# A HEALTHIER NEW MEXICO

## NEW MEXICO STATE HEALTH IMPROVEMENT PLAN

NEW MEXICO
DEPARTMENT OF
HEALTH

MAY 2014

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If you have any questions, comments and/or feedback for Department of Health please email us at: opaforyou@state.nm.us

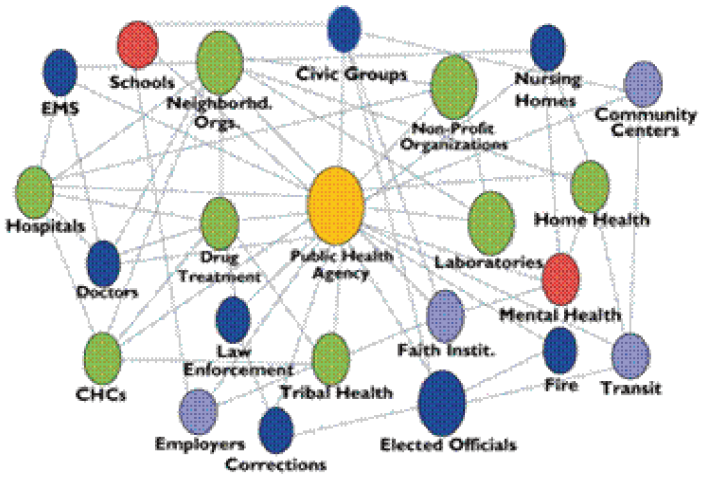
Pictured on the cover: Shiprock, NM

# EXECUTIVE SUMMARY

The New Mexico Department of Health (NMDOH) public health system is unique and diversified. It is a centralized health department serving all of its 33 counties and 22 sovereign nations through four regional public health offices and 54 local public health offices. The partnerships and strong community collaboration are important components to achieving internal objectives and the general work of public health. Through these critical partnerships NMDOH is able to develop the goals, objectives and mission of the department. The NMDOH strives to develop and foster collaborative relationships, which reach the breadth and depth of New Mexico.

For public health in New Mexico this is an exciting time. New Mexico has the opportunity to assure that the best and most appropriate evidence-based interventions are available to address its significant public health challenges confronting the state. New Mexico's population of approximately two million inhabitants is spread over a large geographic area with relatively low population density. New Mexico's rich history and multicultural heritage are strengths. However, these social and cultural differences also pose challenges for improving health status for the population.

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




The Public Health System
http://www.cdc.gov/nphpsp/essentialservices.html

A Healthier New Mexico, the State Health Improvement Plan (SHIP) in compliance with the NMDOH statutory requirement to conduct comprehensive health planning (N.M.S.A. 1978, § 9-7-4.1), which includes: a) identification of state health priorities; b) engagement of cross-disciplinary leaders as partners; and, c) the inclusion of regional, community and tribal input for strategic planning. NMDOH is focused on injury and disease indicators that particularly impact New Mexicans; as well as, adverse health conditions with significant disparities among subpopulations or geographic areas.

# INTRODUCTION AND BACKGROUND

## PRIORITY HEALTH INDICATORS FRAMEWORK

In the spring of 2011, NMDOH engaged its leadership to identify a set of proposed priority health issues for agency programs and partners to strategically focus on to improve health status in New Mexico. In order to complete this process, the department reviewed national publications, such as the Agency for Healthcare Research and Quality (AHRQ) State Snapshots, the Commonwealth Fund State Scorecard, America's Health Rankings, Kaiser State Health Facts and the Annie Casey Foundation Kids Count Data Book.

After this list was compiled, the indicators were compared to the Centers for Disease Control and Prevention (CDC) "Winnable Battles" and the Healthy People 2020 list of leading indicators; as well as, the State of the Health in New Mexico Report and the New Mexico Racial and Ethnic Health Disparities Report Card. The list was presented to a steering committee of senior staff.

Priorities were selected based on the following additional criteria:

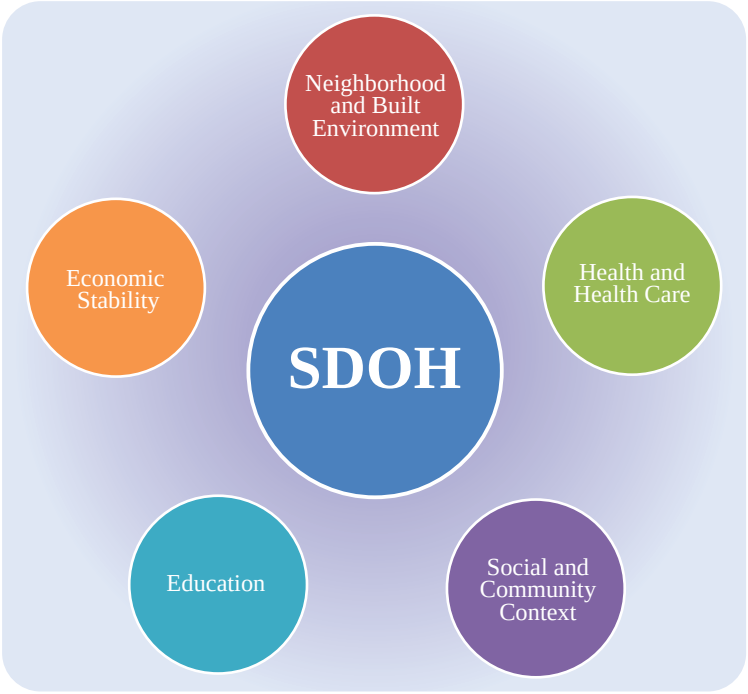
- Indicators where NM's rates are high.
- Indicators where NM ranks in bottom ten of states.
- Indicators that affect large segments of the population.
- Indicators which have large disparities.
- Community Transformation Grant indicators.

In addition to the criteria listed above, the health indicators were selected to represent all life stages of a person. All age groups were represented and factors that demonstrate health disparities and health determinants were examined to provide a representative group of indicators. The process was presented to each Turn the Curve on Health event, including the statewide event and 5 regional events. Participants were then asked to provide input on the proposed indicators.

### PRIORITY HEALTH INDICATORS

| HP2020 Topic Areas | NMDOH Leading Health Indicators |
|---|---|
| Nutrition, Physical Activity, and Obesity | • Childhood Obesity |
| Tobacco | • Adults who smoke |
| Substance Abuse | • Drug Overdose Deaths<br>• Alcohol-Related Deaths |
| Clinical Preventive Services | • Diabetes Hospitalizations<br>• Oral Health<br>• Adult Immunizations |
| Injury and Violence | • Older Adult Fall Deaths |
| Reproductive and Sexual Health | • Teen Births |
| Access to Health Services | • Access to Care |

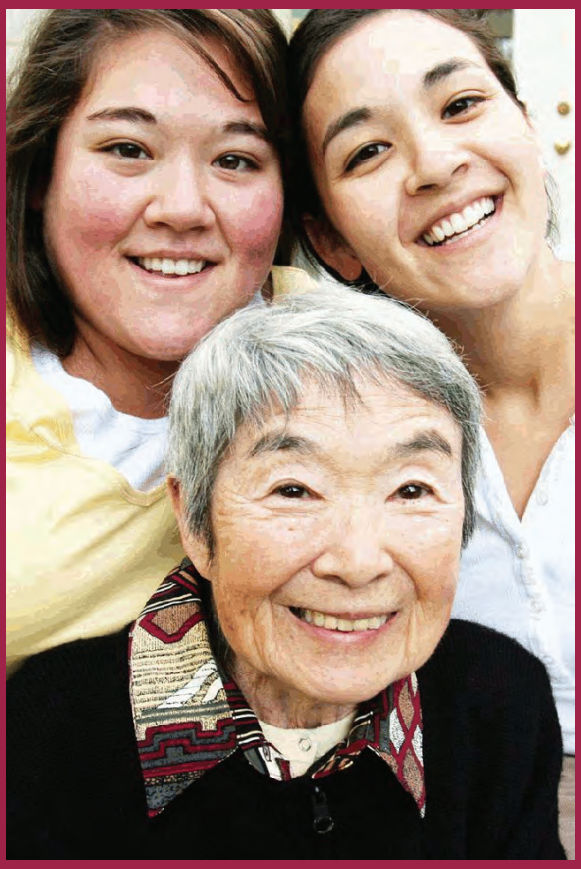
NMDOH recognizes the important and crucial role that the social determinants of health (SDOH) play on overall health status. Improvements in SDOH impact downstream health outcomes with the result of achieving health equity, eliminating disparities, and improving the health of all the people in New Mexico.




Where people live, learn, work, and play are as important to health outcomes as medical intervention. In addition, preferences of individuals from disparate backgrounds impact their health choices and how and when they use the health system. As this recognition increases, public health will have more opportunities to influence policy makers to incorporate environmental and economic considerations into health policies. A health care system that is more appreciative of the diverse cultures of New Mexico may look to public health for lessons learned in applying cultural competence to health improvement efforts. Public health also provides guidance in identifying accountability measurements, other than clinical indicators, that show the impact on population health disparities, and/or economic and healthcare utilization indicators. By including a healthcare system indicator, such as access to care, in the list of leading health indicators, NMDOH helps to better connect the work of the healthcare system to population health.

***A Healthier New Mexico*** (HNM) outlines each SDOH and its accompanying components that affect overall health status. The HNM perspective lays the foundation to view health through multiple lenses rather than just the medical model. The new approach to state health improvement planning will evolve from the collective work accomplished throughout the State to mirror a more upstream approach, reflected in the national Healthy People 2020 initiative.

NMDOH is eager to begin its venture into the future through achieving the results and objectives outlined in A Healthier New Mexico, the state health improvement plan. NMDOH will focus on building on the foundation created over the years and continue to empower, mobilize and strengthen communities and government-to-government relationships through statewide collaborations and partnerships. New Mexico's common goals of improving and ensuring lifelong health for its people will reach across all sectors. NMDOH understands that health is not achieved by one agency nor can it be done alone. NMDOH readily relies on advice and consultation to steer the agency's efforts toward a common vision of a healthier New Mexico.



## NM STATE HEALTH IMPROVEMENT PLAN PROCESS [2014-2016]

The 2014 State Health Improvement Plan (SHIP), A Healthier New Mexico, is one that will evolve each year with strategies and targets established using a collaborative approach that will build upon the previous SHIP, making this a living document relevant to a dynamic environment. Each year, the NMDOH and its partners at the state and local levels will examine strategies to effectively address the nine priority health indicators, measure the effectiveness of the strategies with an attempt to answer the questions: "How well did we do?" (Quality) and/or "Is anyone better off?" (Result or outcome).

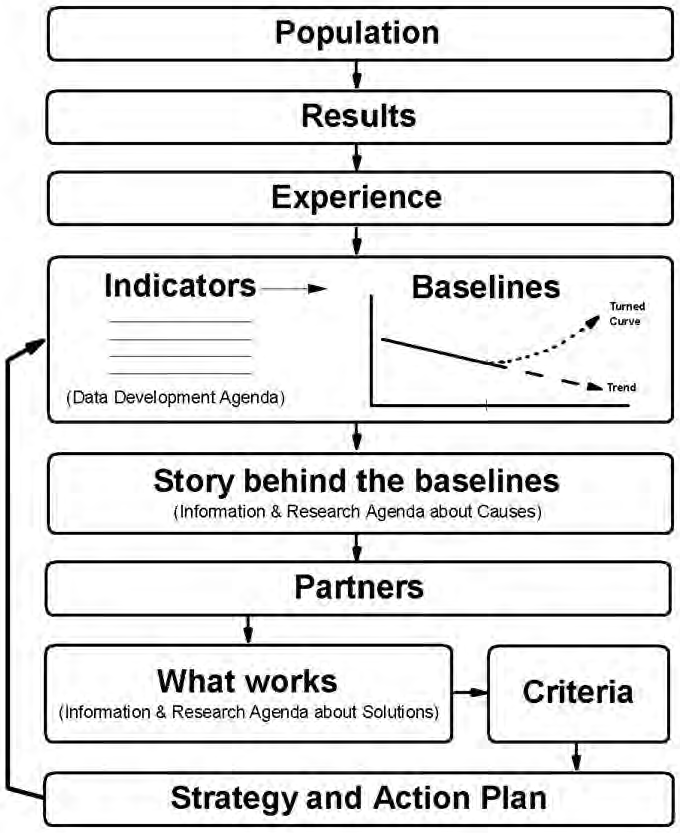
Strategies will be evidence-based or implemented using the Results-Based Accountability or other evaluation model to ensure effectiveness. Many evidence-based and promising practices strategies recommended are based on low-cost, no-cost strategies with contributions from diverse partners. NMDOH promotes these types of strategies as they are more easily sustained.

The sequence of events for the subsequent five years will be planned methodically and strategically, aligning the NMDOH strategies with new and emerging research and evidence.

### Health Improvement Planning Process

First, a planning committee was selected by the NMDOH Cabinet Secretary to include leaders in NMDOH. The team planned the health improvement process to include: a) identifying health priorities for the state; b) engaging cross-disciplinary leaders as partners; and c) incorporating regional, community and tribal input for planning and implementing strategies.

# POPULATION ACCOUNTABILITY
## "TURN THE CURVE"




**WHAT IS THE "END IN MIND"?**
*Choose either a result and indicator or a performance measure*

**HOW ARE WE DOING?**
*Graph the historic baseline and forecast for the indicator or performance measure*

**WHAT IS THE STORY BEHIND THE CURVE OF THE BASELINE DATA?**
*Briefly explain the factors (+ or – and internal and external) that are most strongly influencing the curve of the baseline*

**WHO ARE THE PARTNERS WHO HAVE A ROLE TO PLAY IN TURNING THE CURVE?**
*Identify partners*

**WHAT WORKS TO TURN THE CURVE?**
*Determine what would work to turn the curve. Include no-cost/low-cost strategies, evidence-based*

**WHAT DO WE PROPOSE TO DO TO TURN THE CURVE?**
*Determine what you and your partners propose to do to turn the curve of the baseline.*

### Quality Improvement Model

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

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

## Turn the Curve on Health

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

The ***Turn the Curve*** process was repeated during the months of April and May 2012 in five regional locations: Roswell, Gallup, Las Cruces, Albuquerque, and Santa Fe. At the end of these regional meetings, participants were asked to join the NMDOH to improve health in their local communities by contributing at least one evidenced-based action. Partner agreements were collected and NMDOH subject matter experts continue to work with partners to implement projects.

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

During these meetings, community input was gathered on the selected health indicators. The input served as an opportunity for community partners to put forth health indicators they believed was important for future consideration. There was broad consensus that the nine (9) proposed measures were appropriate priorities for the state.

During each event, NMDOH asked the community partners to select one the nine health indicators to learn more about the indicator and move from "talk to action" toward improved health outcomes. Based on the chosen health indicator, small groups were assembled with the Indicator Lead (IL). The ILs introduced the RBA approach, provided county and state level data for each indicator and the evidence-based and/or promising practices found to be effective to address the specific health indicator. Partners were then asked to establish an agreement to work with NMDOH to implement a strategy to turn the curve on that indicator in their community.

## Summit

In October 2013, NMDOH conducted a Second Statewide ***Turn the Curve on Health*** summit and invited stakeholders from various disciplines across the State. A total of ninety-two (92) participants attended the one-day meeting. NMDOH presented and reviewed the State of Health in New Mexico, the State Health Assessment (SHA), and sought input from the audience on whether the data was representative of our state and asked for input on the current 9 priority health indicators. NMDOH discussed the planning framework for the SHA, presenting the specific data related to tribal assessments and county-level assessments. Participants also were informed of statewide plans for health improvement and asked to provide feedback on the process. The subsequent open dialogue promoted input and a great perspective from the participants. Each section of the agenda was followed by a questions and answers portion in order to focus of participants' questions and allow multiple opportunities for feedback and participation. Recommendations and input were collected by NMDOH staff for inclusion in the SHA and the State Health Improvement Plan.

### Engaging Partners through an Established and Seamless Process

In this section, NMDOH describes the State Health Improvement Plan process for working with state, tribal, and community partners to identify health priorities and to develop a comprehensive state health improvement plan that reflects partnership activities to improve population health.

NMDOH readily relies on three tiers of partners to provide key sources of collaboration and input to state health assessment and improvement efforts:

I. Secretary's Statewide Leadership Consultation
II. State-Level Health Priority Groups
III. Local Level: County, City and Tribal Partners

The ongoing SHIP process will include a variety of engagement opportunities, including a minimum of annual opportunities to allow each level of stakeholders to recommend changes to health priorities and emerging issues, results, indicators, interventions, and performance measures that are based on reviews of assessments and performance reports.

## Secretary's Statewide Leadership Consultation

The Health Cabinet Secretary's Statewide Leadership Consultation includes broad representation from other state agencies, statewide organizations, healthcare providers, and members from counties and sovereign nations. This stakeholder group will review the State Health Assessment to identify priority health issues and themes, evaluate the resources and assets to effectively address those health priority issues, and determine/update the state's priority health issues. This group will convene at least annually, or more frequently as necessary.

The NMDOH Cabinet Secretary may convene a subset of this group to promote enhanced statewide partnership and active participation in the planning process. The group includes other department cabinet secretaries working on population health improvement. The Secretary will also brief the Governor on NMDOH health assessment and improvement priorities and activities.

The Tribal planning process will adhere to the State-Tribal Collaboration Act. The specifics of the planning process shall be determined by the Cabinet Secretary of Health, in close collaboration with the NMDOH tribal liaison, and the state Indian Affairs Department. NMDOH is working on establishing a Tribal section in A Healthier New Mexico in the future.

### State-Level Health Priority Groups

The entities that comprise state-level health priority specific groups focus on one or more of the health priority areas. These existing groups include NMDOH staff and their partners that work together to define statewide objectives and focus on statewide results. These groups establish health area indicators, measures, and strategies for the current nine (9) health priority areas. Further, these groups historically identify policy agendas and engage individuals and organizations responsible for implementing strategies and activities.

**Examples of State-Level Health Priority Groups:**

- Older Adult Fall Deaths: The New Mexico Adult Fall Prevention Coalition
- Dental visits: NM Oral Health Advisory Committee
- Diabetes: New Mexico Diabetes Coalition
- Drug Overdose: Prescription Drug Misuse and Overdose Prevention and Pain Management Advisory Council
- Adult Immunizations: New Mexico Immunizations Coalition
- Obesity: NM Healthier Weight Council
- Access to Care: Developing partnership with HealthInsight New Mexico
- Tobacco: New Mexico Chronic Disease Prevention Council (CDPC) – Tobacco Control Policy Subgroup

### Local Level Participation

The State Health Assessment process will provide county, community and tribal health councils (and their partners) county level data, including rankings and small area data when possible, for each priority health indicator in an effort to identify subpopulation health disparities. After a review of the State Health Assessment, county/tribal profiles, local health issues, and resources and assets, county priority health issues will be identified.

NMDOH regional health promotion teams collaborate with county and tribal health councils to identify evidence-based or promising practice strategies to implement in order to promote collective impact on a health indicator. Health promotion teams strengthen collaborative efforts at the local level, relying on NMDOH program indicator leads to provide health councils and community partners with data, technical assistance and other resources at the request of local communities.

### Community and Tribal Health Councils: Hubs of Local Public Health

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

CHCs assess local health needs, identify gaps in services, develop community health assessments and plans with priorities, and coordinate community health improvement initiatives. Councils serve as vital partners of the statewide public health system, providing local information and feedback to NMDOH and other organizations regarding community health needs and priorities.

## New Mexico's Current Health Council System

The system is comprised of 33 county-based health councils and five tribal health councils (Acoma, Cochiti, San Ildefonso, Santa Clara, and To'Hajiilee). Many of these health councils were originally established under provisions of the 1992 Maternal and Child Health Plan Act. The New Mexico Department of Health provides training, coordination, technical assistance, and other kinds of support to the health councils. The existing health councils have varying degrees of resources and infrastructure. New Mexico's community health councils have achieved a number of positive changes in their communities that in turn result in improved community health:

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

## Planning for Change

In March of 2013, the General Appropriation Act of 2013 passed the New Mexico Legislature and included a recurring state general fund appropriation to the NMDOH Public Health Division of $195,000 for statewide county and tribal health councils.

With this funding, DOH is working with County and Tribal Health Councils (CHC) on the following options that were designed to assist councils at the level they were currently at and offer the resources to get them to the next level.

OPTION 1 (12 CHCs) Capacity Building: Rebuilding council membership, training in community health improvement and beginning to engage community to develop health profiles for the community health assessment.

CHCs: Acoma, Catron, Cochiti, Colfax, Curry, Eddy, Guadalupe, Hidalgo, Roosevelt, San Ildefonso, Sierra, and To'hajiilee

OPTION 2 (18 CHCs) Community Engagement towards a Health Improvement Plan: Use health profile to engage the community, create concise prioritized assessment and distribute back to community.

CHCs: Bernalillo, Chaves, Cibola, DeBaca, Dona Ana, Harding, Lea, Los Alamos, Luna, McKinley, Mora, Otero, San Juan, San Miguel, Sandoval, Santa Clara Pueblo, Socorro, Torrance, Valencia

OPTION 3 (5 CHCs) Community Health Improvement Plan Implementation: With community engagement, select three health priorities, select strategies and assign responsibilities, and begin implementation.

Grant: behavioral health, community health and safety, interpersonal violence, and family resiliency.
Quay: nutrition, physical activity, tobacco use and substance abuse; also described as healthy eating, active living and prevention of unhealthy substance use.

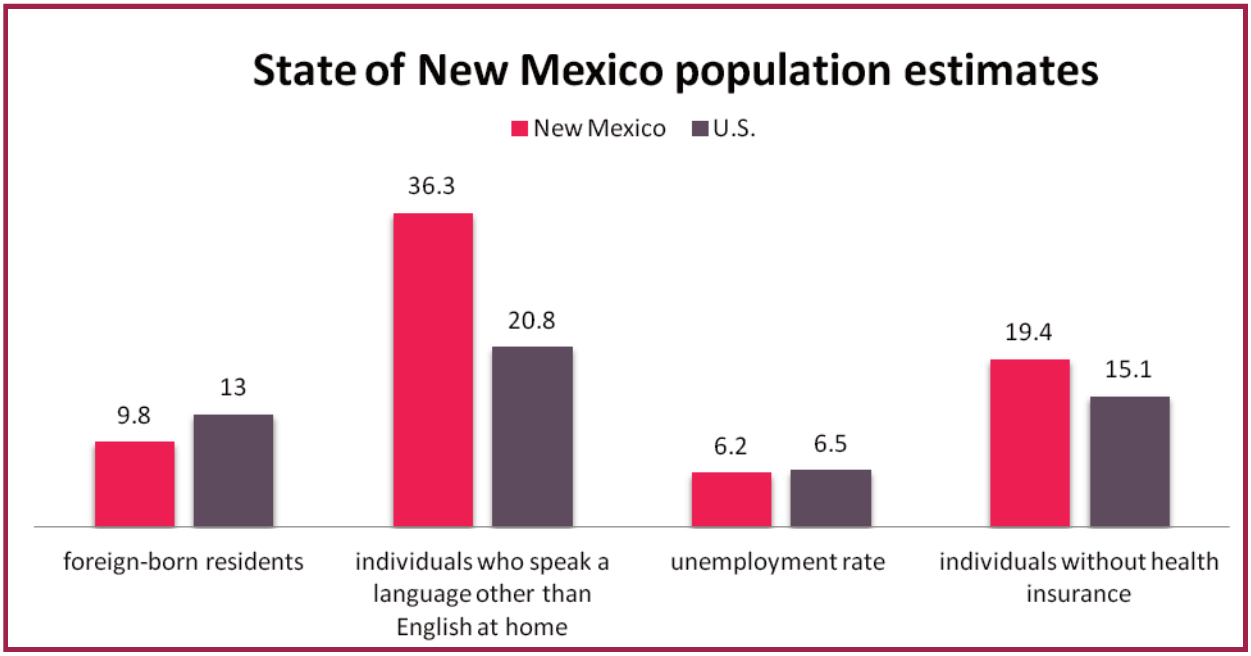
Rio Arriba: nutrition, physical activity, tobacco use and substance abuse; also described as healthy eating, active living and prevention of unhealthy substance use.

Santa Fe: lack of insurance, alcohol abuse, drug abuse, low birth weight babies, suicide, increase consumption of healthy foods.

Taos: ranked in priority, 1. Access/Affordability of healthcare; 2. Alcohol/ substance abuse; and, 3. Behavioral health/suicide.

Lincoln and Union counties elected not to participate in this offer.

## Challenges and Opportunities




Source: U.S. Census Bureau, American Community Survey, 3-Year Summary File.
Downloaded from http://www.factfinder2.census.gov on 4/29/2014

The concept of health disparities is important nationally; however, it is especially relevant for New Mexico. No single race/ethnic group makes up a majority of the state's population. According to the Geospatial and Population Studies Program, University of New Mexico, 2012 state population estimates, 46.4% of New Mexicans were Hispanic and 41.4% were White. Although the United States is increasingly diverse, Whites who are not Hispanic comprise over sixty percent of the national population compared to forty percent of New Mexico's population.

Additionally, NM has 22 sovereign nations (19 pueblos: Acoma, Cochiti, Isleta, Laguna, Nambe, Ohkay Owingeh, Picuris, Pojoaque, Sandia, San Felipe, San Ildefonso, Santa Ana, Santa Clara, Santo Domingo, Taos, Tesuque, Jemez, Zia, Zuni; Navajo Nation; Mescalero Apache Tribe; Jicarilla Apache Nation) within its geographic borders, as well as urban off-reservation based populations.

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

6 of 10 New Mexicans belong to racial/ethnic minorities

36 of 100 speak a language other than English at home

1 of 5 are without health insurance

21 of 100 live below the poverty level

45.4% Female-headed families with children in poverty

New Mexico is a vast state. The land area totals 121,298.15 square miles at 17.2 persons per square mile (U.S. population density is 88.9 persons per square mile). Due to the low density with many people residing in rural parts of the state, it is difficult to access resources, such as health centers, hospitals, food pantries, and grocery stores.

## Health Equity as a Foundational Lens

The strategic approach for New Mexico is to address the social determinants of health that perpetuate health disparities, namely: reduce poverty; promote system and built environment initiatives across traditional and non-traditional sectors; reduce barriers to health and public health services; and, increase cultural and linguistic effectiveness of the public health and healthcare workforce.

Cultural and linguistic competency for New Mexico's public health and healthcare workforce is essential to mitigating barriers. Competencies include knowledge and skills related to race, ethnicity, language, sexual orientation, and cultural expectations and understanding, which contribute to improving access to the health system. New Mexico is dedicated to developing its capacity to communicate effectively and convey information in a way that is easily understood by its diverse populations (e.g., persons of limited English proficiency, low literacy skills or are not literate, and people with disabilities).

New Mexico proposes to develop a cultural assessment tool by which public health agencies may gauge their effectiveness to draw on community based values, traditions, customs and languages to provide access to and for better health care delivery by its providers. The assessment will identify root causes of racial and ethnic inequities, recommend operational and decisional processes to eliminate practices negatively impacting service provision, and inform policy development and resource management.

Many populations in New Mexico bear the weight of serious health disparities (morbidity and mortality); as well as, educational and economic status inequity. The NMDOH approach to health improvement stresses the collective roles and responsibilities among a diverse set of partners. The health improvement planning model, Results-Based Accountability, impresses the importance of a commitment to a common result and the contributions of state and community partners to move from talk to action in the name of improved health outcomes for those most burdened in our state. A Healthier New Mexico intends to shed light on these challenges and encourage collective action toward health equity for all.

### ECONOMIC WELL-BEING

Poverty rate: 20.8%

Extreme poverty rate: 9.2%

### POVERTY BY DEMOGRAPHIC

Child poverty rate: 29%

Senior poverty rate: 13%

Women in poverty: 19.7%

42% of single-parent families with related children that are below poverty

197,000 Hispanic children below 200% poverty

### PARTICIPATION IN FEDERAL PROGRAMS

40,798 Adults and children receiving welfare (TANF)

202,000 Children receiving food stamps (SNAP):

218,000 EITC recipients

26,941 Households receiving federal rental assistance

11,800 Families receiving child care subsidies

11,296 Participants in all Head Start programs

390,698 children enrolled in Medicaid and CHIP

61,405 women and children receiving WIC (Women, Infants and Children supplemental nutrition program)

64,995 Households receiving LIHEAP (Low Income Home Energy Assistance Program)

Source: Spotlight on Poverty and Opportunity, downloaded from http://www.spotlightonpoverty.org 4/22/2014.

### Priorities for the State

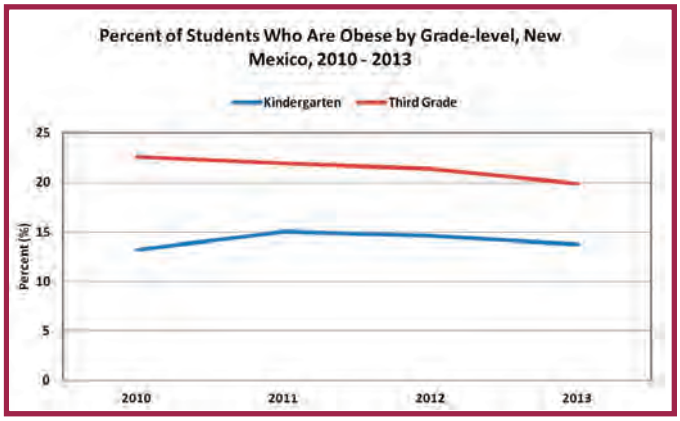
The strategies outlined in this plan reflect those that are done in collaboration with others. The department will report on progress on an annual basis detailing the implementation, timelines, and progress towards meeting the objectives set fourth around these 10 priority indicators. NMDOH will monitor progress on these indicators utilizing the tracking system, Results for People Scorecard. The public will have access to view the tracking system through the NMDOH website. NMDOH is committed to achieving ***A Healthier New Mexico*** in partnership with other dedicated agencies, organizations, non-profit entities, public health professionals, and devoted individuals.

## HEALTH PRIORITY: REDUCE CHILDHOOD OBESITY

## POPULATION HEALTH IMPROVEMENT RESULT: A HEALTHIER NEW MEXICO

**Measurable Objectives:**

- Third grade childhood obesity rates (reduce)
- Percent of students in Healthy Kids Healthy Communities (HKHC) public elementary schools with increased healthy eating opportunities
- Percent of students in HKHC public elementary schools with increased physical activity opportunities
- Percent of students participating in the 5.2.1.O Healthy Eating & Physical Activity Challenge




**Story Behind the Data:** Nationally and in New Mexico, childhood obesity is occurring at very young ages. This means that children are developing unhealthy eating and physical activity habits and sedentary tendencies early in life, making it more difficult for them to lead healthy lifestyles as adults. Obese children are more likely to become obese adults and suffer from chronic diseases such as heart disease, cancer, and diabetes. In 2013, 13.7% of kindergarten and 19.9% of third graders were obese. American Indian children have the highest obesity rates among all racial/ethnic groups in New Mexico. By third grade, nearly one-in-two American Indian students are overweight or obese.

Even though rates remain high, there appears to be a downward trend in obesity prevalence among third grade students; rates have decreased by 11.9% from 2010 to 2013, going from 22.6% to 19.9%. This pattern is not seen among kindergartners, where rates have remained more or less level over the four years. From 2010 to 2013, American Indian third graders experienced a large decrease in obesity rates. Over four years, rates have dropped from 36.6% to 29.5%, corresponding to a 19.4% change. Hispanic students experienced little if any change in obesity prevalence between 2010 and 2013. This is particularly troubling considering this group comprises the majority of elementary school-age children in New Mexico.

## What Works Strategies:

**1 Strategy** Expand children's healthy eating opportunities during the school day, including weekly or monthly fruit and vegetable tastings in the classroom, regular salad bars or pre-made salads, and fruits and vegetables offered as snacks.

| SHIP Measures | Baseline | Target | Responsible Partners |
|---|---|---|---|
| Percent of Healthy Kids Healthy Communities (HKHC) public elementary schools with increased healthy eating opportunities | 59% (FY14) | 75% (FY16) | Healthy Kids New Mexico; Healthy Kids Healthy Communities; NM Interagency Council; PED; HSD; CYFD |
| Percent of students in HKHC public elementary schools with increased healthy eating opportunities | 64% (FY14) | 75% (FY16) | Healthy Kids New Mexico; Healthy Kids Healthy Communities; NM Interagency Council; PED; HSD; CYFD |

**2 Strategy** Expand children's physical activity opportunities before, during, and after school, including opening neighborhood schoolyards for community use and establishing regular walking and biking to school programs.

| SHIP Measures | Baseline | Target | Responsible Partners |
|---|---|---|---|
| Percent of HKHC public elementary schools with increased physical activity opportunities | 55% (FY14) | 65% (FY16) | Healthy Kids New Mexico; Healthy Kids Healthy Communities; NM Interagency Council; DOT |
| Percent of students in HKHC public elementary schools with increased physical activity opportunities | 47% (FY14) | 60% (FY16) | Healthy Kids New Mexico; Healthy Kids Healthy Communities; NM Interagency Council; DOT |

**3 Strategy** Establish and expand the Healthy Kids New Mexico 5.2.1.O Challenge in elementary schools across New Mexico.

| SHIP Measures | Baseline | Target | Group Members |
|---|---|---|---|
| Percent of NM public elementary school districts participating in 5.2.1.O | 21% (FY14) | 30% (FY16) | Healthy Kids New Mexico; Healthy Kids Healthy Communities; NM Interagency Council; PED; HSD; CYFD |
| Percent of third grade students in NM public elementary school districts participating in 5.2.1.O | 20% (FY14) | 30% (FY16) | Healthy Kids New Mexico; Healthy Kids Healthy Communities; NM Interagency Council; PED; HSD; CYFD |

**4 Strategy** **New Mexico Interagency Council for the Prevention of Obesity**
Build greater alignment across 35 state programs to create collaborative and sustainable initiatives and consistent messages to increase physical activity and healthy eating and prevent obesity, especially among children and vulnerable groups.

| SHIP Measures | Baseline | Target | Group Members |
|---|---|---|---|
| Number of licensed childcare facilities that receive training and technical assistance on strategies to increase healthy eating and physical activity | 0% (FY14) | 25% (FY16) | Key Members:<br>**Human Services Department:**<br>Mary Oleske and Stephanie Johnson<br>**Children, Youth and Families Department:**<br>Pam Mitchell, Anita Lovato and Kimberly Jones<br>**Public Education Department:** Donia Intriere<br>**Department of Transportation:** Rosa Kozub<br>**New Mexico Department of Health:**<br>Gwen Bounds (WIC), Patty Morris, Rita Condon and Katharine VonRueden |

# CHILDHOOD OBESITY PREVALENCE TRENDS NM, 2010–13

TABLE 1. PERCENTAGE OF STUDENTS OVERWEIGHT OR OBESE BY GRADE, NM, 2010–13

| | KINDERGARTEN | | | | THIRD GRADE | | | |
|---|---|---|---|---|---|---|---|---|
| | 2010 | 2011 | 2012 | 2013 | 2010 | 2011 | 2012 | 2013 |
| Obese | 13.2% | 15.0% | 14.6% | 13.7% | 22.6% | 21.9% | 21.4% | 19.9% |
| Combined Overweight/Obese | 30.3% | 30.5% | 28.1% | 27.7% | 38.7% | 38.6% | 36.8% | 34.7% |
| Number in Sample | 1,800 | 1,885 | 2,116 | 3,928 | 1,642 | 1,768 | 1,833 | 3,803 |

TABLE 2. PERCENTAGE OF KINDERGARTEN STUDENTS OVERWEIGHT OR OBESE BY RACE/ETHNICITY, NM, 2010–13

| | AMERICAN INDIAN | | | | HISPANIC | | | | WHITE | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Obese | 25.5% | 20.6% | 23.8% | 21.6% | 12.9% | 17.7% | 14.2% | 14.6% | 8.8% | 8.7% | 11.8% | 9.3% |
| Combined Overweight/Obese | 41.0% | 42.7% | 36.8% | 39.6% | 31.8% | 31.5% | 29.2% | 28.6% | 24.8% | 21.9% | 22.1% | 22.2% |
| Number in Sample | 232 | 369 | 222 | 339 | 927 | 842 | 1,279 | 2,417 | 466 | 532 | 505 | 1,018 |

TABLE 3. PERCENTAGE OF THIRD GRADE STUDENTS OVERWEIGHT OR OBESE BY RACE/ETHNICITY, NM, 2010–13

| | AMERICAN INDIAN | | | | HISPANIC | | | | WHITE | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | 2010 | 2011 | 2012 | 2013 | 2010 | 201 | 2012 | 2013 | 2010 | 2011 | 2012 | 2013 |
| Obese | 36.6% | 35.6% | 30.0% | 29.5% | 22.6% | 20.0% | 22.7% | 22.7% | 17.8% | 13.7% | 15.2% | 12.8% |
| Combined Overweight/Obese | 55.4% | 49.7% | 50.0% | 47.3% | 39.4% | 39.7% | 39.3% | 38.8% | 31.7% | 26.5% | 26.5% | 25.1% |
| Number in Sample | 194 | 342 | 201 | 291 | 983 | 802 | 1038 | 2,262 | 369 | 460 | 495 | 1,086 |

TABLE 4. PERCENTAGE OF STUDENTS OVERWEIGHT OR OBESE BY GENDER,NM, 2010–13

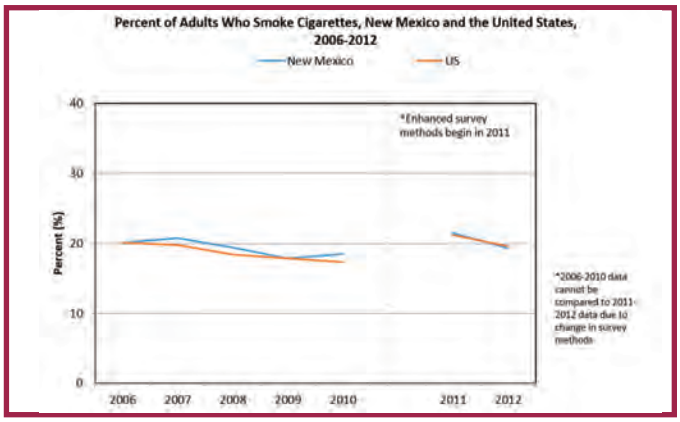
| | FEMALE | | | | MALE | | | |
|---|---|---|---|---|---|---|---|---|
| | 2010 | 2011 | 2012 | 2013 | 2010 | 2011 | 2012 | 2013 |
| Obese | 16.8% | 17.0% | 15.4% | 15.6% | 19.0% | 19.5% | 20.3% | 17.7% |
| Combined Overweight/Obese | 33.6% | 32.9% | 29.9% | 30.1% | 35.4% | 35.8% | 34.6% | 31.9% |
| Number in Sample | 1,757 | 1,776 | 1,977 | 3,73. | 1,685 | 1,877 | 1,972 | 4,001 |

## HEALTH PRIORITY: REDUCE TOBACCO USE

# POPULATION HEALTH IMPROVEMENT RESULT: A HEALTHIER NEW MEXICO

**Measurable Objectives:**

- Adult Cigarette Use by State and County
- Youth Tobacco Use (cigarettes, cigars, smokeless, hookah) by State and County
- Percent of youth and adults exposed to secondhand smoke
- Percent of NM households who completely prohibit smoking in their home
- Percent of QUIT NOW Cessation Services enrollees who are satisfied with services




**Story Behind the Data:** Cigarette smoking continues to decline in New Mexico—from 21.5% (2011) to 19.3% (2012) among adults and from 19.9% (2011) to 14.4% (2013) among high school youth. However, this still represents 302,000 adults and 17,000 youth who smoke cigarettes in NM. Linking New Mexicans directly and through health care systems to proven cessation services such as QUIT NOW (coaching/counseling) and effective nicotine replacement therapies (e.g., patches, gum, and lozenges) is a key strategy. Promoting and making these services available is especially important as the public health world struggles with emergence of new products such as electronic cigarettes and insufficient evidence regarding potential harms and benefits of such products. According to the Centers for Disease Control and Prevention, experimentation and current use of e-cigarettes among youth doubled during 2011-2012. Efforts to encourage and support the creation of smoke-free environments (i.e., homes, cars, campuses) and other policies addressing the time, place, and manner in which tobacco is advertised and sold play an important role in strengthening smoke-free social norms and complementing tobacco use prevention and cessation activities.

**What Works Strategies:**

**1 Strategy** Provide QUIT NOW and DEJELO YA telephone- and web-based cessation services supported by media, training, and community outreach designed to increase tobacco cessation awareness and referrals.

| SHIP Measures | Baseline | Target | Responsible Partners |
|---|---|---|---|
| Number of New Mexicans accessing QUIT NOW and DEJELO YA cessation services | 7,500 (FY14 estimate) | 8,000 (FY16) | DOH-TUPAC Program, Cessation Services Provider, Community-based Organizations, Health Care Providers, County & Tribal Health Councils, Priority Population Networks |
| Percent of QUIT NOW and DEJELO YA enrollees who report being satisfied with the services | 90% (FY13) | 92% (FY16) | DOH-TUPAC, Cessation Services Provider, Community-based Organizations, Health Care Providers, Priority Population Networks, TUPAC Evaluation Team |

**2 Strategy** Expand linkages between Tobacco Use Prevention and Control (TUPAC) Program and other DOH programs and community-based organizations (e.g., non-profits, health councils, tribal groups, priority population networks, etc) to promote QUIT NOW and DEJELO YA cessation services.

| SHIP Measures | Baseline | Target | Responsible Partners |
|---|---|---|---|
| Number of DOH program or community-based organization participants who complete online Brief Tobacco Intervention Training for Health Care Providers | 150 (FY14 estimate) | 200 (FY16) | DOH-TUPAC, Cessation Services Provider, Community-based Organizations, Health Care Providers and Systems, WIC Program |
| Number of new clinics or providers implementing a fax referral system for tobacco users to QUIT NOW and DEJELO YA. | 4 (FY14) | 50 (FY16) | DOH-TUPAC, Cessation Services Provider, WIC Program Clinics, Federally-Qualified Health Centers, Community-based Organizations |

**3 Strategy** Support smoke-free multi-unit housing community secondhand smoke education and voluntary policy efforts through use of data, strategic partnerships, and training statewide.

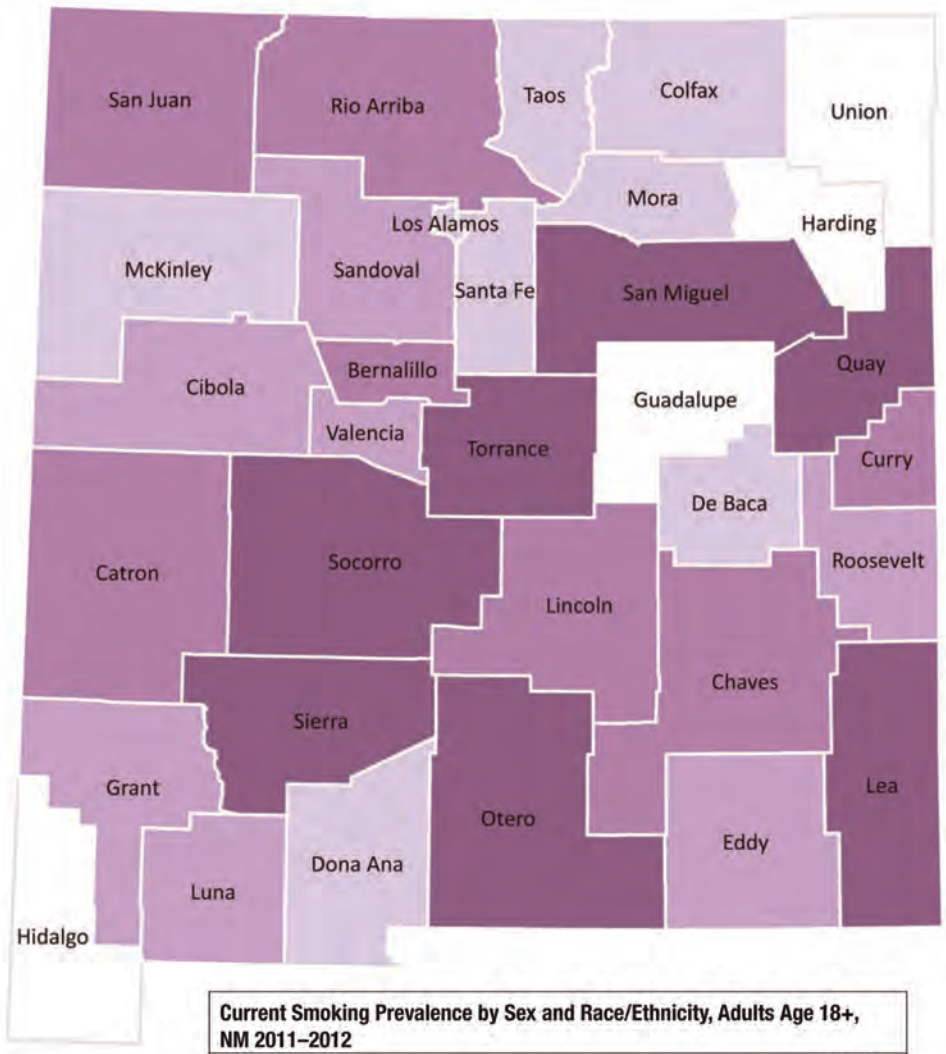
| SHIP Measures | Baseline | Target | Responsible Partners |
|---|---|---|---|
| Number of multi-unit housing units statewide that are protected by a smoke-free policy that was developed through secondhand smoke education and technical assistance efforts with property managers/owners. | 848 (FY14 estimate) | 1,200 (FY16) | American Lung Association, Santa Fe Public Schools, San Juan County Partnership, other Community-based Organizations, County & Tribal Health Councils, Multi-unit Housing Owners, Managers & Tenants, HUD Section 8 Housing Program, NM Public Housing Authorities |

**4 Strategy** **New Mexico Chronic Disease Prevention Council (CDPC) – Tobacco Control Policy Subgroup**

Bring together community partners interested in working on tobacco control policy issues statewide, build and enhance capacity of subgroup to further tobacco policy efforts, provide input to the larger CDPC, and identify appropriate resources.

| SHIP Measures | Baseline | Target | Responsible Partners |
|---|---|---|---|
| Number of New Mexicans accessing QUIT NOW and DEJELO YA cessation services | 7,500 (FY14 estimate) | 8,000 (FY16) | DOH-TUPAC Program, Cessation Services Provider, Community-based Organizations, Health Care Providers, County & Tribal Health Councils, Priority Population Networks |

# ADULT SMOKING PREVALENCE BY COUNTY NM, 2011–2012




| County | Percentage of Adults 18+ |
|---|---|
| NM, Overall | 20.4% |
| Los Alamos | 11.8% |
| Taos | 13.7% |
| McKinley | 13.8% |
| Mora | 15.2% |
| Colfax | 15.5% |
| Santa Fe | 16.8% |
| Dona Ana | 17.0% |
| De Baca | 17.4% |
| Sandoval | 17.8% |
| Cibola | 18.8% |
| Roosevelt | 19.2% |
| Luna | 19.7% |
| Grant | 20.2% |
| Eddy | 20.8% |
| Valencia | 20.9% |
| Bernalillo | 21.0% |
| San Juan | 22.6% |
| Chaves | 22.8% |
| Lincoln | 23.0% |
| Curry | 23.5% |
| Rio Arriba | 23.5% |
| Catron | 24.0% |
| Otero | 24.7% |
| Socorro | 24.8% |
| Lea | 27.4% |
| Quay | 27.6% |
| Sierra | 28.8% |
| San Miguel | 29.4% |
| Torrance | 31.0% |
| Guadalupe | ** |
| Harding | ** |
| Hidalgo | ** |
| Union | ** |

Source: Behavioral Risk Factor Surveillance System survey data, New Mexico Department of Health, Injury and Behavioral Epidemiology Bureau.

**Sample sizes were insufficient to generate reliable estimates.

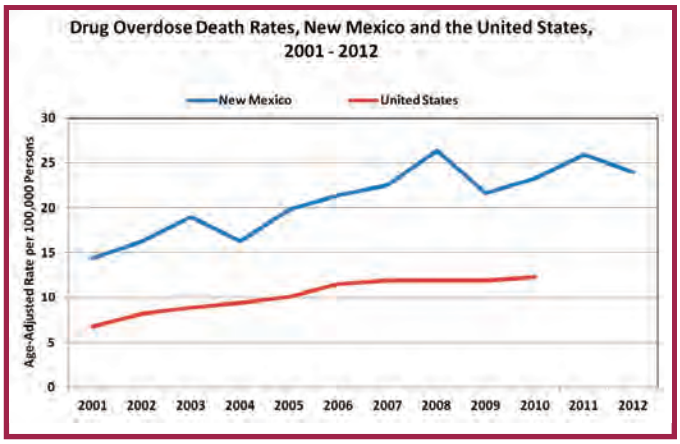
| Current Smoking Prevalence by Sex and Race/Ethnicity, Adults Age 18+, NM 2011–2012 | |
|---|---|
| Male | 23.5% |
| Female | 17.4% |
| **New Mexico, Overall** | **20.4%** |
| American Indian/Alaska Native | 17.6% |
| Asian/Pacific Islander | 16.4% |
| Black/African American | 22.9% |
| Hispanic/Latino | 19.2% |
| White | 19.5% |

## HEALTH PRIORITY: REDUCE DRUG OVERDOSE DEATH RATES

# POPULATION HEALTH IMPROVEMENT RESULT: A HEALTHIER NEW MEXICO

**Measurable Objectives:**

- Reduce drug overdose death rate (24/100,000 in 2012) by 10% by 2015
- Increase percentages of Centennial Care (Medicaid) enrolled patients receiving chronic opioid pain medication who also receive naloxone rescue kit by 2016 (Currently 0, 2016: 15%)




**Story Behind the Data:** In 2010, New Mexico had the second highest drug overdose death rate in the nation, and nearly double the U.S. rate. In 2012, New Mexico's age adjusted drug overdose death rate was 24.2 per 100,000 persons. That year, 486 New Mexicans died of drug overdose. Between 1990 and 2012, the overdose death rate in New Mexico increased 300% and by 79.9% since 2001. Prescription opioids have driven the increase in overdose death rates since 2006.

**What Works Strategies:**

**1 Strategy** Expand prescriber and patient awareness and understanding of overdose prevention education and naloxone rescue kit dispensing as standard of care for chronic pain patients on high dose opioid therapy.

| SHIP Measures | Baseline | Target | Responsible Partners |
|---|---|---|---|
| Percentage of Centennial Care-enrolled patients who receive chronic opioid treatment who are dispensed a naloxone rescue kit at a pharmacy | 0 | 15% | Human Services Department/Medical Assistance Division, Managed Care Organizations, Retail and Community-based Pharmacies, Healthcare and Addiction Treatment Providers |
| Number of patients receiving overdose prevention training and naloxone rescue kits in DOH Co-prescription Pilot Sites in Taos, Santa Fe, Bernalillo and Chaves Counties | 80 (FY14 estimate) | 240 | |

**2 Strategy** Increase collaborations with local drug overdose prevention planning groups, including county and municipal government representatives, in development of capacity to provide public overdose prevention education and naloxone administration training in community-based settings

| SHIP Measures | Baseline | Target | Responsible Partners |
|---|---|---|---|
| Number of active drug overdose community planning initiatives | 4: FY14 Taos, Rio Arriba, Santa Fe, Bernalillo, and Chaves Counties | 10: FY16 | County Health Councils, local government representatives, hospital leadership, law enforcement, community advocates, school districts, medical and treatment providers, pharmacies |

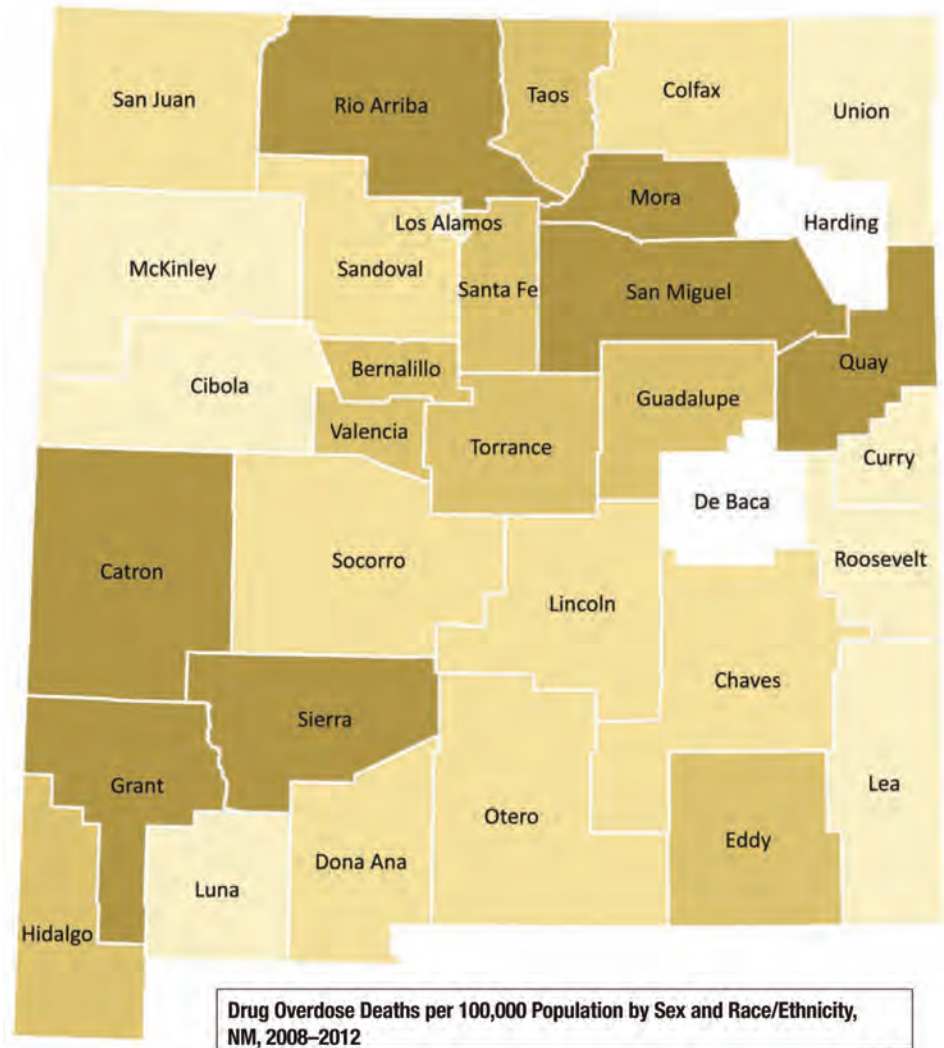
**3 Strategy** Increase collaborations with local county and municipal government public safety departments (county detention, law enforcement and fire) in development of detention center-based overdose prevention training to detainees and naloxone rescue kits upon release.

| SHIP Measures | Baseline | Target | Responsible Partners |
|---|---|---|---|
| Number of county detention centers who provide overdose prevention training and naloxone rescue kits on release to detainees identified as opioid dependent upon entry | 3: FY14 San Miguel, Santa Fe and Taos Counties | 6: FY16 | County and City government leadership, Public Safety Directors, Detention Center Wardens, New Mexico Association of Counties |

**4 Strategy** New Mexico Prescription Drug Misuse and Overdose Prevention and Pain Management Council Issue annual recommendations to the Office of the Governor and State Legislature on policy and program responses to the epidemic of prescription drug overdose.

| SHIP Measures | Baseline | Target | Group Members |
|---|---|---|---|
| Annual recommendations issued | 0% (FY 14) | 15% | Dr. Michael Landen, NM Department of Health<br>Dr. Steve Jenkusky, NM Medical Board<br>Dr. Nancy Darbro, NM Board of Nursing<br>Larry Loring, NM Board of Pharmacy<br>Dr. Bill Barkman, NM Board of Osteopathic Medical Examiners<br>Frances Lovett, NM Board of Acupuncture and Oriental Medicine<br>Dr. Jessica Brewster, NM Board of Dental Health<br>Dr. Steven Seifert, UNM Health Sciences Center<br>Dr. Mark Chiu, NM Medical Soriety<br>Dr. Ernie Dole, NM Association of Pharmacists<br>Margreet Jenness, NM Association of Nurse Practitioners<br>Chris Felt, NM Association of Certified Registered Nurse Anesthetists<br>Dr. Brent Brevard, NM Association of Osteopathic Physicians<br>Dr. Joanna Katzman, Pain Management Specialist<br>Robert Geist, Consumer Health Advocate<br>Jennifer Weiss, Healing Addictions on Our Community<br>Dr. Julie Muche, NM Medical Society |

# DEATHS DUE TO DRUG OVERDOSE
# NM, 2008–2012




| County | Deaths per 100,000 Pop. |
|---|---|
| NM, Overall | 24.3 |
| Union | 3.2* |
| Cibola | 10.1 |
| Curry | 10.7 |
| McKinley | 13.8 |
| Roosevelt | 13.8 |
| Luna | 14.4 |
| Los Alamos | 15.8 |
| Lea | 15.9 |
| San Juan | 18.1 |
| Dona Ana | 18.6 |
| Sandoval | 18.7 |
| Otero | 22.0 |
| Chaves | 22.2 |
| Lincoln | 22.4 |
| Socorro | 22.8 |
| Colfax | 23.6 |
| Torrance | 24.7 |
| Valencia | 24.7 |
| Santa Fe | 25.1 |
| Eddy | 25.9 |
| Guadalupe | 26.0* |
| Bernalillo | 28.9 |
| Hidalgo | 29.4* |
| Taos | 29.7 |
| Grant | 31.2 |
| San Miguel | 33.6 |
| Quay | 37.2 |
| Sierra | 40.0 |
| Catron | 42.5* |
| Mora | 61.0 |
| Rio Arriba | 67.7 |
| De Baca | ** |
| Harding | ** |

| Drug Overdose Deaths per 100,000 Population by Sex and Race/Ethnicity, NM, 2008–2012 | |
|---|---|
| Male | 29.6 |
| Female | 18.9 |
| **New Mexico, Overall** | **24.3** |
| American Indian/Alaska Native | 14.2 |
| Asian/Pacific Islander | 7.3 |
| Black/African American | 20.3 |
| Hispanic/Latino | 25.4 |
| White | 25.2 |

Source: Death Certificate Data, Bureau of Vital Records and Health Statistics (BVRHS), New Mexico Department of Health. Population Data: Geospatial and Population Studies Program, University of New Mexico.

Age adjusted to the U.S. 2000 standard

*Data are not stable and may not represent population risk.

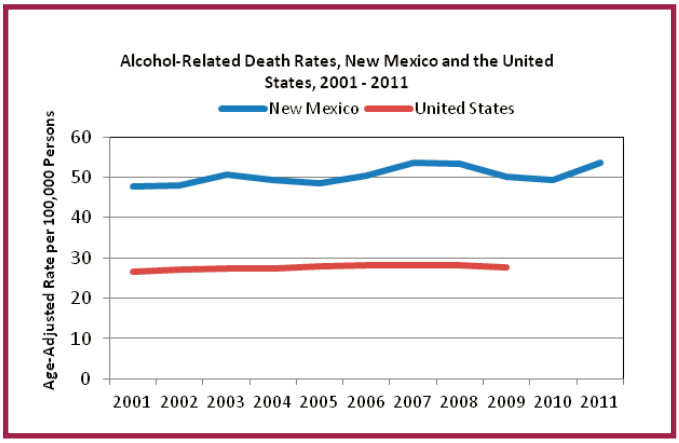
**Population size and number of deaths were insufficient to generate reliable estimates.

## HEALTH PRIORITY: REDUCE ALCOHOL RELATED DEATHS

## POPULATION HEALTH IMPROVEMENT RESULT: A HEALTHIER NEW MEXICO

**Measurable Objectives:**

- Reduce the alcohol-related death rate from 54.3 per 100,000 population in 2012 to 53.8 deaths per 100,000 population in 2014



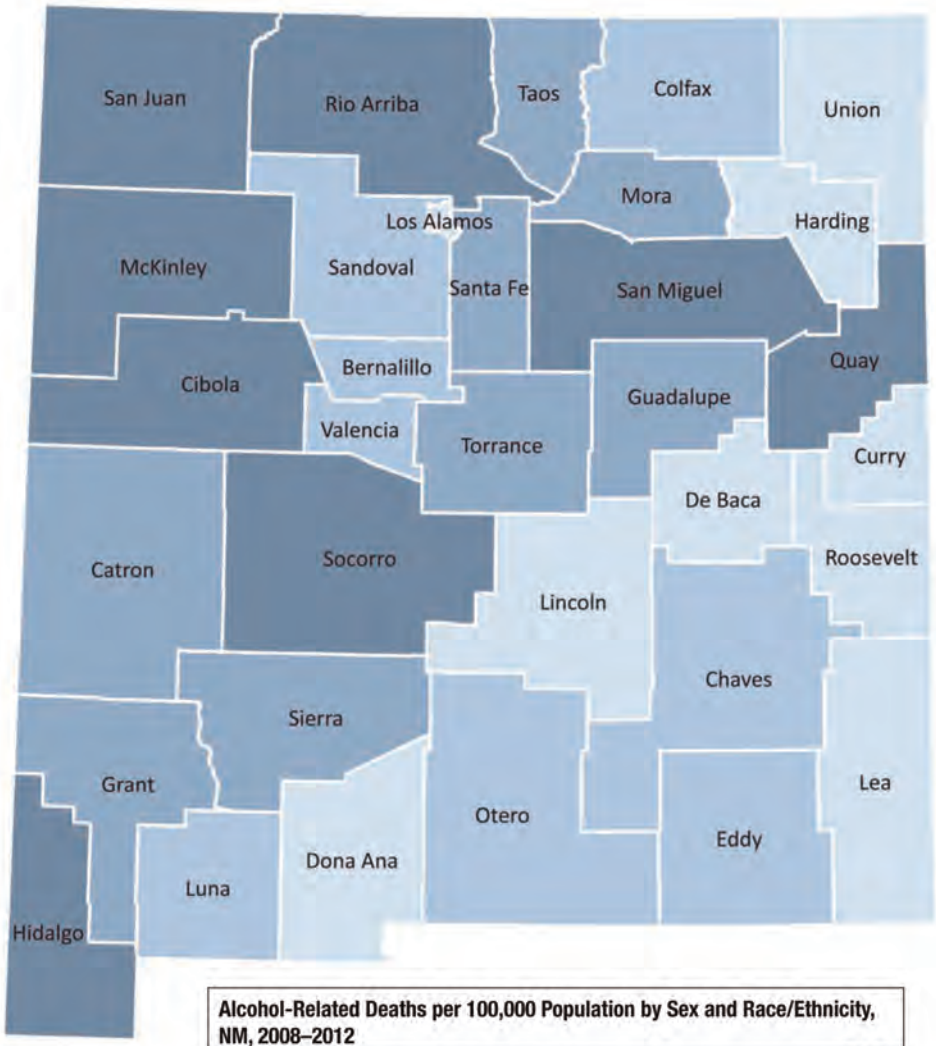

**Story Behind the Data:** Excessive alcohol use (i.e., binge and heavy drinking) is the fourth leading preventable cause of death in the United States. New Mexico has the highest alcohol-related death rate in the U.S., and New Mexico's rate is nearly twice the U.S. rate. The majority of alcohol-related deaths involve working age adults. Alcohol screening and brief counseling can reduce drinking on an occasion by 25% in people who drink too much, but only 1 in 6 adults have ever talked with their doctor or other health professional about alcohol use. Doctors and other health professionals can use alcohol screening and brief counseling to help people who are drinking too much to drink less.

**What Works Strategies:**

**1 Strategy** Increase use of Screening and Brief Intervention and Referral to Treatment (SBIRT).

| SHIP Measures | Baseline | Target | Responsible Partners |
|---|---|---|---|
| Number of Medicaid reimbursement requests for SBIRT (H0049 or H0050) | 0 | 150 | Human Services Department, New Mexico Department of Health, provider groups, SEOW, and Community Coalitions including Partnership for Community Action and the Santa Fe Prevention Alliance |

# ALCOHOL-RELATED DEATHS
# NM, 2008–2012




| County | Deaths per 100,000 Pop. |
|---|---|
| NM, Overall | 52.3 |
| Harding | 8.9* |
| Los Alamos | 25.8 |
| Roosevelt | 30 |
| Union | 32.6* |
| Lincoln | 34.3 |
| Curry | 35.4 |
| Dona Ana | 36.4 |
| Lea | 39.7 |
| De Baca | 40.1* |
| Luna | 42.8 |
| Sandoval | 43.4 |
| Eddy | 44.9 |
| Otero | 45.4 |
| Colfax | 46.5 |
| Bernalillo | 49 |
| Valencia | 50.4 |
| Chaves | 51 |
| Santa Fe | 52.8 |
| Guadalupe | 53.7 |
| Catron | 55.4* |
| Mora | 55.6 |
| Grant | 56 |
| Sierra | 57.1 |
| Torrance | 57.5 |
| Taos | 61.7 |
| Hidalgo | 63.4 |
| San Juan | 68.8 |
| San Miguel | 70.9 |
| Socorro | 76.2 |
| Cibola | 76.9 |
| Quay | 80.5 |
| McKinley | 110.3 |
| Rio Arriba | 116 |

Source: Death Certificate Data, Bureau of Vital Records and Health Statistics (BVRHS), New Mexico Department of Health. Population Data: Geospatial and Population Studies Program, University of New Mexico. Attributable fractions: CDC ARDI, SAES.

Age adjusted to the U.S. 2000 standard

*Data are not stable and may not represent population risk.

| Alcohol-Related Deaths per 100,000 Population by Sex and Race/Ethnicity, NM, 2008–2012 | |
|---|---|
| Male | 75.6 |
| Female | 30.2 |
| **New Mexico, Overall** | **52.3** |
| American Indian/Alaska Native | 120.1 |
| Asian/Pacific Islander | 14.6 |
| Black/African American | 36.3 |
| Hispanic/Latino | 53.0 |
| White | 41.1 |

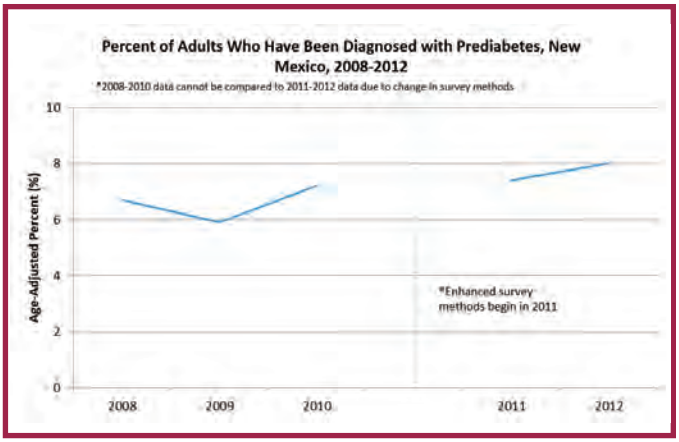
Age adjusted to the U.S. 2000 standard

## HEALTH PRIORITY: DIABETES

# POPULATION HEALTH IMPROVEMENT RESULT(S): REDUCE DIABETES HOSPITALIZATIONS.

**Measurable Objectives:**

- Percent of NM adults 18 & older diagnosed with prediabetes
- Percent of counties with either National Diabetes Prevention Program (NDPP) or accredited/recognized/ licensed chronic disease or diabetes self-management education programs (DSME/DSMP)
- Percent of selected health center organizations with systems to support patient self-management of high blood pressure




**Story Behind the Data:** Effectively managing chronic conditions, including diabetes and high blood pressure, help adults stay out of the hospital. People at risk for developing diabetes includes those with prediabetes, are obese, currently smoke, or have family history of diabetes as well as women who had gestational diabetes. The majority of adults with prediabetes do not know they have the condition. Being diagnosed with prediabetes is the first step in preventing or delaying diabetes, so we expect that the BRFSS estimate of those diagnosed with prediabetes to increase as healthcare and public health efforts about prediabetes reach more New Mexicans. The NDPP is an effective way to help adults with prediabetes to either return to normal blood sugar levels or delay progression to diabetes. Increasing the reach and capacity of the NDPP and officially recognized chronic disease or diabetes self-management programs will help adults with diagnosed conditions, including prediabetes and diabetes, to better manage their disease, potentially preventing costly complications. People with high blood pressure, particularly those with diabetes, who manage their hypertension can decrease their risk of cardiovascular disease or stroke. Healthcare systems that proactively support patient self-management of high blood pressure can make a difference in the number of patients who keep their blood pressure under good control. These efforts can help individuals, communities, and healthcare systems keep people out of the hospital.

**What Works Strategies:**

**1 Strategy** Increase the reach, capacity, and sustainability of NM's National Diabetes Prevention Program (NDPP), a proven program to help adults with prediabetes return to normal blood sugar.

| SHIP Measures | Baseline | Target FY15 | Responsible Partners |
|---|---|---|---|
| 1) Number of NDPP sites in New Mexico<br>2) Number of lifestyle coaches trained<br>3) Number of Master Trainers in NM<br>4) Number of health plans and/or worksites covering the NDPP as a benefit<br>5) Number of National DPP participants in programs supported by DPCP<br>6) Referral system in place<br>7) NDPP website in place | 1) 0 (FY11)<br>2) 0 (FY12)<br>3) 0 (FY14)<br>4) 0 (FY13)<br>5) 0 (FY11)<br>6) No (FY13)<br>7) No (FY13) | 1) 22<br>2) 50<br>3) 1<br>4) 2<br>5) 300<br>6) Yes<br>7) Yes | National DPP CDC- recognized organizations (program delivery sites)<br>Worksites<br>Health Plans<br>NM State University/ County Extension<br>CDC<br>National Association of Chronic Disease Directors<br>Diabetes Training and Technical Assistance Center (Emory University) |

**2 Strategy** Promote awareness of prediabetes among people at high risk for type 2 diabetes.

| SHIP Measures | Baseline | Target FY15 | Responsible Partners |
|---|---|---|---|
| 1) Prevalence (%) of people with self-reported prediabetes<br>2) Marketing Plan<br>3) Number of initiatives or campaigns that raise awareness of diabetes/prediabetes risk factors, and the NDPP among professionals who serve adults at risk of or have diabetes. | 1) 7.4% (2011)<br>2) 0 (FY13)<br>3) 1 (FY12) | 1) 8.1% (2016)<br>2) 1<br>3) 2 | DOH ERD Survey Unit<br>McKee Wallwork and Company<br>Chronic Disease Self- management and Diabetes Self-Management programs<br>National DPP CDC- recognized organizations (program delivery sites)<br>Worksites<br>Health Plans |

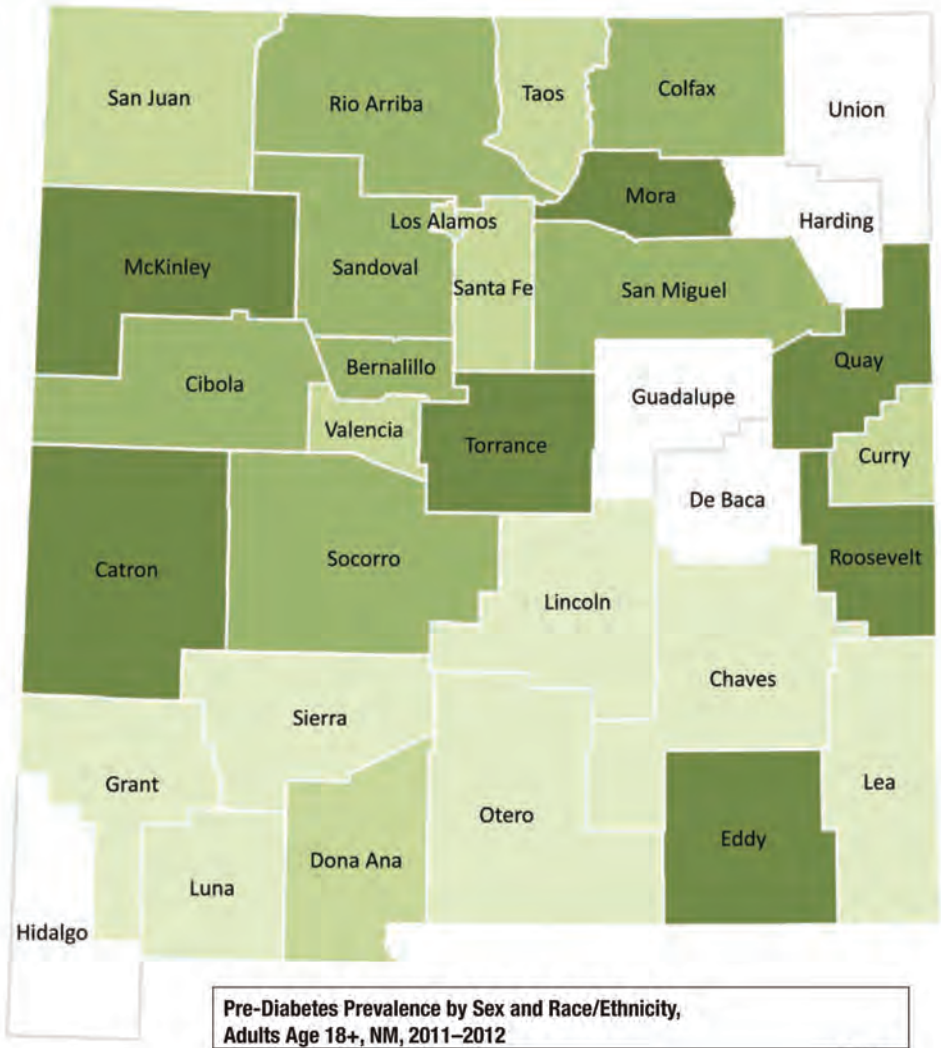
**3 Strategy** Expand Stanford-licensed chronic disease self-management programs (CDSMP) in priority areas and connect these resources to other chronic disease prevention and management resources such as National DPP and Stanford-licensed diabetes self-management programs (DSMP).

| SHIP Measures | Baseline | Target FY15 | Responsible Partners |
|---|---|---|---|
| 1) Number of counties offering at least one 6-week CDSMP workshop | 1) 17 (FY13) | 1) 20 | CDSMP regional licensed providers (Montañas del Norte Area Health Education Center [AHEC], Southern AHEC, City of Albuquerque Department of Senior Services)<br>Healthy Aging Collaborative<br>NM Aging and Long Term Services Department |

**4 Strategy** Increase blood pressure self-management tied with clinical support among federally qualified health centers (FQHCs).

| SHIP Measures | Baseline | Target FY15 | Responsible Partners |
|---|---|---|---|
| Proportion of FQHCs with policies or systems to encourage patient self-management of high blood pressure | 86% of 50 surveyed FQHCs (FY14) | 90% | NM Primary Care Association<br>NMDOH Heart Disease and Stroke Prevention |

# DIAGNOSED PRE-DIABETES PREVALENCE NM, 2011–2012




| County | Percentage of Adults 18+ |
|---|---|
| NM, Overall | 7.7% |
| Luna | 2.8%* |
| Sierra | 3.7%* |
| Lincoln | 4.8%* |
| Lea | 5.9% |
| Otero | 6.3% |
| Grant | 6.5% |
| Chaves | 6.6% |
| Taos | 6.7% |
| Santa Fe | 6.8% |
| Curry | 6.9% |
| San Juan | 7.3% |
| Dona Ana | 7.6% |
| Los Alamos | 7.7% |
| Valencia | 7.7% |
| Bernalillo | 7.8% |
| Socorro | 7.8%* |
| San Miguel | 8.1% |
| Sandoval | 8.5% |
| Colfax | 8.5% |
| Cibola | 8.9% |
| Rio Arriba | 9.2% |
| Catron | 9.5%* |
| Torrance | 9.9% |
| Roosevelt | 10.1% |
| McKinley | 10.2% |
| Quay | 11.1%* |
| Eddy | 13.2% |
| Mora | 17.3%* |
| Harding | ** |
| DeBaca | ** |
| Union | ** |
| Guadalupe | ** |
| Hidalgo | ** |

Source: Behavioral Risk Factor Surveillance System survey data, New Mexico Department of Health, Injury and Behavioral Epidemiology Bureau.

Age adjusted to the U.S. 2000 standard.

*Data are not stable and may not represent population risk.

**Sample sizes were insufficient to generate reliable estimates.

| Pre-Diabetes Prevalence by Sex and Race/Ethnicity, Adults Age 18+, NM, 2011–2012 | |
|---|---|
| Male | 8.0% |
| Female | 7.4% |
| **New Mexico, Overall** | **7.7%** |
| American Indian/Alaska Native | 12.5% |
| Asian/Pacific Islander | 6.3%* |
| Black/African American | 10.5%* |
| Hispanic/Latino | 8.7% |
| White | 6.3% |

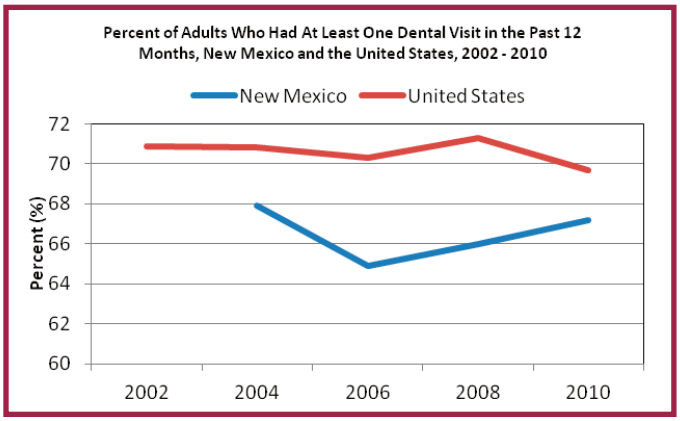
Age adjusted to the U.S. 2000 standard.

## HEALTH PRIORITY: INCREASE DENTAL VISITS

# POPULATION HEALTH IMPROVEMENT RESULT: A HEALTHIER NEW MEXICO

**Measurable Objectives:**

- Increase number of dental providers serving the uninsured and low income populations
- Increase number of Medicaid dental providers
- Promote the importance of oral health
- Provide preventive services to pre-school and school aged children
- Increase consumption of fluoridated water




**Story Behind the Data:** Tooth decay is the most common chronic disease among children, 5 times more common than asthma and 7 times more common than hay fever among 5 to 17 years olds. Access to oral health care in New Mexico continues to be inaccessible to individuals that are uninsured and are low-income. Despite the increase number of adults eligible to enroll in Medicaid, there are not sufficient dental providers accepting Medicaid. Tooth decay and other oral disease are due to: a lack of an understanding of the importance of oral health to general health, poor oral hygiene, poor nutritional habits, and general lack of access to care in rural New Mexico. American Indians and Hispanics have the highest rate of tooth decay among all populations. Hispanic and American Indians are less likely to have a dental visit. Less than half of adults with an annual income of less than $15,000 have had a dental visit within the past year. New Mexico Medicaid provides full dental services for children and limited for adults. In 2012, 40% adults reported having six or more teeth extracted. Less than 50% of new mothers have had their teeth cleaned. Undocumented children and adults are not eligible to participate in Medicaid.

**What Works Strategies:**

**1 Strategy** Increase the number of preventive and treatment services to the uninsured and low-income.

| SHIP Measures | Baseline | Target | Responsible Partners |
|---|---|---|---|
| Increase the number of facilities providing preventive and treatment including expanding the number of dental Medicaid providers. | 20 (FY14) | 25 (SFY16) | State staff, Medicaid, Mira Inc. Participa Inc. NM Smiles Inc. Hidalgo Medical Services UNM Dental Sciences Community Dental Services Sandoval Health Commons FQHC's Community Clinics, NM Dental Association, 501 (C)3. |
| Increase the number of Medicaid recipients receiving preventive or treatment services. | 90% (FY13) | 92% (FY16) | State staff, Medicaid, Mira Inc. Participa Inc. NM Smiles Inc. Hidalgo Medical Services UNM Dental Sciences Community, Dental Services, Sandoval Health Commons FQHC's Community Clinics, NM Dental Association, 501 (C)3 |

**2 Strategy** Increase oral health education PSAs throughout the state.

| SHIP Measures | Baseline | Target | Responsible Partners |
|---|---|---|---|
| Increase the number of oral health Public Service Announcements and other health promotions strategies to increase the awareness of the general public on the importance of oral health to general health. | 3 (FY14) | 5 (FY15) | NM DOH, NM Lobo's SUAVE, KCRA, Albuquerque Journal, Santa Fe New Mexican, Santa Fe Reporter, Dental Providers, NM Head Start, PMS Head Start, YDI Head Start, CYFD, NM Head Start Association, FQHC, Community Clinics, Community Health Workers, Community Health Educators |

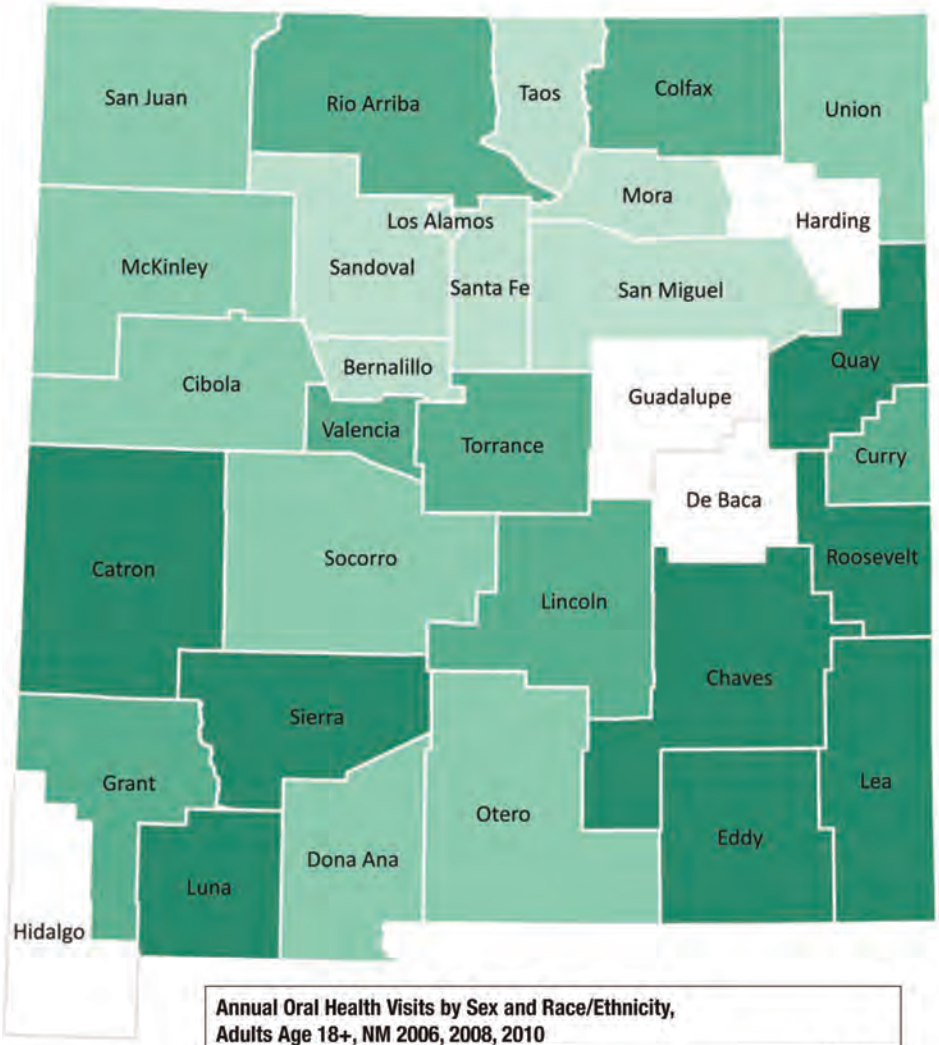
**3 Strategy** Increase the number of children receiving preventive services.

| SHIP Measures | Baseline | Target | Group Members |
|---|---|---|---|
| Number of pre-school aged children receiving fluoride varnish by a dental or medical practitioner. | 500 (FY14) | 1000 (SFY15-16) | NM DOH, State staff, Medicaid, Mira Inc. Participa Inc. NM Smiles Inc. Hidalgo Medical Services UNM Dental Sciences Community, Dental Services, Sandoval Health Commons FQHC's ,, Community Clinics, NM School Health Alliance, PED, School Based Health Centers, NM Dental Association, 501 (C)3, private owned dental facilities, community health workers, and community health educators. |
| Number of elementary age children and adolescents receiving a dental sealant. | 7500 (FY14) | 8,000 (SFY15-16) | |

**4 Strategy** Increase the number of residents to consume fluoridated water.

| SHIP Measures | Baseline | Target | Responsible Partners |
|---|---|---|---|
| Increase the number of individuals consuming fluoridated water | 85,000 | 100,000 | State, county and municipality policy makers, community health councils, NM Dental Association; and the Governor. |

# ADULTS WHO HAD A DENTAL VISIT IN THE PAST 12 MONTHS - NM, 2006, 2008, 2010




| County | Percentage of Adults 18+ |
|---|---|
| NM, Overall | 66.0% |
| Los Alamos | 84.4% |
| Santa Fe | 72.3% |
| Bernalillo | 71.2% |
| Sandoval | 70.3% |
| Mora | 68.1% |
| San Miguel | 67.4% |
| Taos | 64.8% |
| Socorro | 64.5% |
| Otero | 64.4% |
| Dona Ana | 64.1% |
| McKinley | 64.1% |
| San Juan | 63.3% |
| Cibola | 62.9% |
| Union | 62.7% |
| Lincoln | 62.6% |
| Colfax | 62.5% |
| Rio Arriba | 61.8% |
| Valencia | 61.6% |
| Grant | 61.1% |
| Torrance | 60.7% |
| Curry | 60.2% |
| Eddy | 58.6% |
| Sierra | 57.3% |
| Lea | 56.1% |
| Chaves | 54.3% |
| Luna | 51.3% |
| Catron | 51.0% |
| Quay | 49.5% |
| Roosevelt | 49.1% |
| De Baca | ** |
| Guadalupe | ** |
| Harding | ** |
| Hidalgo | ** |

Source: Behavioral Risk Factor Surveillance System survey data, New Mexico Department of Health, Injury and Behavioral Epidemiology Bureau.

**Sample sizes were insufficient to generate reliable estimates.

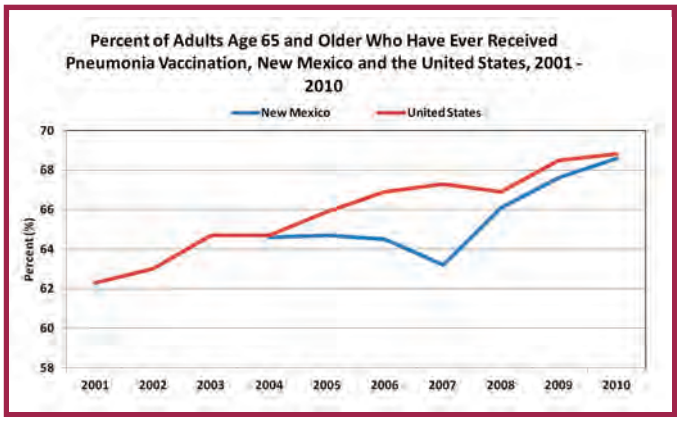
| Annual Oral Health Visits by Sex and Race/Ethnicity, Adults Age 18+, NM 2006, 2008, 2010 | |
|---|---|
| Male | 63.9% |
| Female | 68.1% |
| **New Mexico, Overall** | **66.0%** |
| American Indian/Alaska Native | 63.4% |
| Asian/Pacific Islander | 72.3% |
| Black/African American | 62.0% |
| Hispanic/Latino | 60.6% |
| White | 70.2% |

## HEALTH PRIORITY: INCREASE ADULTS IMMUNIZATIONS (65 AND OLDER) FOR PNEUMOCOCCAL DISEASE

## POPULATION HEALTH IMPROVEMENT RESULT: A HEALTHIER NEW MEXICO

**Measurable Objectives:**

- Percentage of New Mexico Adults Age 65+ Who Have Ever Had a Pneumonia Vaccination by Year, (New Mexico and United States 2000-2010)



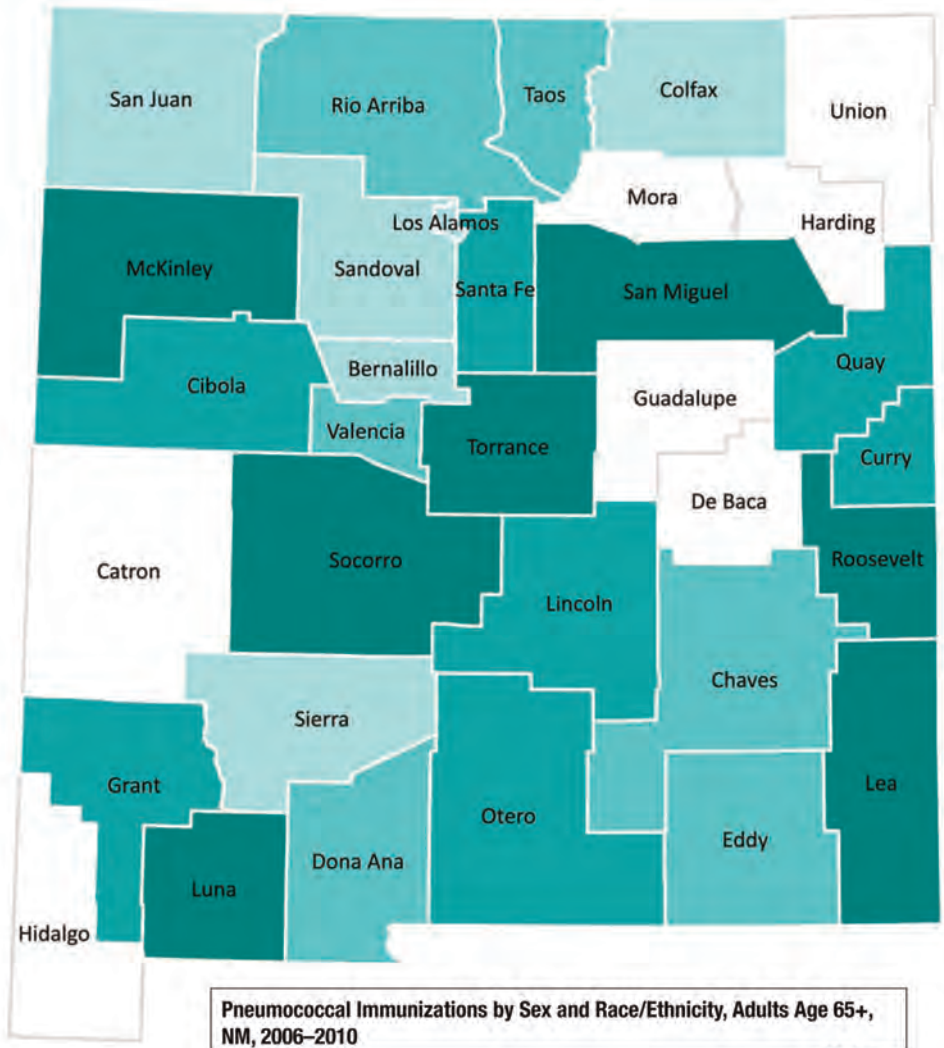

**Story Behind the Data:** There are approximately 40,000 cases of invasive pneumonia in the US each year, one-third of which occur in people 65 and older. Over half of the 5,000 annual deaths occur in this age group. One pneumococcal vaccination at age 65 generally provides lifetime coverage, the cost of which is covered by Medicare. High-risk individuals should receive a booster vaccination, which is also covered by Medicare, 5 years after their initial vaccination. Barriers to adult immunization include not knowing immunizations are needed (health literacy), misconceptions about vaccines, and lack of recommendations from health care providers.

**What Works Strategies:**

**1 Strategy** Expand linkages between the Immunization Program and other DOH programs and community-based organizations (e.g. health councils, tribal groups, etc.) to promote pneumococcal and influenza vaccination.

| SHIP Measures | Baseline | Target | Responsible Partners |
|---|---|---|---|
| Number of pneumococcal immunizations given at tribal health days. | 736 | 1000 (FY 15) | Immunization Program, DOH Tribal Liaison, Indian Health Service, Tribal Health Councils |
| Number of flu clinic points of dispensing conducted to immunize adults against the flu. | 48 | 60 (FY 15) | Immunization Program, Regional Immunization staff, Aging and Long-term Services, AARP, elder recreational centers. |

# ADULTS AGE 65+ WHO HAVE EVER HAD A PNEUMONIA VACCINATION - NM, 2006–2010




| County | Percentage of Adults 65+ |
|---|---|
| NM, Overall | 66.0% |
| Los Alamos | 73.9% |
| Sierra | 72.5% |
| Bernalillo | 71.5% |
| Sandoval | 71.4% |
| Colfax | 70.5% |
| San Juan | 69.5% |
| Taos | 68.4% |
| Valencia | 67.5% |
| Eddy | 66.6% |
| Rio Arriba | 64.5% |
| Dona Ana | 64.2% |
| Chaves | 64.1% |
| Santa Fe | 63.6% |
| Curry | 62.0% |
| Grant | 61.6% |
| Cibola | 61.3% |
| Quay | 60.8% |
| Otero | 59.8% |
| Lincoln | 59.1% |
| McKinley | 59.0% |
| Socorro | 58.4% |
| Luna | 56.3% |
| Roosevelt | 56.0% |
| Lea | 54.5% |
| Torrance | 54.4% |
| San Miguel | 48.3% |
| Catron | ** |
| De Baca | ** |
| Guadalupe | ** |
| Harding | ** |
| Hidalgo | ** |
| Mora | ** |
| Union | ** |

Source: Behavioral Risk Factor Surveillance System survey data, New Mexico Department of Health, Injury and Behavioral Epidemiology Bureau.

**Sample sizes were insufficient to generate reliable estimates.

| Pneumococcal Immunizations by Sex and Race/Ethnicity, Adults Age 65+, NM, 2006–2010 | |
|---|---|
| Male | 63.0% |
| Female | 68.4% |
| **New Mexico, Overall** | **66.0%** |
| American Indian/Alaska Native | 55.4% |
| Asian/Pacific Islander | ** |
| Black/African American | 60.9% |
| Hispanic/Latino | 58.1% |
| White | 69.6% |

**Sample size was insufficient to generate a reliable estimate.

## HEALTH PRIORITY: DECREASE FALL-RELATED DEATHS AMONG ADULTS AGE 65 AND OLDER

## POPULATION HEALTH IMPROVEMENT RESULT: A HEALTHIER NEW MEXICO

**Measurable Objectives:**

- New Mexico's 2012 age-adjusted fall-related death rate for all ages was 13.8/100,000 population (N = 300). The 2012 fall-related death rate for 65+ year olds in NM was 83.6/100,000 population (N = 245)
- Reduce fall-related deaths in older adults (age 65+) by 5% from 83.6/100,000 to 79.4/100,000 in 2014
- Reduce total number of falls (as reported in the Behavioral Risk Factor Surveillance System) in older adults (age 65+) by 5%, from 89,000 in (2012) to 84.5 in FY 2014


**Story Behind the Data:** Fall-related injuries are a serious public health problem, especially among older adults age 65 +. In New Mexico (NM) for 2012, fall-related injury was the fourth leading cause of injury-related death, after poisoning, motor vehicle traffic injuries, and suicide. Fall-related injury was the leading cause of injury-related death, hospitalization and emergency department visits among older adults in 2012. The 2010 age-adjusted fall-related death rate among older adults in New Mexico was the fifth highest among all states and was 1.7 times higher than the national rate.

Fall-related injury seriously affects quality of life. Falls can increase the risk of early death. Older adults are more likely to suffer severe injuries from falling than younger people, resulting in emergency department visits, hospitalizations and long-term rehabilitation. Fall-related injuries can make it hard for older adults to get around and may limit independent living. Many older adults who fall, even those who are not injured, develop a fear of falling. This fear may cause them to limit their activities, leading to reduced mobility and physical fitness and therefore increased risk of falling.

**What Works Strategies:**

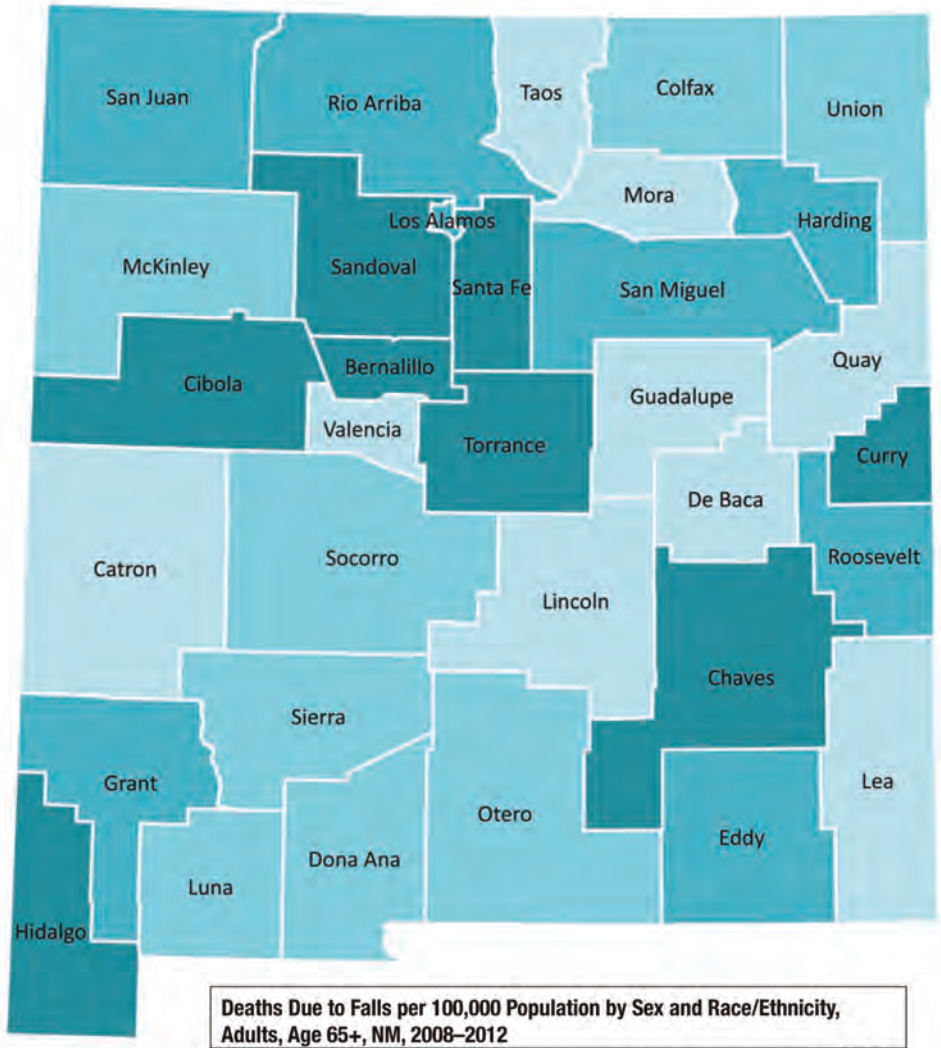
**1 Strategy** Increase older adults' access to evidence-based fall prevention programming. Increase the number of fitness instructors trained in Tai Chi for Better Balance by 20% in 2014-2015.

| SHIP Measures | Baseline | Target | Responsible Partners |
|---|---|---|---|
| Number of individuals certified as Tai Chi for Better Balance instructors | 75 individuals have received certification as Tai Chi Moving for Better Balance Instructors | 2 Master Trainers and 40 additional individuals will be certified as Tai Chi for Better Balance instructors. (FY 15) | New Mexico Seniors Centers<br>Silver Sneakers<br>AARP<br>YMCA<br>Arthritis Foundation New Mexico<br>Dr. Fuzhong Li, Oregon Research Institute<br>Developer of the evidence-based Tai Chi Moving for Better Balance program |

| 1 Strategy cont'd | Increase older adults' access to evidence-based fall prevention programming. Increase the number of fitness instructors trained in Tai Chi for Better Balance by 20% in 2014-2015. | | |
|---|---|---|---|
| **SHIP Measures** | **Baseline** | **Target** | **Responsible Partners** |
| Number of older adults who have completed an evidence-based, community based fall prevention program | 245 older adults have participated in the evidence-based Tai- Chi Moving for Better Balance | 1000 FY16 older adults will have participated in the evidence- based Tai Chi for Adult Falls Prevention. | New Mexico Senior Centers<br>Good Samaritan Society<br>Manzano del Sol Assisted Living Community<br>Jicarilla Apache Senior Center<br>Lotus Dragon Center for Wellness<br>Navajo Nation Division of Health & Education<br>Santa Clare Regional Adult Day Care Center |

| 2 Strategy | Increase medical providers' knowledge about preventable fall risks, and skills in assessing and managing such risks using an evidence-based tool, the Stopping Elderly Accidents, Deaths and Injuries (STEADI) Toolkit.<br><br>Increase providers' ability to adhere for Center for Medicare Services quality indicators in adult falls screening, and to bill for annual fall risk assessments. | | |
|---|---|---|---|
| **SHIP Measures** | **Baseline** | **Target** | **Responsible Partners** |
| Number of older adults who have completed an evidence-based, community based fall prevention program | 245 older adults have participated in the evidence-based Tai- Chi Moving for Better Balance | 1000 FY16 older adults will have participated in the evidence- based Tai Chi for Adult Falls Prevention. | New Mexico Senior Centers<br>Good Samaritan Society<br>Manzano del Sol Assisted Living Community<br>Jicarilla Apache Senior Center<br>Lotus Dragon Center for Wellness<br>Navajo Nation Division of Health & Education<br>Santa Clare Regional Adult Day Care Center |

# FALL-RELATED DEATHS AMONG ADULTS 65+ YEARS OF AGE - NM, 2008–2012




| Deaths Due to Falls per 100,000 Population by Sex and Race/Ethnicity, Adults, Age 65+, NM, 2008–2012 | |
|---|---|
| Male | 88.9 |
| Female | 97.6 |
| **New Mexico, Overall** | **93.7** |
| American Indian/Alaska Native | 81.8 |
| Asian/Pacific Islander | 23.3* |
| Black/African American | 37.1* |
| Hispanic/Latino | 76.9 |
| White | 105.4 |

*Data are not stable and may not represent population risk.

| County | Deaths per 100,000 Pop. |
|---|---|
| NM, Overall | 93.7 |
| Valencia | 0* |
| Catron | 19.1* |
| De Baca | 42.6* |
| Quay | 42.6* |
| Mora | 43.4* |
| Lincoln | 44.1* |
| Guadalupe | 54.8* |
| Lea | 56.8 |
| Taos | 59.7 |
| Socorro | 62.7* |
| Otero | 66.2 |
| Union | 69.1 |
| Dona Ana | 76 |
| Luna | 77.1 |
| McKinley | 77.6 |
| Colfax | 79.4* |
| Sierra | 81 |
| San Miguel | 84.2 |
| San Juan | 87.6 |
| Grant | 88.2 |
| Eddy | 91.6 |
| Rio Arriba | 94.4 |
| Harding | 96.3* |
| Roosevelt | 100.6 |
| Los Alamos | 103.3 |
| Curry | 104 |
| Sandoval | 105.1 |
| Cibola | 108.4 |
| Santa Fe | 110.4 |
| Bernalillo | 111.3 |
| Chaves | 121.8 |
| Torrance | 136.2 |
| Hidalgo | 146.1* |

Source: Death Certificate Data, Bureau of Vital Records and Health Statistics (BVRHS), New Mexico Department of Health. Population Data: Geospatial and Population Studies Program, University of New Mexico.

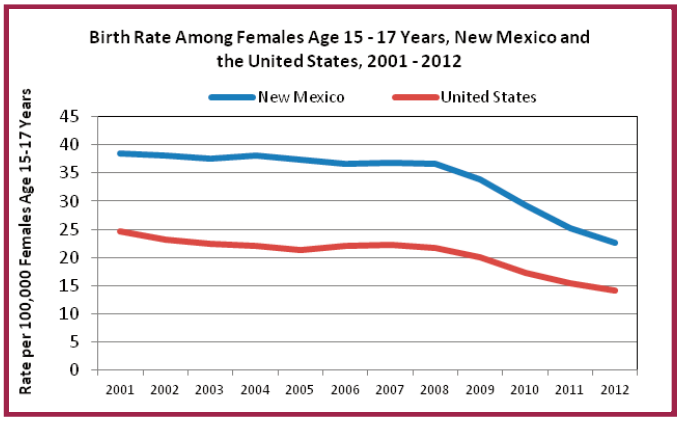
*Data are not stable and may not represent population risk.

## HEALTH PRIORITY: REDUCE TEEN BIRTHS

# POPULATION HEALTH IMPROVEMENT RESULT: A HEALTHIER NEW MEXICO

**Measurable Objectives:**

- The percentage of 15-17 year old teens who are prescribed most-effective and moderately-effective contraceptive methods (IUD, implant, injection, pill, patch, ring) through Title X-funded family planning clinics.
- The number of teen births prevented among 15-17 year old females seen in Title X-funded family planning clinics.
- The number of teens enrolled in evidence-based teen pregnancy prevention programs.
- The percentage of teens enrolled in an evidence-based teen pregnancy prevention program who did not get pregnant or cause a pregnancy.




**Story Behind the Data:** Since 1998, the teen birth rate in New Mexico for 15-to-17 year olds has declined by 41%, which is comparable to national data. Although the teen birth rate is declining in New Mexico among 15-17 year olds, New Mexico's teen birth rate (22.7/1000) is still one of the highest rates in the country. Hispanic teens have the highest birth rates in both New Mexico and nationally but, while rates are declining, there is still work to be done. Factors in the high teen pregnancy rate are poverty, education, rural vs. urban population, and access to services.

In 2012, New Mexico ranked 2nd in percentage of children living in poverty, one of the most important contributing factors to teen 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 New Mexico high school drop-out rate in 2011 was 37%, compared to 22% nationally. Teen parenthood is common in rural areas. Eighteen of New Mexico's 33 counties have teen birth rates higher than the New Mexico state rate.

## What Works Strategies:

**1 Strategy**

**Clinical Evidence-Based Practices:**
- Increase access to confidential family planning services at low- or no-cost through county public health offices, community clinics, and school-based health centers.
- Increase availability of most-effective and moderately-effective primary contraceptive methods for teens (IUD, implant, injection, pill, patch, or ring).

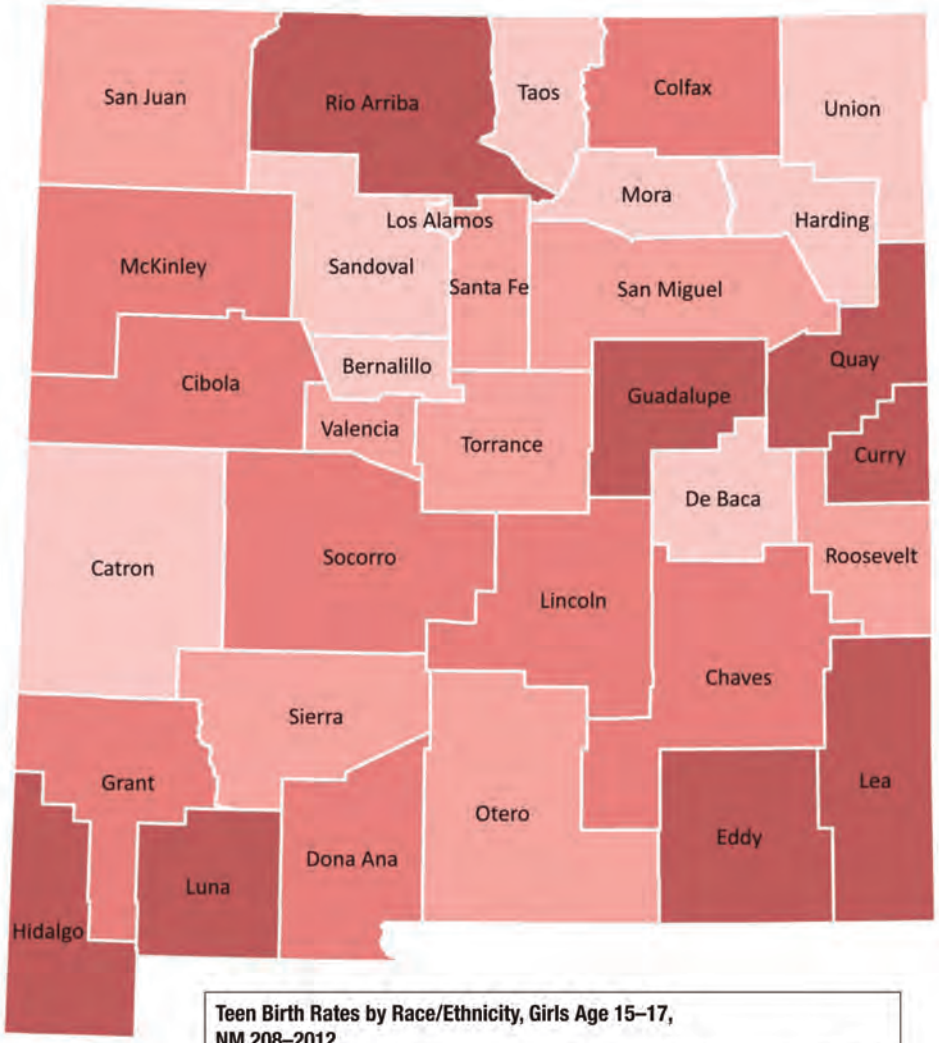
| SHIP Measures | Baseline | Target | Responsible Partners |
|---|---|---|---|
| The percentage of 15-17 year old teens who are prescribed most-effective and moderately-effective contraceptive methods through Title X-funded family planning clinics. | 736 | 1,000 FY16 | Primary care clinics; community-based clinical providers; schools and local school boards; school-based health centers; higher education centers. |
| The number of teen births prevented among 15-17 year old females seen in Title X-funded family planning clinics. | 424 (CY2013) | 425 births 850 pregnancies | |

**2 Strategy**

**Educational Evidence-Based Practices:**
- Implement service-learning programs (Teen Outreach Program [TOP]) and comprehensive sex education programs (¡Cuídate!).
- Implement adult/teen communication programs (Raíces y Alas).

| SHIP Measures | Baseline | Target | Responsible Partners |
|---|---|---|---|
| TOP (Teen Outreach Program) and ¡ Cuídate! | | | |
| The number of teens enrolled in evidence-based teen pregnancy prevention programs. | 744 (FY2013) | 1,000 FY16 | Youth allies; after-school/youth programs; community-based organizations; schools and local school boards. |
| The percentage of teens enrolled in an evidence-based teen pregnancy prevention program who did not get pregnant or cause a pregnancy. | 100% (SY2012-2013) | 100% | |

# TEEN BIRTH RATE
# GIRLS AGE 15–17 - NM, 2008–2012




| Teen Birth Rates by Race/Ethnicity, Girls Age 15–17, NM 208–2012 | |
|---|---|
| New Mexico, Overall | 29.5 |
| American Indian/Alaska Native | 31.5 |
| Asian/Pacific Islander | 7.4 |
| Black/African American | 17.6 |
| Hispanic/Latino | 40.8 |
| White | 12.1 |

Number of births per 1,000 girls in the population

| County | Births per 1,000 Girls Age 15–17 |
|---|---|
| NM, Overall | 29.5 |
| Catron | 0.0* |
| Los Alamos | 5.0* |
| De Baca | 12.1* |
| Union | 15.6* |
| Sandoval | 18.6 |
| Mora | 20.5* |
| Harding | 22.0* |
| Bernalillo | 22.8 |
| Taos | 23.9 |
| San Miguel | 24.2 |
| Torrance | 25.2 |
| Otero | 26.1 |
| Santa Fe | 26.1 |
| Valencia | 27.4 |
| Sierra | 29.9 |
| San Juan | 30.3 |
| Roosevelt | 30.4 |
| McKinley | 31.1 |
| Colfax | 31.3 |
| Lincoln | 34.1 |
| Dona Ana | 34.9 |
| Chaves | 36.8 |
| Grant | 37.1 |
| Cibola | 37.2 |
| Socorro | 37.3 |
| Eddy | 38.9 |
| Rio Arriba | 39.4 |
| Hidalgo | 40.6 |
| Guadalupe | 45.4 |
| Curry | 49.1 |
| Quay | 49.2 |
| Lea | 52.0 |
| Luna | 63.3 |

Source: Birth Certificate Data, Bureau of Vital Records and Health Statistics (BVRHS), New Mexico Department of Health. Population Data: Geospatial and Population Studies Program, University of New Mexico.

*Data are not stable and may not represent population risk.

## HEALTH PRIORITY: INCREASE ACCESS TO CARE (IN DEVELOPMENT)

# POPULATION HEALTH IMPROVEMENT RESULT: A HEALTHIER NEW MEXICO

**Measurable Objectives:**

- Increase the number of practicing health care professionals in New Mexico counties.
- Increase competencies in rural health providers.
- Increase the number of certified Community Health Workers.
- Increase the number of certified CHWs with specialized training.
- Increase the number of integrated public health and health care service centers.

**Story Behind the Data:** Many factors limit access to health care in New Mexico, including a low standard of living, lack of insurance and a large geographical area. The number and distribution of health care professionals is a critical and often-overlooked piece of this equation. New Mexico needs more providers in nearly every health-related profession. In addition, 32 of New Mexico's 33 Counties have been deemed "health professional shortage areas" (excluding Los Alamos county) demonstrating the need to address this critical access to care problem. Detailed analysis of how many additional health providers are needed and where, our capacities to increase the supply, and how best to recruit and retain health professionals to the areas that they are needed will form the groundwork to begin planning effective strategies now and into the future. NMDOH and its partners are working collaboratively to tackle this important statewide issue.

**What Works Strategies:**

1 Strategy

Strategies and SHIP measures for this indicator are in development and will be included when available.

| SHIP Measures | Baseline | Target | Responsible Partners |
|---|---|---|---|
| *IN DEVELOPMENT | TBD | TBD | Centennial Care Providers<br>Hospitals<br>Primary Care Providers |

## POLICY AND ITS IMPACT ON HEALTH

How would a community design a public health or health services program without assessing who is, or even more importantly, who is not accessing their services? How can place be considered when environmental data are disconnected from health condition information? Health plans own the utilization data, clinics maintain patient data, hospitals have ambulatory care data, public health collects a plethora of data – the sources for health and/or population data seem infinite. In general, it would be short-sighted to address population challenges without first describing them. The New Mexico Department of Health and its public health partners have the ability to demonstrate the relevance and value of correlate and associate data to tell a story, inform a policy, improve health outcomes, avert an unwanted outcome – save someone's life. Public health has expertise in how to use data to describe a public health problem and to measure performance toward improving outcomes. Data are how evidence-based practice is determined and informs the design of effective interventions. The data is applied to create crucial feedback loops that ultimately provide information on the impact of selected strategies on public health. Public health has the unique opportunity to mobilize support for the sharing of health information, to understand and communicate the contextual and analytical meaning of data, and build competency in the broader health system workforce for the optimal use of health information.

Statewide, the connectedness between health and social cohesion may be demonstrated through the use of community health workers (CHW), community health representatives (CHR, Tribal Programs), and/or promotoras (Spanish-speaking communities). CHWs impact SDOH as they build supportive relationships with community members and community groups to promote access to resources and health care. CHW's create rapport with their clients because they are from the same community, integrate culturally sensitive approaches, and are knowledgeable about racial and ethnic traditions and beliefs. The CHWs, as professional health contacts, enable their clients to overcome longstanding barriers to the health care delivery system, offering up the ability to connect the individual or family with necessary health resources in an understandable manner. CHWs play a critical role in reducing health disparities, increasing access to care, and coordinating comprehensive care. CHWs extend the reach and quality of health care and reduce the cost of health care. Enhancing the ability to support NM residents, families and individuals is important because NM ranks at or near the bottom of many national health statistics, and is experiencing a continuing and critical shortage of health care providers, particularly in rural and inner-city areas.

## 2014 LEGISLATION = HEALTH POLICY

During the 2014 Legislative Session, the Community Health Workers Act was passed and signed by Governor Susana Martinez. The CHW Act establishes a certification program for Community Health Workers (CHW) in New Mexico. The CHW Act is an important economic development and health improvement strategy for the state. CHWs, if certified, are eligible for Medicaid reimbursement. A great deal of infrastructure already exists with over 800 CHWs operating in the State. After certification, the plan includes the development of specialty areas, including disease management and care coordination as team extenders. Solidifying the status of CHWs is a very popular initiative and the NMDOH is poised to implement.

Telehealth, another legislative initiative, is the use of telecommunication and information technology to provide clinical health care from a distance. Telehealth helps eliminate barriers and improves access to medical services that are often lacking in rural communities. New Mexico is a large rural state with an underserved population, due in part to a shortage of healthcare professionals. Currently, 32 of New Mexico's 33 counties are federally designated as Health Professions Shortage Areas. With the full implementation of the Affordable Care Act, these shortages are expected to dramatically increase as currently uninsured individuals will be expected to seek healthcare coverage. Not only is there a shortage of primary care and advanced practice nurse practitioners, there is a severe shortage of specialty care providers.

Chronic disease hospitalization rates (e.g., diabetes, asthma) are highest in areas of the state that have the lowest access levels to care (especially southeastern New Mexico where 27.2% of adults reported that they lacked healthcare coverage). Telehealth offers an effective method of providing healthcare consultation, training and information services between medical providers and a clinical specialists in the diagnosis, treatment, and management of injury, and infectious and chronic diseases when in-person education is not practical or possible. The demand for specialty care is expected to increase as a result of the Affordable Care Act. Telehealth is one method to bridge these gaps and is a way to provide training and workforce development opportunities to Primary Care Physicians (PCPs), nurses, mid-level healthcare providers, and Community Health Workers in rural areas by connecting them to specialists.

Project ECHO and other Telehealth projects at the University of New Mexico, have experience with providing training and building competencies among PCPs and advanced practice health care professionals. Project ECHO's infrastructure is already in place and the passage of dedicated funding during the 2014 Legislative Session will expand Project ECHO's, as well as other program's, ability to provide additional training and consultation services in underserved areas. Hundreds of rural and urban medical providers will receive training on the best practices in chronic and infectious disease prevention, diagnosis, treatment, and prescribing. And, there will be an increase in the number of knowledge network chronic and infectious disease telementoring clinics offered in the state.

These are examples of how NMDOH works with partners to develop and implement vital public health policy in a collaborative effort to improve health outcomes.

## DEVELOPING A POLICY AGENDA

The New Mexico Department of Health works with local, state, tribal, and cabinet-level partners to develop and promote policy initiatives. These initiatives will create the agenda for future legislation pursued by the department. The 10 priority indicators and their accompanying strategies will allow for more cohesive policy agenda with a systematic approach that serves as the framework to define priorities for the department and its partners statewide. By accomplishing policy initiatives, the overall result of A Healthier New Mexico can be achieved.

## PROPOSED LEGISLATION

New Mexico is a Universal Vaccine Purchasing state. Continuing vaccine purchases and maintaining that federal designation for insured kids helps keep immunization widely accessible for all children in the state. Annually, The Department of Health currently purchases approximately $11 million of vaccines for insured children. The universal vaccine purchasing program is recognized by the Centers for Disease Control to improve childhood immunization coverage rates because it makes vaccines easily available. DOH pays for these vaccines with a combination of state general fund and reimbursements from three insurance carriers. Another 90 carriers do not pay for the vaccines their covered children receive, and there is no mandate to compel them to do so. The insurance reimbursements only cover 41% of the cost of the program. Without a statute to compel broad support for the vaccine purchases, the program will not be able to continue. DOH will be pursing statutory authority during the 2015 legislative session to mandate support by insurers and maintain New Mexico's universal purchasing status.

# CONCLUSION

The New Mexico Department of Health is working to toward achieving health department accreditation for our agency. This process has resulted in a more comprehensive, coordinated and integrated approach to improving the health status for all who live, work, and play in New Mexico. This health improvement plan reflects a growing commitment to improve the quality and results-based work we do with our many, diverse partners. We are blessed with a dedicated and competent workforce that is committed to the well being of the communities we serve. Cabinet Secretary Retta Ward and all NMDOH employees understand the challenges we face to create the conditions associated with health equity and health literacy. A Healthier New Mexico is a work in progress and it reflects our approach to integrating the State Health Assessment and the NMDOH Strategic Plan to achieve the results associated with the health improvement priorities reflected in this important health improvement roadmap.

# RESOURCES

### New Mexico Department of Health

Harold Runnels Building
1190 S. St. Francis Drive
Santa Fe, NM 87505
505-827-2613
http://nmhealth.org

### Public Health Offices and Clinics

New Mexico Department of Health has 54 public health offices throughout the state. For a complete list of public health offices and services provided, please visit http://nmhealth.org/location/public/, or call your regional health office.

### Northeast Regional Office

(Rio Arriba, Taos, Colfax, Union, Los Alamos, Santa Fe, Mora, San Miguel, Guadalupe, and Harding Counties)
605 Letrado Street
Santa Fe, NM 87505
505-476-2600

### Northwest Regional Office (Midtown)

(San Juan, McKinley, Cibola, Bernalillo, Sandoval, Torrance, and Valencia Counties)
2400 Wellesley Dr NE
Albuquerque, NM 87107
505-841-4100

### Southeast Regional Office

(Quay, De Baca, Curry, Lincoln, Roosevelt, Chaves, Eddy, and Lea Counties)
9 East Challenger Street
Roswell, NM 88203
575-347-2409

### Southwest Regional Office

(Catron, Socorro, Grant, Sierra, Hidalgo, Luna, Doña Ana and Otero Counties)
1170 N. Solano Drive
Las Cruces, NM 88001
575-528-5001

### Community Health Councils

New Mexico has 38 community health councils (33 county and 5 tribal) thatwork locally to assess health status and implement health improvement activities. For more details and information on how to join your local community health council, please contact your regional health office.

### DOH Online Resources

Tobacco quit line and web resources.
Call 1-800-QUIT NOW or visit
http://www.quitnownm.com/

ACT-New Mexico: Services for adults with intellectual and developmentaldisabilities. http://actnewmexico.org

Indicator-based Information System (NM-IBIS). For data and information on New Mexico's priority public health issues. http://ibis.health.state.nm.us

Environmental Public Health Tracking System (NM-Tracking). For data and information on New Mexico's environment and related health outcomes.
https://nmtracking.org

New Mexico Statewide Immunization Information System (NMSIIS). New Mexico immunization registry for children and adults. https://nmsiis.health.state.nm.us

### Frequently-Requested Phone Numbers

**Immunization**
Information on schedules and locations.
866-681-5872 (Toll Free)

**Birth and Death Certificate Requests**
Request a birth or death certificate.
866-534-0051 (Toll Free)

**Epidemiology**
Available 24/7 to report notifiable conditions, public health concerns or incidents.
505-827-0006 (Local)

**Nurse Advice**
Access to a RN 24 hours a day, 365 days a year.
877-725-2552 (Toll Free)

**Poison Control**
Call 24/7 for poison emergencies and questions.
800-222-1222 (Toll Free)

**Mental Health**
Call about a crisis, stress, anger, loneliness, etc.
866-HELP-1-NM (Toll Free)

**Children, Youth and Families**
Child abuse/neglect, child care, domestic violence.
800-797-3260 (Toll Free)
505-841-6100 (Local)

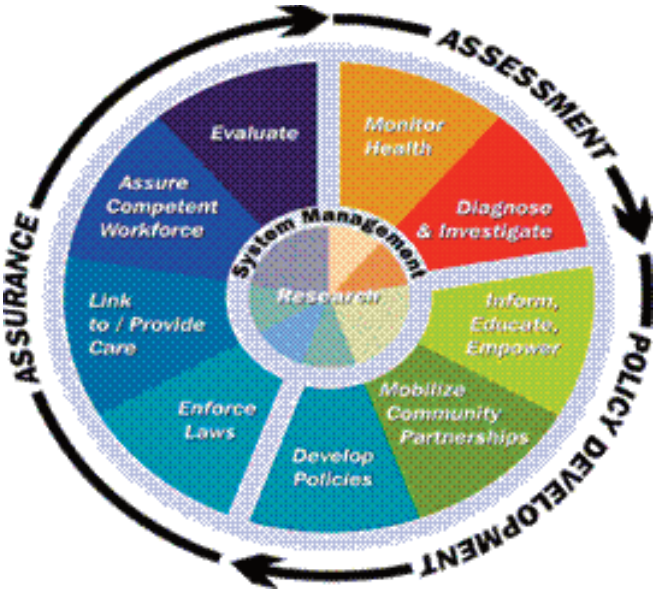



Figure 2: The 10 Essential Public Health Services

The 10 Essential Public Health Services describe the public health activities that all communities should undertake and serve as the framework for the NPHPS instruments. Public health systems should:

1. Monitor health status to identify and solve community health problems.
2. Diagnose and investigate health problems and health hazards in the community.
3. Inform, educate, and empower people about health issues.
4. Mobilize community partnerships and action to identify and solve health problems.
5. Develop policies and plans that support individual and community health efforts.
6. Enforce laws and regulations that protect health and ensure safety.
7. Link people to needed personal health services and assure the provision of health care when otherwise unavailable.
8. Assure competent public and personal health care workforce.
9. Evaluate effectiveness, accessibility, and quality of personal and population-based health services.
10. Research for new insights and innovative solutions to health problems.

## WHAT IS PUBLIC HEALTH?

Public health is the practice of preventing disease and promoting good health by providing the resources and creating environments that help people stay healthy.

### Public health saves money and improves quality of life.

A healthy public gets sick less frequently and spends less money on health care; this means better economic productivity and an improved quality of life for everyone.

### Examples of public health in policy and practice:

- Vaccination programs for school-age children and adults to prevent the spread of disease
- Efforts to make neighborhoods more walkable
- Tobacco cessation media campaigns and "quit lines"
- School nutrition programs to ensure that children have access to nutritious food

### The public health system includes:

Public health agencies at state and local levels

Healthcare providers

Public safety agencies

Human service and charity organizations

Education and youth development organizations

Recreation and arts-related organizations

Economic and philanthropic organizations

Environmental agencies and organizations