The New Mexico Department of Health

Strategic Plan

Fiscal Year 2014 - 2016

State of New Mexico

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New Mexico Department of Health

Retta Ward, Cabinet Secretary

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A Message from the Secretary

Retta Ward
Cabinet Secretary
NM Department of Health

It's a great honor to serve the people of New Mexico. We are a population of over 2 million residents and 6.4 million visitors each year. With more than 3,200 staff members and a budget of $550 million dollars, the Department of Health delivers essential public health and health services to frontier, rural and urban communities and 22 sovereign tribal nations. Our facilities serve as a safety net for people who require long term care, rehabilitation and behavioral health treatment. New Mexico Department of Health (NMDOH) programs work with providers to support people with disabilities and their families. It is also our role to ensure an effective and timely response to public health emergencies. These are among the many ways we serve the people of New Mexico.

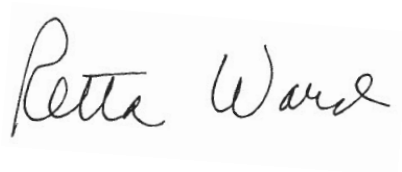
The Department of Health's 2014 – 2016 Strategic Plan is a roadmap for the agency on how to remain a vital part of an effective health system today and into the future. In order to achieve this purpose, we must commit to doing all we can to ensure that there is an adequate and competent workforce, and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

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

In 2012, we began a pursuit of Public Health Accreditation for the NMDOH. The goal of Accreditation is to improve and protect public health by advancing the quality of all our services, and to strengthen collaborative efforts with state and local partners. In May of 2014, we submitted our documentation to the Public Health Accreditation Board. By accomplishing Accreditation, the delivery of public health essential services by the NMDOH will be evaluated according to a set of national standards, which will increase the quality and impact of the work we do.

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

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



Cabinet Secretary
New Mexico Department of Health

Table of Contents

[New Mexico Department of Health Strategic Plan, 2014 - 2016. Updated May 1, 2014]

NMDOH Strategy to increase physical activity and healthy eating in elementary school students: *Increase number of safe walking and biking routes and encourage schools to adopt components of Safe Routes to School*

DEFINITIONS

Population Result

A condition of well-being for children, adults, families or communities.

Population Indicator

Population health indicators are quantifiable characteristics of a population which are used as supporting evidence for describing the health of a population. Population health indicators are often used by governments to guide health care policy. The population may be defined geographically or by characteristic (e.g., all children in one school district, all patients in a facility, children with asthma, all people in a county or members of a tribe).

Population Indicator Baseline

For a population health indicator, the baseline represents the most recently available data to show that a health issue is of such magnitude that it requires action by the program or by a group of stakeholders or partners. Baseline data are necessary as the foundation to determine the ultimate level of success.

Program Performance Measure

A measure of how well a program, agency or service system is working. The NMDOH strives to have good program performance measures that may, directly or indirectly, affect positively the population health indicators and result.

Program Performance Measure Baseline

For a program performance measure, the baseline establishes the value or values to serve as comparison point for future data for performance monitoring. Baseline data are necessary as the starting point to determine the ultimate level of program success, answering the questions "how well are we doing?" and "are people better off?"

Mission, Vision, and Values

The vision, mission, and core values are the foundation for our strategic plan. Together they identify why the organization exists, how it aligns with the State Health Assessment and the State Health Improvement Plan, and how it measures performance. These were created by New Mexico Department of Health employees.

Our Vision

A healthier New Mexico!

Our Mission

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

Our Core Values That Guide Us While Fulfilling Our Mission

Accountability → honesty, integrity, and honor commitments made

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

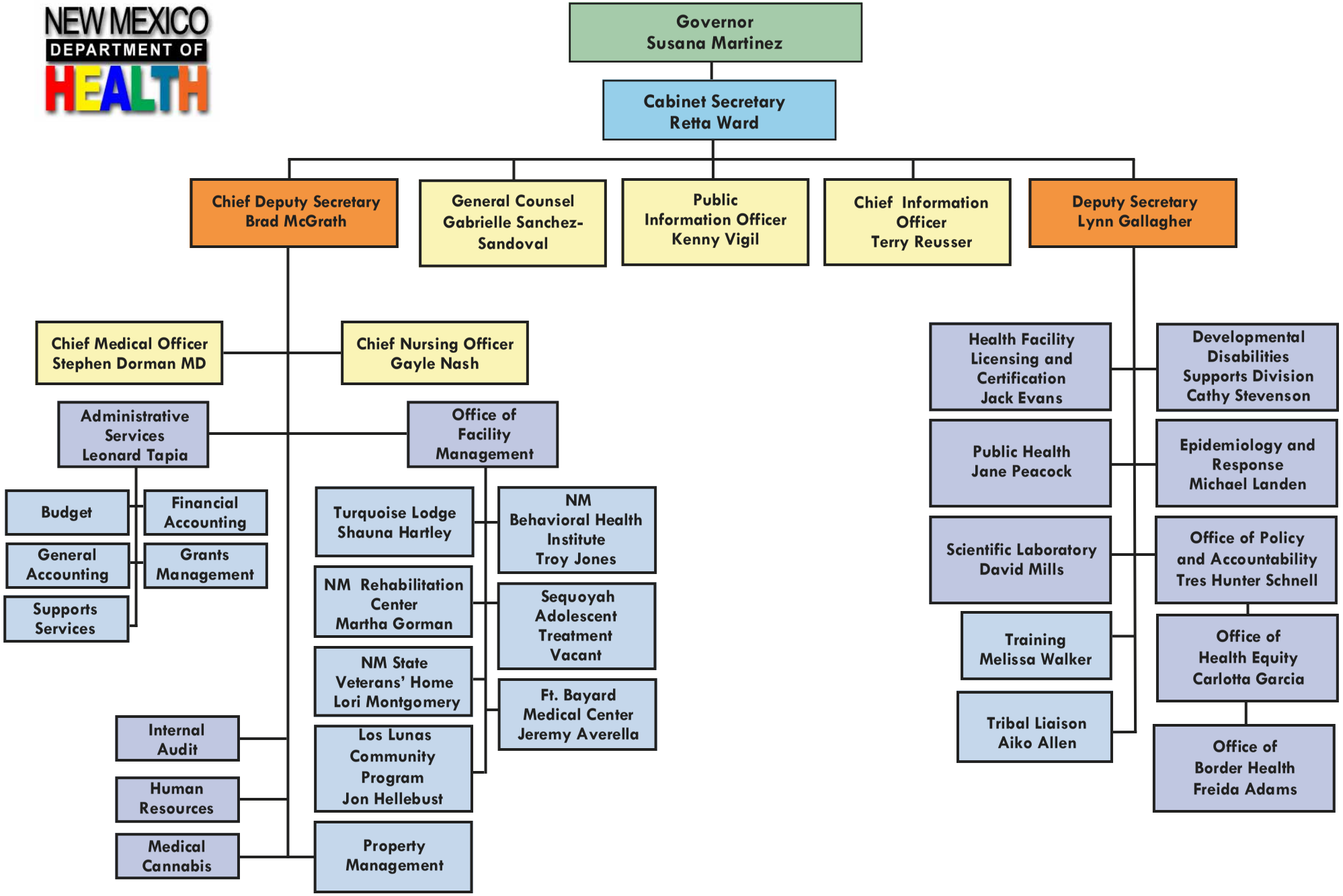
Teamwork → share expertise and ideas through creative collaboration to work toward common goals

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

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

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


View of Health in New Mexico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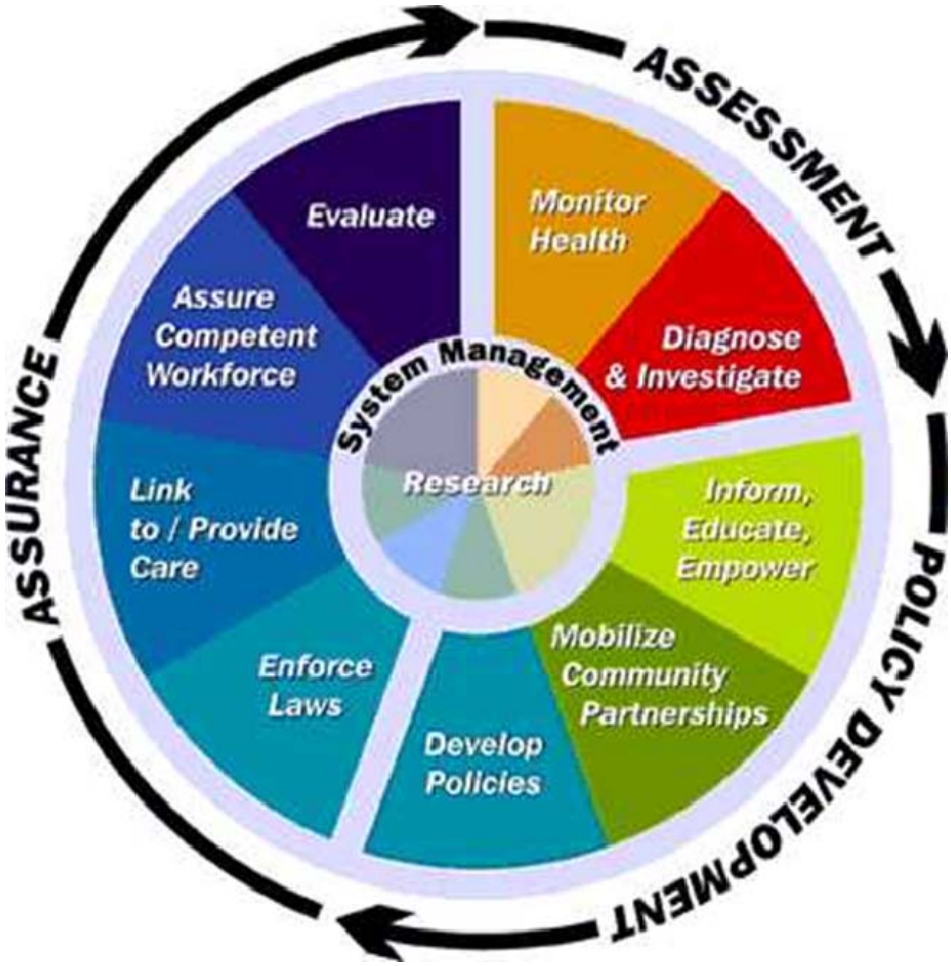
The Functions of a State Health Department

Public health encompasses three core functions:

- ***Assessment*** of information and the health status of the community
- Comprehensive public health ***policy and plan development***
- ***Assurance*** that public health services that work are provided to the community, that public health laws and regulations are enforced and that the workforce is competent and adequate.

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

In order to strengthen public health infrastructure, the Core Public Health Functions Project established a Committee that developed a framework for the Public Health Essential Services in 1994. This framework led the Centers for Disease Control and Prevention and their partners to establish The National Public Health Performance Standards to provide a framework to assess capacity and performance of public health system and their governing bodies. The 2003 *Institute of Medicine* (IOM) report, *The Future of the Public's Health*, called for the establishment of a national Steering Committee to examine the benefits of accrediting governmental public health departments. As a result of these important efforts, a national Public Health Accreditation program was established.



10 ESSENTIAL PUBLIC HEALTH SERVICES

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

Assessment

- ***Monitor*** *health status to identify and solve community health problems.*
- ***Diagnose and investigate*** *health problems and health hazards in the community.*

Policy and Plan Development

- ***Inform, educate****, and empower people about health issues.*
- ***Mobilize*** *community partnerships and action to identify and solve health problems.*
- ***Develop policies and plans*** *that support individual and community health efforts.*

Assurance

- ***Enforce*** *laws and regulations that protect health and ensure safety.*
- ***Link*** *people to needed personal health services and assure the provision of health care when otherwise unavailable.*
- ***Assure*** *competent public and personal health care workforce.*
- ***Evaluate*** *effectiveness, accessibility, and quality of personal and population-based. health services.*

Research *for new insights and innovative solutions (System Management)*

Department Overview

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

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

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

NMDOH is the lead entity in New Mexico providing core public health functions and essential services. The NMDOH main campus is located in Santa Fe and the agency employs approximately 3,200 people in more than 60 locations around the state, and administers an annual budget in excess of $540 million. The NMDOH is divided into 7 divisions (Administrative Services, Information Technology, Public Health, Epidemiology and Response, Scientific Laboratory, Developmental Disabilities Support, and Division of Health Improvement).

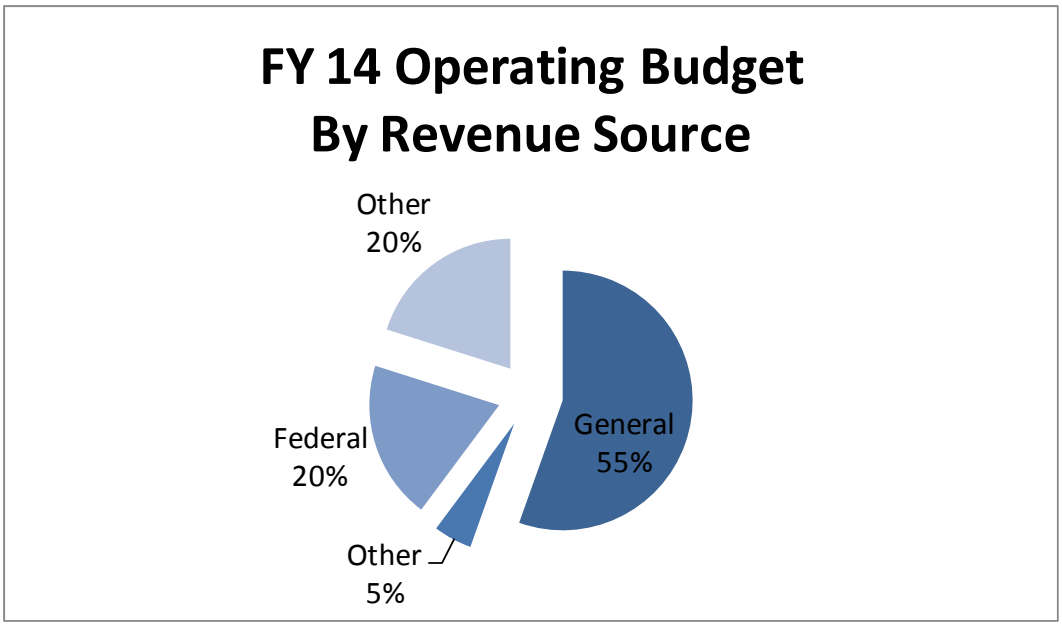
In addition there are several offices which engage in cross-departmental efforts and supports (Office of General Counsel, Public Information Office, Office of Internal Audit, and the Office of Policy and Accountability, which includes the Office of Health Equity, and the Office of Border Health). Finally,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

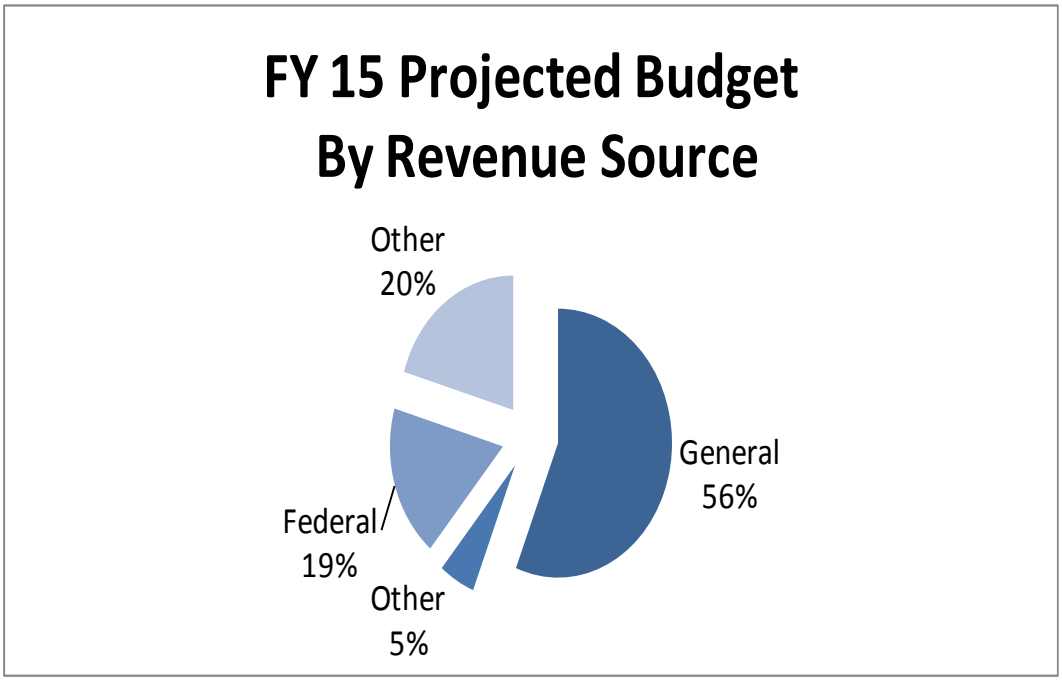
NMDOH has made great progress toward achieving Public Health Accreditation. Cabinet Secretary Retta Ward plans to submit our documentation to the Public Health Accreditation Board on May 13, 2014. The submission of documents to demonstrate that the department meets the requirements of Accreditation standards will be accomplished in May 2014. There are currently 2 states with Public Health Accreditation. The following divisions and offices play a key role in the Department's ability to achieve and maintain Accreditation status.

- **The Public Health Division** provides a coordinated system of community-based public health services focusing on disease prevention and health promotion in order to improve health status, reduce disparities, and ensure timely access to quality, culturally competent health care. It consists of seven bureaus and five regions: Director's Office/Program Support, Pharmacy, Family Health, Infectious Disease, Chronic Disease Prevention and Control, and Health Systems Bureaus, and the Northeast, Northwest, Metro, Southeast and Southwest Regions.
- **The Epidemiology and Response Division** tracks health and disease; monitors health status to identify community health problems; diagnoses, investigates, and controls outbreaks and health problems in communities; prevents and controls injuries; provides vital registration services; provides health information; improves the EMS system; improves the trauma care system; and prepares and responds to health emergencies. It is organized into seven bureaus and two program: Director's Office/Program Support, Vital Records and Health Statistics, Infectious Disease Epidemiology, Emergency Medical Services, Health Emergency Management, Injury and Behavioral Epidemiology, and Environmental Health Epidemiology Bureaus and the Morbidity Surveillance and Community Health Assessment Programs.
- **The Scientific Laboratory Division** provides clinical testing for infectious disease agents in support of public health programs operated by the Department of Health; veterinary, food, and dairy testing for the Department of Agriculture; forensic toxicology (drug) testing in support of the Department of Public Safety and local law enforcement agencies for the Implied Consent Act, and for autopsy investigation performed by the Office of the Medical Investigator; and chemical testing for environmental monitoring and enforcement of law and environmental regulations for the Environment Department. The Scientific Laboratory is organized into one office and four bureaus: Director's Office/Office of Quality, Security, Safety and Emergency Preparedness and the bureaus of Biological Sciences, Chemistry, Toxicology, and Program Support.
- **Information Technology Support Division** provides a broad range of IT services that impact every area of the Department: wide area network; maintain over 400 servers, desktops and laptops; maintain helpdesk services; support applications; and managing multiple IT projects.
- **Office of General Counsel** ensures that public health and NMDOH laws, regulations, and policies are enforced.
- **Administrative Services Division** provides administrative and management services to internal and external customers: professional services agreements, procurement and grant management processes, and budget related support.
- **Office of Policy and Accountability** coordinates the Health Department Accreditation program; provides leadership, workforce development and coaching in quality and performance improvement; and coordinates the policy and legislative activities in the NMDOH.
- **Office of Health Equity** coordinates programmatic efforts to address health disparities, including collaboration with OPA to release health disparity reports; delivers targeted health promotion services to target populations, and provides Cultural and Linguistic training.
- **Office of Border Health** provides public health services in the New Mexico/Mexico Border Region and other border-impact areas of the State; serve as both catalyst and facilitator in ensuring that public health objectives are met in our shared culturally and socio-economically unique Border Region and that necessary preventive and primary health care services are provided to the State's immigrant and migrant community (especially those from Mexico).

Our Resources → Budget, Resources, Future Outlook

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



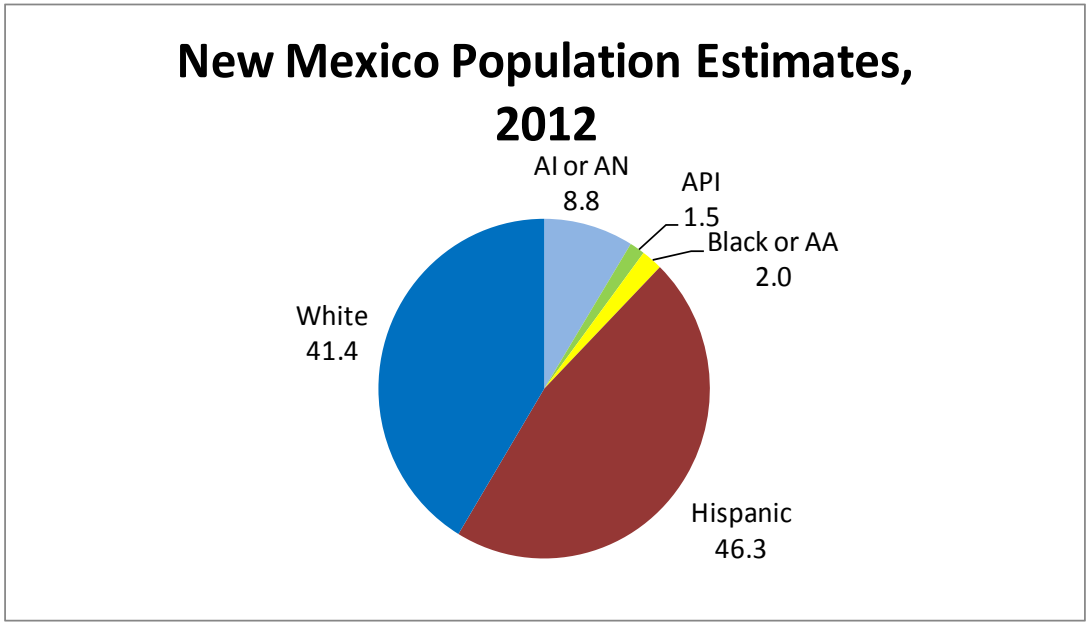


Health Disparity and Health Equity

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

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

According to 2012 state population estimates, 46.4% of New Mexicans were Hispanic and 41.4% were White (Figure 3). The American Indian or Alaska Native population comprised 8.8% of New Mexico's population, the Black or African American population made up 2.0%, and the Asian or Pacific Islander population constituted another 1.5%.



Population Distribution by Race/Ethnicity, New Mexico, 2012

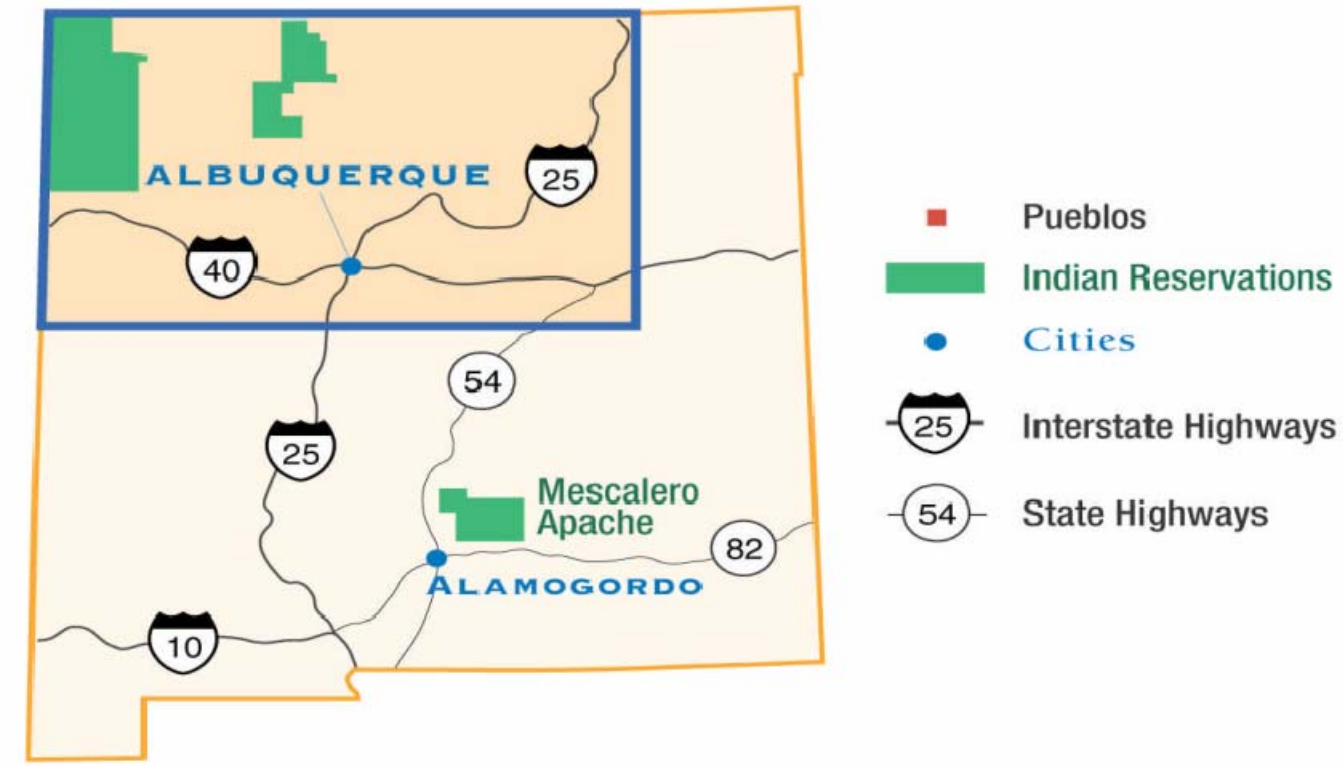
Each of these racial and ethnic groups faces its own health challenges. Differences or disparities in health status and the impact of diseases have been tracked. These disparities are based on comparisons of the health status, access to services, and/or health outcomes of population groups. The disparities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

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

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

New Mexico has 22 federally recognized American Indian tribes. There are 19 Indian pueblos (Acoma, Cochiti, Isleta, Jemez, Laguna, Nambé, Okay Owingeh, Picuris, Pojoaque, Sandia, San Felipe, San Ildefonso, Santa Ana, Santa Clara, Santa Domingo, Taos, Tesuque, Zia, and Zuni) and three Indian reservations in the state (Jicarilla Apache nation, Mescalero Apache reservation, and Navajo Nation). New Mexico is home to 6.2% of the total American Indian population. The *Fort Sill Apache* Tribe is a federally recognized Native American tribe. In 2011, the tribe won the right to establish a reservation in *New Mexico*. Early in 2014, the New Mexico Supreme Court that the state must honor the legitimacy of the tribe. The adjacent map could not be changed in time for the publication of this strategic plan.

New Mexico's Pueblos and Reservations



Our Strategic Planning Council

The Strategic Planning Council (SPC) was established by the New Mexico Department of Health Cabinet Secretary on December 18, 2012. Division and Office Directors and Facility Administrators were requested to appoint representatives to the SPC. The council met once in 2012, 13 times in 2013, and 4 times as of April 30, 2014. The initial planning process spanned over this time period, which included multiple assessments and the development of a Quality Improvement (QI) Plan (Appendix 2). The SPC developed and quality improvement structure led by a Quality Improvement Council. The QI Plan identifies 4 areas for improvement in the agency: Communications, Training and Workforce Development, Health and Safety, and Performance Measures.

The Office of Policy and Accountability has worked with the Cabinet Secretary to conduct 3 additional assessments: Cultural and Linguistic (April 2014); Workforce Development (April 2014); and, Performance Management Self-Assessment (April 2014). The data gathered from NMDOH personnel responding to these assessments will be used to inform capacity-building programs in the agency, developed by the appropriate QI workgroup and adopted by the Cabinet Secretary of Health. assessment data. The SPC will guide the overall planning and improvement process. NMDOH strategic planning cycle: 12/2012 - 5/2014, updated annually or more frequently as needed.

Emerging Threats and Climate Change

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

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

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

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

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

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

The Health System in New Mexico

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

Community health centers are a significant source of care in New Mexico addressing the needs of the HPSAs. There is also a network of 95 medical sites and 40 dental sites of "federally qualified health centers" that are the backbone of New Mexico's health care safety net. These centers provide services to underserved communities, providing access to high quality, family oriented, and comprehensive primary and preventive health care for people who are low-income, uninsured or face other obstacles to getting health care. New Mexico has a total of 36 hospitals, resulting in a bed to population ratio of 1.9 per 1000 population as compared to the U.S. ratio of 2.6.

Our Strengths and Weaknesses

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

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

Identified strengths, areas in which NMDOH excels, were:

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

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

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

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

Quality Improvement and Performance Management Model

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

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

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

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

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

NMDOH also partners with community stakeholders in order to enable us to holistically meet the needs of our customers. We use a series of community health improvement planning events to establish concurrence on health priorities and strategies to improve health status. These events provide for communication opportunities between community stakeholders and Health Department staff. They also serve to educate the staff about community concerns and needs, and to inform stakeholders about pertinent Public Health issues. Examples include: Turn the Curve on Health statewide and regional assessment/planning events; meetings regarding environmental public health issues; focus groups for community assessment purposes; Tribal health promotion events and health improvement partnerships; activities that focus on healthy weight and nutrition related issues; and tobacco use prevention activities. Information learned from these activities is used to inform *A Healthier New Mexico,* the state health improvement plan (SHIP). More detail on the NMDOH SHIP may be found in *A Healthier New Mexico*.

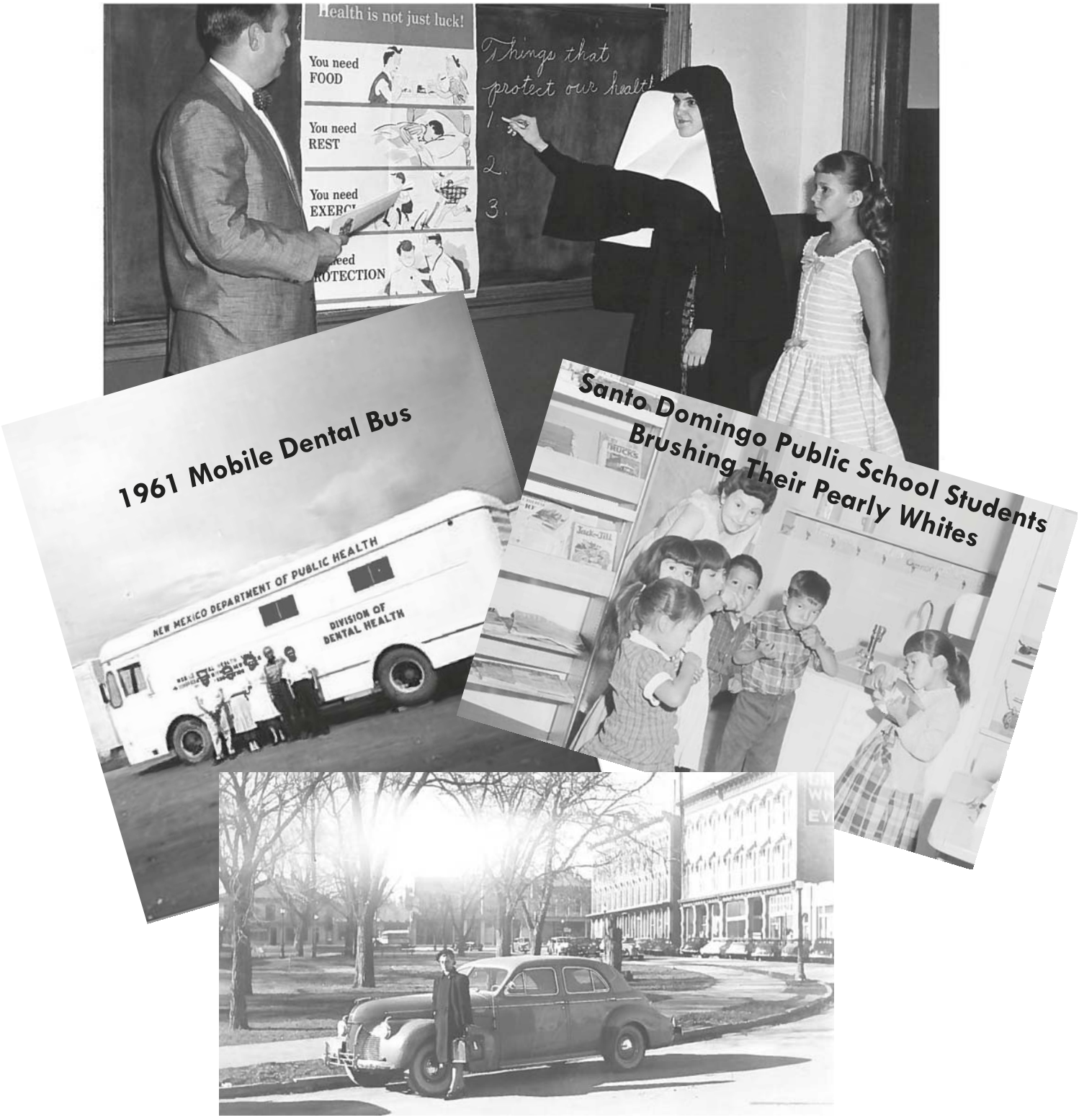
Results and How We Plan to Achieve Them

The NMDOH Strategic Planning Council (SPC) developed seven Results for the agency. The SPC understands the priorities of NMDOH are numerous, with numerous challenges. The Results address public health and healthcare priorities identified by NMDOH senior management and program staff.

After identifying the Results, NMDOH developed relevant performance measures, which were approved by the Cabinet Secretary and the Senior Management Team. These performance measures will help refine and focus our work by identifying a measurable activity that determines progress in attaining the end in mind, the result. The SPC will identify targets and deadlines for achieving them. In sum, each performance measure, when combined with its objective, indicator, baseline data, the story behind the data, what works, partners, and strategies, provides information on how NMDOH programs and facilities attempt to improve population health and its health services.

The SPC has established a Quality Improvement Plan to support positive improvement results in the following areas: (Appendix 2)

- ☆ Training and Workforce Development
- ☆ Health and Safety
- ☆ Communications
- ☆ Performance Measures



A Nurse On the Go in Las Vegas, NM in the 1940s

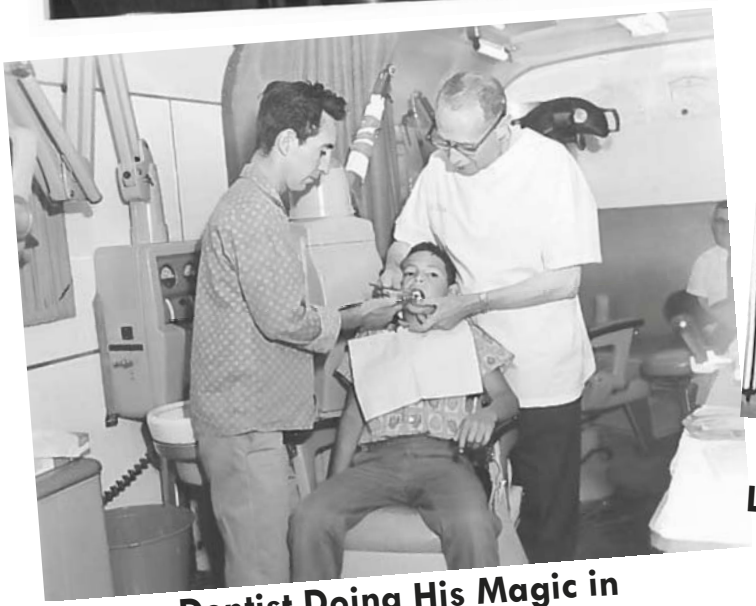
FROM THE DEPARTMENT OF HEALTH SCRAPBOOK

Health promotion messages remain the same today!

Holding your nose makes it hurt less!

Providing nutrition in the school … our Healthy Kids program does that now!

A "Health Clown" in Tucumcari, NM



Dentist Doing His Magic in Pecos, NM in 1963

Practical Nursing Students of the Las Cruces School of Practical Nursing learning how to properly take measurements

A. POPULATION

Public Health

Health Promotion and Prevention

Result 1
Improved health outcomes for the people of New Mexico

Objective

Reduce tobacco use

NM Population Indicator

Percent of adults who smoke

NM Population Indicator Baseline

19.3% in 2012

Story Behind the Data

- New Mexico's adult smoking prevalence declined significantly in the past decade, following similar national trends.
- Despite decreases in overall adult smoking in NM, rates are still significantly higher among some groups, including adults who have lower education, lower income, are unemployed, or uninsured.
- Smoking among NM high school youth remained stagnant and higher than the national rate for several years in the mid to late 2000's, but dropped to 19.9% in 2011.
- Especially high smoking rates are seen among youth with poor academic grades, American Indian youth, and youth whose parents have lower levels of education.
- Significant numbers of youth are also using other tobacco products, including spit tobacco, chew, cigars, and hookah.
- About 92% of New Mexicans are protected from secondhand smoke exposure by the 2007 Dee Johnson Clean Indoor Air Act, but it does not cover tribal lands in the state. Residents who live in multi-unit housing may also experience exposure to secondhand smoke from nearby residents who smoke.

Performance Measure (PHD/P002)

Program Performance Measure	Program PM Baseline	FY15 Target
Percent of QUIT NOW enrollees who successfully quit using tobacco at 7-month follow-up (AGA)	**32%**	**33%**

What Works

- Providing access to cessation services, including those through 1-800-QUIT NOW and www.QuitNowNM.com and the Spanish services at 1-855-DEJELOYA and www.DejeloYa.com.
- Screening all patients in healthcare settings for tobacco use and providing brief interventions or referrals to QUIT NOW Cessation Services.
- Supporting the development of policies to protect all New Mexicans from secondhand smoke exposure, including locations not covered by Dee Johnson Clean Indoor Air Act.
- Increasing the price of all tobacco products, including cigarettes, chew and snuff tobacco, cigars, and roll-your-own tobacco.
- Regulating the time, place, and manner in which tobacco can be advertised and sold in order to prevent youth from initiating tobacco use.

Partners

- NMDOH programs [Tobacco Use Prevention & Control (TUPAC)]; Diabetes Prevention & Control; WIC; Public Health Regions; and Epidemiology & Response Division
- Local, regional, and statewide TUPAC-funded grantees, including media and QUIT NOW Cessation Services providers
- Other state agency partners: NMHSD (Office of Substance Abuse Prevention, Synar Program; and Public Education Department
- Priority Population Networks
- American Cancer Society—Cancer Action Network
- American Lung Association

Strategies

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

Objective

Prevent teen pregnancy

NM Population Indicator

Teen birth rate per 1,000

NM Population Indicator Baseline

25.5% in 2011

Story Behind the Data

- Since 1998, the teen birth rate in New Mexico for 15 – 17 year olds has declined by 41%, which is comparable to national data.
- Hispanic teens have the highest birth rates both in New Mexico and nationally, and while rates are declining there is still work to be done.
- Risk factors impacting the high teen pregnancy rate are poverty, education, rural vs. urban population, and access to services.
- In 2011, New Mexico ranked 2nd in percentage of children living in poverty, one of the most important contributing factors to teenage pregnancy.
- Teens that have dropped out of school are more likely to become pregnant and have a child than their peers who stay in school. The NM high school dropout rate in 2011 was 37%, compared to 22% nationally.
- Teen parenthood is most common in rural areas.
- There is a lack of access to family planning services in all but one of NM counties classified as a health professional shortage area.

Performance Measure (PHD/P002)

Program Performance Measure	Program PM Baseline	FY15 Target
Number of teen births prevented among 15-17 year old females seen in family planning clinics	**448**	**477**
Percent of teens participating in pregnancy prevention programs that report not being pregnant or being responsible for getting someone pregnant during the school year following participation at the end of the school year (AGA)	**99.9%**	**100%**

What Works

- Family Planning Services offering access to confidential reproductive health services at low or no cost. Increased access to family planning services, including School-Based Health Centers.
- Increased availability of highly effective primary contraceptive methods for teens such as: pill form, injectable, patch, ring, IUD, and hormonal implant.
- Service learning programs, adult-teen communication programs, comprehensive sex education, and clinical and educational services for males.

Partners

- Primary Care Clinics
- Community based clinical providers
- School-Based Health Clinics
- University of New Mexico
- Office of School and Adolescent Health
- Human Services Department
- Women, Infants and Children Program

Strategies

- Family Planning Program (FPP) funded clinics will continue to provide confidential, family planning services to teen clients aged 15-17 in Public Health Offices, Primary Care Clinics and School-Based Health Centers.
- Work with Managed Care Providers and Qualified Health Plans to increase the capability to provide and bill for confidential family planning services.
- Continue to promote four population-based strategies (e.g., service learning programs, adult-teen communication programs, comprehensive sex education, and male clinical and educational services).

Objective

Increase use of preventive health services at school-based health centers

NM Population Indicator

Percent of students receiving a comprehensive well exam at school-based health centers

NM Population Indicator Baseline

Data development to collect and analyze information on student visits

Story Behind the Data

- Children and youth in New Mexico face a number of risks to their health and behavioral health; ranging from poor nutrition and lack of immunizations to physical abuse, substance abuse and unplanned pregnancy. All of these problems threaten a student's normal development and present barriers to learning.
- The Office of School and Adolescent Health (OSAH) promotes quality, accessible student and community health services through the development and support of School-Based Health Centers (SBHCs). These centers provide comprehensive primary care and behavioral health services by using a multi-disciplinary health team.
- New Mexico's school-based health centers help address these problems with a unique health care model that includes comprehensive physical, behavioral, and preventive health services provided to children and adolescents in their school, where they spend the largest portion of their day. These critical health care services are provided to students regardless of their ability to pay.
- Comprehensive well exams include: a complete health and developmental history; vision screening; hearing tests; oral health assessment; and other diagnostic tests to identify potential problems. If the exam identifies a risk, then follow-up and treatment are initiated to control health problems.
- One of the many services provided by SBHCs is reproductive health care and education. For communities where teen birth rates are high, SBHCs can be supportive partners in teen pregnancy prevention.
- The New Mexico Alliance for School-Based Health Care represents school-based health centers in New Mexico and promotes, facilitates, and advocates for comprehensive, culturally competent health care in schools.
- In 2012, 14,449 students received 42,997 visits.

Performance Measure (PHD/P002)

Program Performance Measure	Program PM Baseline	FY15 Target
Percent of students receiving a comprehensive well exam at school based health centers (AGA)		**25% (LFC imposed target 35%)**

What Works

- School-based health centers (SBHC) can increase students' health knowledge and access to health-related services, but more intensive or different services are needed if they are to significantly reduce risk-taking behaviors.
- School health services are associated with fewer pregnancies among students.
- There is evidence that SBHCs are popular with young people, and the SBHCs provide important mental and reproductive health services.
- Services also appear to have cost benefits in terms of adolescent health and society as a whole by reducing health disparities and attendance at secondary care facilities.
- Research has demonstrated the SBHCs' impacts on delivering preventive care such as: immunizations; managing chronic illnesses such as asthma, obesity, and mental health conditions; providing reproductive health services for adolescents; and even improving youths' academic performance.
- Save money by reducing after hours and inpatient care.
- Adolescents are 10 to 21 times more likely to go to a SBHC for mental health services than to a community health network.
- According to the 2012 OSAH Annual Student Satisfaction Survey:
    - 90% of students report missing 0-2 classes to access care at their SBHC. At least 50% of students estimated they would have had to miss at least three classes or a full day of school if they accessed care off-site.
    - 90% of students report they are likely to follow SBHC care, and 79% report they have changed behavior after a SBHC visit. Changes include: reduced drug, alcohol, or tobacco use; better eating habits; increased exercise; or increased safe choices about sex.
- SBHC model of care results have demonstrated increased access to care, improved health and education outcomes, and high levels of satisfaction.

Partners

- NM Federally Qualified Health Care Centers (FQHCs)
- University of New Mexico – Pediatrics, Psychiatry, and Health Promotion programs
- Eastern NM University – School of Nursing, Regional Educational Cooperatives
- Indian Health Service (IHS)
- Non-profits and local community-based organizations
- NM Public Education Department (PED)
- NM Human Services Department (HSD)
- NM Managed Care Organizations (e.g., Blue Cross/Blue Shield, Presbyterian, United Health Care, and Molina)
- NM Children Youth and Families Division
- Envision for Health Care Quality
- Apex Education
- NM Alliance for School Based Health Care

Strategies

- Continue to provide technical assistance and training.
- Promote a quality improvement (QI) initiative focused on increasing the efficiency and effectiveness of SBHCs to deliver comprehensive well exams for youth who use the school-based health center.
- Promote positive youth development and resiliency.
- Continue to provide operational funds to support sustainability of SBHC staff and providers needed to deliver services to youth through the SBHCs.

Objective

Encourage physical activity and healthy eating in elementary school students

NM Population Indicator

Percent of third grade students who are obese

NM Population Indicator Baseline

21.4% in 2012

Story Behind the Data

- Obesity is a rapidly growing problem and occurs at very young ages.
- Obese children are more likely to be obese adults and suffer from chronic diseases such as heart disease and diabetes.
- American Indians have the highest rates of obesity among children participating in the WIC program, and among elementary and high school students. This population also has the highest rates of obesity among New Mexico adults.
- Healthy eating and active living are two lifestyle choices that can prevent obesity; however, social and environmental factors make it difficult for many to consume a healthy diet or to be physically active.
- Increased access to inexpensive high fat, high calorie, and high sodium foods make healthy eating more difficult.
- Other factors include working families, concern for children's safety, TV food advertising, and lifestyle of convenience present obstacles to eating healthy and being physically active.

Performance Measure (PHD/P002)

Program Performance Measure	Program PM Baseline	FY15 Target
Percent of elementary school students in community transformation communities who are obese	**3rd Grade: 23.6%**	**5% change**
Percent of elementary school students in community transformation communities participating in classroom fruit and vegetable tastings	**30%**	**40%**
Percent of elementary school students in community transformation communities participating in walk and roll to school	**9%**	**14%**

What Works

- Increased access to fresh fruits and vegetables (Farm to School, Farm to Table, Farmer's Markets, School and Community Gardens).
- Updated and strengthened wellness policies at the school and community level.
- Physical activity incorporated into the daily routines at schools and workplaces.
- Establishment of a Healthy Kids-Healthy Community initiative to create policy and environmental changes to support healthy eating and active living.

Partners

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

Strategies

- Open outdoor school space for community use during non-school hours.
- Build walking and biking trails that connect neighborhoods to schools and promote community usage.
- Increase number of safe walking and biking routes and encourage schools to adopt components of Safe Routes to School.
- Implement the New Mexico Centennial 5.2.1.O Challenge in elementary schools across the state.
- Support childcare providers to make healthy eating and physical activity a part of their daily routine.
- Increase access to and availability of affordable, healthy, and locally grown foods in schools and the community via classroom fruit and vegetable tastings, school and community gardens, healthy corner stores, and farmers' markets.

Objective

Increase immunizations among preschoolers

NM Population Indicator

Percent of preschoolers (19-35 months) fully immunized

NM Population Indicator Baseline

80% in 2011

Story Behind the Data

- Immunization is one of the most effective tools against the spread of communicable diseases. With the development of increased scientific knowledge and technology, the number of diseases for which vaccines have been developed has increased.
- Consequently full immunization requires a number of vaccinations requiring more effort and time on the part of parents to access the health care system to achieve these vaccinations for their children. Immunization schedules may be found at: http://www.immunizenm.org/sched.shtml.
- The Institute of Medicine conducted a thorough review of the current medical and scientific evidence on vaccines and certain health events that may be observed after vaccination. It released a report in August 2011 on 8 vaccines given to children and adults that found the vaccines to be generally safe and serious adverse events following these vaccinations to be rare. Many families continue to believe that there is a link between certain vaccines and Autism resulting in a choice to pursue an exemption from day care and school requirements.

Performance Measure (PHD/P002)

Program Performance Measure	Program PM Baseline	FY15 Target
Percent of preschoolers (19-35 months) fully immunized (Explanatory Measure reported annually)	**80% (2011 calendar year)**	**85%**

What Works

- New Mexico 'Done By One' (DBO) initiative, which optimizes the childhood immunization schedule and has several advantages aims to encourage its acceptance by both providers and parents:
  - It is much simpler: all the needed shots are given at 2, 4, 6, and 12 months.
  - Kids become protected at the earliest possible age.
  - The condensed schedule discourages the practice of deferring shots until next time, resulting in missed opportunities to vaccinate.
- Children seen by practices that always use DBO are more likely to be fully immunized by 24 months than those seen by practices that never use DBO.
- New Mexico requires children entering day care and school to have certain immunizations completed. The New Mexico Immunization Exemption Statute (24-5-3) allows only two types of exemptions for children seeking exemption from required immunizations to enter school, childcare or pre-school. The two exemptions are medical or religious.
- Provide the New Mexico Immunization Toll Free Hotline (866) 681-5872 to respond to questions and concerns from parents and caregivers of school age children.
- Provide cost-free immunizations at public health clinics statewide.

Partners

- Health Care Providers
- Schools
- New Mexico Immunization Coalition
- Santa Fe Immunization Coalition
- Dona Ana County Immunization Coalition
- Centers for Disease Control and Prevention

Strategies

- Professional education/training/technical assistance on immunizations, vaccine storage and handling, immunization recording, and immunization schedules.
- Public education is conducted in collaboration with statewide partners to promote immunization and inform the public about vaccines.
- New Mexico 'Done By One' initiative.
- Provision of vaccination clinics offering cost-free immunization during the evenings and on weekends; and accessibility to vaccines at a variety of community locations, including pharmacies and other commercial locations.

Objective

Reduce infant pertussis cases

NM Population Indicator

Infant pertussis rates

NM Population Indicator Baseline

In 2012 there were 262.1 cases of infant pertussis per 100,000 people

Story Behind the Data

- Pertussis is a highly contagious bacterial infection that causes an uncontrollable violent cough lasting several weeks or even months.
- Pertussis is a respiratory infection that disproportionately impacts infants. Infants with pertussis are at increased risk of hospitalization, secondary complications, and death. In 2012, there were 2 deaths (one infant; one 4 year-old) and 35 pertussis-related hospitalizations (26 infants) in New Mexico. The average length of hospitalization was 4.3 days (range: 1-17 days).
- For 2008-2011 there were less than 20 cases per year among infants; in 2012 there were 76 cases.
- Current prevention strategies and vaccination recommendations emanating from the Centers for Disease Control and Prevention focus on prevention of pertussis among the infant population. Vaccination is recommended beginning at the age of 2 months and continuing until 12-18 months, with older children receiving booster doses. In New Mexico and throughout the country recommendations have been developed to target vaccination of pregnant women and family members in order to prevent high-risk infant pertussis cases.
- The immunization program works with hospitals and others to implement this recommendation.
- Since 2008, the infant pertussis rate has increased a five-fold from 56.2 to 262.1 cases per 100,000.

Performance Measure (PHD/P003)

Program Performance Measure	Program PM Baseline	FY15 Target
Ratio of infant pertussis cases to total pertussis cases of all ages (AGA)	**1:12***	**1:15**

***For 2013, estimated based on mid-year data. The estimate assumes 52 infant cases among 636 total cases for 2013.**

What Works

- Tdap for pregnant women at each pregnancy.
- Cocooning protects infants against pertussis by vaccinating the adults around them.
- Expanded access in health care settings.
- Reduced client out-of-pocket costs.
- Standing orders, reminder systems, assessment, and feedback in provider settings.
- Mass media and small media educational activities.

Partners

- NM Immunizations Coalition
- Clinical Prevention Initiative
- Regional Immunization Staff
- Immunization Providers
- Indian Health Services
- NM Medicaid
- NM Medical Society
- NM Primary Care Association
- NM American Congress of Obstetricians and Gynecologists
- Pediatricians
- Hospital staff
- Individual Care Practitioners

Strategies

- Provide accurate and complete data that supports vaccination prevention activities.
- Collaborate with community organizations and local/regional health partners to increase the number of access points for adults seeking immunizations.
- Assist the Women, Infants and Children (WIC) Program to develop educational and informational materials in order to increase awareness among older adults about vaccines and immunization services.
- Increase advocacy in the community through education of providers (i.e., healthcare providers, WIC staff) by developing and preparing an educational "sound-byte" to be used during patient encounters.
- Collaborate with community services to increase access points to immunizations.
- Educate providers to use reminder recall and the State Immunization Information System for tracking.
- Educate the public about immunization needs.

Objective

Encourage effective management of diabetes

NM Population Indicator

Diabetes hospitalizations rate per 10,000

NM Population Indicator Baseline

13.7 diabetes hospitalizations per 10,000 people in 2011

Story Behind the Data

- Poor eating habits and lack of physical activity can lead to the accumulation of unhealthy weight.
- Being overweight or obese is a risk factor for the development of pre-diabetes and diabetes.
- The relationship between obesity and chronic diseases (including but not limited to diabetes) is a complex web. While obesity may be viewed as a modifiable risk factor for diabetes, socio-cultural, economic, political, environmental, genetic, physiological/biological, and psychological factors all influence obesity at a population and individual level.

- HbA1c is a lab test that shows the average level of blood sugar (glucose) over the previous 3 months; this lab tests indicates how well diabetes is controlled in an individual.
- Interrelated factors, such as inadequate links between healthcare providers (hospital, primary care) or between providers and community programs, and patient fear or denial, can lead to poorly implemented medication or care plans.
- Lack of resources negatively affects access to medications, medical supplies, healthy food, and safe physical activity venues. Cost of medications or specialty care can be barriers to effective prevention of complications or further hospitalization.
- The NMDOH's Diabetes Prevention and Control Program (DPCP) is dedicated to reducing the burden of diabetes in New Mexico by 1) preventing diabetes; 2) preventing complications and disabilities associated with diabetes; and 3) eliminating diabetes-related health disparities. The DPCP works with a variety of health system, organizational, and community partners throughout the state to accomplish these goals.
- The National Diabetes Prevention Program (DPP) is a public-private partnership of community organizations, private insurers, employers, health care organizations, and government agencies. These partners are working to establish local evidence-based lifestyle change programs for people at high risk for type 2 diabetes. The National DPP is a 10-month program, with a 16-week core curriculum followed by 6 post-core sessions (generally once a month for 6 months).
- The NMDOH Rural Primary Health Care Act (RPHCA) Program provides funding to community health centers statewide with the intention of creating positive health outcomes for individuals receiving services from these clinics.

Performance Measure (PHD/P002)

Program Performance Measure	Program PM Baseline	FY15 Target
Percent of patients with diabetes at NMDOH supported community health centers whose HbA1c levels are less than 9%	**68% (Calendar Year 2012)**	**70% (Calendar Year 2013)**

What Works

- Intensive, coordinated management of diabetes and co-morbid conditions by hospital, primary care staff and by individuals and their families.
- Diabetes self-management education in community gathering places for adults and in the home for adolescents.
- Clear, strong coordination and cross-referral among different levels of services (e.g., community-based organizations, health agencies, hospital staff, and specialists) to deliver high-quality care in the community.
- Case management of individuals with diabetes who meet specific risk criteria.
- Disease management, by health care organizations, of their patient populations with diabetes.
- Measuring performance allows an organization to document how well care is currently provided and lays the foundation for improvement. Annually identifying HbA1c values greater than 9 percent among adult patients aged 18 to 75 years allows an organization the opportunity to focus on those patients who are in poor control and at highest risk.

Partners

- Federally Qualified Health Centers
- NM Primary Care Association (NMPCA)
- National Diabetes Prevention Program delivery sites
- Health plans and large worksites
- Aging and Long Term Services Department
- NMDOH Chronic Disease Self Management Program

Strategies

- The Rural and Primary Health Care Act Program collaborates with the New Mexico Primary Care Association and health care organizations to improve tracking and use of A1c results to improve care and clinical outcomes for patients.
- Expand linkages between diabetes education programs throughout NM and NMDOH Chronic Disease Self Management Program.
- Provide disease management, by health care organizations, of their entire patient populations with diabetes.
- Provide case management of individuals with diabetes who meet specific risk criteria.
- Produce consistent guidelines for appropriate diabetes care and for interpretation of clinical lab information.
- Develop treatment plans, and provide patient education at the inpatient and outpatient levels, including use of group education.

Objective

Encourage effective management of diabetes

NM Population Indicator

Diabetes hospitalizations rate per 10,000

NM Population Indicator Baseline

13.7 diabetes hospitalizations per 10,000 people in 2011

Story Behind the Data

- Poor eating habits and lack of physical activity can lead to the accumulation of unhealthy weight.
- Being overweight or obese is a risk factor for the development of pre-diabetes and diabetes.
- The relationship between obesity and chronic diseases (including but not limited to diabetes) is a complex web. While obesity may be viewed as a modifiable risk factor for diabetes, socio-cultural, economic, political, environmental, genetic, physiological/biological, and psychological factors all influence obesity at a population and individual level.
- The HbA1c test is a lab test that shows the average level of blood sugar (glucose) over the previous 3 months; this lab tests indicates how well diabetes is controlled in an individual. [HbA1c means glycated hemoglobin, not the test itself. "When your diabetes is not controlled (meaning that your blood sugar is too high), sugar builds up in your blood and combines with your hemoglobin, becoming "glycated." Therefore, the average amount of sugar in your blood can be determined by measuring a hemoglobin A1c level." From http://diabetes.webmd.com/guide/glycated-hemoglobin-test-hba1c]
- Interrelated factors, such as inadequate links between healthcare providers (hospital, primary care) or between providers and community programs, and patient fear or denial, can lead to poorly implemented medication or care plans.
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- The NMDOH Rural Primary Health Care Act (RPHCA) Program provides funding to community health centers statewide with the intention of creating positive health outcomes for individuals receiving services from these clinics.

Performance Measure (PHD/P002)

Program Performance Measure	Program PM Baseline	FY15 Target
The average weight loss achieved by all National Diabetes Prevention Program participants (a recommended minimum of 5% of starting body weight) from baseline through post-core	**5.8**	**6%**

What Works

- Intensive, coordinated management of diabetes and co-morbid conditions by hospital, primary care staff and by individuals and their families.
- Diabetes self-management education in community gathering places for adults and in the home for adolescents.
- Clear, strong coordination and cross-referral among different levels of services (e.g., community-based organizations, health agencies, hospital staff, specialists) to deliver high-quality care in the community.
- Case management of individuals with diabetes who meet specific risk criteria.
- Disease management, by health care organizations, of their patient populations with diabetes.
- Measuring performance allows an organization to document how well care is currently provided and lays the foundation for improvement. Annually identifying HbA1c values greater than 9 percent among adult patients aged 18 to75 years allows an organization the opportunity to focus on those patients who are in poor control and at highest risk.

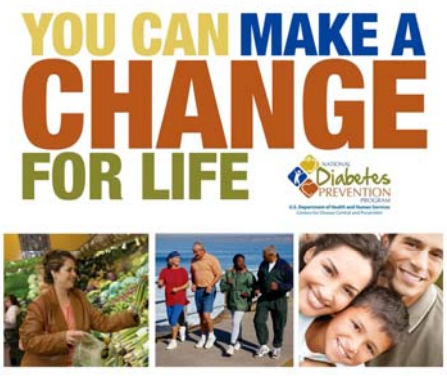
Partners

- Federally Qualified Health Centers
- NM Primary Care Association (NMPCA)
- National Diabetes Prevention Program delivery sites
- Health plans and large worksites
- Aging and Long Term Services Department
- NMDOH Chronic Disease Self Management Program

Strategies

Expand and sustain the National Diabetes Prevention Program (National DPP) by:

- Building infrastructure, including a statewide referral system and cadre of trained lifestyle coaches;
- Marketing the program; and
- Evaluating DPCP's efforts to build a robust National DPP system in NM, which includes all of the above.



Objective

Provide information and support on healthy practices for infants

NM Population Indicator

Percent of WIC recipients that initiate breastfeeding

NM Population Indicator Baseline

77% in 2013

Story Behind the Data

- Obese infants are more likely to be obese adults and suffer from chronic diseases such as heart disease and diabetes.
- Breastfeeding provides health benefits for infants, children, and mothers.
- Research shows that infants who are not exclusively breastfed for the first six months of life are more likely to develop a wide range of chronic and acute diseases, including ear infections, diarrheal diseases, asthma, Sudden Infant Death Syndrome, obesity, and respiratory illnesses.
- Mothers also benefit from breastfeeding with a decreased risk for breast and ovarian cancers.

Performance Measure (PHD/P002)

Program Performance Measure	Program PM Baseline	FY15 Target
Percent of WIC recipients that initiate breastfeeding	**77%**	**82%**

What Works

- The WIC population is at particular risk to not breastfeed and has traditionally had lower breastfeeding rates than the general population. This can be attributed to the additional barriers to breastfeeding that low- and moderate-income women face.
- Peer counselor support has been shown to be effective in improving breastfeeding initiation and duration rates in low-income women in WIC and in women overall. The evidence is clear that a small investment in WIC breastfeeding peer counselors provides a significant return. For all of these reasons, *The Surgeon General's Call to Action to Support Breastfeeding*; the Institute of Medicine report, *Accelerating Progress in Obesity Prevention*; and the *National Prevention Strategy* each call for the support and strengthening of breastfeeding peer support/counseling programs. The NM WIC Program currently has 68 peer counselors working throughout the state.
- Another evidence-based practice that has been proven to help women successfully breastfeed is the Baby Friendly Hospital Initiative. Research shows that when hospitals implement policies such as helping mothers initiate breastfeeding within one hour of birth, allowing babies to stay in the same room with their mothers, and giving infants no food or drink other than breast milk unless medically indicated, allows for more mothers to successfully breastfeed.
- The NM WIC Program is collaborating with the NM Breastfeeding Task Force to promote and support all statewide hospitals to become Baby Friendly certified.

Partners

- United States Department of Agriculture
- Public Health Clinics
- NM Breastfeeding Task Force
- NM PRAMS Project
- Mothers and caregivers of infants

Strategies

- Provide WIC pregnant and breastfeeding mothers with breastfeeding information and support through counseling and group discussion sessions.
- Provide mothers with needed breastfeeding resources and aides, as well as breast pumps to enable them to initiate and continue breastfeeding.
- Use WIC peer counselors to promote breastfeeding and support individual WIC mothers outside of traditional clinic hours through telephone support and follow-up, as well as home and hospital visits.
- Collaborate with the NM Breastfeeding Task Force and other community organizations to provide support for breastfeeding in daycares, worksites, and other public places.

Objective

Reduce the risk of falls in older adults

NM Population Indicator

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

NM Population Indicator Baseline

88 fall-related deaths (per 100,000) among older (65+) adults in 2011

Story Behind the Data

- In NM, falls are the leading cause of injury-related hospitalizations and deaths among adults 65 years and older.
- NM's fall-related death rate among people 65+ years of age and over increased 115% from 1999 to 2008, and decreased 22% from 2008-2010, but increased again in 2011.
- Over 3,100 unintentional fall-related hospitalizations occurred among adults 65+ in 2011.

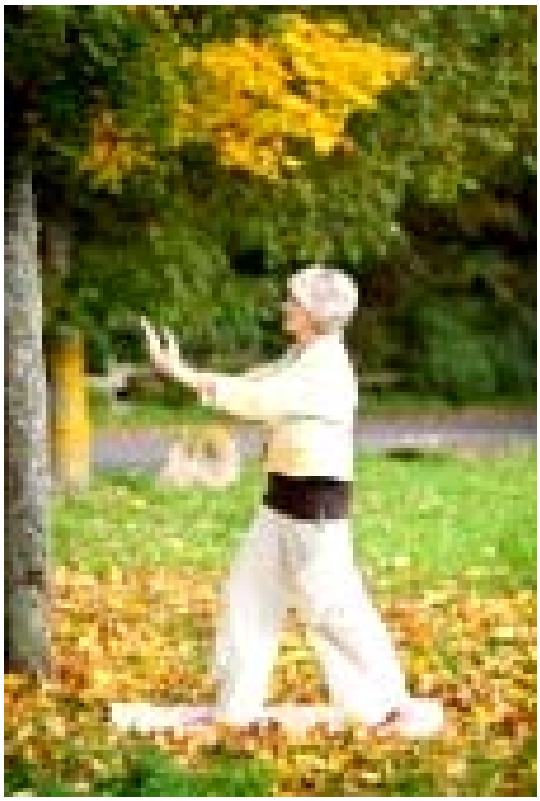
Performance Measure (ERD/P003)

Program Performance Measure	Program PM Baseline	FY15 Target
Number of adults age 65 and older who have completed an evidence-based falls prevention program	**Data development in FY2014***	**To be determined following data baseline**

***The baseline is in the process of being established after first quarter data are received, which is expected to be in October 2013.**

What Works

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



Partners

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

Many new organizations are taking an active role in the coalitions. The expanded members include:

- Webster University
- Central Northern New Mexico University
- Indian Health Services
- Santa Fe Pueblo
- Jemez Pueblo
- Isleta Pueblo
- City of Santa Fe
- City of Albuquerque
- New Mexico Senior Olympics
- Red Cross
- Gentiva
- Presbyterian Hospital
- St. Joseph's Hospital
- the Betty Earhart Senior Center
- ARCA
- Jewish Family Services
- Occupational Therapy Association

Strategies

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

Objective

Prevent prescription overdose deaths

NM Population Indicator

Drug overdose death rate

NM Population Indicator Baseline

25.9 drug overdose deaths per 100,000 persons

Story Behind the Data

- Drug overdose death rates have increased steadily in the United States since 1979. In 2010, New Mexico had the second highest drug overdose death rate in the country.
- Overdose is common among persons who use opioids. The prescription drug overdose death rate has been higher than the illicit drug overdose death rate since 2007.
- Poisoning from drug overdoses has surpassed motor vehicle deaths as the major cause of unintentional injury in New Mexico.
- The Overdose Prevention Training Program (OPTP) was established by the Department of Health, Public Health Division, Harm Reduction Program in 2001 to improve the response to drug overdose through preparing participants or Trained Targeted Responders to respond to possible opioid overdoses, including the provision and administration of naloxone.
- The OPTP program provides overdose prevention education (what is an overdose and what causes an overdose, how overdoses can be avoided, how to identify and properly respond to an opioid overdose, universal safety precautions, rescue breathing, and activating EMS) including the administration of nasal naloxone.
- In 2012, the Department launched pilots in multiple communities around the state in partnership with primary care providers and local pharmacies, whereby patients identified by their providers to be at risk for overdose from their opioid pain medication, are provided (or prescribed) a naloxone rescue kit. While opioid antagonist administration does not automatically guarantee a reversal of the effects of opioid overdose, it is the only definitive care currently available. In addition, the training of opioid users and their peers to prevent, and/or properly respond to an overdose, leads to a decrease in overdose deaths.

Performance Measure (ERD/P003)

Program Performance Measure	Program PM Baseline	FY15 Target
Number of naloxone kits provided in conjunction with prescription opioids	**35**	**350**

What Works

- Screening by health care providers for those with potential drug-related problems.
- Access to overdose prevention education and rescue medication, naloxone.
- Increasing access to behavioral health care and treatment, including school-based health centers.
- Increasing accessibility to medication-assisted therapy, such as methadone or Suboxone.
- Support the Good Samaritan Law.
- Promulgating clinical opioid prescribing guidelines for pain treatment.
- Tracking drug data and overdoses in New Mexico to identify issues related to prescription drugs.
- Implementing comprehensive harm reduction policies and practices statewide, targeting prescription pain medication use/misuse and illicit drug use, including expanded access to overdose rescue medication for all persons at risk of opioid overdose.

Partners

- State agency partners: Human Services Department, including: Office of Substance Abuse Prevention, Medicaid, and Behavioral Health Services Division
- State Epidemiological Outcomes Workgroup
- Tribal Epidemiological Outcomes Workgroup
- Community-based Opioid Overdose Prevention Coalitions; Community-based Contracted Harm Reduction Providers, and County Health Councils
- Local, County, State, and Federal Law Enforcement
- NM Association of Counties
- University of New Mexico: Prevention Research Center; Center for Health Policy; Project ECHO Integrated Addictions; and Psychiatry (IAP) Tele-health Clinic
- PIRE/Behavioral Health Research Center of the Southwest
- NM Drug Policy Alliance

Strategies

- Expanding access to overdose rescue (Naloxone) medications. The number of naloxone kits provided to persons at risk of opioid overdose is a measure of a strategy to attempt to save lives. Use of the kits is expected to reduce prescription opioid overdose deaths. Our primary strategy is to make an opioid antagonist kit (naloxone, a nasal administration device, and instructions) available to people who are at increased risk of prescription opioid overdose. Importantly, the strategy is based upon the delivery of overdose prevention education, within which the naloxone is the final option in a spectrum of steps to reduce risk of overdose.

- The pilots have been organized in collaboration with local community-based prevention planning groups. As such, the Department has supported a number of community-based initiatives in addition to the clinic pilots to include: local law enforcement establishing naloxone carry policy; local public education campaigns and social marketing; and expanded drug take-back initiatives.

Objective

Ensure effective asthma self-management among children

NM Population Indicator

Asthma emergency department (ED) and hospitalization rates of children in South East (SE) New Mexico

NM Population Indicator Baseline

Youth (age 0 -14) asthma ED rate in the SE Region was 90.2 per 10,000 population in 2011. Youth (age 0 -14) asthma hospitalization rate in the SE Region was 23.2 per 10,000 population in 2011

Story Behind the Data

- Emergency department and hospitalization rates are good indicators of the burden of asthma in a community.
- Surveillance data show relatively high asthma hospitalizations and ED visits for children in the Southeastern region of the state.
- Relatively high rates suggest asthma is not adequately managed by healthcare providers, families, and individuals with the disease.
- Other factors contribute to high ED and hospitalization rates, including poor access to healthcare, socioeconomic status, and an adverse environment.

Performance Measure (ERD/P003)

Program Performance Measure	Program PM Baseline	FY15 Target
Percent of children with persistent asthma who show an improvement in their symptoms as a result of asthma self-management education	**Data development in FY2014**	**65%**

What Works

- Asthma self-management education is an effective and economical way to improve asthma symptoms and prevent ED visits and hospitalizations.
- With this method of education, patients learn to: 1) identify and mitigate asthma triggers; 2) use their medication correctly; and 3) recognize and prevent asthma attacks.
- Prior studies show this type of education significantly lowers expensive healthcare utilization and saves money for patients and health insurers.

Partners

- Certified asthma educators and other clinicians on staff at Nor Lea General Hospital

Strategies

- Certified asthma educators working at Nor Lea General Hospital will provide self-management education to children.
- Symptoms will be measured through the Asthma Control Test (ACT), administered by the asthma educator; the educator determines how many visits are necessary to achieve a reduction in symptoms.

Objective

Ensure the provision of quality laboratory practices

NM Population Indicator

Alcohol-Related deaths

NM Population Indicator Baseline

53.7 alcohol-related deaths per 100,000 in 2011

Story Behind the Data

- New Mexico has a relatively high rate of alcohol-related deaths. Excessive alcohol consumption through binge drinking and heavy daily drinking contribute to this high rate.
- SLD Toxicology staff analyze human samples for alcohol (e.g., blood alcohol concentration) and drugs to determine cause of impairment in drivers.
- SLD Toxicology staff analyze cause-of-death toxicology samples from the Office of Medical Investigator (OMI) to determine if alcohol and/or drugs are contributing factors to an individual's death.
- To analyze lab samples, it is critical to exceed published turn-around times to give officials ample time to prepare for court cases.

Performance Measure (SLD/P004)

Program Performance Measure	Program PM Baseline	FY15 Target
Percent of blood alcohol tests from driving-while-intoxicated cases that are completed and reported to law enforcement within 15 working days (AGA)	**95.56%**	**90%**

What Works

- Training keeps analysts up-to-date on current methods.
- Maintaining and updating equipment allows for samples to be analyzed without interruptions.

Partners

- Courts
- Public safety officials (e.g., law enforcement)

Strategies

- Increase staff proficiencies.
- Increase cross-training to ensure staff are always available to analyze samples.
- Implement weekly sample tracking to measure turn-around times.

Objective

Ensure the provision of quality laboratory practices

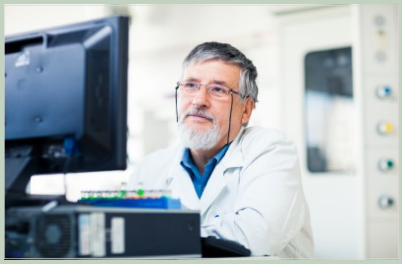
NM Population Indicator

Drug overdose deaths

NM Population Indicator Baseline

25.9 overdose deaths per 100,000 in 2011

Story Behind the Data



- New Mexico continues to have one of the highest drug overdose death rates in the country.
- In recent years the number of deaths due to prescription drugs has increased.
- SLD toxicologists assist the Office of Medical Investigator (OMI) in determining cause of an unexpected death by testing for both illicit and prescription drugs.
- To analyze lab samples, it is critical to exceed published turn-around times to give officials time to prepare death certificates needed for families to file for insurance benefits.
- This measure can indicate when there are competing interests, such as how many scientists are being subpoenaed to give expert witness in court or an increase in driving while impaired either under the influence of alcohol or drugs cases.

Performance Measure (SLD/P004)

Program Performance Measure	Program PM Baseline	FY15 Target
Percent of Office of Medical Investigator (OMI) cause of death toxicology cases that are completed and reported to OMI within 60 calendar days (AGA)	**76.7%**	**90%**

What Works

- Training keeps analysts up-to-date on current methods.
- Maintaining and updating equipment allows for samples to be analyzed without interruptions.

Partners

- Office of Medical Investigator

Strategies

- Increase staff proficiencies.
- Increase cross-training to ensure staff are always available to analyze samples.
- Implement weekly sample tracking to measure turn-around times.

Objective

Ensure the provision of quality laboratory practices

Story Behind the Data

- Rapid identification of diseases, infection, or contamination is integral to the implementation of appropriate and timely public health interventions to prevent further harm.
- Rapid identification is important because there could be select agents (e.g., anthrax), which could be maliciously misused as a weapon of mass destruction.
- Additionally, there could be potential public health endemic agents such as plague, West Nile virus, or Severe Acute Respiratory Syndrome (SARS) carried in ground squirrels, mosquitoes, or birds, respectively.
- Other areas of public health concern regards water (drinking or recreational use), milk, and food safety.
- To analyze lab samples, it is critical to exceed published turn-around times to give officials time to determine the proper course of remedial actions to mitigate contamination, exposure, or illness.

Performance Measure (SLD/P004)

Program Performance Measure	Program PM Baseline	FY15 Target
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	**98.17%**	**95%***

* Industry standard

What Works

- Training keeps analysts up-to-date on current methods.
- Maintaining and updating equipment allows for samples to be analyzed without interruptions.

Partners

- Healthcare facilities
- Epidemiologists
- Public safety officials

Strategies

- Increase staff proficiencies.
- Increase cross-training to ensure staff are always available to analyze samples.
- Implement weekly sample tracking to measure turn-around times.

Objective

Ensure the provision of quality laboratory practices

NM Population Indicator

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

NM Population Indicator Baseline

89.17% in 2013

Story Behind the Data

- Quickly identifying contaminants in the environment is critical in mitigating potential contamination or inadvertent poisoning, which could result in acute illness of people in the same geographical area.
- The Scientific Laboratory Division (SLD) conducts chemical analyses of air, water, and soils in support of the NM Environment Department (NMED) as well as for regulatory purposes by local, tribal, and federal entities which serve to protect the health of New Mexicans.
- It is critical to exceed published turn-around times to give officials ample time to determine the proper course of remedial actions; these actions in turn will mitigate contamination, exposure, or illness.

Performance Measure (SLD/P004)

Program Performance Measure	Program PM Baseline	FY15 Target
Percent of environmental samples for chemical contamination that are completed and reported to the submitting agency within 60 calendar days	**89.17%**	**90%**

What Works

- Training keeps analysts up-to-date on current methods.
- Maintaining and updating equipment allows for samples to be analyzed without interruptions.

Partners

- NM Environment Department
- Environmental Protection Agency
- Municipal/Federal/Tribal water utilities

Strategies

- Increase cross-training to ensure sufficient staff are always available to analyze samples.
- Weekly tracking of sample turn-around times.

Objective

Decrease sexual assault

NM Population Indicator

Number of sexual assaults in New Mexico

NM Population Indicator Baseline

1,338 in 2011

Story Behind the Data

- Sexual assaults are acts of violence where sex is used as a weapon.
- The vast majority of rapes against both women and men remain unreported to police or sexual violence support organizations. In 2009, only 1 in 9.5 adult rapes came to the attention of law enforcement.
- Victims of sexual violence are overwhelmingly female (86% rape victims and 78% victims of non-penetration sex crimes).
- Rape is a crime of opportunity and that opportunity presents itself most often among the vulnerable. In 2011, while 57% of rape victims in law enforcement cases were children and adolescents, greater than three-quarters (82%) of offenders were adults (18 and older).
- According to *Sex Crimes in New Mexico X: An Analysis of 2011 Data from the NM Interpersonal Violence Data Central Repository*, 1,338 incidents of sexual assault were reported to law enforcement in 2011. During that year, 1,978 sexual assault (SA) victims were served by SA service providers, and 1,077 sexually assaulted patients were examined by Sexual Assault Nurse Examiners (SANE).

Performance Measure (ERD/P003)

Program Performance Measure	Program PM Baseline	FY15 Target
Number of people completing a NMDOH-funded sexual assault prevention program	**1,686**	**1,686**

What Works

- Prevention education.
- Training to professionals (e.g., law enforcement, prosecutors, medical staff, school staff, faith community, sexual assault service providers, probation and parole, and corrections staff).
- Education/training programs for students from youth to university.
- Education/training for educators and school staff.

Partners

- NM Sexual Assault Services
- NM Crime Victims Reparation Commission
- NM Coalition of Sexual Assault Program
- Domestic Violence Resources
- CYFD - Domestic Violence
- NM Coalition Against Domestic Violence
- Rape Crisis Center of Central New Mexico
- Community Against Violence (Taos)
- Daybreak Center (Aztec)
- La Pinon Sexual Trauma and Recovery Center (Las Cruces)
- Solace Crisis Treatment Center (Santa Fe)
- Sexual Assault Services of NW New Mexico (Farmington)
- TEWA Women United (Espanola)
- Arise (Roosevelt General Hospital) (Portales)
- Silver Regional Sexual Assault Services (Silver City)
- Aging and Long Term Service Department- Adult Protective Services
- Attorney General's Office
- District Attorneys
- State Police
- Santa Fe Police Dept
- Albuquerque Police Dept
- United Way
- NM Asian Family Center
- Legal Aid Services

Strategies

- Conduct sexual assault prevention programs in class (multiple sessions) settings.
- Network and collaborate to enhance sexual violence prevention efforts with all of partners and other stakeholders.

B. HEALTHCARE

Direct Medical Services: NMDOH Facilities and Services, Public Health Clinics, Emergency Medical Services and New Mexico Health Care System Providers

Result 2
Improved quality, accessibility and utilization of health care services

Objective

Improve the EMS response capability for rural areas of New Mexico

NM Population Indicator

Percent of counties with implementation plans for regionalized EMS Response

NM Population Indicator Baseline

Data development in FY2014

Story Behind the Data

- The purpose of the Emergency Medical Services Act [24-10B-1 NMSA 1978] is to enhance and regulate a comprehensive emergency medical services system in the state as set forth in that act.
- The EMS Bureau is charged with meeting the statutory responsibility of the EMS Act, which states that the bureau is designated as the lead agency for the emergency medical services system and shall establish and maintain a program for regional planning and development, improvement, expansion, and direction of emergency medical services throughout the state.

- Getting adequately trained personnel to the scene as soon as safely possible is a primary goal of EMS response. There are multiple hindrances to this including availability of EMS personnel in rural New Mexico and availability of equipment and training.
- Once a call for assistance is received by a 911 center, and while Emergency Medical Dispatch instructions are being given, first response medical rescue units are dispatched. In rural/frontier areas, these are almost always volunteer, fire department based rescue entities. As simultaneously as possible, a PRC approved EMS ambulance transport is also dispatched.
- Assuring this response in the rural areas often fell to the local community level. This has historically led to a fragmentation of EMS resources, as community EMS response evolved from individual community based volunteer fire systems.
- Even within county governments, "fire districts" are often treated as near independent quasi-governmental entities. While mutual aid agreements between districts are commonplace, there is still a fragmentation and distribution of resources that are redundant and inefficient. Ideally, the county governments can be encouraged to regionalize their multiple fire district structure into a single administrative entity, or create a separate county based "third service" EMS response agency.

Performance Measure (ERD/P003)

Program Performance	Program PM Baseline	FY15 Target
Percent of counties with documented implementation plans for developing regionalized EMS Response	**Data development in FY14**	**27%**

What Works

- Developing a unified command structure, unified medical direction, and common treatment guidelines/protocols.
- Developing standard operating procedures and equipment for emergency response.

Partners

- EMS Regional Offices
- County EMS Chiefs
- EMS Agencies

Strategies

- Develop more efficient regional response plans, including consolidation of administration, personnel, and equipment.

Objective

Improve trauma care at developing and existing trauma centers

NM Population Indicator

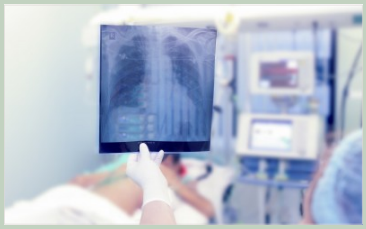
Percent of Acute Care Hospitals with Trauma Center Designation

NM Population Indicator Baseline

60% in FY2013

Story Behind the Data

- There are forty-four acute care hospitals in New Mexico. The following represents the number of Designated Trauma Centers in the State:
  - 1 – Level 1
  - 5 – Level 3
  - 4 – Level 4
  - 3 – Developing



- There are specific programs required by the American College of Surgeons, designed for and presented to trauma nurses and physicians who respond to trauma activations. These have been proven to decrease mortality and morbidity of trauma patients, through recognition of injury, followed by rapid intervention and definitive trauma treatment.
- It is anticipated that tracking the increased trauma education throughout the State will be shown to decrease mortality and morbidity, as it has in other states.

Performance Measure (ERD/P003)

Program Performance	Program PM Baseline	FY15 Target
Percent of emergency department and intensive care unit licensed staff at developing and existing trauma centers who have received training in traumatic injury care	**60%**	**80%**

What Works

- Trauma education has been proven to show a decrease in mortality and morbidity for trauma patients who are seen at designated trauma centers.

Partners

- Acute Care Hospitals in New Mexico
- EMS Agencies
- NM Hospital Association
- Trauma Advisory and System Stakeholder Committee

Strategies

- Gather data on trauma education for licensed personnel in the emergency department and intensive care units at developing and existing trauma centers, to track the increase in trauma education at these facilities, which may correlate with improved trauma care.

Objective

Improve care for patients suffering from a stroke by increasing the percentage of hospitals reporting data to a national registry

NM Population Indicator

Percent of Acute Care (AC) hospitals that are certified stroke centers

NM Population Indicator Baseline

6.8% (3 of 44) of AC hospitals certified as stroke centers in 2012

Story Behind the Data

- According to Department of Health (NMDOH) data, stroke is a leading cause of death in New Mexico, and killed 577 New Mexicans in 2012.
- Those who do survive a stroke often suffer lifelong disability.
- Legislation was passed in 2012, which enacted a new section of the Public Health Act to provide for department of health certification of hospitals as stroke centers.
- Stroke center designation cannot be awarded until stroke data is being submitted to the national registry, which will enable facilities to analyze and improve health care outcomes in stroke patients.

Performance Measure (ERD/P003)

Program Performance	Program PM Baseline	FY15 Target
Percent of acute care hospitals reporting stroke data into the approved national registry	**6.8%**	**13.6%**

What Works

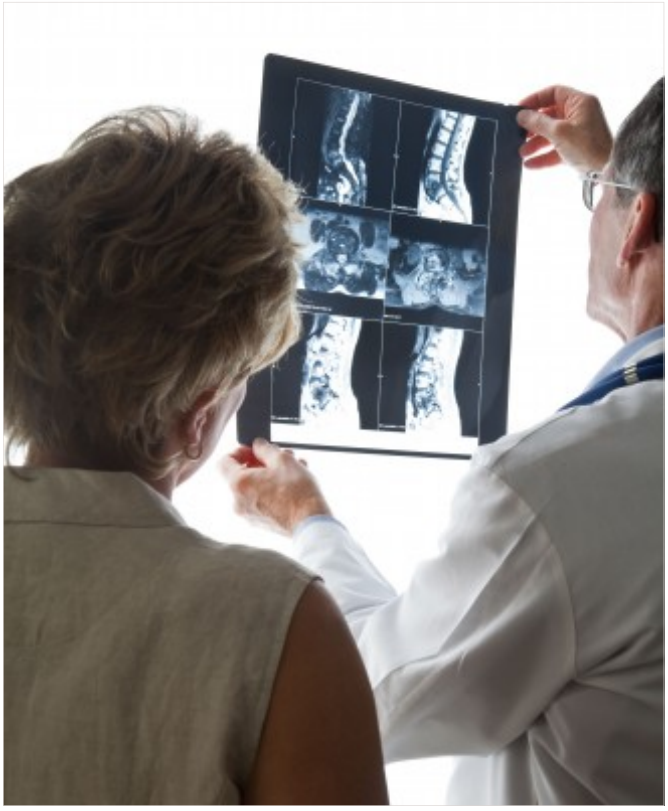
- A hospital obtaining stroke center accreditation and certification has many benefits for the community, including assurance that the hospital adheres to stroke prevention and treatment measures that have been agreed upon by the American Heart and Stroke Associations, the Centers for Disease Control and Prevention, and the Joint Commission.
- Adherence to stroke prevention and treatment measures reduces disability and death associated with stroke.
- Additionally, accreditation and certification will help assure that the hospitals are appropriately reimbursed by Medicare, Medicaid, and third party payers for the improved care delivered to stroke patients.

Partners

- Acute Care Hospitals in New Mexico
- EMS Agencies
- American Heart and Stroke Associations

Strategies

- Collect data on stroke patients in accordance with national guidelines, which will assist in analyzing the potential for facilities to become stroke receiving or referring facilities.
- Analyze data on stroke patients in accordance with national guidelines, which will improve health care outcomes in stroke patients.
- Once data is being submitted, NMDOH will work with the hospitals in achieving other aspects required for stroke center designation. The NMDOH will then, in accordance with NMDOH rules, certify an acute care hospital as a Primary Stroke Center, Comprehensive Stroke Center, or Acute Stroke Capable Center, if the hospital has been accredited at that level by the Joint Commission.



Objective

Improve care for heart attack patients

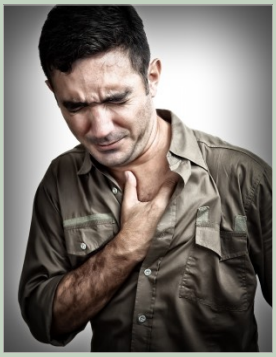
NM Population Indicator

Percent of acute care hospitals with Certified S-T Elevation Myocardial Infarction (Heart Attack) Centers

NM Population Indicator Baseline

2.3% (1 of 44) AC hospitals Certified as S-T Elevation Myocardial Infarction (Heart Attack Centers) in 2012

Story Behind the Data



- Over 3, 000 New Mexicans die every year from cardiovascular disease.
- Currently, the NMDOH does not have access to detailed statewide data for heart attack patients, such as level of care provided at various hospitals, how long it took to receive that care, the number of patients needing transfer to higher levels of care for these specific conditions, and other aspects of heart attack care.
- Only a few hospitals in New Mexico are entering heart attack data into the national heart attack (AMI/STEMI) database, and the Epidemiology and Response Division (ERD) does not currently have access to these datasets. The more hospitals that are entering the data, the better picture of heart attack care we can obtain, allowing ERD and the Emergency Medical Systems Bureau to identify areas of potential improvement in heart attack patient care and outcomes via education and system development.
- Legislation was passed in 2013, which enacted a new section of the Emergency Medical Services Act to provide for Department of Health certification of hospitals as S-T Elevation Myocardial Infarction (Heart Attack) centers.
- STEMI center designation cannot be awarded until cardiac care data is being submitted to the national registry.
- There are forty-four (44) acute care hospitals in New Mexico, currently 4 are submitting cardiac data:
    - UNMH
    - Heart Hospital (Lovelace)
    - Memorial
    - Presbyterian

Performance Measure (ERD/P003)

Program Performance	Program PM Baseline	FY15 Target
Percent of acute care hospitals reporting heart attack care data into the approved national registry	**9.1%**	**13.6%**

What Works

- Like all heart attacks, STEMI is caused by a blockage in the blood vessels that provide oxygen and nutrients to the heart muscle. Primary treatment for STEMI entails eliminating the blockage in the blood vessel, which is called "reperfusion". Reperfusion is most commonly performed through a specialized medical procedure called a percutaneous coronary intervention (PCI).
- Only a minority of U.S. hospitals are capable of performing PCI on an emergency basis. Any delay in receiving PCI can increase the risk of dying from STEMI. Indicate evidence that heart attack care data analysis improves patient outcomes.
- The American Heart Association recommends a multifaceted community-wide approach that involves patient education, improvements in emergency medical system and emergency department care, establishment of networks of STEMI-referral (non-PCI-capable) and STEMI-receiving (PCI-capable) hospitals, and coordinated advocacy efforts to work with payers and policy makers to implement healthcare system redesign.

Partners

- Acute Care Hospitals in New Mexico
- EMS Agencies

Strategies

- Collect data on heart attack patients in accordance with national guidelines, which will assist in analyzing the potential for facilities to become STEMI receiving or referring facilities.
- Analyze data on heart attack patients in accordance with national guidelines, which will improve health care outcomes in heart attack patients.
- Once data is being submitted, the NMDOH will work with the hospitals in achieving other aspects required for STEMI center designation. The NMDOH will then, in accordance with NMDOH rules, certify an acute care hospital as a STEMI Receiving Center, or STEMI Referral Center if the hospital has been accredited at that level by the NMDOH approved accrediting agency.

Objective

Ensure access to hospital treatment in response to a healthcare emergency

Story Behind the Data

- For a healthcare emergency response resulting in a medical surge on the hospital system, the ability to know the location of available healthcare beds is critical to get patients into necessary and appropriate treatment.
- The National Hospital Available Beds for Emergencies and Disasters (HAvBED) system is a real-time, electronic hospital bed tracking/monitoring system to address a hypothetical surge of patients during a mass casualty event. The HAvBED system has been used in actual, adverse events (*i*.e. adverse weather, and wildfires) in other states and in the Southwest region during a neonatal bed shortage in New Mexico.
- The HAvBED system is tested on a weekly basis across all healthcare facilities in New Mexico.

Performance Measure (ERD/P003)

Program Performance Measure	Program PM Baseline	FY15 Target
Percent of hospitals reporting bed availability in the healthcare emergency preparedness bed reporting system within four hours of request	**81%**	**75% (Federal target)**

What Works

- EMResource is a communications and resource management tool that streamlines communications between medical response teams and healthcare providers by monitoring healthcare assets, emergency department (ED) capacity, and behavioral health and dialysis bed status.
- EMResource tracks incident-specific resources that are easily tracked, such as decontamination capability, ventilators, pharmaceuticals, and specialty services.
- Weekly drills allow for healthcare facilities to become comfortable with the use of the HAvBED system.
- Up-to-date healthcare facility information on a web-based system allows us to better manage emergencies involving healthcare needs across the state.

Partners

- Emergency Medical Services
- Hospitals
- Ambulance services
- Emergency Managers
- Office of Medical Investigation
- Long-term Care facilities
- Primary Care facilities

Strategies

- Train hospital personnel on the HAvBED reporting system with EMResource to monitor hospital reporting performance.
- Conduct periodic exercises and drills and evaluate performance.
- Ensure each health care facility personnel have access to and training with EMResource.

Objective

Insure maximum use of facility resources

NM Population Indicator

New Mexico Department of Health Facilities which are accredited by the appropriate accrediting agency

NM Population Indicator Baseline

43% (3 of 7) of NMDOH facilities accredited in 2012

Story Behind the Data

- Joint Commission accreditation and certification is recognized nationwide as a symbol that reflects an organization's commitment to provide high quality health care and improved patient outcomes.
- The facilities operated by the Department of Health provide programs to New Mexicans who may not otherwise be able to receive mental health, substance abuse, nursing home care or rehabilitation services.

Performance Measure (Facilities/P006)

Program Performance	Program PM Baseline	FY15 Target
Percent of staffed beds filled at all facilities (AGA)	**86.7%**	**90%**

What Works

- Maintain responsive communication with referral sources and judicial systems for creating fluid admission processes.
- Sustaining optimal staffing levels in NMDOH facilities.

Partners

- CYFD
- State District Courts
- Third Party Payers
- Referral Agencies
- Veterans Administration
- Community Based Services
- Facility employees

Strategies

- Work to strengthen ties and improve response times with the referral sources to improve and optimize facility admissions.

Objective

Provide quality patient care

NM Population Indicator

Percent of New Mexico Department of Health Facilities accredited by the appropriate accrediting agency

NM Population Indicator Baseline

43% (3 of 7) of NMDOH facilities accredited in 2012

Story Behind the Data

- Accreditation and certification are recognized nationwide as symbols that reflect an organization's commitment to provide high quality health care and improved patient outcomes.
- The facilities operated by the Department of Health provide programs to New Mexicans who may not otherwise be able to receive mental health, substance abuse, nursing home care or rehabilitation services.
- The population at high risk for pressure ulcers is based on a composite score defined by the Centers for Medicare and Medicaid Services (CMS) involving impaired mobility and nutritional status.

Performance Measure (Facilities/P006)

Program Performance	Program PM Baseline	FY15 Target
Percent of Long Term Care (LTC) residents with health care acquired pressure ulcers	**7.3% (Average)** **Fort Bayard -6.1%** **NMBHI – 7.7%** **NMSVH-8.0%**	**6.4% (Average)**

What Works

- Health facility accreditation status ensures that facilities are more likely to provide services according to a set of nationally recognized standards of care.
- Following best practices including assisted turning to increase mobility, ensuring good nutrition, and attentive skin care.
- Training for staff on the prevention of pressure sores.

Partners

- Centers For Medicare and Medicaid Services
- The Joint Commission Accreditation
- Health Facility Licensing
- Facility employees

Strategies

- The measure would demonstrate best practices related to prevention and quality patient care. This measure may also be correlated with staffing effectiveness.
- Continue to collect, report, and analyze data on pressure ulcers to Centers for Medicaid and Medicare.
- Maintain Joint Commission Accreditation for those facilities currently accredited.
- Seek, attain, and maintain appropriate accreditation for those facilities not currently accredited.

Objective

Provide quality patient care

NM Population Indicator

Percent of New Mexico Department of Health Facilities accredited by the appropriate accrediting agency

NM Population Indicator Baseline

43% (3 of 7) of NMDOH facilities accredited in 2012

Story Behind the Data

- Accreditation and certification are recognized nationwide as symbols that reflect an organization's commitment to provide high quality health care and improved patient outcomes.
- The Centers for Medicare and Medicaid Services (CMS) manual describes falls with major injury as: bone fractures, joint dislocations, closed head injuries with altered consciousness, and subdural hematomas.
- The Department of Health (NMDOH) provides programs to New Mexicans who may not otherwise be able to receive mental health, substance abuse, nursing home care or rehabilitation services.

Performance Measure (Facilities/P006)

Program Performance	Program PM Baseline	FY15 Target
Percent of long term care residents experiencing one or more falls with injury (AGA)	**4.2% (Average) Fort Bayard – 3.9% NMBHI – 4.4% NMSVH – 4.2%**	**3.3% (Average)**
Percent of rehabilitation patients experiencing one or more falls with injury (AGA)	**NMRH – 2.04/1000 (patient days)**	**2/1000 (patient days)**

What Works

- Health facility accreditation status ensures that accredited facilities are more likely to provide services according to a set of nationally recognized standards of care.
- Fall risk assessment.
- Training and education for facility staff on the prevention of fall-related injury.

Partners

- Centers For Medicare and Medicaid Services
- The Joint Commission or appropriate accrediting agency
- Health Facility Licensing and Certification, Department Of Health
- Facility employees

Strategies

- Implement effective fall prevention plans, including staff and resident education in NMDOH facilities.
- Improve patient fall risk assessment processes.
- Continue to collect, report, and analyze data on falls with injury to Centers for Medicaid and Medicare.
- Improvement fall prevention performance by using analysis findings to make improvements.
- Maintain Joint Commission Accreditation for those facilities currently accredited.
- Seek, attain, and maintain appropriate accreditation for those facilities not currently accredited.

Objective

Provide quality patient care

NM Population Indicator

Percent of New Mexico Department of Health Facilities accredited by the appropriate accrediting agency

NM Population Indicator Baseline

43% (3 of 7) of NMDOH facilities accredited in 2012

Story Behind the Data

- Accreditation and certification is recognized nationwide as a symbol that reflects an organization's commitment to provide high quality health care and improved patient outcomes.
- The facilities operated by the Department of Health provide programs to New Mexicans who may not otherwise be able to receive mental health, substance abuse, and nursing home care or rehabilitation services.
- Communicating with and sending care information to the next level of care supports the idea that the patient/client/resident is being appropriately discharged and that the receiving agency has all the information they need for continuing care.

Performance Measure (Facilities/P006)

Program Performance	Program PM Baseline	FY15 Target
Percent of behavioral health patients' medical records transmitted to the next level of care within 5 calendar days	**42.8%**	**80%**

What Works

- Health facility accreditation status ensures that facilities are more likely to provide services according to a set of nationally recognized standards of care.
- Beginning discharge planning at the time of admission.
- Good communication with receiving agencies will assist with better aftercare and may prevent readmissions.

Partners

- Joint Commission
- Centers for Medicare and Medicaid Services
- Receiving agencies

Strategies

- Maintain Accreditation for those facilities currently accredited.
- Seek, attain, and maintain appropriate accreditation for those facilities not currently accredited.
- Transfer of medical records in a timely fashion to ensure continuity of care for NMDOH behavioral health clients.

Objective

Improve access to services for individuals with developmental disabilities

NM Population Indicator

Wait time for appropriate developmentally disabled services

Story Behind the Data

- The Developmental Disabilities Waiver (DDW) program serves as an alternative to institutional care and is designed to provide services and support to allow eligible individuals with intellectual/developmental disabilities (I/DD) to participate as active members of their community. An average of 300 people per year are added to the Developmental Disabilities (DD) waiver Central Registry. This means 300 people need to receive an allocation every year just to keep the Central Registry at the same number of people. The Central Registry will not be reduced unless more than 300 people receive an allocation annually.
- Addition of Supports Intensity Scale (SIS)® assessments and changes in procedures at the Income Support Division (ISD) have added to timeframes between receipt of Primary Freedom of Choice and Confirmation of Eligibility and then ISP approval.
- *Mi Via* ("my way") is a new program that provides choices of goods and services to DDSD participants. Also, participants have a key role and responsibility in developing a flexible Service and Support Plan that meets their needs. The choice of *Mi Via* shifts responsibility to the individual/family for designating level of care and for completing the service planning process.
- The Central Registry (CR) contains several status categories reflecting applicants' progress in the application/allocation process. Cases in these status categories comprise the total reported CR "Wait List". The CR status categories are:
    - **Start Status:** An applicant has submitted an application for DD waiver services but verification of intellectual/development disability (I/DD) has not been completed. (About two-thirds of applicants in this category will not match the definition of I/DD and, as a result, will be moved to the Pending Status category or be closed.)
    - **Pending Status:** Reserved for applications of children younger than age eight who have a confirmed specific related condition but do not have documentation of substantial functional limitations in three or more areas of life activities.
    - **Completed Status:** Applicants who: have completed the application process; match the definition of intellectual/developmental disability; and are waiting for allocation.
    - **Allocation on Hold:** This status is for persons who have been offered allocation to the DD waiver and have chosen to not accept an allocation currently.

Performance Measure (DDSD/P007)

Program Performance	Program PM Baseline	FY15 Target
Number of individuals on the developmental disability waiting list (AGA/Explanatory)	**6,205**	**N/A**
Percent of developmental disabilities waiver applicants who have a service plan in place within ninety days of income and clinical eligibility (AGA)	**83%**	**93%**
Number of individuals on the developmental disabilities waiver receiving services (AGA/ Explanatory)	**3,829**	**N/A**

What Works

- Reviewing status reports to determine if systemic or case-specific problems are encountered during the process of eligibility determination.
- Providing technical assistance in job development and training.
- Maintaining contact information for registrants.
- Improving awareness of DD definition and documentation requirements to applicants and providers.
- Evaluating standards used for processing applications and allocations.
- Communicating with providers on prioritizing allocation of individuals to the waiver.
- Providing trainings on the allocation process to case managers and DDSD staff.
- Increasing provider capacity.
- Increasing awareness of services for individuals with developmental disabilities.
- Improving case management services to provide information regarding different types of available services.
- Screening to ensure applicants meet the DD definition.
- Referring individuals with mental health issues to behavioral health system.
- Improving communication with applicants to ensure awareness of eligibility requirements.
- Improving the CR to categorize registrants and gather information on demographics and types

Partners

- Human Services Division's (HSD) Medical Assistance Division (MAD)
- Human Services Division's (HSD) Income Support Division (ISD)
- Molina, Third Party Assessor (TPA)
- Healthcare providers, parent support groups, and case managers
- HSD *Mi Via*
- NMDOH's Vital Records
- Community Providers
- Case Management Agencies

Strategies

- Create a more up-to-date and robust Central Registry database.
- Streamline *Mi Via* to make it easier for individuals and their families to complete the application more independently.
- Reinstitute annual "keeping in touch" mailings to maintain current contact info and determine when people move out-of-state, decease, or decide they are no longer interested in services.
- Create automatic crosswalk with Vital Statistics to identify deaths.
- Participate in bi-weekly meetings with MAD and ISD representatives to: review the DD waiver allocation process; identify barriers; and troubleshoot potential problems.
- Continue weekly internal DDSD allocation meetings to maintain the momentum of moving individuals through the allocation process and ensure we are meeting our timelines.
- Develop pre-services work, assessment, allocation eligibility, and case management a year early so that individuals complete as much of the eligibility process as possible.
- Collaborate with the MAD, the ISD and Molina to identify roles and responsibilities of each party, including individuals/guardians.
- To maximize the number of individuals who enter and receive services, DDSD sent letters of interest on based on the projected number of new allocations.
- Request of the American Association on Intellectual and Developmental Disabilities (AAIDD) to expand their capacity to conduct SIS® assessments for new allocations.
- Assess regional provider capacity based on regional waiting list and provider areas of interest.
- Assess state capacity based on program capacity estimates and information technology evaluation.

Objective

Improve access to services for individuals with developmental disabilities

NM Population Indicator

Percent of adults receiving developmental disabilities day services who are engaged in community-integrated employment

NM Population Indicator Baseline

30% in 2013

Story Behind the Data

- Individuals with intellectual/developmental disabilities experience greater levels of unemployment, underemployment, low wages, and poverty compared to those without disabilities.
- Our state has made steady progress in increasing outcomes and performs above the national average, but strives to be included in the group of states exhibiting increased successful employment outcomes.

Performance Measure (DDSD/P007)

Program Performance	Program PM Baseline	FY15 Target
Percent of adults receiving developmental disabilities day services who are engaged in community-integrated employment (AGA)	**30%**	**33%**

What Works

- Eligibility workers access the state process applications within timelines. Eligibility workers also process promptly case closures and other changes.
- Status reports are reviewed to determine if systemic or case-specific problems are encountered during the process of eligibility determination.
- Providing technical assistance in job development and training.

Partners

- Division of Vocational Rehabilitation
- Supported Employment Leadership Network
- Employment First NM
- Local business owners
- National Supported Employment Network

Strategies

- Collaborate with consultants, Division of Vocational Rehabilitation (DVR), and regional community inclusion coordinators in areas of job development and technical assistance to train and assist providers.
- Assist providers and interdisciplinary teams (IDT) to plan effectively using new service standards and service options.
- Continue to schedule and conduct local Employment Leadership Network meetings to support employment efforts among providers, employers, and individuals served.
- Continue and enhance monitoring provider performance data and provide assistance or intervention as needed.
- Work closely with stakeholders to develop employment First New Mexico (enhanced Institute) to build a sustainable system expertise and local networks to support employment.

Objective

Ensure the quality of health care community-based programs and health care facilities

NM Population Indicator

Number of consumers receiving community-based services that are abused, neglected, exploited, and/or perpetrated by paid caregivers

NM Population Indicator Baseline

475 cases of confirmed abuse, neglect and/or exploitation in FY2013

Story Behind the Data

- To protect consumers that receive community-based services from abuse, neglect, and exploitation perpetrated by paid caregivers, home and community-based service providers are required to file Incident Reports (IR) of abuse, neglect, exploitation and other reportable incidents with the Incident Management Bureau (IMB), as required by regulation.
- Covered populations include people served through the following programs: Developmental Disabilities (DD) Waiver; Medically Fragile Waiver; Family, Infant, Toddler Program (FIT); DD State General Fund; Traumatic Brain Injury Crisis Interim Fund; and some people served through the DD *Mi Via* Waiver. Incidents reported will include: abuse, neglect, exploitation, death, emergency services, law enforcement, and environmental hazards.
- Factors that may impact the actual number of incidents received may include: the number of individuals receiving services, the number of enrolled providers, and the number of incidents that occur.
- Two of the most significant factors impacting the performance measure are: the increase in the reporting of alleged cases of abuse, neglect and exploitation; and the number of vacant investigator positions.
- To address these issues, the NMDOH Division of Health Improvement (DHI) implemented a work plan to complete timely investigation and meet the Jackson Lawsuit recommendations. In addition, DHI has implemented an aggressive recruitment and retention plan to attract and retain quality investigators.

Performance Measure (DHI/P008)

Program Performance Measure	Program PM Baseline	FY15 Target
Percent of abuse, neglect and exploitation incidents for community-based programs investigated within forty-five days (AGA)	**FY12 95.6%** **FY13 89.9%**	**95%**

What Works

- Adequate staff resources.
- Triage incident reports to determine priority, severity, and assignment of cases.
- Provide training and education opportunities to staff working at community-based provider agencies on how to avoid abuse, neglect, and exploitation.
- Provide training to investigators on investigative core competencies.

Partners

- Developmental Disabilities Supports Division
- Aging and Long Term Services (ALTSD)
- Jackson Compliance Administrator experts and consultants
- Adult Protective Services
- Children's Protective Services

Strategies

- The DHI IMB is working diligently to fill vacant investigator positions and to retain quality investigators.
- Collaborate with Adult Protective Services, Children's Protective Services, and Ombudsman program to provide support and advice on how to reduce abuse, neglect, and exploitation incidents.
- Implementation of the Jackson Lawsuit recommendations for systems improvement.
- Develop and implement investigative core competency training.
- Expand the number of investigators to address high case loads.

Objective

Ensure the quality of health care community-based programs and health care facilities.

NM Population Indicator

Percent of report of findings transmitted to provider within twenty business days of survey exit

Program Performance Measure Baseline

50.8% in 2013

Story Behind the Data

- Community program surveys help ensure that individuals are receiving the necessary services and supports as identified in their Individual Service Plan (ISP) in order to achieve desired outcomes.
- The purpose of community provider surveys is to monitor compliance with state and federal regulations, statutes, standards, and policies in order to protect the health and safety of people served. The Division of Health Improvement's (DHI) Quality Management Bureau (QMB) conducts compliance surveys of community based providers for the following services: the Developmental Disabilities Waiver (DDW); Medically Fragile Waiver (MFW); the Family Infant Toddler (FIT) program; Behavioral Health Services (BHS); Community Mental Health Centers (CMHC) and Comprehensive Community Support Services (CCSS).
- The frequency of provider surveys is based on their historical and current performance or service type. For example, the DDW, MFW, and FIT providers are surveyed based on the previous determination of compliance, Compliance with Conditions of Participation (3 years), Partial compliance with Conditions of Participation (2 years), and Noncompliance with Conditions of Participation (1 year). The BHS surveys are conducted on an 18-24 month review cycle for each service, CMHC, and CCSS.
- Providers must develop and implement a Corrective Action Plan for all citations of noncompliance. This Corrective Action Plan is verified by the QMB.
- Several factors have impacted this performance measure in the past year FY13, including: increasing sample sizes of each survey based on agency growth, some agencies had a higher volume of finding, requiring additional time to write the report. Participation of Surveyor staff in the Jackson Community Practice Review has also impacted available writing time. New QMB surveyors are still learning how to become more proficient in completing reports.

Performance Measure (DHI/P008)

Program Performance Measure	Program PM Baseline	FY15 Target
Percent of report of findings transmitted to provider within twenty business days of survey exit	**50.8%**	**95%**

What Works

- Training and mentoring for new surveyors and team leads to become more proficient and efficient in the survey process.
- QA/QI processes to evaluate the efficiency of the survey process.

Partners

- Community providers,
- Developmental Disabilities Supports Division,
- Human Services Division

Strategies

- QMB is working diligently fill vacant surveyor positions and retain quality surveyors.
- QMB is implementing on-going training and mentoring for new surveyors and team leads to become more proficient and efficient in the survey process.
- QMB implements on-going QA/QI processes to evaluate the efficiency of the survey process.
- QMB uses effective communication and team building.

Objective

Ensure the quality of health care in community-based programs and health care facilities

NM Population Indicator

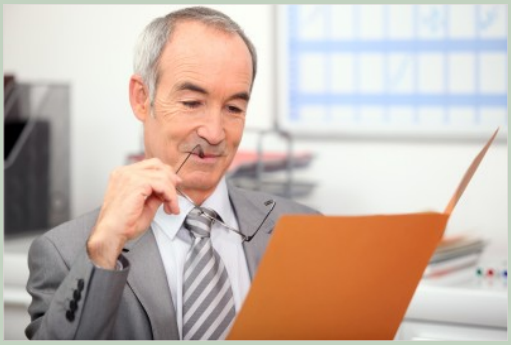
Percent of Centers for Medicare and Medicaid Services 2567 Report/Statement Deficiencies for facility surveys completed ' and distributed within 10 days from survey exit

Program Performance Measure Baseline

15% in 2013

Story Behind the Data

- The Department of Health assures safety and quality care in New Mexico's health care facilities in collaboration with consumers, providers, advocates and other agencies. Through these programs, the Department of Health ensures provider compliance with state and federal standards as it:
  - Conducts health facility surveys, incident investigations and program reviews;
  - Takes appropriate actions for non-compliance with standards; and,
  - Identifies trends and patterns as an educational and compliance tool for providers.



- The timeliness of the survey results allows the facility to stop adverse events that could potentially harm or continue to harm the residents.
- A considerable factor in the low number of this performance measure has been the on-going vacancies at DHI-HFLC. To address this concern, DHI has implemented a work plan to complete timely survey reports and an aggressive recruitment and retention plan to attract and retain quality surveyors.

Performance Measure (DHI/P008)

Program Performance Measure	Program PM Baseline	FY15 Target
Percent of Centers for Medicare and Medicaid Services (CMS) 2567 Report/Statement of Deficiencies for facility surveys completed and distributed within 10 days from survey exit	**15%**	**95%**

What Works

- Appropriate staffing.
- Well trained staff.
- Division of responsibilities.
- Review and streamlining the process.

Partners

- Providers
- Advocates, and consumers
- NM Health Care Association
- New Mexico Association of Home and Hospice Care

Strategies

- Appropriate staffing allows Health Facility Licensing and Certification (HFL&C) staff to survey one week and write a report the following week.
- Teams will be split up at the beginning of the next onsite survey. Surveyors with deficiencies to write will stay behind at the office the first two days while the remainder of the team goes onsite to start the next survey. The surveyors will join their team on survey once the deficiencies are written.
- HFL&C has adapted the number of reviews a 2567 goes through before being sent out to the provider to shorten the timeframe from exit to receipt by the provider.
- HFL&C is developing and implementing a Quality Improvement Plan to identify and implement additional strategies.

Objective

Ensure the quality of health care community-based programs and health care facilities

NM Population Indicator

Percent of facility building plan compliance reviews completed and distributed with 20 days from the date a complete packet is received

Program Performance Measure Baseline

75% in 2013

Story Behind the Data

- Part of the licensure process is to ensure that residential facilities are providing safe environments for patients. Facility building plan reviews are completed by members of the life safety survey team to ensure that safety standards are being met.
- For the last 5 years, 100% of the plan reviews of health care facilities have met the required safety regulations, codes and guidelines standards for infection control, ventilation and safety.
- However, plan review staff was not able to review submitted facility plan packets within the expected timeframe. Life safety code survey team vacancies, cumbersome internal processes, a constraint that plans be submitted in hard copy rather than email, delays in communication with architects, and miscommunication between facility administrators and their architects contributed to the lack of timely turn-around.
- To address this concern, DHI has implemented a work plan to complete timely survey reports and an aggressive recruitment and retention plan to attract and retain quality surveyors.

Performance Measure (DHI/P008)

Program Performance Measure	Program PM Baseline	FY15 Target
Percent of facility building plan compliance reviews completed and distributed with 20 days from the date a complete packet is received	**75%**	**95%**

What Works

- Allowing building plans revisions/updates to be submitted by email when possible.
- Sending all correspondence to both the facility administrator and the architect.
- Aggressively recruiting to fill the manager/ architect vacancy.
- Cross-training so surveyors can review plans and plan reviewers can survey.
- Communicating more effectively with architects and facility administrators.
- Carefully tracking turn-around times between plan submission and responses from plan reviewers.

Partners

- Centers for Medicare and Medicaid Services (CMS)
- local authorities having jurisdiction
- facility architects, facility administrators
- New Mexico Health Care Association
- New Mexico Association for Home and Hospice Care

Strategies

- Looking at reviewing plans electronically and having virtual preliminary meetings via audio and visual on the computer.
- Reduce time between submission of plans, review and licensure by continuously collecting and analyzing data to determine inefficient processes and developing and implementing quality improvement initiatives to correct them.

Objective

Ensure timeliness and good customer service in the medical cannabis

NM Population Indicator

Complete applications approved or denied within thirty days of receipt

Program Performance Measure Baseline

85% in 2013

Story Behind the Data

- Timely review of applications is important in order to provide qualified patients and primary caregivers the protection afforded by the Lynn and Erin Compassionate Use Act, including NMDOH regulations and safe access to medical cannabis.
- To ensure compliance with the Lynn and Erin Compassionate Use Act and Department of Health regulations and to keep up with applications resulting from the steady growth in qualified patients, all staff participate in the application review process.
- The New Mexico NMDOH Medical Cannabis Program has continually expanded since implementation in 2007.
- Per existing statute an applicant must complete a medical certification annually to continue program participation. A significant amount of NMDOH staff time is required to process applications and to provide other types of customer service.
- Many applications are submitted with incomplete information.

Performance Measure (Med Cannabis/P787)

Program Performance	Program PM Baseline	FY15 Target
Percent of complete medical cannabis client applications approved or denied within thirty days of receipt	**85%**	**90%**

What Works

- Enable electronic applications to reduce mailing delays.
- Enhance patient and medical practitioner communications via the MCP website and other methods.
- Implement a database dedicated to the mission and needs of the program.
- Allow unspent licensing fees collected under the Medical Cannabis Fund to remain with the MCP to meet ongoing needs.

Partners

- Medical and Nursing Boards
- Medical practitioner associations
- NMDOH and private IT networking and expertise
- NMDOH public information office
- Advocates
- Legislature
- Patients and their families, caregivers

Strategies

- Open and date stamp incoming mail daily.
- Perform initial data entry and determine if the applications are complete within 14 calendar days of receipt.
- Complete Medical Director review and signature in 7 to 10 days.

C. WORKFORCE DEVELOPMENT

NMDOH and
Health Care Providers

Result 3

A more rewarding work environment to attract and cultivate a skilled, innovative, diverse and committed workforce

Result 4

Recruitment and retention of health professionals to respond for health care

STRATEGIC PLANNING COUNCIL— MEASURE DEVELOPMENT

Objective

A well-educated and informed NMDOH workforce

NM Population Indicator

Percent of NMDOH employees who have completed required training

NM Population Indicator Baseline

Data development in FY2014

Story Behind the Data

- The State of New Mexico requires employees to complete specific training in several areas, including Driver Safety training, new employee orientation, health and safety courses for direct care staff, Health Insurance Portability and Accountability Act (HIPAA).
- Currently, there is no effective and efficient way to track the training record for NMDOH employees.
- A centralized location for workforce development and training opportunities is lacking in NMDOH.
- Employees are one of the great NMDOH assets, and their importance is often overlooked.
- An employee development system ensures that employees deliver what is expected of them.
- NMDOH recently established a Strategic Planning Council (SPC), which includes 3 Quality Improvement workgroups. One of those workgroups is focused on training and workforce development.
- The SPC training and workforce development workgroup is completing a results-based accountability process to determine strategies to improve tracking of employee training and current available training offerings.
- NMDOH currently uses the on-line learning system called *Moodle*, stands for *Modular Object-Oriented Dynamic Learning Environment;* however, it does not have an effective tracking function and is not available to external partners.
- NMDOH has a Training Unit that is responsible for working with NMDOH programs to provide required training. The Training Unit manager sits on the SPC training and workforce development workgroup.

Performance Measure (P001)

Program Performance	Program PM Baseline	FY15 Target
Reduce gaps in NMDOH-wide employee training, such as cultural sensitivity, and develop tools for e-tracking to ensure completion	**Data development – inventory by survey**	**Data development, determined by baseline**

What Works

- Ensuring that employees have access to required training and other opportunities to build competencies to support their ability to perform with results.
- Employees should be engaged in activities aimed at motivating them.
- Expert trainers should be hired to ensure maximum results.
- An employee development system ensures that employees deliver what is expected of them. This is done through many different approaches. First, the individuals will know and be aware of what is expected of them. Second, the individuals will be trained in the tasks that they need to accomplish so that they feel comfortable in their abilities to do them. Third, there will be a system put into place that will hold everyone accountable for their responsibilities.
- Training should be treated as an important investment.

Partners

- NMDOH Training Unit.
- NMDOH Secretary, Deputy Secretaries, and Senior Management.
- NMDOH Office of Policy and Accountability workforce development activities in support of Public Health Accreditation.
- NM Universities and Colleges
- Federal and National agencies that offer technical assistance and training opportunities.

Strategies

- Conduct a process to inventory training opportunities and employee workforce development priorities.
- Invest in a more robust learning management capability to track employee development record.
- Evaluate and improve training courses.
- Ensure that employees have access to training and education in order to effectively and efficiently perform their role.

STRATEGIC PLANNING COUNCIL— MEASURE DEVELOPMENT

Objective

Provide a central electronic location for NMDOH training that can ensure access to and determine employee training needs for job success

NM Population Indicator

Indicator development in FY2014

NM Population Indicator Baseline

Story Behind the Data

- The NMDOH uses the online learning environment for training.
- The NMDOH Office of Policy and Accountability (OPA) maintains the Public Health Learning Collaborative (http://nmphlc.org/) which maintains a focus on public health courses offered in classroom and online environments for NMDOH and their health improvement partners.

- The NMDOH has some training policies in place; additional policies will be developed to respond to developments in practice;
- There is a need for Individual Learning Plans (ILP) to track:
    - required training for NMDOH employees;
    - elective course completion related to professional development; and,
    - continuing education credits (CEUs) necessary for licensure(s).
- The NMDOH has been exploring the potential use of the Moodle™ software package for producing Internet-based courses.

Performance Measure (P001)

Program Performance	Program PM Baseline	FY15 Target
Inventory current NMDOH training programs	**100%**	**100%**

What Works

- Online education for the NMDOH workforce;
- Continuous internal communication;
- The application of the Moodle learning management software; and,
- Training trainers and facilitator at no or low cost.

Partners

- State Office of Personnel
- NMDOH Human Resources Division
- NMDOH Training Unit
- NMDOH Divisions and Offices
- IT contractors
- Continuing Education Unit (CEU) granting entities
- Content experts/contractors
- Intradepartmental training units
- NMDOH Senior Management
- Consumers/NMDOH Employees

Strategies

- Perform an inventory of all training currently provided within each NMDOH division.
- Develop policies and procedures for training areas.
- Employ the Results Based Accountability (RBA) "Train the Coach" facilitator model.
- Develop an action plan to upgrade Moodle™ from 2.0 version to 9.0 including hiring an experienced IT person to install and develop the program. The version 9.0 will facilitate and track ILPs.
- Incorporate specific trainings (*i*.e., ethics/values, cultural competency, safety, performance management, etc.) in an implementation plan.
- Use SharePoint® platform for facilitating document version control and sharing.

STRATEGIC PLANNING COUNCIL— MEASURE DEVELOPMENT

Objective

Develop a certification program for community health workers

NM Population Indicator Baseline

No existing certification of community health workers

Story Behind the Data

- NMDOH is working with stakeholders to develop the community health worker certification program.
- NMDOH is working with stakeholders to develop a statewide competency-based training program for CHWs.
- NMDOH is developing the rules associated with CHW certification.
- CHWs are the link for individuals and families with the state's health and human services system of care.
- Inadequate health professional workforce, especially in rural areas.
- The New Mexico CHW Advisory Council serves as an advisor to the NMDOH Secretary regarding the development of a NM CHW model.

Performance Measure (P002)

Program Performance	Program PM Baseline	FY15 Target
Performance Measure development	**Data development in FY2015**	**NA**

What Works

- Community health workers (CHW) improve access to health care, increase client knowledge and behavioral change, and increase client well being (Whitley et al 2006)
- Community health workers engaged in home visitation improved patient well being, improved disease self-management, and result in health care cost savings (Fedder et al 2003)
- Preliminary data collected by the NM Asthma Program's pilot project at Nor-Lea Hospital suggests that use of certified asthma educators may have been effective in reducing asthma hospitalization visits ad increasing asthma self-management skills since the onset of the intervention.

Partners

- NM Community Health Worker Program, NMDOH
- NM Community Health Worker Association
- Health care providers

Strategies

- Institute a certification program for community health workers so they can begin seeing patients in underserved areas of NM in order to improve rural health in the state.

D. ACCOUNTABILITY

Accountable to the Governor, the Legislature and the Public

Result 5
The Department's work is understandable, accessible and valued

Result 6
Improved fiscal accountability

Result 7
Technology supports timely, data-driven decisions; improved business operations; and improved public information and education

Objective

Ensure health information is available to the public

NM Population Indicator

Percent of individuals accessing the NMDOH website who are satisfied

Percent of individuals accessing the NMDOH website who found it easy to use

NM Population Indicator Baseline

Data development in FY2014

Story Behind the Data

- The NMDOH public website was developed over decades by different individuals, resulting in barriers that make it difficult to navigate and locate desired information.
- NMDOH Chief Information Officer (CIO) and Senior Management Team have prioritized the redesign and clean-up of the public website by the Webmaster and stakeholders.
- Access to public health improvement and health care information is essential to promote healthy people, to provide excellent public health services, and to ensure public safety.
- There is outdated information on the NMDOH public website.
- There are new demands to develop new sites and it is important to develop the new website template prior to adding new sites.

Performance Measure (P001)

Program Performance	Program PM Baseline	FY15 Target
Percent of individuals accessing the NMDOH website who are satisfied	**Data development – customer satisfaction survey responses**	**TBD based on baseline responses**
Percent of individuals accessing the NMDOH website who found it easy to use	**Data development – customer satisfaction survey responses**	**TBD based on baseline responses**

What Works

- Use of a quality improvement model to structure public website improvement process and to measure performance.
- Prioritize the creation of the new NMDOH public website template.
- Support from senior leadership and the CIO to control the development of new web sites during template design.

Partners

- NMDOH Senior Management Team
- IT staff
- Programs with web content
- NMDOH employees

Strategies

- Develop a results-based accountability framework and process to develop and evaluate website improvement activities.
- Develop and implement a customer satisfaction survey for NMDOH public website users.
- Analyze and improve website content based on survey responses.
- Design and apply a new website template that is approved by the Cabinet Secretary, CIO, Senior Management and stakeholders.
- Develop and implement a website management policy and procedure.

STRATEGIC PLANNING COUNCIL — MEASURE DEVELOPMENT

Objective

Improve financial accountability and minimize financial risk

NM Population Indicator

Indicator development in FY2014

NMDOH Facility Population Indicator Baseline

Story Behind the Data

- Facilities Management fulfills the NMDOH mission by overseeing six health care facilities and one community program.
- The Department offers safety net services for those individuals who have no financial resources yet need treatment.
- The safety net services provided throughout New Mexico include programs in mental health, substance abuse, long term care, and physical rehabilitation in both facility and community-based settings.
- Facility staff care for both New Mexico adult and adolescent residents who need continuous care 24 hours-a-day, 365 days-a-year.
- 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 remanded to NMDOH facilities by court order.
- NMDOH financial directors meet periodically to develop standardized methodologies necessary to calculate data for the facilities performance measures. For example, billed third-party revenues collected do not really represent all billable charges, because some uncompensated care cannot be billed to those clients without a payer source (e.g., Medicaid).
- Due to the implementation of the Affordable Care Act, there are eminent, third-party revenue and uncompensated care caveats that have not yet been identified.

Performance Measure (P006)

Program Performance	Program PM Baseline	FY15 Target
Percent of care at all agency facilities that is uncompensated (AGA)	***Data development in FY2014**	**Data development in FY2014**

***Facilities have been reporting the "amount in dollars" of uncompensated care provided. This revised measure intends to reflect the percentage of care by facilities that is uncompensated.**

What Works

- Electronic billing and transcription services.
- Upgraded computers for faster processing.
- Ensuring accurate billing.
- Meetings with payer sources to improve and optimize reimbursements.
- Improved payment by continuing to ensure accurate billing.
- Ongoing, monthly meetings with third-party payers to improve revenue.

Partners

- Facility staff
- Department financial officers
- Payer sources

Strategies

- Conduct monthly Facilities Finance Committee meetings to monitor expenses and increase revenues while ensuring standardized, approved fiscal practices and compliance with requirements in all facilities.
- Continue to improve revenue collections through the implementation of electronic billing and transcription services.
- Work toward Joint Commission certifications to aid in improved reimbursement of care.
- Hire additional administrative (billing-related) staff at Fort Bayard and Las Vegas facilities.

Performance Measure (P006)

Program Performance	Program PM Baseline	FY15 Target
Percent of eligible third party revenue collected at all agency facilities (AGA)	***56.6%**	**90%**

***Facilities have been reporting the data in an inconsistent manner. For FY14 data reporting will be standardized and will reflect standard practices in the hospital industry. The amount currently reported includes uncompensated care (clients without a source of payment).**

Strategies

- Work with facility financial staff to identify current and potential payers and revenue sources.
- Implement electronic billing.
- Coordinate re-billing efforts.
- Implement improved collection strategies.

STRATEGIC PLANNING COUNCIL— MEASURE DEVELOPMENT

Objective

Improve access to information

Program Performance Measure Baseline

Data development in FY2014

Story Behind the Data

- ITSD exists to provide access to "information". The fundamental, base-level of information consists of data stored in a file. Improved analysis of the universe of files, and collaborative communication with the Information Governance Board (IGB) on how to improve this base-level, improves business operations and enables new tools to improve public information and education.
- Data storage can have a major impact on budgeting and staffing resources:
    - Data storage has an impact on budget due to devices required for storage (e.g. servers) and the process timeframe and materials needed to maintain and backup to retain. Device and connection maintenance and backup processing impacts IT hardware budgeting and support staff.
    - Understanding the volume and investigating the options of reducing volume gives NMDOH the ability to plan for increase fiscal accountability.
    - Increased volume affects the staff working experiences by slowing down workflow processes. Discovery of unneeded files enable planning to reduce the volume of data and improve staff working experiences.
    - Because of restrictions and limitations contractually, unneeded data files can have a negative

Performance Measure (P001)

Program Performance	Program PM Baseline	FY15 Target
Number of files on NMDOH servers	***Data development in FY2014**	**30% Reduction**

What Works

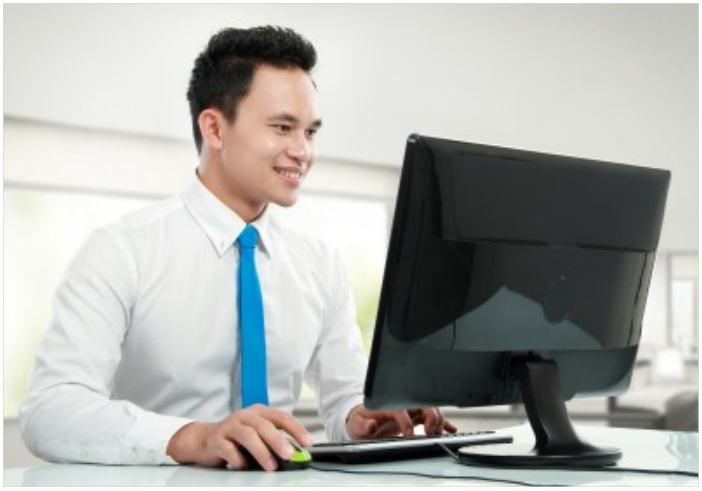
- Use automated network discovery tools to collect information on the number and types of files on the Network and to calculate total size (in terabytes) of data stored.

Partners

- All Program Area business information owners within the Department of Health.
- Data Center partners at the New Mexico Department of Information Technology (DoIT).

Strategies

- Key initiatives for FY14 include: standardizing on new Microsoft Office workplace tools (Word processing, data spreadsheets, presentation and email tools) and SharePoint document management and workflow processing. Both of these initiatives have been a collaborative decision made by the NMDOH Information Governance Board (IGB), consisting of representatives from all program areas within NMDOH and have been funded for FY14. Once implemented, these products will continue to be used in future years.
- Each of these initiatives will enable NMDOH to transition to a newly structured and cost-effective infrastructure environment.
    - Microsoft Office 365 will significantly improve desktop/laptop service management to NMDOH employees and, at the same time, enable ITSD to better structure service delivery and create a more secure environment.
    - SharePoint will improve document management and communication within a Division and across Divisions as needed.
    - SharePoint will better equip ITSD to safeguard information and retain intellectual capital for ease of retrieval.
- A critical component for the success of each of these initiatives is data storage. Without knowing the files and storage we have and without understanding the effort involved and committing to data cleanup across all Divisions will have a severe negative impact to both of these initiatives.
- The performance measure of "Discovery of the number and volume of NMDOH data files" will help identify the impact and the effort needed to improve financial accountability, document management and collaborative communication.



STRATEGIC PLANNING COUNCIL— MEASURE DEVELOPMENT

Objective

Create a more transparent and expedited contract procurement system

NM Population Indicator

Indicator developed in FY2014

NM Population Indicator Baseline

Data development in FY2014

Story Behind the Data

- NMDOH has obtained a shared database to be used by divisions and the Administrative Services Division to track and monitor process performance.
- The new system needs to be installed and piloted, then improved; staff will need to be training on use of the new database.
- The time to fully execute contract is variable.
- There are many different types of agreements.
- The data and, therefore the story, have not been fully captured for use by NMDOH to improve the process.

Performance Measure (P001)

Program Performance	Program PM Baseline	FY15 Target
Time to fully execute professional services contracts	**Data development in FY2015**	**TBD based on baseline**

What Works

- Shared access to information on the status of the contract approval process.
- Standardized training and tracking of agreements.

Partners

- Administrative Services Division staff
- Division Directors/Deputies and Bureau Chiefs
- Program Managers
- Contract Officers
- Department of Finance and Administration
- General Services Department, State Purchasing
- Office of Policy and Accountability and Results-Based Accountability Coaches

Strategies

- Conduct a Results-Based Accountability (RBA) process to develop baseline and target data, understand the story behind the data, identify what works to process agreements effectively and efficiently.
- Select strategies, develop an action plan with performance measures, and monitor and improve performance.

STRATEGIC PLANNING COUNCIL— MEASURE DEVELOPMENT

Objective

Improve vital records work quality

NM Population Indicator

Percent of Bureau of Vital Records and Health Statistics' (BVRHS) customers who are satisfied or very satisfied

NM Population Indicator Baseline

Data development in FY2014

Story Behind the Data

- Birth and Death certificates (Vital Records) are legal documents representing the registration of vital events.
- The registration of these vital records serves to protect the rights of the individual and/or family members to services inherent in the society. As legal documents, vital records must be as accurate as possible and processing may involve contact with the submitting agencies if questions arise.
- In addition because vital records are legal documents, there are strict standards as to who can acquire the birth/death certificate and the documentation required.
- Some customers are unaware of the information they must provide in order to obtain a document.

Performance Measure (P003)

Program Performance	Program PM Baseline	FY15 Target
Percent of vital records front counter customers who are satisfied with the services they receive	***Data development in FY2014**	**TBD based on baseline**

***Baseline will be established through initial implementation of front counter customer service survey. FY13 Baseline sample measure will be available December 2013.**

What Works

- Celebrate Victories, praise employees when they have done a good job with customer service. Positive reinforcement assures your employees that they are appreciated for doing excellent work.
- Identify Deficiencies through either weekly or bi-weekly debriefings. Schedule effective training sessions (technical, people skills and effective customer service engagement).
- Establish a skill set assessment. Take a close look at the people you are putting on the customer service phone or face to face on the front line.
- Measure customer service effectiveness (customer service survey form: hard copy or electronic).
- Consistency…without being consistent you will never achieve measured customer service effectiveness.

Partners

- Hospitals
- Midwives
- Funeral homes
- Office of Medical Examiner
- Physicians
- Tribal authorities
- Family members

Strategies

- BVRHS will run sample measures during the months of November 2013 and December 2013 with every ten counter customers. Beginning in January 2014, BVRHS will begin full program performance measures with every counter customer. Data between January 2014 and June 2014 will provide the FY 15 Target Data.
- Implement a customer service survey which will gauge our customer satisfaction to better align our work to meet customer needs.
- Measure customer service data via a survey with ten check off questions with numerous data boxes.
- Assess our procedures to improve services through quarterly reviews of the survey data.

Appendices

Appendix 1

Quick Guides:
Performance Measures
Acronyms

A QUICK GUIDE TO PERFORMANCE MEASURES		
AGA*	**PERFORMANCE MEASURE**	**PAGE**
Administrative Services Division (P001) (Cabinet Secretary, communication, finance, HR, IT, General Counsel, policy, accreditation, health equity, border health)		
	PM in development: Reduce gaps in NMDOH-wide employee training, such as cultural sensitivity, and develop tools for E-tracking to ensure completion.	96
	PM in development: Inventory current NMDOH training programs	98
	Number of files on NMDOH servers.	108
	PM in development: Time to fully execute professional services contracts.	110
	Percent of individuals accessing the NMDOH website who are satisfied.	104
	Percent of individuals accessing the NMDOH website who found it easy to use.	104
Public Health Division (P002)		
	Percent of QUIT NOW enrollees who successfully quit using tobacco at 7-month follow-up.	26
X	Percent of teens participating in pregnancy prevention programs that report not being pregnant, or being responsible for getting someone pregnant during the school year following participation at the end of the school year.	28
	Number of teen births prevented among 15-17 year old females seen in agency funded family planning clinics.	28
X	Percent of students using school-based health centers that receive a comprehensive well exam.	30
	Percent of elementary school students in community transformation communities participating in walk and roll to school.	32
	Percent of elementary school students in community transformation communities participating in classroom fruit and vegetable tastings.	32
	Percent of elementary students in community transformation communities who are obese.	32
	Percent of preschoolers (19-35 months) fully immunized.	34
	Percent of diabetic patients at agency supported primary care clinics whose HbA1c levels are less than 9%.	39
	The average weight loss achieved by all National Diabetes Prevention Program participants (a recommended minimum of 5% of starting body weight) from baseline through post-core.	41
	Percent of WIC recipients that initiate breastfeeding.	42
	PM in development: Certification of Community Health Workers.	100
Epidemiology and Response Division (P003)		
	Percentage of emergency department and intensive care unit licensed staff at developing and existing trauma centers who have received training in traumatic injury care.	64
	Percent of acute care hospitals reporting stroke data into approved national registry.	66
	Percent of acute care hospitals reporting heart attack data into approved national registry.	68
	Percent of hospitals reporting bed availability in the healthcare emergency preparedness bed reporting system within four hours of request.	70
	Percent of vital records front counter customers who are satisfied with the service they received.	112
X	Ratio of infant pertussis cases to total pertussis cases of all ages.	36
	Number of adults age 65 and older who completed an evidence-based falls prevention program.	44
	Number of naloxone kits provided in conjunction with prescription opioids.	46
	Percent of counties with documented implementation plans for developing regionalized EMS response.	62
	Number of people completed a NMDOH-funded sexual assault prevention program.	58
	Percent of children with persistent asthma who show an improvement in their symptoms as a result of asthma self-management education.	48
*** AGA: Accountability in Government Measure that is included in the NMDOH Budget (Senate Bill 313 FY15)**		

	A QUICK GUIDE TO PERFORMANCE MEASURES	
AGA	**PERFORMANCE MEASURE**	**PAGE**
	Scientific Laboratory Division (P004)	
X	Percent of blood alcohol tests from driving-while-intoxicated cases that are completed and reported to law enforcement within fifteen business days.	50
X	Percent of office of medical investigator cause of death toxicology cases that are completed and reported to office of medical investigator within sixty business days.	52
X	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.	54
X	Percent of environmental samples for chemical contamination that are completed and reported to the submitting agency within sixty business days.	56
	Facilities (P006)	
X	PM in development: Percent of care at all agency facilities that is uncompensated.	106
X	Percent of staffed beds filled at all agency facilities.	72
	Percent of eligible third-party revenue collected at all agency facilities.	107
	Percent of long-term care residents with health care acquired pressure ulcers.	74
	Percent of rehabilitation patients experiencing one or more falls with injury.	76
X	Percent of long-term care patients experiencing one or more falls with injury.	76
	Percent of behavioral health patient medical records transmitted to the next level of care within five calendar days. (FY15SP)	78
	Developmental Disabilities Supports Division (P007)	
X	Percent of developmental disabilities waiver applicants who have a service plan in place within ninety days of income and clinical eligibility.	80
X	Percent of adults receiving developmental disabilities day services who are engaged in community-integrated employment.	82
X	Number of individuals receiving developmental disabilities waiver receiving services.	80
X	Number of individuals on the developmental disabilities waiver waiting list.	80
	Division of Health Improvement (P008 - Health Facility Certification, Licensing and Oversight)	
X86	Percent of abuse, neglect and exploitation incidents for community-based programs investigated within forty-five days.	84
88	Percent of report of findings transmitted to provider within twenty business days of survey exit.	86
90	Percent of CMS 2567 Report/Statement Deficiencies for facility surveys completed and distributed within 10 days from survey exit.	88
	Percent of facility building plan compliance reviews completed and distributed with 20 days from the data a complete packet is received.	90
	Medical Cannabis (P787)	
P787	Percent of complete medical cannabis client applications approved or rejected within thirty calendar days of receipt.	92

ACRONYM GUIDE	
AC	Acute Care
ALTSD	Aging and Long-Term Services Department
ASD	Administrative Services Division
BVRHS	Bureau of Vital Records and Health Statistics
CCSS	Comprehensive Community Support Services
CDC	Centers for Disease Control and Prevention
CIO	Chief Information Officer
CHW	Community Health Worker
CMHC	Community Mental Health Centers
CMS	Centers for Medicare and Medicaid Services
CR	Central Registry
CTG	Community Transformation Grant
CYFD	Children, Youth, and Families Department
DD	Developmental Disabilities
DDSD	Developmental Disabilities Services Division
DDW	Developmental Disabilities Waiver
DHI	Division of Health Improvement
DoIT	Department of Information Technology
DPCP	Diabetes Prevention and Control Program
DPP	National Diabetes Prevention Program
ED	Emergency Department
EMS	Emergency Medical Services
ERD	Epidemiology and Response Division
FIT	Family Infant Toddler Program
FPP	Family Planning Program
FQHC	Federally Qualified Health Care Centers
HFL&C	Health Facility Licensing and Certification
IHS	Indian Health Services
HPSA	Health Professional Shortage Areas
HSD	Human Services Department
I/DD	Intellectual/Developmental Disabilities
IGB	Information Governance Board
IMB	Incident Management Bureau
ISD	Income Support Division
IT	Information Technology
ITSD	Information Technology Services Division
LPN	Licensed Practical Nurse
MCP	Medical Cannabis Program

ACRONYM GUIDE	
NACCHO	National Association of County and City Health Officials
NM	New Mexico
NMBHI	New Mexico Behavioral Health Institute
NMDOH	New Mexico Department of Health
NMED	New Mexico Environment Department
NMPCA	New Mexico Primary Care Association
NMRH	New Mexico Rehabilitation Center
NMSVH	New Mexico State Veteran's Home
OBH	Office of Border Health
OGC	Office of General Counsel
OHE	Office of Health Equity
OIA	Office of Internal Audit
OMI	Office of Medical Investigator
OPA	Office of Policy and Accountability
OSAH	Office of School and Adolescent Health
PED	Public Education Department
PHD	Public Health Division
PIO	Public Information Office
PM	Performance Measure
PPACA	Patient Protection and Affordable Care Act
PRAMS	Pregnancy Risk Assessment and Monitoring System
QA	Quality Assurance
QI	Quality Improvement
QMB	Quality Management Bureau
RBA	Results-Based Accountability
RN	Registered Nurse
RPHCA	Rural Primary Health Care Act
SARS	Severe Acute Respiratory Syndrome
SBHC	School-Based Health Centers
SLD	Scientific Laboratories Division
SPC	Strategic Planning Council
TUPAC	Tobacco Use Prevention and Control
UNM	University of New Mexico
UNMH	University of New Mexico Hospital
WIC	Women, Infants, and Children

Appendix 2

NMDOH Quality Improvement Plan

New Mexico Department of Health Quality Improvement Plan 2014-2016

NEW MEXICO DEPARTMENT OF HEALTH

Purpose

The purpose of the New Mexico Department of Health (NMDOH) Quality Improvement Plan (QIP) is to provide guidance about how the New Mexico Department of Health will manage, deploy, and review quality throughout the organization. It describes the processes and activities that will be put into place to ensure quality deliverables are produced consistently and are continuously improved.

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

Policy Statement

The New Mexico Department of Health has an interest in systematically evaluating and improving the quality of its programs, processes, and services in order to achieve a high level of efficiency, effectiveness, and customer satisfaction.

Accreditation and Quality Improvement

The New Mexico Department of Health is applying for health department accreditation under the Public Health Accreditation Board's (PHAB) voluntary, national accreditation program. Under this accreditation program, quality improvement is a cornerstone and reinforces the importance for system-wide quality improvement in public health. Through the accreditation process continuous quality improvement is a foundation, as is exhibited through reaccreditation every five years and reports submitted annually to PHAB. Accreditation and quality improvement are two processes that must work in harmony.

Definitions

Performance Management System

A fully functioning performance management system that is completely integrated into health department daily practice at all levels includes: 1) setting organizational objectives across all levels of the department, 2) identifying indicators to measure progress toward achieving objectives on a regular basis, 3) identifying responsibility for monitoring progress and reporting, and 4) identifying areas where achieving objectives requires focused quality improvement processes. (Public Health Accreditation Board. *Standards and Measures Version 1.0*. Alexandria, VA, May 2011).

Quality Improvement (QI)

Quality improvement in public health is the use of a deliberate and defined improvement process, such as Plan-Do-Check-Act, which is focused on activities that are responsive to community needs and improving population health. It refers to a continuous and ongoing effort to achieve measurable improvements in the efficiency, effectiveness, performance, accountability, outcomes, and other indicators of quality in services or processes which achieve equity and improve the health of the community. Measurable improvements are evaluated by the Performance Management System. (Riley, Moran, Corso, Beitsch, Bialek, and Cofsky. *Defining Quality Improvement in Public Health*. Journal of Public Health Management and Practice. January/February 2010).

Strategic Plan

A strategic plan results from a deliberate decision-making process and defines where an organization is going. The plan sets the direction for the organization and, through a common understanding of the mission, vision, goals, and objectives, provides a template for all employees and stakeholders to make decisions that move the organization forward. (Swayne, Duncan, and Ginter. *Strategic Management of Health Care Organizations*. Jossey Bass. New Jersey. 2008).

Overview of Quality Improvement in the New Mexico Department of Health

When initiating a quality improvement activity, a natural evolution of change tends to occur, reflecting impact on both the people and processes within the organization. To gain a solid understanding of the barriers, drivers, and nuances along the journey to a QI culture, the National Association of County and City Health Officials (NACCHO) developed the Roadmap to a Culture of QI (QI Roadmap) based on real experiences of practitioners in the field. The QI Roadmap provides guidance on progressing through six phases or levels of QI integration until a culture of QI has been reached and can be sustained. The QI Roadmap also describes the six foundational elements of a QI culture that should be cultivated over time.

The New Mexico Department of Health used the QI Roadmap to assess the amount of activities around quality improvement that are occurring department wide. Currently the NMDOH is in phase three of the QI Roadmap. Discrete quality improvement efforts, generally informal or ad hoc QI activities, are practiced in isolated instances throughout the Department often without consistent use of data or alignment with the steps in a formal quality improvement process. Moving forward, the NMDOH shares some of the characteristics that are listed for phase four, including the use of data to drive decision-making, a data collection system for storing and tracking performance data is currently being implemented Department wide, and formal, in-house quality improvement technical assistance and training is offered to all staff.

Governance Structure

Quality Improvement Council

The Strategic Planning Council (SPC) was established in December 2012 to ensure department-wide input related to strategic planning, quality improvement and other topics related to Public Health Accreditation. As described previously, the SPC has a stated mission and several goals. Providing broad input and oversight for department-wide quality improvement (QI) projects is one of these major tasks. Therefore, the SPC and its members also serve as the Quality Improvement Council (QIC) for NMDOH.

The Quality Improvement Council was established within the SPC to oversee the quality improvement process. As a component of the SPC, the QIC has representation from all divisions and facilities in the Department of Health. QIC members are excited and motivated to work with senior managers to offer NMDOH employees a chance to assist in forging the Department's future. The QIC is responsible for conducting QI efforts and for promoting, challenging, and empowering NMDOH employees to participate in the ongoing process of QI.

The responsibilities of the Council include:

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

The QIC, as part of the SPC, meets once a month for 90 minutes and maintains records and minutes of all meetings. At least annually, the QIC will provide an update of the QIP to the Cabinet Secretary.

The Quality Improvement Council, as part of the Strategic Planning Council, identifies and defines goals and specific objectives to be accomplished each year. Quality improvement tools and techniques applied in a variety of group and team situations enable the important data collection, problem analysis, and employee involvement, which are keys to improving performance. Progress in meeting these goals and objectives are an important part of the annual evaluation of quality improvement activities. The following criteria were developed by the members of the SPC in regards to selecting which NMDOH level quality improvement projects to focus on.

Scope

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

Customers

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

Number of projects

The Strategic Planning Council will pick only one project at a time from each of the four QI focus areas. While there are many quality projects that are not selected, these can continue within their divisions. The Office of Policy and Accountability (OPA) will provide training and support on Results-Based Accountability to these as well; to the extent they have the time and resources.

Project Selection

The NMDOH conducted an Employee Engagement Survey in 2013, which asked employees to identify areas for team improvement. The employees were provided ten areas to select from:

- Mission (Our TEAM understands and follows the overall NMDOH mission, vision, and values.)
- Quality (I understand how success is measured and can contribute to ensuring quality services.)
- Customer Service (We provide services which are timely and tailored to our customers.)
- Training (I have the training needed to accomplish my work successfully and in compliance with rules and regulations.)
- Opportunities for growth (I have the tools I need to learn, do my job better and have career advancement within the NMDOH.)
- Safety (My work place is well maintained and physically safe place to work.)
- Communication (I receive the information I need to do my job effectively.)
- Teamwork (My colleagues and I hold each other accountable and contribute to achieve results.)

- Diversity (My workplace consistently demonstrates support for adverse workforce.)
- Equity (My workplace consistently demonstrates fairness and justice among employees.)

The top three areas, as identified by NMDOH employees were:

- 67.5% Opportunities for Growth
- 51.0% Training
- 49.7% Communication

Two follow-up questions were asked:

- How can your team improve in these areas? (Please provide examples)
- What should be changed to eliminate the weaknesses? (Please provide examples)

Using the text analysis tool within Survey Monkey, the program utilized to administer the Employee Engagement Survey, the top five most common words identified within the qualitative text were:

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

A search within the qualitative data was then conducted, specifically searching for the identified key words. The results of the aforementioned review were summarized and presented to the Quality Improvement Council. The QIC, using the previously stated criteria, voted on, and choose four focus areas.

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

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

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

Performance Measures: A performance measure is a numeric description of an agency's work and the results of that work. Performance measures are based on data, and tell a story about whether an agency or activity is achieving its objectives and if progress is being made toward attaining policy or organizational goals. A performance measure is a quantifiable expression of the amount, cost, or result of activities that indicate how much, how well, and at what level, products or services are provided to customers during a given time period.

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

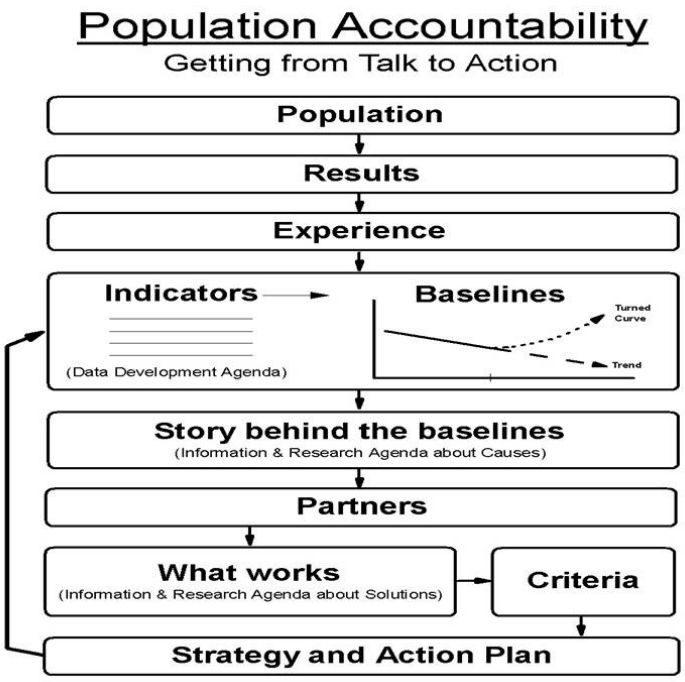
Quality Improvement Model

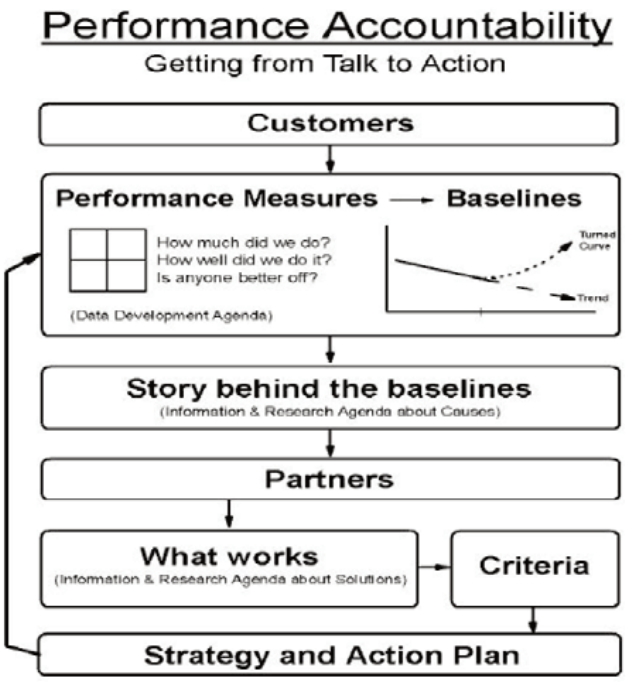
Quality improvement activities emerge from a systematic and organized framework for improvement. This framework, adopted by the Cabinet Secretary, is understood, accepted, and utilized throughout the NMDOH. This is a result of continuous education and involvement of staff at all levels of population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

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

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

The RBA model can be applied in two ways, either as population accountability or performance accountability. Population accountability is about the well being of whole populations in a community, city, county, state or nation. Performance accountability is about the well being of client populations, e.g. programs, agencies, and service systems. Below are visuals of how the RBA model can be used either for populations or performance through the "Turn the Curve" process.





Current Quality Improvement Projects

Training and Workforce Development

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

Story Behind Data: NMDOH uses the online learning environment for training; NMDOH OPA maintains the Public Health Learning Collaborative, which maintains a focus on public health courses offered in classroom and online environments for NMDOH and their health improvement partners; and NMDOH has some training policies in place; policies need to be developed to respond to the evolving developments in practice;

a. There is a need for Individual Learning Plans (ILP) to:
   i. Track required training for NMDOH and/or profession;
   ii. Track elective course completion related to professional development; and,
   iii. Continuing education credits necessary for licensure.

What Works: Online education for most of the workforce, constant internal communication (to keep things on task), Moodle learning management software and, Train the Trainer/Facilitator (No cost/low cost)

Partners: State Office of Personnel, NMDOH Human Resources Division, NMDOH Training Unit, NMDOH Divisions and Offices, IT contractors, CEU granting entities, Content Experts/contracts, Intradepartmental training units, NMDOH Senior Management, Consumers/NMDOH Employees

Strategies: Develop policies and procedures for training areas, employ train the trainer/facilitator model, develop an action plan to move Moodle from 1.9 version to 2.3 version for internal/external use, incorporate critical training (i.e. ethics/values, cultural competency, safety, performance management) in an overall implementation plan for training, use SharePoint platform for facilitating work

Membership list: Erica Pierce, Scientific Labs Division; Tuula Piispanen-Krabbe, Training Unit; Melissa Walker, Training Unit; Louie Trujillo, Facilities; Frances Tweed, Facilities; Greg Manz, Bureau of Health Emergency Management; Christina Iyengar, Bureau of Health Emergency Management; Dan Maxwell, Division of Health Improvement; Carlotta Garcia, Office of Health Equity; Alexis Avery, Public Health Division

Meeting Schedule: Monthly and as needed for document deadlines.

Identified Goals:

- Developing a NMDOH training inventory.
- Developing a "one stop" location for all NMDOH employees to access information on NMDOH training opportunities.
- Creating a tracking system for employee training for all NMDOH Training Unit classes.
- Assist in developing a workforce development program.
- Assist in creating leadership development, management development, and succession planning/career development training opportunities for all NMDOH employees.

Health and Safety

Objective: Increase health and safety for the NMDOH's employees and the people we serve

Indicator: Sharps injuries across all public health offices (PHOs)

Baseline: 8 reported sharps injuries across all public health offices (2012)

Story Behind Data: In 2010, there were four reported sharps injuries reported from the NMDOH's PHOs. Although there were only two reported sharps injuries in 2011, in 2012 there were eight reported sharps injuries. Further, these counts are likely an underestimate, as many such injuries are underreported due to:

- Shame by the professional;
- Unclear reporting process; and
- Intensely busy workload, thereby preventing ample time for reporting.

What Works: Preventing sharps injuries has the following intended outcomes:

- Increased Efficiency: Time saved, Cost saved
- Increased Effectiveness: Increase in preventative behaviors, Decreased Incidence/Prevalence

Partners: PHO staff, contractors, custodians

Strategies:

- Prioritize prevention at the Division level
- Update procedures for prevention and reporting
- Develop training and competency
- Reposition used sharps containers
- Investigate newly-designed containers which may alleviate sticks
- Rewards for reporting
- Simplify reporting process

Membership list:
David Selvage, Epidemiology and Response Division; Alexander Gallegos, Scientific Laboratory Division; Stephen Dorman, Chief Medical Officer; Deborah Thompson, Epidemiology and Response Division; Andrew Gans, Public Health Division

Identified Goals:

Communications

Objective: Create a new website that uses simple language, consistent, easy to navigate, accessible and current, which meets the needs of our diverse audience.

Story Behind Data:

- Not enough staff.
- Access to edit sites through Contribute has affected the site in terms of having wrong and old information.
- It is not centralized and consistent.
- It does not use simple, common language. The language needs to be developed at a certain educational level that will be of service to everyone (NM families, providers, research audience).
- Information is not prioritized to best achieve our goals and values.
- The site needs to be able to reach all audiences especially the accessibility, and bilingual audience.
- No regular maintenance schedule or procedures: Website Content Management/Organization Policy, Website Maintenance Policy, Outdated Information Prevention Policy.
- It is on an old server and needs to be on a newer server version.
- Does not have a custom search engine.

What Works:

- Look at Arizona, Florida, Texas, and Vermont webpages
- Reduce number of websites
- Mandate Policies
- Archiving
- Consolidate Information
- Support and Buy-In from IT Governance Board (IGB)

Partners:

- Web Development Staff
- Help Desk
- NM Families
- NMDOH Staff
- Research Community
- Healthcare Providers
- Information Governance Board (IGB)

Strategies:

- Mandate policies and get approval from IGB
- Restructure and consolidate web content
- Create sustainable resources that support the NMDOH Site

Membership list:

Clint Sulis, Information Technology Services Division; Martin Maniscalco, Information Technology Services Division; Christina Perea, Office of Policy and Accountability; Javier Rios, Office of Health Equity; Kenny Vigil, Communications Director

Meeting Schedule:

Members meet once a month for two hours.

Identified Goals:

- Develop website policies by October 2013
- Create and distribute a website customer satisfaction survey by October 2013
- Complete redesigned website rough draft by December 2013
- Launch the new website by January 2014
- Restructure and consolidate web content by December 2015
- Create sustainable resources that support the new NMDOH website (ongoing)
- Restructure and consolidate web content within two years
- Migrate website policies into new NMDOH policy format
  - Forms and procedures within policies need to be developed
- Create sustainable resources that support the new NMDOH website
- Possibly support the Public Information Officers, Kenny Vigil and David Morgan with developing an employee survey in regards to how NMDOH employees would like to receive communications (ex: Newsletter, E-news, etc.)
- Possibly collaborate as a group to address employee communications survey results and create a communications outlet to better communication amongst the department.

Performance Measures

Objective: To improve on behalf of the DOH both the quantities of Performance Measures (PM) as well as the proportion of Performance Measures of type "Outcome."

Indicator: Percentage of "Outcome" type Performance Measures relative to all types combined ("Explanatory," "Efficiency," "Quality," "Output," and "Outcome").

Baseline: To provide at least two years of baseline data, we chose to use FY13 as the baseline dataset. In the table below, note that in FY13 there were only 11 PMs for the DOH, of which approximately 18.5% were of type "Outcome." By FY15, the DOH has increased the numbers of PMs to 31, of which approximately 38.7% are of type "Outcome."

FY13					
Explanatory	Efficiency	Quality	Output	Outcome	TOTAL
3	3	0	3	2	11
27.3%	27.3%	0.0%	27.3%	18.2%	100.0%

FY14					
Explanatory	Efficiency	Quality	Output	Outcome	TOTAL
3	3	1	5	4	16
18.8%	18.8%	6.3%	31.3%	25.0%	100.0%

FY15					
Explanatory	Efficiency	Quality	Output	Outcome	TOTAL
2	8	6	3	12	31
6.5%	25.8%	19.4%	9.7%	38.7%	100.0%

Story Behind the Data:
Performance Measures are quantifiable measure of outcomes, output, efficiency or cost-effectiveness to gauge if agencies are meeting objectives. Performance management is a shared responsibility throughout a public health system, involvement of internal and external partners in examining ways to better manage performance is encouraged (Riley, et al., 2010).

New Mexico's Accountability in Government Act (AGA; 1999) and the Public Health Accreditation Board (PHAB) stress accountability through the alignment of program activities, strategies, resources and measures of program performance.

The Performance Measure type "Outcome" is a measurement of impact or public benefit of a program (*e.g.*, rate of measles cases, per 1,000 population); this type is also a measure of the extent to which a service has achieved its goals or objectives, and met accepted standards. The PM type "Outcome" serves as the gold standard for Performance Management systems.

Outcome means a change, or lack of change, in the health of a defined population that is related to a public health intervention – such as the tests, investigations, or educational services you offered as part of your process, above. Outcomes can be of three types[2,3]:

> ***Health Status Outcome.*** A change, or lack of change, in physical or mental status.
>
> ***Social Functioning Outcome.*** A change, or lack of change, in the ability of an individual to function in society.
>
> ***Consumer Satisfaction.*** The response of an individual to services received from a health provider or program.

What Works: Accountability in Government Act (AGA) training, with a focus on Results Based Accountability (RBA) as the methodology to develop and monitor Performance Measures. Membership List: Lee Collen, Epidemiology and Response Division, Fred Schaum, Aging and Long Term Services

Strategies:
- One-on-one consultation
- Trainings

Identified Goals: To improve in both the numbers (to ensure sufficient representation of the DOH Programs as well as those programs receiving proportionally more of the State General Funds) as well as the "Outcome" type of Performance Measures.

Literature Cited:
[1]Riley, WJ, LM Beitsch, HM Parsons, JW Moran (2010) "Quality Improvement in Public Health: Where Are We Now?" ***J Public Health Management Practice*** 16(1): 1-2.

[2]Lichiello, P (XX) "The Turning Point Guidebook for Performance Measurement, University of Washington Health Policy Analysis Program, under contract to the Robert Wood Johnson Foundation/University of Washington Turning Point National Program Office.

[3]Hatry, HP, Fall, M, Singer, TO, and Liner, EB (1990) "Monitoring the Outcomes of Economic Development Programs". Washington, DC: The Urban Institute Press.

Other Agency QI Projects

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

Monitoring and Oversight

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

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

Annual Evaluation

Our QIP will be evaluated and updated on an annual basis for effectiveness in achieving the quality improvement goals that were implemented throughout the past year. A summary of activities, improvements made, processes modified, projects in progress, and recommendations for changes to the QIP will be compiled and forwarded to the Strategic Planning Council.

Dedicated Resources

The Office of Policy and Accountability provide administrative and technical support for the NMDOH's quality improvement initiatives. This support includes:

- Providing staff coordination for the monthly QI Council meetings, including:
  - Facilitating meetings
  - Developing and distributing the agenda
  - Maintaining meeting minutes
- Providing staff training in QI methods and tools.
- Assisting program staff to track their performance data.
- Providing technical assistance to programs conducting continuous QI or quality planning, which may include data collection/analysis, advice on quality methods/tools or meeting facilitation.
- RBA Coaching/training.

As needed, training specialists and consultants are also available to QI project teams and to the QI Council.

Attachment A

Quality Improvement Submission Form

To initiate a quality improvement idea or project, complete this submission form. Submission forms can be emailed to any quality improvement council member and will be reviewed and either approved or declined within thirty days.

Employee Name:	**Date:**
Explain the gap in service, efficiency or process targeted for improvement (what is the problem?):	
Explain why this project is a priority:	
What is the desired result? (Example: Reduced Turn Around Time)	
How would you like to improve? (Process)	
What customers will benefit? (Circle all that are applicable) Program External Internal Other:	
Do you have information/evidence/data available to support the need to work on this topic? Yes No	
If yes, please describe here:	
What kind of improvement will result? (Select all that apply):	

	Enhanced Employee Performance
	Improved Teamwork and Communications
	Improved Use of Resources
	Improved Working Conditions and Employee Morale
	Increased Efficiency
	Improved Quality of Services
	Increased Safety
	Reduced Cost
	Reduced Waste
	Satisfied Customers/Stakeholders
	Other:

Proposed project aligns with? (Check all that apply)	
	Accreditation
	Cultural Competency
	Department Mission, Vision, Values
	Department Strategic Plan
	Health Improvement Plan(s)
	Program Planning or Evaluation
	Other:

QI Proposal Approval	**Approved**	**Declined**	**Needs Further Review**
NMDOH Strategic Planning Council Date Received:			

Attachment B

Quality Improvement Reporting Form

Project Name:	Date:
1) Who are your customers?	
2) How can you measure if your customers are better off?	
3) How can you measure if you are delivering services well?	
4) How are you doing on the most important of these measures?	
5) Who are the partners that have a role to play in doing better?	
6) What works to do better, including no-cost and low-cost ideas?	
7) What do you propose to do?	
8) What is the return on investment? (skills/knowledge, attitude/opinion, behavior, circumstance)	
Team Members:	
Reported by:	

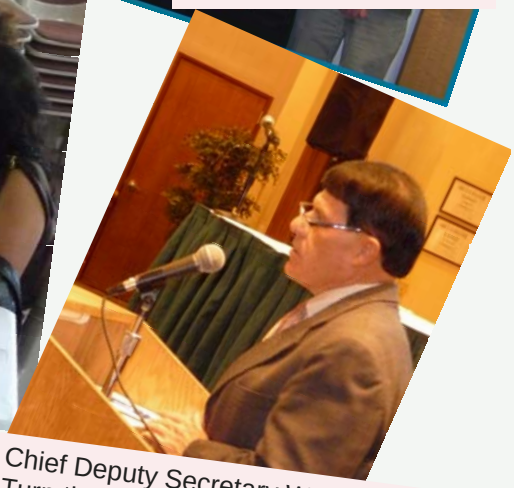
	Date Received:	Date Reviewed:	Comments:
NMDOH Strategic Planning Council Date Received:			

Our Workforce

RBA Train the Trainer Course 2012

Strategic Planning Council Members, 2013

Introduction to Public Health Course 2012



Chief Deputy Secretary Welcoming at Turn the Curve on Health Summit, 2013

Our Cabinet Secretary Signing the Accreditation Charter, 2013

Proud NMDOH team members with their Accreditation tee shirts won by submitting “benefits of Accreditation” contest, 2013

NMDOH Cabinet Secretary and Accreditation Coordinator drawing the winners of Workforce Development Assessment survey completion contestants, 2014


NEW MEXICO
DEPARTMENT OF
HEALTH