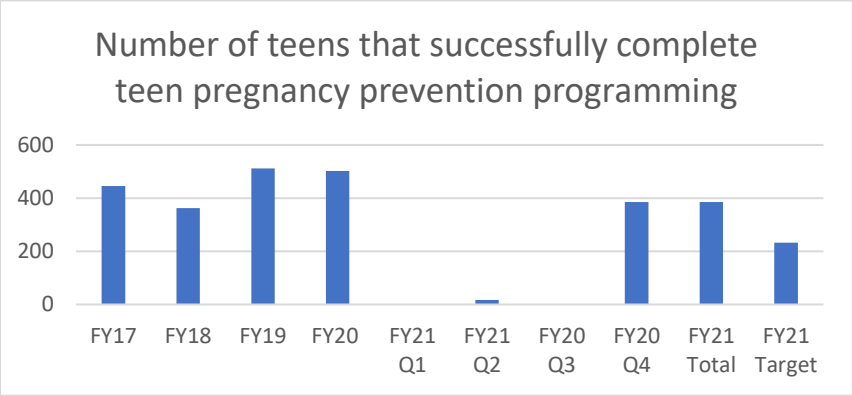
Major Quarterly Action Steps:	Goal Completion Date				
	Q1	Q2	Q3	Q4	Target
1) Dispense most or moderately effective contraceptives to teens aged 15-19 in local public health offices.	X	X	X	X	**62.5%**
2) Fund staff in public health offices to provide the broad range of contraceptive methods and confidential family planning services throughout the state.	X	X	X	X	
3) Ensure that most and moderately effective contraception are available on the formulary for clients to select.	X	X	X	X	

PHD PERFORMANCE MEASURE #7

Number of teens that successfully complete teen pregnancy prevention programming

Results

FY17	FY18	FY19	FY20	FY21 Q1	FY21 Q2	FY21 Q3	FY21 Q4	FY21 Total	FY21 Target
446	362	512	502	n/a	17	0	368	385	≥232



MEASURE DESCRIPTION:
This measure counts students who successfully complete a youth development program to prevent unintended teen pregnancy 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. Final reports and completion numbers are generated when programming is completed by June 2021.

STORY BEHIND THE DATA:
Since 2014, the teen birth rate among 15-to-19-year-olds in New Mexico (NM) has declined by 41.9% to 21.7 per 1,000 in 2019 (NM Indicator-Based Information System provisional data) and is tied in 2018 for the seventh highest in the nation (at 25.2 per 1,000, with Tennessee and Texas) (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-IBIS, 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.

IMPROVEMENT ACTION PLAN:

Major Quarterly Action Steps:	Goal Completion Date				
	Q1	Q2	Q3	Q4	Target
1) Contract with schools and community organizations to provide TOP.	X	X	X	X	
2) Gather client data.	X	X	X	X	
3) Implement FY21 youth development programming with all cohorts.	X	X	X	X	**232**

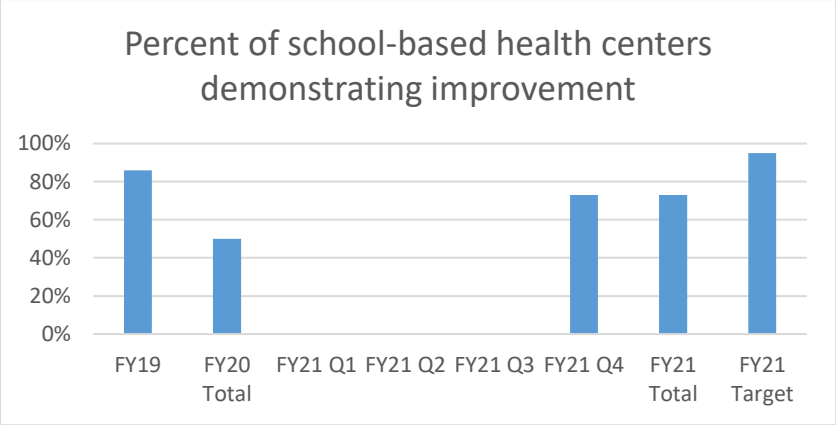
Due to a change in curricula in FY21 to more Teen Outreach Program (TOP) clubs that are longer in duration (6 to 9 months), there were fewer students completing programming in Q2. COVID and the change to virtual meetings also impacted the number of students who registered for the shorter curriculum (12 to 14 weeks), Teen Connection Project (TCP). All remaining teen participants are expected to complete programming in Q4.

PHD PERFORMANCE MEASURE #8

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

Results

FY19	FY20	FY21 Q1	FY21 Q2	FY21 Q3	FY21 Q4	FY21 Total	FY20 Target
86%	50%	0%	0%	0%	73%	73%	≥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 (SBHC) report their annual QI goal to the Office of School and Adolescent Health (OSAH) in their operational plan, as well as their mid-year progress and end of year progress toward those goals.

STORY BEHIND THE DATA:
This year many schools remained closed to in-person learning and many SBHC staff continued to be re-assigned within their organizations to COVID duties, resulting in less than half (46%) of OSAH funded SBHC having on-site availability at the school. Of that 46%, one day per week was the average amount of time they were available on-site per week compared to an average of 3 days a week in previous years. Engaging clinical care practices in QI activities is essential to achieving the triple aim: improving the health of the population, enhancing patient experiences and outcomes, and reducing the per capita cost of care. To that end, DOH funded school-based health centers are required to complete a pediatric, QI initiative annually. The FY21 target was not achieved due to the closure of schools in March 2020. SBHC sponsors quickly transitioned from in-person visits to telehealth visits to meet the adolescents needs. Our SBHC sponsors creatively reached out to students to deliver more telehealth services. Also, many SBHC staff were responsible for COVID delivery of related activities within their FQHC or hospitals and were unable to provide care at the SBHC.

IMPROVEMENT ACTION PLAN:

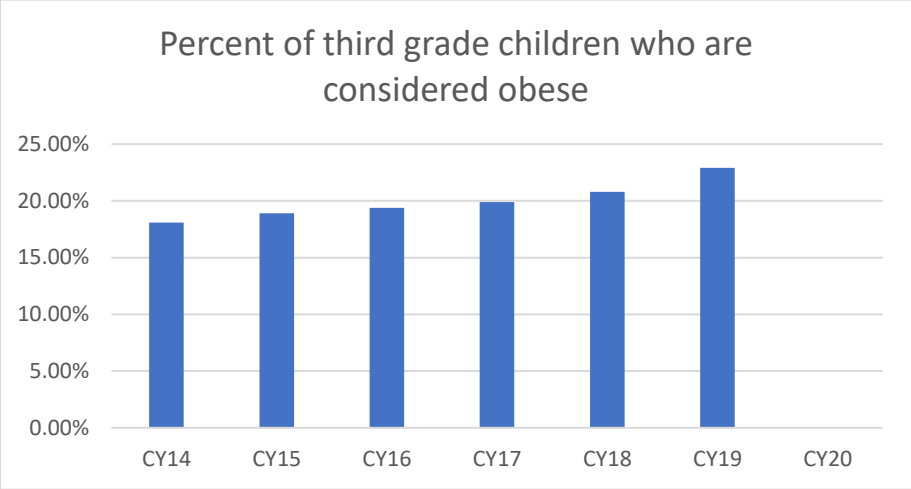
Major Quarterly Action Steps:	Goal Completion Date				
	Q1	Q2	Q3	Q4	Target
1) Complete review of QI goals in operational plans	X				
2) Complete review of mid-year progress reports		X			
3) Complete assessment of SBHCs on target to complete required number of student surveys			X		
4) Complete review of year-end progress reports.				X	**>95%**

PHD PERFORMANCE MEASURE #9

Percent of third grade children who are considered obese

Results

CY14	CY15	CY16	CY17	CY18	CY19	CY20	FY21 Target
18.1%	18.9%	19.4%	19.9%	20.8%	22.9%	n/a	Explanatory



MEASURE DESCRIPTION:
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 2019, the Obesity, Nutrition, and Physical Activity Program (ONAPA) and its partners, completed statewide childhood obesity surveillance by measuring 7,346 kindergarten and third grade students in 59 randomly selected public elementary schools, and in March 2020, published its New Mexico Childhood Obesity 2019 update. ONAPA, Healthy Kids Healthy Communities, and statewide partners also built support for measuring an additional 2,975 students in 31 schools so these communities would have more comprehensive childhood obesity data. School closures and other restrictions during the COVID-19 pandemic prevented the collection of statewide childhood obesity data for CY20. Statewide childhood obesity surveillance will continue in 2021, when schools resume normal in-person operations.

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 (46.2%) American Indian students are overweight or obese, followed by Hispanics at 38.3%.

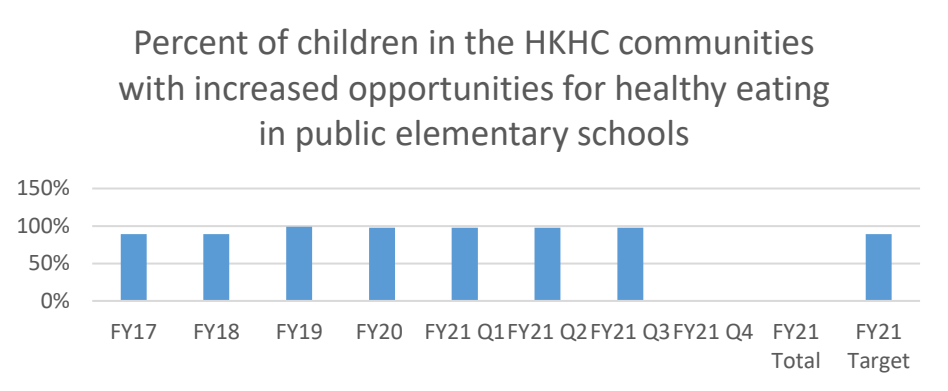
IMPROVEMENT ACTION PLAN:
Annual calendar year explanatory measure, thus no quarterly action required.

PHD PERFORMANCE MEASURE #10

Percent of children in the Healthy Kids Healthy Communities (HKHC) with increased opportunities for healthy eating in public elementary schools

Results

FY17	FY18	FY19	FY20	FY21 Q1	FY21 Q2	FY21 Q3	FY21 Q4	FY21 Total	FY21 Target
89%	89%	99%	97.9%	97.9%	97.9%	97.9%	August 2021	n/a	≥89%



MEASURE DESCRIPTION:
Numerator: Elementary-school age children in public schools with increased opportunities for healthy eating during the school day on an ongoing and regular basis. HKHC elementary schools' students represent 20% of New Mexico's elementary school-age population.
Denominator: Total public 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 public elementary schools. Our program aggregates, analyzes, and reports results by the end of the summer to assess environmental, policy, and systems changes over time. The FY21 Q1, Q2 and Q3 data reported above reflect FY20 data, as FY21 data will be collected in FY21 Q4 and is not yet available. We anticipate that the FY21 data will be different from previous years due to COVID-19-related challenges.

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 2019, 15.4% of kindergarten and 22.9% 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. FY21 Q4 data will be available in August 2021.

IMPROVEMENT ACTION PLAN:

Major Quarterly Action Steps:	Goal Completion Date				
	Q1	Q2	Q3	Q4	Target
1) Establish and implement strong wellness policies to improve school nutrition	X	X	X	X	
2) Implement sustainable healthy eating interventions coupled with nutrition education	X	X	X	X	
3) Work with local schools to create a plan for participation and promotion of events	X	X	X	X	

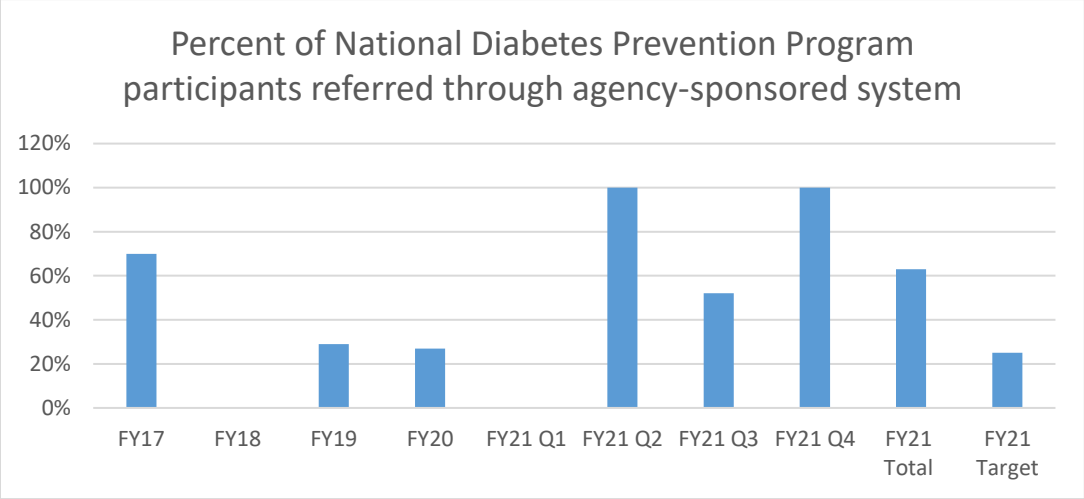
The COVID-19 pandemic caused widespread school closures during the majority of FY21. ONAPA's statewide efforts pivoted to virtual delivery, educational materials, social media communications, and local school and community partnerships.

PHD PERFORMANCE MEASURE #11

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

Results

FY17	FY18	FY19	FY20	FY21 Q1	FY21 Q2	FY21 Q3	FY21 Q4	FY21 Total	FY21 Target
70%	0%	29%	27%	0%	100%	52%	100%	63%	≥25%



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

DATA SOURCE/METHODOLOGY:
DPCP's centralized referral and data system, accessed through Paths to Healthier 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 and if left unrecognized and untreated it can progress to diabetes. In 2018, an estimated 567,000 New Mexican adults had prediabetes and only 3 out of 10 were aware of their condition. The CDC states without weight loss and physical activity, 15-30% of prediabetics will develop diabetes within 5 years, but with access to a lifestyle change program like the NDPP, their risk of getting type 2 diabetes can be cut in half.

IMPROVEMENT ACTION PLAN:

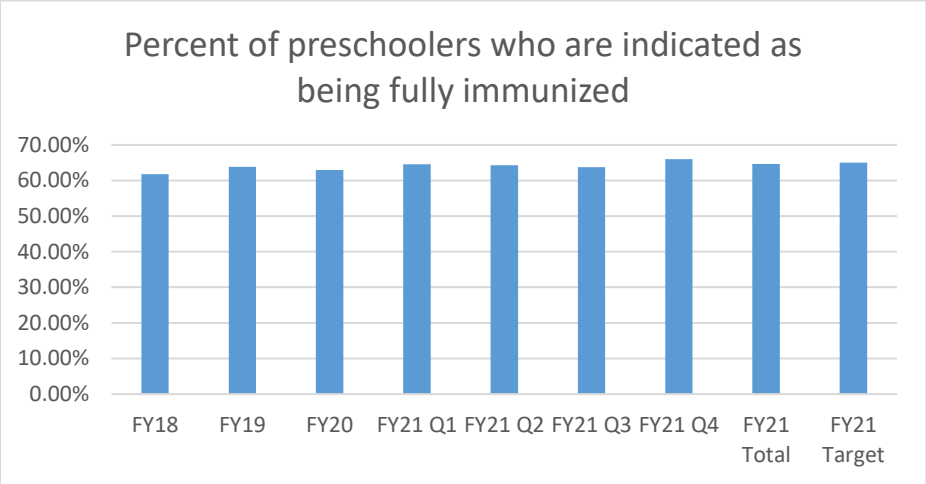
Major Quarterly Action Steps:	Goal Completion Date				
	Q1	Q2	Q3	Q4	Target
1) Receive referrals from healthcare providers.	n/a	X	X	X	
2) Promote and incorporate HIPAA compliant referral and data management system, Paths to Health NM and Workshop Wizard, into existing and newly identified healthcare systems.	X	X	X	X	
3) Disseminate branded Paths to Health NM promotional materials (rack cards, Rx pads).	250	n/a	2,000	3,300	
4) Generate referrals through EClinical Works electronic health record system.	n/a	n/a	n/a	n/a	

PHD PERFORMANCE MEASURE #12

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

Results

FY18	FY19	FY20	FY21 Q1	FY21 Q2	FY21 Q3	FY21 Q4	FY21 Total	FY21 Target
61.80%	63.85%	62.93%	64.59%	64.32%	63.75%	66%	64.66%	≥65%



MEASURE DESCRIPTION:
Numerator: Number of NM children 19-35 months of age, who are up-to-date for the 4:3:1:3:3:1 (4 DTaP, 3 Polio, 1 MMR, 3 HIB, 3 HepB, and 4 pneumococcal) immunization series in NMSIIS.
Denominator: Corresponding birth cohort data for 19-35-month-olds from NM Vital Records.

DATA SOURCE/METHODOLOGY:
The data source is New Mexico Vital Records Bureau and the New Mexico Statewide 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:
This measure assesses New Mexico's success in attaining high levels of immunization coverage among its preschool population. The Healthy People 2020 objective is 80%, which is a realistic target for New Mexico as well.

IMPROVEMENT ACTION PLAN:

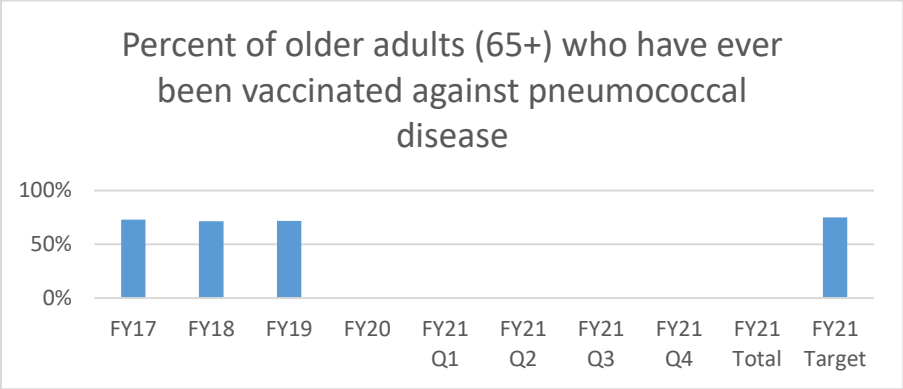
Major Quarterly Action Steps:	Goal Completion Date				
	Q1	Q2	Q3	Q4	Target
1) Improve registry data by reducing the number of duplicate client records.	X	X	X	X	
2) Implement Data Quality Improvement plan.	X	X	X	X	
3) Hire contract staff to assist with onboarding, data exchange and quality improvement.	X	X	X	X	
4) Collect revenue for the Vaccines Purchase Act (VPA) to assure continued supply of vaccines.	X	X	X	X	**100%**
5) Expand NMSIIS to support enhanced tracking of program objectives.	X	X	X	X	

PHD PERFORMANCE MEASURE #13

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

Results

FY17	FY18	FY19	FY20	FY21 Q1	FY21 Q2	FY21 Q3	FY21 Q4	FY21 Total	FY21 Target
73.0%	71.3%	71.6%	n/a	n/a	n/a	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. The US Healthy People 2020 Target for this measure is 90%. Availability of new data anticipated soon.

STORY BEHIND THE DATA:
Because the BRFSS system is only updated annually, quarterly data is not yet available and will not be available until the fall of 2021. 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). All Public Health Offices, including participating Adult 317 providers have access to pneumococcal vaccine available for order through our Immunization Registry.

IMPROVEMENT ACTION PLAN:

Major Quarterly Action Steps:	Goal Completion Date				
	Q1	Q2	Q3	Q4	Target
1) Ensure public health offices and partner organizations have access to PCV13 and PPSV23 for their uninsured patients.	X	X	X	X	
2) Promote pneumococcal vaccination at community virtual events serving older adults.	X	X	X	X	
3) Notify 65+ adults of annual wellness visit due date through registry reminder/recall project.	X	X	X	X	
4) Educate providers on the importance of Immunization against pneumonia and influenza as part of the initiative to reduce morbidity and mortality for the entire population as a whole.	X	X	X	X	

PROGRAM P003: Epidemiology and Response Division (ERD)

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):

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	

FY21	General Fund	Other State Funds	Federal Funds	Other Transfers	TOTAL	FTE
200	$4,944,900	$400,600	$42,171,300	$127,600	$47,644,400	
300	$1,299,800	$33,300	$42,944,200	$252,600	$44,529,900	
400	$4,680,000	$80,300	$11,270,400	$100,700	$16,131,400	
TOTAL	$10,924,700	$514,200	$96,385,900	$480,900	$108,305,700	

Program Performance Measures:

1. Percent of youth who were sexually assaulted in the last 12 months.
2. Number of youth who have completed an evidence-based or evidence-supported sexual assault primary prevention program.
3. Rate of suicide per 100,000.
4. Number of community members trained in evidence-based suicide prevention program.
5. Percent of hospitals with emergency department based self-harm secondary prevention program.
6. Rate of alcohol-related deaths per 100,000 population (FY21 HB2 Measure).
7. Percent of persons receiving alcohol screening and brief intervention (a-SBI) services.
8. Rate of drug overdose deaths per 100,000 population (FY21 HB2 Measure).
9. Percent of retail pharmacies that dispense naloxone (FY21 Key & HB2 Measure).
10. Percent of opioid patients also prescribed benzodiazepines (FY21 Key Measure).
11. Rate of heat related illness hospitalizations per 100,000 population.
12. Rate of cardiovascular disease (heart disease & stroke) deaths per 100,000 population.
13. Percent of NM hospitals certified for stroke care.
14. Rate of fall-related deaths per 100,000 adults, aged 65 years or older.
15. Percent of emergency department based secondary prevention of older adult fractures due to falls program.
16. Rate of pneumonia and influenza death rate per 100,000 population.
17. Percent of cities and counties with Access and Functional Needs (AFN) plans that help prepare vulnerable populations for a public health emergency (FY21 Key Measure).
18. Percent of persons hospitalized for influenza who were treated with antivirals within 2 days of onset of illness.
19. Rate of avoidable hospitalizations per 100,000 population.
20. Percent of death certificates completed by Bureau of Vital Records and Health Statistics within 10 days of death (FY21 Key Measure).
21. Average time to provide birth certificate to customer.

COVID-19 Related Activities:

The Epidemiology and Response Division has been working 24/7 on COVID-19 activities since March 2020, pulling in staff members from all program areas. These activities include:

- Established and supported two hotlines to handle thousands of health and non-health related questions, with an additional dedicated provider line. Connected the Vaccine Registration Technical Assistance line as an option to the 1-855 hotline and provided support to callers who required supplemental assistance with scheduling vaccine appointments.
- Provided 24/7 support via the 1-855 hotline for providers with questions about positive COVID-19 patients, for those who are positive with COVID-19, for those with direct exposure to a COVID-19 case, or for those who have questions about symptoms and whether it might be COVID-19. Also provided assistance regarding COVID-19 vaccines, completing registration profiles, and assisting with scheduling vaccine appointments when an event code was available. From March 11, 2020 to March 11, 2021, the hotline received 328,937 calls.
- Helped create and publish a COVID-19 webpage. The website is updated daily and displays COVID-19 testing results in New Mexico. There are also several resources for the public, clinicians, and laboratories. Daily press releases are posted on the website and links to the statewide and county demographic portal.
- Helped create and monitor a COVID-19 test result portal, which was added to the NMDOH website for members of the public and healthcare providers, to access demographic information about cases statewide and by county.
- Conducted case investigations of individuals in NM who are positive for COVID-19 and contact tracing of individuals who have direct exposure to COVID-19 cases (support provided from 8 AM to 8 PM). Case investigation and contact tracing allow for instructing persons infectious or exposed in how to prevent further spread. Investigations additionally allow understanding of characteristics of exposure, disease, and transmission so that additional control measures can be taken.
- Implemented isolation procedures to prevent further spread of the virus. This also includes identifying and notifying close contacts of each positive case, implementing home quarantine for close contacts, and performing check-ins for COVID-19 symptoms for 14 days post exposure.
- Provided support to other entities conducting case investigations, such as the Navajo Nation and area offices of the Indian Health Service.
- Coordinated investigations for special populations such as the homeless, those in long-term care facilities, and American Indians.
- Utilized influenza surveillance sites to test symptomatic individuals with influenza-like illness for COVID-19 in order to monitor community spread in New Mexico.
- Disseminated 7 health alerts (HAN) to New Mexico providers advising them about the updated application for non-hospital use of monoclonal antibody infusions, encouraging more COVID-19 testing in pediatric populations, providing guidance for reporting of COVID-19 vaccine breakthrough cases, clarifying reporting requirements for positive and negative SARS-CoV-2 results, and announcing that Bamlanivimab/Etesevimab therapeutic treatment had received Emergency Uses Authorization The most recent HAN in this quarter was issued on March 23, 2021.
- Continued to hold conference calls with various groups, e.g., long-term care facilities, detention centers, homeless service providers, etc. to update them on the outbreak and provide guidelines they might need.
- Onboarded testing facilities to transmit laboratory results electronically.
- Produced a wide variety of epidemiological reports on a weekly and daily basis for leadership (daily epi report, LTCF report, acceleration curves, laboratory results, Red-to-Green Framework metrics) and the public (Data Dashboard, Weekly Epi Reports, Modeling Subsite).
- Supported data requirements for vaccination plan implementation and developed FAQs.
- Supported policy and data needs for the Public Education Department to manage the re-opening of schools.
- Updated policies, e.g., quarantine and, isolation (including changes due to vaccination status of individual, infectious period, laboratory results interpretation, on the web and provided consultations on these policies through the call center, meetings, press inquiries, and constituent requests.

IMPROVEMENT ACTION PLAN Key:

Major Quarterly Action Steps:	**Goal Completion Date**				
	Q1	**Q2**	**Q3**	**Q4**	**Target**
1) **X** denotes quarter(s) the action step was accomplished	X	X	X	X	
2) **-** denotes no action step was accomplished in that quarter	-	-	-	-	
3) **n/a** means the action step was not applicable during that quarter	n/a	n/a	n/a	n/a	
4) **P** denotes partial completed action	P	P	P	P	

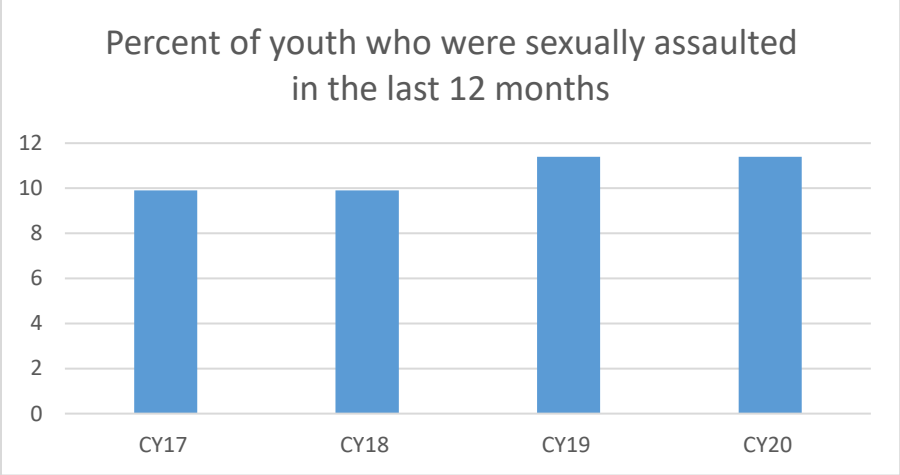
ERD PERFORMANCE MEASURE #1

Percent of youth who were sexually assaulted in the last 12 months

Results

CY17	CY18	CY19	CY20	FY20 Target
9.9%	9.9%*	11.4%	Fall 2021	Explanatory

Note: YRRS data for this question are collected every 2 years on odd numbered years. Values with "" are using the previous year's data as a placeholder.



MEASURE DESCRIPTION:
Numerator: Weighted number of public high school students who answered 'one or more times' to the question, "During the past 12 months, how many times did anyone force you to do sexual things that you did not want to do? (Count such things as kissing, touching, or being physically forced to have sexual intercourse.)"
Denominator: Weighted number of public high school students (grades 9-12) who completed the NM Youth Risk and Resiliency Survey (YRRS) for the year indicated, and who answered the question above (see numerator).

DATA SOURCE/METHODOLOGY:
Eligibility: To be eligible for the NM YRRS, a respondent must be a student enrolled in a New Mexico public high school and must be capable of completing the survey without assistance from another person.
Calculation method: Weighted percent of respondents indicating response above (see numerator). Data are weighted to reflect the demographic population parameters of all NM public high school students.
Data Source: Centers for Disease Control and Prevention (CDC). Youth Online. High School Youth Risk Behavior Survey (YRRS). Data for this measure are collected once every two years, in the fall semester of odd numbered years. Nevertheless, data are highly reliable, as the survey is conducted each year using identical methodology, and response rates have been consistently high.

STORY BEHIND THE DATA:
Data from the 2019 New Mexico High School Youth Risk & Resiliency Survey (NM HS YRRS) indicate that 9.4% of all public high schoolers in NM have been raped (physically forced to have sex) during their lifetime. Female high schoolers (13.3%) reported about 3 times more frequently than their male counterparts (5.7) that they were that they were physically forced into unwanted sexual encounter. Data from the 2019 NM HS YRRS clearly indicate priority youth populations in NM that are at greater risk for sexual violence, including females, youth who identify as LGBTQI+ (Lesbian, Gay, Bisexual, Transgender, Questioning, Intersex), Black/African-Americans American Indians and Alaska Natives, youth living with disabilities, and youth who are foreign-born.

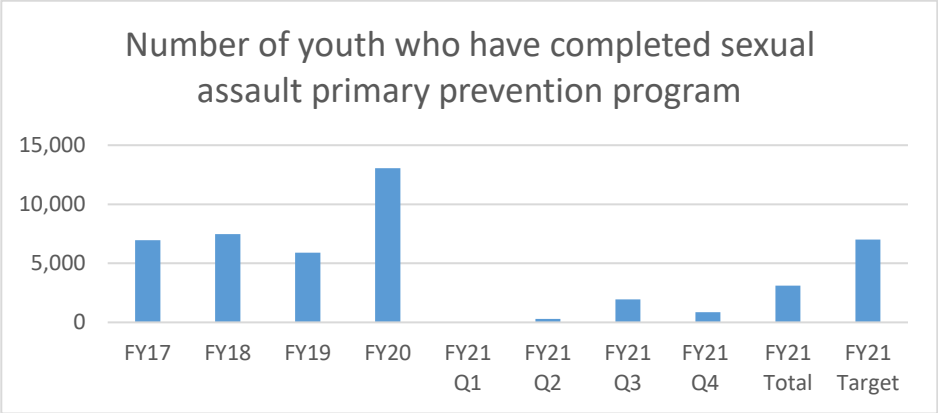
IMPROVEMENT ACTION PLAN:
This is an annual calendar year explanatory measure with no quarterly results.

ERD PERFORMANCE MEASURE #2

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

Results

FY17	FY18	FY19	FY20	FY21 Q1	FY21 Q2	FY21 Q3	FY21 Q4	FY21 Total	FY21 Target
6,962	7,470	5,905	13,051	0*	287	1,958	867	3,112	≥7,000



MEASURE DESCRIPTION:
This output measure is based on the number of students and youth who have completed primary prevention programs.

DATA SOURCE/METHODOLOGY:
Calculation method: NMDOH has program contractors that conduct evidence-based and/or evidence-supported sexual assault primary prevention programs for NM youth. The contractors turn-in completion headcounts that are added up each quarter. Data are collected and evaluated to measure program reach.

STORY BEHIND THE DATA:
According to the 2019 NM HS YRRS 11.4% of NM high school youth reported being forced to do sexual things (counting such things as kissing, touching, or being physically forced to have sexual intercourse) they did not want done by anyone, one or more times during the 12 months before the survey. In 10 of 11 DOH funded programs, evaluative data showed youth to have significant decreases in attitudes that are risk factors for sexual violence perpetration. Public health orders during FY21 to prevent the spread of COVID-19 included remote learning for students. This impacted the ability of contractors to go into schools and conduct sexual assault primary prevention programs. Consequently, there was an overall reduction in the number of youth who could complete the program and over 50% our target. In Q1, no youth could complete the program at all. Q3 had the highest number of youth completing the program, but it was still very low.

IMPROVEMENT ACTION PLAN:

Major Quarterly Action Steps:	Goal Completion Date				
	Q1	Q2	Q3	Q4	Target
1) Train youth in evidence-based or supported sexual assault primary prevention programs.	0*	287	1,958	867	**7,000**
2) Gather and analyze evaluation data.	X	X	X	X	
3) Develop community and societal level interventions.	X	X	X	X	

*Public health orders to prevent COVID-19 spread continue to impair contractors' ability to conduct sexual assault primary prevention programs in schools as planned. Since restrictions may remain in place, modifications to curricula are in process, geared toward digital delivery along with creation of primary prevention programs designed to reach youth via non-school-based means.

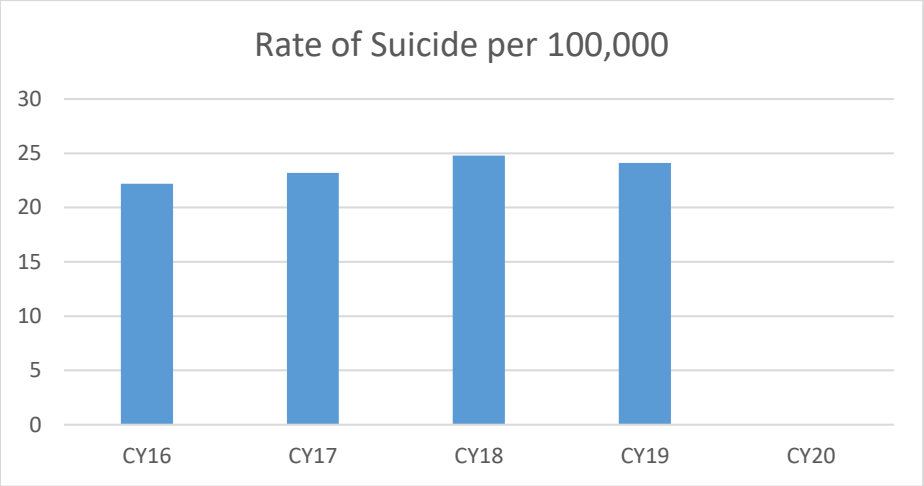
ERD PERFORMANCE MEASURE #3

Rate of suicide per 100,000 population

Results

CY16	CY17	CY18	CY19	CY20	FY21 Target
22.2	23.2	24.8	24.1	Fall 2021	Explanatory

*Death data for CY2020 have not been released yet and are expected to be released in November of 2021.



MEASURE DESCRIPTION:
Numerator: The total number of suicide deaths among New Mexico residents annually.
Denominator: Population estimate of the number of New Mexico residents.
Age-Adjusted Standard: The suicide death rate is age-adjusted to the 2000 U.S. standard population.

DATA SOURCE/METHODOLOGY:
Bureau of Vital Records and Health Statistics, Death Certificate Database (Numerator). Suicide deaths are defined by underlying cause of death based on International Classification of Diseases, version 10 (ICD-10) codes of X60-X84, Y87.0, and *U03.
Suicide deaths include only deaths of New Mexico residents. Deaths for persons of unknown age are not included in age-adjusted rates. Validity hinges on the correct reporting of cause of death; suicide deaths may be subject to local misclassification of the underlying cause of death. In some cases, the medical investigator is unable to determine the cause of death and cause of death is listed as undetermined. It is also possible that some deaths ruled as accidents (unintentional injuries) may be suicides as may occur with some motor vehicle crashes and prescription, illicit drug, or alcohol overdoses. New Mexico Population Estimates (Denominator), New Mexico's Indicator-Based Information System (NM-IBIS), University of New Mexico Geospatial and Population Studies Program.

STORY BEHIND THE DATA:
The suicide rate in New Mexico (NM) has consistently been more than 1.5 times higher than national rates. In 2018, NM had the second highest age-adjusted suicide rate in the United States. Between 2017 and 2018, deaths by suicide in NM increased by 6.7% compared to an increase across the nation of 1.4%. In 2018, state data showed 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 - 44 years. The highest rate increase between 2017 and 2018 was in children 10-14 years. Over a broader timespan from 2009 to 2018, the rate of increase in suicide in New Mexico was 37% compared to a rate 14.2% increase for the US for this same time.

IMPROVEMENT ACTION PLAN:
This is an annual calendar year explanatory measure, so no quarterly action is required.

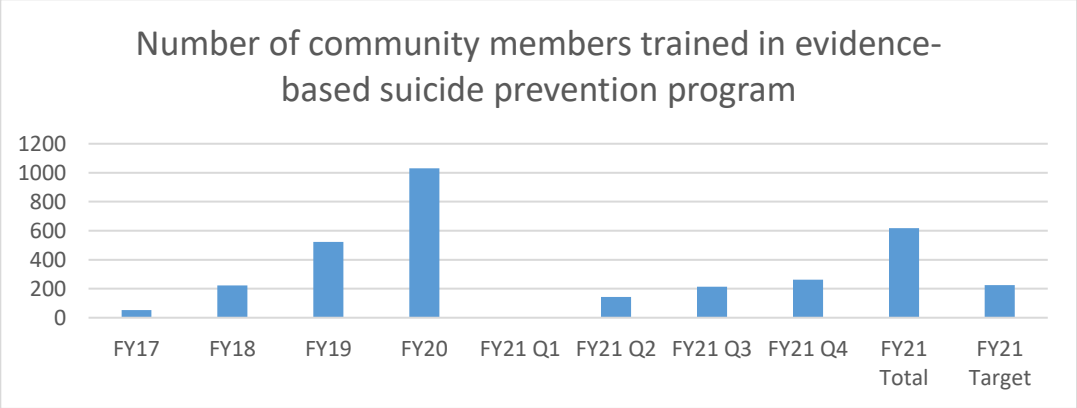
ERD PERFORMANCE MEASURE #4

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

Results

FY17	FY18	FY19	FY20	FY21 Q1	FY21 Q2	FY21 Q3	FY21 Q4	FY21 Total	FY21 Target
52	222	522	1,030	0*	143	213	262	618	225

*Due to COVID-19, no trainings occurred in Q1.



MEASURE DESCRIPTION:
Number of individual community members who have completed an evidence-based suicide prevention program.

DATA SOURCE/METHODOLOGY:
Public Health Division, Office of School and Adolescent Health (OSAH) training log combined with Epidemiology and Response Division Office of Injury Prevention (OIP) tracking system/attendance records. Totals represent the number people trained; however, some trainees completed multiple trainings. There are also different layers/levels of training (regular informative versus train-the-trainer).

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. The NM suicide rate has been more than 50% higher than the national rate over the past decade, and in 2017, NM had the fourth highest suicide rate in the United States. 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. DOH continues to increase awareness of suicide by educating about risk factors and warning signs to community members. In addition, the Department of Health's Office of Injury Prevention continues to partner with the Office of School and Adolescent Health (OSAH) in building capacity in local communities and with other within- and outside-state government agencies to offer gatekeeper trainings via gatekeeper train-the-trainer programs. Due to the impact of COVID-19, no trainings could occur in Q1. However, during FY21 the overall target of 225 community members trained was met and actually exceeded by more than double.

IMPROVEMENT ACTION PLAN:

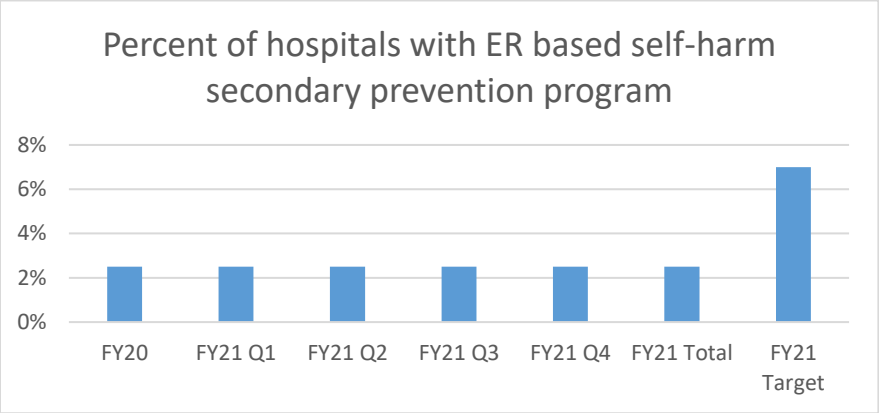
Major Quarterly Action Steps:	Goal Completion Date				
	Q1	Q2	Q3	Q4	Target
1) Provide support to OSAH by dissemination of course information.	X	X	X	X	
2) Remain actively certified to train – facilitate / co-facilitate as needed.	X	X	X	X	

ERD PERFORMANCE MEASURE #5

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

Results

FY20	FY21 Q1	FY21 Q2	FY21 Q3	FY21 Q4	FY21 Total	FY21 Target
2.5%	2.5%	2.5%	2.5%	2.5%	2.5%	7%



MEASURE DESCRIPTION:
Numerator: Number of hospitals with emergency department-based secondary suicide prevention programs.
Denominator: 37 NM hospitals with emergency departments (2020).
Criteria for eligibility: Hospitals in New Mexico with an emergency department.
Calculation method: Count of established secondary programs in EDs divided by 37 hospitals.

DATA SOURCE/METHODOLOGY:
OIP Suicide Prevention Program provides data for the numerator.
NMDOH Syndromic Surveillance System and hospital reports provide the denominator.

STORY BEHIND THE DATA:
Reducing the high rate of suicide in NM 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. An evidence-based program has been developed for hospital staff who care for individuals presenting to the hospital Emergency Department (ED) with a suicide attempt, are treated, and are then discharged home. The program aims to educate hospital care providers involved with suicidal patients and includes ED physicians, nurses, nurse practitioners, physician assistants, crisis counselors, clinical care navigators, peer support workers (when available), and others identified by the hospital leadership. The program goal is to reduce the risk of suicide re-attempts as one aspect of a comprehensive effort needed to address suicide in the state and thus includes a patient-centered safety plan, a quick referral to follow-up care, and contacts to support patients during the first 6 months following the patient's discharge.

IMPROVEMENT ACTION PLAN:

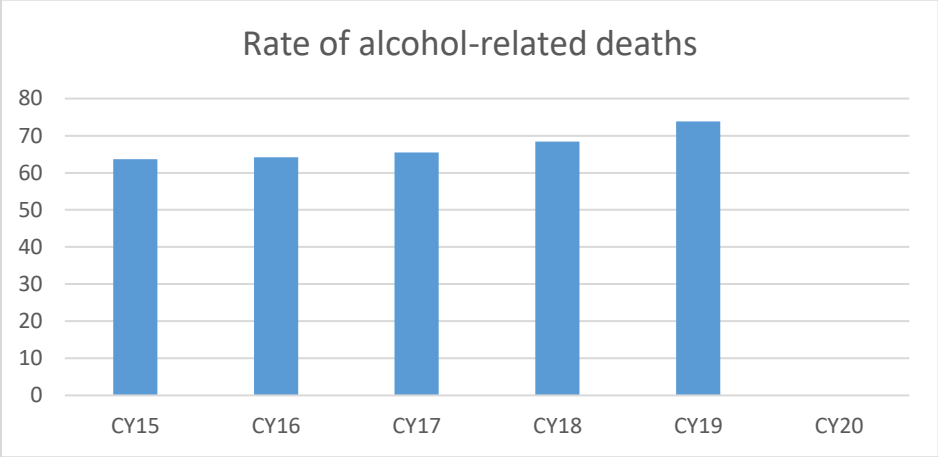
Major Quarterly Action Steps:	Goal Completion Date				
	Q1	Q2	Q3	Q4	Target
1) Phone and e-mail ED program contacts monthly to assess readiness to begin program.	X	X	X	X	
2) Tailor program components and training sessions for each ED that becomes available.	n/a	n/a	X	X	
3) Conduct training sessions for each ED when they are ready, and components are designed for their community/county.	n/a	n/a	n/a	X	

ERD PERFORMANCE MEASURE #6

Rate of alcohol-related deaths per 100,000 population

Results

CY15	CY16	CY17	CY18	CY19	CY20	FY21 Target
63.7	64.2	65.5	68.4	73.8	Fall 2021	Explanatory



MEASURE DESCRIPTION:
Numerator: Number of alcohol-related deaths. The CDC updated the Alcohol-Related Disease Impact (ARDI) database in the Summer of 2020. The numbers in this chart reflect the rates based on ARDI v.3. These are not comparable to previous reports which reported death rates based on ARDI v.2.
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 Alcohol-related Disease Impact (ARDI).

STORY BEHIND THE DATA:
New Mexico has the highest alcohol-related death rate in the US. New Mexico's CY19 alcohol-related death rate is twice the US. The alcohol-related death rate in New Mexico increased almost 8% between 2018 and 2019.

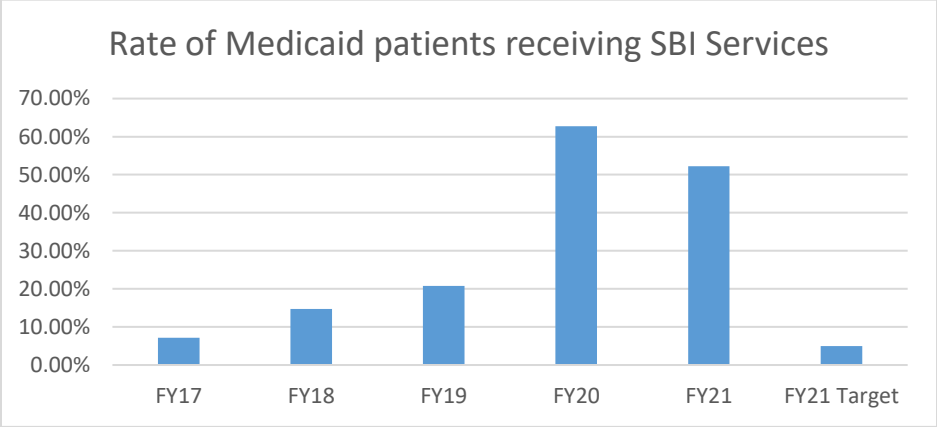
IMPROVEMENT ACTION PLAN:
While this is an annual year explanatory measure and no quarterly results are required, NMDOH ERD staff reach out to local (county/tribal/pueblo/national) health councils about the importance of including alcohol-related strategies. Data, presentations, and support are offered 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.

ERD PERFORMANCE MEASURE #7

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

Results

FY17	FY18	FY19	FY20	FY21	FY21 Target
7.2	14.7	20.8	62.7	52.2	≥5%



*Rate of adults 18-64 years of age.

MEASURE DESCRIPTION:
Numerator: Number of persons receiving SBI services and subsequent alcohol diagnosis.
Denominator: Total number of persons 18 to 64.

DATA SOURCE/METHODOLOGY:
Data is from HSD/Medicaid; UNM/GPS population.
All rates use the previous calendar year's population.
FY20 changed slightly when calculated based on the 2019 population data, which became available in FY21 Q2.

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. Due to the impact of COVID-19 on clinical settings, we had fewer brief interventions in FY21 compared to FY20. The goal was to increase by at least 5% over the rate that we reported last year. We decreased from the rate that we reported last year due to COVID-19.

IMPROVEMENT ACTION PLAN:

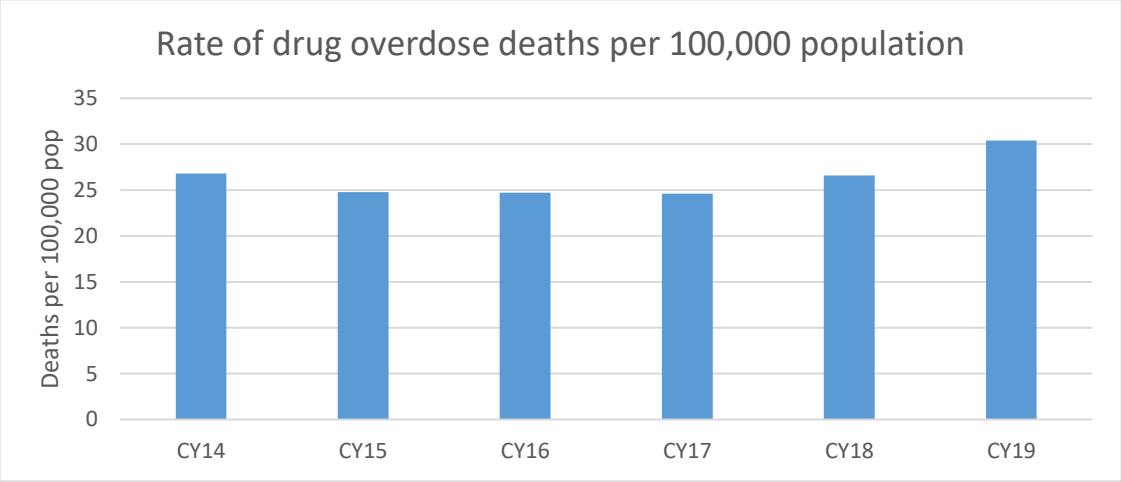
Major Quarterly Action Steps:	Goal Completion Date				
	Q1	Q2	Q3	Q4	Target
1) Recalculate FY20 rate with 2019 population data.	n/a	X	n/a	n/a	
2) Produce SBI Infographic visual.	n/a	n/a	n/a	n/a	
3) Request updated SBI data and calculate the FY21 rate.	n/a	n/a	n/a	X	

ERD PERFORMANCE MEASURE #8

Rate of drug overdose deaths per 100,000 population

Results

CY14	CY15	CY16	CY17	CY18	CY19	CY20	FY21 Target
26.8	24.8	24.7	24.6	26.6	30.4	Fall 2021	Explanatory



MEASURE DESCRIPTION:
Numerator: 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:
NMDOH Bureau of Vital Records and Health Statistics death data; UNM/GPS population estimates. Data are available annually on a calendar-year basis, typically in June for the prior year.

STORY BEHIND THE DATA:
New Mexico has long had one of the highest rates of drug overdose deaths in the US. Between 2015 and 2017 NM reported 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 Prescription Monitoring Program (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.

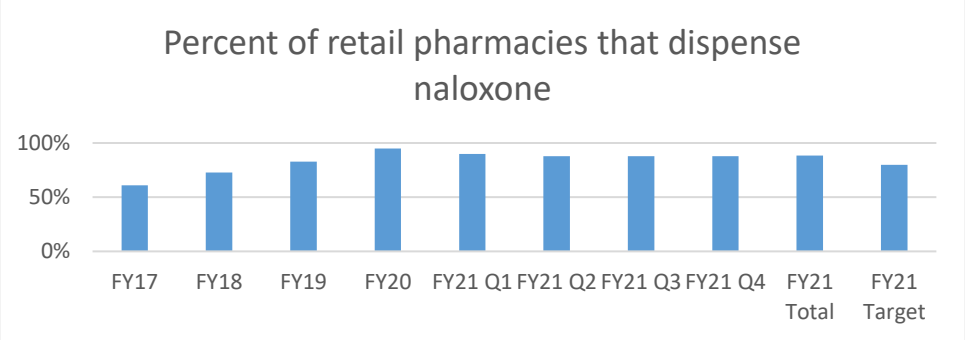
IMPROVEMENT ACTION PLAN:
While this is an annual explanatory measure and no quarterly actions are required, the Epidemiology and Response Division is working with the Behavioral Health Services Division (BHSD) in the Human Services Department (HSD) on a plan to decrease methamphetamine-involved deaths. 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.

ERD PERFORMANCE MEASURE #9

Percent of retail pharmacies that dispense naloxone

Results

FY17	FY18	FY19	FY20	FY21 Q1	FY21 Q2	FY21 Q3	FY21 Q4	FY21 Total	FY21 Target
61%	72.9%	82.9%	94.8%	89.9%	87.8%	87.8%	87.8%	88.3%	≥85%



MEASURE DESCRIPTION:
Numerator: Number of retail pharmacies with a Medicaid claim for naloxone.
Denominator: Total number of retail pharmacies in New Mexico. The reporting for this measure lags a quarter to increase accuracy of the data. Pharmacies have 90 days to submit Medicaid claims, so the data are not complete at the end of a quarter.

DATA SOURCE/METHODOLOGY:
NM Human Services Department Medicaid Claims Data; NM Board of Pharmacy.

STORY BEHIND THE DATA:
The purpose of this measure is to ensure that all New Mexicans continue to have access to naloxone, the opioid overdose reversal drug, at their local pharmacy. In FY19 and FY20, 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. In June 2019, Senate Bill 221 went into effect. This bill requires that naloxone be co-prescribed with opioid prescriptions that have a duration of 5 days or more and to educate on the risk of opioid overdose and naloxone use. There was a large increase in Medicaid claims for naloxone in FY20 Q1 due to the new law (Section 24-2D-6 NMSA 1978). In general, almost all pharmacies stock naloxone, can order it, know how to bill for it, and are aware of recent laws about mandatory co-prescriptions and the use of the statewide standing order. However, there are reasons that not 100% of pharmacies dispense naloxone in a given year. For example, one of the pharmacies on the list had closed completely, a couple don't accept Medicaid, and some have it in stock but rarely ever need to dispense it.

IMPROVEMENT ACTION PLAN:

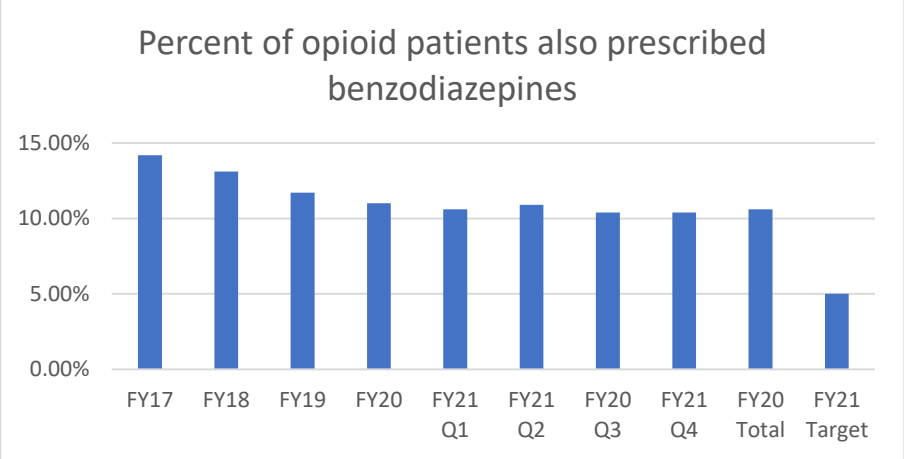
Major Quarterly Action Steps:	Goal Completion Date				
	Q1	Q2	Q3	Q4	Target
1) Obtain valid standing order and provide to New Mexico Pharmacist Association.	X	n/a	n/a	n/a	
2) Monitor Medicaid Claims data to ensure retail pharmacies continue to fill naloxone prescriptions and the measure stays above target.	X	X	X	X	
3) Generate list of retail pharmacies not distributing naloxone based on Medicaid Claims data twice annually.	n/a	X	n/a	X	
4) Educate retail pharmacists about naloxone dispensing guidelines by the DOH Overdose Prevention Pharmacist.	n/a	n/a	X	X	

ERD PERFORMANCE MEASURE #10

Percent of opioid patients also prescribed benzodiazepines

Results

FY17	FY18	FY19	FY20	FY21 Q1	FY21 Q2	FY21 Q3	FY21 Q4	FY21 Total	FY21 Target
14.2%	13.1%	11.7%	11.0%	10.6%	10.9%	10.4%	10.4%	10.6%	≤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:
New Mexico Board of Pharmacy Prescription Monitoring Program (PMP) data. Data are processed quarterly, approximately 6 weeks after the end of the quarter to ensure complete data. We continue to work with the PMP vendor to decrease this timeline, however the timeline is also impacted by the Board of Pharmacy (BOP) rules and the requirement for the complete data necessary for the reporting process. Full-year data presented are the average of the relevant quarters. One impact of the Covid-19 pandemic has been the reduction to the number of opioid patients thought to be related to the surgeries that were not performed. The denominator has fallen more than the numerator for FY20 Q2.

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 benzodiazepine 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 and the guide was distributed by the NM provider licensing boards to their licensees. The Council includes voting representatives from several state agencies and stakeholder groups.

IMPROVEMENT ACTION PLAN:

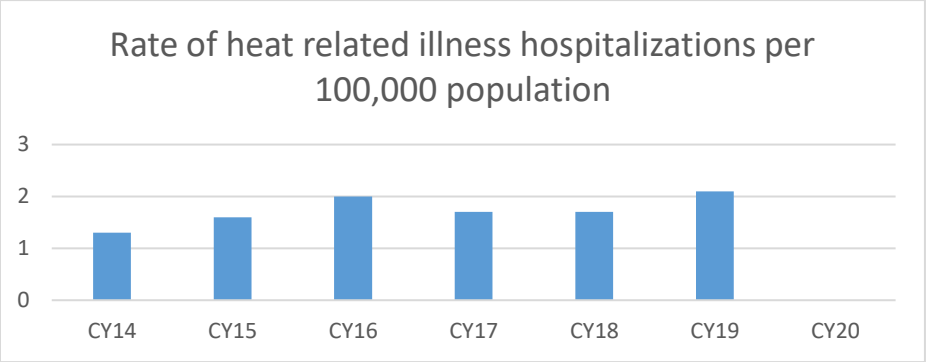
Major Quarterly Action Steps:	Goal Completion Date				
	Q1	Q2	Q3	Q4	Target
1) Provide quarterly reports to BOP including co-prescription rates for provider feedback reports and distribution to professional licensing boards.	X	X	X	X	

ERD PERFORMANCE MEASURE #11

Rate of heat related illness hospitalizations per 100,000 population

Results

CY14	CY15	CY16	CY17	CY18	CY19	CY20	FY21 Target
1.3	1.6	2	1.7	1.7	2.1	Fall 2021	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.
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 Data (HIDD), made available by the Health Systems Epidemiology Program, Epidemiology and Response Division, New Mexico Department of Health.

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. Environmental conditions such as air temperature are a key issue for this measure. Older adults and children are at increased risk for heat-related disease and death with increasing temperatures. Data for CY 2019 are expected in November 2020.

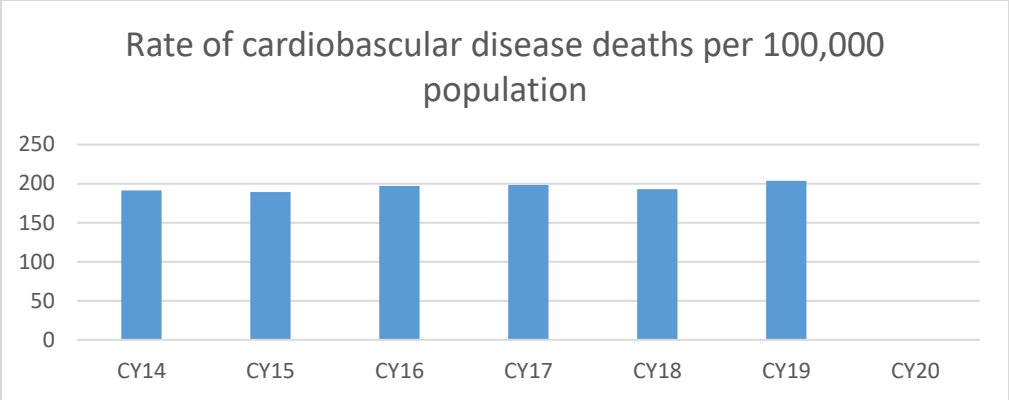
IMPROVEMENT ACTION PLAN:
The measure tracks hospitalization trends over time for heat-related illness as an emerging health effect of climate change. While this is an annual year explanatory measure and no quarterly results action is required, the Epidemiology and Response Division's Environmental Health Epidemiology Bureau submitted a grant application for implementing 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. A Climate and Health Adaptation Work Group (CHAWG) has been formed with partners from various groups to work on the plan for New Mexico and provide updates to the Climate Change Taskforce convened by the Governor. The CHAWG continues to work on identifying strategies for action to mitigate the effects of high temperatures on residents of New Mexico in partnership with other bureaus in ERD and external partners including the National Weather Service, University of New Mexico and New Mexico State University.

ERD PERFORMANCE MEASURE #12

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

Results

CY14	CY15	CY16	CY17	CY18	CY19	CY20	FY20 Target
191.4	189.3	197.2	198.1	193	203.7	Fall 2021	Explanatory



MEASURE DESCRIPTION:
Numerator: Annual number of NM residents whose recorded primary cause of death was one of the ICD-10 cardiovascular disease codes within the range of 100-199.
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 2019, 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 which continued thru 2018 and 2019. Also, there was an increase from 2018-2019 in the percent of patients in NM who received IV thrombolytic therapy within 60 min (2018=70%, 2019=77%), within 45 min (2018=41%, 2019=55%), and within 30 min (2018=17%, 2019=27%). Decreasing the treatment window for stroke patients has been linked with lower rates of disability and mortality following stroke.

IMPROVEMENT ACTION PLAN:
While this is an annual calendar year explanatory measure and no quarterly actions are required, the Epidemiology and Response Division has done the following:

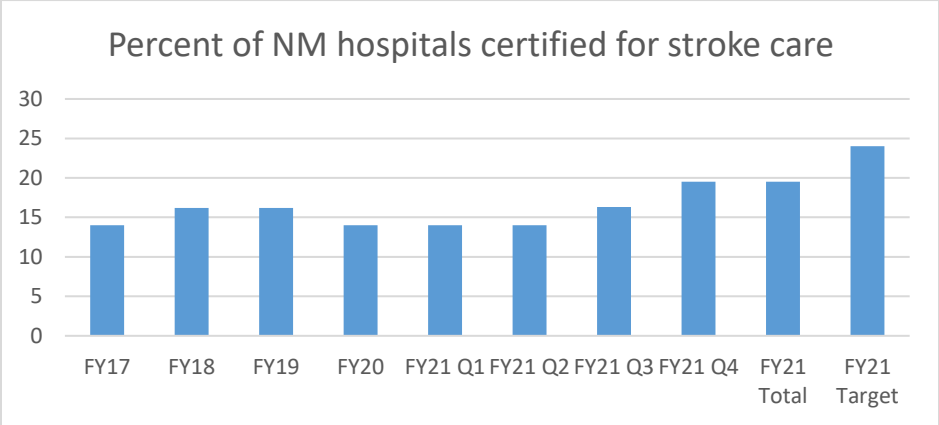
- Work with Presbyterian Healthcare Services on implementing a self-measured blood pressure protocol for patients in its Central Delivery System.
- Receive referred patients from Presbyterian Healthcare Services in its Central Delivery System to the YMCA's self-measured-blood pressure program (self-measured blood pressure with clinical support).
- Work with Lovelace Medical Group to identify undiagnosed patients with high blood pressure.
- Provide CEUs to community health workers at no cost, with a focus on chronic diseases including high blood pressure and high blood cholesterol.
- Review the new recommendations made by American Stroke Association for all categories found in the establishment of stroke systems of care for implementation.

ERD PERFORMANCE MEASURE #13

Percent of NM hospitals certified for stroke care

Results

FY17	FY18	FY19	FY20	FY21 Q1	FY21 Q2	FY21 Q3	FY21 Q4	FY21 Total	FY21 Target
14%	16.20%	16.20%	14%	14%	14%	16.3%	19.5%	19.5%	≥24%



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 (TJC) list of certified stroke care centers, as well as the list of certified stroke care centers from accreditation agency Det Norske Veritas' (DNV-GL).

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. Eight out of 43 acute care hospitals in NM are certified for stroke care. Currently, one facility is now certified as a Comprehensive Stroke Center (the first and only in NM), six are designated as Primary Stroke Centers, and one is designated as Acute Stroke Ready. Thus, a total of 18.6% of hospitals in New Mexico are designated to provide stroke specific care to patients. While we are making progress toward our goal, we are not quite there yet. In the second half of FY20 (February 2019), the Lea Regional Hospital in Hobbs, NM surrendered their Primary Stroke Center certification. Lea Regional administration decided to take this step in an effort to focus their resources towards other operations. However, in FY21, Eastern New Mexico Medical Center in Roswell, NM and Memorial Medical Center in Las Cruces, NM received their Primary Stroke Center certifications, increasing the percentage of hospitals certified for stroke care in NM to 18.6%. We anticipate Christus St. Vincent's Hospital will receive their Primary Stroke Center certification within FY22, increasing the percentage of stroke certified hospitals to 20.9%. Ultimately, there is a significant time commitment, with the process of stroke certification taking up to 2 years to complete. Despite these challenges, more hospitals are interested in investigating the process and achieving stroke care certification, and we will continue to work to facilitate these efforts.

IMPROVEMENT ACTION PLAN:

Major Quarterly Action Steps:	Goal Completion Date				
	Q1	Q2	Q3	Q4	Target

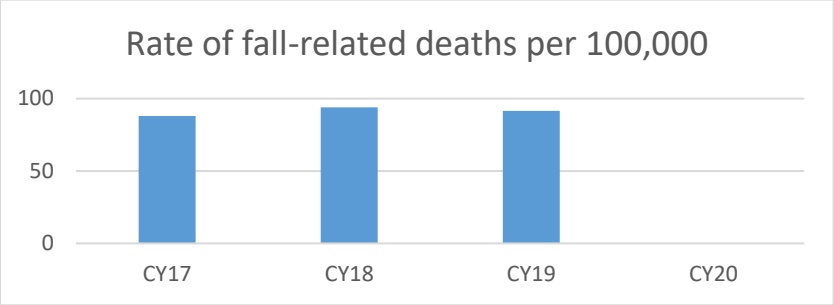
1) Work with certified hospitals to maintain or elevate their accreditation and certification level. – Ongoing throughout the year	X	X	X	X	
2) Encourage hospitals to submit stroke data and begin the path of becoming certified as a stroke care center. – Ongoing throughout the year	X	X	X	X	
3) Send award letters to stroke care hospitals to help with stroke data registry cost.	X	-	-	-	
4) Analyze hospital stroke data sets with recently acquired data registry access and identify opportunities for system improvement. – Ongoing throughout the year	X	X	X	X	

ERD PERFORMANCE MEASURE #14

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

Results

CY17	CY18	CY19	CY20	FY21 Target
87.9	93.9	91.6	Fall 2021	Explanatory



MEASURE DESCRIPTION:
Numerator: Number of unintentional fall-related deaths for New Mexico residents aged 65 years and older
Denominator: Population estimate of the number of New Mexico residents aged 65 and older
Criteria for Eligibility/Inclusion: Fall-related deaths are defined by underlying cause of death based on the death certificate using International Classification of Diseases, versions 10 (ICD-10) codes. Any death with the underlying ICD-10 codes of W00-W19 is considered an unintentional fall-related death.

DATA SOURCE/METHODOLOGY:
Bureau of Vital Records and Health Statistics, Death Certificate Database (Numerator).
New Mexico's Indicator-Based Information System (NM-IBIS). University of New Mexico Geospatial and Population Studies Program. New Mexico Population Estimates (Denominator).

STORY BEHIND THE DATA:
According to the latest data from CDC's Wonder, unintentional falls deaths in 2019 were ranked as the 1st leading cause of injury deaths among individuals aged 65 years or older in New Mexico. In 2019, there were 345 unintentional deaths for falls among individuals aged 65 years or older in New Mexico. Males a had higher death rate for unintentional falls (94 deaths per 100,000, n=473 deaths) than females (89 deaths per 100,00, n=531 deaths) in New Mexico between 2017 and 2019. During that same period, the rate of death for unintentional falls was highest among non-Hispanic Whites (98 deaths per 100,000, n=636 deaths) than among Hispanics (86 deaths per 100,000, n=313) or non-Hispanic American Indian/Alaskan Natives (70 deaths per 100,000, n=43). And the rate of unintentional falls deaths were highest among individuals aged 85 years or older (433 deaths per 100,000, n=533 deaths) compared to individuals aged 80-84 years (144 deaths per 100,000, n=185); 75-79 years (76 deaths per 100,000, n=147 deaths); 70-74 years (30 deaths per 100,000, n=89 deaths); or 65-69 years (14 deaths per 100,000, n=50 deaths).

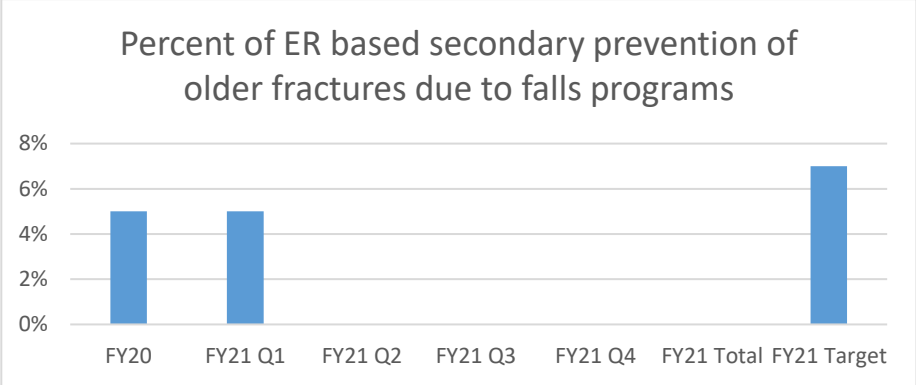
IMPROVEMENT ACTION PLAN:
This is an annual calendar year explanatory measure so quarterly results are not required. The NMDOH Adult Falls Prevention Program efforts are aimed at conducting primary prevention of adult falls and their efforts include:
- Expanding the network of instructors available statewide to implement evidence-based falls prevention interventions. Instructor trainings will be conducted online to train new prevention leaders to teach courses online.
- Increasing the number of professionals trained on the use of the Stopping Elderly Accidents, Deaths, and Injuries STEADI Falls Prevention Toolkit to assess for fall-risk.
- Providing education on falls prevention, encourage older adults to exercise, and refer older adults to evidence-based interventions.

ERD PERFORMANCE MEASURE #15

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

Results

FY20	FY21 Q1	FY21 Q2	FY21 Q3	FY21 Q4	FY21 Total	FY21 Target
5%	5%	0%	0%	0%	0%	7%



MEASURE DESCRIPTION:
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
Criteria for eligibility: New Mexico hospitals with emergency departments | Exclusions: Hospitals without emergency departments

DATA SOURCE/METHODOLOGY:
The Falls Prevention Program provides data for the numerator. NMDOH Syndromic Surveillance and hospital reports provide data for the denominator.

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 adults 65 and older because 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 program includes ensuring a quick referral to follow-up care and encourages patient to participate in an evidence-based falls prevention intervention. While the coordinator position for this measure has been vacant since September of 2020, the underlying difficulty in meeting expected results is that through the evaluation of the program it has been determined the emergency department is not the appropriate time or place for the fall prevention program to be effective. In this setting, there is no time to conduct education and thus, progress cannot be made. The program understands the importance of fall prevention program activity and is continually working to develop more effective strategies related to evidence-based research, while considering factors relevant to New Mexico.

IMPROVEMENT ACTION PLAN:

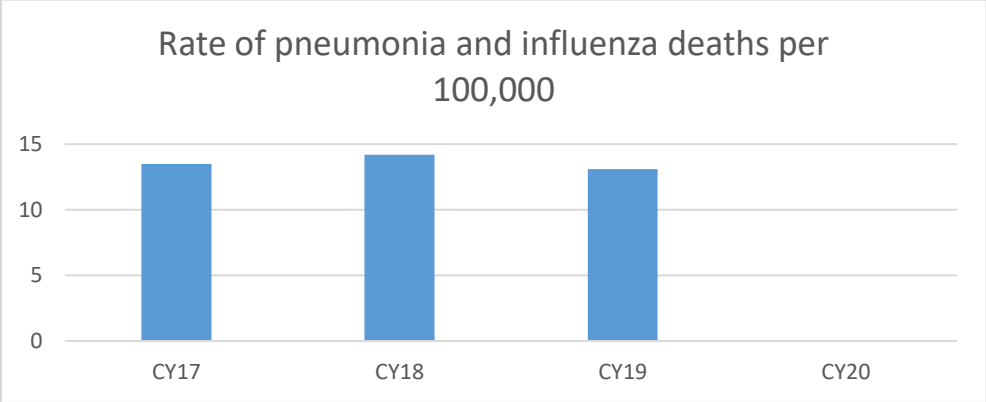
Major Quarterly Action Steps:	Goal Completion Date				
	Q1	Q2	Q3	Q4	Target
1) Manage and continuously evaluate existing hospital-based programs.	X	-	-	-	
2) Determine program effectiveness through continuous evaluation and recommend program changes as determined necessary.	X	-	-	-	

ERD PERFORMANCE MEASURE #16

Rate of pneumonia and influenza death per 100,000 population

Results

CY17	CY18	CY19	CY20	FY21 Target
13.5	14.2	13.1	Fall 2021	Explanatory



MEASURE DESCRIPTION:
Numerator: Number of cases with pneumonia or influenza as a cause of death.
Denominator: Population estimates provided by the University of New Mexico, Geospatial and Population Studies (GPS) program.
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). This rate is age-adjusted to the standard 2000 U.S. 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 Population Studies (GPS) Program, ttp://gps.unm.edu/.

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, thereby recognizing the importance of influenza antiviral medications in preventing influenza-related deaths and increasing their use among hospitalized influenza patients during outbreaks in healthcare facilities. NMDOH promotes and assures the use and availability of influenza and pneumococcal vaccines.

IMPROVEMENT ACTION PLAN:
While this is an annual calendar year explanatory measure and no quarterly actions are required, the Epidemiology and Response Division will:

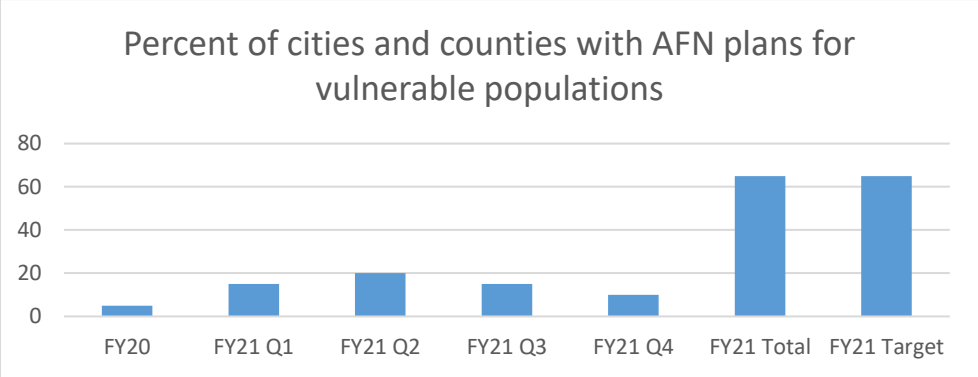
- Measure the percent of children by age group who receive the pneumococcal vaccine, the percent of adults ≥65 years of age who receive pneumococcal vaccine, the percent of the population ≥6 months of age who receive influenza vaccine, the rate of P&I death and hospitalization, and the use of anti-viral medications among hospitalized cases attributed to influenza.
- Conduct viral isolation of specimens to detect changes in circulating viral strains and to compare what is circulating with vaccine strains.
- Convene a Quarterly Health Status Indicator meeting to interact with and engage stakeholders involved in P&I-related activities. Anticipated date of availability: Dependent on finalized data from BVRHS which is expected in November 2020.

ERD PERFORMANCE MEASURE #17

Percent of cities and counties with Access and Functional Needs (AFN) plans that help prepare vulnerable populations for a public health emergency

Results

FY20	FY21 Q1	FY21 Q2	FY21 Q3	FY21 Q4	FY21 Total	FY21 Target
5%	15%	20%	15%	10%	65%	65%



MEASURE DESCRIPTION:
Numerator: Number of New Mexico Counties reporting Access and Functional Needs (AFN). plans (either stand-alone, Functional Annexes or integrated in EOP) in current Emergency Operations Plans (EOP) Operational Planning Cycle.
Denominator: Number of New Mexico Counties (33)

DATA SOURCE/METHODOLOGY:
Monitored and measured query response from each county's Emergency Management Office or designated individual responsible for the county's emergency management planning. Not all counties adopt and include Access and Functional Needs Plans.

STORY BEHIND THE DATA:
Jurisdictional Access and Functional Needs (AFN) plans assist in identifying the actions, responsibilities, and roles in creating synchronized emergency operations assistance and coordination from the Department of Health (DOH) for New Mexicans and visiting individuals to New Mexico with Access and Functional Needs (AFN). In order to increase the number of counties that utilize AFN planning, DOH provides templates and access to workshops about AFN.

IMPROVEMENT ACTION PLAN:

Major Quarterly Action Steps:	Goal Completion Date				
	Q1	Q2	Q3	Q4	Target
1) Distribute AFN Annex/EOP planning templates to county Emergency Management Offices.	X	n/a	n/a	n/a	
2) Conduct virtual AFN inclusion planning workshops.	n/a	X	n/a	n/a	
3) Conduct virtual AFN accessible communications workshops.	n/a	n/a	X	n/a	
4) Distribute AFN accessible communications outline to county Emergency Management Offices – for inclusion in AFN Plans within EOP's.	n/a	n/a	X	n/a	

ERD PERFORMANCE MEASURE #18

Percent of persons hospitalized for influenza who were treated with antivirals within 2 days of onset of illness

Results

FY19	FY20	FY21	FY21 Target
Data not collected	Fall 2021	Fall 2022	Explanatory

Graph will be added once more data is received.

MEASURE DESCRIPTION:
Numerator: The numerator is the number of case-patients treated with antivirals (AVs) at any time during hospitalization (AV treatment rate), and within 2 days of illness onset (<2 days).
Denominator: The denominator is the total number of laboratory-confirmed influenza cases hospitalized in 7 New Mexico counties: Bernalillo, Chavez, Dona Ana, Grant, Luna, Santa Fe, and San Juan.

DATA SOURCE/METHODOLOGY:
The data source for this measure is the Emerging Infections Program's (EIP) Influenza Surveillance Network (FluSurv-NET), which conducts active population-based surveillance for hospitalized laboratory confirmed influenza in both adults and children. FluSurv-NET data from New Mexico is stored on a state-specific EIP database. Data is pulled using SQL and analyzed using SAS or R.

STORY BEHIND THE DATA:
This PM measures AV treatment rate in hospitalized cases and captures the timing of antiviral treatment administration in relation to illness onset. The Program's strategies are aimed towards reducing the death rate from pneumonia and influenza. The main interventions capable of reducing this number are the seasonal influenza vaccine, and treatment with AVs. Therefore, measuring the percent of hospitalized cases treated with antivirals in a timely manner is an indicator of how often this intervention is being used correctly to prevent complications of influenza, and therefore, reduce the number of influenza-related deaths, in theory. The data used by this measure is routinely and systematically collected by the EIP surveillance officers through medical chart review. The performance measure reproduced each season. However, it cannot be measured quarterly due to the ongoing collection of data throughout the flu season and year. Seasonal datasets are finalized by the first day of the following influenza season, October 1st. However, due to resource constraints during the COVID-19 pandemic, this data was not collected for the 2019-2020 influenza season.

Due to the pandemic, during 2020-2021 the percent of persons hospitalized for influenza who were also treated with antivirals within 2 days of onset reported is probably inaccurate for several reasons. First, fewer people were hospitalized for influenza than we have ever seen previously. Second, some of the cases reported may not have been appropriate to report. For example, one had no respiratory symptoms at all, and the start of these symptoms determine the onset of illness. Therefore, a calculation could not be made. Third, in some cases, an onset date was not listed, so there is no way to determine if antivirals were received within 2 days of onset. Finally, because influenza was not widely circulating, rapid antigen tests were less reliable. It is likely that up to half of these cases were actually false positives.

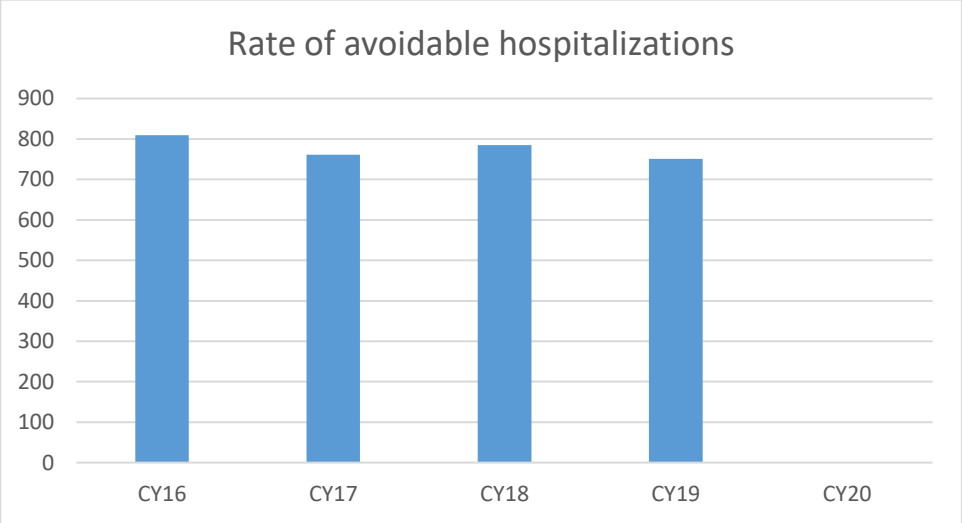
IMPROVEMENT ACTION PLAN:
No improvement plan needed with explanatory measure.

ERD PERFORMANCE MEASURE #19

Rate of avoidable hospitalizations per 100,000 population

Results

CY16	CY17	CY18	CY19	CY20	FY21 Target
809.3	760.9	785.0	750.9	Fall 2021	Explanatory



MEASURE DESCRIPTION:
Numerator: Ambulatory Care Sensitive Condition (ACSC) related hospitalizations.
Denominator: New Mexico Population Estimate, CY2018. The Population Estimate for CY2019 has not been released at the time of preparing this report.
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/). *The data is collected and prepared in the Fall for the previous Calendar Year. For example, CY2020 data will be available in Fall 2021.*

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 hospitalizations are avoidable with proper control and management of various conditions, adequate access to primary care, and with preventative public health measures.

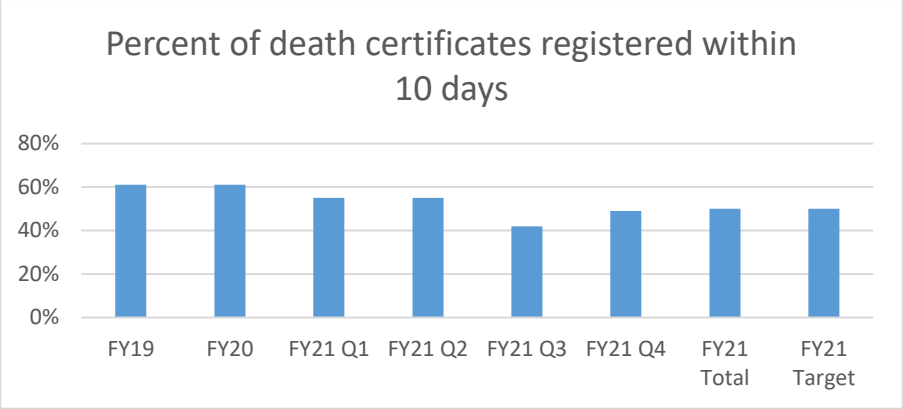
IMPROVEMENT ACTION PLAN:
The Epidemiology and Response Division's Health Systems Epidemiology Program currently analyzes avoidable hospitalization data annually upon collection of the annual hospital inpatient discharge dataset and disseminates these data via various methods, e.g., epidemiology reports, 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.

ERD PERFORMANCE MEASURE #20

Percent of death certificates completed by Bureau of Vital Records and Health Statistics within 10 days of death

Results

FY19	FY20	FY21 Q1	FY21 Q2	FY21 Q3	FY21 Q4	FY21 Total	FY21 Target
61%	61%	55%	55%	42%	49%	50%	50%



MEASURE DESCRIPTION:
Numerator: Number of death certificates registered within 10 days of death.
Denominator: Total number of death certificates registered in the time period.

DATA SOURCE/METHODOLOGY:
The electronic death registration system, the Data Application for Vital Events (DAVE), used by the Bureau of Vital Records and Health Statistics reporting database is queried for all death certificates registered in the time period for deaths that occurred in New Mexico (denominator), and the number of days that have elapsed since the date of death. The number of days is categorized as 0-10 days (numerator) and 11 or more days.

STORY BEHIND THE DATA:
Timeliness of death reporting and registration is important to citizens who are managing the legal affairs of a deceased individual, for example with life insurance claims, closing bank accounts and credit cards. At the population level, timely death reporting is important for providing provisional statistical data for disease prevention and control, for example monitoring drug overdose deaths, suicide deaths, and infectious disease deaths, including COVID-19.

IMPROVEMENT ACTION PLAN:

Major Quarterly Action Steps:	Goal Completion Date				
	Q1	Q2	Q3	Q4	Target
1) Work with Office of Medical Investigator (OMI) to design CMEv3 interoperability software.	X	X	X	X	
2) Work with OMI to implement CMEv3 software.	n/a	n/a	n/a	n/a	
3) Implement an automated reminder system for certifiers and funeral homes.	-	-	-		

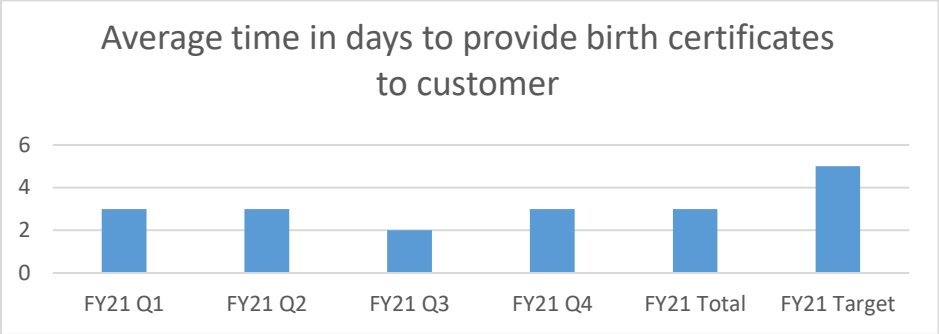
The Bureau of Vital Records and Health Statistics will work with the Office of the Medical Investigator to implement data interoperability between their database and the electronic death registration system (DAVE) so that information on deaths is transferred in real-time. This will remove the barriers and errors associated with re-entering the data into DAVE. The Bureau will work with their electronic death registration system vendor to implement an automated reminder system for death certifiers and funeral homes with pending death certificates.

ERD PERFORMANCE MEASURE #21

Average time to provide birth certificate to customer

Results

FY20	FY21 Q1	FY21 Q2	FY21 Q3	FY21 Q4	FY21 Total	FY21 Target
N/A	3 days	3 days	2 days	3 days	3 days	5 days



MEASURE DESCRIPTION:
Numerator: The amount of time it takes to provide a birth certificate to customers once the Vital Records office receives the Birth Search application and copy of payment from Wells Fargo.
Denominator: Total number of customers who need to do an amendment to a birth certificate.
Exclusions: Customers that are not entitled to a birth certificate.

DATA SOURCE/METHODOLOGY:
Wells Fargo Emailed Data Log received on a weekly basis.

STORY BEHIND THE DATA:
Vital records are important legal documents and are key to many essential activities, so having satisfied customers who use the Bureau of Vital Records and Health Statistics services reflects positively on the state. Due to statute requirements Vital Records is responsible for all money coming into the office and it must be deposited within 24 hours.

IMPROVEMENT ACTION PLAN:

Major Quarterly Action Steps:	Goal Completion Date				
	Q1	Q2	Q3	Q4	Target
1) Monitor mail receive dates every week.	X	X	X	X	
2) Monitor employee batch work folder every week.	X	X	X	X	

PROGRAM P004: Scientific Laboratory Division (SLD)

Program Description and Purpose:

The Scientific Laboratory Division (SLD) provides a wide variety of laboratory services to programs operated by numerous partner agencies across the state of New Mexico. The activities of SLD in support of State agencies are mandated in statute and are essential for the successful mission of the programs it supports.

SLD services include:

- Veterinary, food and dairy testing for the Department of Agriculture
- Certification inspections of milk and water testing laboratories for the Environment Department
- Chemical testing for environmental monitoring and the enforcement of environmental laws and regulations for the Environment Department
- Clinical testing for infectious diseases that are of public health significance (e.g. Zika, Ebola, West Nile virus, avian influenza, Chikungunya, Dengue, etc.) for the Department of Health and the Centers for Disease Control & Prevention
- Biosecurity outreach and training to clinical laboratories and first responders across the state
- Identification of agents of bioterrorism in cooperation with the Federal Bureau of Investigation and state law enforcement agencies
- 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
- Expert witness testimony for forensic toxicology testing in state courts
- Training and certification of law enforcement officers to perform breath alcohol testing within the state

Program Budget (in thousands):

FY20	General Fund	Other State Funds	Federal Funds	Other Transfers	TOTAL	FTE
200	$5,379,000	$1,272,500	$1,543,000	$119,100	$8,313,600	134
300	$170,600	$33,500	$61,200	$34,500	$299,800	
400	$2,193,800	$593,900	$1,551,300	$628,100	$4,967,100	
TOTAL	$7,743,400	$1,899,900	$3,155,500	$781,700	$13,580,500	

FY21	General Fund	Other State Funds	Federal Funds	Other Transfers	TOTAL	FTE
200	$5,542,100	$1,276,500	$3,072,600	$119,100	$10,010,300	136
300	$169,300	$30,000	$656,800	$34,500	$890,600	
400	$2,293,200	$497,500	$2,688,600	$582,900	$6,062,200	
TOTAL	$8,004,600	$1,804,000	$6,418,000	$736,500	$16,963,100	

Program Performance Measures:

1. Percent of blood alcohol tests from driving-while-intoxicated cases that are completed and reported to law enforcement within 30-calendar days (FY21 Key Measure)
2. Percent of environmental samples for chemical contamination that are completed and reported to the submitting agency within 60-business days
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

COVID-19 Related Activities:

SLD provides 24/7 COVID-19 diagnostic testing services for the state of New Mexico. To support this significant increase in workload, SLD has reassigned personnel from Biological Sciences Bureau sections, and has hired numerous additional staff to support testing. Temporary workers continue to provide support for data entry, specimen handling, testing, and supply tracking. The Biological Sciences Bureau has received and is validating instrumentation for COVID-19 detection in wastewater specimens.

IMPROVEMENT ACTION PLAN Key:

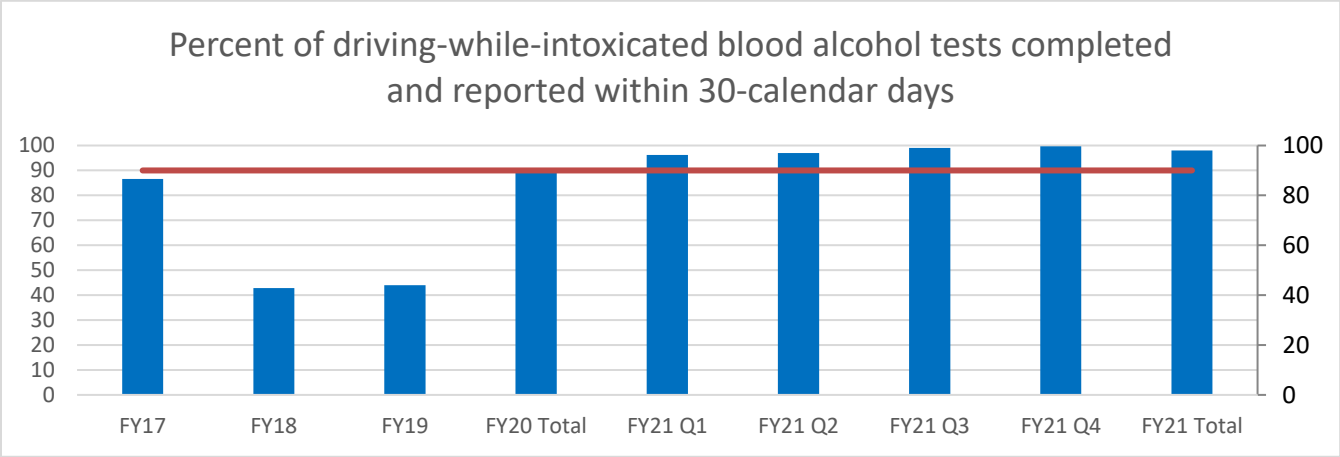
Major Quarterly Action Steps:	Goal Completion Date				
	Q1	Q2	Q3	Q4	Target
1) **X** denotes quarter(s) the action step was accomplished	X	X	X	X	
2) **-** denotes no action step was accomplished in that quarter	-	-	-	-	
3) **n/a** means the action step was not applicable during that quarter	n/a	n/a	n/a	n/a	
4) **P** denotes partial completed action	P	P	P	P	

SLD PERFORMANCE MEASURE #1

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

Results

FY17	FY18	FY19	FY20	FY21 Q1	FY21 Q2	FY21 Q3	FY21 Q4	FY21 Total	FY21 Target
87%	43%	44%	91%	96%	97%	99%	99%	98%	95%



MEASURE DESCRIPTION:
Denominator: Number of cases reported out during the quarter/year.
Numerator: Number of cases reported out within 30-calendar days of receipt.

DATA SOURCE/METHODOLOGY:
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 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. SLD staff 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). The Bureau exceeded its target for this quarter with 99% of cases completed and reported within 30 days. The Toxicology Bureau has validated a new drug screening method during the fourth quarter.

IMPROVEMENT ACTION PLAN:

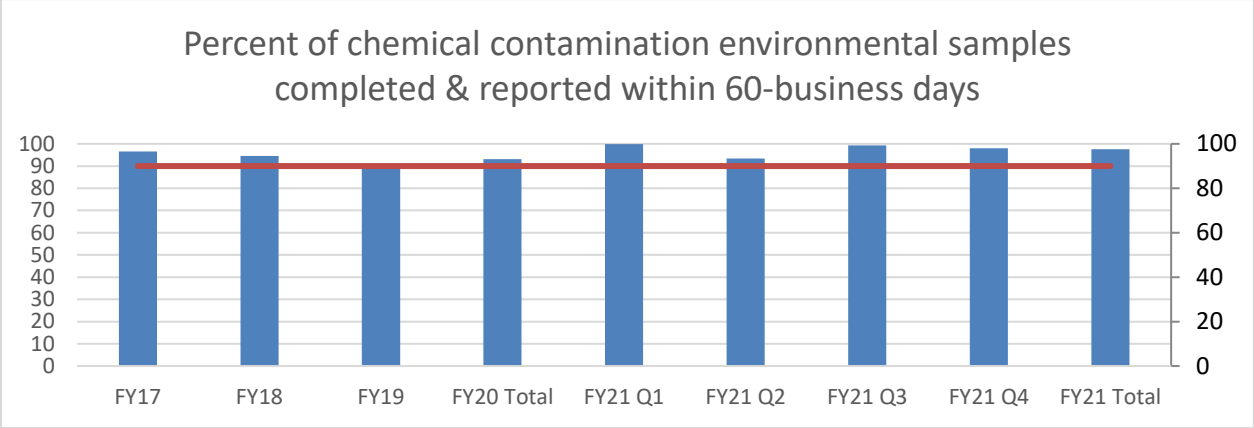
Major Quarterly Action Steps:	Goal Completion Date				
	Q1	Q2	Q3	Q4	Target
1) Hire and train 3 staff in the drug screening section.	-	P	P	X	**95%**
2) Cross-train 4 current staff in blood alcohol test methods.	-	P	P	X	**95%**
3) Run at least 1 EIA and 1 blood alcohol method per week.	P	X	-	P	**95%**
4) Complete technical & administrative case reviews within 30 days.	P	P	P	X	**95%**

SLD PERFORMANCE MEASURE #2

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

Results

FY17	FY18	FY19	FY20	FY21 Q1	FY21 Q2	FY21 Q3	FY21 Q4	FY21 Total	FY21 Target
97%	95%	91%	91%	99.9%	93.4%	99.3%	98%	97.6%	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:

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:

The Scientific Laboratory Division 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. Turnaround times are based on the needs of the New Mexico Environment Department (NMED). Bureau staff are no longer required to log samples into the LIMS, which allows for more testing time. Three analyst positions were filled during the quarter and hiring to fill additional vacant analyst positions continues. For FY21 Q4, the bureau reported 98% results within the established turnaround time, exceeding its target for this quarter. New instrumentation was received in Q4 to replace antiquated equipment and support new testing methods for NMED, State Public Water Supply System, and Medical Cannabis programs.

IMPROVEMENT ACTION PLAN:

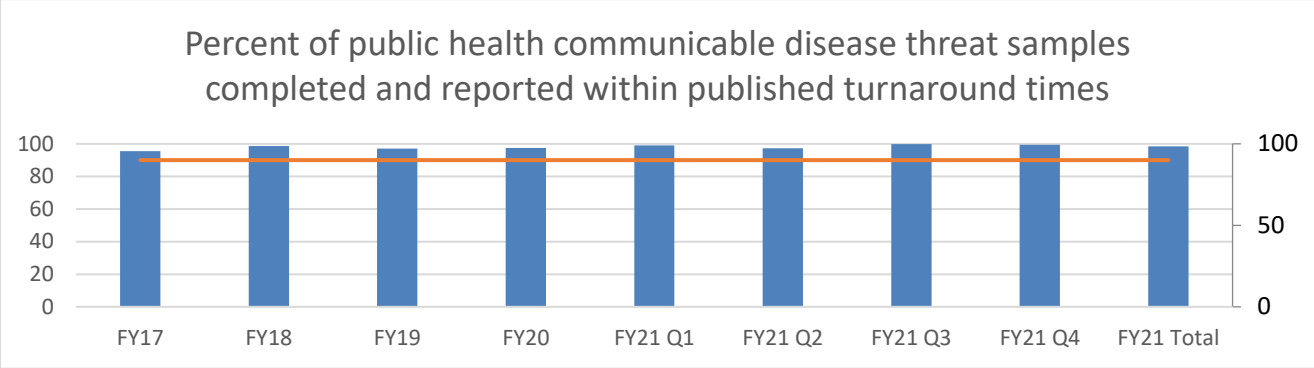
Major Quarterly Action Steps:	Goal Completion Date				
	Q1	Q2	Q3	Q4	Target
1) Complete Environmental Protection Agency audit.	P	X	-		**90%**
2) Hire staff to fill current bureau vacancies.		P	P	P	**90%**
3) Continue to cross-train staff for coverage of analytical methods.		P	P	P	**90%**

SLD PERFORMANCE MEASURE #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

Results

FY17	FY18	FY19	FY20	FY21 Q1	FY21 Q2	FY21 Q3	FY21 Q4	FY21 Total	FY21 Target
95%	99%	97%	97%	99%	97%	99.8%	99.5%	98.5%	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 turnaround times for tests listed in SLD's DIRECTORY OF SERVICES.

DATA SOURCE/METHODOLOGY:
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:
The Biological Sciences Bureau of the Scientific Laboratory Division (SLD) tests for commonly occurring 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 Administration, Veterinary Diagnostic Services, city and county agencies, epidemiologists, hospitals, and patient testing laboratories to detect and confirm bacterial and viral causes for infectious disease. The training of new analysts has allowed the bureau to maintain routine testing during the pandemic. The Bureau completed validation of SARS-CoV-2 antibody testing and Biofire Respiratory Panel, which includes SARS-CoV-2, exceeding the 90% target by reaching 99.5% for FY21 Q4. The Biological Sciences Bureau will be validating six new laboratory methods expanding and strengthening detection and surveillance capacity for infectious diseases. Cross training of staff will continue as the COVID-19 pandemic continues and infectious diseases re-emerge.

IMPROVEMENT ACTION PLAN:

Major Quarterly Action Steps:	Goal Completion Date				
	Q1	Q2	Q3	Q4	Target
1) Continue to fill positions to ensure routine testing is completed in a timely manner.		P	X		**90%**
2) Complete pilot study for the identification of contamination in seafood.		P	P	n/a	**90%**
3) Receive accreditation as an ELITE laboratory for Legionella testing.		X			**90%**
4) Validate COVID-19 testing on the BioFire instrument platform.		-	X		**90%**

PROGRAM P006: Facilities Management Division (FMD)

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):

FY20	General Fund	Other State Funds	Federal Funds	Other Transfers	TOTAL	FTE
200	$46,093,300	$54,175,400	$7,588,500	$738,600	$108,595,800	2,003
300	5,221,300	$6,652,900	$308,800	$734,500	$12,917,500	
400	$10,854,100	$11,991,400	$1,184,800	$2,981,300	$27,011,600	
TOTAL	$62,168,700	$72,819,700	$9,082,100	$4,454,400	$148,524,900	

*$4,050,000 is for the Fort Bayard Medical Center building lease

FY21	General Fund	Other State Funds	Federal Funds	Other Transfers	TOTAL	FTE
200	$48,103,000	$54,699,500	$7,763,800	$738,600	$111,304,900	2,003
300	$3,096,600	$8,285,700	$808,800	$618,700	$12,809,800	
400	*$10,187,200	$12,852,000	$1,474,800	$2,648,500	$27,162,500	
TOTAL	$61,386,800	$75,837,200	$10,047,400	$4,005,800	$151,277,200	

Program Performance Measures:

1. Percent of eligible third-party revenue collected at all agency facilities (FY21 Key & HB2 Measure)
2. Percent of beds occupied
3. Number of overtime hours worked
4. Number of direct care contracted hours
5. Percent of dementia only residents on antipsychotics
6. Number of significant medication errors per 100 patients (FY21 Key & HB2 Measure)
7. Percent of long-term care residents experiencing one or more falls with major injury (FY21 Key & HB2 Measure)
8. Percent of long-term Veterans Home residents experiencing facility acquired pressure injuries
9. Customer overall satisfaction (State Veterans Home)
10. Percent of adolescent residents (SATC & NMBHI Care Unit) who successfully complete program
11. Percent of priority Request for Treatment clients who are provided an admission appointment to Turquoise Lodge's program within 2 days
12. Rate of medical detox occupancy at Turquoise Lodge Hospital
13. Number of naltrexone initiations on alcohol use disorders
14. Number of naltrexone initiations on opioid use disorders
15. Number of buprenorphine inductions conducted or conducted after referrals on opioid use disorders
16. Number of Narcan kits distributed or prescribed

COVID-19 Related Activities:

The Facilities have prioritized a unified COVID-19 response since March 2020 by closing to the public and posting signage on all entry doors, at all DOH facilities, warning individuals visiting not to come if they have flu like symptoms, an above average temperature, or are not feeling well. The signs were created in both Spanish and English.

All Facilities implemented COVID-19 actions based on guidance from national health entities, including the Center for Disease Control (CDC), Centers for Medicare and Medicaid Services (CMS) and Veterans Administration (VA), in addition to the State of New Mexico's recommendations and/or mandates.

If a visitor is to enter, additional screening questions are asked (from CMS guidelines), including:
1. Have you traveled to a state that has COVID-19 cases?
2. Do you reside with someone who has tested positive for COVID-9?

Employee/vendor screening is conducted daily, on all shifts. Individuals with above average temperatures or potentially flu like symptoms are sent home until symptoms are resolved. And, if a determination is made that the staff member needs help, the DOH hotline number for testing and assistance is provided.

Travel into New Mexico requires a mandatory 14-day self-quarantine. Direct care staff is required to wear face masks and gloves, while non-direct care staff must wear face masks. Resident screening/testing for new residents upon admission to a facility is implemented with a quarantine until the test results are obtained.

Internal employee operations require social distancing practices, for example:
- Groups are limited to five or less.
- Individuals are asked to allow six feet of space separation.
- Resident activities are revised to accommodate restrictions, such as mall group activities and an increase of one-on-one activities.

IMPROVEMENT ACTION PLAN Key:

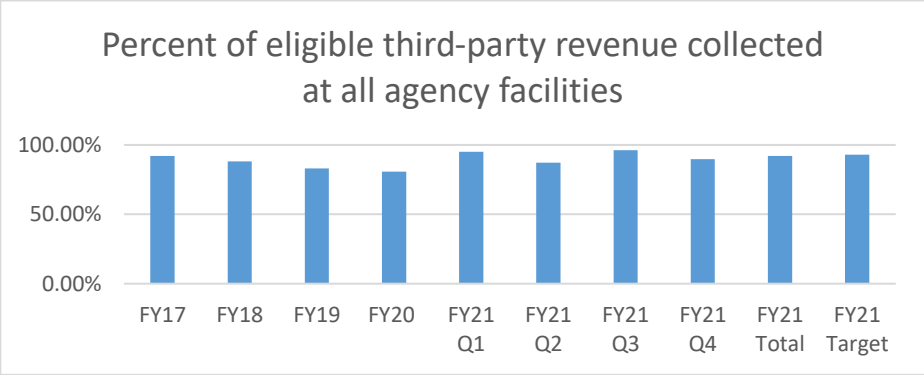
Major Quarterly Action Steps:	**Goal Completion Date**				
	Q1	**Q2**	**Q3**	**Q4**	**Target**
1) **X** denotes quarter(s) the action step was accomplished	X	X	X	X	
2) **-** denotes no action step was accomplished in that quarter	-	-	-	-	
3) **n/a** means the action step was not applicable during that quarter	n/a	n/a	n/a	n/a	
4) **P** denotes partial completed action	P	P	P	P	

FMD PERFORMANCE MEASURE #1

Percent of eligible third-party revenue collected at all agency facilities

Results

FY17	FY18	FY19	FY20	FY21 Q1	FY21 Q2	FY21 Q3	FY21 Q4	FY21 Total	FY21 Target
92.0%	88.1%	83.0%	80.8%	95.1%	87.2%	96.2%	89.7%	92.1%	≥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.

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:
Revenue collection 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 DOH is directly affected. Work to improve collection rates is continuous as addressed in the action plan below.

IMPROVEMENT ACTION PLAN:

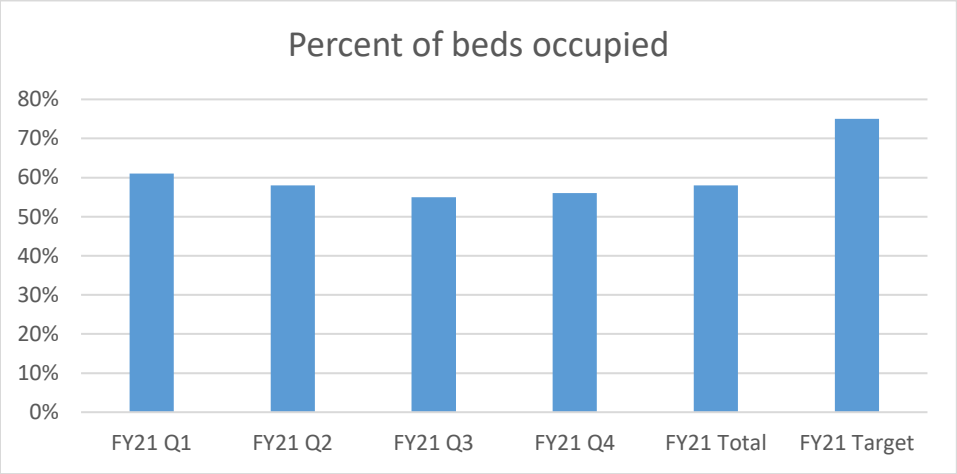
Major Quarterly Action Steps:	Goal Completion Date				
	Q1	Q2	Q3	Q4	Target
1) Fill vacant billing and collection positions which have a high turnover.	X	P	P	P	
2) Provide training to new and existing staff.	X	P	P	-	
3) Monitor claims submission errors and research and/or seek Information Technology staff's assistance with billing clearinghouse setup and transmission issues.	X	X	X	X	
4) Ensure prior authorization processes are in place.	X	X	X	X	
5) Monitor denied claims, research denials, and take appropriate action to resolve and resubmit claims.	X	X	X	X	
6) Communicate regularly with third party representatives to resolve unpaid claims.	X	X	X	X	
7) Review Managed Care Organization contracts to ensure services are eligible and billable under contracts; process amendments as necessary.	X	X	X	X	
8) Share best practices across Facilities and with DOH's Public Health Division medical billing/collection unit.	X	X	X	X	

FMD PERFORMANCE MEASURE #2

Percent of beds occupied

Results

FY21 Q1	FY21 Q2	FY21 Q3	FY21 Q4	FY21 Total	FY21 Target
61%	58%	55%	56%	58%	≥75%



MEASURE DESCRIPTION:
Numerator: Average daily census
Denominator: Number of licensed beds

DATA SOURCE/METHODOLOGY:
The average daily census information is obtained from the Electronic Healthcare Records Systems used by each Facility and the LLCP. The number of licensed beds is the number of beds formally recognized by the specific regulatory agency or body in which qualifications are met to operate.

STORY BEHIND THE DATA:
The percent of licensed beds helps determine and maximize revenue. Licensed beds would be the maximum number of beds a facility can operate. Most do not operate at this maximum level due to staffing shortages and/or building construction/improvements/maintenance as required to meet regulatory compliance. Most recently and as demonstrated in the FY21 Q1, Q2, and Q3, COVID-19 has significantly impacted the bed availability in Facilities. For months, the NMRC was marked and repurposed as a state COVID overflow Facility, and usual operations were shut down. In addition, the Facilities have reduced available beds for safety of patients and staff and for general population admissions, some facilities are limited to available space being secured wings which offer specific and different level of care.

IMPROVEMENT ACTION PLAN:

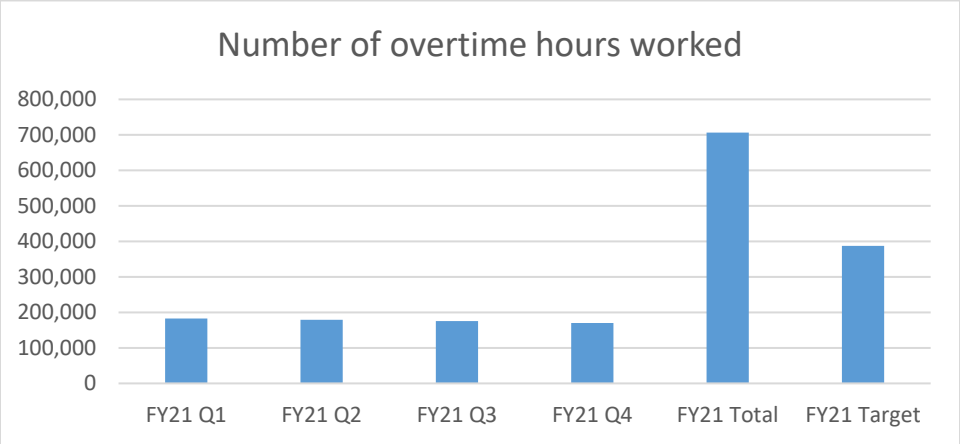
Major Quarterly Action Steps:	Goal Completion Date				
	Q1	Q2	Q3	Q4	Target
1) Assess licensed and available beds, on a continual basis.	X	X	X	X	

FMD PERFORMANCE MEASURE #3

Number of overtime hours worked

Results

FY21 Q1	FY21 Q2	FY21 Q3	FY21 Q4	FY21 Total	FY21 Target
182,686	178,853	175,350	169,825	706,714	387,000



MEASURE DESCRIPTION:
Numerator: N/A
Denominator: N/A

DATA SOURCE/METHODOLOGY:
The total number of overtime hours worked is obtained from Kronos, the electronic timekeeping system.

STORY BEHIND THE DATA:
Too much overtime in care facilities is linked to issues including medical errors, inconsistent levels of care, reduction in the quality of care, declining patient satisfaction, staff fatigue and burnout, low staff moral and rising turnover. The DOH already faces challenges with increasing costs of providing healthcare, state funded appropriation reductions/limitations, state hiring freeze, an increased need of safety net services for citizens, and healthcare workforce shortages. One of DOH's goals is to monitor and reduce overtime in the FMD where it has significant impacts to budget and services. Due to Covid-19, overtime levels vary between facilities. Some have experienced a reduction in overtime because of reduced service levels, however in others an increase is seen due to staffing shortages during staff required quarantines, etc.

IMPROVEMENT ACTION PLAN:

Major Quarterly Action Steps:	Goal Completion Date				
	Q1	Q2	Q3	Q4	Target
1) Explore, implement, and manage ways to reduce overtime.	X	X	X	P	
2) Establish and implement controls to prevent employees form working excessive overtime.	X	X	X	-	
3) Set specific dollar or percentage overtime reduction goals for the facilities and monitor performance in achieving these goals.	X	-	-	-	
4) Actively recruit to fill vacant positions and regularly conduct "rapid hire" events.	X	X	P	P	

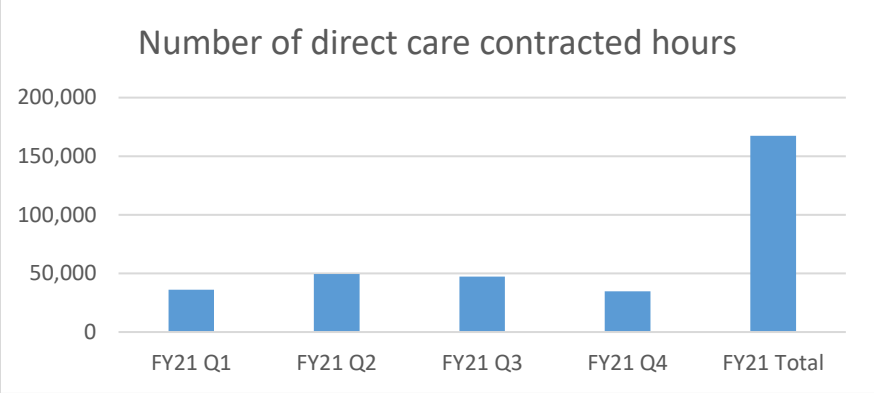
FMD PERFORMANCE MEASURE #4

Number of direct care contracted hours

Results

FY21 Q1	FY21 Q2	FY21 Q3	FY21 Q4	FY21 Total	FY21 Target
*36,015	*49,598	*47,236	*34,630	*167,479	Baseline

*Reported information is not all-inclusive of direct care contract hours, as data gathering requires a manual process and a significant amount of administrative time. Facilities are working to improve the reporting of results.



MEASURE DESCRIPTION:
Measures the number of direct care contracted hours worked.

DATA SOURCE/METHODOLOGY:
The total number of direct care contracted hours is obtained from Kronos, the electronic timekeeping system.

STORY BEHIND THE DATA:
According to federal (the Centers for Medicare and Medicaid Services) and state (New Mexico's Administrative Code) mandates, healthcare facilities are required to employ the appropriate ratio of clinical direct care staff needed to provide the optimal level of care. For example, in a Long-Term Care environment, per those guidelines, there should be one nursing staff available 24/7 for about every 6 patients. Depending on the acuity of the healthcare system, the ratio of clinicians to patient increases, but the average ratio is 1:4 to 1:6, fluctuating based on the levels of mental state, illness, suicide risk, etc. Plus, with rehab and dietary patient services, facilities may also be required to employ physical, speech and occupational therapists, dieticians, and pharmacists. Thus, with resignations or hard to fill positions, health care facilities often contract out those vacancies to meet the staff ratio requirements mandated for patient safety and quality of care.

IMPROVEMENT ACTION PLAN:

Major Quarterly Action Steps:	Goal Completion Date				
	Q1	Q2	Q3	Q4	Target
1) Assess current contract staffing hours and ways to reduce number of contract staff.	X	X	X	X	

FMD PERFORMANCE MEASURE #5

Percent of dementia only residents on antipsychotics

Results

FY21 Q1	FY21 Q2	FY21 Q3	FY21 Q4	FY21 Total	FY21 Target
*N/A	*N/A	*N/A	*N/A	*N/A	16%

*This is a new performance measure for the FMD and with that has come data gathering challenges. Work is in process to establish a system to extract the necessary data, with sources being a combination of manual and electronic pharmacy and healthcare records.

New Measure: Information is forthcoming. Graph will be added once quarterly data is documented.

MEASURE DESCRIPTION:

This measures the percent of dementia only residents on antipsychotic medications.
Numerator: Number of dementia only residents on antipsychotics.
Denominator: Number of dementia only residents.

DATA SOURCE/METHODOLOGY:

The percent of dementia only residents on antipsychotics will be obtained through manual and electronic pharmacy and healthcare records such as psychiatric progress notes, Minimum Data Sets (MDS-entails comprehensive standardized assessments of each resident's functional capabilities and health needs) and pharmacy records.

STORY BEHIND THE DATA:

DOH, in line with the Centers for Medicare and Medicaid Services (CMS) and physician recommendations, is committed to reducing the antipsychotic medication use for its nursing home long-stay dementia-based population. The goal is to ensure that resident behaviors are not controlled with chemical restraints and instead new ways or practices are found and implemented that enhance the quality of life, maintain a quality of care, and provide a person-centered care for every dementia resident. One alternative, for example, is following a model of care plan where treatment is more resident centered where one would live more in "their space".

IMPROVEMENT ACTION PLAN:

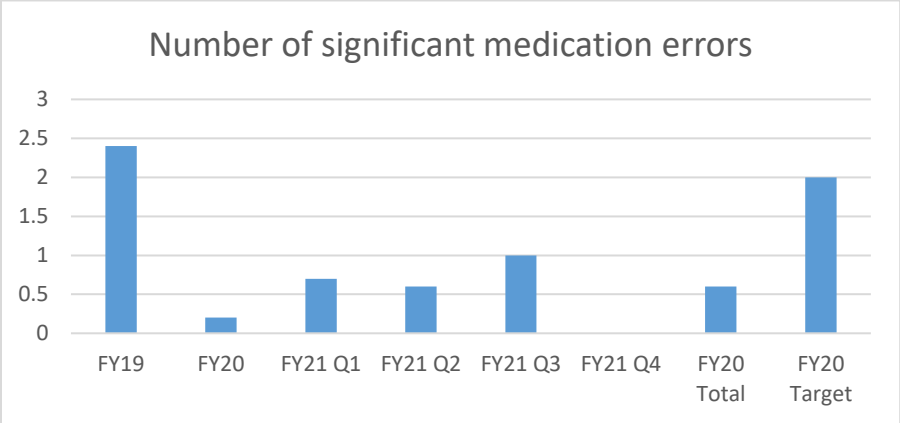
Major Quarterly Action Steps:	Goal Completion Date				
	Q1	Q2	Q3	Q4	Target
1) Discuss, evaluate, and explore the current practices/models of care related to dementia residents used across the 3 DOH nursing facilities.	X	X	X	X	
2) Review monthly pharmacy reports in the Quality Assurance Process Improvement Committee or Behavior Management Committee with a focus/goal of reducing antipsychotic medication use.	X	X	X	X	
3) Evaluate whether antipsychotic gradual dose reductions have been implemented.	X	X	X	X	

FMD PERFORMANCE MEASURE #6

Number of significant medication errors

Results

FY19	FY20	FY21 Q1	FY21 Q2	FY21 Q3	FY21 Q4	FY21 Total	FY21 Target
2.4	.2	.7	.6	1.0	0.0	.6	≤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 medication errors.
Denominator: Total number of client days divided by days in the months 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", as defined by the National Coordinating Council for Medication Error Reporting and Prevention (NCC MERP) Index.

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, each of which serve a distinct population, monitor and report the rate of significant Category D or higher medications errors, according to the NCC MERP Index for Categorizing Medication Errors. This index addresses interdisciplinary error causes and promotes safe medications use. 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:

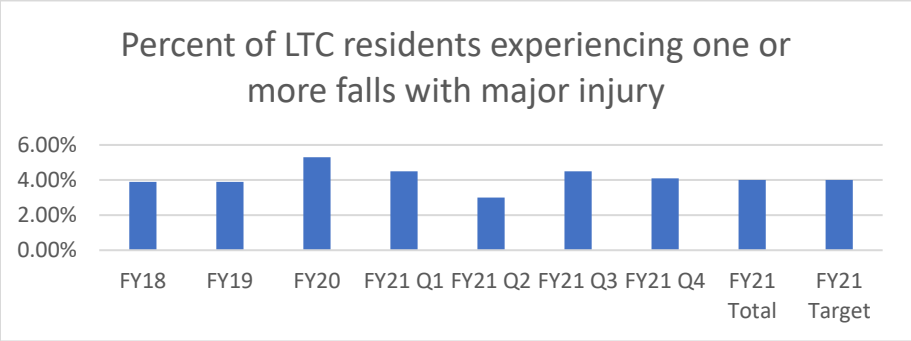
Major Quarterly Action Steps:	Goal Completion Date				
	Q1	Q2	Q3	Q4	Target
1) Foster a continuous culture of patient safety and quality improvement framework.	X	X	X	X	
2) Monitor actual and potential medication errors that occur/may occur, including near misses, then investigate root causes.	X	X	X	X	
3) Establish goals, adopt best practices, and provide training to improve the medication system.	X	X	X	X	

FMD PERFORMANCE MEASURE #7

Percent of long-term care residents experiencing one or more falls with major injury

Results

FY18	FY19	FY20	FY21 Q1	FY21 Q2	FY21 Q3	FY21 Q4	FY21 Total	FY21 Target
3.9%	3.9%	5.3%	4.5%	3.0%	4.5%	4.1%	4.0%	≤4%



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 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.

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. DOH's long term care facilities continue to build a falls prevention infrastructure. Every new long-term care resident is assessed for fall risk. This assessment is then included in each individual resident's care plan. Falls committees review CASPER reports and care plans as well as post fall therapy review for more aggressive approaches. Smartsheets are being used to standardize across long term care populations, combined with continuous staff education and reinforcement. Plus, the addition of occupational therapy at NMSVH and NMBHI is being instituted for enhanced interventions.

IMPROVEMENT ACTION PLAN:

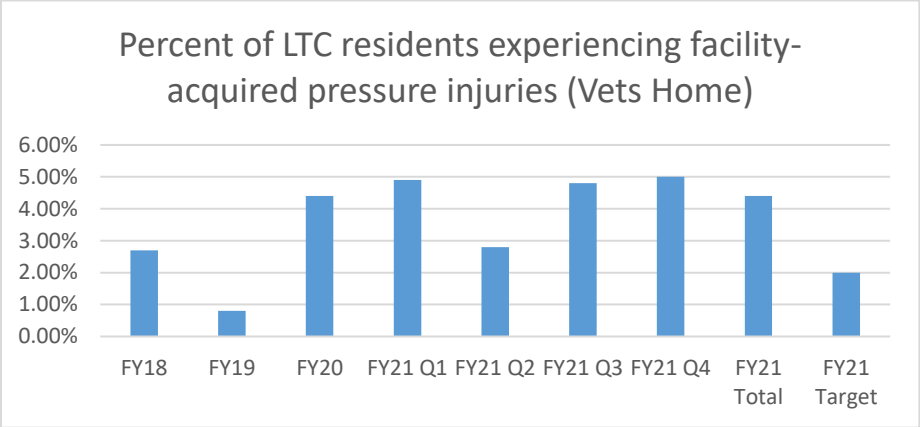
Major Quarterly Action Steps:	Goal Completion Date				
	Q1	Q2	Q3	Q4	Target
1) Educate employees, residents, and family members.	X	X	X	X	
2) Provide services that focus on strengthening and improving balance and mobility.	X	X	X	X	
3) Develop individualized resident treatment plans following a fall.	X	X	X	X	
4) Track and report on causes of falls through Active Falls Prevention Committees.	X	X	X	X	

FMD PERFORMANCE MEASURE #8

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

Results

FY18	FY19	FY20	FY21 Q1	FY21 Q2	FY21 Q3	FY21 Q4	FY21 Total	FY21 Target
2.70%	0.80%	4.4%	4.9%	2.8%	4.8%	5.0%	4.4%	<2%



MEASURE DESCRIPTION:
Percent of Veterans Home LTC residents experiencing a stage 2 - unstageable facility acquired pressure injury.
Numerator: Total number of Veterans Home LTC residents with stage 2 – unstageable facility acquired pressure injuries for the quarter.
Denominator: Average total number of LTC residents served for the quarter.

DATA SOURCE/METHODOLOGY:
Pressure injury data is obtained utilizing the facility Monthly Pressure Injury Report for the number of residents with facility acquired pressure injuries and the facility DOH FY 2021 Monthly Performance Report Smartsheet for total residents served. The data is rolled up for quarterly reporting.

STORY BEHIND THE DATA:
Historical data for FY 2018 and FY 2019 annual rate is based on an average of the calculated monthly pressure injury rates. The 12 months were added together, then divided by 12. FY20 and FY21 pressure injury calculations are based on a quarterly rate, as described above. A performance action team (PAT) was developed to improve NMVH pressure injury rates. With ongoing oversight by the Quality Assurance Performance Improvement (QAPI) Committee, the team continues to implement actions to lower the facility acquired pressure injury rate. FY21 Q3 shows an increase in facility acquired pressure injuries. March 22, 2021, a root cause analysis (RCA) was initiated. Actions were developed and implemented to address individual resident needs and prevent reoccurrence of similar types of pressure injuries.

IMPROVEMENT ACTION PLAN:

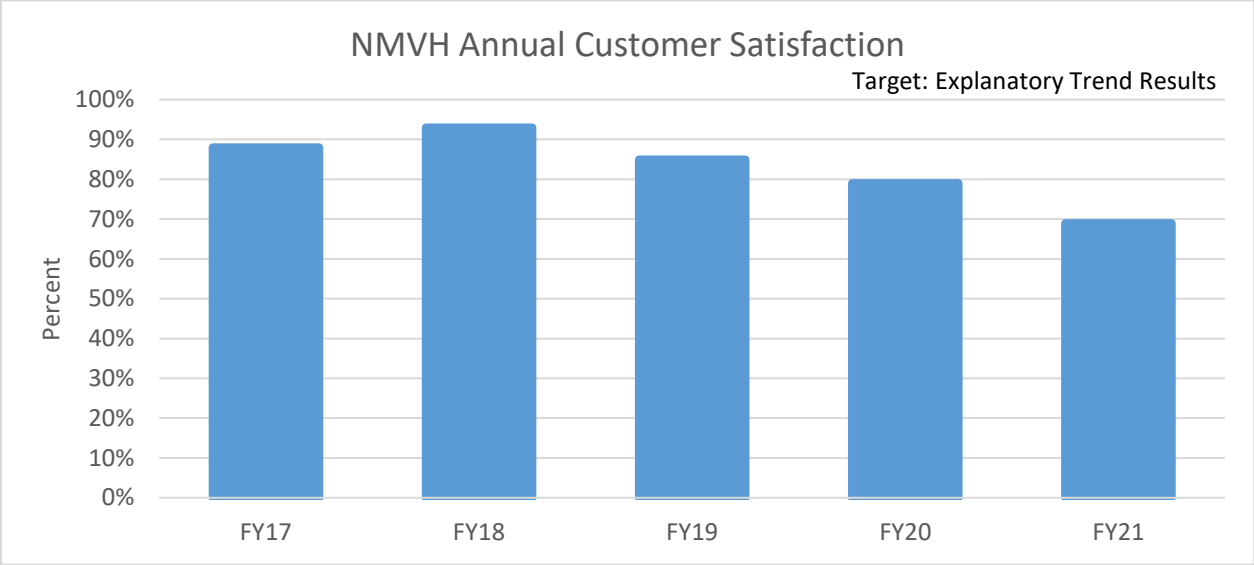
Major Quarterly Action Steps:	Goal Completion Date				
	Q1	Q2	Q3	Q4	Target
1) Provide oversight and monthly reporting by the Quality Assurance Performance Improvement (QAPI) Committee.	X	X	X	X	
2) Meet to work on pressure injury prevention measures (PAT).	X	n/a	X	X	
3) Monitor and implement offloading.	X	X	X	X	
4) Provide continued oversight and monitoring of repositioning.	99%	100%	100%	100%	95%

FMD PERFORMANCE MEASURE #9

Customer Overall Satisfaction (Veterans Home)

Results

FY17	FY18	FY19	FY20	FY21 Total	FY21 Target
88%	93%	85%	79%	69%	Explanatory



MEASURE DESCRIPTION:
Annual surveys are available to the New Mexico Veterans' Home (NMVH) residents and resident families/Power of Attorney (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:
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 FY21 with results consisting of 530 positive responses out of 768 responses received.

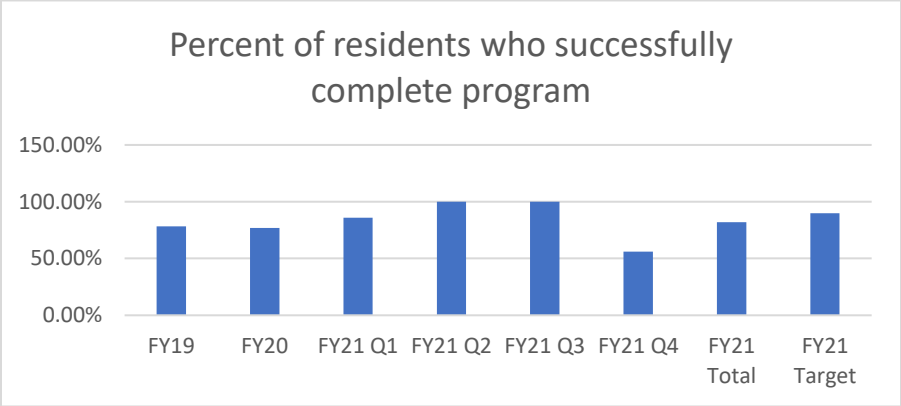
IMPROVEMENT ACTION PLAN:
FY20 satisfaction results demonstrated a decrease in resident satisfaction results at 77% and an increase in family/POA satisfaction results at 88%. Comment sections on the survey results exhibit some dissatisfaction related to COVID-19 state and federal implemented guidelines. While this is an annual explanatory measure and no quarterly actions are required, a Performance Action Team (PAT) worked on actions for improvement of customer satisfaction.

FMD PERFORMANCE MEASURE #10

Percent of adolescent residents who successfully complete program

Results

FY19	FY20	FY21 Q1	FY21 Q2	FY21 Q3	FY21 Q4	FY21 Total	FY21 Target
78.4%	77%	86%	100%	100%	56%	82%	≥90%



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:
NMDOH has youth Residential Treatment programs providing intensive services for adolescents with serious emotional and behavioral problems and this performance measure demonstrates programs meeting their goal for successful program discharges. A successful discharge is a resident discharged to a lower level or recommended level of care at the time of admission. In Q4, 4 out of 10 discharges were unsuccessful due to:

- Arrest-Violation of conditions of probation
- Higher level of care – Acute
- Parental decisions to discharge before completing treatment

IMPROVEMENT ACTION PLAN:

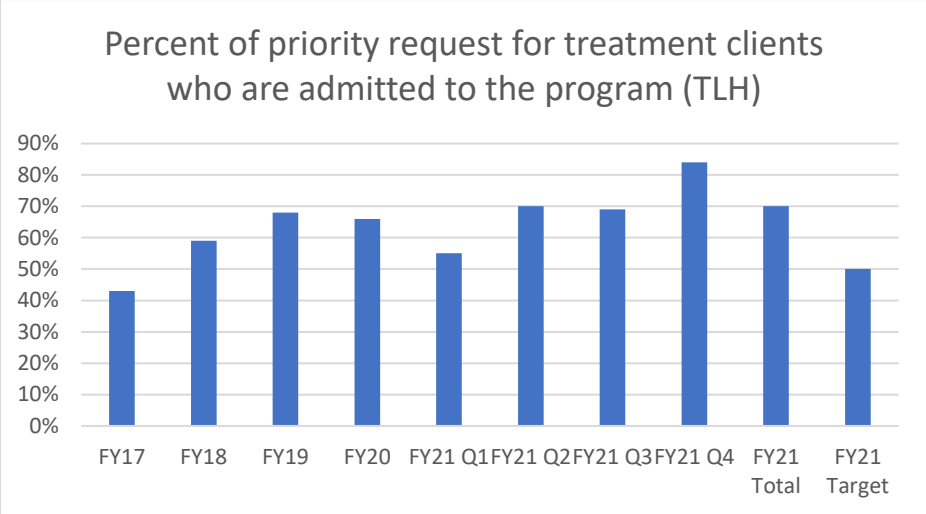
Major Quarterly Action Steps:	Goal Completion Date				
	Q1	Q2	Q3	Q4	Target
1) Provide individualized treatment and services, meeting the needs of each resident.	X	X	X	X	
2) Tailor program recruitment criteria to ensure availability of appropriate treatment services.	X	X	X	X	
3) Review and develop ongoing program strategies.	X	X	X	X	

FMD PERFORMANCE MEASURE #11

Percent of priority Request for Treatment clients who are provided an admission appointment to Turquoise Lodge's program within 2 days

Results

FY17	FY18	FY19	FY20	FY21 Q1	FY21 Q2	FY21 Q3	FY21 Q4	FY21 Total	FY21 Target
43%	59%	68%	66%	55%	70%	69%	84%	70%	50%



MEASURE DESCRIPTION:
Numerator: Number of admitted Priority Patients per month.
Denominator: Total number of Approved Priority Patients per month.
Priority population = includes pregnant injecting users, pregnant substance abusers, other injecting drug users, women with dependent children, parenting women, and women and men seeking to regain custody of their children.

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. TLH has been able to successfully triage and admit patients in their priority population well above the target goal.

IMPROVEMENT ACTION PLAN:

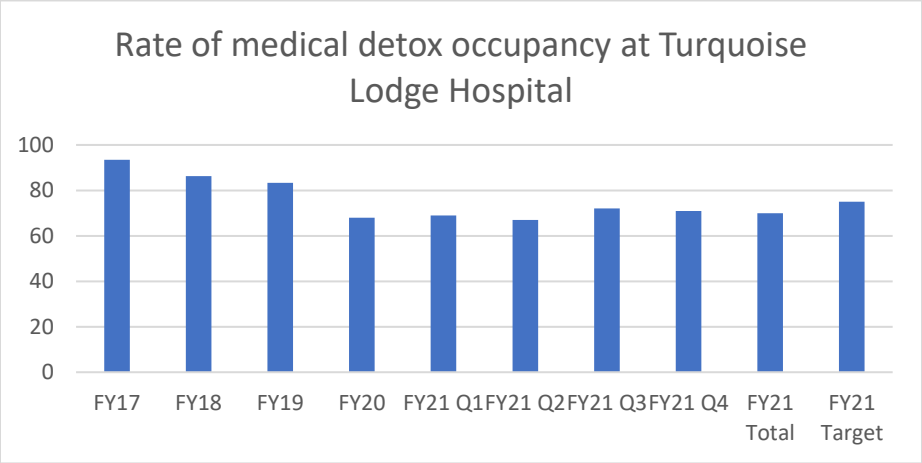
Major Quarterly Action Steps:	Goal Completion Date				
	Q1	Q2	Q3	Q4	Target
1) Utilize the Crystal Report to more quickly see intervention outcomes.	X	X	X	X	

FMD PERFORMANCE MEASURE #12

Rate of medical detox occupancy at Turquoise Lodge Hospital

Results

FY17	FY18	FY19	FY20	FY21 Q1	FY21 Q2	FY21 Q3	FY21 Q4	FY21 Total	FY21 Target
93.4%	86.3%	83.3%	67.9%	69%	67%	72%	71%	70%	≤75%



MEASURE DESCRIPTION:
Numerator: Average 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% and in New Mexico the average rate was 56%. During Q2, Q2, Q3 and Q4, COVID significantly impacted the capacity to admit patients into medical detox due to TLH having to reduce licensed bed capacity to ensure proper social distancing. Therefore, TLH was unsuccessful in meeting the 75% target goal.

IMPROVEMENT ACTION PLAN:

Major Quarterly Action Steps:	Goal Completion Date				
	Q1	Q2	Q3	Q4	Target
1) Schedule three to five admissions per day, five days per week.	50%	50%	50%	50%	
2) Monitor processes, occupancy rate, and implement changes, as necessary.	X	X	X	X	
3) Increase nursing resources to complete pre-admission assessments.	X	X	X	X	

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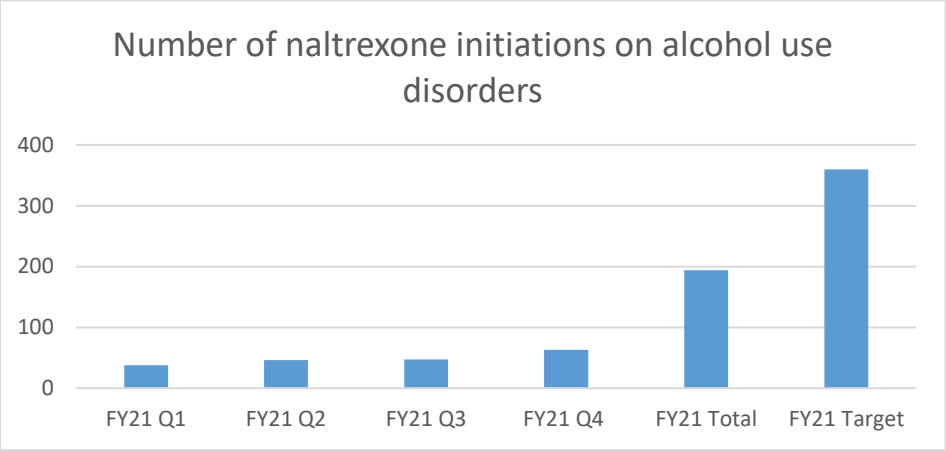
FMD PERFORMANCE MEASURE #13

Number of naltrexone initiations on alcohol use disorders

Results

FY21 Q1	FY21 Q2	FY21 Q3	FY21 Q4	FY21 Total	FY21 Target
38	46	47	63	194	360



MEASURE DESCRIPTION:
This measures the number of naltrexone initiations on alcohol use disorders.

DATA SOURCE/METHODOLOGY:
Pharmacy system (QS1 & Quick Mar).

STORY BEHIND THE DATA:
According to the Substance Abuse and Mental Health Services Association (SAMHSA), naltrexone can be provided either in an oral formulation OR as a monthly intramuscular injection as extended-release naltrexone. Either formulation is approved by the Food and Drug Administration (FDA) to treat both opioid and alcohol use disorder as a medication assisted treatment option. In addition, if naltrexone is contraindicated then acamprosate can be utilized as an alternative treatment for alcohol use disorder. These medications have shown to be beneficial in the reduction of alcohol cravings and relapse prevention. In August 2020, the Department of Health highlighted a recently published report by the federal Centers of Disease Control and Prevention that identifies New Mexico having the highest rate of alcohol-related deaths in the country and New Mexico's alcohol-related death rate of 52.3 per 100,000 population was almost twice the U.S rate for the years 2011 through 2015.

IMPROVEMENT ACTION PLAN:

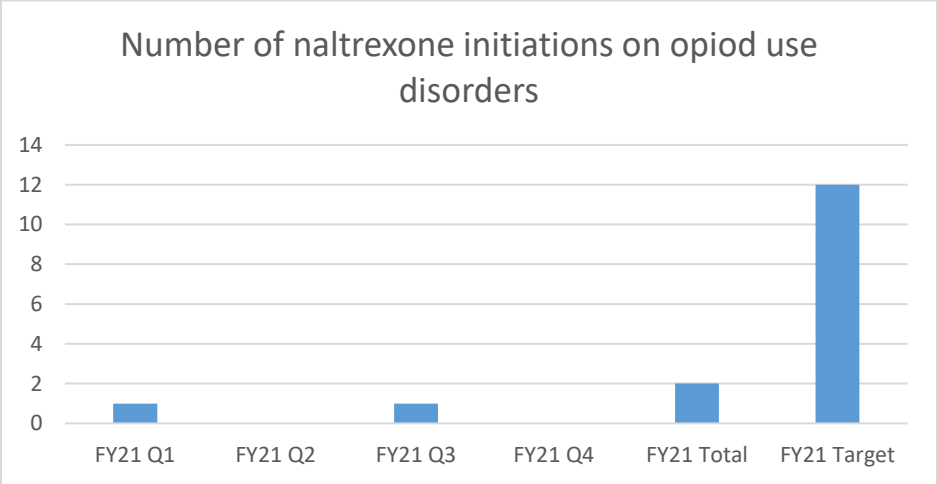
Major Quarterly Action Steps:	Goal Completion Date				
	Q1	Q2	Q3	Q4	Target
1) Ensure all medical providers have a current prescribing license for MAT and that each provider is credentialed appropriately.	X	X	X	X	
2) Have each medical provider to conduct an addiction medicine assessment review the patient's prescription monitoring program registry (PMP) and make best practice recommendations, e.g., type of MAT.	X	X	X	X	
3) Discuss with patient MAT recommendations.	X	X	X	X	

FMD PERFORMANCE MEASURE #14

Number of naltrexone initiations on opioid use disorders

Results

FY21 Q1	FY21 Q2	FY21 Q3	FY21 Q4	FY21 Total	FY21 Target
1	0	1	0	2	12



MEASURE DESCRIPTION:
This measures the number of naltrexone initiations on opioid use disorders.

DATA SOURCE/METHODOLOGY:
Pharmacy system (QS1 & Quick Mar).

STORY BEHIND THE DATA:
According to the Substance Abuse and Mental Health Services Association (SAMHSA), naltrexone can be provided either in an oral formulation OR as a monthly intramuscular injection as extended-release naltrexone. Either formulation is approved by the Food and Drug Administration (FDA) to treat both opioid and alcohol use disorder as a medication assisted treatment option. In addition, if naltrexone is contraindicated then acamprosate can be utilized as an alternative treatment for alcohol use disorder. These medications have shown to be beneficial in the reduction of alcohol cravings and relapse prevention. In August 2020, the Department of Health highlighted a recently published report by the federal Centers of Disease Control and Prevention that identifies New Mexico having the highest rate of alcohol-related deaths in the country and New Mexico's alcohol-related death rate of 52.3 per 100,000 population was almost twice the U.S rate for the years 2011 through 2015.

IMPROVEMENT ACTION PLAN:

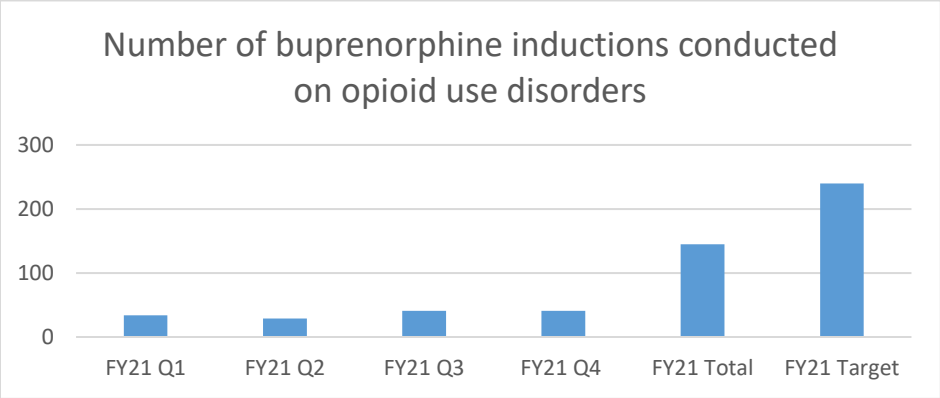
Major Quarterly Action Steps:	Goal Completion Date				
	Q1	Q2	Q3	Q4	Target
1) Ensure all medical providers have a current prescribing license for MAT and that each provider is credentialed appropriately.	X	X	X	X	
2) Have each medical provider to conduct an addiction medicine assessment review the patient's prescription monitoring program registry (PMP) and make best practice recommendations, e.g., type of MAT.	X	X	X	X	
3) Discuss with patient MAT recommendations.	X	X	X	X	

FMD PERFORMANCE MEASURE #15

Number of buprenorphine inductions conducted or conducted after referrals on opioid use disorders

Results

FY21 Q1	FY21 Q2	FY21 Q3	FY21 Q4	FY21 Total	FY21 Target
34	29	41	41	145	240



MEASURE DESCRIPTION:
This measures the number of buprenorphine inductions conducted or conducted after referrals on opioid use disorders.

DATA SOURCE/METHODOLOGY:
Pharmacy system (QS1 & Quick Mar).

STORY BEHIND THE DATA:
There are three evidence-based medication assisted treatments (MAT), approved by the (FDA) for the treatment of opioid use disorder. Naltrexone, buprenorphine and methadone are the approved medications and the utilization of one of these medications precludes the use of the other two medications. The choice of (MAT) for opioid use disorder is determined by the physician who assesses the patient's history, past treatments, patient preference, and post admission treatment availability in deciding on opioid (MAT) suitability. Several peer reviewed studies have validated the benefits of buprenorphine in the treatment of opioid use disorders. Perhaps the most striking studies was conducted in 2003 by Kakko et al., which shows that for those patients who presented for treatment of opioid use disorder and were not provided (MAT), 100% dropped out of treatment, whereas those who were started on buprenorphine, 75% remained in treatment. Therefore, buprenorphine induction has been proven to enhance the retention in treatment. According to recent Department of Health data, New Mexico's overdose deaths decreased between 2014 and 2017. However, the drug overdose death rate increased in 2018 and New Mexico's overdose rate remains 17% higher than the national drug overdose rate.

IMPROVEMENT ACTION PLAN:

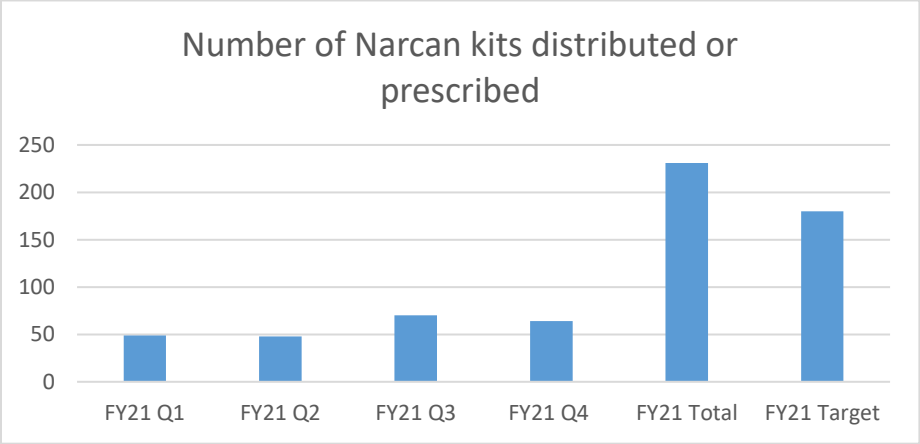
Major Quarterly Action Steps:	Goal Completion Date				
	Q1	Q2	Q3	Q4	Target
1) Ensure all medical providers have a current prescribing license for MAT and that each provider is credentialed appropriately.	X	X	X	X	
2) Have each medical provider to conduct an addiction medicine assessment review the patient's prescription monitoring program registry (PMP) and make best practice recommendations, e.g., type of MAT.	X	X	X	X	
3) Discuss with patient MAT recommendations.	X	X	X	X	

FMD PERFORMANCE MEASURE #16

Number of Narcan kits distributed or prescribed

Results

FY21 Q1	FY21 Q2	FY21 Q3	FY21 Q4	FY21 Total	FY21 Target
49	48	70	64	231	180



MEASURE DESCRIPTION:
This measures the number of Narcan kits distributed or prescribed.

DATA SOURCE/METHODOLOGY:
Pharmacy system (QS1 & Quick Mar).

STORY BEHIND THE DATA:
According to the Substance Abuse and Mental Health Services Association (SAMHSA), Narcan, otherwise known as Naloxone, is a medication approved by the Food and Drug Administration (FDA) and designed to rapidly reverse opioid overdose. The use of Narcan by the lay public has shown efficacy in the prevention of opioid overdose deaths in several studies. One of the highest risk groups for susceptibility for overdose are those patients who have had a period of abstinence, which occurs in the setting of a social rehabilitation program. The value of education, training and distribution of Narcan to all our patients at TLH is not only important for the patients with opiate use disorder but also to patients who may be exposed to others with opiate use disorders. Increased weekly "Narcan trainings" for opioid users and their personal contacts helped the Facilities surpass the FY21 target.

Citations:
Patricia Pade, Patrick Fehling, Sophie Collins & Laura Martin (2017) Opioid overdose prevention in a residential care setting: Naloxone education and distribution, Substance Abuse, 38:1, 113-117, DOI: 10.1080/08897077.2016.1176978

IMPROVEMENT ACTION PLAN:

Major Quarterly Action Steps:	Goal Completion Date				
	Q1	Q2	Q3	Q4	Target
1) Identify patients with opioid misuse disorder and/or patients who are surrounded by individuals who are at high risk to overdose; provide weekly Narcan class 100% of the time.	X	X	X	X	
2) Provide weekly Narcan class 100% of the time.	X	X	X	X	
3) At discharge, provide kits to patient with an educational document on how to use Narcan while making nursing staff available to answer any remaining questions.	X	X	X	X	

PROGRAM P007: Developmental Disabilities Supports Division (DDSD)

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. DDSD oversees home and community-based Medicaid waiver programs and these include:

- The Developmental Disabilities Waiver (Traditional Waiver)
- The Medically Fragile Waiver (Traditional Waiver)
- The Mi Via Self-Directed Waiver
- The Supports Waiver

DDSD's 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 exercise their right to make choices and grow and contribute to their community.

Program Budget (in thousands):

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	
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	189
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	

* 500s are waiver payments

FY21	General Fund	Other State Funds	Federal Funds	Other Transfers	TOTAL	FTE
200	$7,988.3	$6,427.7	$0.0	$0.0	$14,416.0	
300	$9,900.8	$1,451.3	$0.0	$25.0	$11,377.1	
400	$8,578.0	$1,670.6	$0.0	$180.0	$10,428.9	182
500*	$131,658.4	$0.0	$0.0	$0.0	$131658.4	
TOTAL	$158,125.5	$9,549.9	$0.0	$205.0	$167,880.4	

Program Performance Measures:

1. Number of individuals on the developmental disabilities' waiver waiting list (FY21 HB2 Measure)
2. Number of individuals receiving developmental disability waiver services (FY21 HB2 Measure)
3. Number of individuals receiving developmental disability supports waiver services
4. Number of people on the waiting list that are formally assessed once allocated to the DD Waivers
5. Percent of developmental disabilities waiver applicants who have a service and budget in place within 90-days of income and clinical eligibility (FY21 Key Measure)
6. Percent of adults of working age (22 to 64 years), served on the DD Waiver (traditional or Mi Via) who receive employment supports (FY21 Key Measure)
7. Percent of DD Waiver providers in compliance with General Events timely reporting requirements (2-day rule) (FY21 Key Measure)

COVID-19 Related Activities:

DDSD's primary responses to COVID-19 have shifted based on the course of the pandemic.

1. DDSD has continued to monitor COVID events in HCBS populations including vaccinations, exposures, tests, confirmed positive tests, hospitalizations, and deaths. See COVID Performance Measures #7, 8, 10.
2. DDSD has continued to promote participation of individuals with I/DD and their caregivers in COVID vaccination. See COVID Performance Measure 10.

3. DDSD has continued to enforce all COVID guidance documents issued. Over 30 guidance documents were issued since the beginning of the pandemic. Effective 7/1/21, in accordance with Governor's directives, DDSD rescinded all previous COVID guidance. (https://www.nmhealth.org/publication/view/general/6776/).
4. DDSD has continued to conduct remote monitoring visits of all HCBS participants. Effective 5/1/21, DDSD staff began conducting Jackson 11A high acuity and high aspiration Nursing and 11B behavioral visits via video. Effective 7/1/2021, DDSD began to conduct Jackson 11A and 11B visits face to face. During FY21, DDSD staff conducted: 1,760 Jackson 11A, 11B, and 11C visits, 3,135 Regional Office Monitoring visits, and 11,782 remote phone contacts to Mi Via participants. Results of all contacts are maintained in a secure, web-based platform.
5. DDSD staff continue to meet internally on a regular basis to address COVID-related issues.
6. DDSD has continued to provide all division operations. All staff have worked remotely or observe COVID-19 safe practices when it has been necessary to go to the office. DDSD will return to offices beginning 7/19/21 in accordance with the DOH Non-Mandatory Telework Policy (HR.08).
7. All provisions of **Appendix K, the CMS Emergency Preparedness and Response and COVID-19 Addendum,** for all HCBS providers will be effective until six months following the end of the federal Public Health Emergency. As possible, these provisions have been included in HCBS Waiver Standards, including options for remote services, increased service limits for AT and Supported Living, and fingerprint requirements.

IMPROVEMENT ACTION PLAN Key:

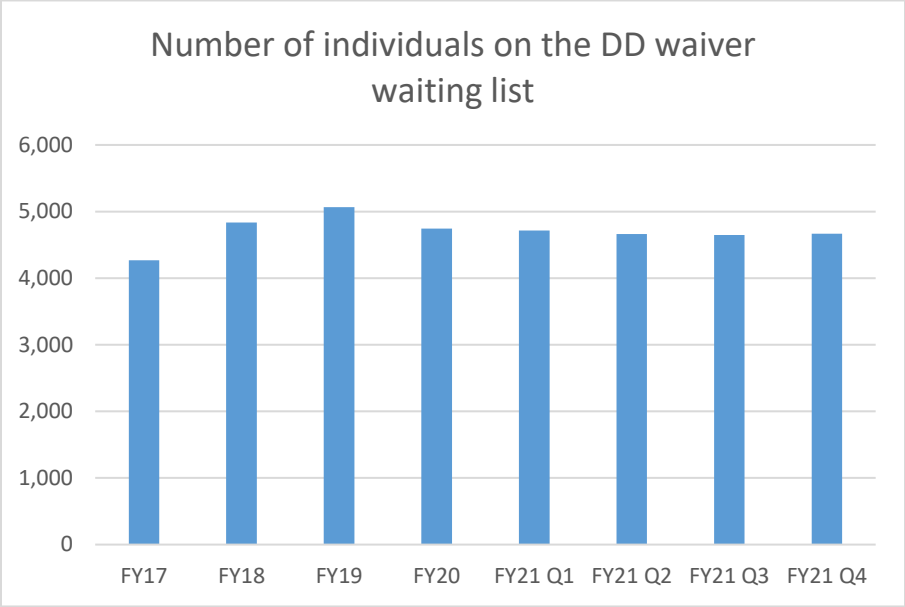
Major Quarterly Action Steps:	**Goal Completion Date**				
	Q1	**Q2**	**Q3**	**Q4**	**Target**
1) **X** denotes quarter(s) the action step was accomplished	X	X	X	X	
2) **-** denotes no action step was accomplished in that quarter	-	-	-	-	
3) **n/a** means the action step was not applicable during that quarter	n/a	n/a	n/a	n/a	
4) **P** denotes partial completed action	P	P	P	P	

DDSD PERFORMANCE MEASURE #1

Number of individuals on the DD Waiver waiting list

Results

FY17	FY18	FY19	FY20	FY21 Q1	FY21 Q2	FY21 Q3	FY21 Q4	FY21 Total	FY21 Target
4,266	4,834	5,064	4,743	4,713	4,660	4,646	4,669	4,669	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 wait list include the Developmental Disabilities (DD) and Mi Via Waivers. Individuals are offered waiver services as funding for allocation slots becomes available. Individuals that meet the requirements can receive standard Medicaid benefits and other services while on the waiting list. As of June 30, 2021, there were 4,669 individuals on the wait list for HCBS Waivers. These individuals have been determined to meet the definition of developmental disability. Of those individuals, 486 have placed their allocation on hold. This means these individuals were offered waiver services and have chosen to continue on the wait list for now. The number of individuals on the wait list increased slightly during the fourth quarter of FY21, as more individuals who applied for waiver services and were determined to match the criteria exceeded the number of individuals removed from the wait list through allocations or attrition.

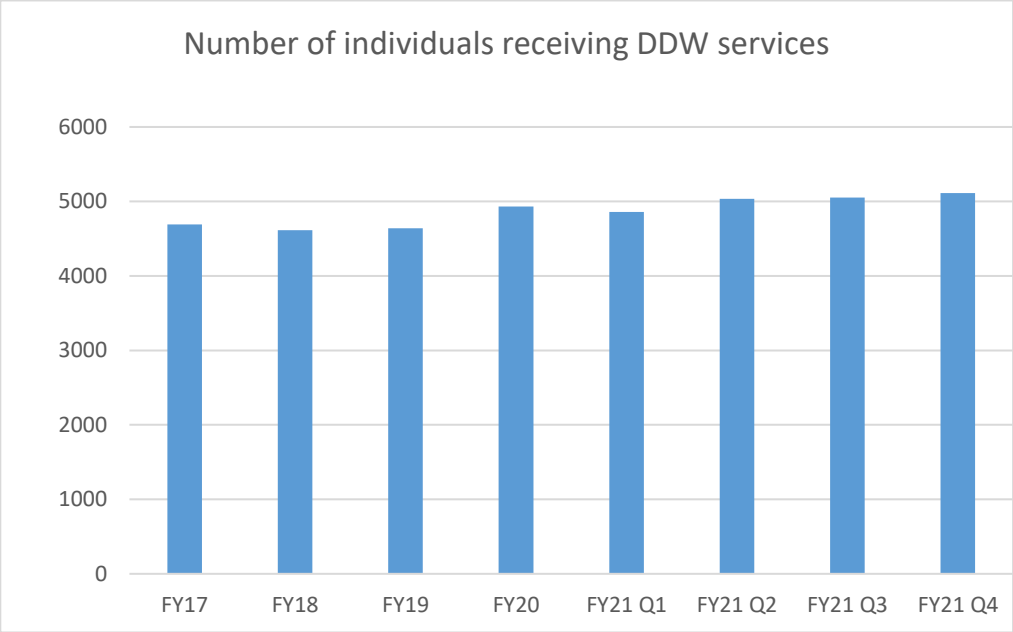
IMPROVEMENT ACTION PLAN:
While this is an annual explanatory measure and no quarterly actions are required, of course DDSD will continue to increase applicant awareness of services that are available to them while they are on the wait list such as Medicaid, State General Fund, and community-based service options.

DDSD PERFORMANCE MEASURE #2

Number of individuals receiving developmental disability waiver services

Results

FY17	FY18	FY19	FY20	FY21 Q1	FY21 Q2	FY21 Q3	FY21 Q4	FY21 Total	FY21 Target
4,692	4,616	4,641	4,934	4,859	5,034	5,053	5,111	5,111	Explanatory



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

DATA SOURCE/METHODOLOGY: NM Human Services Department Client Counts and Expense Report 7-9-2021.

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, which includes a choice between Mi Via (self-directed) waiver and the tradition DD Waiver 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 FY21 Q4 the Developmental Disabilities Supports Division (DDSD) had 5,111 persons receiving Developmental Disability Waiver services (NM Human Services Department Client Counts and Expense Report 7-9-2021.).

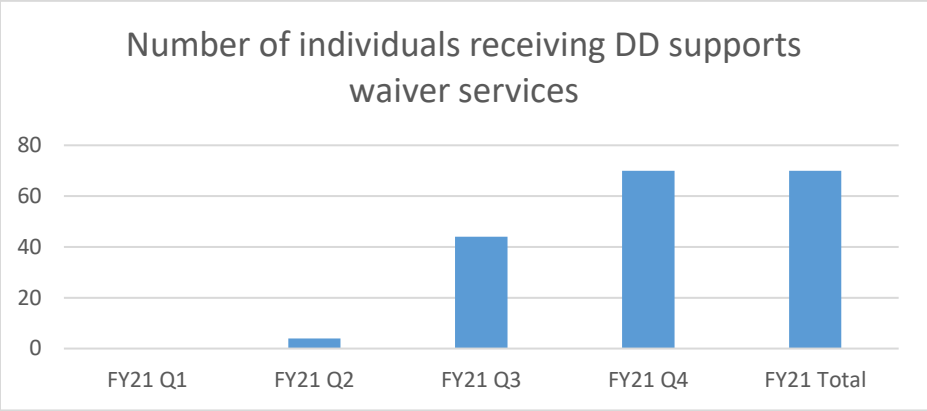
IMPROVEMENT ACTION PLAN:
While this is an annual explanatory measure and no quarterly actions are required, DDSD will continue to monitor the allocation process to ensure people receive timely DD Waiver services as allocation slots become available.

DDSD PERFORMANCE MEASURE #3

Number of individuals receiving developmental disability supports waiver services

Results

FY20	FY21 Q1	FY21 Q2	FY21 Q3	FY21 Q4	FY21 Total	FY21 Target
New Program	New Program	4	44	70	70	Explanatory



MEASURE DESCRIPTION:
This explanatory measure indicates the number of individuals receiving disability supports waiver services.

DATA SOURCE/METHODOLOGY:
NM Human Services Department Client Counts and Expense Report 7-9-2021.

STORY BEHIND THE DATA:
This performance measure follows the newly developed Supports Waiver intended to provide support to individuals on the DD Waiver Wait list. Despite increasing participation observed in FY21 Q4, the continued low level of participation in the supports waiver appears to be the result of the following:

1. A high nonresponse rate to offer letters resulting from factors such as fear of losing place on waitlist, and hesitancy during COVID. Many individuals who were unresponsive to the Supports Waiver responded when they received a DD Waiver allocation within the same year.
2. Community Support Coordinators have not had any in person contact with Supports Waiver participants during the Public Health Emergency (PHE) making planning difficult.
3. We anticipate 3-6 months between the date a Supports Waiver offer is accepted and the date of entry into services. This time period was longer during PHE and first year of operation.
4. There are two 90-day periods defined to get someone into services. Pre-eligibility where the Community Supports Coordinator assists the participant in taking necessary steps to establish the Supports Waiver Category of Eligibility.

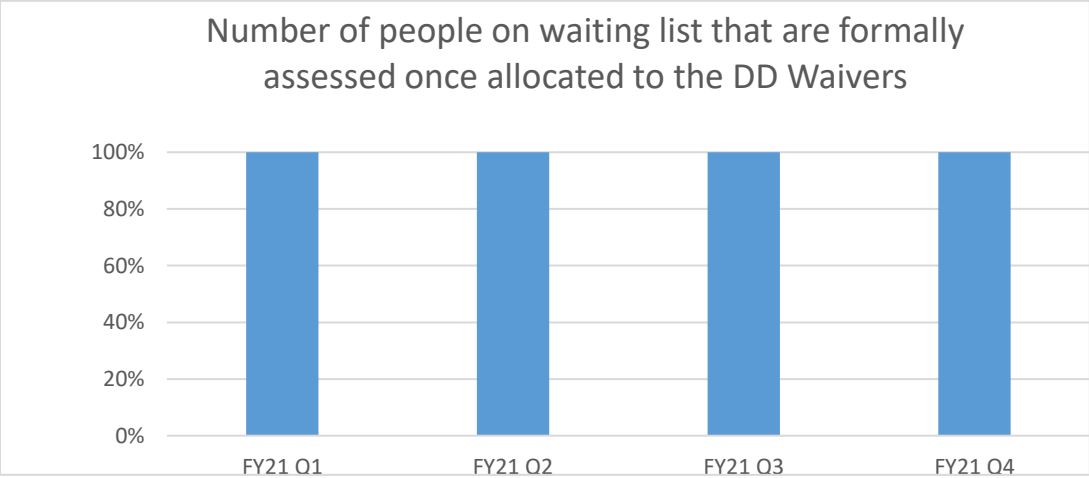
IMPROVEMENT ACTION PLAN:
While this is an annual explanatory measure and no quarterly actions are required, DDSD will continue to monitor allocation process for the Supports Waiver to ensure people receive timely Supports Waiver Services when offers are accepted. While the stated measurement is the number of individuals in Supports Waiver services, the goal of the Supports Waiver overall is to provide an option of support while individuals wait for the comprehensive waiver. DDSD is embarking on an educational campaign, as well as partnering with provider agencies and advocacy groups to boost enrollment and Supports Waiver Offer Response rate.

DDSD PERFORMANCE MEASURE #4

Number of people on the waiting list that are formally assessed once allocated to the DD Waivers

Results

FY20	FY21 Q1	FY21 Q2	FY21 Q3	FY21 Q4	FY21 Total	FY21 Target
New Measure	100%	100%	100%	100%	100%	100%



MEASURE DESCRIPTION:
Numerator: Number of individuals who initiated DD Waiver services with a post-allocation assessment.
Denominator: Number of individuals who initiated DD Waiver services.

DATA SOURCE/METHODOLOGY:
New Mexico Department of Health, Developmental Disabilities Supports Division, Central Registry.

STORY BEHIND THE DATA:
This performance measure was developed to ensure that individuals receiving services through the DD Waiver are properly assessed and receive waiver services at an appropriate level. 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 are properly assessed prior to receiving waiver services. During FY21 Q4, 68 out of 68 individuals who initiated DD Waiver services had a post-allocation assessment in place prior to receiving waiver services.

IMPROVEMENT ACTION PLAN:

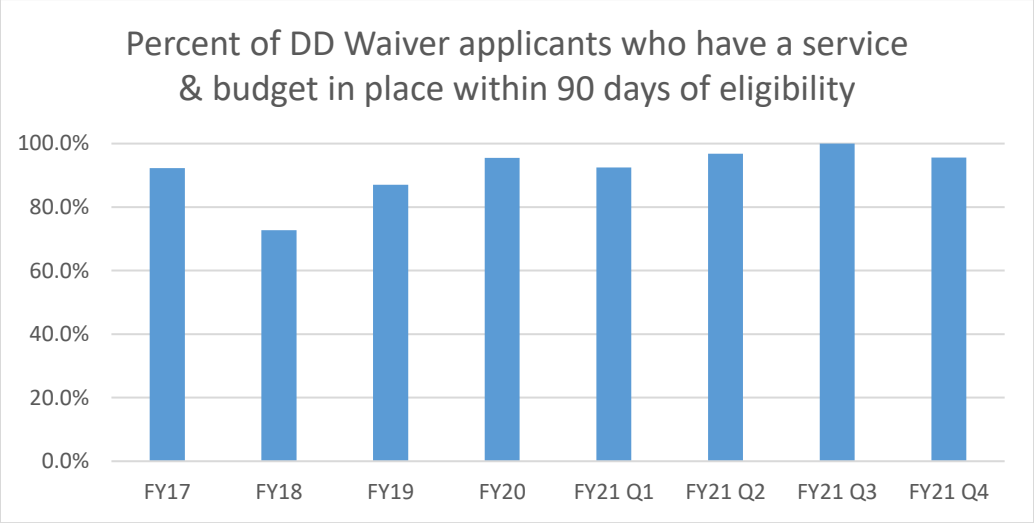
Major Quarterly Action Steps:	Goal Completion Date				
	Q1	Q2	Q3	Q4	Target
1) Address and ensure post-allocation assessments during the pandemic are addressed on a case-by-case basis, as new challenges are presented.	X	X	X	X	100%

DDSD PERFORMANCE MEASURE #5

Percent of developmental disabilities waiver applicants who have a service & budget in place within 90 days of income and clinical eligibility

Results

FY17	FY18	FY19	FY20	FY21 Q1	FY21 Q2	FY21 Q3	FY21 Q4	FY21 Total	FY21 Target
92.3%	72.7%	87.0%	95.5%	92.5%	96.8%	100%	95.6%	97.4%	≥95%



MEASURE DESCRIPTION:
This indicator measures the percentage of newly allocated individuals 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. During FY21 Q4, 65 out of 68 individuals had a service plan in place within 90 days of income and clinical eligibility determination.

IMPROVEMENT ACTION PLAN:

Major Quarterly Action Steps:	Goal Completion Date				
	Q1	Q2	Q3	Q4	Target
1) Ensure and address timely placements into services during the pandemic on a case-by-case basis, as new challenges are presented.	X	X	X	X	**95%**

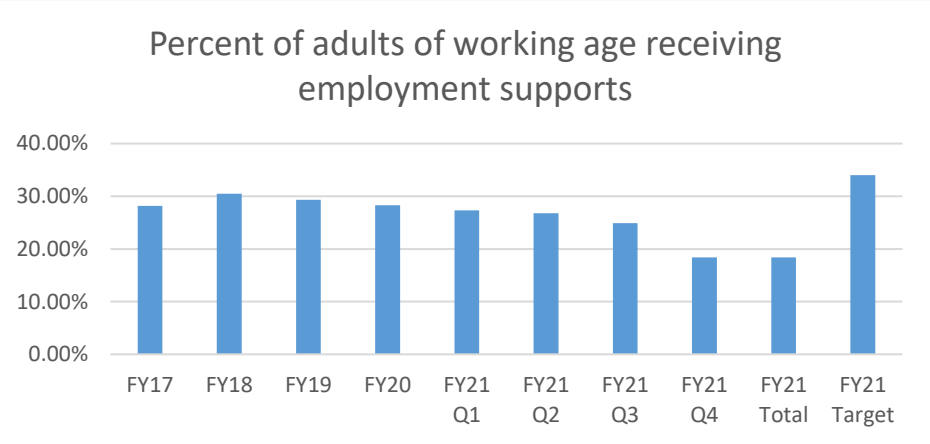
DDSD PERFORMANCE MEASURE #6

Percent of adults of working age (22 to 64 years) served on the DD Waiver (traditional or Mi Via) who receive employment supports

Results

FY17	FY18	FY19	FY20	FY21 Q1	FY21 Q2	FY20 Q3	FY20 Q4	FY20 Total	FY20 Target
28.2%	30.5%	29.3%	28.3%*	27.3%*	26.8%*	24.9%	18.4%	18.4%	≥34%

* Data are derived from claims and are subject to revision.



MEASURE DESCRIPTION:
This indicator measures the percentage of waiver participants who receive employment related services.

DATA SOURCE/METHODOLOGY:
New Mexico Department of Health, DDSD, Omnicaid Database. All figures are derived from claims paid during the period July 1, 2020 through June 30, 2021. The one-year period (ending with FY21 Q4) is utilized to provide both recent and reliable data. This one-year time period aligns with the performance measure target (34%), which is 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 waiver participants in both Traditional and Mi Via between the ages of 22 to 64 years inclusive.

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 19%. Community Integrated Employment (CIE) includes supports that allow individuals with developmental disabilities to participate as active community members and realize the benefits of employment. Employment First (E1st) expects that working age individuals with I/DD should be given the opportunity to work in the community. In FY21 Q4, 18.7% of eligible adults received employment services. Recent COVID related impacts are reflected in the Medicaid/Omnicaid billing data as there is a significant decline in individuals accessing employment supports. However, people are returning to the workforce. Online courses, just-in-time trainings and remote based meetings have been made available for stakeholders who are navigating employment services.

IMPROVEMENT ACTION PLAN:

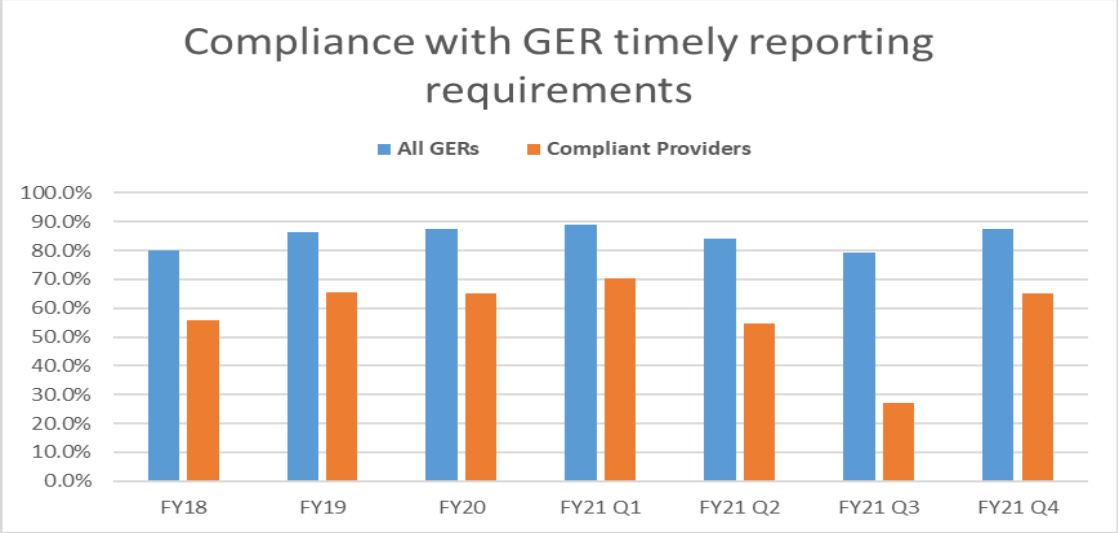
Major Quarterly Action Steps:	Goal Completion Date				
	Q1	Q2	Q3	Q4	Target
1) Release online/on demand training focused on education related to employment.	X	X	X	X	≥34%
2) Host Day & Employment Community of Practice.	X	X	X	X	≥34%

DDSD PERFORMANCE MEASURE #7

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

Results

	FY18	FY19	FY20	FY21 Q1	FY21 Q2	FY21 Q3	FY21 Q4	FY21 Total	FY21 Target
All GERs	80.1%	86.5%	87.3%	88.9%	84.0%	79.1%	87.3%	83.0%	86%
Compliant Providers	55.8%	65.3%	65.2%	70.4%	54.7%	27.0%	65.2%	35.3%	86%



MEASURE DESCRIPTION:
This measure indicates the degree to which General Events Reports (GERs) are addressed in a timely manner.
Numerator for ALL GERs: The number of GERs submitted and approved in two full days.
Denominator for all GERs: The number of GERS submitted and approved.
Numerator for Compliant Providers: The number of providers submitting 86% or more of their GERs in a timely manner.
Denominator for Compliant Providers: The number of providers submitting GERs.

DATA SOURCE/METHODOLOGY:
New Mexico Department of Health, DDSD, Therap Database, April 2021.

STORY BEHIND THE DATA:
The timely submission and approval of GERs 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 pose a risk to adults in the DDW program, but do not meet criteria for Abuse, Neglect & Exploitation (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, except for medication errors, of the event date. Following review of the compliance data, DDSD conducts outreach to the provider agencies that are not compliant with the requirement and remediation is requested. DDSD is utilizing the Therap GER system to track and monitor COVID-19 related events, including positive testing, which has added an increase in system reporting. In FY21 Q4, 83% of the 5,617 GERs submitted were submitted and approved in a timely manner. In FY21 Q4, 65% of the 69 providers submitting GERs complied with GER reporting requirements for timely reporting.

IMPROVEMENT ACTION PLAN:

Major Quarterly Action Steps:	Goal Completion Date				
	Q1	Q2	Q3	Q4	Target
1) Conduct case review for providers who are not adhering to GER requirements.	X	X	X		86%
2) Initiate appropriate interventions with provider agencies not adhering to requirements.	X	X	X		86%

The decrease in compliance among providers appears to have been the result of a large influx of vaccine related GERs beginning in Q3. Although providers did an excellent job at reporting vaccine-related event through GERs, many of the GER approvals were delayed, in part, due to the high demand for vaccinations.

PROGRAM P008: Health Certification Licensing and Oversight (DHI)

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):

FY20	General Fund	Other State Funds	Federal Funds	Other Transfers	TOTAL	FTE
200	$4,571.60	$4,350.60	$2,076.40	$1749.60	$12,748.20	183
300	$309.50	$170.50	$96.00	$139.10	$715.10	
400	$510.20	$452.00	$584.20	$158.00	$1,704.40	
TOTAL	$5,391.30	$4,973.10	$2,756.60	$2,046.70	$15,167.70	

FY21	General Fund	Other State Funds	Federal Funds	Other Transfers	TOTAL	FTE
200	$4,869.00	$3,401.97	$2,088.45	$1788.20	$12,147.62	183
300	$683.50	$42.33	$19.63	$153.20	$898.66	
400	$403.70	$418.48	$391.86	$110.80	$1,324.84	
TOTAL	$5,956.20	$3,862.79	$2,499.95	$2,052.20	$14,371.12	

Program Performance Measures:

1. Rate of abuse for developmental disability waiver and mi via waiver clients (FY21 HB2 Measure)
2. Rate of re-abuse for developmental disability waiver and mi via waiver clients (FY21 HB2 Measure)
3. Percent of abuse, neglect and exploitation investigations completed within required timeframes (FY21 Key & HB2 Measure)
4. Percent of (IMB) assigned investigations initiated within required timelines
5. 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
6. Percent of Caregiver Criminal History Screening (CCHS) Appeal Clearance recidivism/re-offense (conviction) after a successful appeal
7. Percent of Assisted Living Facilities (ALFs) in compliance with caregiver criminal history screenings requirements
8. Percent of Assisted Living Facilities (ALF) complaint surveys initiated within timeframes
9. Percent of improved accuracy in nursing home Incident Reports (IRs) submitted following participation in a DHI quality training on reporting requirements
10. 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) (FY21 Key Measure)
11. Percent of health facility survey of statement of deficiencies (CMS form 2567/state form) distributed to the facility within 10-days of survey exit (DOB-LTC) (FY21 Key Measure)
12. 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)

COVID-19 Related Activities:

DHI has been very adaptable and flexible in responding and redirecting resources to address the department's and communities' needs during the pandemic. Activities include:

- Offer services to healthcare providers/facilities to keep them in background screening compliance by having them send in manual fingerprint cards to the department, this was in response to numerous closures of the electronic fingerprint sites located throughout the state because of COVID-19.
- Lead offsite surveillance infection control surveys for all ESRD facilities.
- Manage offsite COVID-19/Infection control complaint surveys for LTC and Non-Long-Term Care (NLTC).
- Conduct CMS infection control surveys as approved by CMS.
- Administer Life Safety Code (LSC) initial surveys virtually so facilities can get their temporary license without risk of potential COVID-19 exposure to the patient and surveyor. Initial surveys, beside immediate jeopardy, are the only surveys CMS will approve during the pandemic.
- Conduct DD Waiver, Mi Via, and Med Frag. Waiver compliance surveys in a modified format, which includes:
    - No on-site visits (All surveys being conducted via desk audit and video observations occurring when possible).
    - On-site survey revisions, moving from a 1-week to a 2-week process and completing all surveys virtually. Additionally, tools had to be revised to comply with CMS Appendix K approval, which allowed for particular requirements to be waived as a result of the COVID-19 PHE.
    - Interviews with individuals, staff and administrators are being conducted via phone or video when possible.
    - Continue to complete all required surveys remotely.
    - The overall 20-day distribution timeline continues to be maintained above the 80% performance measure set. In FY21 2nd quarter 100% of reports were distributed on time, in 3rd quarter 93.7% were sent out on time.
    - Over the 12-month period QMB went from 56.6% (FY20 Q4) to 74.3% (FY21 Q3).
    - QMB Compliance team has implemented the QMB Operations Manual.
- Conduct Jackson surveys via QMB's Individual Quality Review team, with the following modifications:
    - No on-site visits (All surveys being conducted remotely via desk audit and video observations occurring when possible).
    - Interviews with individuals, staff and administrators are being conducted via phone or video when possible.
    - The IQR team continued its required work per the Jackson Settlement Agreement regardless of the COVID-19 pandemic. The IQR was able to successfully get 5 approved surveyors and transition the IQR from oversite of the federally appointed Community Monitor to DHI.
    - In Q1, the IQR was able to add an additional 2 IQR healthcare surveyors to the team. These individuals were approved in the 2nd and 3rd qtr. as qualified surveyors following a substantially similar training process used by the previous Community Monitor.
    - IQR continues to independently complete required regional power point and data reports, as required, which can be located on the DHI website
    - In FY21 Q4 IQR has begun to complete in-person home visits and observations.
- Organize weekly surveillance reviews utilizing video and photograph verification for all LTC facilities (Nursing Homes, Assisted Living and Immediate Care Facilities). Daily offsite surveillance reviews are conducted for Nursing Homes with positive COVID cases during FY20 Q3 – FY21 Q1.
- Host survey agency weekly information calls with Nursing Homes, Assisted Living, and Intermediate Care Facilities/for Individuals with Intellectual Disabilities facilities with ALTSD, Epidemiology and New Mexico Healthcare Association.
- Conduct CMS Focus Infection Control surveys as assigned by CMS and during all onsite surveys in Nursing Homes.
- Assist ERD's nurse hotline with DHI registered nurses.
- Conducted rapid response outreach and intervention for various other health care facility types; ESRD's, Home Health agencies, medical offices, ICF's etc.
- Hold monthly "DHI Call Connection" meetings with Home Health, Hospice, and End Stage Renal Disease on COVID-19 questions and concerns.
- Carry out offsite COVID-19/Infection control complaint surveys.
- Conduct CMS Immediate Jeopardy (IJ) surveys as approved by CMS.
- Respond to the newly created DHICOVID19.DOH@state.nm.us email to assist with COVID-19 questions, waivers, etc. DHI has devoted significant time to this strategic response system.
- Report weekly to CMS on our surveyors' PPE supplies and COVID-19 work.
- Work with CMS to conduct Home Health initial surveys virtually so facilities can get their annual license without risk of potential COVID-19 exposure to the patient and surveyor. Initial surveys, beside IJ, are the only surveys CMS will approve during the pandemic.
- Provide temporary administrative support staff to SLD for assisting with test kit assembly during FY 20 Q3 and Q4.

- Have Incident Management Bureau conduct modified abuse, neglect and exploitation investigations for waiver participants. Investigations are being conducted with phone and video interviews, and reviews are recorded. We returned to the field on June 1, 2021, for in person/on site interviews for Emergency, P1 and all Jackson case assignments. As of July 1, 2021 - IMB is completely back to in person /on site investigations – for all case assignments.

Q4 Program Accomplishments:

- DHI processed 1,381 Certified Nurse Aide (CNA) applications, 543 CNA Reciprocities, 663 Renewals, and 16 CNA verifications. There are currently 48 state approved CNA programs.
- DHI processed 11,620 Caregiver Criminal History Screening checks.

IMPROVEMENT ACTION PLAN Key:

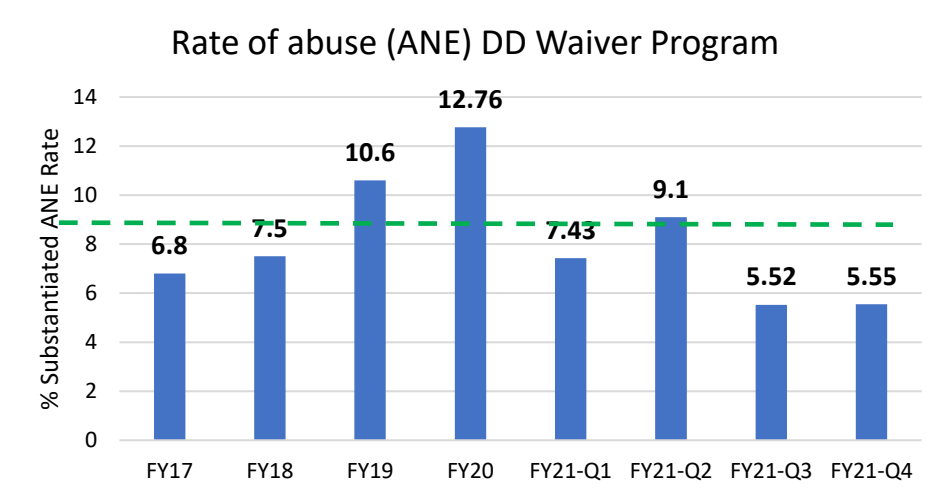
Major Quarterly Action Steps:	**Goal Completion Date**				
	Q1	**Q2**	**Q3**	**Q4**	**Target**
1) **X** denotes quarter(s) the action step was accomplished	X	X	X	X	
2) **-** denotes no action step was accomplished in that quarter	-	-	-	-	
3) **n/a** means the action step was not applicable during that quarter	n/a	n/a	n/a	n/a	
4) **P** denotes partial completed action	P	P	P	P	

DHI PERFORMANCE MEASURE #1

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

Results

FY17	FY18	FY19	FY20	FY21 Q1	FY21 Q2	FY21 Q3	FY21 Q4	FY21 Total	FY21 Target
6.8%	7.5%	10.6%	12.76%	7.43%	9.10%	5.52%	5.55%	5.55%	Explanatory



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. The abuse rate is an explanatory measure, nationally abuse rate data varies greatly from state to state on how it is sampled, collected, and reported. The green bar represents the division's goal/target for the abuse rate to be 9 percent or less of the total population of individuals receiving waiver services.

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 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, investigations are counted in the quarter completed.

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.

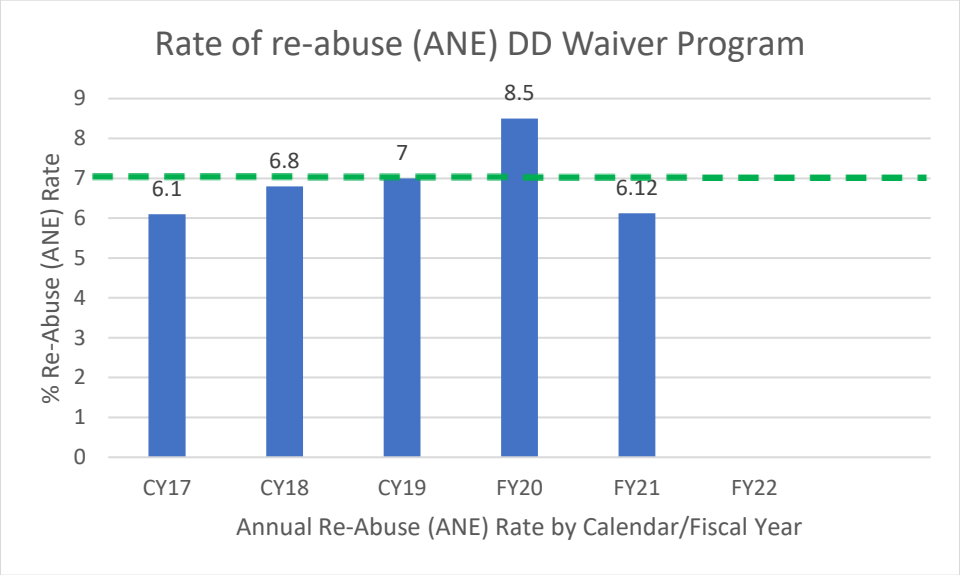
IMPROVEMENT ACTION PLAN:
This is an annual fiscal year explanatory measure, so no quarterly action is required.

DHI PERFORMANCE MEASURE #2

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

Results

CY15	CY16	CY17	CY18	CY19	FY20	FY21	FY21 Target
16.3%	18.5%	6.1%	6.8%	7.0%	8.5%	6.12%	Explanatory



MEASURE DESCRIPTION:
Numerator: Number of repeat substantiated cases involving the same consumer over a 12-month period.
Denominator: Total number of substantiated cases.
The repeat or re-abuse rate is an explanatory measure, nationally re-abuse rate data varies greatly from state to state on how it is collected and reported. The green bar represents the division's goal/target for the abuse rate to be 7 percent or less of the total population of individuals receiving waiver services.

DATA SOURCE/METHODOLOGY:
This annual data comes from the Incident Management Bureau (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. Lack of adequate supervision, failure to follow health care plans, and staff training are the most common reasons for substantiated neglect. 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.

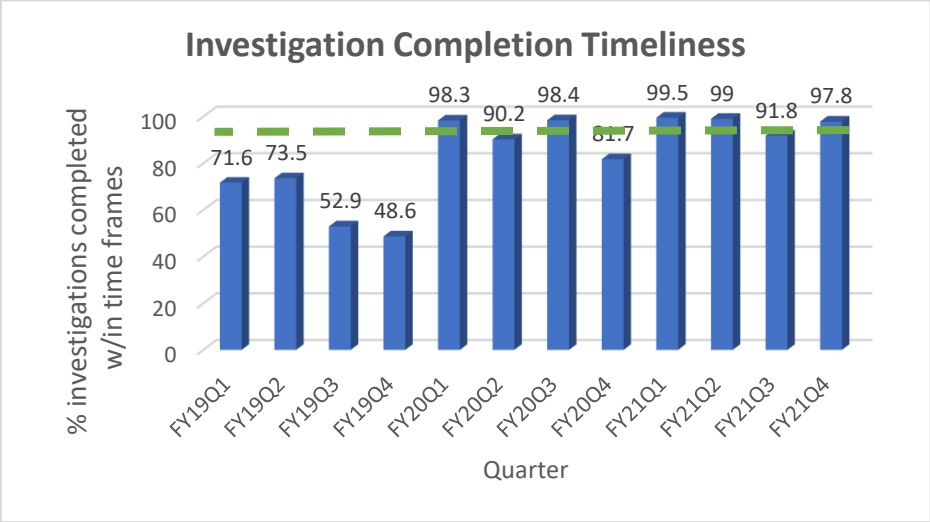
IMPROVEMENT ACTION PLAN:
This is an annual fiscal year explanatory measure, so no quarterly action is required.

DHI PERFORMANCE MEASURE #3

Percent of abuse, neglect and exploitation investigations completed within required timeframes

Results

FY19	FY20	FY21 Q1	FY21 Q2	FY21 Q3	FY21 Q4	FY21 Total	FY21 Target
48.6%	81.7%	99.5%	99%	91.8%	97.8%	96.3%	86%



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.
The green bar represents the Centers for Medicaid and Medicare Services (CMS) performance measure benchmark of 86% for the 1915-C Home and Community Based waiver program.

DATA SOURCE/METHODOLOGY:
This data comes from DHI's Investigation Management Bureau (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. IMB completed and closed a total of over 600 backlog cases from February to September of 2019. Catching up on the backlog effected this case timeliness measure. Since October 2019, IMB is current on all case load and all cases have been completed within the 45-day time frame or with an approved extension for the more egregious cases.

IMPROVEMENT ACTION PLAN:

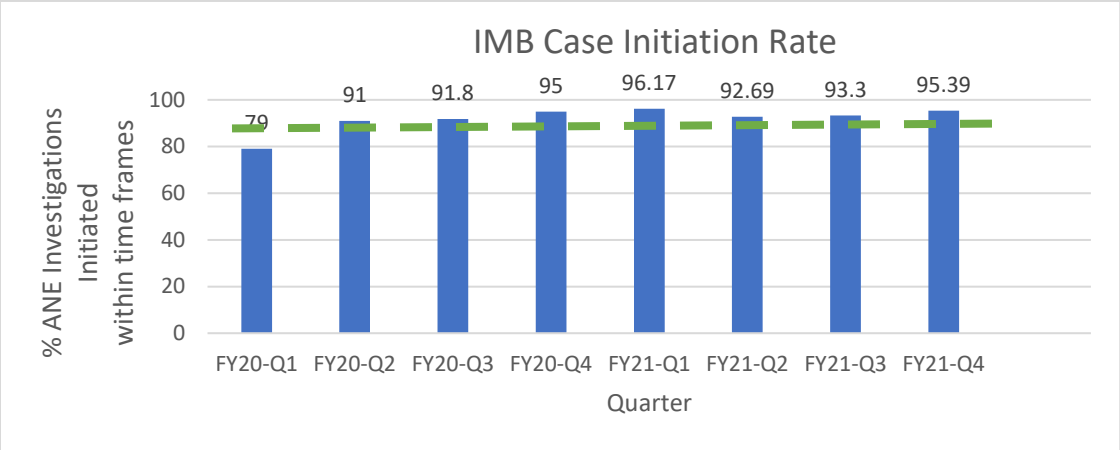
Major Quarterly Action Steps:	Goal Completion Date				
	Q1	Q2	Q3	Q4	Target
1) Complete all investigations within timelines with no backlog of cases	X	X	X	X	86%

DHI PERFORMANCE MEASURE #4

Percent of (IMB) assigned investigations initiated within required timelines

Results

FY20	FY21 Q1	FY21 Q2	FY21 Q3	FY21 Q4	FY21 Total	FY20 Target
90.3%	96.17%	92.69%	93.3%	95.39%	94.41%	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.
The green bar represents the Center for Medicaid and Medicare Services (CMS) performance measure benchmark of 86% for the 1915-C Home and Community Based waiver program.

DATA SOURCE/METHODOLOGY:
This data comes from DHI's Investigation Management Bureau (IMB) Database.

STORY BEHIND THE DATA:
A critical component of keeping individuals safe is the timely initiation of Abuse Neglect and Exploitation (ANE) investigations. Case initiation is defined as the investigator making direct contact with someone identified in the case, e.g., 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:

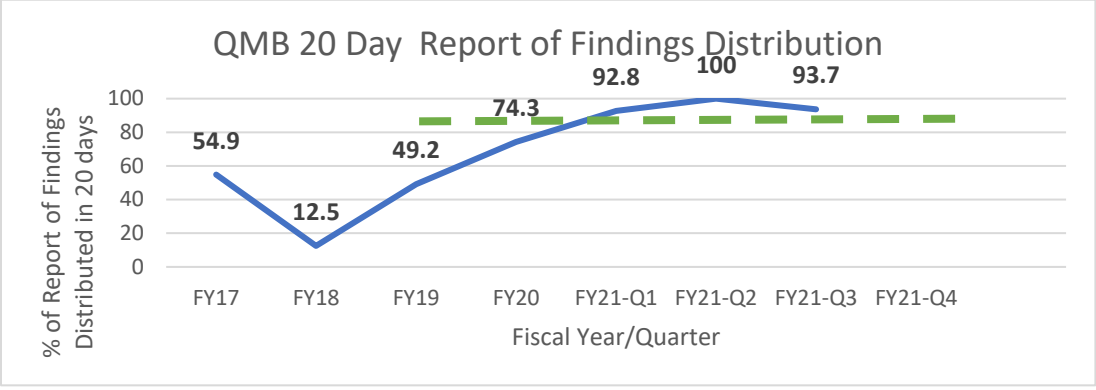
Major Quarterly Action Steps:	Goal Completion Date				
	Q1	Q2	Q3	Q4	Target
1) Initiate all ANE Investigations within time frames	X	X	X	X	86%

DHI PERFORMANCE MEASURE #5

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

Results

FY17	FY18	FY19	FY20	FY21 Q1	FY21 Q2	FY21 Q3	FY21 Q4	FY21 Total	FY21 Target
54.90%	12.50%	54.5%	72.7%	80.7%	100%	93.7%			86%



MEASURE DESCRIPTION:

This measure assesses the 20-day distribution time, which begins one-working day following the HCBS waiver survey exit. This measures how quickly the surveyed provider receives formal notice of a deficiency.

Numerator: Total number of survey reports completed and distributed within 20 working days.

Denominator: Total number of surveys reports completed and distributed in a quarter.

The green bar represents the Centers for Medicaid and Medicare Services (CMS) performance measure benchmark of 86% for the 1915-C Home and Community Based waiver program.

DATA SOURCE/METHODOLOGY:

The Quality Management Bureau (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 the compliance percentage with this internal requirement. There is a one quarter reporting lag in QMB survey reports as survey dates cross the quarter.

STORY BEHIND THE DATA:

This measure assesses the 20-day distribution time, which begins one-working day following the HCBS waiver survey exit. QMB uses lean and six sigma quality improvement tools such as process mapping to continuously improve and streamline. A second supervisor was added to the review process to reduce the reviews and edits wait time and other improvements include the ability to fill all vacant QMB surveyor positions in order to timely meet workload requirements. QMB is also revising the survey into a 2-week hybrid remote process for admin file reviews and on-site home visits, observations, and interviews.

IMPROVEMENT ACTION PLAN:

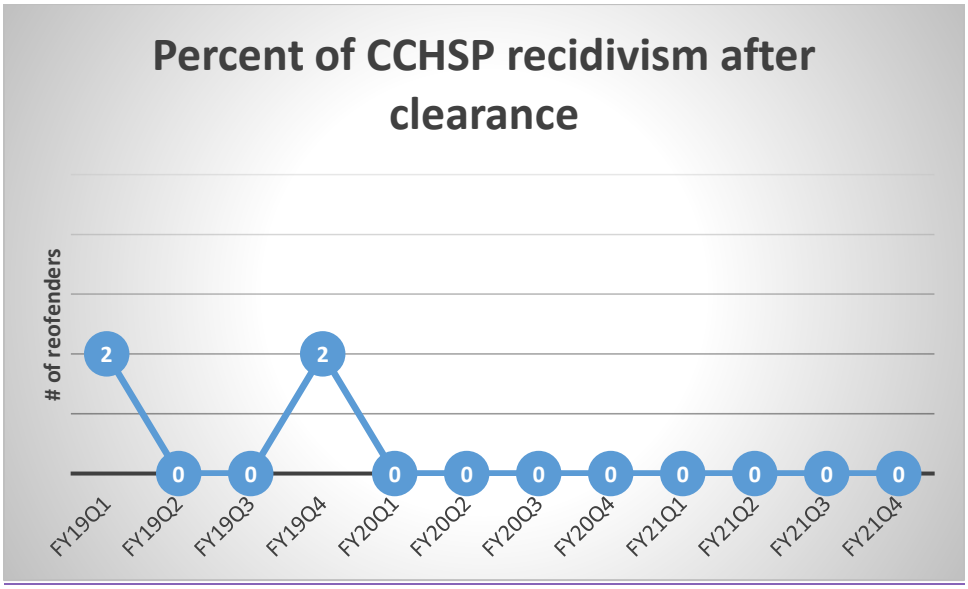
Major Quarterly Action Steps:	Goal Completion Date				
	Q1	Q2	Q3	Q4	Target
1) Train surveyors on writing and editing reports (ongoing activity).	X	X	X	X	
2) Train supervisors on editing reports (ongoing activity).	X	X	X	X	

DHI PERFORMANCE MEASURE #6

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

Results

FY19	FY20	FY21 Q1	FY21 Q2	FY21 Q3	FY21 Q4	FY21 Total	FY21 Target
4	0	0	0	0	0	0	≤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:
Caregiver Criminal History Screening Program (CCHSP) database at: https://nmhealth.cchsp.com

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. There were no re-offences (convictions) after applicants had successfully gone through the CCHSP Reconsideration Appeal board in FY21.

IMPROVEMENT ACTION PLAN:

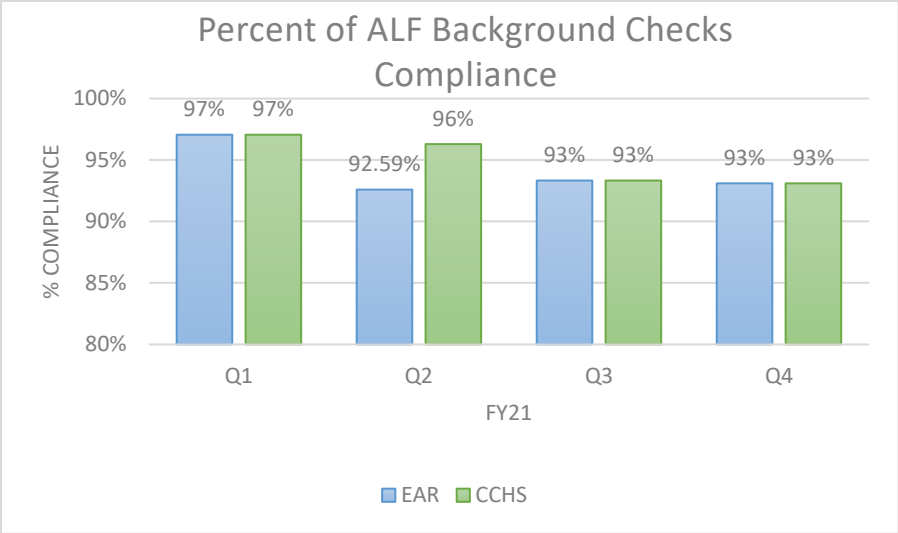
Major Quarterly Action Steps:	Goal Completion Date				
	Q1	Q2	Q3	Q4	Target
1) Monitor recidivism when appeals received.	X	X	X	X	

DHI PERFORMANCE MEASURE #7

Percent of Assisted Living Facilities (ALFs) in compliance with caregiver criminal history screening requirements

Results

FY20	FY21 Q1	FY21 Q2	FY21 Q3	FY21 Q4	FY21 Total	FY21 Target
77% EAR 77% CCHS	97% EAR 97% CCHS	93% EAR 96% CCHS	93% EAR 93% CCHS	93% EAR 93% CCHS	94% EAR 95% CCHS	85%



MEASURE DESCRIPTION:
This measure monitors the compliance of Assisted Living Facilities (ALFs) 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 Source: HTTPS://HFLCShared (\\dhirndcolm002) H:\Review Office\Reviewer\LTC TRACKING LOG\Licensed Only. A total of 105 on-site surveys were conducted for FY21.

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. During the FY20's fourth quarter there was a significant change in survey process due to the COVID-19 protocols which limited on-site surveys. Throughout FY21 onsite investigations resumed.

IMPROVEMENT ACTION PLAN:

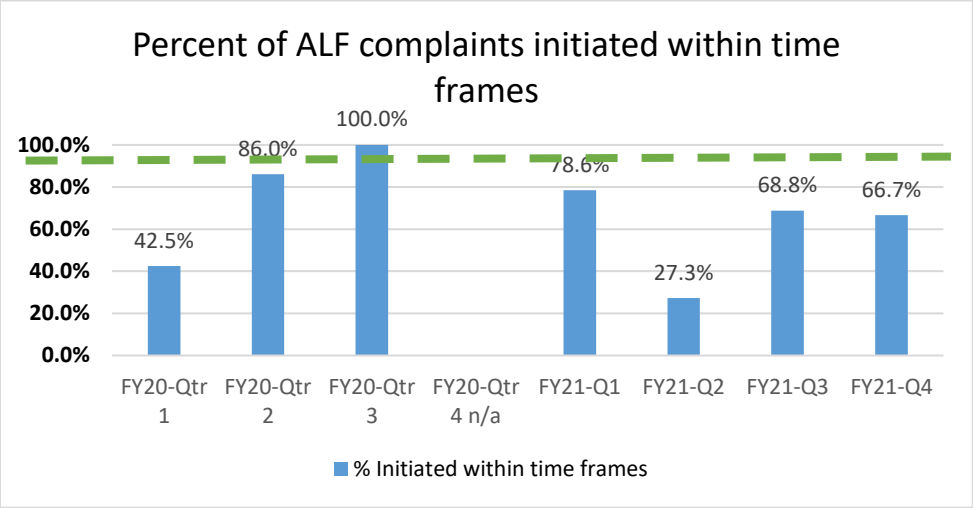
Major Quarterly Action Steps:	Goal Completion Date				
	Q1	Q2	Q3	Q4	Target
1) Monitor continually.	P	P	P	P	

DHI PERFORMANCE MEASURE #8

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

Results

FY20	FY21 Q1	FY21 Q2	FY21 Q3	FY21 Q4	FY21 Total	FY21 Target
70%	78.6%	27.3%	68.8%	66.7%	48.4%	85%



MEASURE DESCRIPTION:
This performance measure reports on the percent of assisted living facilities complaints initiated within timeframes.

DATA SOURCE/METHODOLOGY:
Data Source: HTTPS://HFLCShared (\\dhirndcolm002)H:\ReviewOffice\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 surveyors. There has been a historical backlog of complaints pending survey investigation. With the addition of new surveyor staff in FY19 and FY20, the outstanding complaint backlog had been completed by FY20 Q2. During the Covid pandemic in FY20 Q3 and Q4, DHI suspended on-site investigations and monitoring activities and implemented Covid-19 monitoring protocols. The suspension of onsite survey investigations in FY21, in combination with losing (5) surveyors to retirement and other reasons, created another complaint backlog. At the completion of FY21 Q4, (5) surveyor positions have been posted and in the process of hire. New, trained staff will aide in completing the investigating backlog and ensure that all complaints investigations are initiated within required timelines.

IMPROVEMENT ACTION PLAN:

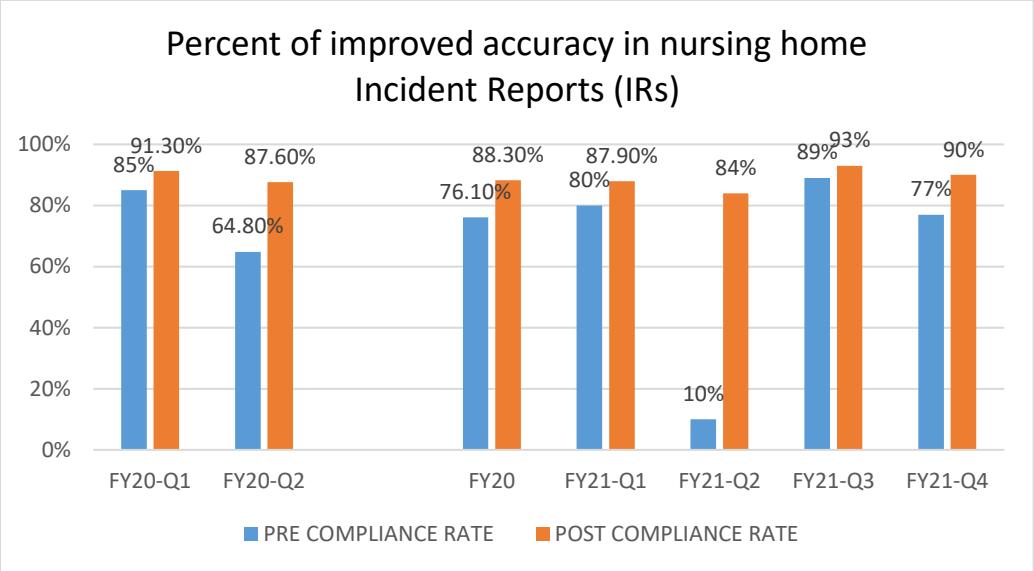
Major Quarterly Action Steps:	Goal Completion Date				
	Q1	Q2	Q3	Q4	Target
1) Monitor continually for completion of all ALF complaint surveys within timeframes.	X	X	X	X	
2) Maintain complaint survey reviews completion status, to avoid backlog.	P	P	P	P	

DHI PERFORMANCE MEASURE #9

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

Results

FY20	FY21 Q1	FY21 Q2	FY21 Q3	FY21 Q4	FY21 Total	FY21 Target
88.3%	87.90%	84.0%	93%	90%	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:
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 a 5-calendar day 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, adding additional staff time. This measure looks at the impact of DHI's quality training to nursing homes, specifically whether they 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, as well as their follow-up investigations and summary of corrective and preventive actions taken. During FY20 Q3 and Q4, DHI suspended on-site surveying and monitoring activities due to Covid-19 protocols. Utilizing WebEx technology DHI has completed over 10 trainings during FY21 Q4.

IMPROVEMENT ACTION PLAN:

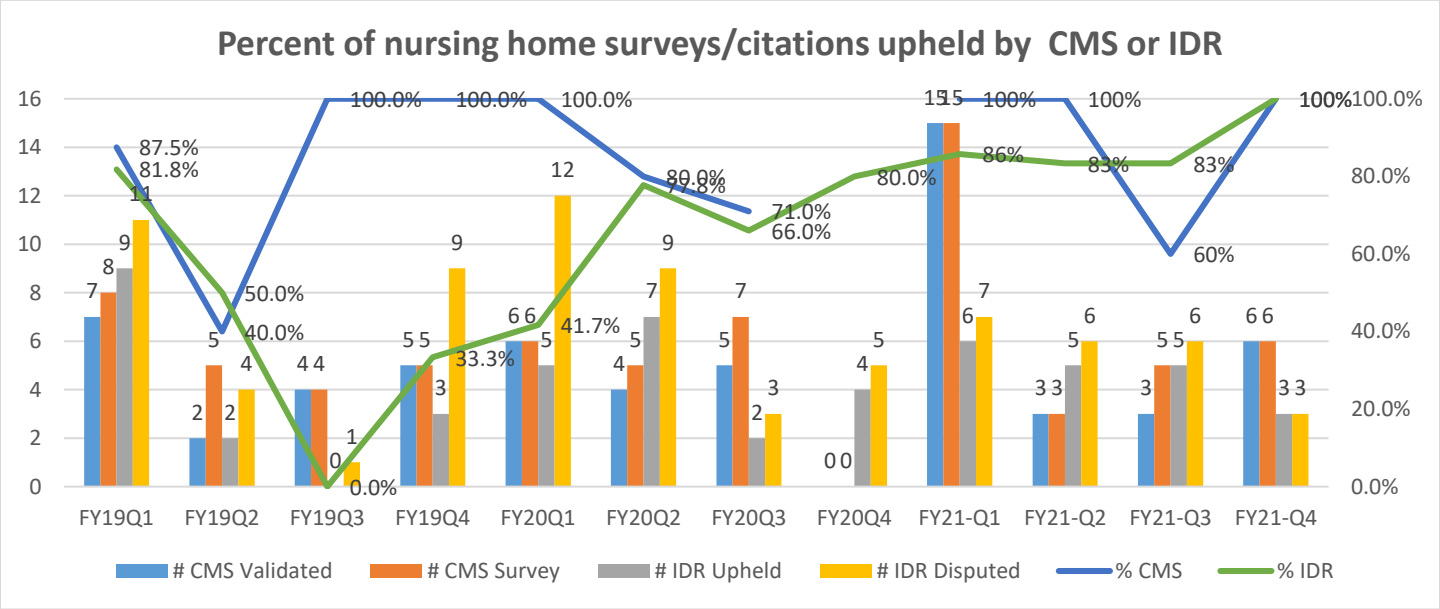
Major Quarterly Action Steps:	Goal Completion Date				
	Q1	Q2	Q3	Q4	Target
1) Identify nursing facilities targeted for IR training.	X	X	X	X	≥85%
2) Conduct IR training and monitor for improvement.	X	X	X	X	

DHI PERFORMANCE MEASURE #10

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)

Results

FY19	FY20	FY21 Q1	FY21 Q2	FY21 Q3	FY21 Q4	FY21 Total	FY21 Target
85% CMS 47% IDR	83.3% CMS 62% IDR	100% CMS 85.71% IDR	100% CMS 100% IDR	60% CMS 83.3% IDR	100% CMS 100% IDR		90%



MEASURE DESCRIPTION:
This performance measure reports evidential validity and defensibility, supporting non-compliance with federal regulations when deficiencies have been cited. These reports are pulled from CMS citation reviews as well as nursing home requests for Informal Dispute Resolution (IDR) of deficiencies. 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:
Data Source: HTTPS://HFLCShared(\\dhirndcolm002)(H:)\NHquality(QualityIndicator)

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 IDR of deficiencies cited. The measure is a useful quality improvement tool for writing of citations that are thus supportable when challenged.

IMPROVEMENT ACTION PLAN:

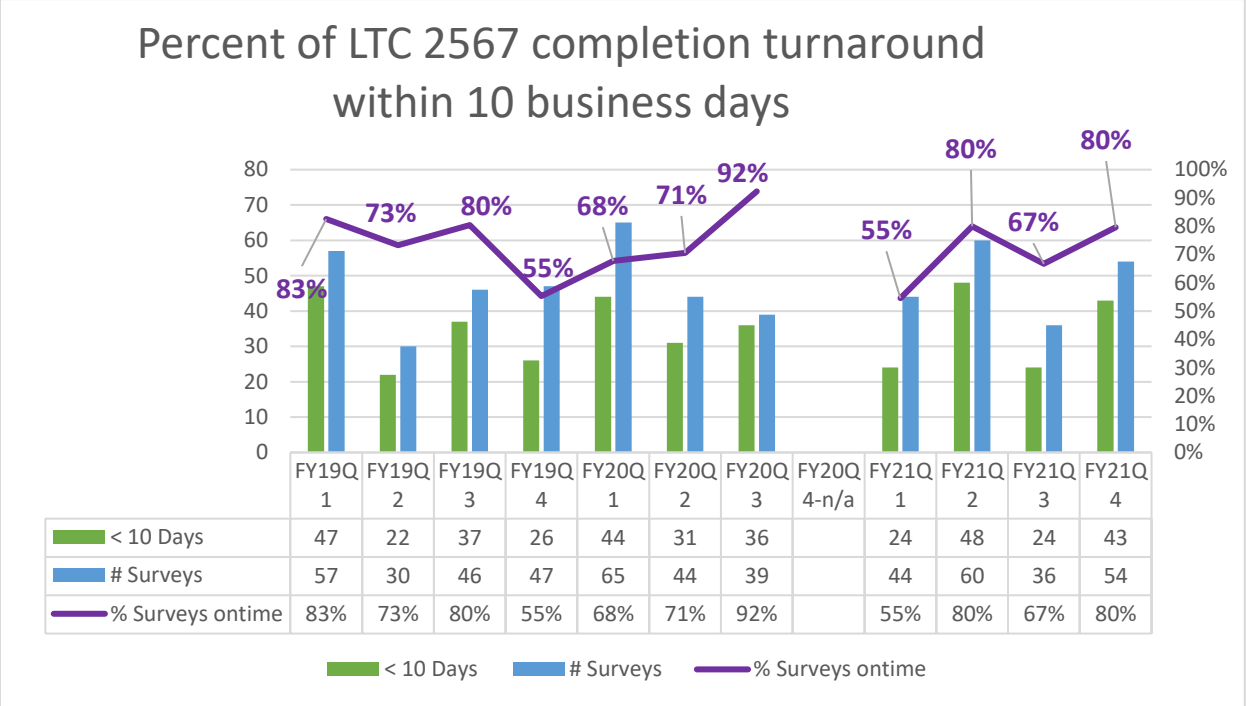
Major Quarterly Action Steps:	Goal Completion Date				
	Q1	Q2	Q3	Q4	Target
1) Monitor for Improvement.	X	X	X	X	

DHI PERFORMANCE MEASURE #11

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)

Results

FY17	FY18	FY19	FY20	FY21 Q1	FY21 Q2	FY21 Q3	FY21 Q4	FY21 Total	FY21 Target
89%	89%	73.3%	75%	54.5%	80%	67%	80%		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 the Long-Term Care Tracking log.

STORY BEHIND THE DATA:

Providing regulatory oversight to health facilities is key to DHI's mission to ensure that safe healthcare services are being provided to all New Mexicans. 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 FY20 Q4, and FY21 Q1 there was a suspension in sending enforcement reports to facilities pending direction from CMS related to the COVID-19 response. Changes in CMS enforcement criteria related to non-compliance identified for infection control also delayed the release of survey reports in FY21 Q1. With the resumption of onsite survey investigation after a 6-month suspension due to the Covid pandemic, came additional complaint investigation assignments. These not only extended onsite

survey time but also the offsite survey time in which surveyors are writing deficiencies and their survey investigation reports. This contributed to longer delays in getting the 2567 report to the providers.

IMPROVEMENT ACTION PLAN:

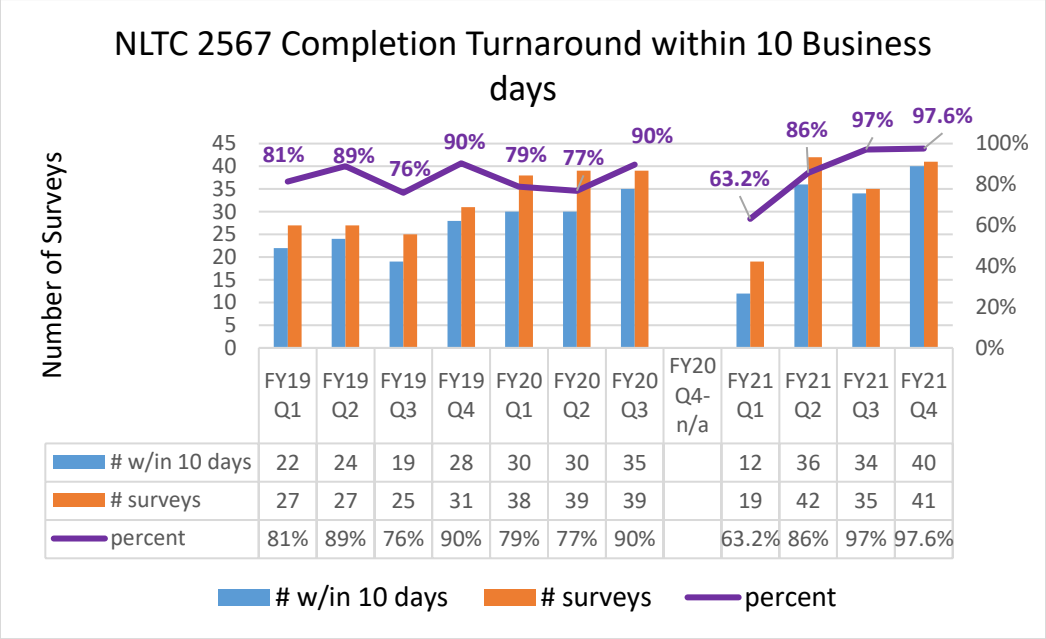
Major Quarterly Action Steps:	Goal Completion Date				
	Q1	Q2	Q3	Q4	Target
1) Conduct off-site monitoring video call checks, a COVID-19 procedural change.	X	X	X	X	

DHI PERFORMANCE MEASURE #12

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)

Results

FY19	FY20	FY21 Q1	FY21 Q2	FY21 Q3	FY21 Q4	FY21 Total	FY21 Target
84.50%	81.8%	63.1%	86%	97%	97.6%	81.75%	85%



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. There is a one quarter data lag in reporting.

STORY BEHIND THE DATA:
Providing regulatory oversight to health facilities is key to DHI's mission to ensure that safe healthcare services are provided to all New Mexicans. 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 business 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. The change in the complaint process has created an influx of assigned surveys.

IMPROVEMENT ACTION PLAN:

Major Quarterly Action Steps:	Goal Completion Date				
	Q1	Q2	Q3	Q4	Target
1) Conduct off-site monitoring video call checks, a COVID-19 procedural change.	X	X	X	X	

PROGRAM P787: Medical Cannabis Program (MCP)

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):

FY20	General Fund	Other State Funds	Federal Funds	Other Transfers	TOTAL	FTE
200		$2,197,200			$2,197,200	28
300		$1,073,500			$1,073,500	
400		$823,200			$823,200	
TOTAL		$4,093,900			$4,903,900	

FY21	General Fund	Other State Funds	Federal Funds	Other Transfers	TOTAL	FTE
200		$3,247,200			$3,247,200	28
300		$1,207,300			$1,207,300	
400		$845,500			$845,500	
TOTAL		$5,300,000			$5,300,000	

Program Performance Measures:

1. Percent of complete medical cannabis client applications approved or denied within thirty calendar days of receipt
2. Percent of registry identification cards issued within 5 business days of application approval

COVID-19 Related Activities:

The Medical Cannabis Program has been staffing a 24/7 Emergency Response Line for first responders to help them access testing, results, and CDC and DOH guidance for disinfection and PPE usage. This is especially important when a first responder comes into contact with someone who states they are COVID-19 positive or has symptoms. This activity started at the end of FY20 Quarter 3 and has continued through FY21 Quarter 4. During this time, there were over 6,000 calls, events, and incidents regarding First Responders through this Emergency Response Line.

IMPROVEMENT ACTION PLAN Key:

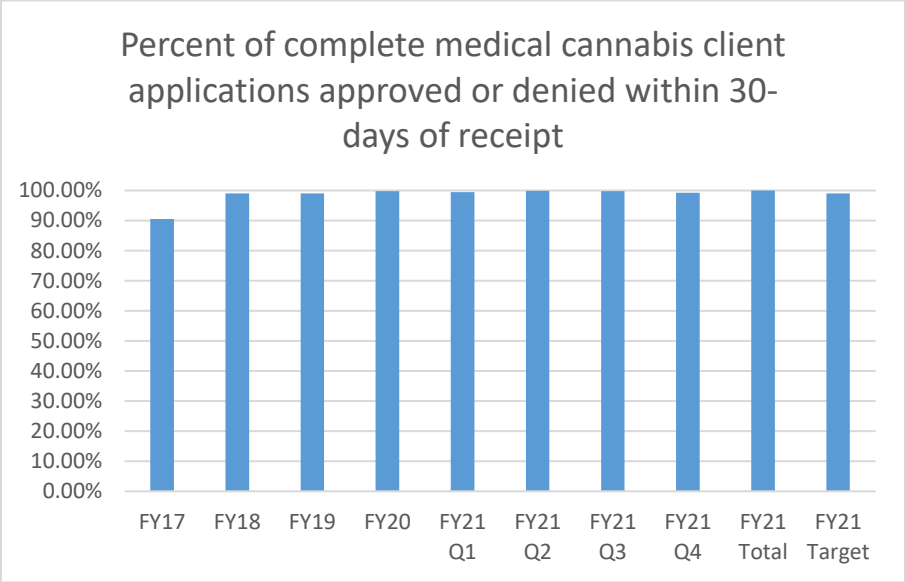
Major Quarterly Action Steps:	**Goal Completion Date**				
	Q1	**Q2**	**Q3**	**Q4**	**Target**
1) **X** denotes quarter(s) the action step was accomplished	X	X	X	X	
2) **-** denotes no action step was accomplished in that quarter	-	-	-	-	
3) **n/a** means the action step was not applicable during that quarter	n/a	n/a	n/a	n/a	
4) **P** denotes partial completed action	P	P	P	P	

MCP PERFORMANCE MEASURE #1

Percent of complete medical cannabis client applications approved or denied within 30-days of receipt

Results

FY17	FY18	FY19	FY20	FY21 Q1	FY21 Q2	FY21 Q3	FY21 Q4	FY21 Total	FY21 Target
90.50%	99.00%	99.00%	99.8%	99.51%	99.8%	99.8%	99.03%	99.98%	≥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:
Processing 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 FY21-Q4, 99% percent of completed patient applications were processed in 30-days. For the entire FY21, the percent of completed patient applications within 30 days was 99.98%.

IMPROVEMENT ACTION PLAN:

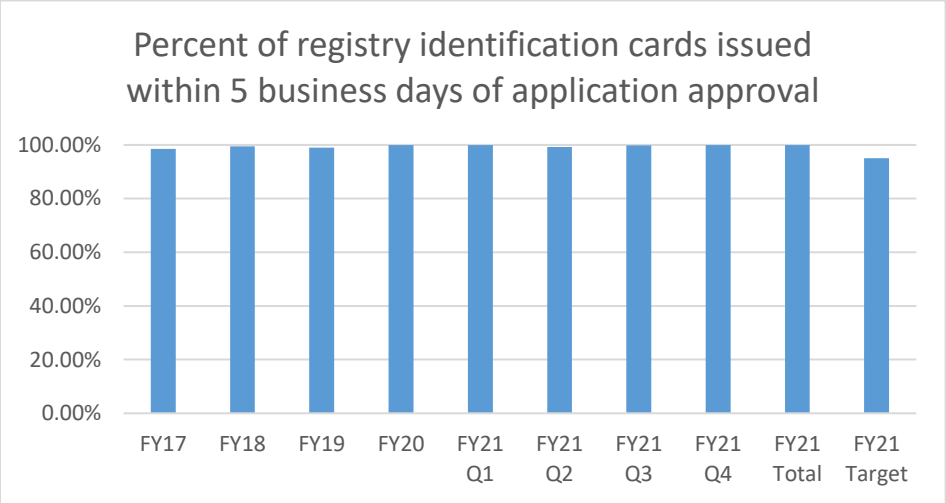
Major Quarterly Action Steps:	Goal Completion Date				
	Q1	Q2	Q3	Q4	Target
1) Continue process for streamlining patient applications by regularly reviewing forms to improve clarity and make them easier to read and complete.	X	X	X	X	**Q1, Q2, Q3, Q4**
2) Implement operational changes to meet increasing demand for services.		X	X	X	**Q4**
3) Revise letters for deficient applications.			X	X	**Q3**
4) Review change and/or upgrade existing software systems for electronic application submissions.		X		X	**Q2**

MCP PERFORMANCE MEASURE #2

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

Results

FY17	FY18	FY19	FY20	FY21 Q1	FY21 Q2	FY21 Q3	FY21 Q4	FY21 Total	FY21 Target
98.50%	99.50%	99%	99.9%	99.99%	99.2%	99.83	99.98%	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 FY21-Q4, the Medical Cannabis Program exceeded its target by printing and mailing 99.98% of patient registry ID cards within 5-days of application approval. For the entire FY-21, the percent of patient registry cards mailed within the 5-day period was 99.98%.

IMPROVEMENT ACTION PLAN:

Major Quarterly Action Steps:	Goal Completion Date				
	Q1	Q2	Q3	Q4	Target
1) Continue process for streamlining patient applications by regularly reviewing forms to improve clarity and make them easier to read and complete.	X	X	X	X	**Q1, Q2, Q3, Q4**
2) Implement operational changes to meet increasing demand for services.		X	X	X	**Q4**
3) Revise letters for deficient applications.			X	X	**Q3**
4) Review change and/or upgrade existing software systems for electronic application submissions.		X		X	**Q2**