Michelle Lujan Grisham
GOVERNOR

David R. Scrase, M.D.
ACTING CABINET SECRETARY

FY22 QUARTER 4 PERFORMANCE REPORT

DEPARTMENT OF HEALTH

NMDOH
NEW MEXICO DEPARTMENT OF HEALTH

Table of Contents

DEPARTMENT OF HEALTH OVERVIEW

Agency Mission:

To ensure health equity, we work with our partners to promote health and well-being and improve health outcomes for all people in New Mexico.

- Under the leadership of Acting Secretary David Scrase, DOH solicited feedback and conducted strategic planning sessions with the entire department to update the DOH mission and goals in 2021, now reflecting a renewed commitment to health equity. The pandemic heightened long-standing population health disparities and underscored the importance of adequately funding public health infrastructure, which had been chronically under-resourced nation-wide for several decades. Closing health inequities and building key public health capacities will be heavily weighted as the department moves into a more comprehensive strategic planning process.

Agency Goals:

- We expand equitable access to services for all New Mexicans.
- We improve health status for all New Mexicans.
- We ensure safety in New Mexico healthcare environments.
- We support each other by promoting an environment of mutual respect, trust, open communication, and needed resources for staff to serve New Mexicans and to grow and reach their professional goals.

Key Strategic Plan Initiatives:

Beginning in March 2020, when the COVID-19 virus prompted a public health emergency in New Mexico, the department hastened to build public health capacity and emergency management infrastructure, diverting much of its resources away from programs and services that were previously established as key strategic plan initiatives. Until recently, most agency resources were 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 much of the past several years. Level one ensures that staff and resources are available to respond to health emergencies 24 hours per day, seven days per week. The department is finally able to begin a gradual disengagement from the grip of pandemic emergency management and is looking toward restoring other public health programmatic functions and services. As regular activities resume, NMDOH will withdraw from COVID-19 performance measures. The Department plans to undergo an extensive reassessment of its current strategic plan after such a prolonged period of crisis response and necessary transformation. The following initiatives will be updated or retired at that time.

Address COVID-19 related health disparities and advance health equity by expanding NMDOH's capacity and services:

- Prevent and control COVID-19 infection among underserved populations at high risk
- Develop and maintain workforce capacity
- Build infrastructural operations
- Reduce health disparities

Promote effective substance use disorder treatment (SUD):

- 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) and decrease mortality rates, improving State Health Improvement Plan (SHIP) priority performance 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

PUBLIC HEALTH DIVISION	P002
EPIDEMIOLOGY AND RESPONSE DIVISION	P003
SCIENTIFIC LABORATORY DIVISION	P004
FACILITIES MANAGEMENT DIVISION	P006
DEVELOPMENTAL DISABILITIES SUPPORTS DIVISION	P007
HEALTH CERTIFICATION LICENSING AND OVERSIGHT	P008
MEDICAL CANNABIS PROGRAM	P787

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	

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):

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	820.5
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	

FY22	General Fund	Other State Funds	Federal Funds	Other Transfers	TOTAL	FTE
200	$18,939.83	$1,254.13	$23,424.59	$2,833.03	$46,440.58	786
300	$11,836.90	$3,040.12	$48,390.05	$7,259.88	$70,526.95	
400	$8,514.86	$26,055.50	$24,981.09	$179.28	$59,730.74	
TOTAL	$39,291.58	$30,349.75	$96,795.74	$10,261.20	$176,698.27	

*Actual Budget as of 8/4/22

Program Performance Measures:

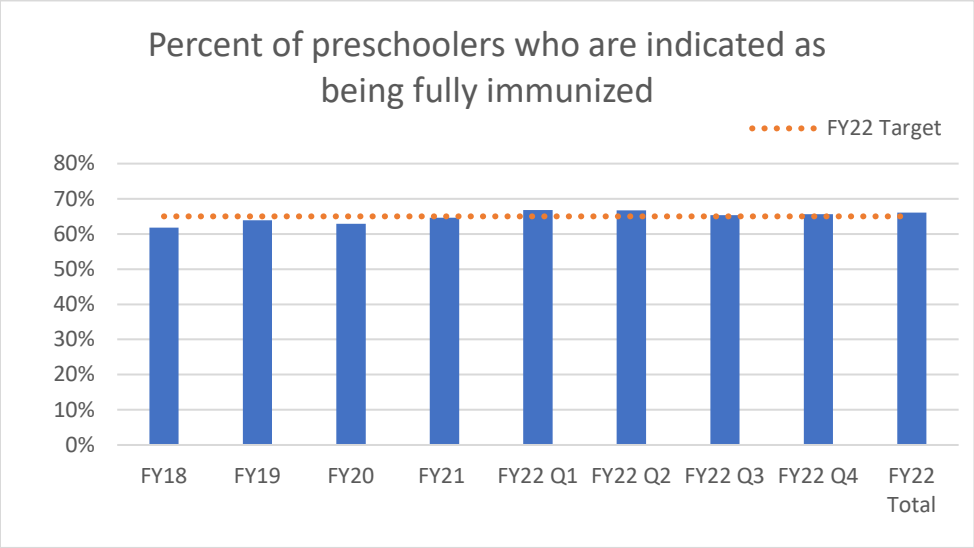
1. Percent of preschoolers (19-35 months) who are indicated as being fully immunized (FY22 Key & HB2 Measure).
2. Percent of NMDOH funded school-based health centers that demonstrate improvement in their primary care or behavioral health care focus area (FY22 Key & HB2 Measure).
3. Percent of older adults who have ever been vaccinated against pneumococcal disease.
4. Percent of participants in the National Diabetes Prevention Program that were referred by a health care provider through the agency-sponsored referral system.
5. Percent of third grade children who are considered obese.
6. Percent of children in Healthy Kids, Healthy Communities with increased opportunities for healthy eating in public elementary schools.
7. Percent of adolescents who smoke.
8. Percent of adults who smoke.
9. Percent of New Mexico adult cigarette smokers who access cessation services (FY22 Key Measure).
10. Number of births to teens per 1,000 females aged 15-19.
11. Number of teens who successfully complete a youth development program to prevent unintended pregnancy.
12. Percent of female clients ages 15-19 seen in NMDOH public health offices who are provided most or moderately effective contraceptives (FY22 Key & HB2 Measure).
13. Number of successful overdose reversals per client enrolled in the NMDOH Harm Reduction Program (FY22 Key Measure).

PHD PERFORMANCE MEASURE #1

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

Results

FY18	FY19	FY20	FY21	FY22 Q1	FY22 Q2	FY22 Q3	FY22 Q4	FY22 Total	FY22 Target
61.80%	63.85%	62.93%	64.66%	66.8%	66.7%	65.3%	65.6%	66.1%	≥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. The New Mexico Department of Health, Infectious Disease Bureau, Immunization Program has met the target for Fiscal Year 2022. During the COVID-19 Pandemic the rates for preschoolers being immunized declined as routine healthcare visits were not occurring. The immunization rates are rising again as routine healthcare visits are occurring more frequently and additional messaging has been promoted for vaccine catch up in support of the New Mexico Childcare/Pre-School/School Entry Immunization Requirements in efforts to keeping New Mexico's children protected from vaccine-preventable diseases. The New Mexico Department of Health, Infectious Disease Bureau, Immunization Program Got Shots campaign in collaboration with the New Mexico Immunization Coalition are going to continue messaging efforts for the importance of receiving vaccinations.

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	

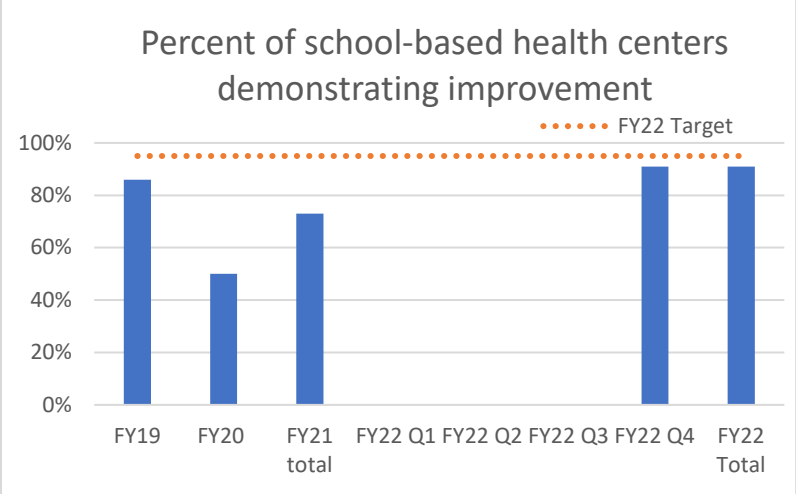
PHD PERFORMANCE MEASURE #2

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	FY22 Q1	FY22 Q2	FY22 Q3	FY22 Q4	FY22 Total	FY22 Target
86%	50%	73%	n/a*	n/a*	n/a*	91%	91%	≥95%

*No primary and behavioral health care was provided in throughout first three quarters of the year due to COVID-19



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:

As adolescents throughout the state returned to school for in-person learning this fall, school-based health centers continued to meet their health care needs. SBHCs have returned to providing integrated primary and behavioral health care for adolescents. School districts also continue to enlist SBHCs in assisting with COVID testing and vaccination efforts. Quality improvement is a standard practice for the medical sponsors of our SBHCs and are based on national standards of practice. Finding new and innovative ways to meet these measures was a challenge in FY 21 because of the pandemic and since many of these improvements to care require an in person visit with a health care provider. With a return to in person learning, SBHCs were able to entertain more visits, however, there is an even greater need for behavioral health care for adolescents.

IMPROVEMENT ACTION PLAN:

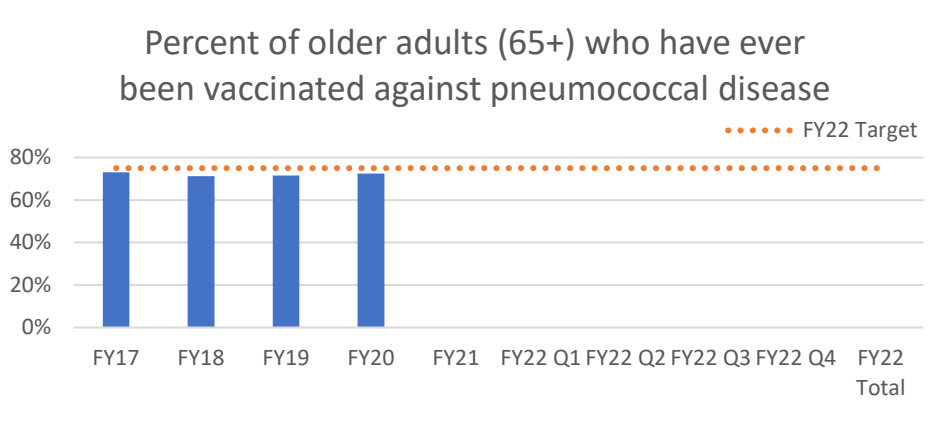
Major Quarterly Action Steps:	Goal Completion Date				
	Q1	Q2	Q3	Q4	Target
1) Complete review of QI goals in operational plans	X				
2) Complete review of mid-year progress reports		X			
3) Complete assessment of SBHCs on target to complete required number of student surveys			X		
4) Complete review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

PHD PERFORMANCE MEASURE #3

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

Results

FY17	FY18	FY19	FY20	FY21	FY22 Q1	FY22 Q2	FY22 Q3	FY22 Q4	FY22 Total	FY22 Target
73.0%	71.3%	71.6%	72.4%	Fall 2022	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 2022. 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:

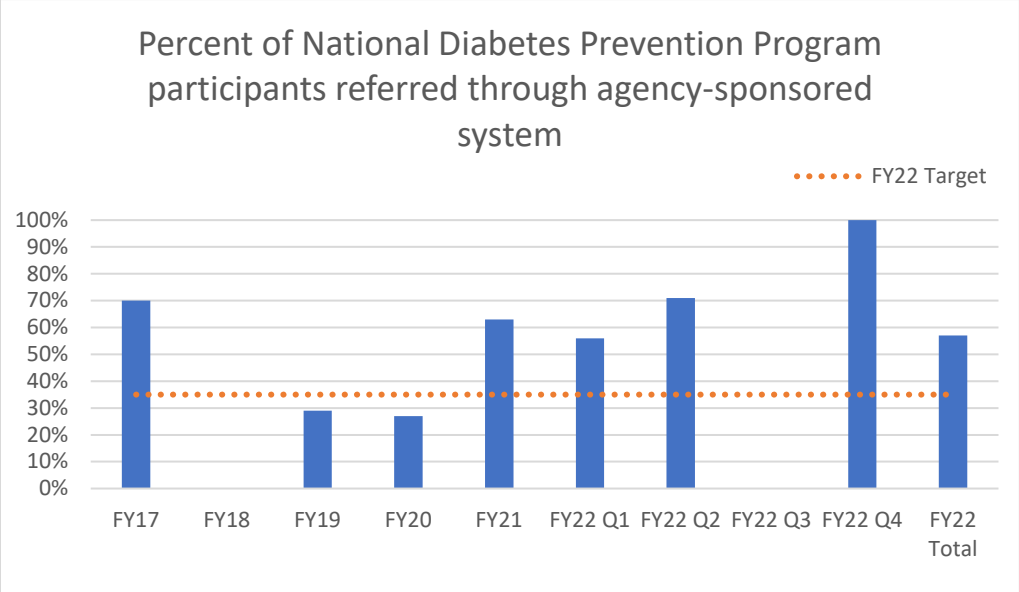
Major Quarterly Action Steps:	Goal Completion Date				
	Q1	Q2	Q3	Q4	Target
1) Ensure public health offices and partner organizations have access to PCV13 and PPSV23 for their uninsured patients.	X	X	X	X	
2) Promote pneumococcal vaccination at community virtual events serving older adults.	X	X	X	X	
3) 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	

PHD PERFORMANCE MEASURE #4

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	FY22 Q1	FY22 Q2	FY22 Q3	FY22 Q4	FY22 Total	FY22 Target
70%	0%	29%	27%	63%	56%	71%	0%	100%	57%	35%



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:
The National Diabetes Prevention Program (National DPP) is a CDC-recognized lifestyle change program that is proven to help prevent or delay type 2 diabetes. The 1-year program is focused on implementing lifestyle interventions focused on reducing body weight and increasing physical activity. Individuals who have or are at risk for prediabetes are eligible for the program. Throughout the pandemic there was a shift to an online platform to deliver courses, which proved difficult to sustain as many of the participants needed to learn a new way of participating in National DPP. In FY22, there was an increase in National DPP programs being offered in NM, which has translated to greater accessibility statewide. It is anticipated that as NMDOH increases the number of programs available, there will be an increase in provider referrals to National DPP. Overall, because the program is for a full year, keeping individuals committed and on track continues to be the greatest barrier faced in generating large amounts of referrals and getting participants to complete the entire program. Although we do receive referrals for NDPP not all of them come from a health care provider through our Paths to Health NM site. In Q3 we had 7 participants, but none were referred by a provider and in Q4 we had 8 participants and all 8 were referred by a provider, which further explains the fluctuation from Q3 to Q4. In FY23, we will be switching to an actual number of referrals rather than a percentage.

IMPROVEMENT ACTION PLAN:

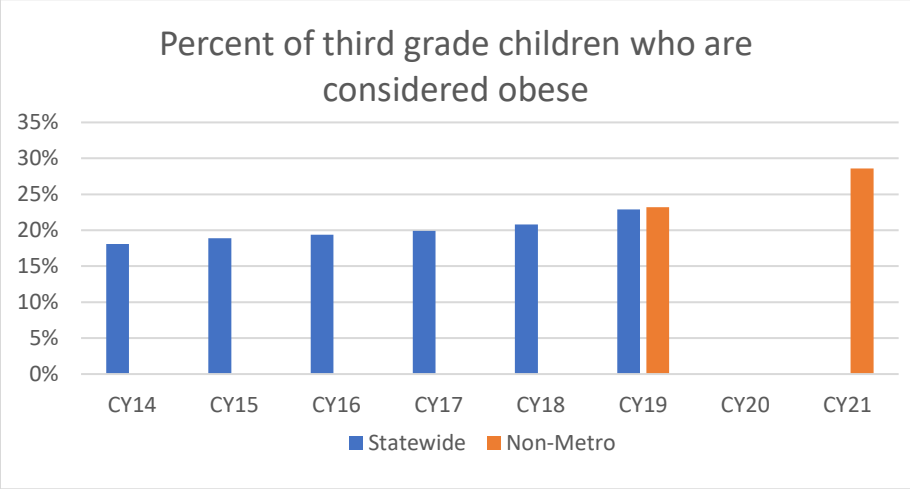
Major Quarterly Action Steps:	Goal Completion Date				
	Q1	Q2	Q3	Q4	Target
1) Receive referrals from healthcare providers.	n/a	X	X	X	
2) Promote and incorporate HIPAA compliant referral and data management system, Paths to Health NM and Workshop Wizard, into existing and newly identified healthcare systems.	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 #5

Percent of third grade children who are considered obese

Results

	CY14	CY15	CY16	CY17	CY18	CY19	CY20	CY21	FY22 Target
Statewide	18.1%	18.9%	19.4%	19.9%	20.8%	22.9%	n/a	n/a	Explanatory
Non-Metro (Proxy Measure)	-	-	-	-	-	23.2%	n/a	28.6%	



MEASURE DESCRIPTION:
Obesity is defined as body mass index (BMI) at or above the 95th percentile of the sex-specific BMI-for-age growth charts established by the Centers for Disease Control and Prevention (CDC) (2000). Growth charts can be found here: https://www.cdc.gov/growthcharts/clinical_charts.htm.

DATA SOURCE/METHODOLOGY:
The Obesity, Nutrition, and Physical Activity Program (ONAPA) partners with elementary schools to conduct statewide Body Mass Index (BMI) surveillance annually. School closures during the COVID-19 pandemic prevented the collection of statewide BMI data for CY20. In CY21, low participation rates in the metro area prevented the calculation of a childhood obesity percentage representative of the entire state. The non-metro childhood obesity percentage is presented as a proxy measure in lieu of the statewide measure.

STORY BEHIND THE DATA:
In CY21, the percentage of third grade children with obesity in non-metro areas of New Mexico was 28.6%, whereas in CY19, the percentage among the same population was 23.2%. The difference is not statistically significant. The higher percentage in CY21 may be attributed to the COVID-19 pandemic, which has caused economic hardship, limited physical activity, and increased food insecurity, which are contributing factors of obesity. Additionally, school closures limited student access to healthy food and physical activity, including policy, systems, and environmental changes supported by ONAPA. Data collected in future years will help determine whether this upward trend is statistically significant.

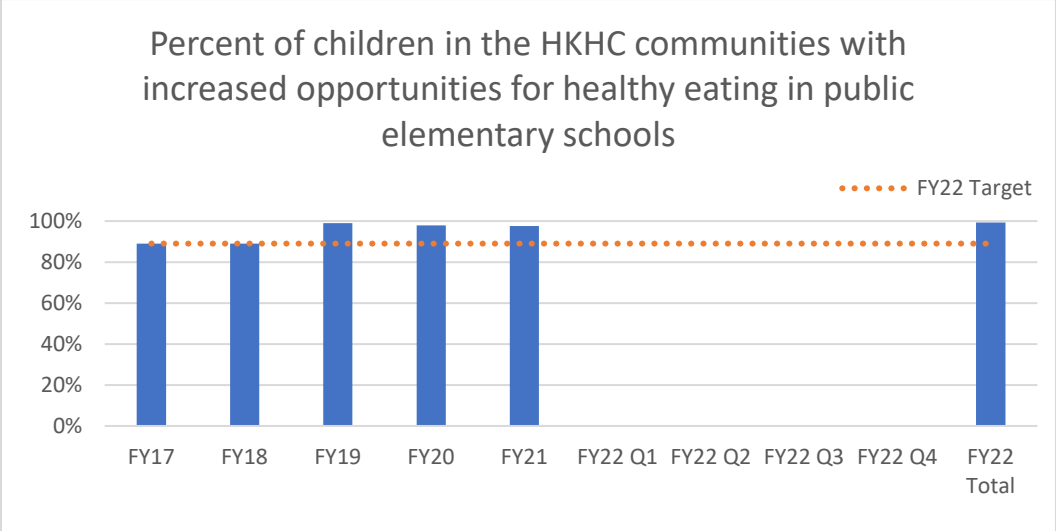
IMPROVEMENT ACTION PLAN:
Annual calendar year explanatory measure, thus no quarterly action required.

PHD PERFORMANCE MEASURE #6

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	FY22 Q1	FY22 Q2	FY22 Q3	FY22 Q4	FY22 Total	FY22 Target
89%	89%	99%	97.9%	97.6%	n/a	n/a	n/a	n/a	99.3%	≥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. Quarterly estimates are not provided. Our program aggregates, analyzes, and reports results by the end of the summer to assess environmental, policy, and systems changes over time.

STORY BEHIND THE DATA:

Increasing healthy eating and physical activity opportunities in schools is a best practice for helping prevent obesity by exposing children to healthy behaviors at an early age. Healthy Kids Healthy Communities (HKHC) is an initiative from the Obesity, Nutrition and Physical Activity (ONAPA) Program that increases opportunities for healthy eating in schools through policy, systems, and environmental changes, such as serving New Mexico Grown produce in school meals, establishing gardens, supporting non-food fundraising, and providing nutrition education. As of FY22, HKHC works in 9 counties and 2 tribal communities in New Mexico, which were selected based on need and geographic/demographic diversity.

In FY22, the percentage of children in HKHC with increased opportunities for healthy eating was 99.3%, which is higher than 97.6%, the percentage in FY21. In FY20 and FY21, the COVID-19 pandemic limited HKHC's programming to virtual strategies. When schools reopened in FY22, HKHC was able to implement in-person programming once more, increasing the number of healthy eating opportunities in FY22.

IMPROVEMENT ACTION PLAN:

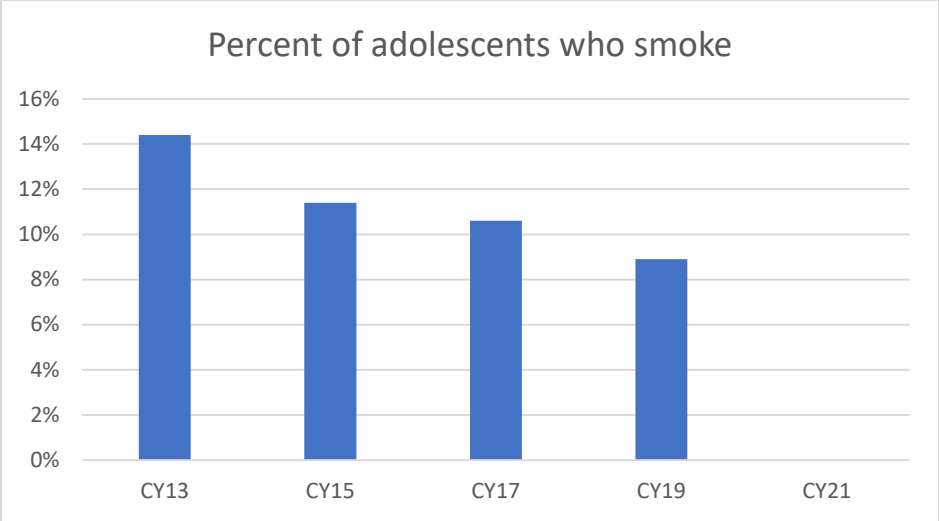
Major Quarterly Action Steps:	Goal Completion Date				
	Q1	Q2	Q3	Q4	Target
1) Establish and implement strong wellness policies to improve school nutrition	X	X	X	X	
2) Implement sustainable healthy eating interventions coupled with nutrition education	X	X	X	X	
3) Work with local schools to create a plan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

PHD PERFORMANCE MEASURE #7

Percent of adolescents who smoke

Results

CY13	CY15	CY17	CY19	CY21	FY22 Target
14.4%	11.4%	10.6%	8.9%	Fall 2022	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)

STORY BEHIND THE DATA:
A current smoker is defined as a youth in grades 9-12 in New Mexico public high school who smoked cigarettes on one or more days in the past month. This data is from the *New Mexico Youth Risk and Resiliency Survey, New Mexico Department of Health and Public Education Department, 2019* and is reported on https://ibis.doh.nm.gov/indicator/summary/TobaccoSmokeYouth.html . The measure will not change because surveillance is conducted every other year. The data that was collected in 2021 has not yet been made available, however. The data provided above has a 95% interval with a range of 7.8%-10.2%. When comparing to the Q4 FY21 data, the data remains the same for reasons stated above in which the data collected in 2021 Youth Risk and Resiliency Survey (YRRS) is not yet made available. The *Live Vape Free* program, which was launched in April 2022, is a program to support youth vapers with a texting program and multimedia experience tailored to their needs to teach the skills to quit vaping for good. This program will also provide concerned adults with a self-paced, online learning program to support them in their conversations with youth vapers. Since its inception of the program, eight (8) youth have enrolled into the services.

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

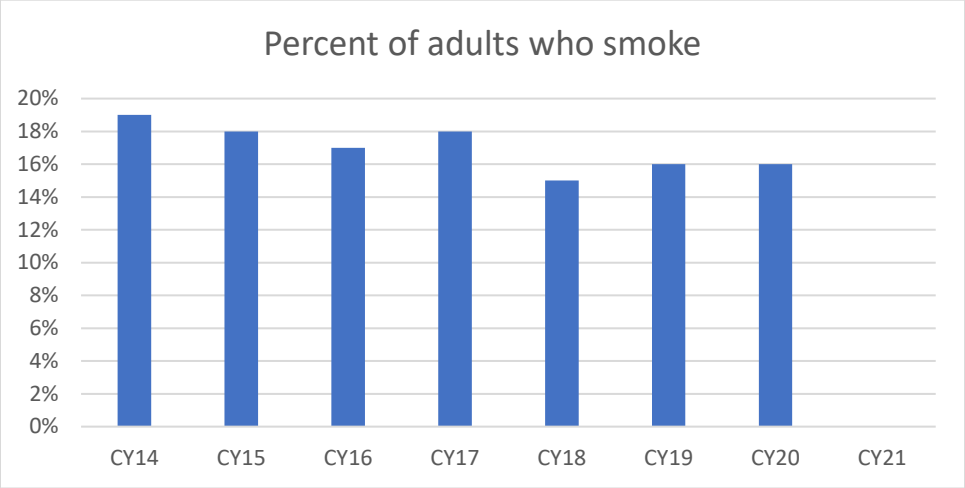
PHD PERFORMANCE MEASURE #8

Percent of adults who smoke

Results

CY14	CY15	CY16	CY17	CY18	CY19	CY20	CY21	FY22 Target
19.1%	17.5%	16.6%	17.5%	15.2%	16.0%	Fall 2022*	n/a	Explanatory

*The pandemic has delayed the release of new data



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). Most recent annual data has not yet been made available due to the pandemic response.

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 were 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 data source is from the New Mexico Behavioral Risk Factor Surveillance System, New Mexico Department of Health, 2019 and was reported on https://ibis.doh.nm.gov/indicator/summary/TobaccoSmokeAdult.html

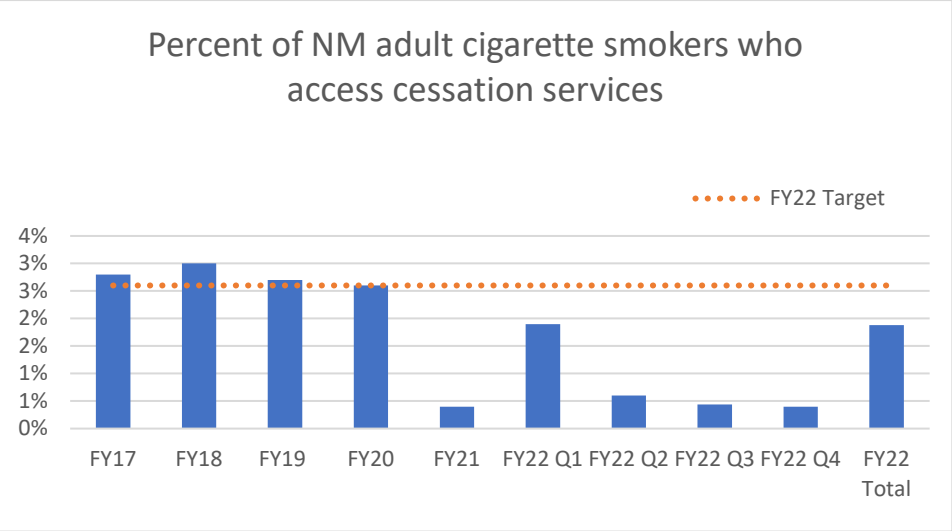
IMPROVEMENT ACTION PLAN:
Annual calendar year explanatory measure, thus no quarterly action plan results.

PHD PERFORMANCE MEASURE #9

Percent of New Mexico adult cigarette smokers who access cessation services

Results

FY17	FY18	FY19	FY20	FY21	FY22 Q1	FY22 Q2	FY22 Q3	FY22 Q4	FY22 Total	FY22 Target
2.8%	3.0%	2.7%	2.6%	1.9%	0.60%	0.32%	0.44%	0.40%	1.88%	≥2.6%



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 Nicotine Use Prevention and Control (NUPAC) Program served 1,044 NM tobacco users in Q4 through its QUIT NOW and DEJELO YA tobacco cessation services. Overall, FY22 utilization of the Nicotine Addiction Treatment services has declined over the past few years. This is par nationally as other states also see a decline in adult cigarette smokers accessing cessation services. Despite the continued increase in provider/staff trainings on providing brief tobacco interventions with patients and training on fax referrals to the QUIT NOW services, the program continues to face challenges of conversion rates of providing brief tobacco interventions to Quitline fax referrals and continues to be underutilized. NUPAC continues to train health care providers across New Mexico to provide interventions and referrals to the QUIT NOW/DEJELO YA services and staff are increasing field promotion of Nicotine Addiction Treatment Services. NUPAC continues to promote QUIT NOW/ DEJELO YA services through paid advertisements and hopes to increase cessation engagement through 2 new programs: The Live Vape Free Program and the Mini Quit Challenge.

IMPROVEMENT ACTION PLAN:

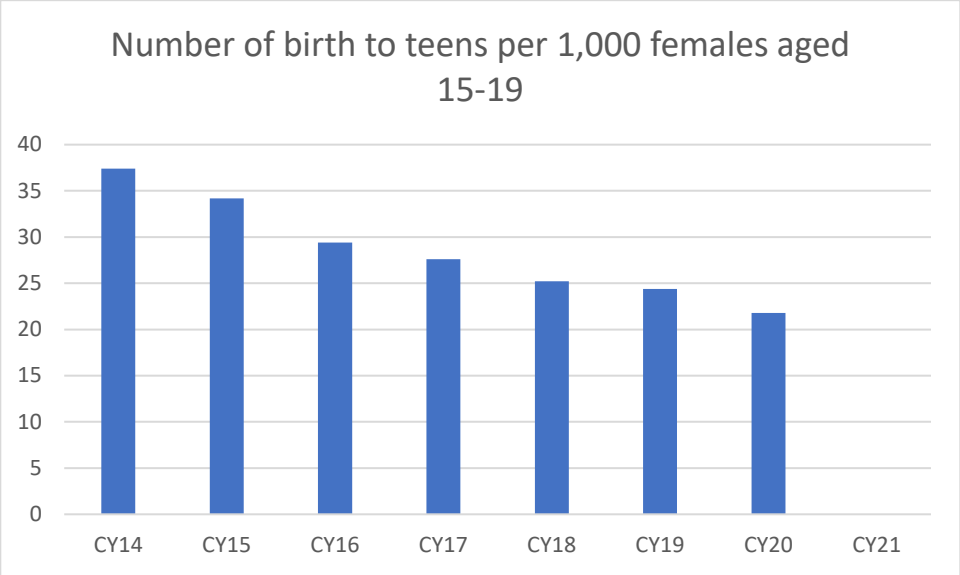
Major Quarterly Action Steps:	Goal Completion Date				
	Q1	Q2	Q3	Q4	Target
1) Maintain phone- and web-based tobacco cessation services with optional supports.	X	X	X	X	
2) Promote QUIT NOW and DEJELO YA services using a variety of methods (TV, online, print, niche marketing) to reach target of 8,000 enrollments 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 #10

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

Results

CY14	CY15	CY16	CY17	CY18	CY19	CY20	CY21	FY22 Target
37.4	34.2	29.4	27.6	25.2	24.4	21.8	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. Since 2015, the teen birth rate among 15-to-19-year-olds in New Mexico (NM) has declined by 36.3% to 21.8 per 1,000 in 2020 (NM-IBIS) and is the tenth highest in the nation in 2020 (National Center for Health Statistics). Between 2019 and 2020, NM's teen birth rate decreased by 10.2%, compared to a national decrease of 7.8% (National Center for Health Statistics). In NM, teen birth rates are highest for American Indians and Hispanics (at almost double the reference rate).

This rate is not a quarterly rate, so quarterly analysis/comparison is not available. This rate is a calendar-year rate, so analysis/comparison across fiscal year is not available. This rate is obtained from DOH/ERD/BVRHS directly and is usually delayed by 18 months due to data cleaning and analysis. DOH/PHD/FHB/FPP does not conduct primary data collection that pertains to vital records/heath statistics.

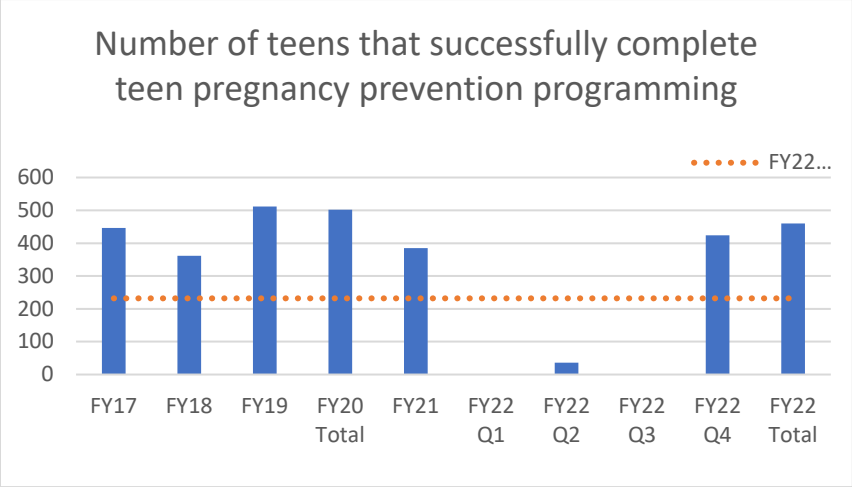
IMPROVEMENT ACTION PLAN:
An annual calendar year explanatory measure, thus no quarterly action plan results.

PHD PERFORMANCE MEASURE #11

Number of teens who successfully complete a youth development program to prevent unintended teen pregnancy

Results

FY17	FY18	FY19	FY20	FY21	FY22 Q1	FY22 Q2	FY22 Q3	FY22 Q4	FY22 Total	FY22 Target
446	362	512	502	385	n/a	36	n/a	424	460	≥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 2015, the teen birth rate among 15-to-19-year-olds in New Mexico (NM) has declined by 36.3% to 21.8 per 1,000 in 2020 (NM-IBIS) and is the tenth highest in the nation in 2020 (National Center for Health Statistics). Between 2019 and 2020, NM's teen birth rate decreased by 10.2%, compared to a national decrease of 7.8% (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 access to services. Proactive service-learning, positive youth development, and comprehensive sex education programming are all protective factors for teens to reduce risky sexual behaviors.

Programming is nine-months in duration; quarterly reporting is not available due to the length and breadth of programming. 368 teens completed programming in FY21 Q4, with a total of 385 completing during FY21. For FY22 Q4, 424 teens completed programming, with a total of 460 completing during FY22. Fewer teens joined in FY21 due to COVID restrictions for in-person vs virtual learning and due to COVID fatigue with virtual learning. In FY22, even though the programming was on a hybrid (in-person and virtual learning) model, teens had experienced in-person programming and continued the programming in a hybrid model.

IMPROVEMENT ACTION PLAN:

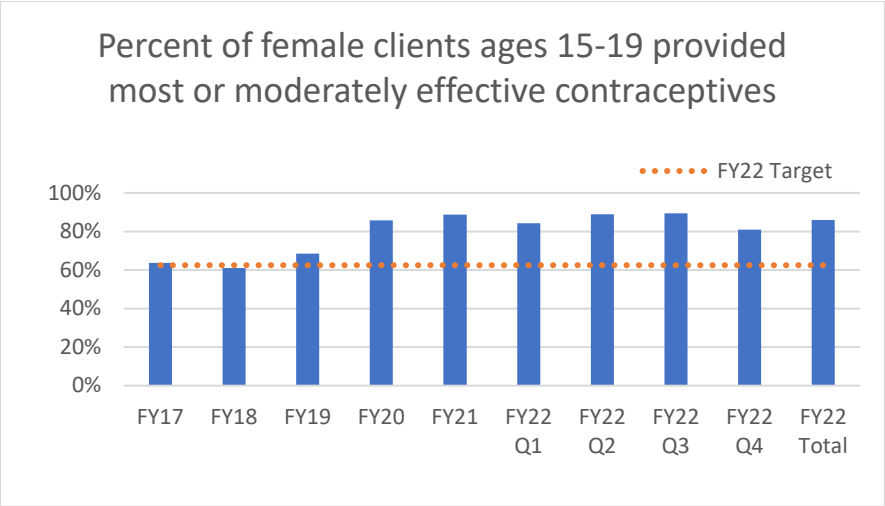
Major Quarterly Action Steps:	Goal Completion Date				
	Q1	Q2	Q3	Q4	Target
1) Contract with schools and community organizations to provide TOP.	X	X	X	X	
2) Gather client data.	X	X	X	X	
3) Implement FY21 youth development programming with all cohorts.	X	X	X	X	**232**

PHD PERFORMANCE MEASURE #12

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	FY22 Q1	FY22 Q2	FY22 Q3	FY22 Q4	FY22 Total	FY22 Target
63.7%	61%	68.5%	85.8%	88.8%	84.3%	89.0%	89.5%	81.0%	86%	≥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.

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]) are available at 41 of the 43 public health offices that offer family planning services. During Q4, 36 Public Health Offices provided family planning services, due to ongoing COVID-related services. Since 2015, the teen birth rate among 15-to-19-year-olds in New Mexico (NM) has declined by 36.3% to 21.8 per 1,000 in 2020 (NM-IBIS) and is the tenth highest in the nation in 2020 (National Center for Health Statistics). Between 2019 and 2020, NM's teen birth rate decreased by 10.2%, compared to a national decrease of 7.8% (National Center for Health Statistics).

The percentage for FY22 Q3 was 89.5%. The percentage for FY22 Q4 was 81%. The percentage for FY21 Q4 was 94.5%. The percentage for FY22 Q4 was 81%. There are many reasons for a decrease in the quarterly percentage (such as clinician shortage and long wait-times for appointments, especially for most effective methods), however both the numerators and the denominators for each quarter are relatively close: the numerators range from 356 (in Q2) to 458 (in Q1), and the denominators range from 400 (in Q2) to 543 (in Q1). The difference in percentages by quarter is not significant and remains in the 80% range for each quarter. In Q4, the percentage of teens receiving the cost effective methods (IUDs and implants) was 20%, which was the highest by-quarter percentage in FY22.

IMPROVEMENT ACTION PLAN:

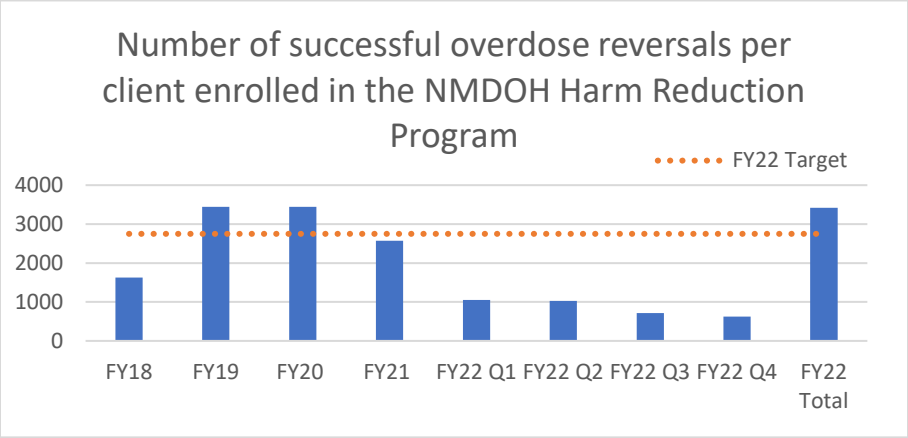
Major Quarterly Action Steps:	Goal Completion Date				
	Q1	Q2	Q3	Q4	Target
1) Dispense most or moderately effective contraceptives to teens aged 15-19 in local public health offices.	X	X	X	X	**62.5%**
2) Fund staff in public health offices to provide the broad range of contraceptive methods and confidential 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 #13

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

Results

FY18	FY19	FY20	FY21	FY22 Q1	FY22 Q2	FY22 Q3	FY22 Q4	FY22 Total	FY22 Target
1,629	3,446	3,444	2,572	1,051	1,028	714	627	3,420	2,750



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 FY21, the program faced challenges related to shifting trends in the mode of consumption of substances, and the COVID-19 pandemic's impact on staffing has led to decreased program utilization. In FY22, the Hepatitis and Harm Reduction Program has seen a significant increase in overdose reversals from FY21. This appears to be due to an increased perceived risk of overdose, which is likely related to the supply chain of illicit substances being adulterated by fentanyl. As a result of the Legislature passing HB52 in 2022, it is anticipated NMDOH will begin noticing an increase in naloxone distribution and overdose reversals as the Hepatitis and Harm Reduction Program is able to provide appropriate supplies used to reduce overdose and increase participant engagement. It is important to note that quarterly figures are likely an undercount of utilized naloxone for opioid reversal as the department relies on self-reporting from individuals when they return for refills.

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%**

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):

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	

FY22	General Fund	Other State Funds	Federal Funds	Other Transfers	TOTAL	FTE
200	$4,197.79	$94.97	$21,457.24	$281.16	$26,031.16	298
300	$559.60	$6,524.00	$21,445.83	$0.68	$28,530.11	
400	$4,219.95	$1,366.60	$17,660.23	$15.53	$23,262.31	
TOTAL	$8,977.33	$7,985.57	$60,563.30	$297.37	$77,823.58	

*Actual budget as of 8/4/22

Program Performance Measures:

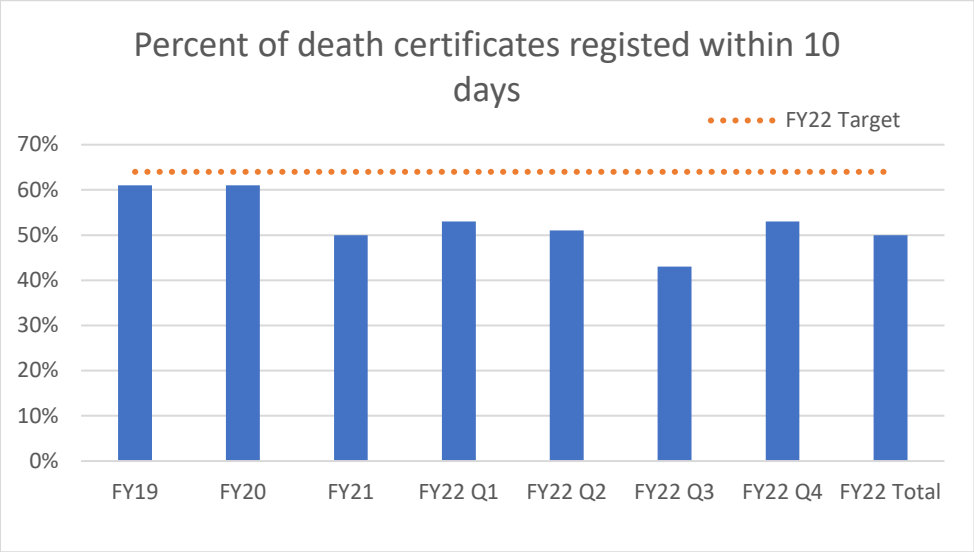
1. Percent of death certificates completed by Bureau of Vital Records and Health Statistics within 10 days of death (FY22 Key Measure).
2. Average time to provide birth certificate to customer.
3. Percent of youth who were sexually assaulted in the last 12 months.
4. Number of youth who have completed an evidence-based or evidence-supported sexual assault primary prevention program.
5. Rate of cardiovascular disease (heart disease & stroke) deaths per 100,000 population.
6. Percent of NM hospitals certified for stroke care.
7. Rate of avoidable hospitalizations per 100,000 population.
8. Rate of heat related illness hospitalizations per 100,000 population.
9. Rate of drug overdose deaths per 100,000 population (FY22 HB2 Measure).
10. Percent of retail pharmacies that dispense naloxone (FY22 Key & HB2 Measure).
11. Percent of opioid patients also prescribed benzodiazepines (FY22 Key Measure).
12. Rate of alcohol-related deaths per 100,000 population (FY22 HB2 Measure).
13. Percent of persons receiving alcohol screening and brief intervention (a-SBI) services.
14. Rate of suicide per 100,000.
15. Number of community members trained in evidence-based suicide prevention program.
16. Percent of hospitals with emergency department based self-harm secondary prevention program.
17. Rate of pneumonia and influenza death rate per 100,000 population.
18. Percent of cities and counties with Access and Functional Needs (AFN) plans that help prepare vulnerable populations for a public health emergency (FY22 Key Measure).
19. Percent of persons hospitalized for influenza who were treated with antivirals within 2 days of onset of illness.
20. Rate of fall-related deaths per 100,000 adults, aged 65 years or older.
21. Percent of emergency department based secondary prevention of older adult fractures due to falls program.

ERD PERFORMANCE MEASURE #1

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

Results

FY19	FY20	FY21	FY22 Q1	FY22 Q2	FY22 Q3	FY22 Q4	FY22 Total	FY22 Target
61%	61%	50%	53%	51%	43%	53%	50%	64%



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.

COVID-19 has affected timeliness for FY21 and FY22, showing a decreased timeliness rate of about 18%. The FY22 timeliness has remained constant with that of FY21, although for Qtr4, there was improved timeliness for the death certificates registered. The improved timeliness seen in Qtr4 will likely continue in Qtr1 of FY23. A FY22 Target of 64% was chosen to reflect a relevant and attainable goal when the previous target of 50% was achieved consecutively.

IMPROVEMENT ACTION PLAN:

The BVRHS will work with the Office of the Medical Investigator (OMI) 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. OMI is currently working with its vendor to finish coding for CMEv3 interoperability software so that the software can be tested by OMI and the BVRHS for implementation the end of the 2022 calendar year.

Quarterly Action Steps not required for annual measures. Quarterly Action Steps are required for quarterly measures. A minimum of two but no more than four are requested.

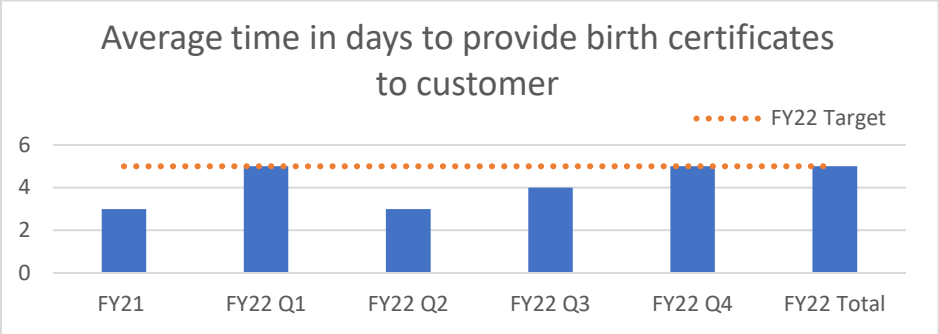
Major Quarterly Action Steps:	**Goal Completion Date**				
	Q1	**Q2**	**Q3**	**Q4**	**Target**
1) Work with OMI to design CMEv3 interoperability software	X	Not initiated by OMI	Not initiated by OMI	Initiated in September	**FY 23 Implementation**
2) Work with OMI to implement CMEv3 software	n/a	Work in progress	Work in progress	Work in progress	**FY23 Implementation**
3) Implement an automated reminder system for certifiers and funeral homes	-	Not ready due to payment issues	Not ready due to payment issues	Will be implemented in the end of the calendar year with data release for DAVE.	**FY 23 Implementation**

ERD PERFORMANCE MEASURE #2

Average time to provide birth certificate to customer

Results

FY21	FY22 Q1	FY22 Q2	FY22 Q3	FY22 Q4	FY22 Total	FY22 Target
3 days	5 days	3 days	4 days	5 days	5 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, such as obtaining state and federal benefits, obtaining a passport, use as a form of ID, and obtaining a Real ID. The ability to offer efficient and effective customer service for those requiring services offered by the BVRHS is essential and reflects positively on the State. Due to statute requirements, Vital Records is responsible for all money coming into the office to process orders and having that money deposited within 24 hours. Due to statute requirements, Vital Records is also responsible to ensure orders are started and completed timely for services. Throughout the COVID-19 pandemic, there have been increased wait times from the time an application is sent to the Wells Fargo PO Box and received by the BVRHS from Wells Fargo. There have been increased wait times since FY21, which the average was 3 days. For FY22, the average wait time has been 5 days, although the BVRHS remains within the timeliness outlined in the Vital Records Act and NMAC policies.

IMPROVEMENT ACTION PLAN:
The bureau is changing the way we track incoming mail by dates received. We can then control how many days the mail is out and coordinate the issuance of birth certificates to customers. The bureau is assigning batch work to employees every week to ensure that birth certificate requests are being processes and sent to the customer within 5 business days.

Major Quarterly Action Steps:	Goal Completion Date				
	Q1	Q2	Q3	Q4	Target
1) Monitor mail receive dates every week.	X	X	X	X	5 days
2) Monitor employee batch work folder every week.	X	X	X	X	5 days

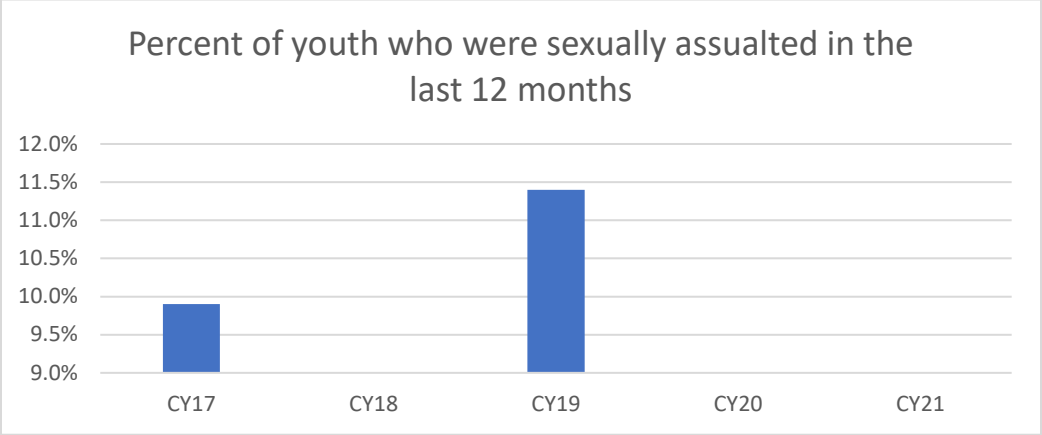
ERD PERFORMANCE MEASURE #3

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

Results

CY17	CY18	CY19	CY20	CY21	FY21 Target
9.9%	n/a*	11.4%	n/a*	Fall 2022	Explanatory

*Note: YRRS data for this question are collected every 2 years on odd numbered years.



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 11.4% of all public high schoolers in NM were sexually assaulted in the last 12 months and 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.

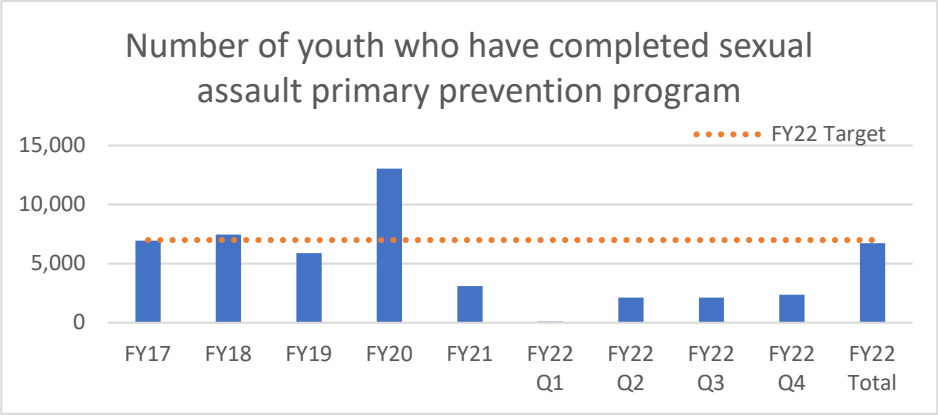
IMPROVEMENT ACTION PLAN:
This is an annual calendar year explanatory measure with no quarterly results.

ERD PERFORMANCE MEASURE #4

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

Results

FY17	FY18	FY19	FY20	FY21	FY22 Q1	FY22 Q2	FY22 Q3	FY22 Q4	FY22 Total	FY22 Target
6,962	7,470	5,905	13,051	3,112	103	2,134	2,120	2,376	6,733	≥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:
Data from 2021 are not yet released, however, 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. The DOH funds several contracts to deliver evidence-based or evidence-supported sexual assault primary prevention programs for youth. 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. In FY21 the total reach was only 3,112 youth, which more than doubled by the end of FY22 to 6733. In FY21 public health orders to prevent the spread of COVID- impaired contractors' ability to conduct sexual assault primary prevention programs in schools. Program delivery methods shifted to online delivery for remote learning. In addition, curriculum modifications were made by contractors to gear toward digital delivery along with creation of primary prevention programs designed to reach youth via non-school-based means.

IMPROVEMENT ACTION PLAN:

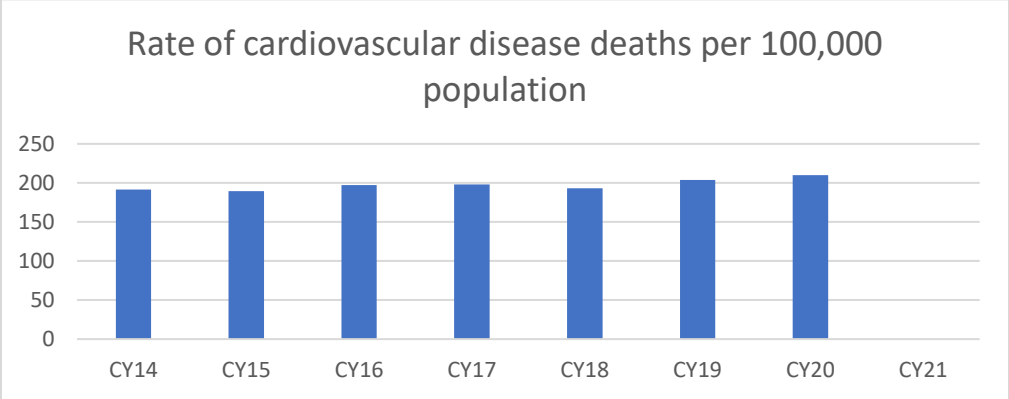
Major Quarterly Action Steps:	Goal Completion Date				
	Q1	Q2	Q3	Q4	Target
1) Train youth in evidence-based or supported sexual assault primary prevention programs.	103	2,134	2,120	2,376	**7,000**
2) Gather and analyze evaluation data.	X	X	X	X	
3) Develop community and societal level interventions.	X	X	X	X	

ERD PERFORMANCE MEASURE #5

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

Results

CY14	CY15	CY16	CY17	CY18	CY19	CY20	CY21	FY22 Target
191.4	189.3	197.2	198.1	193	203.7	209.9	Fall 2022	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:
The rate of cardiovascular (CVD) deaths describes the number of New Mexico residents whose primary cause of death was attributed to one of the following ICD-10 disease codes: I20, Angina, I21, First Myocardial Infarction, I25, Chronic Ischemic Heart Disease, or I63, Cerebral Infarction, standardized to the US 2,000 population. There has been a significant increase in CVD deaths since the historical baseline of 197.2 in 2016. It is unclear what factors led to the increase, but worsening air quality may be a contributing factor. The annual rate is for calendar year (CY) 2020 as CY 2021 data are not available until Fall 2022.

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:

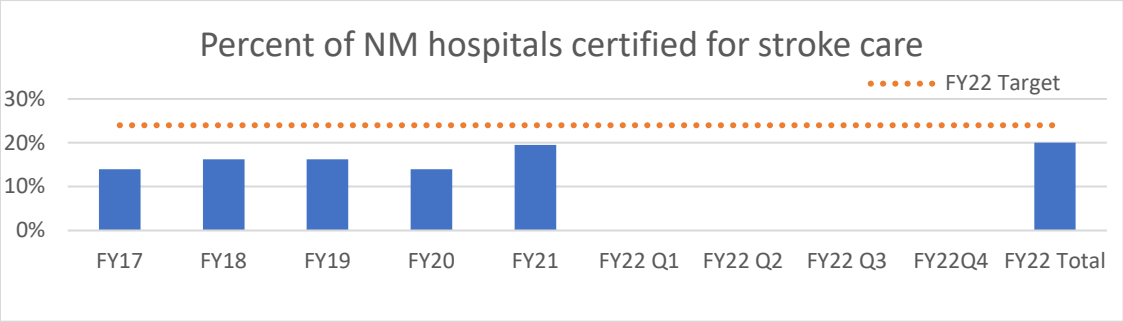
- Work with Presbyterian Healthcare Services on implementing a self-measured blood pressure protocol for patients in its Central Delivery System.
- Receive referred patients from Presbyterian Healthcare Services in its Central Delivery System to the YMCA's self-measured-blood pressure program (self-measured 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 #6

Percent of NM hospitals certified for stroke care

Results

FY17	FY18	FY19	FY20	FY21	FY22 Q1	FY22 Q2	FY22 Q3	FY22 Q4	FY22 Total	FY22 Target
14%	16.20%	16.20%	14%	19.5%	n/a	n/a	n/a	n/a	20%	≥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. 8 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. DOH will continuously work with hospitals to maintain or elevate current stroke certifications, identify hospitals who could qualify for a stroke certification, and guide those hospitals toward obtaining a stroke certification.
Due to the vacant Stroke position at the EMS Bureau and the Covid activities that the staff was doing, the only report that can be supplied at this time is the Annual report.

IMPROVEMENT ACTION PLAN:

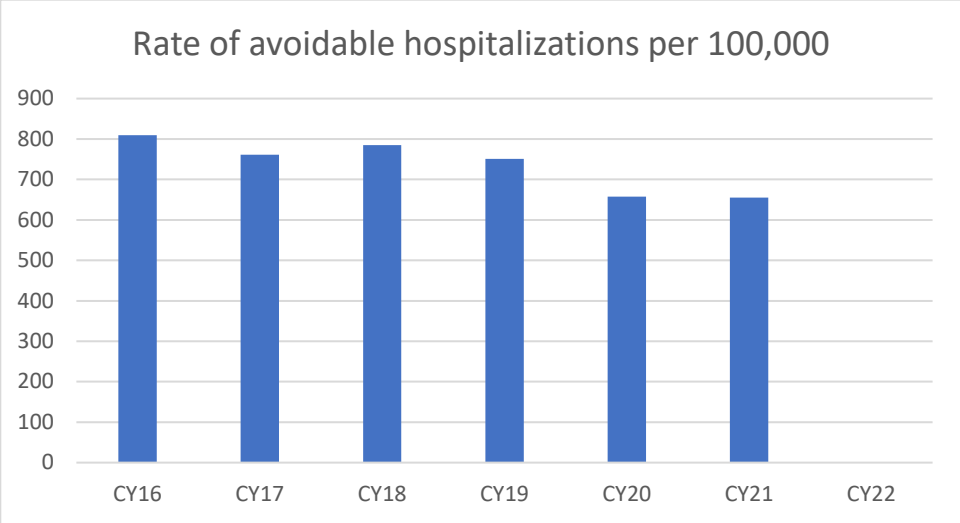
Major Quarterly Action Steps:	Goal Completion Date				
	Q1	Q2	Q3	Q4	Target
1) Work with certified hospitals to maintain or elevate their accreditation and certification level. – Ongoing throughout the year	X	X	X	X	
2) Encourage hospitals to submit stroke data and begin the path of becoming certified 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 #7

Rate of avoidable hospitalizations per 100,000 population

Results

CY16	CY17	CY18	CY19	CY20	CY21	CY22	FY22 Target
809.3	760.9	785.0	750.9	657.8	655.4	Fall 2023	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, CY2022 data will be available in Fall 2023.*

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.

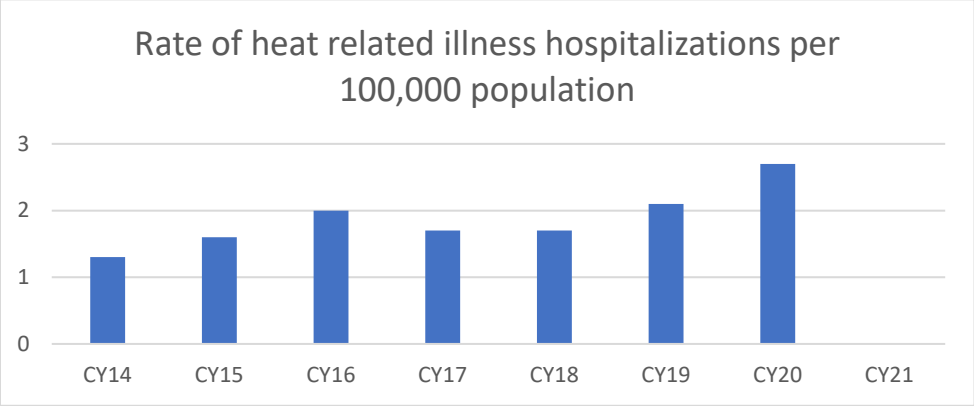
IMPROVEMENT ACTION PLAN:
The Epidemiology and Response Division's Health Systems Epidemiology Program currently analyzes avoidable hospitalization data annually upon collection of the annual hospital inpatient discharge dataset and disseminates these data via various methods, e.g., epidemiology reports, 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 #8

Rate of heat related illness hospitalizations per 100,000 population

Results

CY14	CY15	CY16	CY17	CY18	CY19	CY20	CY21	FY22 Target
1.3	1.6	2	1.7	1.7	2.1	2.7	Fall 2022	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:
Heat-related Illness (HRI) is defined as a constellation of explicit effects of hot weather on the body, including heat stroke, and sunstroke (hyperthermia), heat syncope or collapse, heat exhaustion, heat cramps, heat fatigue, heat edema, and other unspecified clinical effects attributed to excessive heat exposure. The HRI hospitalization rate is defined as the number of admissions to an acute care in-state hospital that occurs per 100,000 New Mexico residents and standardized to the US 2,000 population. Cases of HRI are classified as any admission with a primary or other diagnosis included in the range of the International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM), T67, X30, or X32 (excluding cases with a code W92). However, cases with a code of E900.1 (man-made source of heat) anywhere in the patient medical record are excluded. There has been a steady, but not-yet significant increase in the rate of HRI hospitalizations since 2018, from 1.7 per 100,000 to 2.7 per 100,000 NM residents. This rate is expected to increase as temperatures are expected to climb in coming years. Dedicated funding to combat the effects of climate-related illness is needed.

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

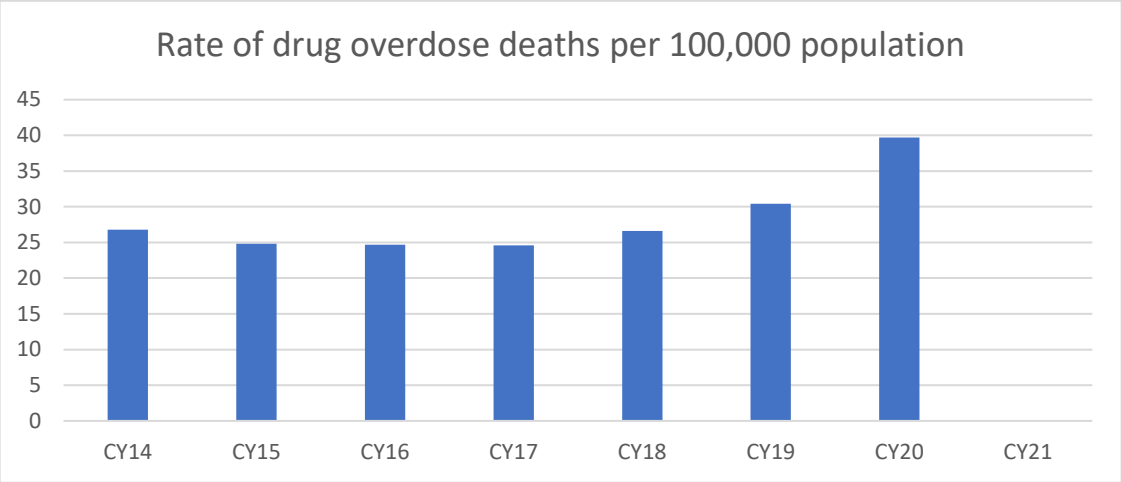
on the plan for New Mexico and provide updates to the Climate Change Taskforce convened by the Governor. The CHAWG continues to work on identifying strategies for action to mitigate the effects of high temperatures on residents of New Mexico in partnership with other bureaus in ERD and external partners including the National Weather Service, University of New Mexico and New Mexico State University.

ERD PERFORMANCE MEASURE #9

Rate of drug overdose deaths per 100,000 population

Results

CY14	CY15	CY16	CY17	CY18	CY19	CY20	CY21	FY22 Target
26.8	24.8	24.7	24.6	26.6	30.4	39.7	Fall 2022	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. The 2000 U.S. standard population has been in use for mortality data since 1999. There are no plans to change from the 2000 standard as it is widely accepted and statistically sound.

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 has increased rapidly since 2017 due to the influx of methamphetamine and illicit fentanyl. 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 Rx opioid-involved death rates have been decreasing while methamphetamine-involved and fentanyl-involved death rates have increased. These trends continued in 2021.

IMPROVEMENT ACTION PLAN:

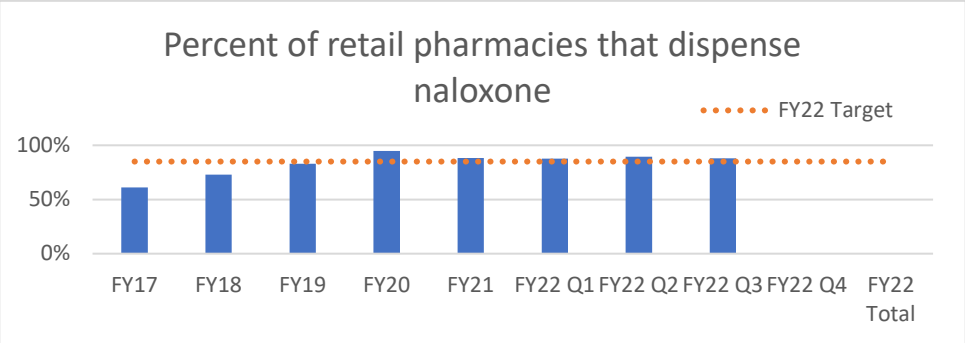
While this is an annual explanatory measure and no quarterly actions are required, the Epidemiology and Response Division is working with the Behavioral Health Services Division (BHSD) in the Human Services Department (HSD) on a plan to decrease methamphetamine-involved deaths. The draft plan includes 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 #10

Percent of retail pharmacies that dispense naloxone

Results

FY17	FY18	FY19	FY20	FY21	FY22 Q1	FY22 Q2	FY22 Q3	FY22 Q4	FY22 Total	FY22 Target
61%	72.9%	82.9%	94.8%	88.3%	87.8%	89.4%	88%	Fall 2022	n/a	≥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 narrative does not change quarterly, and no update is available without final data. This measure provides visibility into the over-all distribution of naloxone throughout New Mexico. The list of retail pharmacies is compared to Medicaid claims data to identify pharmacies that are/are not distributing naloxone. Given the ongoing challenge of curtailing opioid addiction and overdose, it is important to identify pharmacies not distributing naloxone so that they can be contacted for additional encouragement and education on the importance of distributing naloxone. 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 each 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:

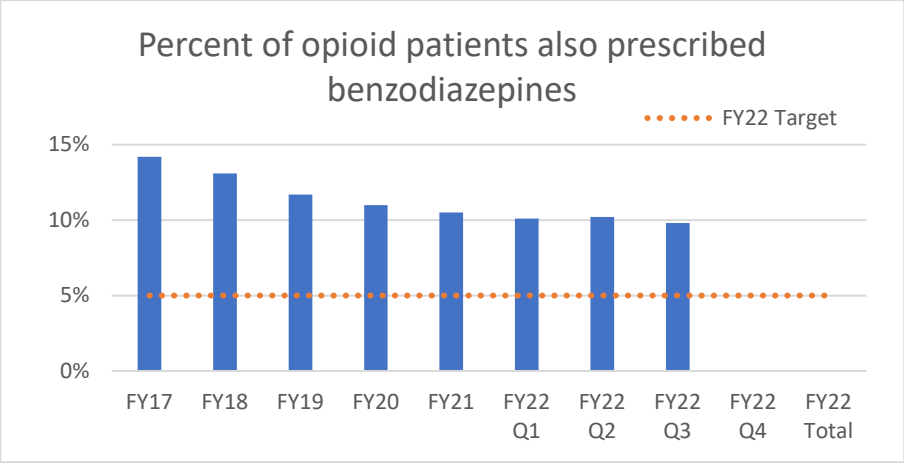
Major Quarterly Action Steps:	Goal Completion Date				
	Q1	Q2	Q3	Q4	Target
1) Obtain valid standing order and provide to New Mexico Pharmacist Association.	X	n/a	n/a	n/a	
2) Monitor Medicaid Claims data to ensure retail pharmacies continue to fill naloxone prescriptions and the measure stays above target.	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 #11

Percent of opioid patients also prescribed benzodiazepines

Results

FY17	FY18	FY19	FY20	FY21	FY22 Q1	FY22 Q2	FY22 Q3	FY22 Q4	FY22 Total	FY22 Target
14.2%	13.1%	11.7%	11.0%	10.5%	10.1%	10.2%	9.8%	Fall 2022	n/a	≤5%



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

DATA SOURCE/METHODOLOGY:
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. 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. The rate of decrease in this measure slowed after FY20 Q3, probably due to disruptions caused by the COVID-19 pandemic.

IMPROVEMENT ACTION PLAN:

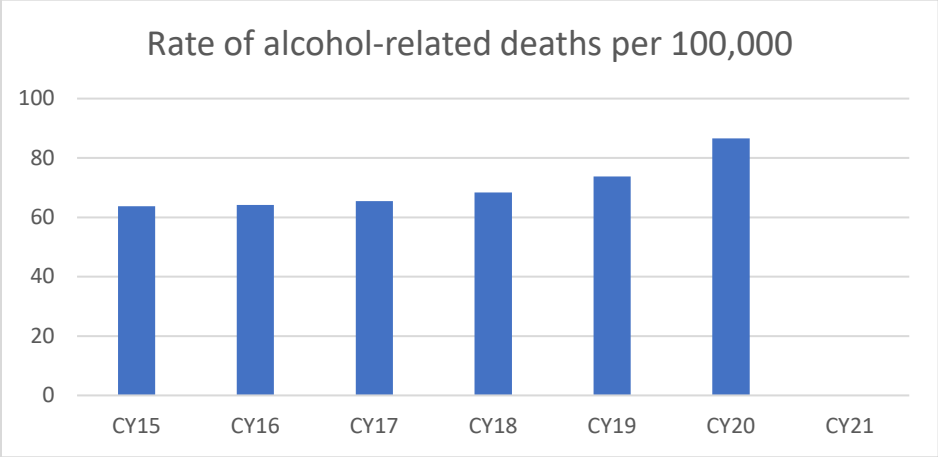
Major Quarterly Action Steps:	Goal Completion Date				
	Q1	Q2	Q3	Q4	Target
1) Provide quarterly reports to BOP including co-prescription rates for provider feedback reports and distribution to professional licensing boards.	X	X	X	X	

ERD PERFORMANCE MEASURE #12

Rate of alcohol-related deaths per 100,000 population

Results

CY15	CY16	CY17	CY18	CY19	CY20	CY21	FY22 Target
63.7	64.2	65.5	68.4	73.8	86.6	Fall 2022	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. The 2000 U.S. standard population has been in use for mortality data since 1999. There are no plans to change from the 2000 standard as it is widely accepted and statistically sound

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 CY20 alcohol-related death rate is twice the US. The alcohol-related death rate in New Mexico increased almost 17% between 2019 and 2020. It is estimated that the rate for CY 2021 will exceed the CY 2020 numbers. 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.

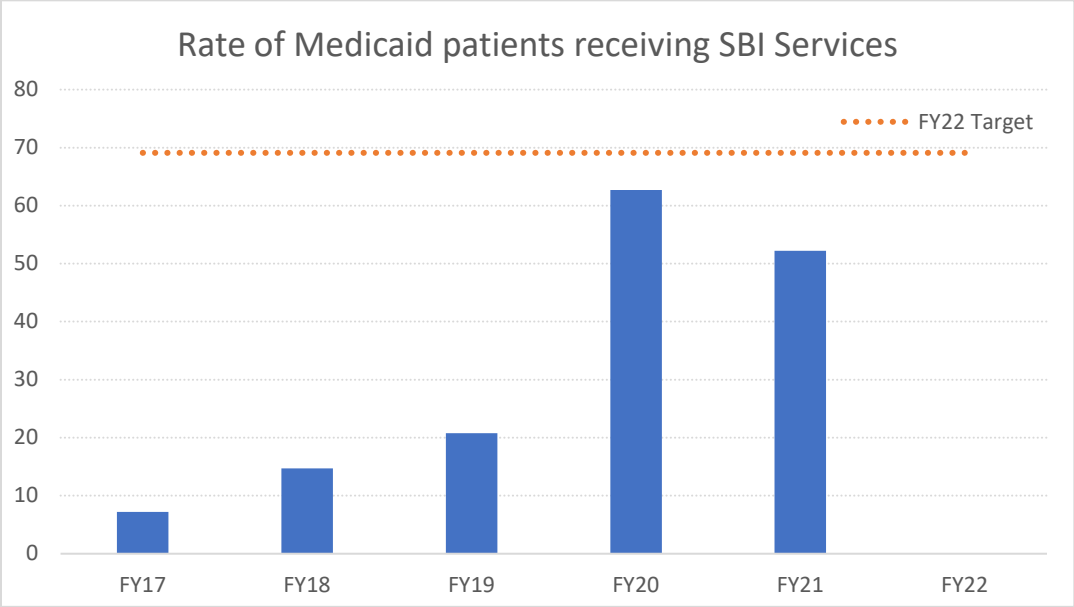
IMPROVEMENT ACTION PLAN:
While this is an annual year explanatory measure and no quarterly results are required, NMDOH ERD staff reach out to local (county/tribal/pueblo/national) health councils about the importance of including alcohol-related strategies. Data, presentations, and support are offered 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 #13

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

Results

FY17	FY18	FY19	FY20	FY21	FY22	FY22 Target
7.2	14.7	20.8	62.7	52.2	Fall 2022	69.1



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:

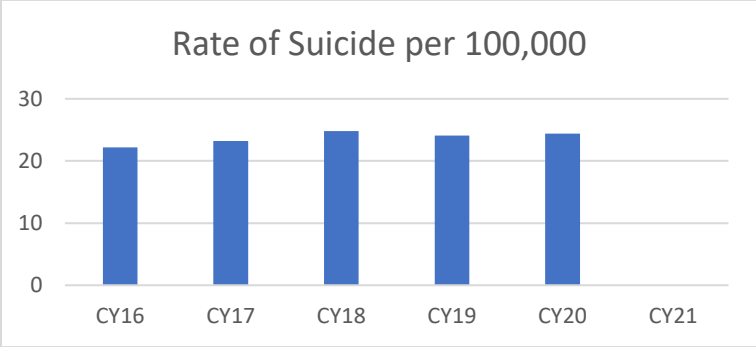
Major Quarterly Action Steps:	Goal Completion Date				
	Q1	Q2	Q3	Q4	Target
1) Recalculate FY20 rate with 2019 population data.	n/a	X	n/a	n/a	
2) Produce SBI Infographic visual.	n/a	n/a	n/a	n/a	
3) Request updated SBI data and calculate the FY21 rate.	n/a	n/a	n/a	X	

ERD PERFORMANCE MEASURE #14

Rate of suicide per 100,000 population

Results

CY16	CY17	CY18	CY19	CY20	CY21	FY22 Target
22.2	23.2	24.8	24.1	24.4	Fall 2022	Explanatory



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. The 2000 U.S. standard population has been in use for mortality data since 1999. There are no plans to change from the 2000 standard as it is widely accepted and statistically sound.

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:
New Mexico's 2020 age-adjusted suicide rate reflects a 22.6% increase between 2010 and 2020, the state is 4th in the nation for its age-adjusted rate of suicide. Of the 522 deaths by suicide in state residents, about half occurred in individuals between 15 and 44 years of age. Individuals ages 55-64 years had a lower rate of suicide death in 2020 compared to the prior year (22.8/100,000 population vs. 28.5/100,000 population, respectively). As occurred in 2019, between three and four times as many males as females died by suicide in 2020. The age-adjusted suicide rate for non-Hispanic whites decreased slightly in 2020 from 2019 (28.6/100,000 population vs. 28.7/100.000 population, respectively) while the age-adjusted suicide rate for American Indians in the state increased from 29.5/100,000 in 2019 to 35.2/100,000 in 2020. The public health region of the state showing the greatest age-adjusted suicide rate increase (21.1% increase) between 2019 and 2020 was the Northwest Health Region, with a rate of 36.7/100,000 population in 2020 up from 30.3/100,000 population in 2019. American Indians from 25 to34 years of age experienced a high rate (87.9 deaths per 100,000). Consistent with the recent past, firearms were the leading method for fatal self-harm (58.2%) followed by suffocation (26.0%), overdose or poisoning (10.3%), and other causes (such as falls) (5.5%).as falls) (5.5%).

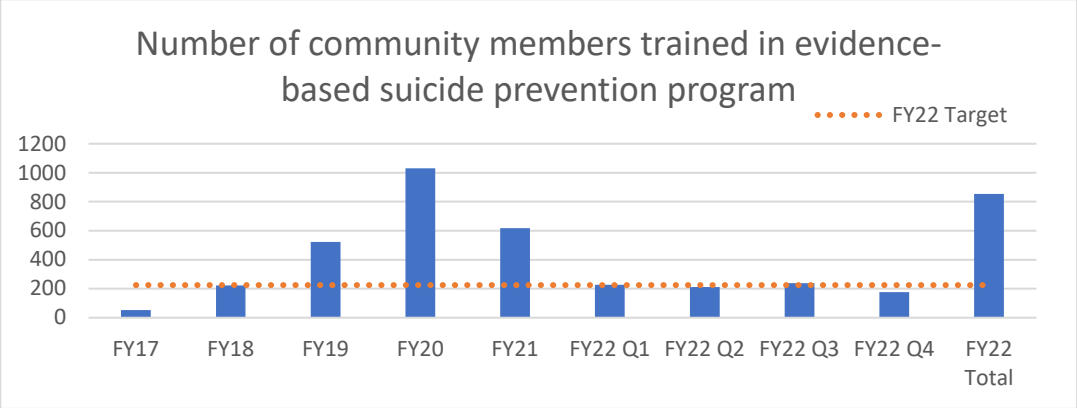
IMPROVEMENT ACTION PLAN:
This is an annual calendar year explanatory measure, so no quarterly action is required.

ERD PERFORMANCE MEASURE #15

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

Results

FY17	FY18	FY19	FY20	FY21	FY22 Q1	FY22 Q2	FY22 Q3	FY22 Q4	FY22 Total	FY22 Target
52	222	522	1,030	618	226	212	238	177	853	225



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:
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) to build capacity in local communities and with other within- and outside-state government agencies to offer gatekeeper trainings via gatekeeper train-the-trainer programs. The target for FY 22 is 800 and the target per quarter is 200. DOH is pleased to report an increase in community members trained in Q3 compared to Q2. The target for FY21 was 225 with an actual reach of 618 community members trained in an evidence-based suicide prevention program. The target for FY 22 is 800 and the target per quarter is 200 with an actual reach of 853 community members trained in an evidence-based suicide prevention program. Exceeding the projected FY22 target and greatly increasing the total reach in FY22 from the total reach in FY21, is largely due to effective promotion of available online trainings. Visit https://trainmeosah.com/ for more information regarding the Office of School and Adolescent Health Training Portal.

IMPROVEMENT ACTION PLAN:

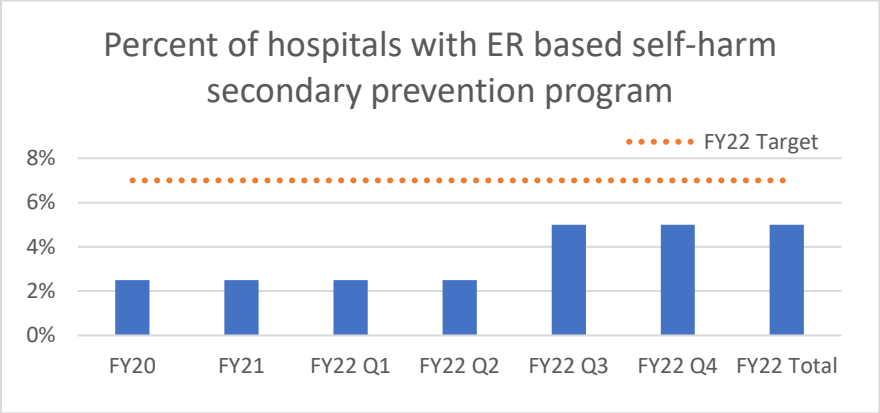
Major Quarterly Action Steps:	Goal Completion Date				
	Q1	Q2	Q3	Q4	Target
1) Provide support to OSAH by dissemination of course information.	X	X	X	X	
2) Remain actively certified to train – facilitate / co-facilitate as needed.	X	X	X	X	

ERD PERFORMANCE MEASURE #16

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

Results

FY20	FY21	FY22 Q1	FY22 Q2	FY22 Q3	FY22 Q4	FY22 Total	FY22 Target
2.5%	2.5%	2.5%	2.5%	5%	5%	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 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 to address suicide in the state and 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.

FY22 Goal: 7% of EDs will have Secondary Prevention of Suicide programs (n=3/37) in FY22

Establish a minimum of three (3) hospitals (7%) with emergency department-based secondary prevention programs for individuals who present with a suicide attempt, are treated, and discharged home. During early quarters of the current fiscal year, delays in program implementation occurred due to the pandemic and the hospitals' need to address COVID-19 as a priority in the emergency department program sites. In the later part of Q3, resource demands in emergency departments lessened and the program was implemented at a second facility. Two hospitals have established these programs and collaboration is underway with three others. At the close of FY21, only one hospital had the program implemented for a reach of 2.5% which has doubled by the close of FY22 to 5%.

IMPROVEMENT ACTION PLAN:

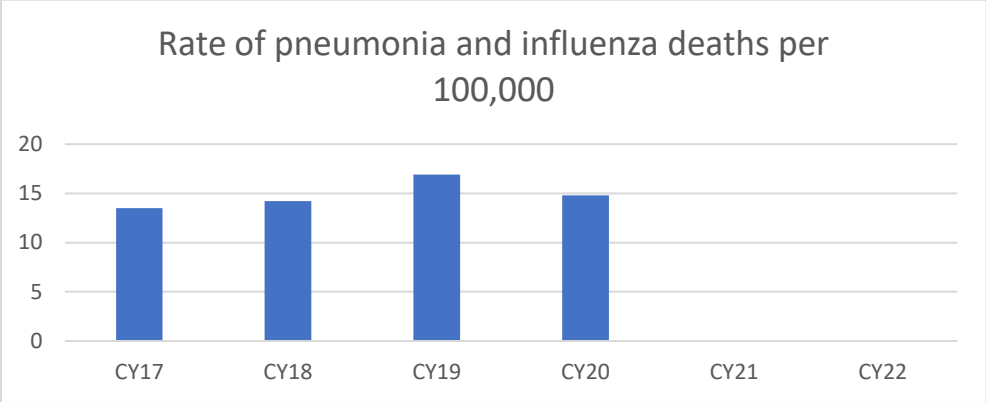
Major Quarterly Action Steps:	Goal Completion Date				
	Q1	Q2	Q3	Q4	Target
1) Phone and e-mail ED program contacts monthly to assess readiness to begin program.	X	X	X	X	
2) Tailor program components and training sessions for each ED that becomes available.	n/a	n/a	X	X	
3) Conduct training sessions for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

ERD PERFORMANCE MEASURE #17

Rate of pneumonia and influenza death per 100,000 population

Results

CY17	CY18	CY19	CY20	CY21	CY22	FY22 Target
13.5	14.2	16.9	14.8	Fall 2022	Fall 2023	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 2020, it is estimated that influenza caused 9 million – 41 million illnesses, 140,000 – 710,000 hospitalizations and 12,000 – 52,000 deaths annually. 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.

The COVID-19 pandemic affected P&I deaths in the US and New Mexico. Covid-Safe Practices (CSP) and pandemic-associated mandates led to a significant decline in non-COVID respiratory illness overall in 2020. While the burden has increased as these mandates have been lifted and compliance to CSP measures among the public has decreased in 2021 and 2022, most measures of respiratory burden -including P&I deaths- have still remained below what has been observed in the prior 10 years.

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.

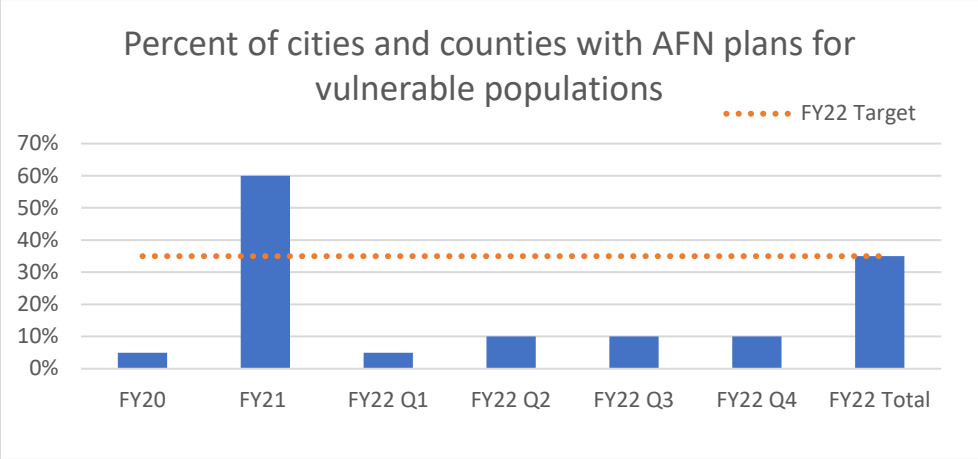
- Conduct viral isolation of specimens to detect changes in circulating viral strains and to compare what is circulating with vaccine strains.
- Convene a Health Status Indicator meeting to revisit interventions for influenza in the time of COVID-19 so we can better target prevention and control efforts.

ERD PERFORMANCE MEASURE #18

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	FY22 Q1	FY22 Q2	FY22 Q3	FY22 Q4	FY22 Total	FY22 Target
5%	60%	5%	10%	10%	10%	35%	35%



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) and/or jurisdictions (cities/villages)

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.

Access and Functional Needs (AFN) inclusion planning at the local level Office of Emergency Management (OEM) supports in identifying the activities, responsibilities, and functions in creating coordinated disaster/emergency operations assistance and coordination from the Department of Health (DOH)/Bureau of Health Emergency Management (BHEM) for New Mexicans and individuals visiting or traveling through New Mexico with Access and Functional Needs (AFN). In order to increase the number of counties that use AFN inclusion planning. BHEM provides fillable templates, SME guidance and access to seminars/training regarding AFN integration/inclusion into local EM planning.

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 #19

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

Results

FY19	FY20	FY21	FY22	FY22 Target
Data not collected	10%*	17%**	Fall 2023	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 from REDCap 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 false positives.

**The 2021-2022 flu season has similar limitations to the 2020-2021 season described above. While hospitalization rates were higher than the previous year (2020-2021), they remained below most every year in the prior decade. Additionally, hospitalizations increased near and after the end of the 'traditional' season (4/30/2022). As a result, cases reported after that date (approximately 30% of all cases) did not have comprehensive chart reviews and thus data on antiviral usage is, with rare exceptions, unavailable. When excluding cases after the traditional season, ARV usage approaches prior years (71.1% total, 24.8% within 2 days).

IMPROVEMENT ACTION PLAN:

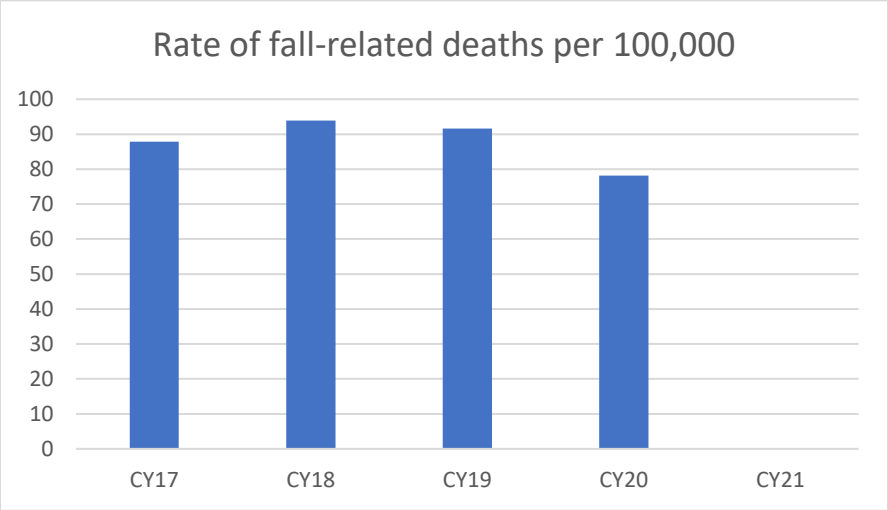
No improvement plan needed with explanatory measure.

ERD PERFORMANCE MEASURE #20

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

Results

CY17	CY18	CY19	CY20	CY21	FY22 Target
87.9	93.9	91.6	78.2	Fall 2022	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:

The statewide rate of fall-related deaths in New Mexico among adults 75 years of age and older decreased 16.9% from a rate of 197.3 deaths per 100,000 in 2019 to 163.9 deaths per 100,000 in 2020. The fall-related death rate in the 65–74-year range remained approximately the same from 2019 (19.5 deaths per 100,000) to 2020 (19.7 deaths per 100,000). The New Mexico Bureau of Vital Records and Health Statistics reported a total of 307 deaths related to falls among adults aged 65 years and older residing in New Mexico for 2020, which is 40 fewer deaths than were reported in 2019.

According to the Centers for Disease Control and Prevention (CDC), New Mexico improved from the tenth highest rate of fall-related deaths among adults 65 years and older in the nation in 2019 to the nineteenth highest rate of fall-related deaths in this age range in 2020. Even with this improvement in rank among states, the 2020 fall-related 65 and older death rate in New Mexico of 78.2 deaths per 100,000 was 19.7% higher than the national rate of 65.6 deaths per 100,000.

NMDOH Adult Falls Prevention Program efforts are aimed at conducting primary prevention of adult falls through promotion of, and by conducting and promoting evidence-based falls prevention interventions within communities, clinical assessments of vision and medications for older adults, and physical/occupational therapy-based exercise programs.

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:

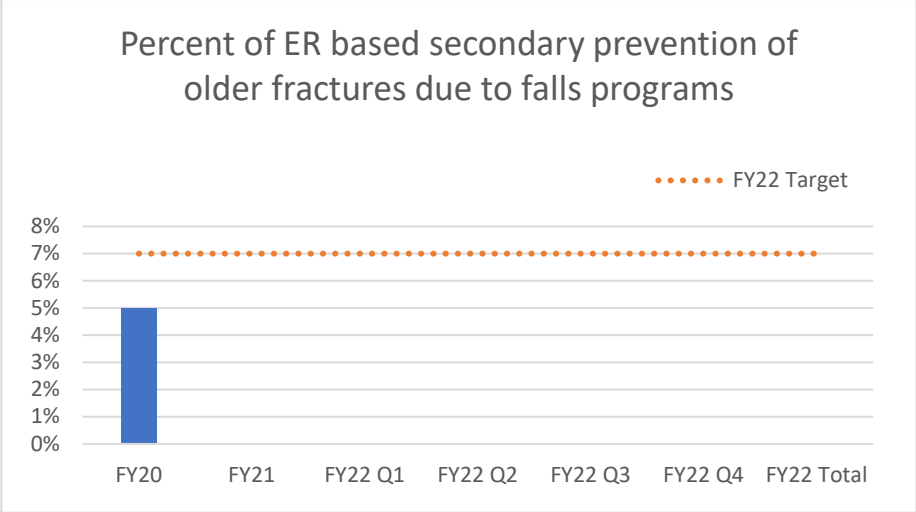
- Expanding the network of instructors available statewide to implement evidence-based falls prevention interventions. Instructor trainings will be conducted online to train new prevention leaders to teach courses online.
- Increasing the number of professionals trained on the use of the Stopping Elderly 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 #21

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

Results

FY20	FY21	FY22 Q1	FY22 Q2	FY22 Q3	FY22 Q4	FY22 Total	FY22 Target
5%	0%	n/a	n/a	n/a	n/a	n/a	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.
This measure has been replaced effective FY23.

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	-	-	-	

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):

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	

FY22	General Fund	Other State Funds	Federal Funds	Other Transfers	TOTAL	FTE
200	$4,742.80	$1,289.69	$1,996.59	$49.72	$8,078.81	191
300	$47.01	$0.00	$219.78	$0.00	$266.79	
400	$2,166.71	$279.90	$2,715.95	$477.06	$5,639.62	
TOTAL	$6,956.52	$526.78	$4,932.32	$1,569.59	$13,985.22	

*Actual Budget as of 8/4/22

Program Performance Measures:

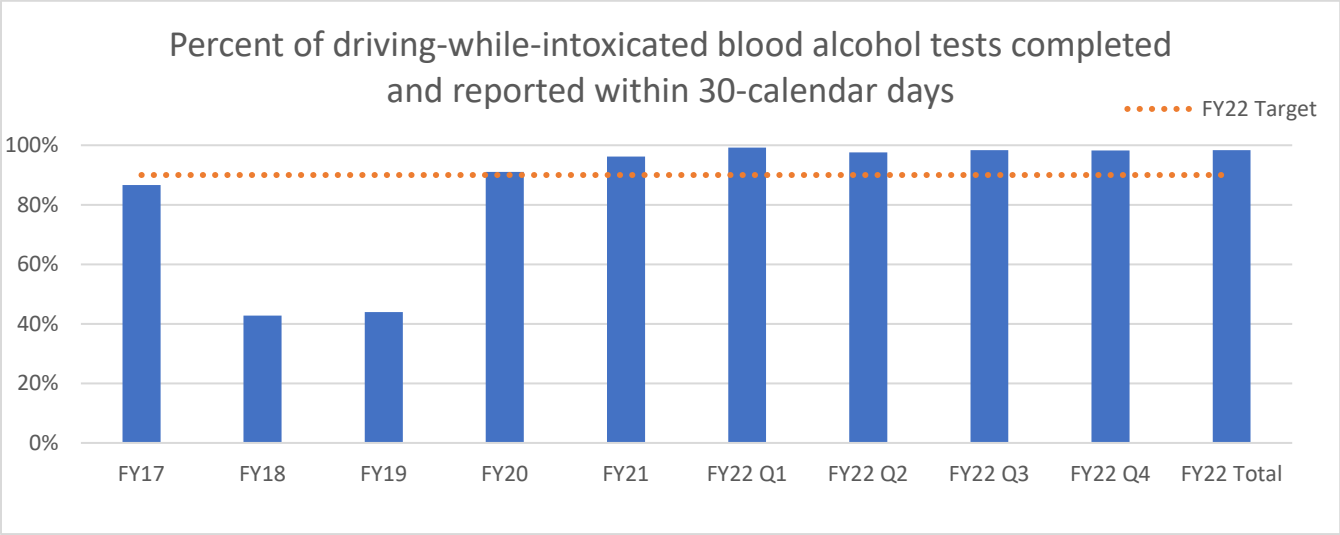
1. Percent of blood alcohol tests from driving-while-intoxicated cases that are completed and reported to law enforcement within 30-calendar days (FY22 Key Measure)
2. Percent of environmental samples for chemical contamination that are completed and reported to the submitting agency within 60-business 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

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	FY22 Q1	FY22 Q2	FY22 Q3	FY22 Q4	FY22 Total	FY22 Target
87%	43%	44%	91%	98%	99.2%	97.6%	98.3%	98.2%	98.4%	≥90%



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

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. SLD Toxicology staff analyzes 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 carboxyhemoglobin. This quarter performance was the same as last quarter. This primarily is due to the hard work of the staff manager taking on extra duties due to the lack of a line supervisor. Two new employees were being trained and there was an update in our Laboratory Informatics Management System (LIMS). This update included integration of the LIMS with instrumentation which required testing by staff to ensure accurate data flow and reporting. We were able to maintain due to hard work by all employees. In comparison to FY21 Q4 the number of DWI cases is lower but performance was much higher this Quarter. There was help with technical review for both Enzyme Immunoassay (EIA) and BAC cases. All staffing resources were going to performing work and not teaching and training new employees. Some success stories are that the Drug Screening Sections has completely validated the Orbitrap testing platform. Testing is available for drug screening on this platform. Validation of the EIA Buprenorphine was completed, and the re-validation of the EIA Sertraline was also completed. The LIMS project is also complete.

IMPROVEMENT ACTION PLAN:

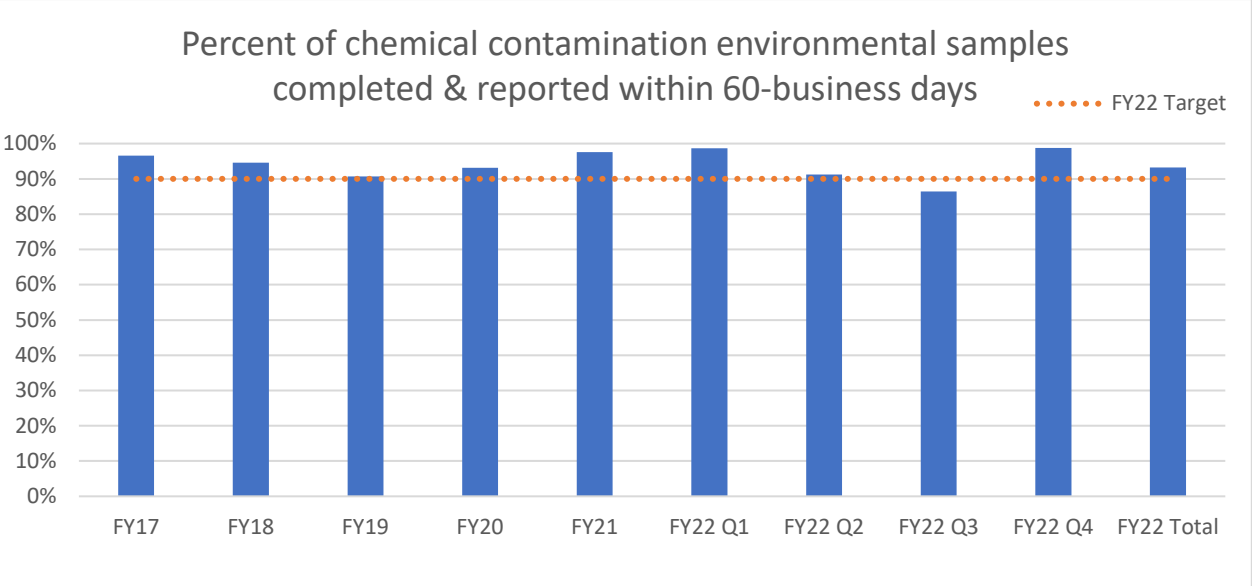
Major Quarterly Action Steps:	Goal Completion Date				
	Q1	Q2	Q3	Q4	Target
1) Run at least one blood alcohol method per week.	X	X	X	X	**90%**
2) Run at least 1 EIA per week	X	X	X	X	**90%**
3) Complete technical & administrative case reviews within 30 days.	P	P	P	P	**90%**

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	FY22 Q1	FY22 Q2	FY22 Q3	FY22 Q4	FY22 Total	FY22 Target
97%	95%	91%	91%	97.6%	98.7%	91.2%	86.4%	98.8%	93.2%	≥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. Chemistry had an increase in completed samples within 60 days from FY22 Q3. This was due to a more stable workforce. The new employees are settling in, are completing competencies which has allowed them to help with testing. FY22 Q4 and FY21 Q4 have stayed the same. This is due to a more stable work schedule after COVID and the ability to work 4 10-hour days. A success for this quarter is that the Organic Chemistry section has finished their validation of UCMR 5 EPA Method 537.1. The EPA has also granted SLD approval to test samples for this method as well. This is half of the testing required for PFAS.

IMPROVEMENT ACTION PLAN:

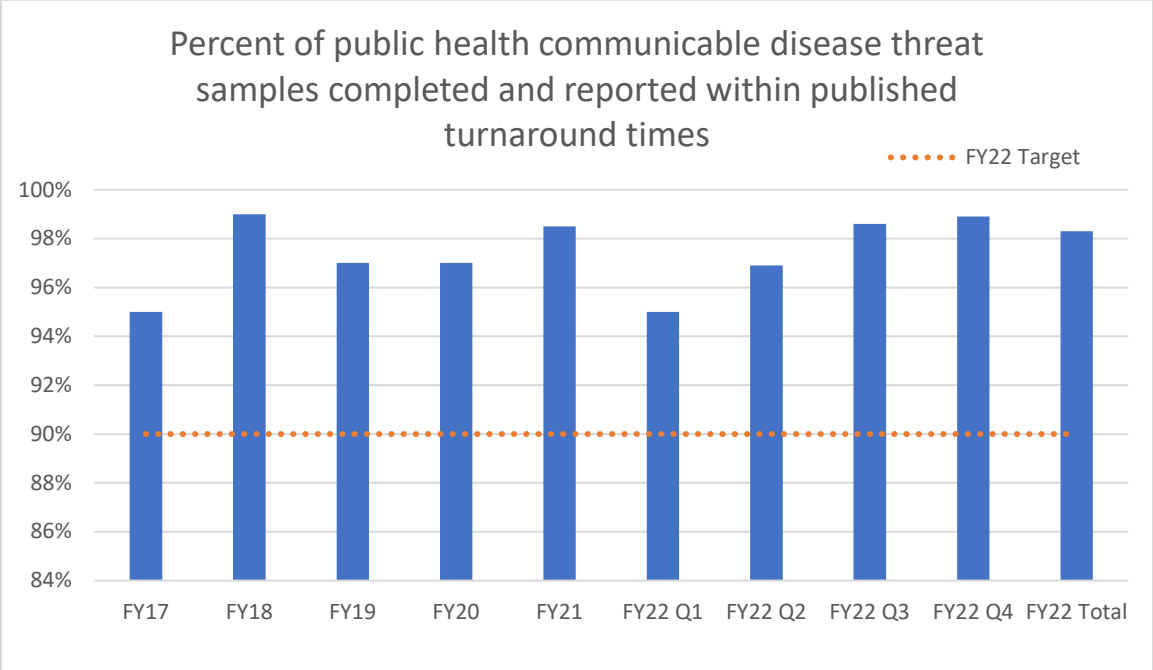
Major Quarterly Action Steps:	Goal Completion Date				
	Q1	Q2	Q3	Q4	Target
1) Complete Environmental Protection Agency audit.	N/A	N/A	N/A	N/A	**90%**
2) Hire staff to fill current bureau vacancies.	P	P	P	P	**90%**
3) Continue to cross-train staff for coverage of analytical methods.	P	P	P	P	**90%**
4) Method Validation for PFAS analyzed by EPA method 533,571.1	P	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	FY22 Q1	FY22 Q2	FY22 Q3	FY22 Q4	FY22 Total	FY22 Target
95%	99%	97%	97%	98.5%	95%	96.9%	98.6%	98.9%	98.3%	≥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 turnaround time for FY22 Q4 was about the same as for FY22 Q3 and the same as for FY21 Q4. These numbers are about the same because of cross training of new employees which has reduced the impact from losing staff. Success stories: The testing for COVID in wastewater was initiated this quarter. The validation for the LAMP assay (a PCR rapid screening method) for Salmonella has been completed. Significant progress has occurred on the bidirectional communication between SLD's LIMS and PHDs BEHR database.

IMPROVEMENT ACTION PLAN:

Major Quarterly Action Steps:	Goal Completion Date				
	Q1	Q2	Q3	Q4	Target
1) Obtain all components for COVID-19 wastewater testing.	P	P	X	X	**90%**
2) Implement Whole Genome Sequencing analysis in SLD's Laboratory Management System.	P	P	X	X	**90%**
3) Complete validations on analyses that have been delayed due to COVID.	P	P	P	P	**90%**
4) Continue to cross train staff to ensure that turnaround times are met.	P	P	P	P	**90%**
5) Validate the LAMP assay for Salmonella	n/a	n/a	P	P	**90%**
6) Begin validation of MALDI-TOF for Mycobacterium identification	n/a	n/a	P	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):

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	

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

FY22	General Fund	Other State Funds	Federal Funds	Other Transfers	TOTAL	FTE
200	$41,751.54	$47,218.16	$6,782.10	$615.40	$96,367.20	1,930
300	$3,232.96	$5,352.52	$1,059.36	$890.07	$10,534.89	
400	$8,586.19	$7,773.04	$1,763.96	$2,031.75	$20,154.94	
TOTAL	$53,570.68	$60,343.72	$9,605.41	$3,537.22	$127,057.03	

Program Performance Measures:

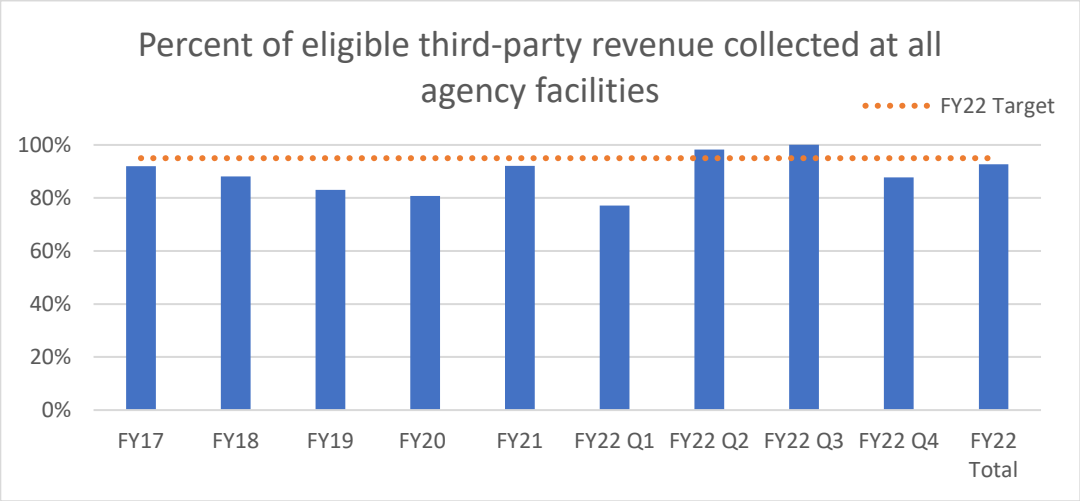
1. Percent of eligible third-party revenue collected at all agency facilities (FY22 Key & HB2 Measure)
2. Number of overtime hours worked
3. Number of direct care contracted hours
4. Percent of dementia only residents on antipsychotics
5. Number of significant medication errors per 100 patients (FY22 Key & HB2 Measure)
6. Percent of in-house acquired pressure ulcers for long term care residents – long stays
7. Percent of in-house acquired pressure ulcers for long term care residents – short stays
8. Percent of beds occupied
9. Percent of adolescent residents (SATC & NMBHI Care Unit) who successfully complete program
10. Percent of patients educated on Medication Assisted Treatment (MAT) option while receiving medical detox services
11. Percent of MAT inductions conducted or conducted after referrals on alcohol use disorders
12. Percent of MAT inductions conducted or conducted after referrals on opiate use disorders
13. Number of Narcan kits distributed or prescribed
14. Rate of medical detox occupancy at Turquoise Lodge Hospital
15. Percent of priority Request for Treatment clients who are provided an admission appointment to Turquoise Lodge's program within 2 days
16. Percent of long-term care residents experiencing one or more falls with major injury (FY22 Key & HB2 Measure)

FMD PERFORMANCE MEASURE #1

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

Results

FY17	FY18	FY19	FY20	FY21	FY22 Q1	FY22 Q2	FY22 Q3	FY22 Q4	FY22 Total	FY22 Target
92.0%	88.1%	83.0%	80.8%	92.1%	77.1%	98.3%	108.3%	87.7%	92.7%	≥95%



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. Q4 target was not met with the 87.7% result but the annual result of 92.7% demonstrated consistency with last fiscal year. Quality improvement aimed at improving collection rates is continuous. 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	

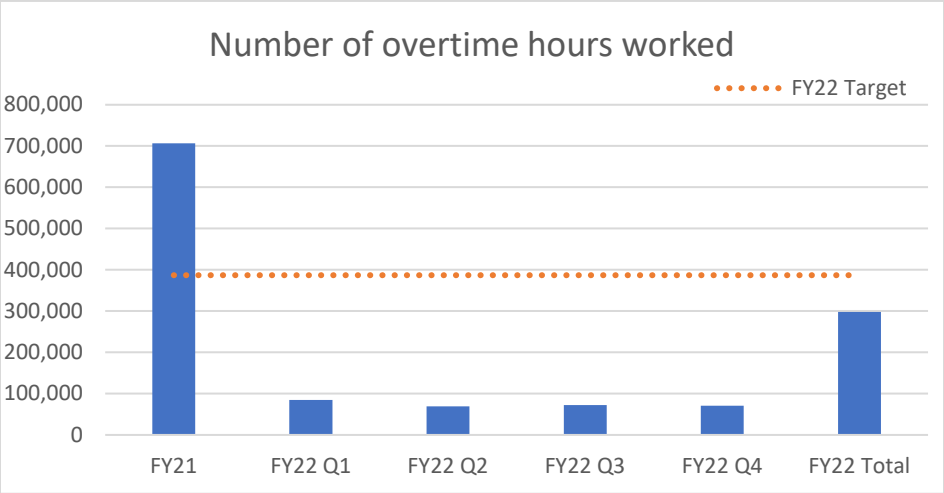
5) Monitor denied claims, research denials, and take appropriate action to resolve and resubmit claims.	X	X	X	X	
6) Communicate regularly with third party representatives to resolve unpaid claims.	X	X	X	X	
7) Review Managed Care Organization contracts to ensure services are eligible and billable under 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

Number of overtime hours worked

Results

FY21	FY22 Q1	FY22 Q2	FY22 Q3	FY22 Q4	FY22 Total	FY22 Target
706,714	84,870	69,514	72,505	71,024	297,913	≤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. We saw an 18% drop in OT from Q1 to Q2. However, Q3 and Q4 saw a slight increase and then remained steady for the remainder of the FY. Overtime in 2022 can be attributed to staffing challenges due to extended quarantines for Covid positive staff, high turn-over rate, FMLA, and a lack of qualified candidates in the job market, competition with private sector healthcare facilities for staff.

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	

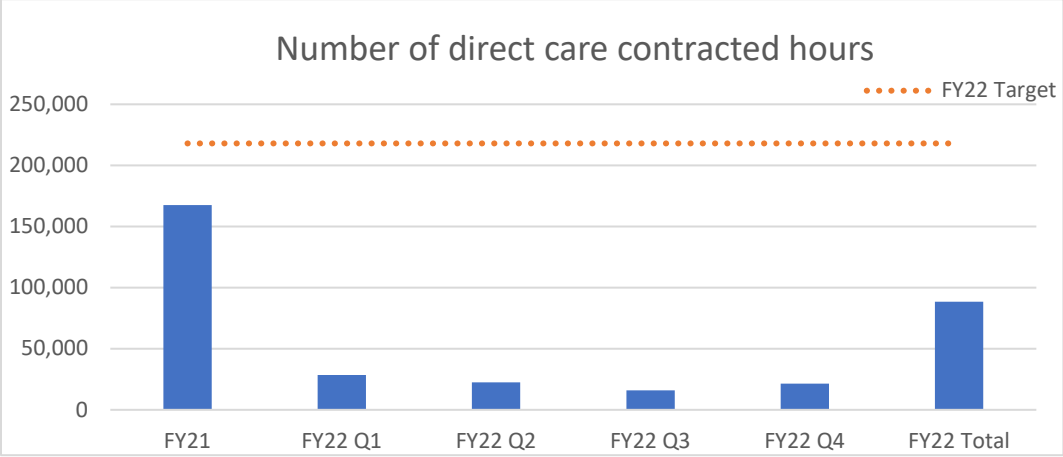
FMD PERFORMANCE MEASURE #3

Number of direct care contracted hours

Results

FY21	FY22 Q1	FY22 Q2	FY22 Q3	FY22 Q4	FY22 Total	FY22 Target
*167,479	28,445.86	22,558.54	15,847.53	21,540	88,391.75	218,000

*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.
As staffing improves the need for agency (contract) staff decreases. The facilities have increased their efforts in recruiting and retaining healthcare professionals in classified positions therefore somewhat reducing their reliance on contracted staff. Q3 saw the most significant decrease in the need for agency while Q4 saw an increase with the Covid BA5 variant surge. While most facilities have an average of 40 open positions, larger facilities such as NMBHI and LLCP have 80+ openings primarily in front line care staff. Care staff positions such as behavioral health techs are traditionally not readily available even within agency.

IMPROVEMENT ACTION PLAN:

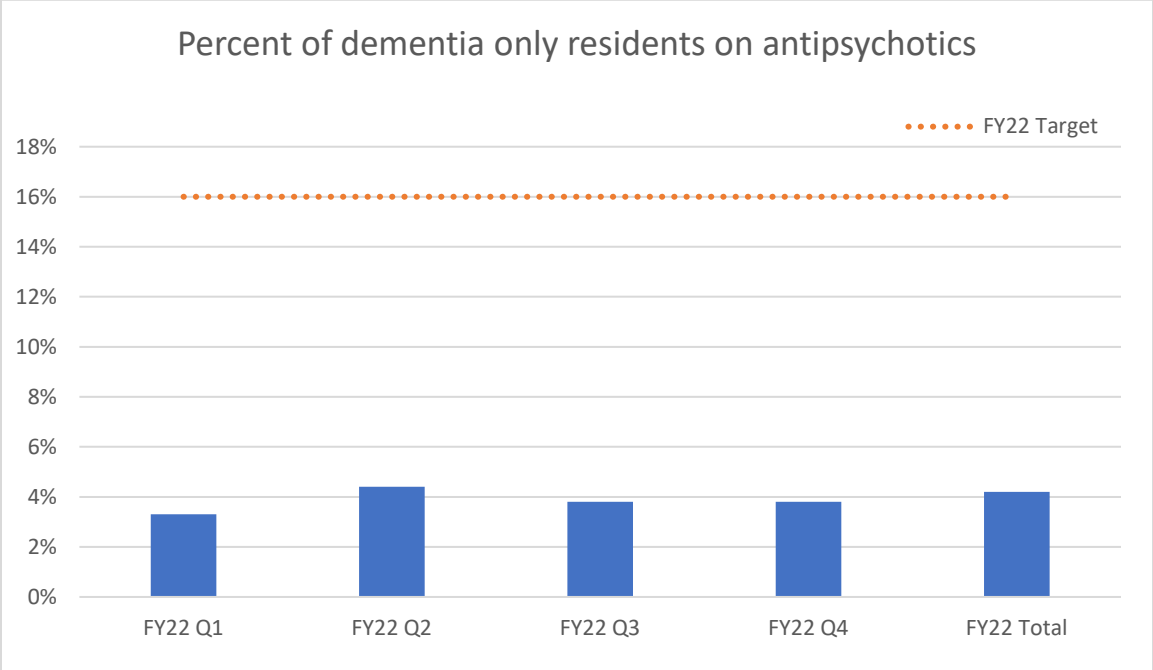
Major Quarterly Action Steps:	Goal Completion Date				
	Q1	Q2	Q3	Q4	Target
1) Assess current contract staffing hours and ways to reduce number of contract staff.	X	X	X	X	

FMD PERFORMANCE MEASURE #4

Percent of dementia only residents on antipsychotics

Results

FY21	FY22 Q1	FY22 Q2	FY22 Q3	FY22 Q4	FY22 Total	FY22 Target
-	3.3%	4.4%	3.8%	3.8%	4.2%	16%



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".

The percent of dementia only residents on antipsychotics went down from FY 21 to FY22 significantly. This reduction could be attributed to several different changes that long-term care facilities are attempting. The first is to clarify diagnoses for residents to ensure that those who do have a behavioral health disorder are appropriately diagnosed. The second is that facilities are required to do gradual dose reductions and there has been an emphasis placed on reducing the antipsychotic medication for those individuals with dementia only diagnoses.

IMPROVEMENT ACTION PLAN:

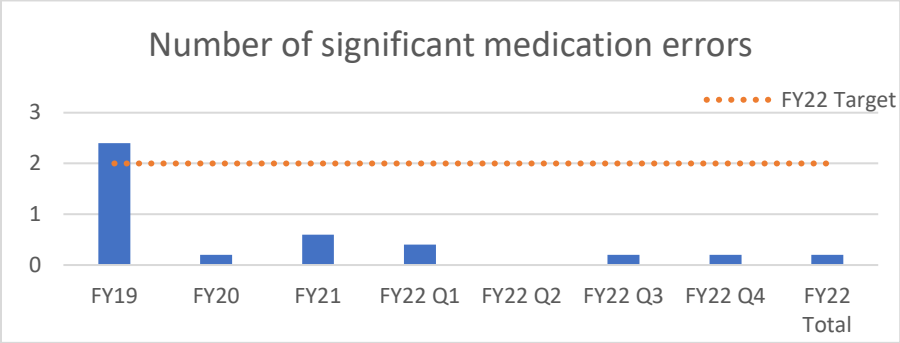
Major Quarterly Action Steps:	Goal Completion Date				
	Q1	Q2	Q3	Q4	Target
1) Discuss, evaluate, and explore the current practices/models of care related to dementia residents used across the 3 DOH nursing facilities.	X	X	X	X	
2) Review monthly pharmacy reports in the Quality Assurance Process Improvement 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 #5

Number of significant medication errors

Results

FY19	FY20	FY21	FY22 Q1	FY22 Q2	FY22 Q3	FY22 Q4	FY22 Total	FY22 Target
2.4	0.2	0.6	0.4	0.0	0.2	0.2	0.2	≤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. This metric needs to be updated to % medication error per 1000 patient days. Self-reporting may underestimate these metrics. We will educate quality champions and administrators to encourage reporting of medications errors.

IMPROVEMENT ACTION PLAN:

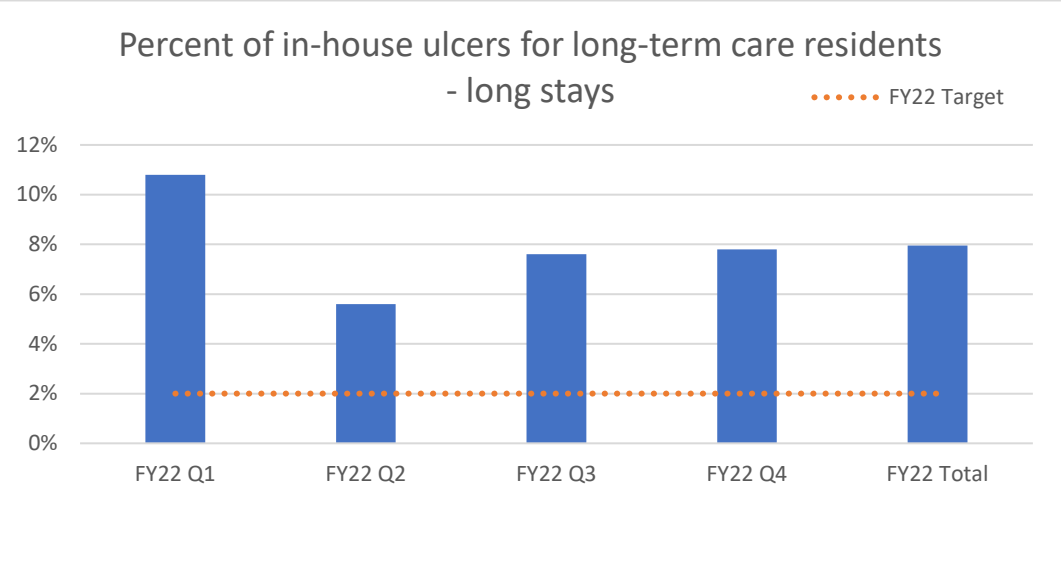
Major Quarterly Action Steps:	Goal Completion Date				
	Q1	Q2	Q3	Q4	Target
1) Foster a continuous culture of patient safety and quality improvement framework.	X	X	X	X	
2) Monitor actual and potential medication errors that occur/may occur, including near misses, then investigate root causes.	X	X	X	X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

FMD PERFORMANCE MEASURE #6

Percent of in-house acquired pressure ulcers for long term care residents – long stays

Results

FY20	FY21	FY22 Q1	FY22 Q2	FY22 Q3	FY22 Q4	FY22 Total	FY22 Target
-	-	10.8%	5.6%	7.6%	7.8%	7.95%	<2%



MEASURE DESCRIPTION:
This measure captures the percentage of long-stay, high-risk residents with Stage II-IV or unstageable pressure ulcers.

DATA SOURCE/METHODOLOGY:
Certification and Survey Provider Enhanced Reports (CASPER) Report MDS 3.0 Facility Level Quality Measure Report (N015.03). Data collected by MDS.

STORY BEHIND THE DATA:
Most high risk/unstageable pressure ulcers are due to a combination of immobility plus, poor nutrition and poor nursing practices. We are concerned with our rate of pressure ulcers and have been addressing the issue at both the facility level and the administrative level. A new quality improvement council for the facilities has been created. The goal of this council is to share data and best practices among the facilities. Training in the facilities needs to be optimized. We will focus our energies on the coming year to decrease the incidence of pressure ulcers. The current percentage of pressure ulcers is above our stated goal and is unacceptable.

We did not achieve our goal for this important metric. We have expanded our quality council to include all facilities. Pressure ulcer will be an area of emphasis in the new fiscal year.

IMPROVEMENT ACTION PLAN:

Major Quarterly Action Steps:	Goal Completion Date				
	Q1	Q2	Q3	Q4	Target
Make this quality metric a priority for all LTC facilities	X	X	X	X	
Team rounding on all patients with pressure ulcers	X	X	X	X	

FMD PERFORMANCE MEASURE #7

Percent of in-house acquired pressure ulcers for long term care residents – short stays

Results

FY20	FY21	FY22 Q1	FY22 Q2	FY22 Q3	FY22 Q4	FY22 Total	FY22 Target
-	-	n/a	n/a	n/a	n/a	n/a	<2%

Currently, this is not a measure Facilities tracks and measures over time.

MEASURE DESCRIPTION:

Changes in Skin Integrity Post-Acute Care: Pressure Ulcer/Injury.

DATA SOURCE/METHODOLOGY:

Certification and Survey Provider Enhanced Reports (CASPER) Report MDS 3.0 Facility Level Quality Measure Report, measure description Pressure Ulcer/Injury (S038.02). Data Collected by MDS.

STORY BEHIND THE DATA:

Most high risk/unstageable pressure ulcers are due to a combination of immobility plus, poor nutrition and poor nursing practices. We are concerned with our lack of data of pressure ulcers and have been addressing the issue at both the facility level and the administrative level. A new quality improvement council for the facilities has been created. The goal of this council is to track and share data and best practices among the facilities. Training in the facilities needs to be optimized. We will focus our energies on the coming year to decrease the incidence of pressure ulcers. Pressure ulcers will be an area of emphasis in the new fiscal year.

IMPROVEMENT ACTION PLAN:

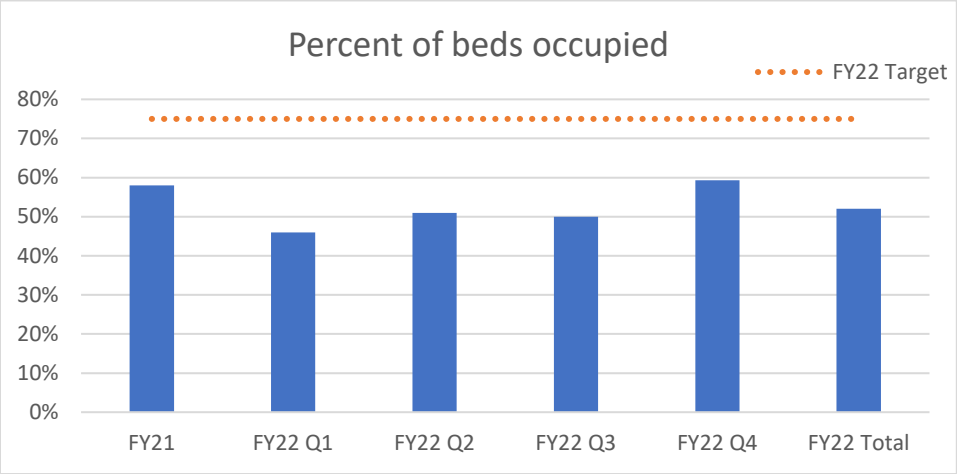
Major Quarterly Action Steps:	Goal Completion Date				
	Q1	Q2	Q3	Q4	Target
Team rounding on all patients with pressure ulcers	X	X	X	X	
Make this quality metric a priority for all LTC facilities	X	X	X	X	

FMD PERFORMANCE MEASURE #8

Percent of beds occupied

Results

FY21	FY22 Q1	FY22 Q2	FY22 Q3	FY22 Q4	FY22 Total	FY22 Target
58%	46%	51%	50%	59.3%	52%	≥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. We see a growth rate of 28% in our facilities' census from Q1 to Q4. As staffing improves, the number of operational beds will increase providing increased access to care. Staffing continues to be the number one challenge to increasing census in the facilities. For most, if not all, of FY22, LLCP was on self-imposed moratorium for our Supported Living business due to our staffing crisis which means they will not admit any new Supported Living residents this year. Target is ≥75%; LLCP performance is well above target. NMBHI was forced to evacuate their facility for two weeks in May which compounded their already low staffing levels.

IMPROVEMENT ACTION PLAN:

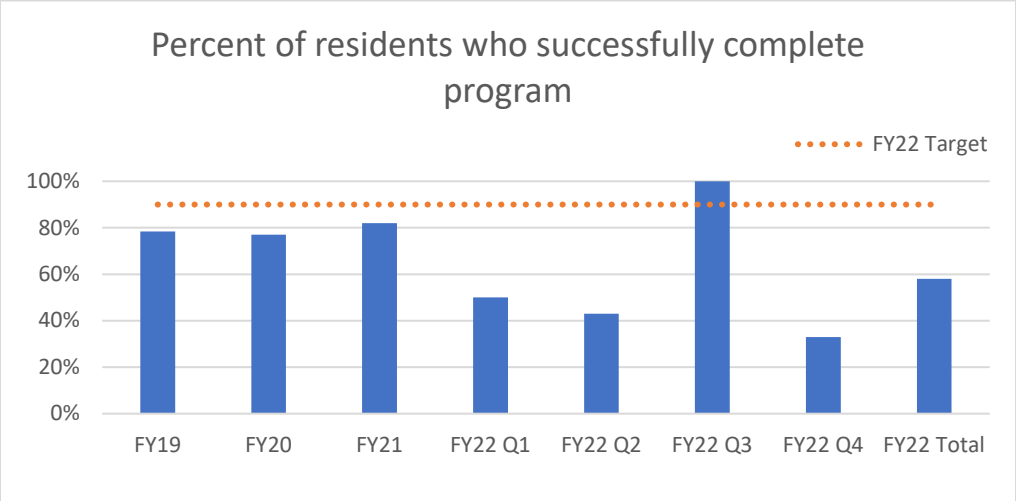
Major Quarterly Action Steps:	Goal Completion Date				
	Q1	Q2	Q3	Q4	Target
1) Assess licensed and available beds, on a continual basis.	X	X	X	X	

FMD PERFORMANCE MEASURE #9

Percent of adolescent residents who successfully complete program

Results

FY19	FY20	FY21	FY22 Q1	FY22 Q2	FY22 Q3	FY22 Q4	FY22 Total	FY22 Target
78.4%	77%	82%	50%	43%	100%	33%	58%	≥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:
This measure assesses and evaluates the percentage of successful discharges from NM DOH Sequoyah Adolescent Treatment Center, for residents who successfully completed treatment goals while admitted. A successful discharge is a resident discharged to a lower level or recommended level of care. The low number of discharges significantly impacted the overall data for this year. The CARE unit at NMBHI had very few discharges and one event, leading to two unsuccessful discharges, significantly impacted the overall number. SATC and NMBHI are working now to raise the census so that the unsuccessful discharges do not impact the other numbers so strong.
A successful discharge is a resident discharged to a lower level or recommended level of care at the time of admission. Unsuccessful discharges can be due to

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

IMPROVEMENT ACTION PLAN:

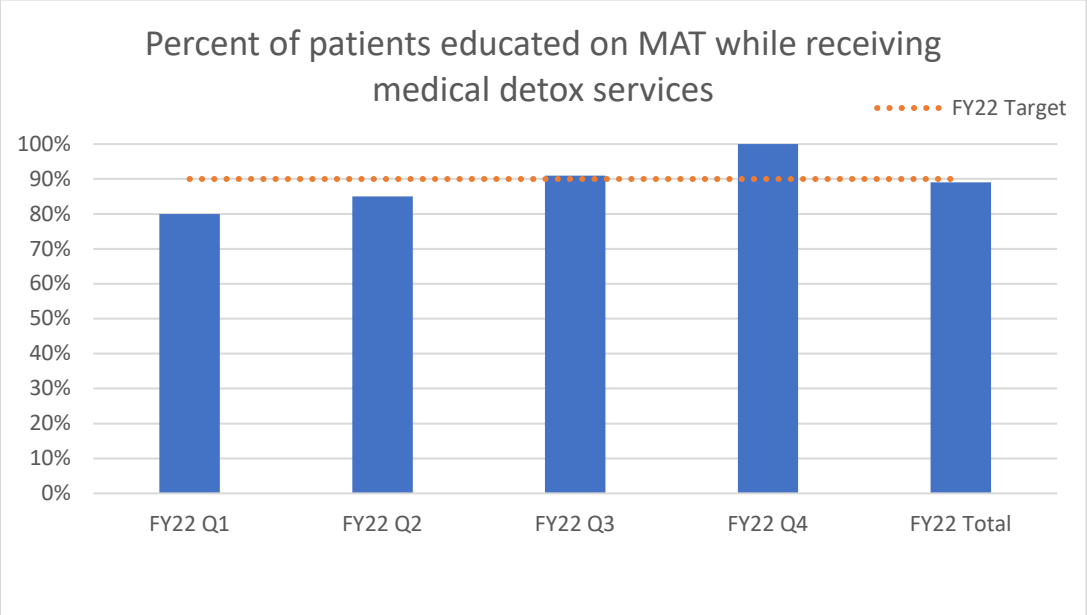
Major Quarterly Action Steps:	Goal Completion Date				
	Q1	Q2	Q3	Q4	Target
1) Provide individualized treatment and services, meeting the needs of each resident.	X	X	X	X	
2) Tailor program recruitment criteria to ensure availability of appropriate treatment services.	X	X	X	X	
3) Review and develop ongoing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

FMD PERFORMANCE MEASURE #10

Percent of patients educated on MAT option while receiving medical detox services

Results

FY21	FY22 Q1	FY22 Q2	FY22 Q3	FY22 Q4	FY22 Total	FY22 Target
-	80%	85%	91%	100%	89%	90%



MEASURE DESCRIPTION:
Percent of patients in medical detox services educated on MAT.

DATA SOURCE/METHODOLOGY:
Smartsheets dashboard # 146, data from TLH.

STORY BEHIND THE DATA:
Medication Assisted Treatment (MAT) combines behavioral therapy and medications that treat substance use disorders related to alcohol, heroin, and opioid use. This combination of counseling and behavioral therapies can help some people sustain recovery and involves several drugs shown to demonstrate safe and effective treatment, including buprenorphine, methadone, and naltrexone. MAT programs are clinically driven and tailored to meet each patient's needs. In FY22 Q4 100% of patients were educated on MAT option while receiving alcohol detox services.
We saw a steady increase in the education related to MAT for patients receiving medical detox services. This improvement resulted from a coordinated effort led by the facilities leadership.

IMPROVEMENT ACTION PLAN:

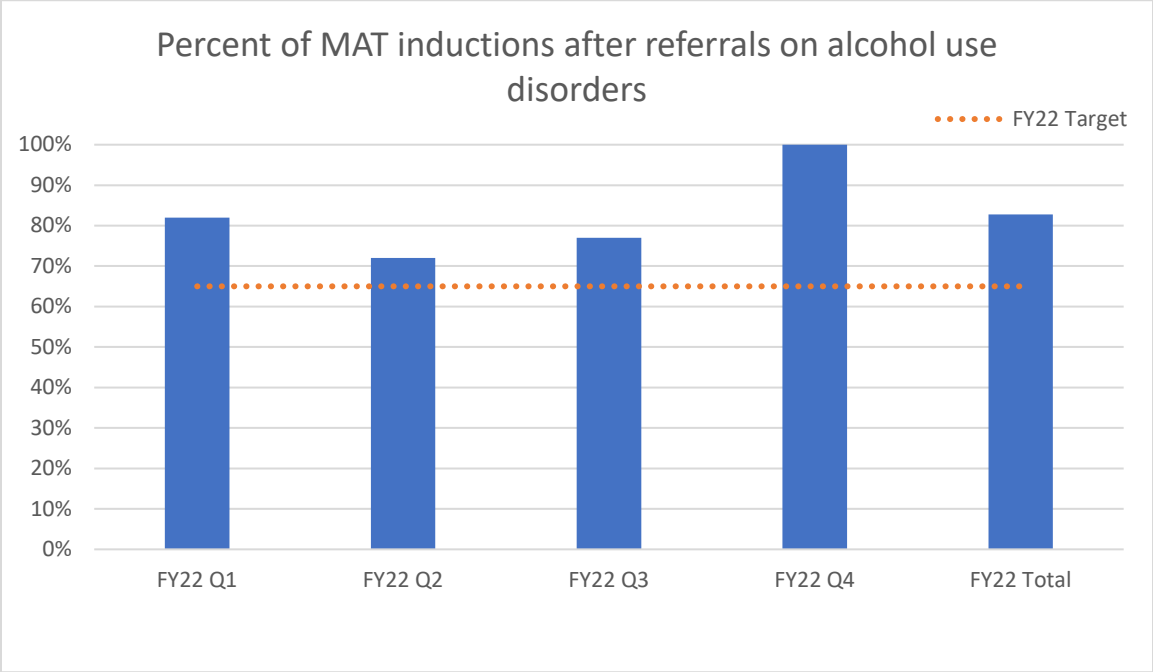
Major Quarterly Action Steps:	Goal Completion Date				
	Q1	Q2	Q3	Q4	Target
Sustain current practice	X	X	X	X	

FMD PERFORMANCE MEASURE #11

Percent of Medication Assisted Treatment (MAT) inductions conducted or conducted after referrals on alcohol use disorders

Results

FY21	FY22 Q1	FY22 Q2	FY22 Q3	FY22 Q4	FY22 Total	FY22 Target
-	82%	72%	77%	100%	82.8%	65%



MEASURE DESCRIPTION:
Percent of patients in which start MAT therapy for alcohol use disorder.

DATA SOURCE/METHODOLOGY:
Smartsheets dashboard # 149, data from TLH.

STORY BEHIND THE DATA:
Medication Assisted Treatment (MAT) combines behavioral therapy and medications that treat substance use disorders related to alcohol, heroin, and opioid use. This combination of counseling and behavioral therapies can help some people sustain recovery and involves several drugs shown to demonstrate safe and effective treatment, including buprenorphine, methadone, and naltrexone. In FY22 Q4 100% of patients were educated on MAT option while receiving medical alcohol detox services.
We saw a steady increase in the education related to MAT for patients receiving medical alcohol detox services. This improvement resulted from a coordinated effort led by the facilities leadership.

IMPROVEMENT ACTION PLAN:

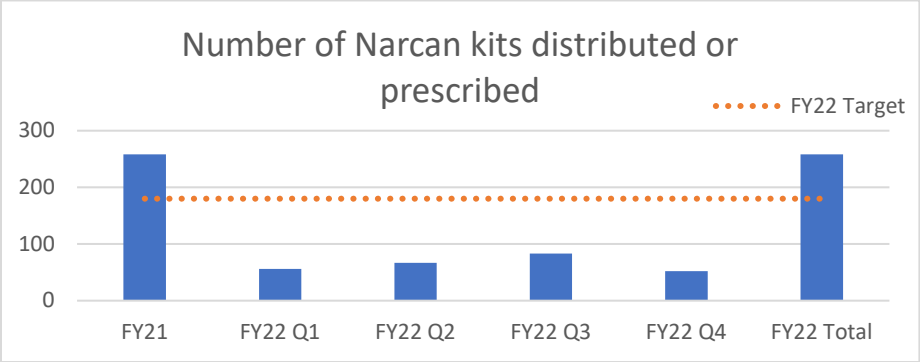
Major Quarterly Action Steps:	Goal Completion Date				
	Q1	Q2	Q3	Q4	Target
Ensure all patients with opiate use disorder are screened for MAT use	X	X	X	X	

FMD PERFORMANCE MEASURE #13

Number of Narcan kits distributed or prescribed

Results

FY21	FY22 Q1	FY22 Q2	FY22 Q3	FY22 Q4	FY22 Total	FY22 Target
258	56	67	83	52	258	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), Naloxone is a medication approved by the Food and Drug Administration (FDA) and designed to rapidly reverse opioid overdose (Narcan is a brand name for Naloxone). The use of Naloxone 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.
Q4 results show in decrease in the number of Narcan kits distributed or prescribed from previous quarters. This is an annual target, so the quarterly results for the for 4 quarters (258) has already surpassed the annual target of 180. Facilities at DOH were proactive in distributing Narcan kits.

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:

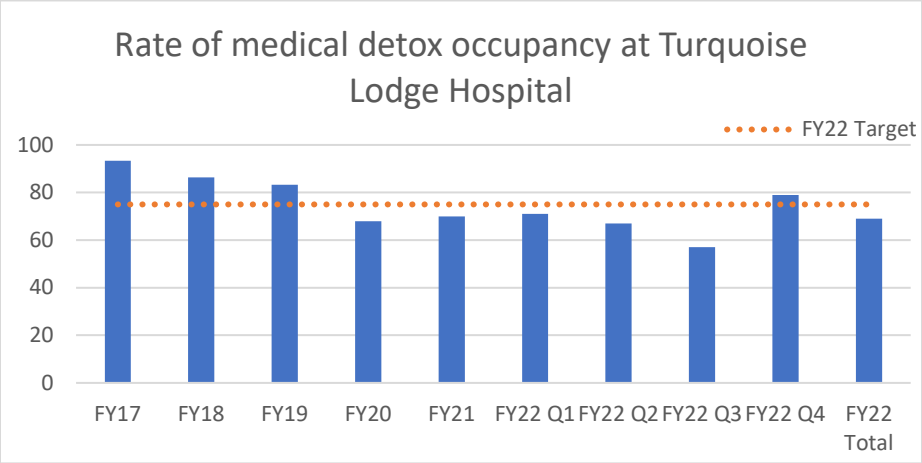
Major Quarterly Action Steps:	Goal Completion Date				
	Q1	Q2	Q3	Q4	Target
1) Identify patients with opioid misuse disorder and/or patients who are surrounded by individuals who are at high risk to overdose; provide weekly Narcan class 100% of the time.	X	X	X	X	
2) Provide weekly Narcan class 100% of 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	

FMD PERFORMANCE MEASURE #14

Rate of medical detox occupancy at Turquoise Lodge Hospital

Results

FY17	FY18	FY19	FY20	FY21	FY22 Q1	FY22 Q2	FY22 Q3	FY22 Q4	FY22 Total	FY22 Target
93.4%	86.3%	83.3%	67.9%	70%	71%	67%	57%	79%	69%	≤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%.

The hospital occupancy rate is a management indicator that provides information on the hospital's service capacity, helping assess whether there are missing or empty beds and to know about the usability of the spaces. In March of FY20, Turquoise Lodge Hospital began operating at half capacity due to pandemic circumstances and a need to ensure each customer in our facility had adequate social distancing opportunities to safeguard health and safety guidelines. The pandemic posed other obstacles to admitting patients into our medical detox facility which included, potential patients expressed hesitant feelings about entering an inpatient facility due to fears of COVID transmission. This data trend was confirmed by the CDC as of June 30, 2020, an estimated 41% of US adults either delayed or avoided medical care because of fears related to COVID-19. In FY21, Turquoise Lodge Hospital maintained a 70% occupancy rate and in FY 22, sustained a 69% occupancy rate, which we did not meet our target goal for FY 22 of 75% or above. There was no significant change in data when comparing these fiscal years and the lack of goal attainment can be attributed to operating a facility under these circumstances.

IMPROVEMENT ACTION PLAN:

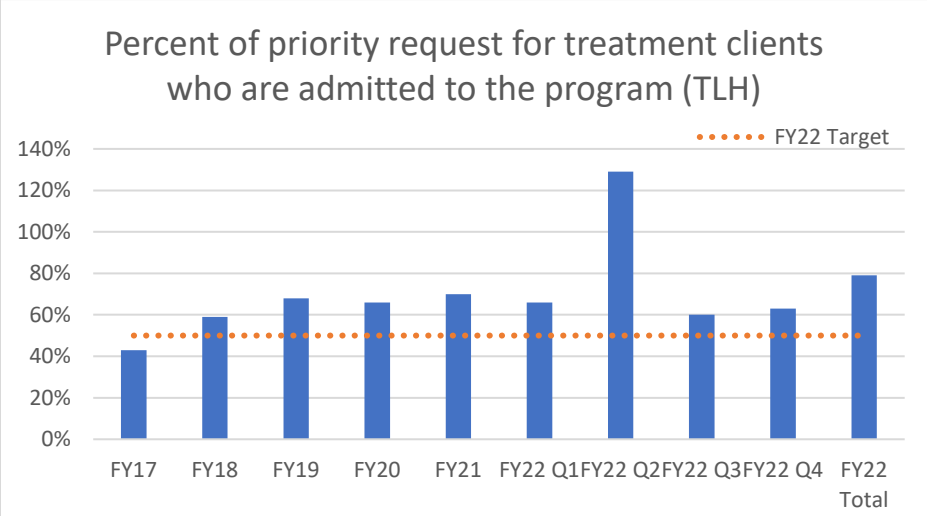
Major Quarterly Action Steps:	Goal Completion Date				
	Q1	Q2	Q3	Q4	Target
1) Schedule three to five admissions per day, five days per week.	50%	50%	50%	50%	
2) Monitor processes, occupancy rate, and implement changes, as necessary.	X	X	X	X	
3) Increase nursing resources to complete pre-admission assessments.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

FMD PERFORMANCE MEASURE #15

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	FY22 Q1	FY22 Q2	FY22 Q3	FY22 Q4	FY22 Total	FY22 Target
43%	59%	68%	66%	70%	66%	129%	60%	63%	79%	≥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 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 decrease New Mexico's drug overdose and alcohol death rate through active engagement of priority populations. Studies show that addiction affects the family in many ways including emotionally, financially, legally, and medically. Turquoise Lodge Hospital has consistently met their goal in FY 21 and FY 22, of providing admission appointments within 2 days for this challenging population. Our success is contributed to close monitoring of access data and weekly access meetings with all disciplines involved in identifying appointment times.

IMPROVEMENT ACTION PLAN:

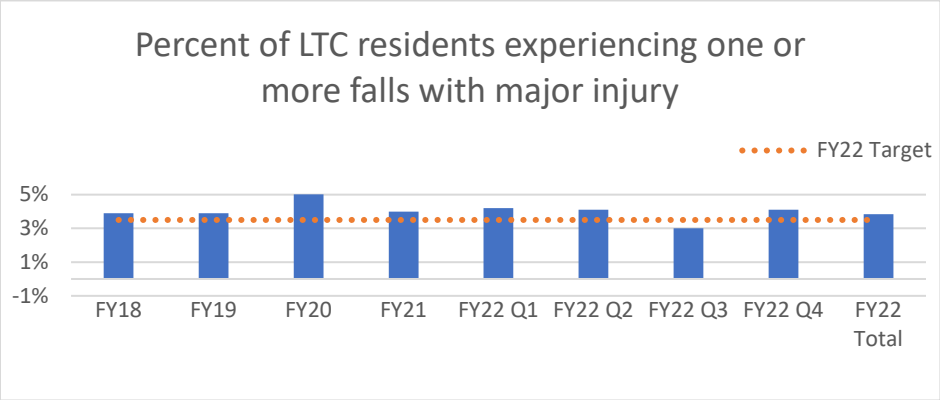
Major Quarterly Action Steps:	Goal Completion Date				
	Q1	Q2	Q3	Q4	Target
1) Utilize the Crystal Report to more quickly see intervention outcomes.	X	X	X	X	

FMD PERFORMANCE MEASURE #16

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

Results

FY18	FY19	FY20	FY21	FY22 Q1	FY22 Q2	FY22 Q3	FY22 Q4	FY22 Total	FY22 Target
3.9%	3.9%	5.3%	4.0%	4.2%	4.1%	3.0%	4.1%	3.85%	≤3.5%



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. We did not achieve our goal for this important metric. We have expanded our quality council to include all facilities. Falls will be an area of emphasis in the new fiscal year.

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	

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	$7,988.3	$6,427.7	$0.0	$0.0	$14,416.0	182
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	
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	

* 500s are waiver payments

FY21	General Fund	Other State Funds	Federal Funds	Other Transfers	TOTAL	FTE
200	$7,670.61	$0.00	$0.00	$5,680.04	$13,350.65	204
300	$6,780.14	$0.34	$0.00	$1,018.56	$7,799.04	
400	$3,499.37	$47.86	$0.00	$804.41	$4,351.65	
500*	$35,493.56	$0.00	$0.00	$0.00	$35,493.56	
TOTAL	$53,443.68	$48.20	$0.00	$7,503.02	$60,994.89	

Program Performance Measures:

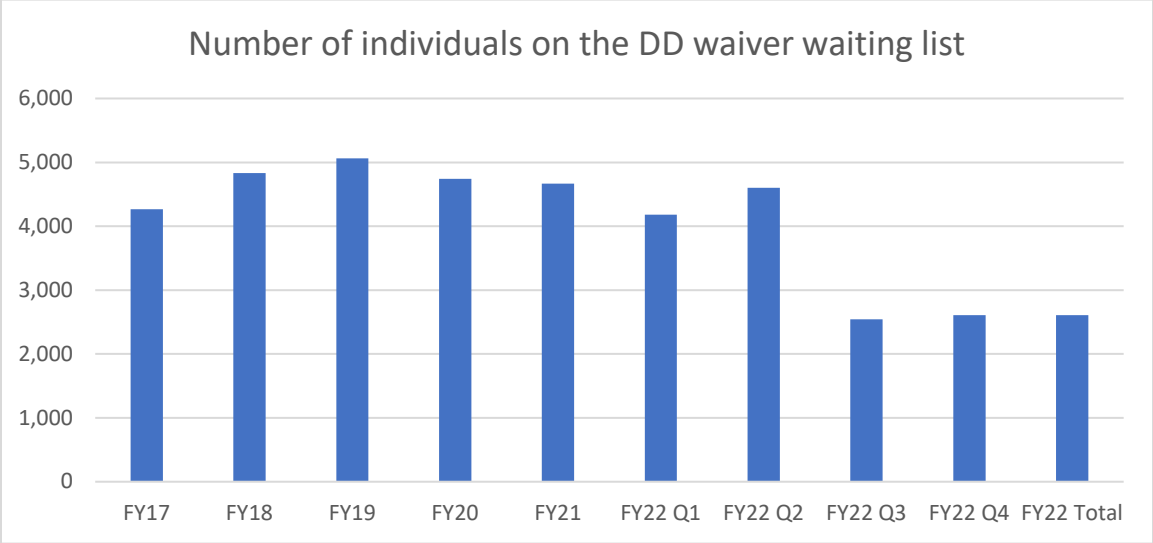
1. Number of individuals on the developmental disabilities' waiver waiting list (FY22 HB2 Measure)
2. Number of individuals receiving developmental disability waiver services (FY22 HB2 Measure)
3. Number of individuals receiving developmental disability supports waiver services
4. Percent of developmental disabilities waiver applicants who have a service and budget in place within 90-days of income and clinical eligibility (FY22 Key Measure)
5. Percent of adults of working age (22 to 64 years), served on the DD Waiver (traditional or Mi Via) who receive employment supports (FY22 Key Measure)
6. Number of people on the waiting list that are formally assessed once allocated to the DD Waivers
7. Percent of DD Waiver providers in compliance with General Events timely reporting requirements (2-day rule) (FY22 Key Measure)

DDSD PERFORMANCE MEASURE #1

Number of individuals on the DD Waiver waiting list

Results

FY17	FY18	FY19	FY20	FY21	FY22 Q1	FY22 Q2	FY22 Q3	FY22 Q4	FY22 Total	FY22 Target
4,266	4,834	5,064	4,743	4,669	4,179	4,604	2,543	2,610	2,610	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, 2022, there were 2,610 individuals on the wait list for HCBS Waivers. These individuals have been determined to meet the definition of developmental disability. Of those individuals, 735 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 has decreased significantly during FY22 as the division implementation the Super Allocation Plan with the goal of eliminating the Wait List. The Wait List will continue to decrease as long as the number of individuals removed from the wait list through allocations or attrition exceeds the number of individuals who apply for waiver services and were determined to match the criteria.

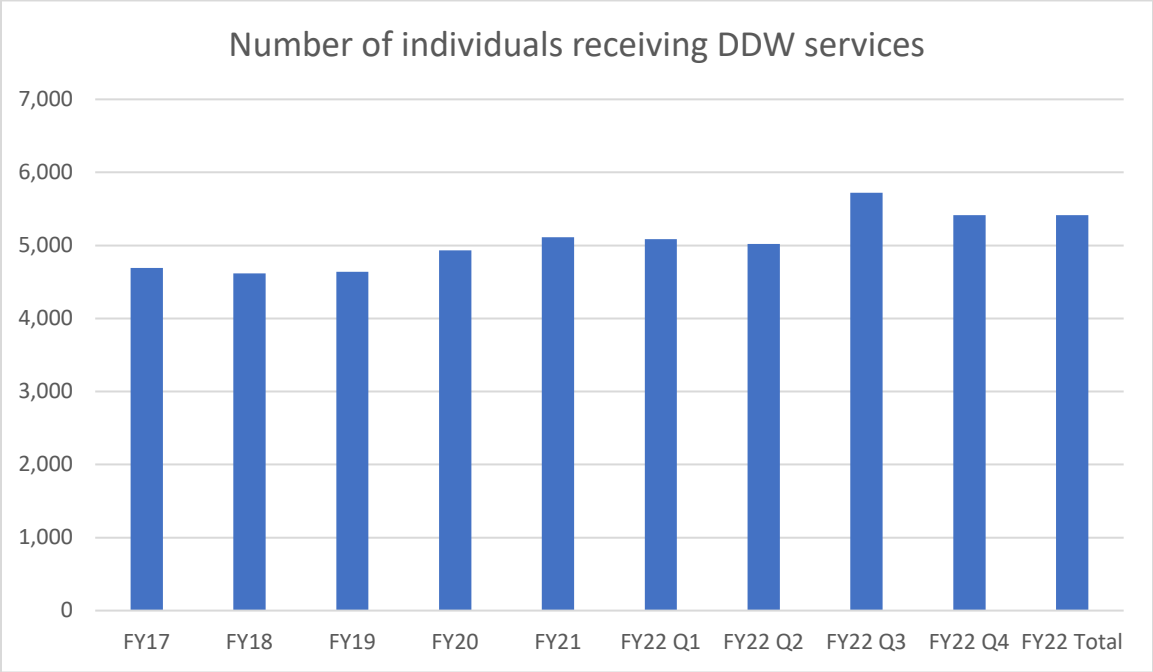
IMPROVEMENT ACTION PLAN:
While this is an annual explanatory measure and no quarterly actions are required, of course DDSD will continue to increase applicant awareness of services that are available to them while they are on the wait list such as Medicaid, State General Fund, and community-based service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

DDSD PERFORMANCE MEASURE #2

Number of individuals receiving developmental disability waiver services

Results

FY17	FY18	FY19	FY20	FY21	FY22 Q1	FY22 Q2	FY22 Q3	FY22 Q4	FY22 Total	FY22 Target
4,692	4,616	4,641	4,934	5,111	5,088	5,022	5,722	5,416	5,416	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 Courts and Expense Report 6-17-22.

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 traditional 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 FY22 Q4 the Developmental Disabilities Supports Division (DDSD) had 5,416 persons receiving Developmental Disability Waiver services (NM Human Services Department Client Counts and Expense Report 6-17-22.). The number of individuals receiving DD Waiver services is rising due to application of ARPA funding to decrease waitlist and allocate more individuals.

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

FY21	FY22	FY21 Target
70	220	Explanatory

Graph will be added once more data is received

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 6.17.22

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 FY22 Q4, the continued low level of participation in the Supports Waiver appears to be the result of suspension of SW offers due to the allocation plan for all on waitlist. Current Supports Waiver participants are being allocated to the DD and MIVia Waiver and transitioning out of Supports Waiver each quarter.

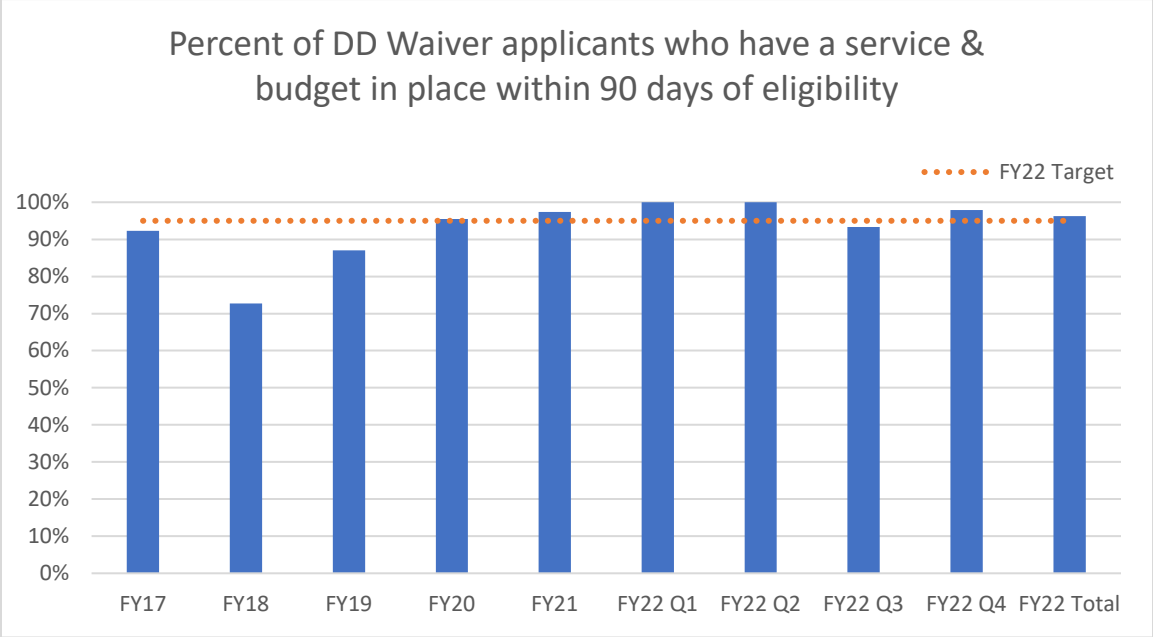
IMPROVEMENT ACTION PLAN:
While this is an annual explanatory measure and no quarterly actions are required, DDSD will continue to monitor allocation process for the Supports Waiver to ensure people receive timely Supports Waiver Services when offers are accepted. While the stated measurement is the number 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

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	FY22 Q1	FY22 Q2	FY22 Q3	FY22 Q4	FY22 Total	FY22 Target
92.3%	72.7%	87.0%	95.5%	97.4%	100%	100%	93.3%	97.9%	96.3%	≥95%



MEASURE DESCRIPTION:

Numerator: Number of individuals who initiated DD Waiver services with a post-allocation assessment.
Denominator: Number of individuals who initiated DD and MiVia 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 FY22 Q4, 139 out of 142 individuals who initiated DD and MiVia 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) 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%**

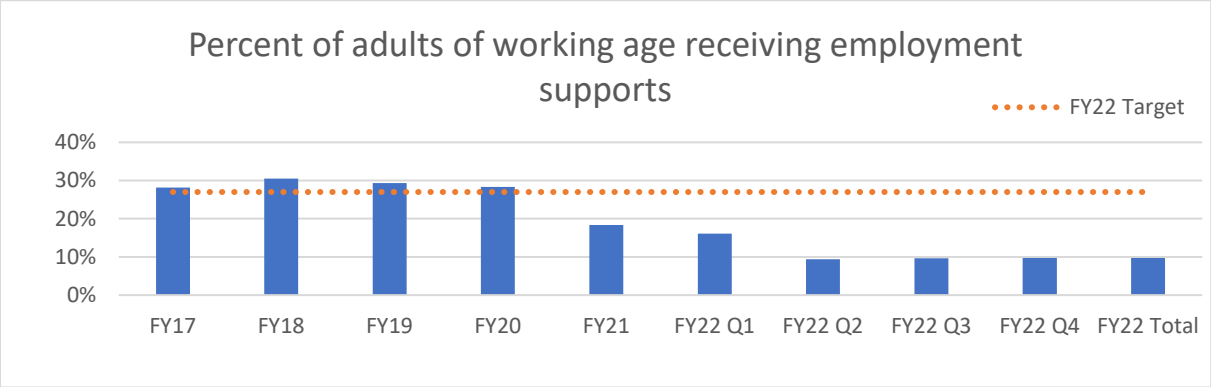
DDSD PERFORMANCE MEASURE #5

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	FY22 Q1	FY22 Q2	FY22 Q3	FY22 Q4	FY22 Total	FY22 Target
28.2%	30.5%	29.3%	28.3%*	18.4%	16.1%	9.4%	9.65%	9.75%	9.75%	≥27%

* 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, Omnicad Database. All figures are derived from claims paid during the period July 1, 2021, through June 30, 2022. The one-year period (ending with FY22 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. 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 FY22 Q4, 9.75% of eligible adults received employment services. Recent COVID related impacts are reflected in the Medicaid/Omnicad billing data as there is a significant decline in individuals accessing employment supports. However, people are returning to the workforce, slowly. As indicated, FY22 continued to reflect the impact of COVID for those employed and those seeking employment. After a decline mid FY22, we did see a slight overall increase to 9.75% to close out FY 22.

IMPROVEMENT ACTION PLAN:

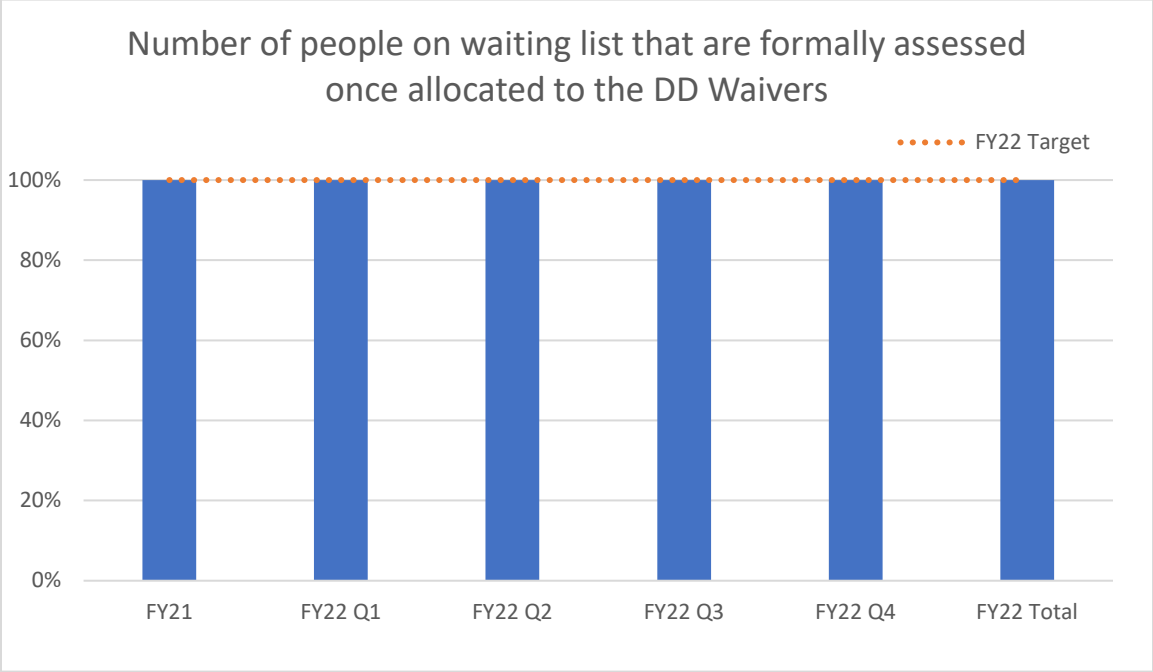
Major Quarterly Action Steps:	Goal Completion Date				
	Q1	Q2	Q3	Q4	Target
1) Release online/on demand training focused on education related to employment.	X	X	X	X	≥34%
2) Host Day & Employment Community of Practice.	X	X	X	X	≥34%

DDSD PERFORMANCE MEASURE #6

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

Results

FY21	FY22 Q1	FY22 Q2	FY22 Q3	FY22 Q4	FY22 Total	FY22 Target
100%	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 FY22 Q4, 142 out of 142 individuals who initiated DD Waiver services had a post-allocation assessment in place prior to receiving waiver services.

IMPROVEMENT ACTION PLAN:

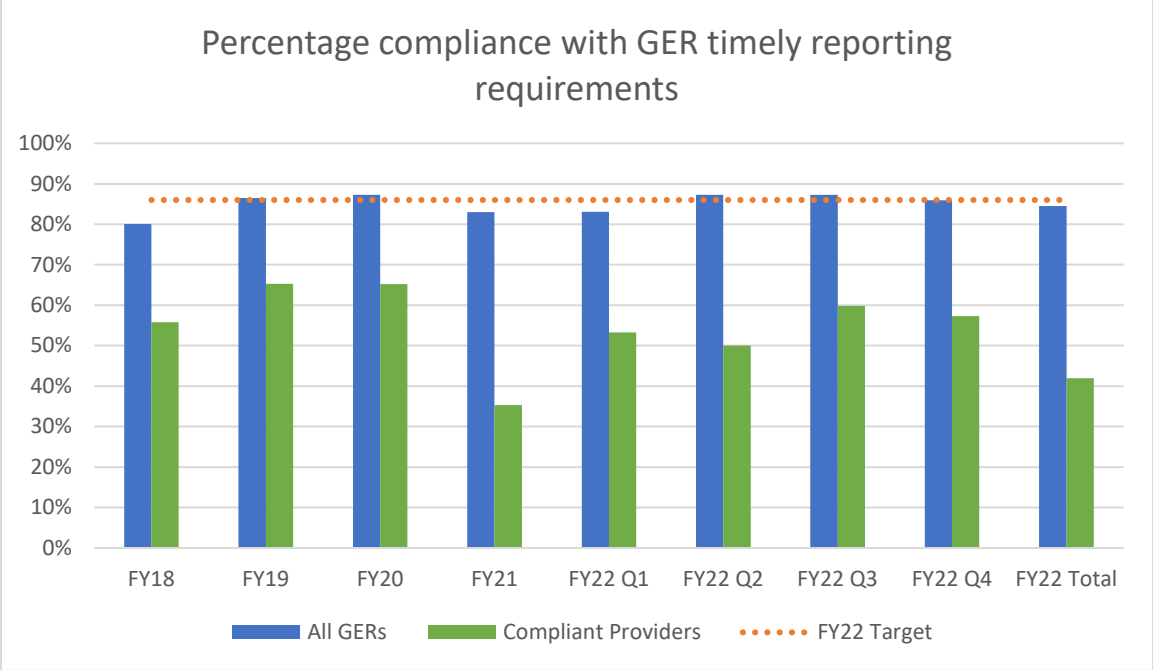
Major Quarterly Action Steps:	Goal Completion Date				
	Q1	Q2	Q3	Q4	Target
1) Address and ensure post-allocation assessments during the pandemic are addressed on a case-by-case basis, as new challenges are presented.	X	X	X	X	100%

DDSD PERFORMANCE MEASURE #7

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

Results

	FY18	FY19	FY20	FY21	FY22 Q1	FY22 Q2	FY22 Q3	FY22 Q4	FY22 Total	FY22 Target
All GERs	80.1%	86.5%	87.3%	83.0%	83.1%	87.3%	87.3%	85.9%	84.5	86%
Compliant Providers	55.8%	65.3%	65.2%	35.3%	53.3%	50%	59.8%	57.3%	42%	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, June 2022.

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) full 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 FY22 Q1 53.3% of 40 of 75 providers met GER requirements for timely reporting and 83.1% of the 5,787 GERs submitted were submitted and approved in a timely manner. In FY22 Q2, 50% of the 84 providers submitting GERs complied with GER reporting requirements for timely reporting. Overall, GER compliance was 87.3% (5601/6413).
In FY22 Q3 59.8% of 82 providers were compliant with GER requirements for timely reporting. Overall, GER timely reporting compliance was 87.3% (5539/6346). In FY22 Q4 57.3% of 75 providers with GER requirements for timely reporting. Overall, GER timely reporting compliance was (5241/6099) 85.9%. In FY22 Annual 42.0% of 88 providers were compliant with GER requirements for timely reporting. Overall GER timely reporting compliance was (21015/24867) 84.5%. In FY22 Q1, 83.1% of the 5,787 GERs submitted were submitted and approved in a timely manner. In FY22 Q2, 50% of the 84 providers submitting GERs complied with GER reporting requirements for timely reporting. Overall GER compliance was 87.3% (5601/6413). In FY22 Q3 59.8% of 82 providers were compliant with GER requirements for timely reporting. Overall GER timely reporting compliance was 87.3% (5539/6346).

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.
- Processing over 44,000 caregiver criminal history screenings annually.

Program Budget (in thousands):

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	

FY22	General Fund	Other State Funds	Federal Funds	Other Transfers	TOTAL	FTE
200	$5,245.92	$1,132.78	$2,308.63	$3,792.36	$12,479.69	174
300	$545.78	$33.28	$26.69	$48.91	$654.67	
400	$377.49	$79.89	$461.80	$521.99	$1,441.16	
TOTAL	$6,169.19	$1,245.95	$2,797.12	$4,363.26	$14,575.52	

Program Performance Measures:

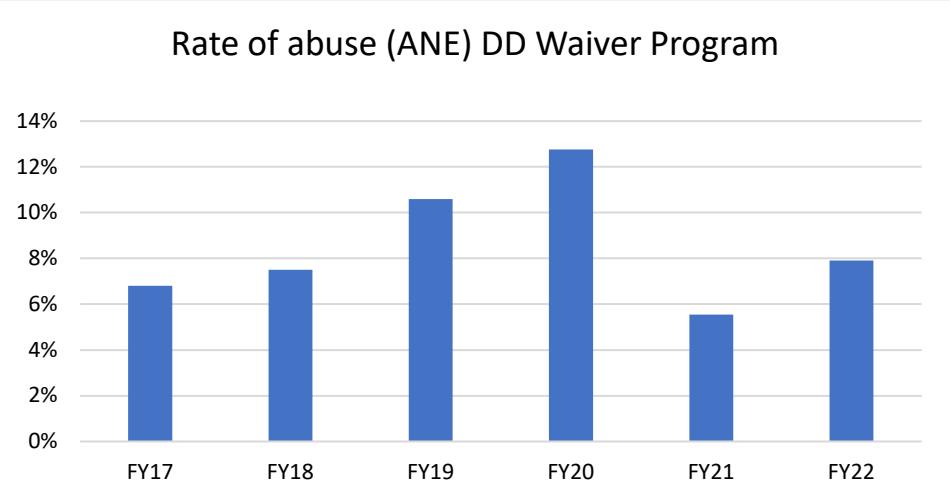
1. Rate of abuse for developmental disability waiver and mi via waiver clients (FY22 HB2 Measure)
2. Rate of re-abuse for developmental disability waiver and mi via waiver clients (FY22 HB2 Measure)
3. Percent of abuse, neglect and exploitation investigations completed within required timeframes (FY22 Key & HB2 Measure)
4. Percent of Long-Term Care (LTC) health facility survey of statement of deficiencies (CMS form 2567/state form) distributed to the facility within 10-days of survey exit (FY22 Key Measure)
5. 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) (FY22 Key Measure)
6. Percent of improved accuracy in nursing home Incident Reports (IRs) submitted following participation in a DHI quality training on reporting requirements
7. Percent of (IMB) assigned investigations initiated within required timelines
8. Percent of Assisted Living health facility (ALF) survey statement of deficiencies (CMS form 2567/state form) distributed to the facility within 10 days of survey exit
9. The number of Caregiver Criminal History Screening (CCHS) Appeal Clearance recidivism/re-offense (conviction) after a successful appeal
10. 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
11. Percent of Acute and Continuing Care (ACC) health facility survey of statement of deficiencies (CMS form 2567/state form) distributed to the facility within 10-days of survey exit (FY22 Key Measure)

DHI PERFORMANCE MEASURE #1

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

Results

FY17	FY18	FY19	FY20	FY21	FY22	FY22 Target
6.8%	7.5%	10.6%	12.76%	5.55%	7.91%	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.

DATA SOURCE/METHODOLOGY:
This data comes from the IMB computer database. Eligibility: Individuals eligible for the DDW, MFW (adult only) and Mi Via waivers, calculated from quarterly reports of populations from DDSD, as tracked by the UNM Continuum of Care 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. 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.

This explanatory measure has been trending in FY21 and FY22 between 5.5% and 8%. With the expansion of waiver services and the allocations to eliminate the waiting list, this performance measure is at risk of increasing. In order to protect individuals, it is important to have a robust incident management system that can respond to the expansion of waiver services.

In order to sustain a responsive incident management system DHI-IMB is requesting a base budget increase and the additional 34 FTEs for Investigators and Surveyors to meet the increase in investigations and oversite of the waiver program.

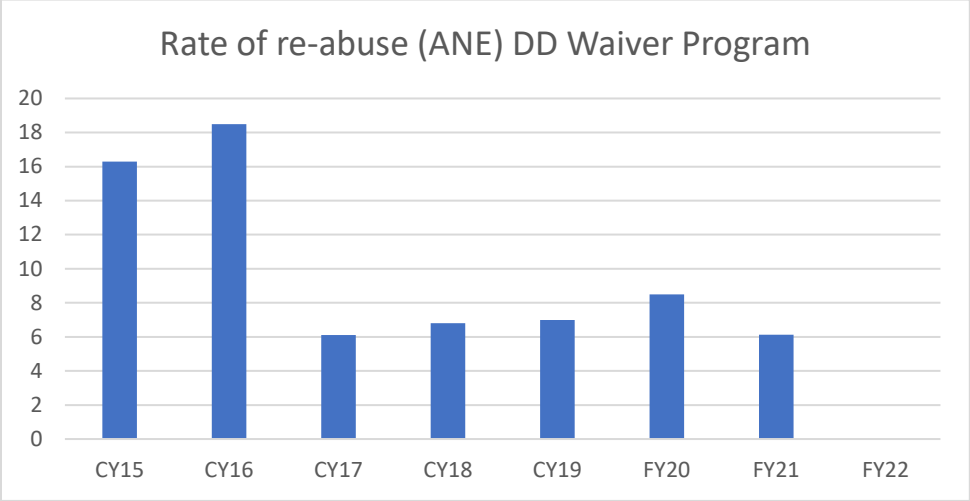
IMPROVEMENT ACTION PLAN:
This is an annual fiscal year explanatory measure, so no quarterly action is required.

DHI PERFORMANCE MEASURE #2

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

Results

CY15	CY16	CY17	CY18	CY19	CY20	CY21	CY22	FY22 Target
16.3%	18.5%	6.1%	6.8%	7.0%	8.5%	6.12%	Fall 2022	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.

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.
*Re-abuse data is reported on the calendar year cycle.

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.
This explanatory measure has been trending in CY20 and CY21 between 8.5% and 6%. With the expansion of waiver services and the allocations to eliminate the waiting list, this performance measure is at risk of increasing. In order to protect individuals, it is important to have a robust incident management system that can respond to the expansion of waiver services.

In order to sustain a responsive incident management system DHI-IMB is requesting a base budget increase and the additional 34 FTEs for Investigators and Surveyors to meet the increase in investigations and oversite of the waiver program.

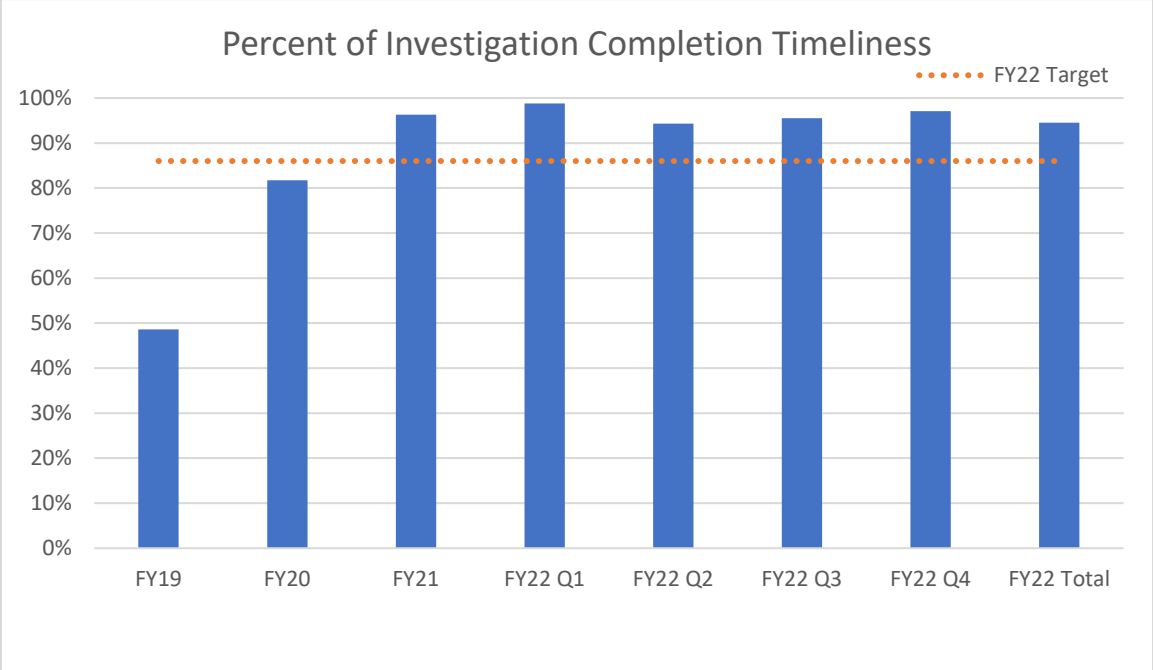
IMPROVEMENT ACTION PLAN:
This is an annual fiscal year explanatory measure, so no quarterly action is required.

DHI PERFORMANCE MEASURE #3

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

Results

FY19	FY20	FY21	FY22 Q1	FY22 Q2	FY22 Q3	FY22 Q4	FY22 Total	FY22 Target
48.6%	81.7%	96.3%	98.8%	94.3%	95.5%	97.1%	94.51%	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.

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.

DHI-IMB has worked diligently to maintain a high level of performance in the face of many challenges including the expansion of the new supports and services waiver and the steady allocation of new individual to the other home and community-based waiver programs as we see the elimination of the waiting list. With the addition of the new waiver and thousands of new people being added to services, IMB investigators are stretched to the limit. To relieve some of the workload IMB has been able to utilize contract

investigators. By utilizing contractors to supplement the increase in workload IMB was able to achieve a 94.5% compliance with investigation time frames.

In order to sustain compliance and meet the incredible increase in wavier participants DHI-IMB is requesting a base budget increase and the additional 34 FTEs for Investigators and Surveyors to meet the increase in investigations and oversite of the waiver program.

IMPROVEMENT ACTION PLAN:

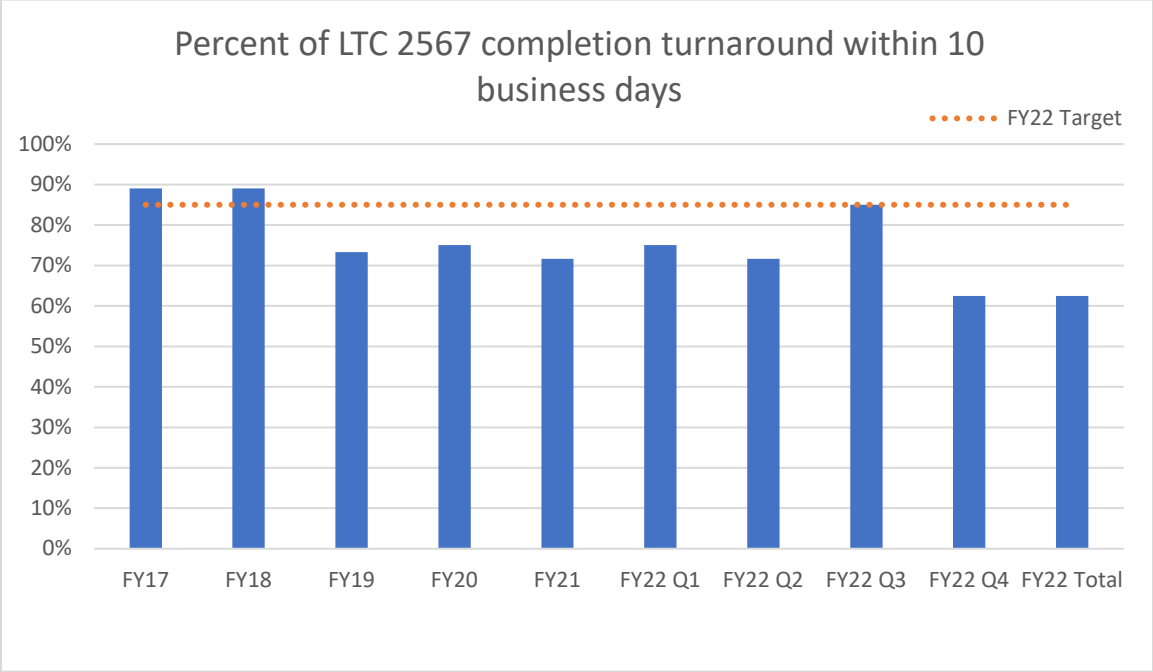
Major Quarterly Action Steps:	**Goal Completion Date**				
	Q1	Q2	Q3	Q4	**Target**
1) Complete all investigations within timelines with no backlog of cases	X	X	X	X	86%

DHI PERFORMANCE MEASURE #4

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

Results

FY17	FY18	FY19	FY20	FY21	FY22 Q1	FY22 Q2	FY22 Q3	FY22 Q4	FY22 Total	FY22 Target
89%	89%	73.3%	75%	71.6%	75%	71.6%	85%	62.5%	62.5%	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.

During FY 22, DHI has experienced a significant increase in survey workload and complaint surveys requiring additional time to complete survey investigations and write and review citations, many times having to investigate onsite at one facility to meet complaint deadline prior to previous survey report being completed. In addition, more citations and higher scope and severity deficiencies require additional time for review and corrections to ensure each deficiency is defensible. In Q4 three SMQT (CMS certified) Nursing Home surveyors resigned from their positions, leaving vacancies and increased workload and assignments for remaining staff.

To continue to improve performance and meet the target, DHI has provided multiple training sessions for surveyors throughout the year targeting investigation skills, gathering supportive evidence, and writing the survey reports. With improved competency, surveyors will need less time to complete their survey reports which in turn results in less time needed for review allowing us to meet the 10-working day target. In addition, DHI is continuously working to fill those three nurse positions left vacant which will ease workload assignment and allow more time to complete one survey before another survey is scheduled.

IMPROVEMENT ACTION PLAN:

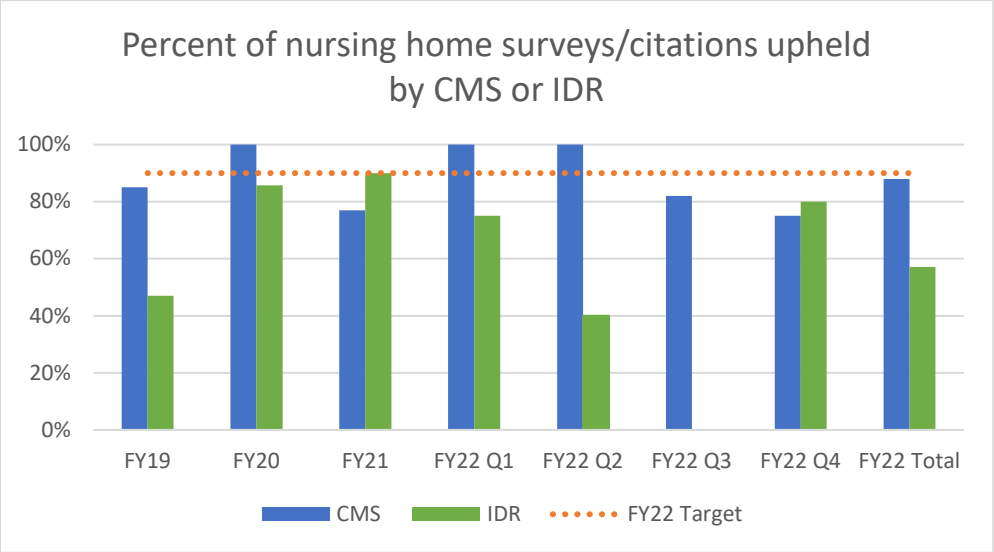
Major Quarterly Action Steps:	Goal Completion Date				
	Q1	Q2	Q3	Q4	Target
1) Conduct off-site monitoring video call checks, a COVID-19 procedural change.	X	X	X	X	

DHI PERFORMANCE MEASURE #5

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

Results

FY19	FY20	FY21	FY22 Q1	FY22 Q2	FY22 Q3	FY22 Q4	FY22 Total	FY22 Target
85% CMS	100% CMS	77% CMS	100% CMS	100% CMR	82% CMS	75% CMS	88% CMS	90% CMS
47% IDR	85.71% IDR	90% IDR	75% IDR	40% IDR	0% IDR	80% IDR	57.1% IDR	90% IDR



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.

Note: Fluctuation with percentages are significantly affected by small number of citations reviewed during the quarter. The lower the "n" the greater the variance. This variable has contributed to decrease in percentage from quarter to quarter and from totals for FY21 to FY22.

In addition, independent reviews of IDR requests by the Bureau Chief resulted in removal of the deficiency from the survey report without ever being reviewed by the IDR committee, which accounted for 80% of the “not supported” deficiencies for FY22.

In FY22, the IDR committee has incorporated providing feedback regarding the IDR request for both the surveyors that wrote the report and for the facility that made the IDR request. DHI takes this feedback and has provided target surveyor training to improve defensibility of the citations. In addition, DHI also reviews CMS feedback when a CMP is not imposed by CMS and has sought additional feedback from CMS and has incorporated “lessons learned” training to surveyors and the Quality Assurance Reviewers to ensure that the next deficiency is more defensible.

IMPROVEMENT ACTION PLAN:

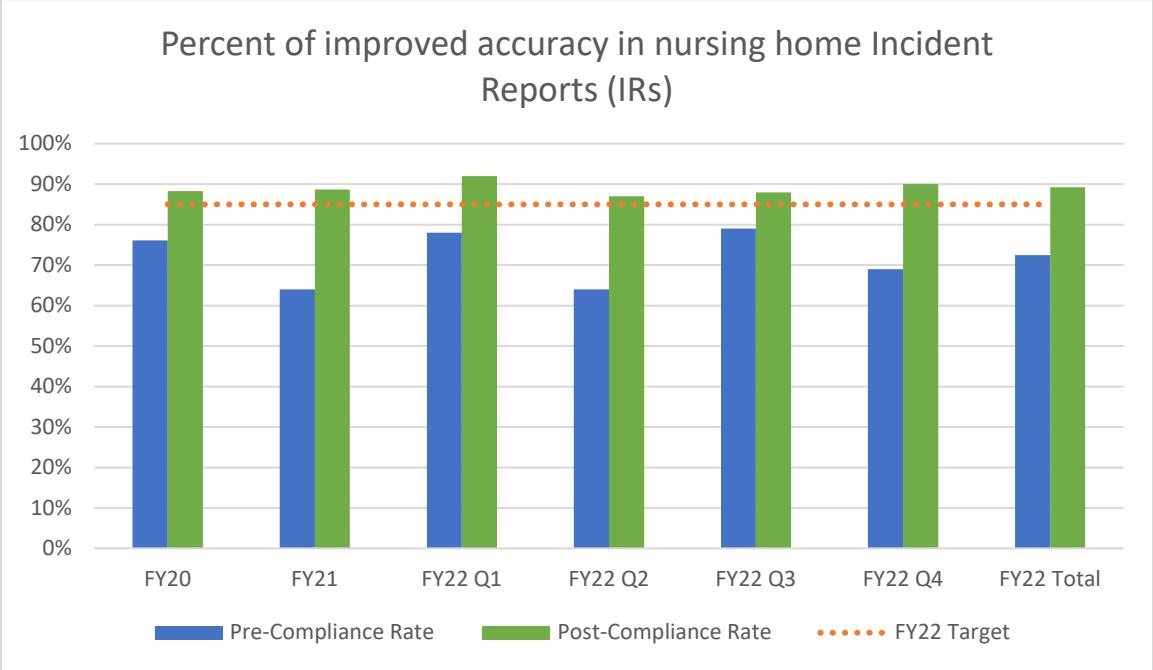
Major Quarterly Action Steps:	**Goal Completion Date**				
	Q1	**Q2**	**Q3**	**Q4**	**Target**
1) Monitor for Improvement.	X	X	X	X	

DHI PERFORMANCE MEASURE #6

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

Results

FY20	FY21	FY22 Q1	FY22 Q2	FY22 Q3	FY22 Q4	FY22 Total	FY22 Target
Pre 76.1%	Pre 64%	Pre 78%	Pre 64%	Pre 79%	Pre 69%	Pre 72.5%	≥85%
Post 88.3%	Post 88.7%	Post 92%	Post 87%	Post 88%	Post 90%	Post 89.2%	



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.
DHI Complaints program has provided 57 facilities trainings on Facility Reporting in FY22.

Understanding reporting requirements is vital for healthcare facilities to be in compliance with federal and state regulations. DHI implemented a reporting training for all healthcare facility types. Before the training healthcare facilities had a score of 64% accuracy. After receiving the reporting training facilities improved to 88.7 accuracy. This demonstrated the training was impactful. FY22 is where we see the improvement in healthcare facilities retaining & understanding the reporting requirements. Before the reporting training healthcare facilities had a score of 72.5% much higher than the score of 64% in FY21. After receiving the reporting training healthcare facilities has a score of 89.2%. An improvement from 88.7% to 89.2%. With the fluctuation of staff in our healthcare facilities the reporting training is a key and necessary component to achieve compliance with state and federal regulations.

It is important to recognize that in FY22 DHI has added over 20 new health facilities in New Mexico including 3 boarding homes, while the volume of complaints continues to increase from an average of 1200 per month in FY21 to over 1500 per month in FY22. In order to meet the increasing demand DHI is requesting additional personnel and resources to sustain the increase in workload, as we are able to obtain additional staff we will be able to maintain and achieve a higher performance ensuring safe healthcare services for all New Mexicans.

IMPROVEMENT ACTION PLAN:

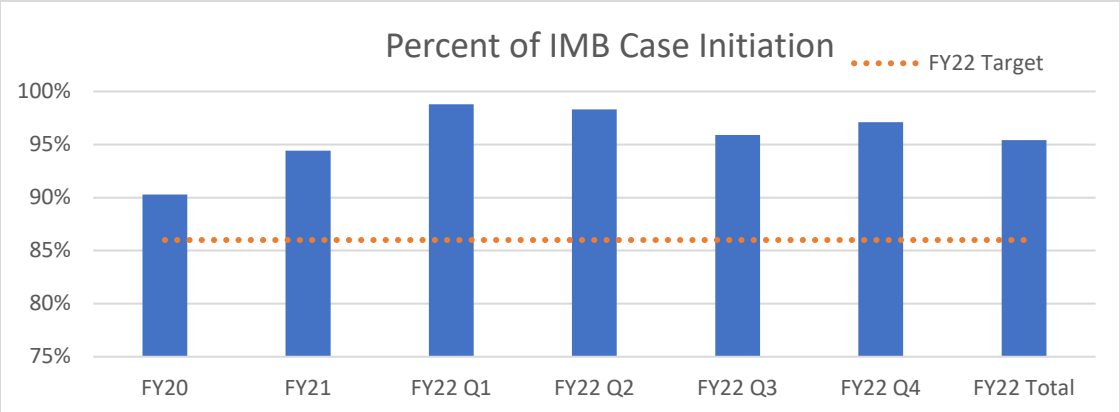
Major Quarterly Action Steps:	**Goal Completion Date**				
	Q1	**Q2**	**Q3**	**Q4**	**Target**
1) Identify nursing facilities targeted for IR training.	X	X	X	X	≥85%
2) Conduct IR training and monitor for improvement.	X	X	X	X	

DHI PERFORMANCE MEASURE #7

Percent of (IMB) assigned investigations initiated within required timelines

Results

FY20	FY21	FY22 Q1	FY22 Q2	FY22 Q3	FY22 Q4	FY22 Total	FY22 Target
90.3%	94.41%	98.8%	98.3%	95.9%	97.1%	95.4%	86%



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

DATA SOURCE/METHODOLOGY:
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 1790 investigations for SFY 22.

DHI-IMB has worked diligently to maintain a high level of performance in the face of many challenges including the expansion of the new supports and services waiver and the steady allocation of new individual to the other home and community-based waiver programs as we see the elimination of the waiting list. With the addition of the new waiver and thousands of new people being added to services, IMB investigators are stretched to the limit. To relieve some of the workload IMB has been able to utilize contract investigators. By utilizing contractors to supplement the increase in workload IMB was able to achieve a 94.4% compliance in FY21 and a 95.4% compliance with initiating investigations within required timeframes.

In order to sustain compliance and meet the incredible increase in wavier participants DHI-IMB is requesting a base budget increase and the additional 34 FTEs for Investigators and Surveyors to meet the increase in investigations and oversite of the waiver program.

IMPROVEMENT ACTION PLAN:

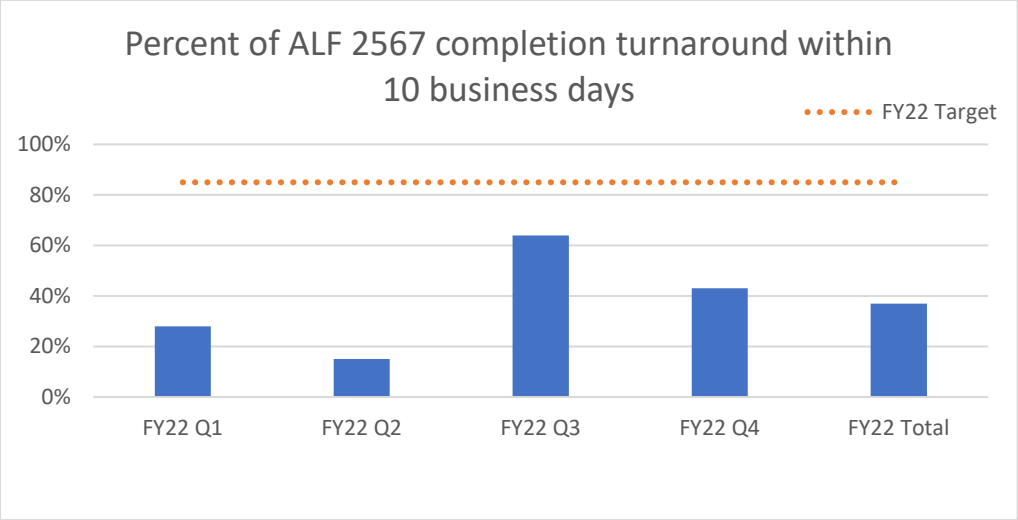
Major Quarterly Action Steps:	Goal Completion Date				
	Q1	Q2	Q3	Q4	Target
1) Initiate all ANE Investigations within time frames	X	X	X	X	86%

DHI PERFORMANCE MEASURE #8

Percent of Assisted Living facility (ALF) survey statement of deficiencies (CMS form 2567/state form) distributed to the facility within 10 days of survey exit

Results

FY20	FY21	FY22 Q1	FY22 Q2	FY22 Q3	FY22 Q4	FY22 Total	FY22 Target
-	-	28%	15%	64%	43%	37%	85%



MEASURE DESCRIPTION:

This Output measures captures the timeliness of Assisted Living Facilities (ALFs) health facility survey work to complete the survey statement of deficiencies (state form) within 10 days of exiting the facility post survey

DATA SOURCE/METHODOLOGY:

DHI management manually tracks this data using a spreadsheet. The formula for the measure is:
Numerator: The number of ALF health facilities surveyed in a quarter who receive the State Form (statement of deficiencies) within 10 business days of survey exit.
Denominator: The number of ALF health facilities surveyed in a quarter who receive the State Form (statement of deficiencies).

STORY BEHIND THE DATA:

This is a new performance measure started in FY22.

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 policy to issue state forms within 10 business days.

In FY 22, DHI had hired and trained (6) new surveyor positions and the learning curve and limited experience contributed to longer report writing and review times.

In addition, DHI experienced a significant increase in survey workload and complaint surveys requiring additional time to complete survey investigations and write and review citations, many times having to investigate onsite at one facility to meet complaint deadline prior to previous survey report being completed. In addition, higher severity deficiencies require additional time for quality

assurance review (internal and from General Counsel to ensure a civil monetary penalty/fine can be supported) and for corrections to ensure each deficiency is defensible.

During the 4th Quarter two (2) lead investigators/surveyors were assigned to the Boarding Home project which delayed completion of survey reports and correction of the survey report after review.

To continue to improve performance and meet the target, DHI has provided multiple training sessions for surveyors throughout the year targeting investigation skills, gathering supportive evidence and writing the survey reports. In addition, DHI has imposed more stringent timelines for surveyors to complete their survey reports and submit for quality assurance review within 10 working days of survey completion. In addition, DHI is preparing to hire (3) new surveyor positions which will ease workload assignment and allow more time to complete one survey before another survey is scheduled. With more experience and competency, surveyors will need less time to write their survey reports allowing DHI to submit the survey reports to providers within 10 working days following the completion of the investigation.

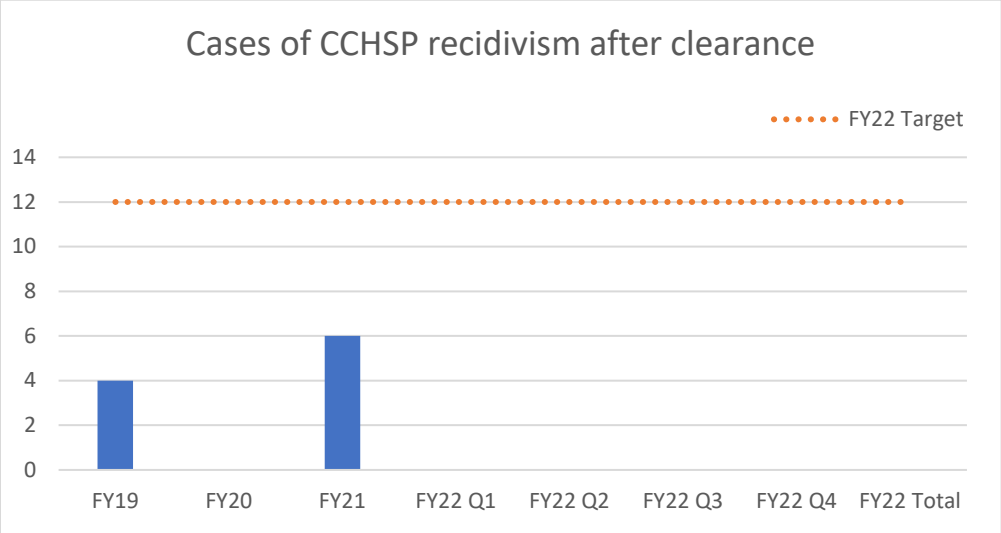
IMPROVEMENT ACTION PLAN:
To continue to improve performance and meet the target, DHI has provided multiple training sessions for surveyors throughout the year targeting investigation skills, gathering supportive evidence, and writing the survey reports. In addition, DHI has imposed more stringent timelines for surveyors to complete their survey reports and submit for quality assurance review within 10 working days of survey completion. In addition, DHI is requesting to hire (3) new surveyor positions which will ease workload assignment and allow more time to complete one survey before another survey is scheduled. With more experience and competency, surveyors will need less time to write their survey reports allowing DHI to submit the survey reports to providers within 10 working days following the completion of the investigation.

DHI PERFORMANCE MEASURE #9

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

Results

FY19	FY20	FY21	FY22 Q1	FY22 Q2	FY22 Q3	FY22 Q4	FY22 Total	FY22 Target
4	0	6	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 FY22.

It is important to observe that the volume of background checks has increased significantly from FY 21 to FY 22, doubling from 40,000 annually to 80,000 annually, while maintaining a 1.5 day processing time and the recidivism rate improved from six (6) in FY21 to zero (0) recidivism rate for FY22. CCHSP is requesting additional personnel and resources a to meet the increase in workload demand and remain sustainable.

IMPROVEMENT ACTION PLAN:

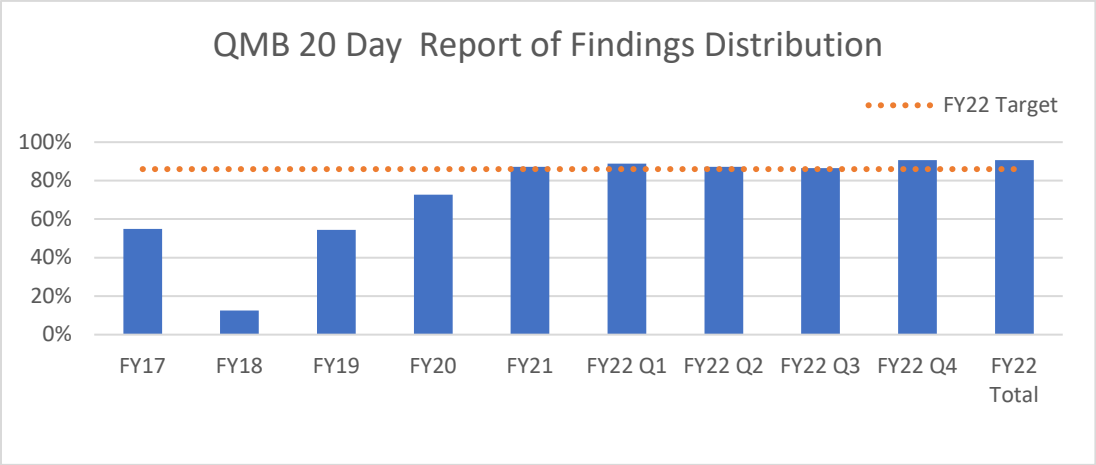
Major Quarterly Action Steps:	Goal Completion Date				
	Q1	Q2	Q3	Q4	Target
1) Monitor recidivism when appeals received.	X	X	X	X	

DHI PERFORMANCE MEASURE #10

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	FY22 Q1	FY22 Q2	FY22 Q3	FY22 Q4	FY22 Total	FY22 Target
54.90%	12.50%	54.5%	72.7%	87.1%	88.9%	87.2%	86.5%	90.7%	90.6%	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.

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.

In prior years, QMB had two (2) supervisors and were not fully staffed with Healthcare Surveyors. Because of the lack of staffing QMB management staff were also participating in surveys regularly as team members, reducing the time availability to edit reports. Additionally, there was weekly extensive Statewide travel with multiple overnights. This also resulted in staff adjusting hours at the end of each week to reduce overtime hours. Each of these areas affected the turnaround time of report writing, editing and distribution.

In FY2022 QMB began to survey the Supports Waiver and with the addition of the new waiver, a third supervisor was added to the review process. This 3rd supervisor assisted in reducing the amount of time QMB mgt staff was on survey and helped reduced editing wait time. Other improvements include the ability to fill all vacant QMB surveyor positions in order to timely meet workload requirements. The ability to fully staff QMB assisted in allowing surveyors the needed time to complete the report writing. Beginning in March 2020 as a result of the COVID-19 pandemic QMB also revised the survey into a 2-week hybrid remote process. The administrative process is now conducted remotely while residential and community visits, observations, and interviews are conducted in-person. Initially, the change process and need for proper equipment slowed the distribution time. Once needed equipment and training took place, surveyors with the assistance of management staff mastered the remote process. Additionally the remote process reduced the survey travel and on-site time for surveyors. Surveyors went from being on the road or out of town from 3 – 5 days per week, to 1- 2 days. This reduction in travel time helped to reduce staff burnout and reduced the amount of time adjustment due to travel. It has also allowed for QMB management staff to be readily available to assist surveyors and edit reports timely. The 2-week survey model has allowed extra writing time for reports for surveyors. These improvements have allowed for meeting 20-day distribution in FY21 and FY22.

IMPROVEMENT ACTION PLAN:

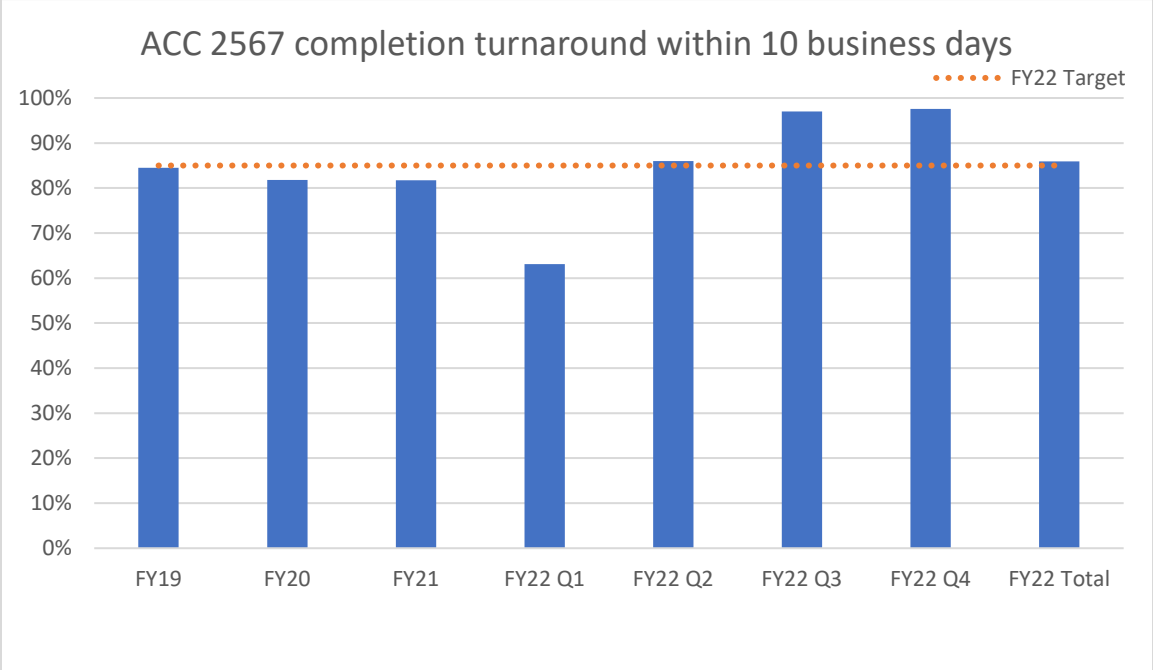
Major Quarterly Action Steps:	Goal Completion Date				
	Q1	Q2	Q3	Q4	Target
1) Train surveyors on writing and editing reports (ongoing activity).	X	X	X	X	
2) Train supervisors on editing reports (ongoing activity).	X	X	X	X	

DHI PERFORMANCE MEASURE #11

Percent of Acute and Continuing Care (ACC) 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	FY22 Q1	FY22 Q2	FY22 Q3	FY22 Q4	FY22 Total	FY22 Target
84.50%	81.8%	81.75%	63.1%	86%	97%	97.6%	85.9%	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 Acute and Continuing Care health facilities (formerly known as, non-Long-term Care) 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. Although DHI met its target goal a high vacancy rate has impacted DHI's timeliness of reports and DHI has experienced a significant increase in survey workload and complaint surveys.

For FY21 we did not meet our goal of 85% for the 10-day requirement. This was due to a combination of staff shortage, increase in complaints and a change in management. We were at 81.75%. For FY22 we did meet our goal of 85% for the 10-day requirement. In anticipation of facing the same and new challenges in FY22 we implemented new processes and tracking tools to ensure the 85% threshold was achieved, as well as, working to continuously to fill and train vacant surveyor positions as positions turnover. The 86% score clearly shows the new process and tools are helping in achieving our goal. During FY22 DHI added 20 new licensed health

facilities, including the addition of transplant specialty hospitals formally overseen by CMS. In addition, DHI continued to experience an increase in complaints. In order to meet the increasing demand DHI is requesting additional personnel and resources to sustain the increase in workload, as we are able to obtain more staff, we will be able to maintain and achieve a higher percentage score in years to come.

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	$0.00	$3,247,200	$0.00	$0.00	$3,247,200	28
300	$0.00	$1,207,300	$0.00	$0.00	$1,207,300	
400	$0.00	$845,500	$0.00	$0.00	$845,500	
TOTAL	$0.00	$5,300,000	$0.00	$0.00	$5,300,000	

FY21	General Fund	Other State Funds	Federal Funds	Other Transfers	TOTAL	FTE
200	$0.00	$1,331.25	$0.00	$0.00	$1,331.25	18
300	$0.00	$346.34	$0.00	$0.00	$346.34	
400	$0.00	$274.88	$0.00	$0.00	$274.88	
TOTAL	$0.00	$1,952.47	$0.00	$0.00	$1,952.47	

Program Performance Measures:

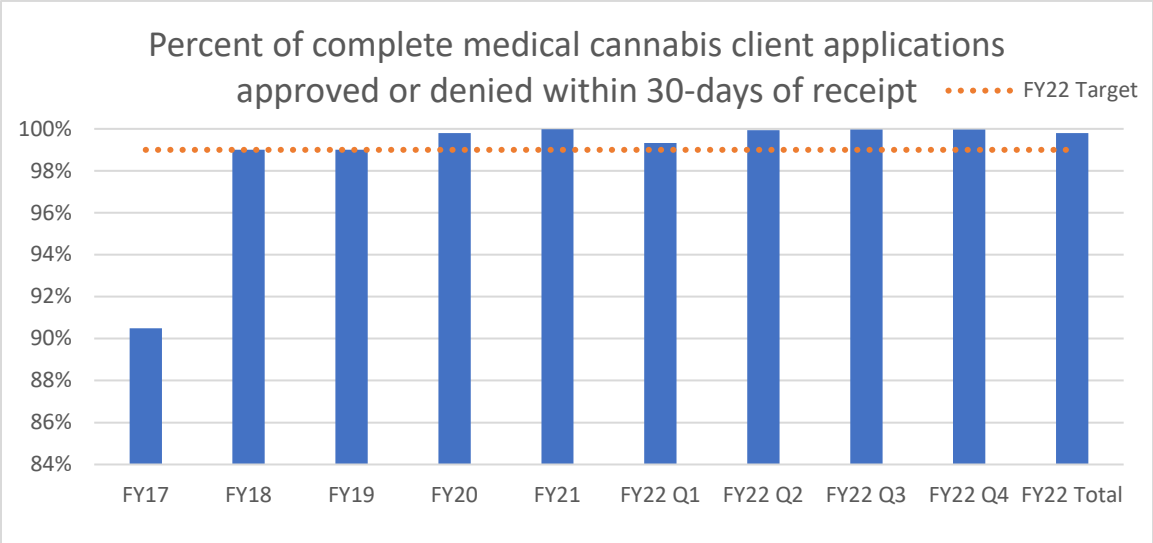
1. Percent of complete medical cannabis client applications approved or denied within thirty calendar days of receipt
2. Percent of registry identification cards issued within 5 business days of application approval

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	FY22 Q1	FY22 Q2	FY22 Q3	FY22 Q4	FY22 Total	FY22 Target
90.50%	99.00%	99.00%	99.8%	99.98%	99.33%	99.94%	99.96%	99.96%	99.8%	≥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. This measure assesses the success of the program in processing applications for enrollment in the program within the thirty-calendar day statutory time-limit requirements and ensuring patients will be able to have legal ability to access (purchase or grow their own) medical cannabis to help alleviate their medical conditions. This measure has remained consistent during each quarter of FY22 and during the previous two years (FY 20 and FY21). This consistency demonstrates the excellent level of service provided to patients.

IMPROVEMENT ACTION PLAN:

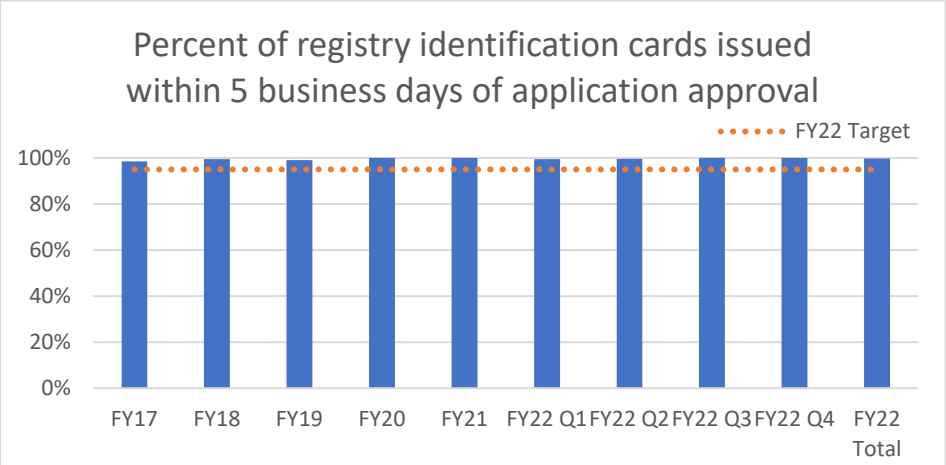
Major Quarterly Action Steps:	Goal Completion Date				
	Q1	Q2	Q3	Q4	Target
1) Continue process for streamlining patient applications by regularly reviewing forms to improve clarity and make them easier to read and complete.	X	X	X	X	**Q1, Q2, Q3, Q4**
2) Implement operational changes to meet increasing 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	FY22 Q1	FY22 Q2	FY22 Q3	FY22 Q4	FY22 Total	FY22 Target
98.50%	99.50%	99%	99.9%	99.98%	99.41%	99.61%	99.97%	99.98%	99.74%	≥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. This measure assesses the success of the program in sending enrollment cards to patients who have been approved to be in the program within the statutory time-limit requirements and ensuring patient are not waiting any longer than necessary to have the legal ability to access (purchase or grow their own) medical cannabis to help alleviate their medical conditions. This measure has remained consistent during each quarter of FY22 and during the previous two years (FY 20 and FY21). This consistency demonstrates the excellent level of service provided to patients.

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**