NEW MEXICO STATE HEALTH IMPROVEMENT PLAN

2014-2016

New Mexico Department of Health

"Values are key components of our work. Believing in these core values and living them every day is our bond and shared philosophy. These values drive our success."
– Retta Ward, Cabinet Secretary, New Mexico Department of Health

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New Mexico State Health Improvement Plan

Executive Summary

Transforming the Public Health System

The New Mexico Department of Health (NMDOH) public health system is very unique and diversified. NMDOH is a centralized health department responsible for serving all 33 counties through 5 Regional Health offices and 55 local health offices. Partnerships and strong community collaboration are very important components to achieving the work conducted internally. It is through these partnerships that we can begin to develop the goals, objectives and missions of this department. We strive to develop and foster these relationships which span across the State of New Mexico.

This is an exciting time for public health in New Mexico. We have the opportunity to assure that we are using the best and most appropriate evidence-based interventions available to address the significant public health challenges confronting the State. New Mexico's population of approximately 2 million inhabitants is spread over a large geographic area with relatively low population density. Our rich history and multicultural heritage are strengths; these social and cultural differences also pose challenges for improving health status for our population.

In 2012, NMDOH signed a letter of intent to pursue Public Health Accreditation. Public Health Accreditation is a priority for the NMDOH. Accreditation is a voluntary, national program overseen by the Public Health Accreditation Board (PHAB), an independent oversight body. The goal of the national public health accreditation program is to improve and protect the health of the public by advancing the quality and performance of *all* health departments in the country – state, local, territorial and tribal. Accreditation will drive the department to continuously improve the quality of the services we deliver to the community.

The NMDOH adopted a new model and useful processes and tools for health improvement that combine assessment, policy development, policy development, and planning for health improvement for New Mexicans. The motivation was to: better align health priorities to respond to the Healthy People 2020 initiative; engage communities to develop a common goal for health improvement; and advance performance and population accountability.

> "A collaborative effort to identify, analyze, and address health problems in a state; assess applicable data; develop measurable health objectives and indicators; inventory statewide health assets and resources; develop and implement coordinated strategies; identify accountable entities; and cultivate state public health system "ownership" of the entire process. The results of the state health improvement process are contained in a written document, the state health improvement plan."

The State Health Improvement Plan process (SHIP) includes: identification of state health priorities; engagement of cross-disciplinary leaders as partners; and the inclusion of regional, community and tribal input for strategic planning. We focused on health indicators that affect New Mexicans, as well as adverse health conditions with relatively large disparities among subpopulations or geographic regions. This is an unprecedented period of change and opportunity for the New Mexico Department of Health.

The Value of Partnerships between Community Health Councils, NMDOH, and Other Partners

Issue	Value of Community Health Councils for DOH	Value of DOH for Community Health Councils	Value of Other Partners
Public Health Accreditation	• Community level health improvement efforts that impact health	• Can provide methodology for and share understanding of broader implications of PH accreditation • Share understanding of accreditation domains/standards/measures (specific arenas of accreditation) for local entities	• Population and performance measures • Contributions to improve population heal through partnerships
Community - Level Assessments	• Health priorities identified at local level • Local data assessments using NM-IBIS, UNM, other NMDOH and local data • Integration of Results-Based Accountability (RBA) into program planning and evaluation	• Provide data collected at the state level – registries, surveillance systems, etc. • Technical assistance for data assessments • Funding for community-level assessments • Support from regional health promotion teams support	• Expertise and research resulting from work on social determinants and health (e.g. Alliance of CHCs, Kellogg, Grantmakers in Health; Con Alma Health Foundation, etc.)
Meaningful Use of Data	• Analysis of the community context for data • Analysis of services and gaps • Integration of information from local experts	• Analysis of data - epidemiology, clinical, surveillance, etc. • RBA guidance - perform RBA training • NMDOH goals & strategic plans • Statewide health assessment of needs • Evidence-based/promising practices and models • Scorecards for capturing local data/efforts	• Sharing of effective practices and models applied and tested in NM and region (e.g. PACE for older adult; Pathway's Pay for Outcomes; Developmental Assets, NM Association of Grantmaker models, GiH models, etc.)
Building Stakeholder Relationships	• Convening community meetings • Bringing stakeholders to the table • Engagement of community leaders and building support	• State level stakeholder development • Sharing of lessons learned • Linkages w/ other state departments • Assistance in identifying best practices • Coordinating data exchanges with partners for new data	• Sharing of expertise in training and research • Sharing of resources • Sharing of skills to fill gaps in public health workforce
Implementing Best Practices Expanding Support	• Building community support for CHC and NMDOH priorities • Mobilization of community members in support of legislative and budget priorities • Engagement of local legislators • Mobilization of community partners to extend services into communities	• Validation of CHCs and their work • Framing of PH issues for CHCs and their local constituencies • Searching for and submitting applications for additional funding	• Building core support for public health efforts at different levels with stakeholders and their constituencies

The Affordable Care Act (ACA)

The Affordable Care Act (ACA) requires us to transcend our traditional roles in public health to adapt to an evolving health care system. As the ACA, along with accrediting and governance entities, shifts accountability for health outcomes to additional stakeholders such as providers/practitioners, payers of health care, and communities. New opportunities arise for public health. These opportunities position public health to influence how the health care system evolves by using their expertise in policy development, community mobilization, effective data use and the forging of effective partnerships.

Requires Integrated Approaches to Preventions, Primary Care, and Overall Health

As the ACA formalizes the goal for health systems that everyone achieve or maintain optimal health, the complexities of a sufficient health care system are unveiled. Public health has long been cognizant of the need for non-traditional partnerships and can attest to the success of such collaborations. Public health leaders often engage and support important stakeholders, often mediating between their opposing interests. As other sectors of the health care system realize the need for integration, public health can provide leadership in mobilizing communities and facilitating productive partnerships to strategize new approaches.

"The Patient Protection and Affordable Care Act (ACA) is a landmark law that moves the health care system in the direction of prevention of disease and supports the role of local health departments."

Must Address the Increasing Burden of Chronic Conditions Among Our Populations

Chronic conditions increase the level of intervention and care needed from the health care system, for a longer period of time. The ACA promotes that entities other than local public health departments such as nurse-managed clinics, community health centers, and school-based centers increase their capacity to strategically address these health needs. Simultaneously, existing health management models, such as for chronic diseases are being replaced with population health improvement models that emphasize the importance of assessing and addressing physical, psychological, economic and environmental needs of the population. While these models may be newly emerging in clinical settings or disease-management programs, the associated concepts are not novel in public health, but rather, fundamental. As the transition of service delivery shifts from public health clinics to other community-based service centers, public health practitioners - particularly those with experience at the local and regional levels - can offer expertise in the design of alternative service strategies using a population health improvement approach.

Promotes the Acknowledgement That Place Matters

Where people live, learn, work, and play can be as important to health outcomes as medical intervention. In addition, preferences of individuals from disparate backgrounds impact their health choices and how and when they use the health system. As this recognition increases, public health will have more opportunities to influence policy makers to incorporate environmental and economic considerations into health-related policies. A health care system more appreciative of cultural relevance can look to public health for lessons learned in applying cultural sensitivity to health improvement efforts. Public health can also provide guidance in identifying accountability measurements other than clinical indicators that show the impact on known population health disparities, and/or economic and healthcare utilization indicators.

Cannot Succeed Without the Convergence of Health, Economic, Environmental and Demographic Information

How would a community design health programs without understanding who is, or even more importantly, who is *not* accessing their services? How can place be considered when environmental data are disconnected from health condition information? Health plans own the utilization data, clinics maintain patient data, hospitals have ambulatory care data, public health collects a plethora of data – the sources for health and/or population data seem infinite. It would be short-sighted to address population problems without first describing these populations. Public health can demonstrate the relevance and value of combining data to tell a story, inform a policy, avert an unwanted outcome -- save someone's life. Public health has expertise in using data to create a context from which to design interventions or create crucial feedback loops that ultimately impact health. Public health has the unique opportunity to mobilize support for the sharing of health information, understand and communicate the contextual and analytical meaning of data, and build competency in the broader health system workforce for the optimal use of health information.

Desired Result

In 2010, NMDOH adopted a new model and useful processes and tools for health improvement that combines: assessment, policy development and planning, and performance management for improving the health of New Mexicans. Our motivation was to: better align health priorities with the Healthy People 2020 initiative; engage communities to develop common goals for health improvement; and advance performance and population accountability. Our ultimate goal is to improve health through the development of a state health improvement plan to be used by communities, NMDOH and partners who are responsible for planning, implementing and measuring strategies that address health priorities.

Health Disparity and Health Equity

"Health disparities" was first officially defined as "differences in the incidence, prevalence, mortality and burden of disease and other adverse health conditions that exist among specific population groups in the United States". Health disparities are relative, and are identified by comparing the health status, access to services and/or health outcomes of population groups. Characteristics such as race or ethnicity, limited English proficiency, disabilities, sexual orientation, gender identity, economic status and geographic location may affect one's ability to achieve good health. Although there have been national efforts to reduce health disparities and achieve health equity during the past two decades (Healthy People 2000, 2010, 2020 and the National Partnership for Action to End Health Disparities), these efforts have been hampered by a lack of consistency in collecting and reporting health data. The Patient Protection and Affordable Care Act passed in 2010 not only addresses access to care, it also addresses the need for improved data to identify significant health differences that often exist between segments of the population. As a result the Office of Minority Health in the United States Department of Health and Human Services has released new minimum data standards for Race and Ethnicity, Sex, Primary Language and Disability Status. Improved data will assist in efforts to target affected populations and monitor efforts to reduce health disparities and move the United States to a status of health equity — "the attainment of the highest level of health for all people".

Who We Are

The concept of health disparities is important for all but is especially relevant for a state such as New Mexico. No single race/ethnic group makes up a majority of the state's population. According to 2011 state population estimates 43.1% of New Mexicans were Hispanic and 41.5% were White. Although the United States is increasingly diverse, Whites who are not Hispanic comprise over sixty percent of the national population compared to forty percent of New Mexico's population. Although New Mexico has a slightly smaller percentage of foreign-born residents (NM 9.7%, US 12.7%), it has a larger percentage of individuals who speak a language other than English at home (36%) than is true nationally (20.1%). Economically, New Mexico has a lower unemployment rate than the nation (NM 6.9%, U.S. 7.6%) but a higher rate of individuals without health insurance (NM 21%, US 16%) and a higher rate of individuals living below 100% of poverty (NM 23.8%, US 20.2%).

In summary:

- 6 of 10 New Mexicans belong to racial/ethnic minorities

- 36 of 100 speak a language other than English at home
- 1 of 5 are without health insurance, and
- 24 of 100 live below the poverty level.

Similar to the nation, New Mexico's older population is growing rapidly. The number of New Mexicans over the age of 65 increased 26 percent between 2000 and 2010. This number is expected to increase even more rapidly in the next decade with the aging of the "Baby Boomers" who began turning 65 in 2011.

Access to Healthcare

The National Healthcare Disparities Report identifies American Indians/Alaska Natives, Hispanics and people living in poverty as experiencing disparities in access to care. As the above data demonstrate, a substantial proportion of New Mexicans fall into these categories. In addition, New Mexico has the fifth largest land area among the fifty states but contains only four cities with populations of 50,000 or more.

Thirty-two of New Mexico's thirty-three counties contain health professional shortage areas. Over forty percent of the state's population is estimated to live in a Primary Care Health Professional Shortage Area.

Quality Improvement Model

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

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

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

NM State Health Improvement Plan Process

[2014-2016]

In the spring of 2011, the Department wanted to identify priority health issues that our programs and partners would focus on to improve community health. We examined how New Mexico ranks compared to other states on health issues by reviewing national publications, such as the Agency for Healthcare Research and Quality (AHRQ) State Snapshots, the Commonwealth Fund State Scorecard, America's Health Rankings, Kaiser State Health Facts and the Annie Casey Foundation Kids Count Data Book. New Mexico received rankings ranging from 33 (of 50) for America's Health Rankings to 46 (of 50) in the Kids Count Data Book. Each of these publications contains multiple indicators so the Department decided to concentrate on the indicators where New Mexico was ranked in the bottom 10 of the states.

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

Nine Health Indicators:

- **Healthy Weight**
- **Diabetes**
- **Tobacco Use**
- **Teen Births**
- **Adult Immunization**
- **Oral Health**
- **Elder Falls**
- **Drug Overdose Deaths**
- **Alcohol-Related Deaths**

The State Health Improvement Plan process is visualized in a graphical format (Figure 1). First, a planning committee was selected by the Secretary of Health to include leaders in the NMDOH. The planning team identified the health improvement process to include: identifying health priorities for the state, engaging cross-disciplinary leaders as partners, and incorporating regional, community and tribal input for planning and implementing strategies.

To begin the process, the team compiles an analysis of population health indicators focusing on indicators that affect relatively large portions of the population and/or those with large disparities. To identify the potential health focus areas, population health indicators are identified in national and state reports and a selection was made of indicators where New Mexico ranked the lowest in the United States; indicators that affected large segments of the population and indicators with large disparities. Based on this review, health focus areas were selected as proposed health of focus areas for the health improvement plan.

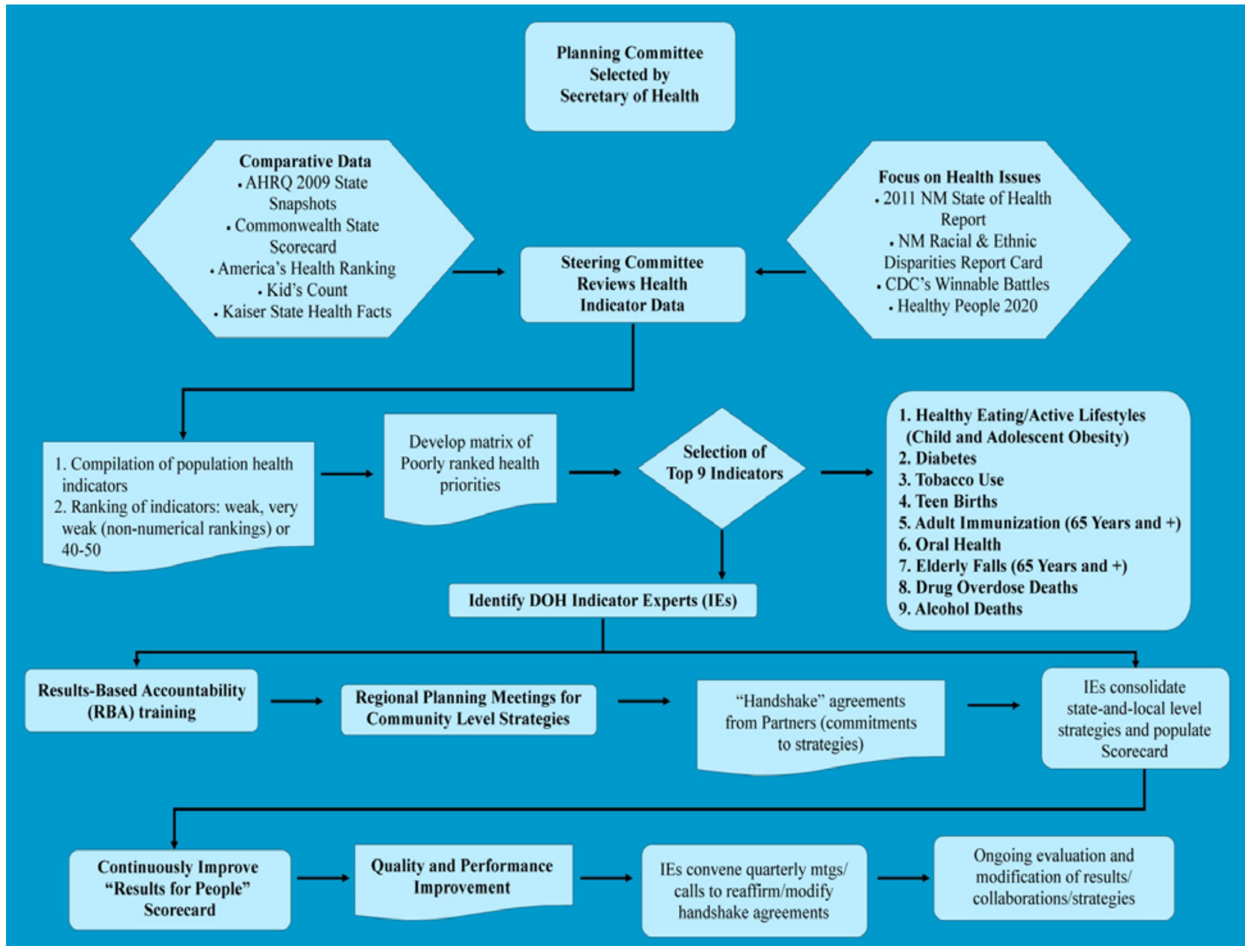

Figure 1. The State Health Improvement Plan process in graphical format

The RBA approach and proposed health indicators were discussed at a meeting with key stakeholders from across New Mexico. Leaders from other government agencies, hospitals, community clinics and non-profit organizations were convened to discuss health conditions and their organization's contribution to address the conditions.

Turn the Curve on Health

In December 2011, NMDOH welcomed state leaders to participate in a Turn the Curve on Health kick-off event. Each participant from the public or private sector selected one of the nine health areas to focus on for the day. The process was lead by a Results-Based Accountability facilitator. Each health area was staffed by a NMDOH subject matter expert. Participants examined relevant data, contributed to the story behind the data, learned about existing evidence-based and promising interventions, and offered their contribution to population health improvement.

The Turn the Curve or Results-Based Accountability process was repeated during the months of April and May 2012 in 5 regional locations: Roswell, Gallup, Las Cruces, Albuquerque, and Santa Fe. At the end of these regional meetings, participants were asked to join the NMDOH to improve health in their

local communities by contributing at least one evidenced-based action. Partner agreements were collected and NMDOH subject matter experts are continuing to work with partners to implement projects.

This important work relies on a robust collaborative network of NMDOH state and regional staff and local community partners, including a strong relationship with community health councils. The work to strengthen this system will continue over the next months and in future years.

During these meetings, community input was gathered on the selected health indicators. This input served as an opportunity for community partners to put forth health indicators they felt were important for future consideration. NMDOH asked the community partners to select 1 the 9 health indicators about which they wanted to learn more. Based on the chosen health indicator, small groups were assembled with the Indicator Lead (IL). The IL introduced the RBA approach, provided county and state level data for each indicator and the evidence-based and/or promising practices found to be effective to address the specific health indicator.

Following the small group discussions, partnerships were confirmed through "Handshake Agreements." (Appendix B). These "Handshake Agreements" are outlined commitments signed by partners on the proposed strategies they want to implore in their communities or target populations in order to address the chosen health focus area. In addition, the handshake agreements outline what NMDOH will provide, assist in and commit to in their work with community partners. These agreements have served as a mechanism to promote internal NMDOH and external partner collaboration. Indicator Leads have hosted call-ins following the regional meetings with their partners to provide assistance, if requested by the partner, and to hear progress reports on implementation efforts.

"Results for People Scorecard"

The "Results for People Scorecard" (Scorecard) is a results management database used to track performance and population data. The Scorecard reports actions taken to implement strategies addressing the priority health areas. Strategies are accompanied by performance measures monitored periodically by those accountable. Annual review of all strategies and program results will be conducted by Lead Indicators, Health Promotion staff, and community partners. Strategies will be revised accordingly.

A Scorecard is developed to feature:

- The latest available data on the indicator for each of the 9 priority health issues;
- Background information (indicator trend, NM data in compared to national data, high-risk populations/areas of the state);
- Evidence-based/promising interventions;
- Current partners;
- Strategies/activities planned by the NMDOH and its partners with demonstrated accountability through the "Handshake Agreements"; and
- Hyperlinks to the NMDOH Indicator-Based Information System (NM-IBIS), which provides access to public health datasets and information on New Mexico's priority health issues.

NMDOH is committed to illustrating the valuable work accomplished within the department, and by community partners and stakeholders. Much of the work that is done throughout the department is data driven and demonstrated through performance measures to examine effectiveness over time. Currently, the evidence-based strategies that are employed are too new to reveal data that could demonstrate a reduction in the individual health indicators. Therefore, the work that we are doing now within the communities, counties and regions will be showcased in order to provide progress reports, health education, transparency and additional resources for people who visit the webpage.

We will continue to use data to track progress but as more of an internal component. The work that we do ultimately will be uniformly tracked in the Scorecard. NMDOH maintains NM-IBIS, a public health data warehouse that offers state and county data presented by health indicator. The NMDOH webpage and NM-IBIS offer a complimentary approach for transparency (data) and education (resources). Both venues serve constituents in the capacity they may need.

Engaging Partners

In this section, NMDOH describes the State Health Improvement Plan (SHIP) process for working with state and community partners to identify health priorities and to develop a comprehensive health improvement plan that reflects partnership activities to improve population health. New Mexico's SHIP Process requires three levels of stakeholder involvement.

State Level Cross Cutting Health Priorities group

The State Crosscutting Health Priorities Group has broad representation from the state, county and tribes, and will review the State Health Assessment (SHA) to identify health issues and themes, evaluate the resources and assets to effectively address those health priority issues, and determine/update the state priority health issues. This group will convene at least once annually, or more frequently as necessary, to review the health assessment and progress toward improvement of identified health priorities, and to make changes to the health priorities as needed.

The Cabinet Secretary of Health will convene a subset of this group to promote enhanced statewide partnership and active participation in the planning process. This group includes other department cabinet secretaries working on population health improvement.

The Tribal planning process will adhere to the State-Tribal Collaboration Act. The specifics of the planning process shall be determined by the Cabinet Secretary of Health, in close collaboration with the NMDOH tribal liaison, and in collaboration with the Department of Indian Affairs.

New Mexico cabinet secretaries:

- Human Services
- Children, Youth and Families
- Public Education
- Environment
- Aging and Long Term Services
- Higher Education
- Indian Affairs
- Transportation
- Homeland Security and Emergency Management

State Single Issue Workgroups

The entities that comprise state-level health priority specific groups focus on one or more of the health priority areas. These groups are convened by NMDOH programs, define statewide objectives and focus on statewide results, including health indicators, measures, and strategies for the current nine (9) health priority areas. Further, these groups historically address needed policy change, as well as engage individuals and organizations responsible for implementing strategies and activities.

Examples of Single Issue Workgroups:

- Elder Falls: The New Mexico Adult Fall Prevention Coalition
- Dental visits: NM Oral Health Advisory Committee
- Diabetes: New Mexico Diabetes Coalition
- Drug Overdose: Prescription Drug Misuse and Overdose Prevention and Pain Management Advisory Council
- Teen Pregnancy: New Mexico Teen Pregnancy Coalition
- Adult Immunizations: NM Immunizations Coalition
- Obesity: NM Healthier Weight Council

Community Level Participation

County, community and tribal health councils (and their partners) will review the State Health Assessment (SHA) and their own county/tribal profiles to identify health issues and themes, resources and assets, and identify county priority health issues. They will consider contributions to the SHIP.

The State Health Assessment process will provide county level data, including rankings and small area data when possible, for each priority health indicator and for counties and tribes with the worst rankings. NMDOH regional health promotion teams will collaborate with community health councils in order to identify specific strategies that may be implemented to improve a particular health indicator. Health promotion teams will strengthen collaboration efforts with NMDOH indicator leads to provide health councils and community partner data, technical assistance and other resources as requested.

SHIP Monitoring and Reporting

The ongoing SHIP process will have a minimum of annual status updates that will allow each level of stakeholder involvement to recommend changes to the priorities, results, measures and strategies based on review of the assessments.

Role of the New Mexico Alliance of Health Councils in the NM Health Equity Partnership

There is a long history in NMDOH of recognizing the value of community-based health improvement planning and action. This philosophy is based on research and experience that community members are in the best position to identify their own health needs and priorities, and to mobilize their communities to address those needs. New Mexico is one of a small minority of states with a centralized, statewide health department with regional and local health offices, rather than county or municipal-based health departments. This establishes the critical need for community-based health assessment, planning and action at the local level. It is especially true in those communities with significant health disparities due to inequitable resource allocation and inadequate public health policies.

The newly-established NM Health Equity Partnership funded by the W.K. Kellogg Foundation and managed by the Santa Fe Community Foundation, combines the collective strengths of three statewide activities that are designed to build local capacity: support for the NM Alliance of Health Councils (NMAHC); expansion of Place Matters teams to cover four counties; and statewide training in Health Impact Assessment. The initiative is intended to address necessary changes in policies, systems and physical infrastructure with the goal of creating conditions in which children, families and individuals can be healthy.

The NMAHC is committed to developing a unified voice for all 38 county/tribal health councils to advocate for policies and systems changes that support community health improvement. Health councils contribute significantly to assessment and planning in their local communities and serve as conveners for multiple sectors to address community priorities. By their very nature, health councils are designed to engage local and statewide agencies, tribal entities, and non-profit organizations committed to improving the health of their community. This is a hallmark characteristic of all of New Mexico's county/tribal health councils. The desired outcome of this collective approach is to dramatically improve the capacity of local communities to address the social and environmental factors that affect health through community-based initiatives and local policy and systems change, with the ultimate goal of closing racial/ethnic and geographic health disparities gaps, particularly for vulnerable children.

Specific goals of the NMAHC are to:

- Build capacity of all county/tribal health councils to continue and expand their work;
- Establish a unified voice to define and promote the value and services of county/tribal health councils in New Mexico; and
- Promote state and local policies and funding that support community health improvement and health equity for all NM communities and cultures.

These goals will be accomplished through the following activities:

- Convening annually one statewide and four regional conferences to exchange information, build community, and conduct training;
- Hosting additional workshops and training sessions, such as the proposed HIA training, Results-Based Accountability, assessment/planning, funding strategies, addressing health disparities and promoting health equity, community mobilization, and building effective coalitions;
- Sharing knowledge and best practices, and disseminating resource information in support of health councils' work through improved communications channels, such as email, newsletter, website and web-based communications;
- Researching potential funding opportunities and disseminating information to all health councils;
- Developing and submitting funding proposals to support the NMAHC;
- Providing assistance to individual health councils or groups of councils to apply for funding;
- Identifying shared policy priorities for improving community health and health equity, and developing position papers on those policy priorities;
- Collaboration with other organizations on advocating for shared priorities; and
- Communicating legislative updates to Alliance members and supporters.

NMDOH has formed a strong partnership with NMAHC at the state and regional levels by providing Results-Based Accountability training for trainers and coaches to NMAHC and community health council members. The NMDOH Public Health Division and its regional public health promotion teams have worked closely with CHCs over the years and is further developing these vital partnerships to support population health improvement.

Historical Perspective

In general, community health councils plan and coordinate community-level responses to pressing health issues. Members of health councils typically include representatives of various community sectors: health care providers, schools, public health officials, health advocates, health care consumers, and community members interested in housing, transportation, economic development, and community wellness.

New Mexico's Current Health Council System

The system is comprised of 33 county-based councils and 5 tribal health councils (Acoma, Cochiti, San Ildefonso, Santa Clara, and To'Hajiilee). The health councils were originally established under provisions of the 1992 Maternal and Child Health Plan Act. The New Mexico Department of Health provides training, coordination, technical assistance, and other kinds of support to the health councils. Existing health councils have varying degrees of resources.

Community Health Councils: The Hub of Local Public Health Systems

Community health councils (CHC) assess local health needs, identify gaps in services, develop community health plans and priorities, and coordinate community health initiatives. Councils serve as vital partners of the statewide public health system, providing local information and feedback to NMDOH and other organizations regarding community health issues.

Addressing Urgent Health Needs

Health councils work to address locally-identified urgent health issues, such as youth suicide clusters, teen pregnancy prevention, diabetes and obesity prevention, drug overdose death and mental health issues, and access to primary health care.

Achieving Outcomes

New Mexico's community health councils have been able to achieve a number of positive changes in their communities that in turn result in improved community health:

- **Coordination of services,** resulting in more collaboration, less duplication, and cost savings.
- **Integration of services,** with facilitated referral processes among health care providers.
- **Joint programs and community events** involving health care providers, social service agencies, volunteer organizations, and state offices.
- **Bringing additional funds to New Mexico communities,** through collaborative grant proposals and providing assistance to agencies with health data and proposal writing.
- **Policy changes** to improve community health, in such areas as tobacco use, under-age drinking, improved community fitness facilities, and other areas.
- **Improving health disparities,** identifying and addressing gaps in services and barriers to access to health care for specific populations and community segments.

NMDOH is in the process of supporting the rebuilding of infrastructure capacity and strengthening relationships, with the ultimate goal of increasing formal and effective collaborative efforts with our

partners. For example, NMDOH will soon send letters to County Managers and Tribal Health Council leaders offering our support, funds for assessment and planning, and continued collaboration.

In March of 2013, the General Appropriation Act of 2013 passed the New Mexico Legislature and included a state general fund appropriation to the NMDOH Public Health Division of $195,000 for statewide health councils. These funds are recurring annually and will support the development and sustainability of the most under-resourced community and tribal health councils statewide.

Achieving Results: New Mexico Public Health Accreditation

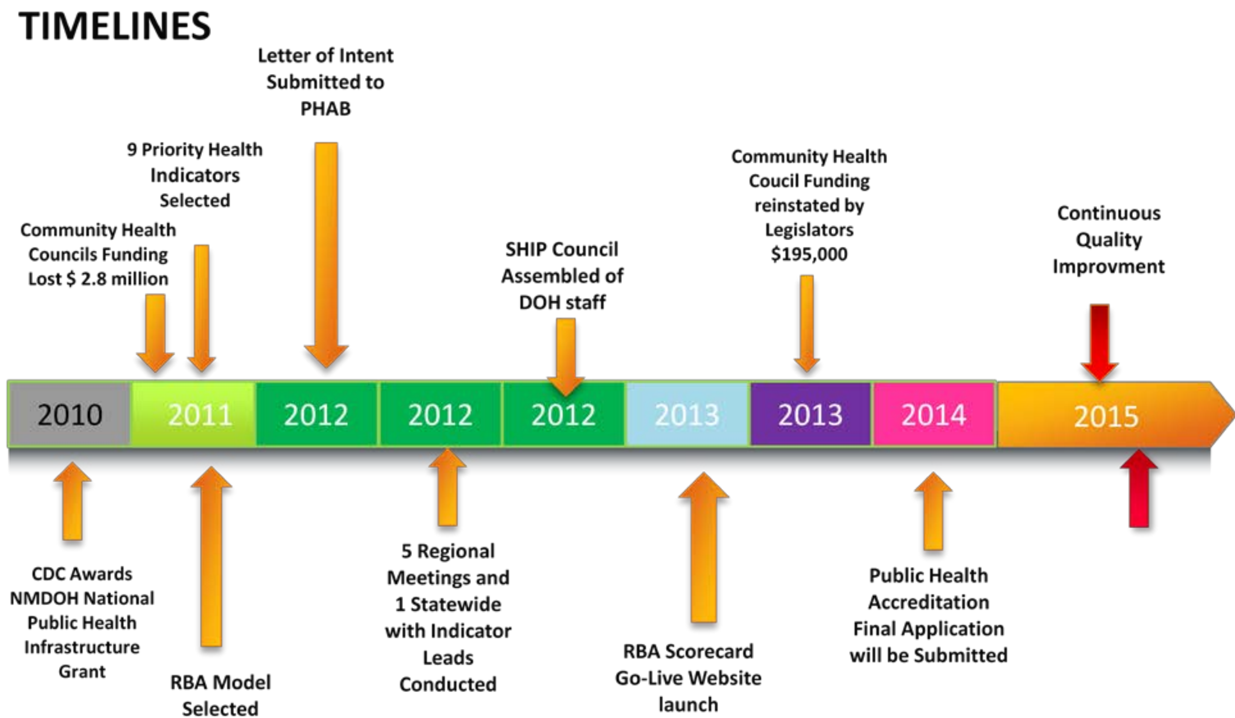

Figure 2. NMDOH Public Health Accreditation Application Timeline

Nine Priority Health Indicators

Healthy Weight

Reduce Child and Adolescent Obesity

Story Behind the Curve

- Obesity is a growing problem and occurs at very young ages. In 2011, 15% of kindergarten and 21.9% of third grade students were obese.
- American Indians have the highest rate of obesity among all age groups in New Mexico. By third grade one in two American Indian students are obese or overweight.
- Obese children are more likely to be obese adults and suffer from heart disease and diabetes.
- Healthy eating and active living are two lifestyle choices that can prevent obesity but social and environmental factors make it difficult for many to eat healthy or be physically active.
- Kids no longer want to play outside. They would prefer to sit and play video games or watch TV.
- Increased access to inexpensive high fat, high calorie and high sodium foods make healthy eating more difficult.
- Other factors; working families, concern for children's safety, TV food advertising, lifestyle of convenience.

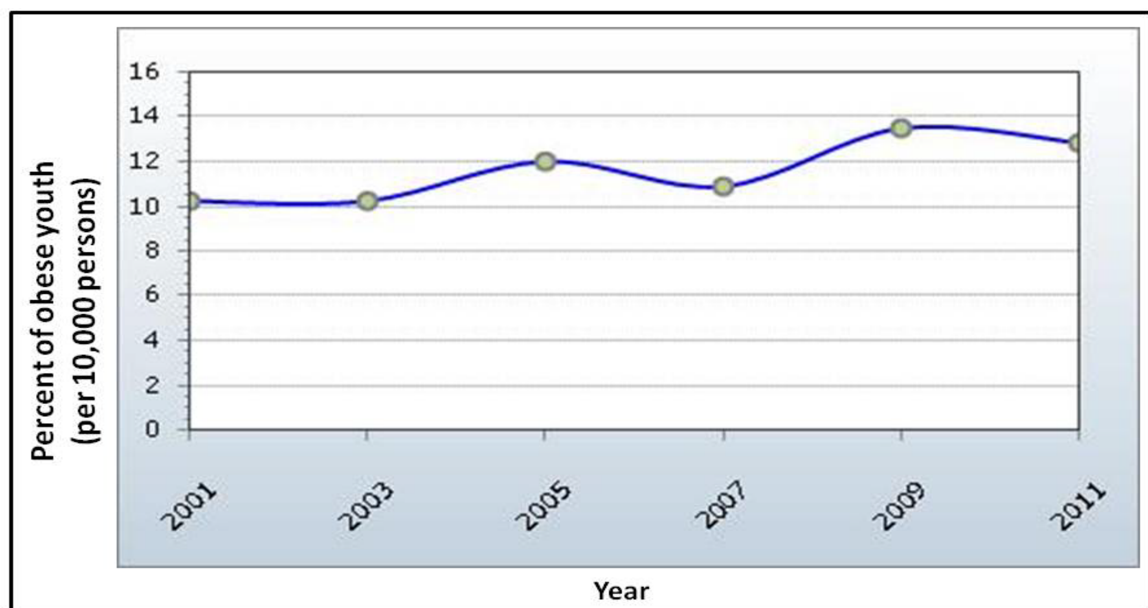

Figure 3. Percent of obese youth, 2001-2011

What Works

- Increased access to fresh fruits and vegetables (Farm to School, Farm to Table, Farmer's Markets, School and Community Gardens, and food buying clubs).
- Increased access to safe and open facilities for physical activity (Joint-Use agreements, Safe Routes to School, Complete Streets, Safe places for play and Prescription Trails).
- Updating and strengthening wellness policies at the school and community levels.
- Incorporating healthy eating and physical activity into the daily routines at childcare facilities, schools and the workplace.
- Establishing a Healthy Kids Healthy Community initiative to create policy and environmental changes to support healthy eating and active living.

Partners

- NM Interagency Council for the Prevention of Obesity
- NM Agriculture Department
- NM Public Education Department
- NM Children, Youth and Families Department
- NM Human Services Department
- NM Aging and Long Term Services Department
- NM Healthier Weight Council
- NM Cooperative Extension Services
- NM Food and Agriculture Policy Council
- NM Envision
- NM County Health Councils
- NM Healthy Kids Healthy Communities
- NM State Parks
- NM Hunger Task Force

Strategies

NMDOH strategies to provide technical assistance and training to:

- NM licensed and registered childcare centers and homes to support healthy eating;
- schools and school districts to support walking school buses, in which children walk together from a safe site to school;
- schools and school districts to support the establishment of safe, active and welcoming outdoor school space for community use;
- schools and school districts to support the purchase of locally grown food for school meals; and,
- rural and frontier communities to support increased access to an affordable and healthy food supply.

New Mexico Children's Cabinet Strategies:

- Conduct a statewide survey on New Mexico children's eating and physical activity behaviors. The results will provide statistics on actual behaviors, which will allow for targeted, educational reform efforts to be made toward our families, schools, and communities; and,
- Promote healthy diet choices, increasing access to healthy foods, and the creation of safe places for physical activity.

Diabetes

Reduce Diabetes-Related Hospitalizations

Story Behind the Curve

- Data show hospitalization for diabetes as the primary diagnosis upon discharge but does not include data from federal hospitals such as IHS and VA hospitals and thus undercounts the number of hospitalizations.
- Hospitalization represents the most severe cases of disease and indicates that the disease is not well-controlled.
- Lack of follow-up on A1c results or the importance of monitoring A1c.
- Language and cultural barriers exist between patients and providers.
- Patient denial or fear can lead to non-compliance with medication and treatment plan and poor eating habits because of lack of knowledge on adapting cultural/traditional foods.
- Lack of resources affects both access to care and ability to make lifestyle changes.
- Inadequate links between healthcare providers and between providers and community programs affect care.

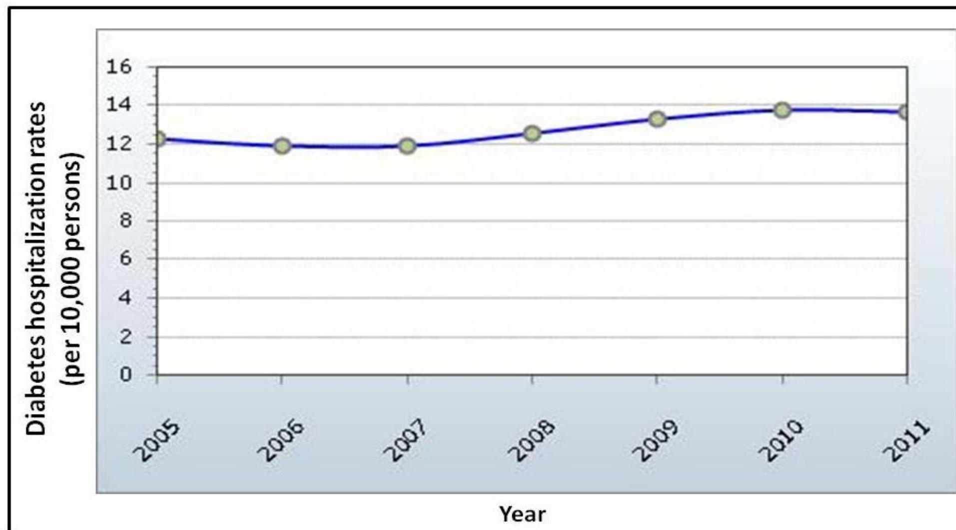

Figure 4. Diabetes hospitalization rates (per 10,000 persons), 2005-2011

What Works

- Intensive management of diabetes and co-morbid conditions by hospital, primary care staff and by individuals and their families through improving glycemic control, provider monitoring of A1c and diabetic retinopathy screening.
- Diabetes self-management education in community gathering places for adults in the home for adolescents.
- Case Management.
- Lifestyle change programs for people at high risk for type 2 diabetes.

Partners

- Federally Qualified Health Centers
- NM Primary Care Association
- Diabetes Self-Management Education (DSME) programs
- NM Hospitals
- Tribal and community diabetes programs
- Physical activity and nutrition organizations
- Other DOH chronic disease programs (TUPAC, Arthritis)
- DOH Office of Community Health Workers
- Zia Association of Diabetes Educators
- American Heart Association
- NM Medical Review Association

Strategies

- Support health care organizations in assessing and implementing practice changes to improve quality of care for people with and at risk for diabetes through use of the Planned Care Model and/or Patient Centered Medical Home and supported by provider education.
- CMS will provide more personalized case management and nutrition services to children and youth with diabetes and pre-diabetes.
- Produce consistent guidelines to interpreting glucose levels, developing treatment plans and providing patient education including the use of group education.
- Expand *My CD* peer training to improve self-management of diabetes.

Drug Overdose Deaths

Reduce Drug Overdose Deaths

Story Behind the Curve

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

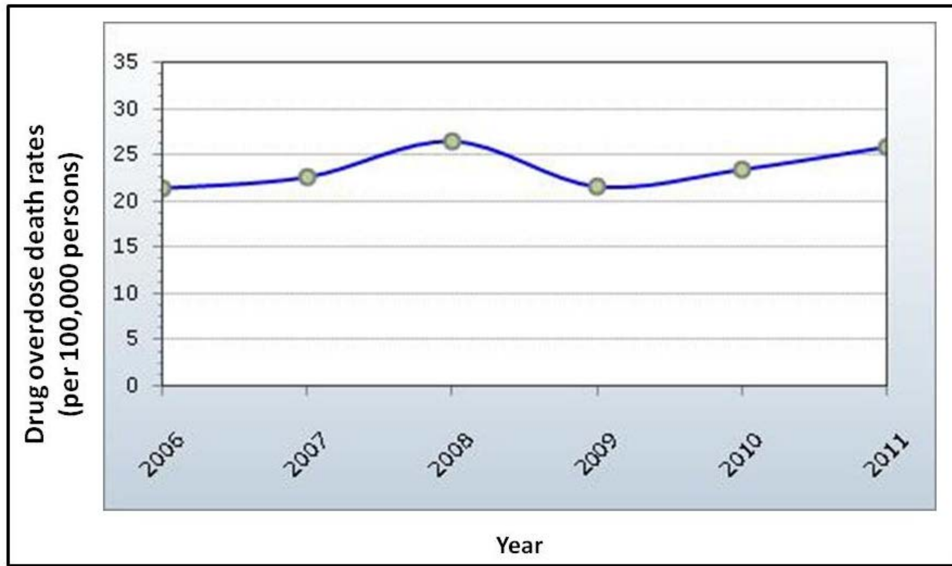

Figure 5. Drug overdose death rates (per 100,000 persons), 2006-2013.

What Works

Intervention	Description of Intervention	Level of Effectiveness
Treatment	Effective, accessible substance abuse treatment programs could reduce overdose among people struggling with addiction.	**Promising Practices** as recommended by CDC in "*Policy Impact, Prescription Painkiller Overdoses*"
Restriction Programs	Restriction practices improve the coordination of care and use of medical services as well as ensure appropriate access for patients that are high risk for overdose. Examples of restrictive measures include those taken by Washington state to limit high risk Medicaid clients to one pharmacy, one provider, one hospital and one physician.	**Promising Practice** as recommended by CDC in "*Policy Impact, Prescription Painkiller Overdoses*"
Community Outreach and Awareness	Promote community education regarding the smart storage of drugs, safe disposal of drugs, and what to do if an overdose occurs. Promoting aware of the good Samaritan law helps family member report a drug overdose without fear of arrest. *	**Promising Practice** Centers for Disease Control as referenced in CDC website.

Prescription Drug Monitoring Programs	CDC recommends the start up or improvement of prescription drug monitoring programs (PDMP's) to track all prescriptions for painkillers in the State. Information should be used to track and identify improper and prescribing of painkillers. PDMP's work best when they are paired with aggressive prevention, treatment and enforcement. In addition, PDMP's should be used to identify improper prescribing practices.	**Promising practice** as recommended by CDC in Vital Signs "*Prescription Painkiller Overdoses in the US*". And CDC in "*Prescription Drug Overdose: State Health Agencies Respond*"
Leadership and Coordination	State agencies should identify a permanent home for drug overdose issues in order to avoid fragmentation of services.	**Promising practice** as recommended by CDC in "*Prescription Drug Overdose: State Health Agencies Respond*"
Screening	Health care providers should provide screening and monitoring for substance abuse and mental health issues.	**Promising Practice** as recommended by CDC in Vital Signs "*Prescription Painkiller Overdoses in the US*". Recommended as a promising practice by the Washington State Department of Health in Poisoning and Drug Overdose.
Project Lazarus	A public health, pain medication overdose prevention model based upon multi-sector partnership (hospital EDs, county law enforcement, managed care organizations, state health department, public insurance brokers, boards of medicine and pharmacy) with following components: (1) community coalition building, (2) monitoring and epidemiologic surveillance, (3) provider education, (4) naloxone (5) project evaluation	**Evidence Based** **69% reduction** in poisoning mortality rate from 2009 to 2011; **15% reduction** in substance abuse and overdose-related ED visits from 2008 to 2010 in Wilkes County, NC
Intervention	**Description of Intervention**	**Level of Effectiveness**
Community Awareness	Local Communities/individuals can provide community education about the storing of prescription medication and the proper disposal.	**Promising Practice** as recommended by CDC in Vital Signs "*Prescription Painkiller Overdoses in the US*".
Treatment	Effective, accessible substance abuse treatment programs could reduce overdose among people struggling with addiction. School based health centers can be developed to assist with addiction and drug related problems amongst youth and their family members.	**Promising Practice** as recommended by CDC in "*Policy Impact, Prescription Painkiller Overdoses*"
Screening	Health care providers should provide screening and monitoring for substance abuse and mental health issues.	**Promising Practice** as recommended by CDC in Vital Signs "*Prescription Painkiller Overdoses in the US*".
Implement a Pharmacy Take Back Program	Pharmacy Take Back programs allow citizens to bring back unwanted or outdated medications to the pharmacy for proper disposal in order to reduce diversion to other users. Drugs collected are incinerated. This can be implemented	**Promising Practice** as recommended by Washington State in "*Poisoning and Drug Overdose*".

	on a local or statewide level.	
Awareness	Use of Poison Control Centers saves lives and costs in other medical spending, yet in New Mexico it is being used infrequently with regard to prescription medication overdose. Local communities could take action to increase the awareness of the statewide Center as a resource for medication management and/or overdose.	**Promising Practice** as recommended by Washington State in "*Poisoning and Drug Overdose*".
Education	Increase education and professional awareness of the magnitude, risk, and signs of unintentional overdose	**Promising Practice** as recommended by Washington State in "*Poisoning and Drug Overdose*".
County Pilot of Project Lazarus	A public health, pain medication overdose prevention model based upon multi-sector partnership (hospital EDs, County law enforcement, managed care organizations, county health department, public insurance brokers, boards of medicine and pharmacy) with following components: (1) community coalition building, (2) monitoring and epidemiologic surveillance, (3) provider education, (4) naloxone (5) project evaluation	**Evidence Based** **69% reduction** in poisoning mortality rate from 2009 to 2011; **15% reduction** in substance abuse and overdose-related ED visits from 2008 to 2010 in Wilkes County, NC

Partners

- NMDOH Programs (Substance Abuse Epidemiology Program; Office of injury Prevention, Emergency Medical Services Bureau, Office of School and Adolescent Health, Public Health Division Harm Reduction Program, Public Health Clinics)
- Other state agency partners: Human Services Department (Office of Substance Abuse Prevention, Office of Medicaid), Workers' Compensation Administration
- State Epidemiological Outcomes Workgroup
- Tribal Epidemiological Outcomes Workgroup
- Community-based drug overdose prevention planning tables
- New Mexico Association of Counties
- University of New Mexico: Prevention Research Center, RWJ Center for Health Policy, Project ECHO Integrated Addictions and Psychiatry tele-health clinic and Chronic Pain tele-health clinic
- PIRE/Behavioral Health Research Center of the Southwest
- New Mexico Drug Policy Alliance
- New Mexico Poison Control Center
- Local, state, and federal law enforcement agencies

Strategies

- Increase access to overdose prevention education and naloxone for persons at-risk of misuse or overdose of their prescribed pain medication (Co-prescription Pilots).
- Increase reach and access to public health overdose prevention and naloxone services.

- Expand protocol/service scope of Basic Emergency Responders to include administration of naloxone.
- Expand professional education to healthcare providers on the role of overdose prevention education and naloxone for high risk patients receiving opioid pain medication.
- Expand healthcare licensing board oversight of prescribing practices.

Tobacco Use

Reduce Tobacco Use

Story Behind the Curve

- New Mexico's adult smoking prevalence declined significantly between 2001 and 2010, following similar national trends.
- Despite decreases in overall adult smoking in NM, rates are still significantly higher among adults who have lower education, lower income, are unemployed, or uninsured.
- Smoking among NM high school youth remains stagnant and higher than the national rate (24% vs. 19.5% respectively). Especially high smoking rates are seen among youth with poor academic grades, American Indian youth, and youth experiencing food insecurity.
- About 92% of New Mexicans are protected from secondhand smoke exposure by the 2007 Dee Johnson Clean Indoor Air Act, but it does not cover tribal lands in the state.

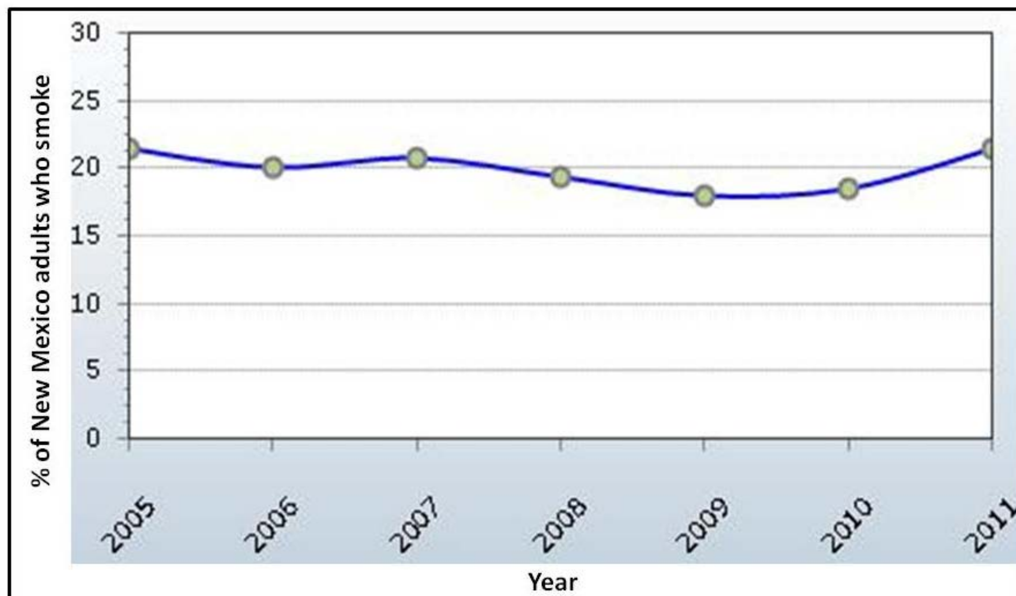

Figure 6. Percent of adults who smoke, 2005-2011

What Works

- Increasing the price of all tobacco products, including cigarettes, chew and snuff tobacco, cigars, and roll-your-own tobacco.
- Regulating the time, place, and manner in which tobacco can be advertised and sold in order to prevent youth from initiating tobacco use.
- Supporting the development of policies to protect all New Mexicans from secondhand smoke exposure, including locations not covered by Dee Johnson Clean Indoor Air Act.
- Screening all patients in healthcare settings for tobacco use and providing brief interventions or referrals to 1-800-QUIT NOW.

Partners

- NMDOH programs [Tobacco Use Prevention & Control (TUPAC); Diabetes Prevention & Control; WIC; Public Health Regions; Epidemiology & Response Division]
- Local, regional, and statewide TUPAC-funded grantees, including media and 1-800-QUIT NOW service providers
- Other state agency partners: NMHSD (Office of Substance Abuse Prevention, Synar Program; Public Education Department)
- Priority Population Networks (African American Health Network, Southwest Tribal Tobacco Coalition, Disabilities Advisory Group About Tobacco, Juntos Podemos, Fierce Pride)
- American Cancer Society—Cancer Action Network; American Lung Association

Strategies

- Provide QUIT NOW telephone- and web-based cessation services supported by media, training, and community outreach designed to increase tobacco cessation awareness and referrals.
- Expand linkages between Tobacco Use Prevention and Control (TUPAC) Program and other DOH programs (e.g., WIC, Children's Medical Services, PRAMS, etc) and community organizations (e.g., non-profits, health councils, tribal groups, priority population networks, etc) to promote QUIT NOW cessation services.
- Support smoke-free multi-unit housing community secondhand smoke education and voluntary policy efforts through use of data, strategic partnerships (CTG, TUPAC grantees and new community partners) and training statewide.

Teen Births

Reduce Teen Births

Story Behind the Curve

- The birth rate for teens ages 15-17 has declined, but it is nearly 30% higher than the national rate.
- NM is ranked as the 3rd poorest state in the nation. Poverty is a cause as well as a consequence of early childbearing.

- Hispanics have the highest rate among all populations in New Mexico accounting for 69% of all births to teen girls ages 15-17.
- Hispanic teens tend to look at the prospect of pregnancy more favorably than teens from other racial and ethnic groups.
- Sexually active Hispanic teens are less likely to use contraception than other teens.
- Many NM teens do not have immediate access to family planning or birth control services. Barriers include socioeconomic status, clinic location and transportation. Services at community clinics are often not available at teen friendly hours e.g. after-school.
- Increased awareness and accountability for a male's role in birth control and teen pregnancy is needed.
- Parents often find it difficult to talk with teens about sensitive issues such as sex and reproductive health.
- Parents may not communicate their values to their children and in some families the stigma of teens having children isn't as powerful.
- There is a lack of support services and systems for youth such as prevention services and early intervention to prevent unintended and unplanned pregnancies.

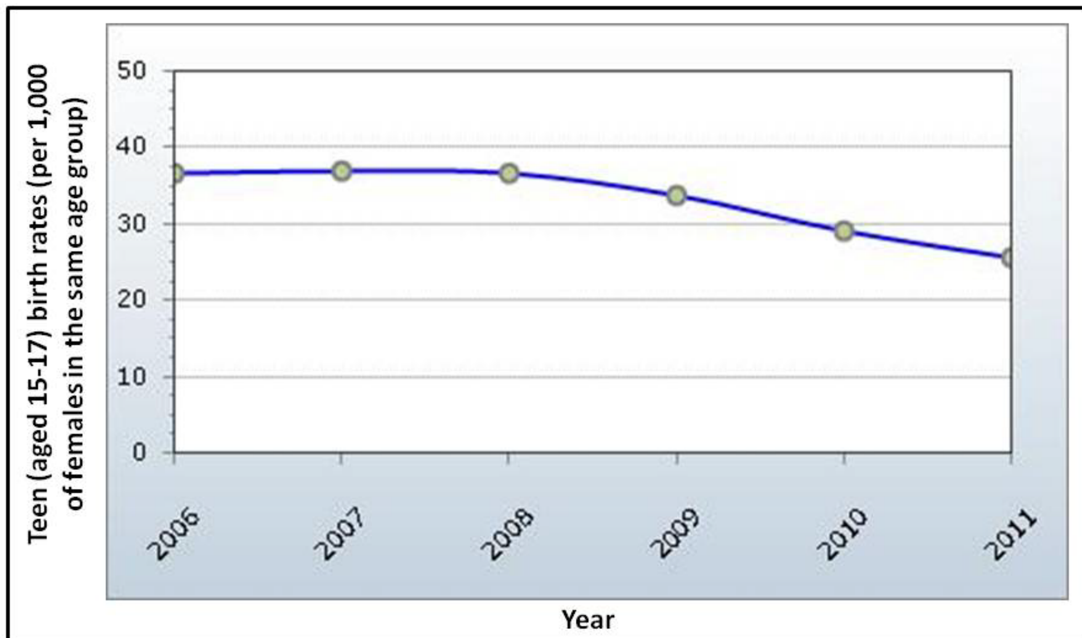

Figure 7. Teen (aged 15-17) birth rates (per 1,000 of females in the same age group), 2006-2011

What Works

Evidence-Based Interventions:

- Confidential Clinical Services including School Based Health Centers.
- Service Learning Programs/Youth Development (All4You, Teen Outreach Program, CAS-Carrera).

- Comprehensive Sex Education Programs (Cuídate!, Draw the Line/Respect the Line, Making a Difference, Making Proud Choices, Safer Choices).
- Male Involvement Programs (Reproductive Health Counseling for Young Men).

Promising Practices include:

- Male involvement programs (Wise Guys Male Responsibility Curriculum).
- Adult-Teen communication programs (Plain Talk, Raíces y Alas).
- Natural helpers and teens listening to teens (peer-to-peer leadership).
- Peer group education.
- Early childhood intervention programs.
- Mentorship programs for males and females.
- Community health workers.

Partners

- New Mexico Teen Pregnancy Coalition
- Community based clinical providers
- School Based Health Clinics
- Office of School and Adolescent Health
- Children Youth and Families Department
- Public Education Department
- Human Services Department
- Schools/school boards
- Parent organizations
- Indian Health Services
- Community Colleges/Universities
- Community Health Councils
- After-school/Youth Programs
- Youth Allies
- Policy Makers

Strategies

- Expand Title X family planning services at school-based health centers (SBHCs) that have local school board approval to dispense contraceptives, to assist the SBHCs with confidential family planning services on-site.
- Expand comprehensive sex education programs through local advocacy at individual schools and school districts.
- Incorporate service learning programs into higher education opportunities through pipeline programs and college credits.
- Increase adult-teen communication programs on teen pregnancy prevention through the provision of resources and materials to local communities.

Adult Immunization

Increase Adult Immunization

Story Behind the Curve

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

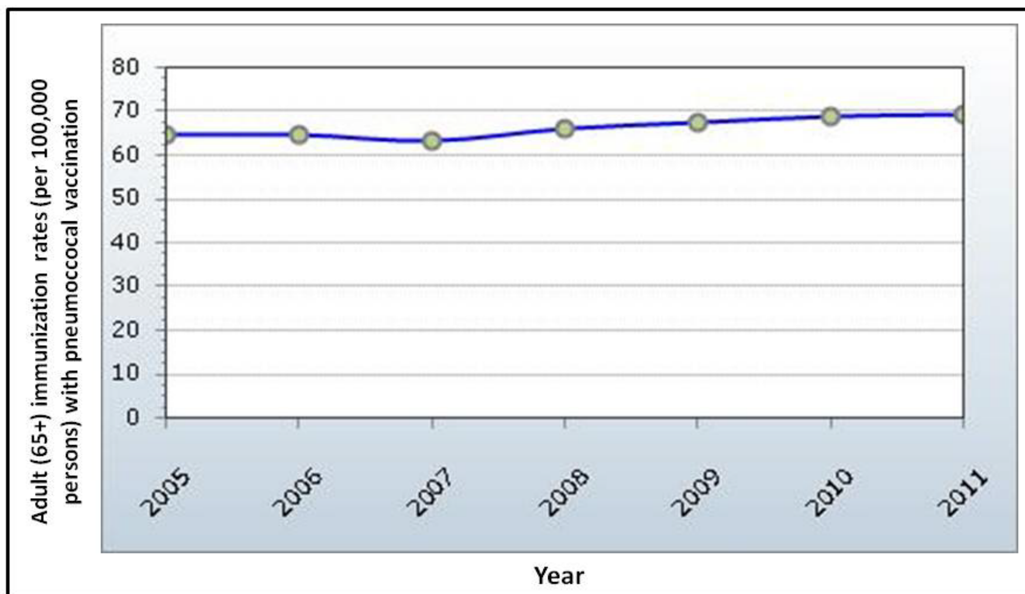

Figure 8. Adult (65+) immunization rates (per 100,000 persons) with pneumococcal vaccination, 2005-2011

What Works

- Expanded access in health care settings.
- Reduced client out-of-pocket costs.
- Standing orders, reminder systems, assessment and feedback in provider settings.
- Mass and small media, educational activities.

Partners

Traditional

- NM Immunizations Coalition
- Clinical Prevention Initiative
- NM Medical Review
- Regional Immunization Staff
- Immunization Providers
- Indian Health Services
- Aging & Long-Term Services
- AAIHB

Non-Traditional

- AARP
- Senior Olympics
- Other elder recreational centers
- Business focusing on elders

Strategies

- Collaborate with community services to increase access points to immunizations.
- Educate providers to use reminder recall, IIS tracking.
- Educate public about elder adult immunization needs.

Oral Health

Improve Oral Health

Story Behind the Curve

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

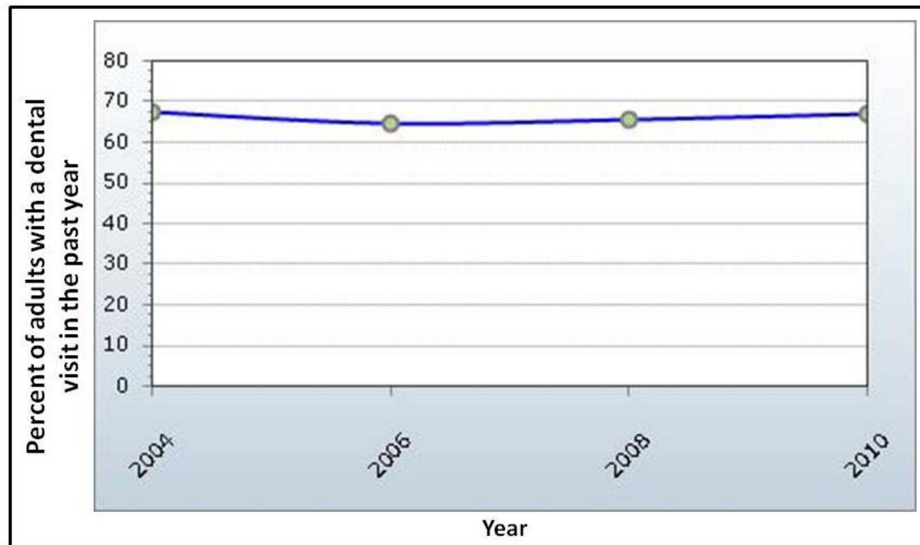

Figure 9. Percent of adults with a dental visit in the past year, 2004-2010

What Works

- Oral health education for children.
- Parent education on importance of oral health.
- Promotion of fluoridated water consumption.
- Connecting primary care with dental care.
- Increasing the number of Medicaid provider providing preventive services.
- Increasing the number of Medicaid providers serving children and young adults.
- Provide preventive health services such as fluoride varnish and dental sealants
- School based programs.
- FORMAS registration by dental/medical providers.
- Dental case management services.

Partners

- NM Oral Health Advisory Committee
- NM Dental Association
- NM Dental Hygiene Association
- Children, Youth, and Family Department
- DOH Contractors
- Head Start

Strategies

- Increase Policymakers' Awareness of the Importance of Expanding Adult Medicaid Services.
- Implement a Culturally Appropriate and Bilingual Prevention Campaign (PSA) to promote Oral Health.
- Develop a NM Oral Health Surveillance System.
- Increase Access to Oral Health Care for Those Living in Long-term Care Facilities and Nursing Homes.
- Develop an Oral Health Strategic Plan.

Elder Falls

Reduce Elder Falls

Story Behind the Curve

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

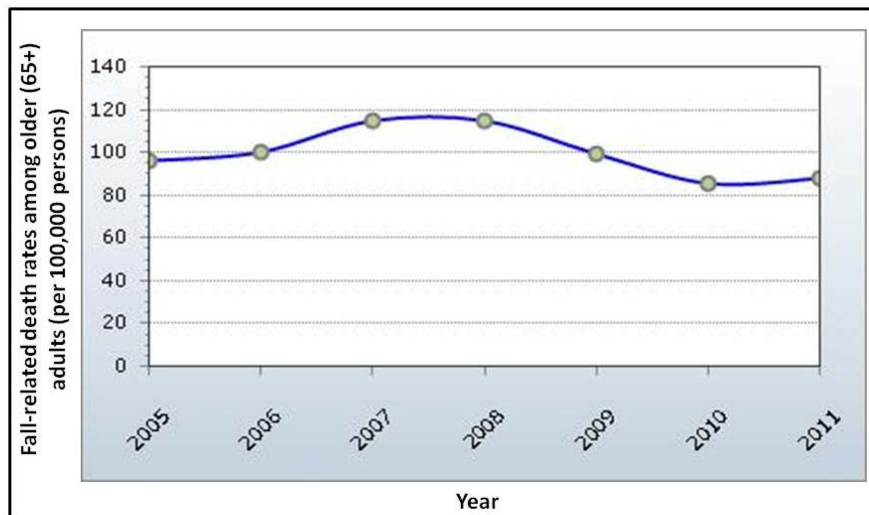

Figure 10. Fall-related death rates among older (65+) adults (per 100,000 persons) 2005-2011

What Works

- Exercise based interventions for balance, gait and strength training.
- Environmental adaptation to reduce fall risk factors in the home and in daily activities.
- Medication review, regardless of the number of medications prescribed, with particular attention to medications that affect the brain such as sleeping medications and antidepressants.
- Screening and risk assessment focused on client's history, physical examination, functional assessment, and environmental assessment for referral and falls evidence-based interventions.

Partners

- The New Mexico Adult Fall Prevention Coalition
- Office of Injury Prevention
- AARP
- New Mexico Aging and Long Term Services Department
- Indian Area Agency on Aging
- Indian Health Services (IHS)
- the University of New Mexico (UNM) Geriatric Education Center
- St. Vincent's Hospital
- the Governor's Commission on Disability
- UNM Prevention Research Center

Strategies

- Provide the Tai Chi: Moving for Better Balance evidence based exercise program to people interested in implementing this program to older adults within their communities.
- Expand linkages between Office of Injury Prevention Older Adult Fall Prevention program and the Aging and Long Term Services Department and the NMDOH Chronic Disease Self Management Program to promote older adult fall prevention.
- Build partnerships to address fall prevention.

Alcohol-Related Deaths

Reduce Alcohol-Related Deaths

Story Behind the Curve

- New Mexico had the highest alcohol-related (AR) death rate in the nation from 1997 through 2007 (most recent year available).
- From 1990-2007, NM's AR chronic disease death rate was 1.5 to 2 times US rate; the US rate declined 16%, but NM's rate remained high and unchanged.
- From 1990-2007, NM's AR injury death rate was 1.4 to 1.8 times US rate; and increased by 18% while the US rate decreased 3%.

- Male AR death rates are greater than twice the female rates.
- More than 75% of AR deaths in NM occur before age 65.
- High rates among American Indian males and females and Hispanic males drive the overall high state rates.
- Excessive alcohol consumption (binge and heavy drinking) is primary risk factor.

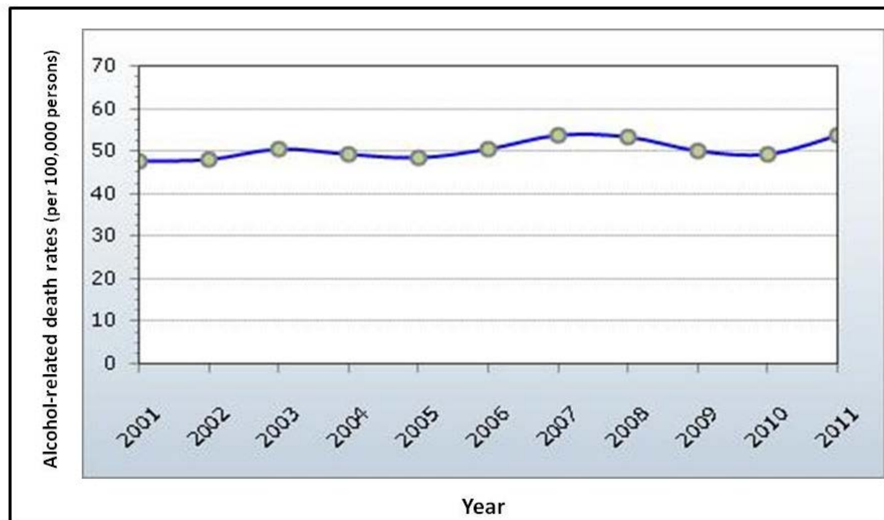

Figure 11. Alcohol-related death rates (per 100,000 persons), 2001-2011

What Works

- Increasing the price of alcoholic beverages.
- Regulating the physical availability of alcoholic beverages (e.g., minimum legal drinking age law enforcement; regulation of outlet density).
- Policies that modify the drinking environment (e.g., enhanced enforcement of on-premise laws; increased server and social host liability.
- Comprehensive drinking/driving countermeasures (e.g., DWI law enforcement in the form of sobriety checkpoints, accompanied by a public awareness campaign).
- Screening and brief intervention (SBI) for at-risk drinkers.

Partners

- NMDOH programs (Substance Abuse Epidemiology Program; Office of Injury Prevention; Office of School and Adolescent Health, Regions)
- Other state agency partners: NMHSD (Office of Substance Abuse Prevention), NMDOT, NMDFA, NMRLD, NMDPS
- State Epidemiological Outcomes Workgroup
- Tribal Epidemiological Outcomes Workgroup
- Community Coalitions: Partnership for Community Action; Santa Fe Underage Drinking Prevention Alliance
- New Mexico Association of Counties and Local DWI Programs

- UNM: Prevention Research Center; Center for Health Policy; Center on Alcoholism, Substance Abuse, and Addictions

Strategies

- Reduce excessive alcohol consumption using strategies recommended by the Community Guide.
- Reduce alcohol-impaired driving using strategies recommended by the Community Guide.
- Implement Alcohol Screening and Brief Intervention (ASBI) more broadly in New Mexico.

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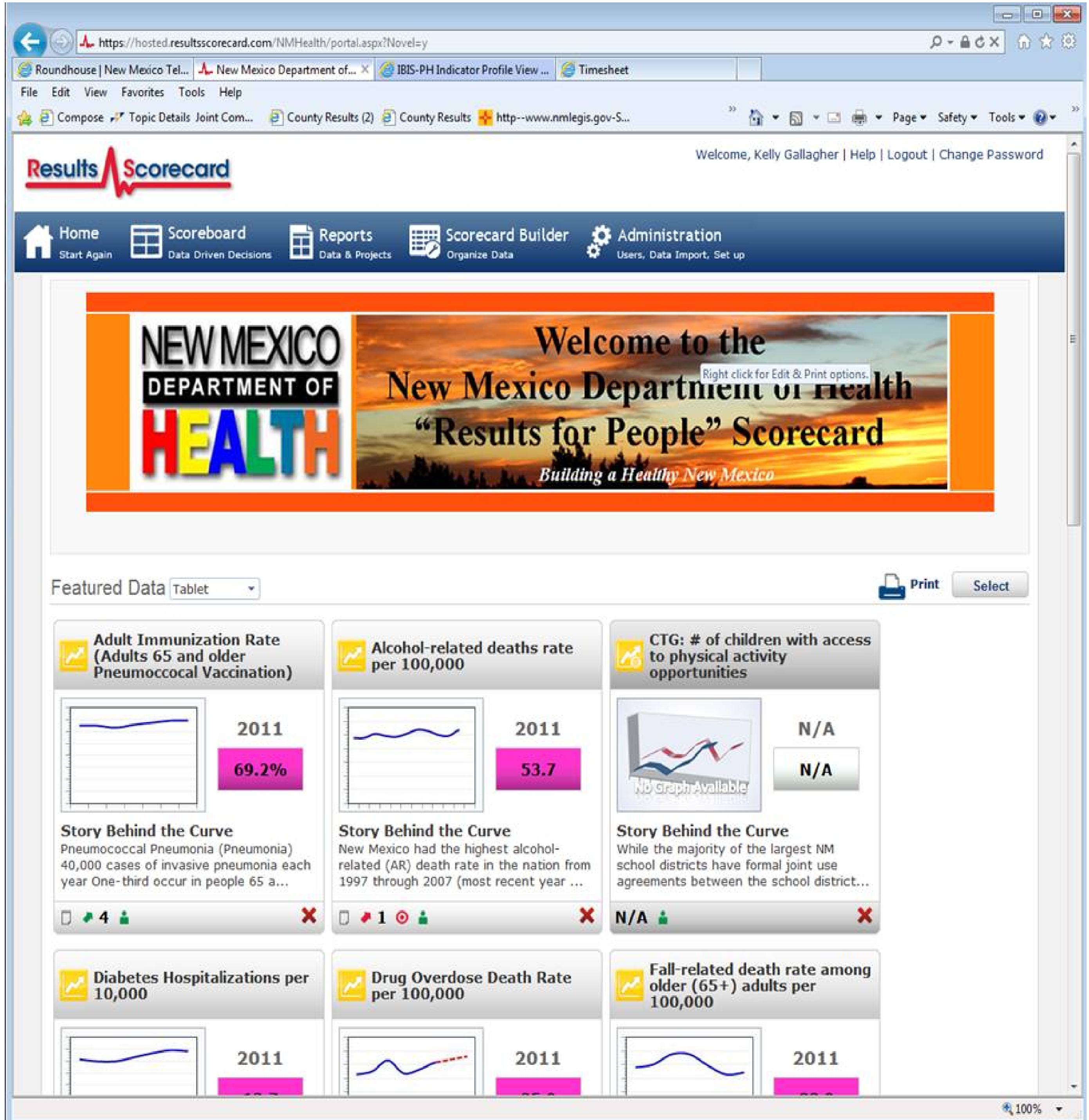
Appendices

Appendix A



Appendix B

New Mexico's "Turn the Curve on Health"
Partnership Handshake

Purpose: By committing to New Mexico's Turn the Curve on Health* initiative you join a network of partners working together to "turn the curve" on high priority health issues affecting the health and lives of New Mexicans.

Health Issues Focus:

- Child and adolescent obesity
- Diabetes
- Tobacco use
- Teen births
- Adult immunizations (≥ 65 Years)
- Oral Health
- Fall-related injury and deaths among older adults (≥ 65 Years)
- Unintentional drug overdose deaths
- Alcohol-related injury and chronic disease deaths

Network participants agree to periodically take part in a two-way communication on local and statewide initiatives and results related to these health issues. Partners will contribute ideas and report information on local activities and results related to these issues.

Department of Health's Commitment:

The ***Department of Health*** agrees to participate in New Mexico's "Turn the Curve on Health" and will assist with the following activities:

☒ We agree to give communities access to view an electronic *Scorecard*, which is a tool to track ideas, data, activities and ***results*** at both local and state levels.

☒ We agree to add information, updates, and stories on your local strategy implementation activities.

☒ We agree to offer ongoing assistance (see Resource Guide) to you, your community or your organization in order to create a condition of well-being for members of your community.

☒ We agree to provide bi-annual Turn the Curve updates on the state's progress to the Governor and the New Mexico Legislature.

☒ I/We, ____ agree to provide the following to support the success of this Partner's contribution:

____

____

Telephone: ______________________________ Email: ____

Partner Commitment: *(Please Print)*

_______________________________________ (Name of Individual, program or organization) from

__________________________ County/Tribe agrees to make a contribution to "Turn the Curve on Health in New Mexico" to improve population health on this health issue (only check one indicator per page):

☐ Child and adolescent obesity	☐ Teen Births	☐ Fall-related Injury/Death
☐ Diabetes	☐ Adult Immunization	☐ Drug Overdose Death
☐ Tobacco Use (non-ceremony)	☐ Oral Health	☐ Alcohol-related Injury/Death

☐ I/We agree to contribute with the following strategy (ies) to improve population health related to this issue:

____

____

☐ I/We agree to participate in quarterly conference calls in 2012 and 2013, coordinated by DOH, on the health issue specified above.

☐ I/We agree to have this strategy included in the published NM State Health Improvement Plan.

☐ I/We agree to provide information on our strategy implementation activities and progress related to the health issue for the Turn the Curve *Scorecard* and related reports.

☐ I/We agree to collaborate with other partners to support community implementation efforts.

☐ I/We agree to provide resources for local activities related to this "Turn the Curve on Health" issue.

☐ I/We agree to initiate policy/process changes to address disparities related to this health issue.

☐ I/We agree to provide my organization's web site link to be included in Turn the Curve publications and the *Scorecard*. The address is:

____

Contact Information: *(Please Print)*

Contact Name: ___________________________ Position/Title: ______________________________

Alternate Contact Name: _________________________ Telephone: ___________________________

Program or Organization: ____

Mailing Address: ____

Telephone: _________________________________ Fax: ______________________________

Email: ____