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FY20 QUARTER 2 PERFORMANCE REPORT

DEPARTMENT OF HEALTH

NEW MEXICO
DEPARTMENT OF
HEALTH

DEPARTMENT OF HEALTH

Agency Mission:

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

Agency Goals/Objectives:

Community Engagement – to Improve Organizational Communication & Collaboration
Data & Evaluation – to Provide Benchmarks for Practice Improvements & Monitor State Health Status
Effective Business Practices – to Develop Policies & Plans that Support Agency-Wide Health Efforts
Employee Competence – to Assure a Competent Public Health Workforce
Healthy New Mexico – to Improve the Health Status of All New Mexicans

Key Strategic Plan Initiatives:

Track and support existing public health measures and priorities, while continuing to improve data collection activities

- Push performance measure orientation toward more outcome and output measures
- Focus explanatory population-based indicators toward the SHIP, since they require long-range, cross agency influence

Publish updated NM-IBIS Community Health Status Indicators (CHSIs) annually

- Involve community and tribal stakeholders in defining priority indicators for community health assessment
- Engage NMDOH program and epidemiologist staff in defining/operationalizing measures appropriately
- Ensure NMDOH program and epidemiologist staff maintain data and narrative context for NM-IBIS CHSIs annually appropriately

Redesign waivers to eliminate the DDW waitlist

- Design and implement three phased plan to eliminate wait list
- Create and implement a Supports Waiver
- Secure Rate increase for providers
- Disengage seven remaining requirements in the Jackson Settlement

Implement the State Health Improvement Plan (SHIP) priorities

- Identify NMDOH leads
- Involve and engage stakeholder groups and other state health-oriented agencies
- Determine best implementation practices in concert with external stakeholders
- Involve pertinent state partners in state health priority setting and implementation efforts
- Determine cross-agency strategies for collective statewide action

Promote effective substance use disorder treatments

- Map existing substance use treatment facilities, include tribal locations, and identify gaps
- Institute evaluation tools, with Behavioral Health Supports Division, and apply to known programs
- Expand Medical Assisted Treatment in Public Health Clinics and Primary Care Facilities
- Identify effective interventions for alcohol and methamphetamine abuse

AGENCY PROGRAMS

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

PROGRAM #1: PUBLIC HEALTH DIVISON (PHD)

Program Description, Purpose and Objectives:
The Public Health Division (PHD) fulfills the New Mexico Department of Health's mission by working with individual families, communities and partners to improve health, eliminate disparities, and ensure timely access to quality, culturally competent health care.

Program Budget (in thousands):

FY19	General Fund	Other State Funds	Federal Funds	Other Transfers	TOTAL	FTE
200	$ 21,658.50	$ 3,396.70	$ 23,947.10	$ 3,017.90	$ 52,020.20	820.5
300	$ 15,367.10	$ 5,049.50	$ 10,538.80	$ 11,401.50	$ 42,356.90	
400	$ 12,287.40	$ 32,902.90	$ 35,318.50	$ 245.10	$ 80,753.90	
TOTAL	$ 49,313.00	$ 41,349.10	$ 69,804.40	$ 14,664.50	$ 175,131.00	

FY20	General Fund	Other State Funds	Federal Funds	Other Transfers	TOTAL	FTE
200	$ 22,374.90	$ 3,189.80	$ 25,107.10	$ 3,144.00	$ 53,815.80	816.5
300	$ 15,367.10	$ 4,950.50	$ 10,760.00	$ 12,086.70	$ 43,164.30	
400	$ 12,259.10	$ 33,401.20	$ 34,888.80	$ 305.90	$ 80,855.00	
TOTAL	$ 50,001.10	$ 41,541.50	$ 70,755.90	$ 15,536.60	$ 177,835.10	

Program Performance Measures:

Program Objective 1: Link people to needed personal health services and assure the provision of health care when otherwise unavailable

1. Percent of New Mexico adult cigarette smokers who access cessation services
2. Percent of participants in the National Diabetes Prevention Program that were referred by a health care provider through the agency-sponsored referral system
3. Percent of QUIT NOW enrollees who successfully quit using tobacco by 7-month follow-up
4. Number of successful overdose reversals per client enrolled in the NMDOH Harm Reduction Program (FY20 Key Measure)
5. Percent of female clients ages 15-19 seen in NMDOH public health offices who are provided most or moderately effective contraceptives (FY20 Key Measure)

Program Objective 2: Work with health system and surveillance partners to monitor health status to identify community problems

6. Percent of third grade children who are considered obese
7. Percent of adolescents who smoke
8. Percent of adults who smoke
9. Percent of preschoolers (19-35 months) who are indicated as being fully immunized
10. Percent of older adults who have ever been vaccinated against pneumococcal disease

Program Objective 3: Work with community partners to inform, educate and empower people about health issues

11. Number of teens that successfully complete teen pregnancy prevention programming (FY20 Key Measure)
12. Number of high school youth trained in the Evolvement youth engagement program to implement tobacco projects in their school/community
13. Number of WIC clients participating in food tastings and/or cooking demonstrations in WIC clinics with kitchens

Program Objective 4: Work with communities to develop policies and plans that support individual and community efforts

14. Percent of children in Healthy Kids, Healthy Communities with increased opportunities for healthy eating in public elementary schools
15. Percent of adults who are considered obese

Program Objective 5: Work with health care delivery systems to evaluate effectiveness, accessibility and quality of personal and population-based health services

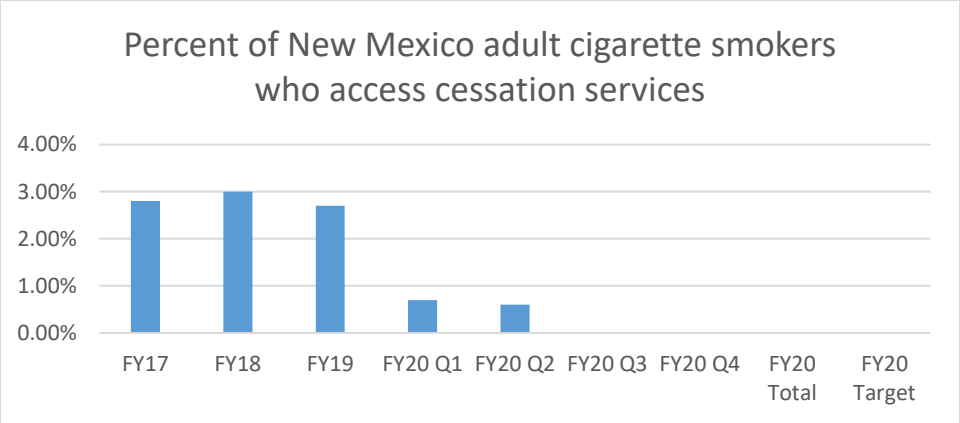
16. Percent of NMDOH funded school-based health centers that demonstrate improvement in their primary care or behavioral health care focus area
17. Rate of diabetes hospitalization per 1,000 diagnosed persons
18. Rate of births to teens per 1,000 females aged 15-19

PHD PERFORMANCE MEASURE #1

Percent of New Mexico adult cigarette smokers who access cessation services

Results

FY17	FY18	FY19	FY20 Q1	FY20 Q2	FY20 Q3	FY20 Q4	FY20 Total	FY20 Target
2.8%	3.0%	2.7%	0.7%	0.6%				≥2.89%



MEASURE DESCRIPTION:
Numerator: Number of adult cigarette smokers who access NMDOH Cessation Services.
Denominator: Total estimated number of adult cigarette smokers in NM.

DATA SOURCE/METHODOLOGY:
Annual QUIT NOW and DEJELO YA Cessation Services utilization and enrollment reports; Behavioral Risk Factor Surveillance System (BRFSS); UNM Geospatial and Population Studies population estimates as reported in NM IBIS.

STORY BEHIND THE DATA:
The New Mexico Department of Health's (NMDOH's) Tobacco Use Prevention and Control Program successfully reached 0.7% of adult smokers through its QUIT NOW and DEJELO YA tobacco cessation services in Q1 of FY20, aiming toward an accumulative annual target of 2.5% or higher. Although cigarette smoking continues to decline in the state, there are still about 246,000 adult cigarette smokers and users of other types of tobacco. Of the remaining smokers, about 2 in 3 have attempted to quit in the past year and 8 in 10 say they plan to quit in the next 6-months. The strong interest in smoking cessation among remaining smokers points to a continued need and opportunity to reach and serve additional people through QUIT NOW and DEJELO YA.

IMPROVEMENT ACTION PLAN:

Major Quarterly Action Steps:	Goal Completion Date				
	Q1	Q2	Q3	Q4	Target
1) Make available consistent cessation services throughout the entire fiscal year	X	X			
2) Develop content for mass media and targeted media to promote use of services		X			
3) Train health care providers	X	X			
4) Conduct ongoing monitoring, evaluation and tailoring of services	X	X			

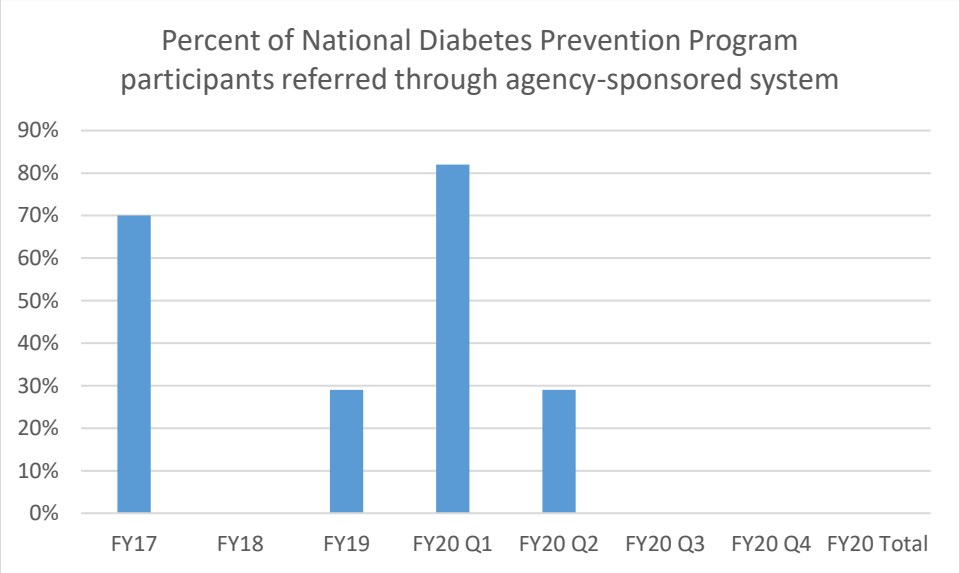
NMDOH Tobacco Cessation Services include quit coaching/counseling, free nicotine medications, phone- and web-based support, as well as services in Spanish. Enrollment and follow-up data are evaluated on a monthly basis in order to adjust promotion efforts and service delivery.

PHD PERFORMANCE MEASURE #2

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

Results

FY17	FY18	FY19	FY20 Q1	FY20 Q2	FY20 Q3	FY20 Q4	FY20 Total	FY20 Target
70%	0%	29%	82%	29%				≥25%



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

DATA SOURCE/METHODOLOGY:
DPCP's centralized referral and data system, accessed through Paths to Healthier NM, Tools for Healthier Living, and data from the referral and data management system service software, Workshop Wizard.

STORY BEHIND THE DATA:
Prediabetes, a precursor to diabetes, is when blood sugar levels are higher than normal, but not high enough to be diagnosed as diabetes. There may be no external symptoms of disease. In 2018, an estimated 567,000 New Mexican adults had prediabetes and only 3 out of 10 with the condition were aware of it. Unrecognized and untreated, prediabetes can progress to diabetes and lead to serious and costly health complications. Older adults, African Americans, and American Indians are at higher risk for prediabetes. The CDC states without weight loss and physical activity, 15-30% of people with prediabetes will develop diabetes within 5 years. Increasing access to a proven, structured lifestyle change program, such as the National Diabetes Prevention Program (NDPP), can cut an adult's risk of getting type 2 diabetes in half by losing weight, eating healthy, and being more active.

IMPROVEMENT ACTION PLAN:

Major Quarterly Action Steps:	Goal Completion Date				
	Q1	Q2	Q3	Q4	Target
1) Receive referrals from healthcare providers	X	X			**120/yr**
2) Promote and incorporate HIPAA compliant referral and data management system, Workshop Wizard, into existing and newly identified healthcare systems	X	X			
3) Identify healthcare professional venues to share the Prevent Diabetes STAT toolkit, Workshop Wizard and Paths to Health NM: Tools for Healthier Living website	X	X			
4) Generate referrals through EClinical Works electronic health record system	X	X			
5) Disseminate branded Paths to Health NM: Tools for Health Living "Rack Cards"	X	250			

Successes achieved in Q2 include:

- Two new health systems began using the agency-sponsored referral system to make referrals to National DPP: Nor-Lea Regional Hospital and El Centro Family Health
- More than 250 Paths to Health NM Rack cards were shared with health systems partners and lifestyle coaches to facilitate provider referrals through the agency-sponsored referral system
- NMDOH National DPP programs in Albuquerque and Roswell recruited more than half of their participants from provider referrals

Barriers to achieving success in Q2 include:

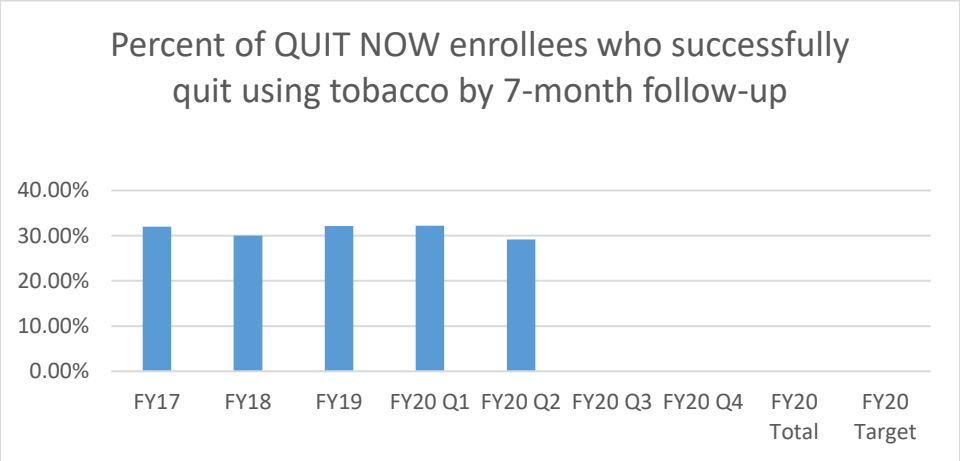
- Length of time to connect EHR systems such as EClinical Works with the agency-sponsored referral system
- Shortage of clinicians/providers available to conduct trainings for healthcare professionals

PHD PERFORMANCE MEASURE #3

Percent of QUIT NOW enrollees who successfully quit using tobacco by 7-month follow-up

Results

FY17	FY18	FY19	FY20 Q1	FY20 Q2	FY20 Q3	FY20 Q4	FY20 Total	FY20 Target
32.00%	30.00%	32.15%	32.20%	29.2%				≥30%



MEASURE DESCRIPTION:
A sample of QUIT NOW enrollees is contacted 7-months after enrollment to determine whether they still had not been using tobacco for the previous month. The measure represents the percentage of those people reached at follow-up who responded that they are still done using tobacco.

DATA SOURCE/METHODOLOGY:
New Mexico QUIT NOW Cessation Services Quarterly Evaluation Report compiled by TUPAC's contracted program evaluation team.

STORY BEHIND THE DATA:
The New Mexico Department of Health's (NMDOH's) Tobacco Use Prevention and Control Program reached QUIT NOW enrollees for a 7-month follow-up and found that 32.2% remained quit in Q1 of FY20, slightly better than the target of 30%. New Mexico's 7-month quit rate for QUIT NOW enrollees continues to track slightly above the 28.7% seen across 37 other state quitlines in the U.S. About two in three adult tobacco users want to quit, which translates into about 150,000 New Mexican adults who are potentially interested or actively trying to quit tobacco. QUIT NOW provides the quit coaching and FDA-approved medications to help these tobacco users accomplish their goal of quitting tobacco.

IMPROVEMENT ACTION PLAN:

Major Quarterly Action Steps:	Goal Completion Date				
	Q1	Q2	Q3	Q4	Target
1) Contact QUIT NOW enrollees for follow-up	X	X			
2) Train healthcare providers and health centers on tobacco use screening and referral to quitting services	X	X			
3) Provide online and in-person trainings to increase awareness	X	X			
4) Finalize new online training for behavioral health providers and promote participation	X	X			

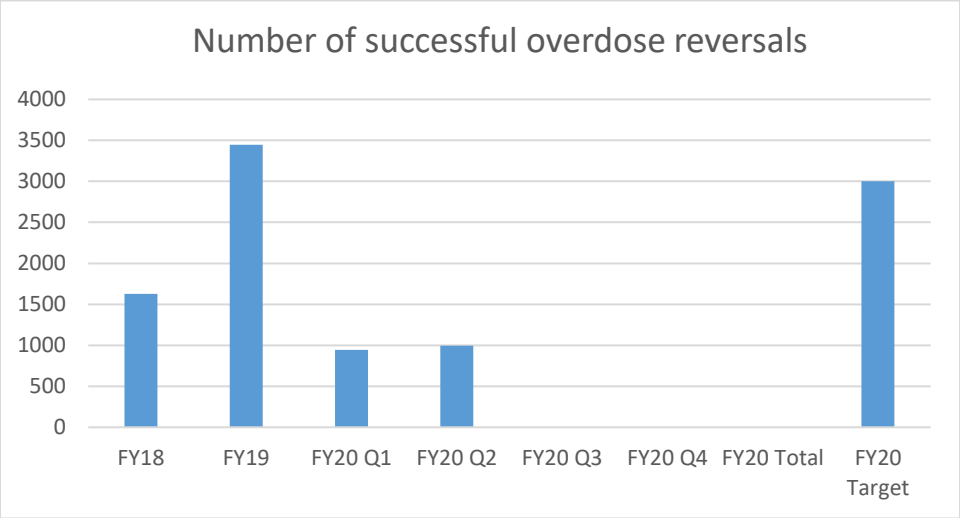
NMDOH Tobacco Cessation Services and follow-up of enrollees is on track through Q2. Final review and approval of the new behavioral health online training is taking longer than expected but should be complete in Q3.

PHD PERFORMANCE MEASURE #4

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

Results

FY17	FY18	FY19	FY20 Q1	FY20 Q2	FY20 Q3	FY20 Q4	FY20 Total	FY20 Target
	1629	3446	943	996				3,000



MEASURE DESCRIPTION:
This measure is the number of successful reversals per number of overdose prevention compared to the number of naloxone distribution and education sessions.

DATA SOURCE/METHODOLOGY:
NMDOH's Hepatitis and Harm Reduction Naloxone Distribution Database as compiled by the Hepatitis and Harm Reduction Program, with the support of Substance Use Epidemiology staff from the Epidemiology and Response Division.

STORY BEHIND THE DATA:
The New Mexico Department of Health Hepatitis and Harm Reduction Program has one of the nation's longest standing overdose prevention education and naloxone distribution programs. In Q3 of FY2016, the New Mexico Legislature passed legislation that reduced barriers to providing naloxone to individuals at highest risk of experiencing an opioid overdose. This allowed the program to rapidly increase the number of individuals reached. This data shows that the number of individuals who reported that they had successfully utilized naloxone to reverse an opioid overdose has remained steady. It is important to note that this number is likely an undercount of those that utilized naloxone to reverse an opioid overdose as this is based on self-reporting when individuals return to receive a refill.

IMPROVEMENT ACTION PLAN:

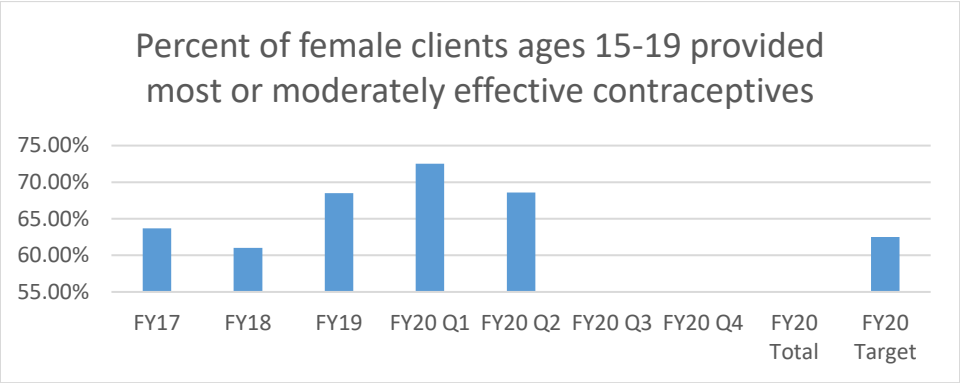
Major Quarterly Action Steps:	Goal Completion Date				
	Q1	Q2	Q3	Q4	Target
1) Increase percentage of individuals enrolled in program who have reported successfully utilizing naloxone to 30%	X	X			**3000**
2) Continue to train providers on overdose prevention curriculum throughout the state, at least 1 training in each health region per year	X	X			

PHD PERFORMANCE MEASURE #5

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

Results

FY17	FY18	FY19	FY20 Q1	FY20 Q2	FY20 Q3	FY20 Q4	FY20 Total	FY20 Target
63.7%	61%	68.5%	72.5%	68.6%				≥ 62.5%



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

DATA SOURCE/METHODOLOGY:
The NM Family Planning Annual Report - reports are generated on a quarterly basis to determine the percentage of teens who report using most or moderately effective contraception during a given timeframe.

STORY BEHIND THE DATA:
Access to and availability of effective contraceptive methods contribute to the steady decrease in New Mexico's teen birth rate. The broad range of contraceptive methods (including IUDs and implants [most-effective] and pills, injectables, and rings [moderately-effective]) is available at 39 of the 44 public health offices that offer family planning services. Since 2013, the teen birth rate among 15-to-19-year-olds in New Mexico has declined by 41.3% to 25.2 per 1,000 in 2018 (NM-IBIS), which is the seventh highest in the nation (National Center for Health Statistics). In NM, teen birth rates are highest for American Indians and Hispanics (at almost double the reference rate).

IMPROVEMENT ACTION PLAN:

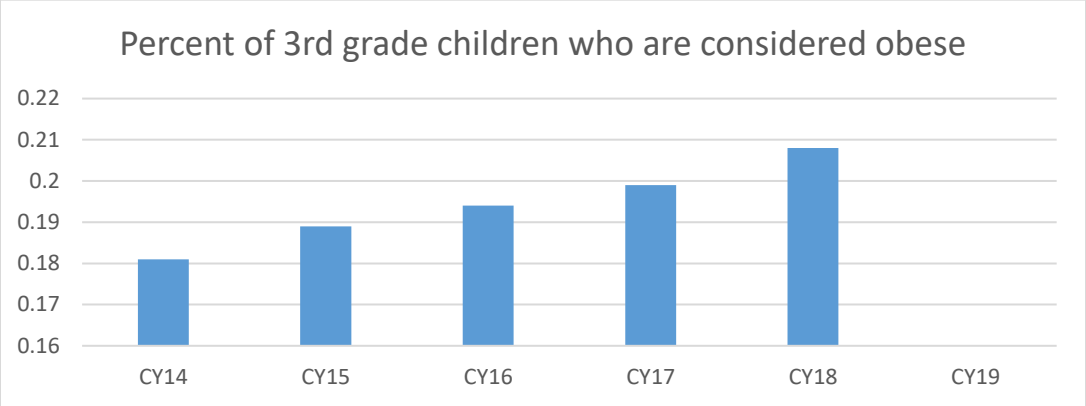
Major Quarterly Action Steps:	**Goal Completion Date**				
	Q1	**Q2**	**Q3**	**Q4**	**Target**
1) Dispense most or moderately effective contraceptives to teens aged 15-19 in local public health offices	73%	69%			**62.5%**
2) Fund staff in public health offices to provide the broad range of contraceptive methods and confidential family planning services throughout the state	X	X			**n/a**
3) Ensure that most and moderately effective contraception are available on the formulary for clients to select	X	X			**n/a**

PHD PERFORMANCE MEASURE #6

Percent of third grade children who are considered obese

Results

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



MEASURE DESCRIPTION:
Obesity is defined as Body Mass Index (BMI) at or above the 95th percentile for children of the same age and sex.

DATA SOURCE/METHODOLOGY:
In the fall of 2018, the Obesity, Nutrition, and Physical Activity Program (ONAPA) and its partners, completed statewide childhood obesity surveillance by measuring 6,604 kindergarten and third grade students in 56 randomly-selected public elementary schools, and in March 2019, published its New Mexico Childhood Obesity 2018 update. ONAPA and its partners also built support for measuring an additional 3,000 students in 31 HKHC schools, so these communities would have more comprehensive childhood obesity data.

STORY BEHIND THE DATA:
Childhood obesity occurs when a child is well above the healthy weight for his/her age and height. Obese children are more likely to become obese adults with increased risk of chronic conditions, including heart disease and type 2 diabetes. American Indian children have the highest rates among all racial/ethnic groups, by third grade nearly one-in-two (42.3%) American Indian students are overweight or obese, followed by Hispanics at 37.7%

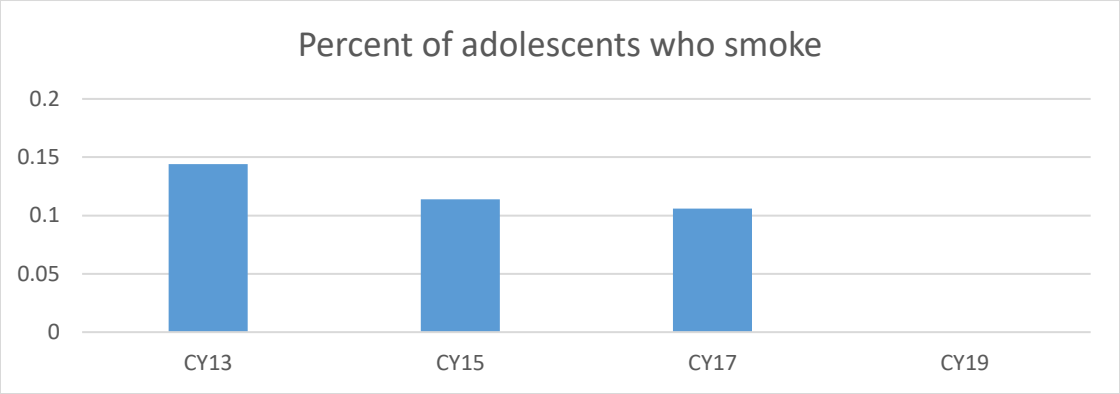
IMPROVEMENT ACTION PLAN:
Annual calendar year explanatory measure, thus no quarterly actions required.
Due to the annual data collection activities that takes place regularly in the fall and spring, the Calendar Year 2019 results should be anticipated in the next publication of the New Mexico Childhood Obesity 2019 update in early March 2020.

PHD PERFORMANCE MEASURE #7

Percent of adolescents who smoke

Results

CY13	CY15	CY17	CY19	FY20 Target
14.4%	11.4%	10.6%	n/a	Explanatory



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

DATA SOURCE/METHODOLOGY:
The Youth Risk and Resiliency Survey (YRRS) is conducted every two years and was in the field in the of fall 2019.

STORY BEHIND THE DATA:
The most recent youth smoking rate was 10.6% and comes from the 2017 YRRS. New national data showed a significant decline in youth smoking between 2018 (8.1%) and 2019 (5.8%), and while New Mexico youth smoking trends typically mirror those in the U.S., we will have to wait until early 2020 to determine if this holds true for 2019 results.

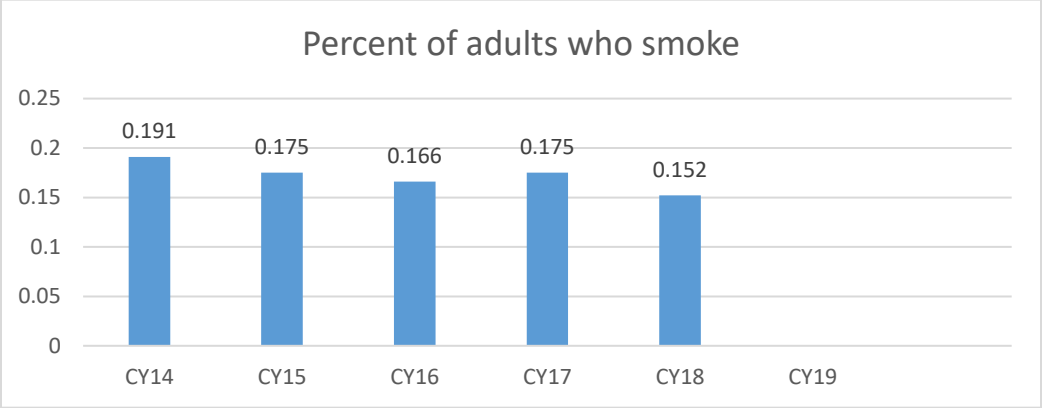
IMPROVEMENT ACTION PLAN:
Annual calendar year explanatory measure, thus no quarterly results required.
New Mexico youth smoking data for 2019 will not be available until early 2020.

PHD PERFORMANCE MEASURE #8

Percent of adults who smoke

Results

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



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

DATA SOURCE/METHODOLOGY:
Behavioral Risk Factor Surveillance System (BRFSS) data via New Mexico Internet Based Information System (NM IBIS).

STORY BEHIND THE DATA:
Cigarette smoking is the leading preventable cause of disease, disability, and death in the U.S. and in New Mexico. Cigarette use kills over 2,800 New Mexicans and afflicts 84,000 people with tobacco-related diseases. Smoking also costs New Mexico about $844 million annually in healthcare-related costs. Smoking among New Mexicans has reached an all-time low of 15.2% and has declined by 30% among adults since 2011, which translates into about 100,000 fewer smokers in 2018. However, smoking rates have stagnated or not declined as quickly among certain subgroups, including low-income, uninsured, Medicaid-insured and lesbian/gay New Mexicans.

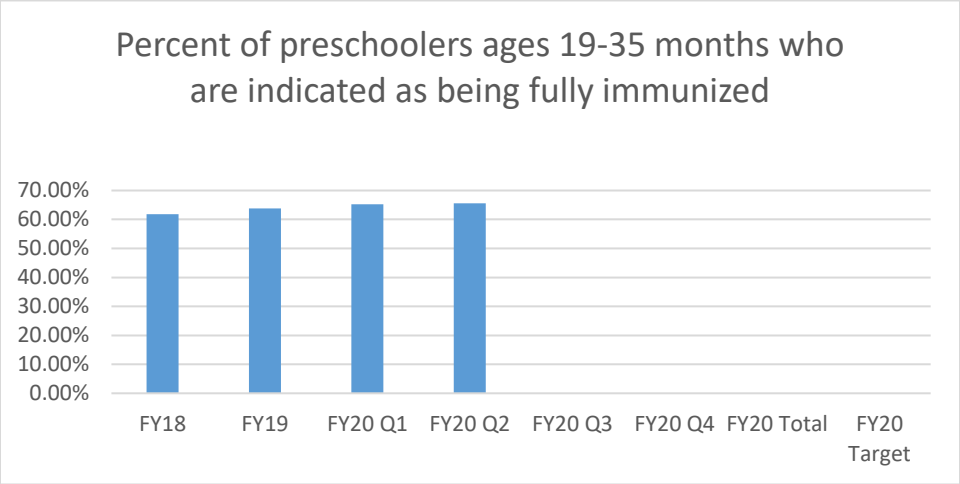
IMPROVEMENT ACTION PLAN:
Annual calendar year explanatory measure, thus no quarterly action plan results. New Mexico youth smoking data for 2019 will not be available until early 2020.

PHD PERFORMANCE MEASURE #9

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

Results

FY17	FY18	FY19	FY20 Q1	FY20 Q2	FY20 Q3	FY20 Q4	FY20 Total	FY20 Target
n/a	61.80%	63.85%	65.20%	65.58%				≥65%



MEASURE DESCRIPTION:

Numerator: Number of NM children 19-35 months of age, who are up-to-date for the 4:3:1:3:3:1 (4 DTaP, 3 Polio, 1 MMR, 3 HIB, 3 HepB, and 4 pneumococcal) immunization series in NMSIIS.

Denominator: Corresponding birth cohort data for 19-35-month-olds from NM Vital Records.

DATA SOURCE/METHODOLOGY:

The data source is New Mexico Vital Records Bureau and the New Mexico Statewide Information System (NMSIIS). Reports were generated from NMSIIS to determine the percentage of preschoolers (age 19-35 months) who are fully immunized factoring in the total reported births during this timeframe from Vital Records.

STORY BEHIND THE DATA:

This measure assesses New Mexico's success in attaining high levels of immunization coverage among its preschool population. The Healthy People 2020 objective is 80%, which is a realistic target for New Mexico as well.

IMPROVEMENT ACTION PLAN:

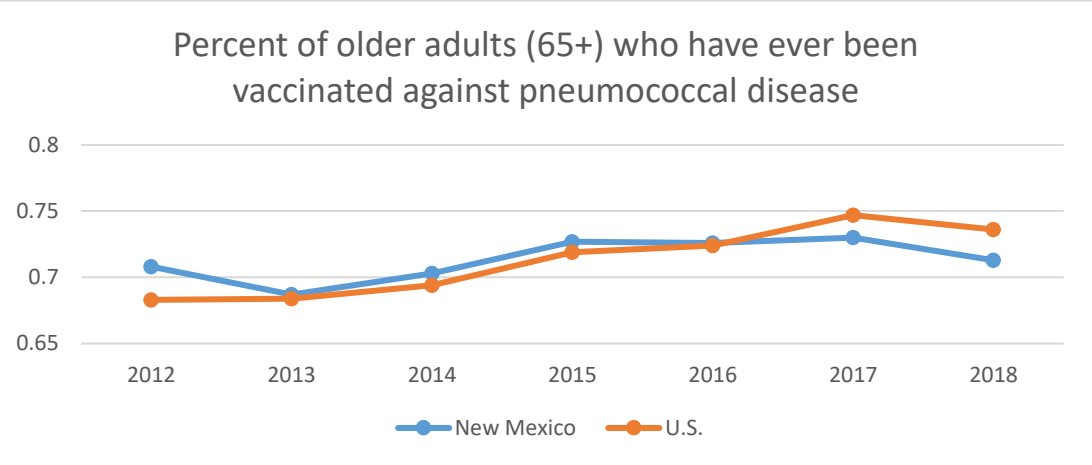
Major Quarterly Action Steps:	Goal Completion Date				
	Q1	Q2	Q3	Q4	Target
1) Improve registry data by reducing the number of duplicate client records		X			100%
2) Implement Data Quality Improvement plan		X			100%
3) Hire contract staff to assist with onboarding, data exchange and quality improvement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

PHD PERFORMANCE MEASURE #10

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

Results

FY17	FY18	FY19	FY20 Q1	FY20 Q2	FY20 Q3	FY20 Q4	FY20 Total	FY20 Target
73.0%	71.3%	n/a	n/a	n/a				≥75%



MEASURE DESCRIPTION:
Numerator: Number of survey respondents age 65 and older who have ever had a pneumonia immunization. Data are weighted to adjust for effects of sample design and to represent the population distribution of adults by sex, age group, and area of residence. Denominator: Total number of survey respondents age 65 and older, excluding missing, "Don't Know" and "Refused" responses.

DATA SOURCE/METHODOLOGY:
Data for this indicator report are from the Behavioral Risk Factor Surveillance System (BRFSS), an ongoing survey of adults regarding their health-related behaviors, health conditions, and preventive services. Data are collected in all 50 states, D.C., and U.S. territories. The US Healthy People 2020 Target for this measure is 90%. Availability of new data anticipated August 2020.

STORY BEHIND THE DATA:
Recommended immunizations for adults, aged 65 years and older, include a yearly immunization against influenza (flu) and a one-time immunization against pneumococcal disease: pneumococcal polysaccharide 23-valent vaccine (PPSV23). Adults 65 and over may also benefit from pneumococcal conjugate 13-valent vaccine, which protects against an additional 13 strains of pneumococcal bacteria and is recommended based on shared clinical decision-making between an individual and their provider.

IMPROVEMENT ACTION PLAN:

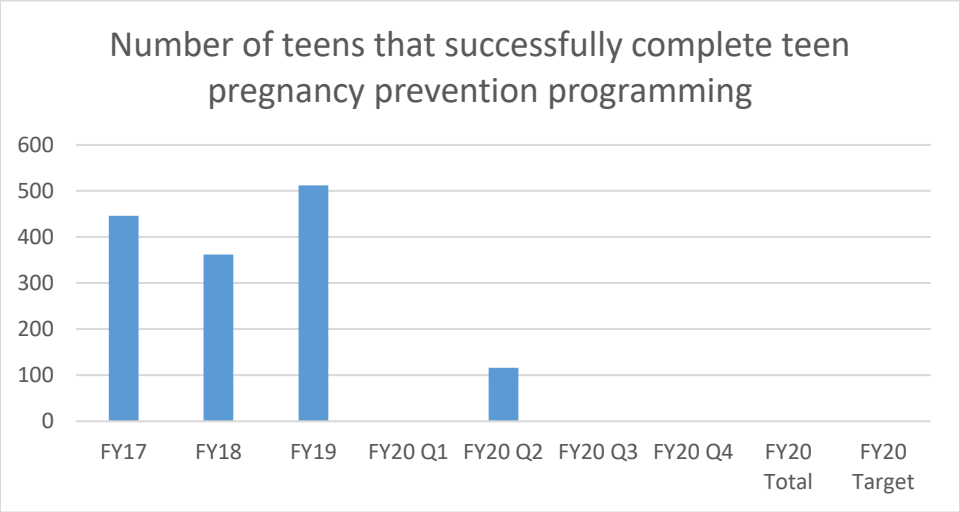
Major Quarterly Action Steps:	Goal Completion Date				
	Q1	Q2	Q3	Q4	Target
1) Ensure public health offices and partner organizations have access to PCV13 and PPSV23 for their uninsured patients	X	X			
2) Promote pneumococcal vaccination at community events serving older adults	600	X			
3) Notify 65+ adults of annual wellness visit due date through registry reminder/recall project	X	X			
4) Expand Community Health Worker train-the-trainer session statewide		100 %			12/31/ 19

PHD PERFORMANCE MEASURE #11

Number of teens that successfully complete teen pregnancy prevention programming

Results

FY17	FY18	FY19	FY20 Q1	FY20 Q2	FY20 Q3	FY20 Q4	FY20 Total	FY20 Target
446	362	512	0	116				≥325



MEASURE DESCRIPTION:
This is a measure of the count of students who successfully complete a specific teen pregnancy prevention program over a 12-month period.

DATA SOURCE/METHODOLOGY:
Curriculum specific data analysis by monitoring and auditing of Master Lists, Attendance Lists, and the Wyman Connect website for data collection. Reports are generated when programming is complete.

STORY BEHIND THE DATA:
Since 2013, the teen birth rate among 15-to-19-year-olds in New Mexico has declined by 41.3% to 25.2 per 1,000 in 2018 (NM-IBIS) and is the seventh highest in the nation (National Center for Health Statistics). Teens who drop out of school are more likely to become pregnant and have a child than peers who graduate. Seventy-one percent of teen mothers report that their pregnancy was unintended or mistimed, compared to 44% of all mothers (NM Indicator-Based Information System, 2018). Some reasons for higher teen parenthood in mixed urban/rural areas include lack of health insurance, increased poverty, transportation barriers, and less access to services. In NM, teen birth rates are highest for American Indians and Hispanics (at almost double the reference rate). Proactive service-learning, positive youth development, and comprehensive sex education programming are all protective factors for teens to reduce risky sexual behaviors.

IMPROVEMENT ACTION PLAN:

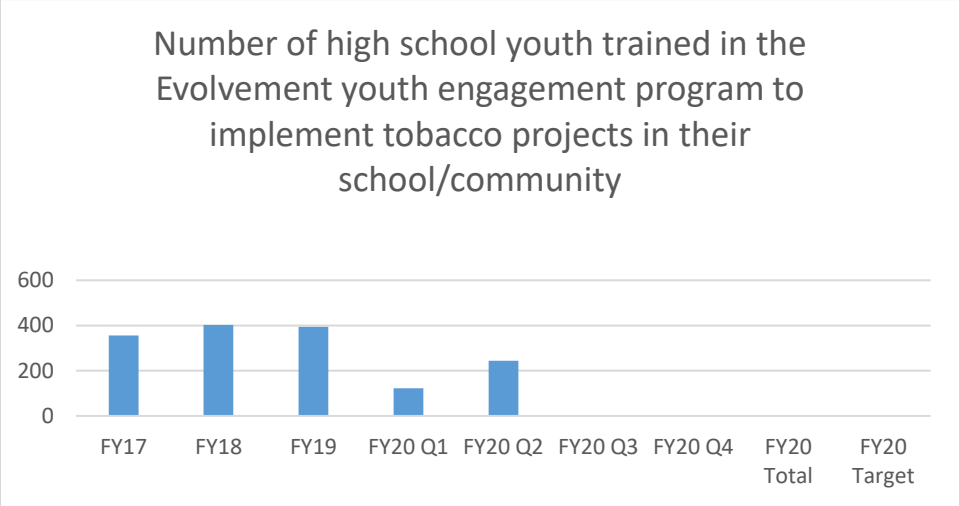
Major Quarterly Action Steps:	Goal Completion Date				
	Q1	Q2	Q3	Q4	Target
1) Contract with schools and community organizations to provide both TOP and Project AIM	Y	Y			**n/a**
2) Gather client data	Y	Y			**n/a**
3) Implement FY20 teen pregnancy prevention programming with all cohorts	Y	Y			**n/a**

PHD PERFORMANCE MEASURE #12

Number of high school youth trained in the Evolvement youth engagement program to implement tobacco projects in their school/community

Results

FY17	FY18	FY19	FY20 Q1	FY20 Q2	FY20 Q3	FY20 Q4	FY20 Total	FY20 Target
356	402	394	122	244				≥375



MEASURE DESCRIPTION:
Calculates youth who are enrolled in a high school that has been officially recruited and selected for participation in the Evolvement youth engagement program. Youth also need to have undergone approved training in the program and engaged in the development and implementation of one or more tobacco prevention projects in their school or community during the school year.

DATA SOURCE/METHODOLOGY:
Youth enrolled in a high school that has been recruited and selected for participation in the Evolvement youth engagement program. Data from TUPAC Contractor Annual Report and online electronic evaluation reporting system.

STORY BEHIND THE DATA:
Training youth in the Evolvement youth engagement program is a key strategy in implementing tobacco prevention campaigns in schools and communities across New Mexico. Increasing awareness and education on the harms of tobacco use and nicotine addiction through prevention campaigns, along with other interventions, can help reduce youth tobacco use prevalence. Campaigns implemented by trained Evolvement youth are designed to address topics such as emerging tobacco products, as well as restrict youth access to tobacco by educating New Mexico communities, parents, and retailers to help prevent illegal tobacco sales to minors.

IMPROVEMENT ACTION PLAN:

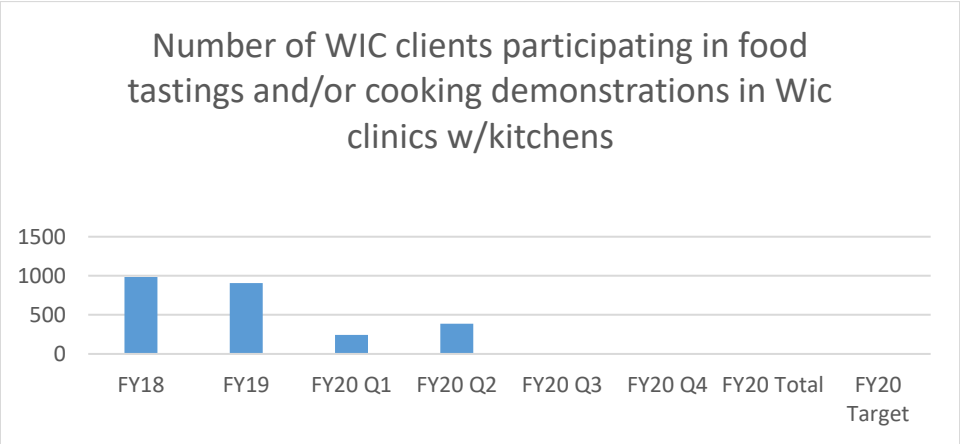
Major Quarterly Action Steps:	Goal Completion Date				
	Q1	Q2	Q3	Q4	Target
1) Train youth on youth engagement strategies across four different school trainings in different parts of the state	122	244			≥375
2) Seek out schools expressing interest in joining Evolvement	X	X			
3) Sign Memoranda of understanding with participating schools	14	3			

PHD PERFORMANCE MEASURE #13

Number of WIC clients participating in food tastings and/or cooking demonstrations in WIC clinics with kitchens

Results

FY17	FY18	FY19	FY20 Q1	FY20 Q2	FY20 Q3	FY20 Q4	FY20 Total	FY20 Target
n/a	986	906	244	385				>1,232



MEASURE DESCRIPTION:
The Obesity, Nutrition and Physical Activity Program (ONAPA) is currently working with WIC and New Mexico State University Cooperative Extension Services (CES) to implement nutrition education using WIC approved foods in WIC clinics with kitchens.

DATA SOURCE/METHODOLOGY:
ONAPA works closely with WIC clinics and NMSU CES (as appropriate) to collect information on the number of WIC clients who participate in food tastings.

STORY BEHIND THE DATA:
Between 2016 and 2018, 66.2.7% of New Mexico's adults were overweight or obese. Adults with lower socioeconomic status are more likely to practice unhealthy lifestyle behaviors, be overweight or obese, and suffer from chronic conditions. Women, Infants, and Children (WIC) clients (women and their children under the age of 5) are considered low-income and at risk for food insecurity. With the addition of federal Supplemental Nutrition Assistance Program Education (SNAP-Ed) funding in fiscal year 2016, the ONAPA program expanded its reach to the low-income adult population for the first time, specifically those participating in food assistance programs within tribal communities and high-poverty counties. The SNAP-Ed program has the greatest potential impact on nutrition and physical activity behaviors with interventions and strategies geared towards low-income women and children.

IMPROVEMENT ACTION PLAN:

Major Quarterly Action Steps:	**Goal Completion Date**				
	Q1	**Q2**	**Q3**	**Q4**	**Target**
1) Coordinate and provide nutrition education to WIC recipients using WIC-eligible foods	X	X			
2) Expand food demos in WIC clinics without kitchens to reach more recipients	2	4			
3) Identify WIC staff interested in participating in training to conduct tastings and demos	n/a	n/a			
4) Identify nutrition education curriculum that uses WIC foods and begin training WIC staff	n/a	n/a			

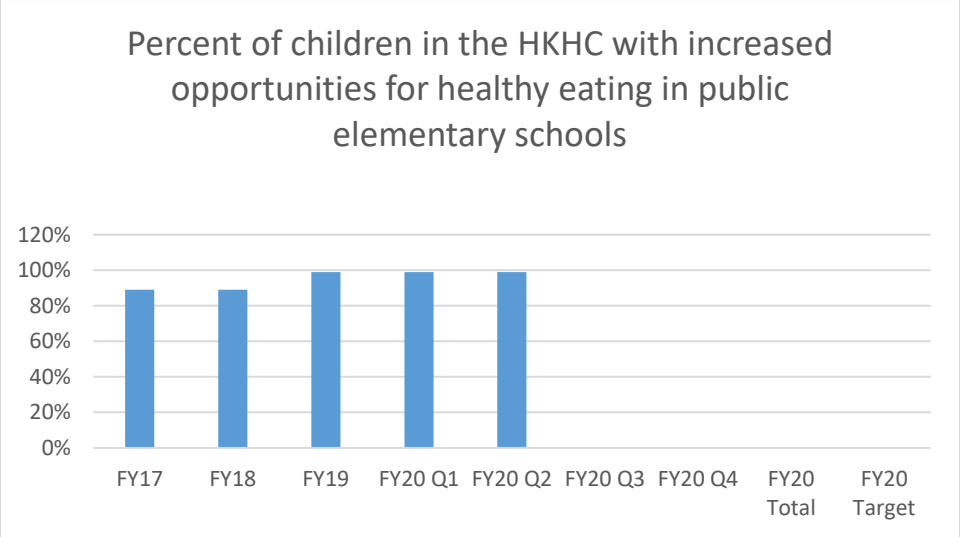
Planning for items 3 and 4 have begun. ICAN vacancies affected last two quarters of attendance.

PHD PERFORMANCE MEASURE #14

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

Results

FY17	FY18	FY19	FY20 Q1	FY20 Q2	FY20 Q3	FY20 Q4	FY20 Total	FY20 Target
89%	89%	99%	99%	99%				>89%



MEASURE DESCRIPTION:
This measure represents elementary-school age children in schools with increased opportunities for healthy eating during the school day on an ongoing and regular basis; the denominator is total elementary school population of schools within HKHC communities.

DATA SOURCE/METHODOLOGY:
Data on healthy eating is collected annually at the end of the school year by HKHC coordinators in local elementary schools. Our program aggregates, analyzes, and reports results by the end of the summer to assess environmental, policy, and systems changes over time.

STORY BEHIND THE DATA:
Increasing healthy eating and physical activity opportunities in schools is a best practice for preventing obesity, by exposing children to healthy lifestyle behaviors at an early age. In 2018, 13.3% of kindergarten and 20.8% of third grade students in New Mexico were obese; obese children are more likely to become obese adults with an increased risk of chronic health conditions. Healthy eating and physical activity are two lifestyle behaviors that can help prevent obesity.

IMPROVEMENT ACTION PLAN:

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

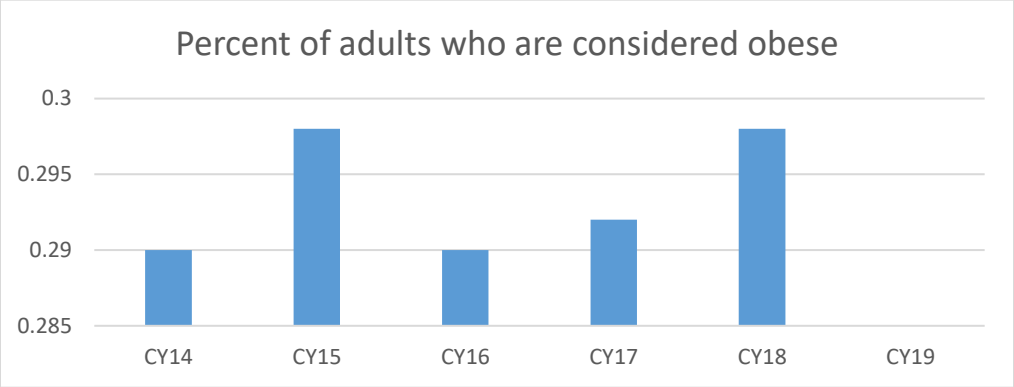
The Obesity, Nutrition, and Physical Activity Program (ONAPA) works closely with local coordinators in 13 Healthy Kids Healthy Communities (HKHC) to implement all three of these action steps each quarter to support the overall performance measure.

PHD PERFORMANCE MEASURE #15

Percent of adults who are considered obese

Results

CY14	CY15	CY16	CY17	CY18	CY19	CY20	FY20 Target
29%	29.8%	29.%	29.2%	29.8%			Explanatory



MEASURE DESCRIPTION:
The percent of respondents whose self-reported height and weight corresponds to a Body Mass Index (BMI) equal to or greater than 30.0.

DATA SOURCE/METHODOLOGY:
Data for this indicator report are from the Behavioral Risk Factor Surveillance System (BRFSS), an ongoing survey of adults regarding their health-related behaviors, health conditions, and preventive services. Data are collected in all 50 states, D.C., and U.S. territories. Responses have been weighted to reflect the New Mexico adult population by age, sex, ethnicity, geographic region, marital status, education level, home ownership and type of phone ownership.

STORY BEHIND THE DATA:
Among New Mexico's adults, 65.7% are overweight or obese (American Indians have the highest rate at 75%). Similarly, over one-in-four adults, ages 45 years old and older, have been diagnosed with two or more chronic diseases. Adults with lower socioeconomic status are at greater risk for adopting unhealthy lifestyle behaviors, becoming overweight or obese, and developing chronic disease.

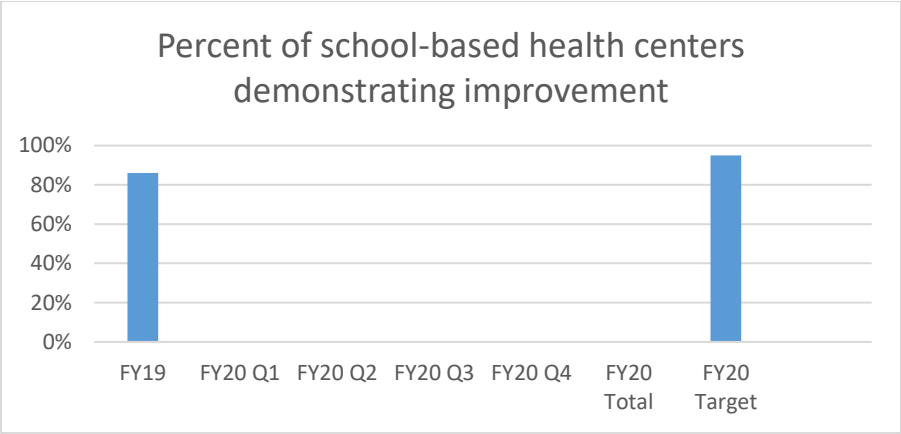
IMPROVEMENT ACTION PLAN:
Annual calendar year explanatory measure, thus no quarterly action plan results. The Obesity, Nutrition, and Physical Activity Program (ONAPA) does not collect these data and cannot predict when 2019 BRFSS results will be available.

PHD PERFORMANCE MEASURE #16

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

Results

FY17	FY18	FY19	FY20 Q1	FY20 Q2	FY20 Q3	FY20 Q4	FY20 Total	FY20 Target
		86%	0%	0%				95%



MEASURE DESCRIPTION:
NMDOH funded school-based health centers are required to complete a Quality Improvement initiative as part of their contract. This annual measure reports the number of school-based health centers that meet their year-long QI goal.

DATA SOURCE/METHODOLOGY:
School based health centers report their annual QI goal to the Office of School and Adolescent Health (OSAH) in their operational plan, as well as their mid-year progress and end of year progress toward those goals.

STORY BEHIND THE DATA:
Engaging clinical care practices in quality improvement (QI) activities is essential to achieving the triple aim of improving the health of the population, enhancing patient experiences and outcomes, and reducing the per capita cost of care, as well as improving provider experience. School based health centers are no exception to these goals. To that end, DOH funded school-based health centers are required to complete a pediatric, QI initiative annually. OSAH includes 12 different QI focus areas including primary and behavioral health care, and administrative processes. FY19 was the first year for this performance measure.

IMPROVEMENT ACTION PLAN:

Major Quarterly Action Steps:	Goal Completion Date				
	Q1	Q2	Q3	Q4	Target
1) Collect and review QI goals in operational plan reports	X	X			
2) Collect and review midyear progress reports	X	X			

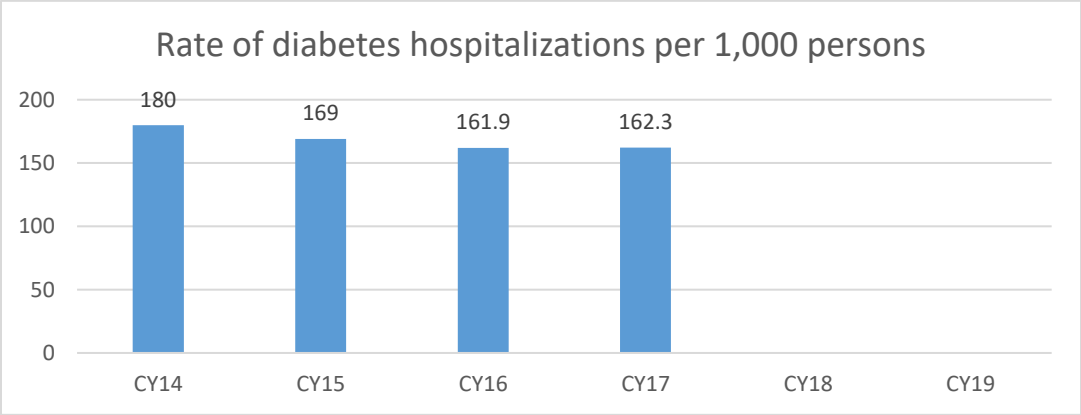
PHD PERFORMANCE MEASURE #17

Rate of diabetes hospitalization per 1,000 diagnosed persons

Results

CY14	CY15	CY16	CY17	CY18	CY19	CY20	FY20 Target
180	169	161.9	162.3				Explanatory

Graph of Data Above



MEASURE DESCRIPTION:
Numerator: Adult hospitalizations with diabetes listed as any diagnosis.
Denominator: New Mexico population of adults with diabetes

DATA SOURCE/METHODOLOGY:
Hospital Inpatient Discharge data, Behavioral Risk Factor Surveillance System, and inter-census data are utilized to estimate the age-adjusted rate of diabetes hospitalization.

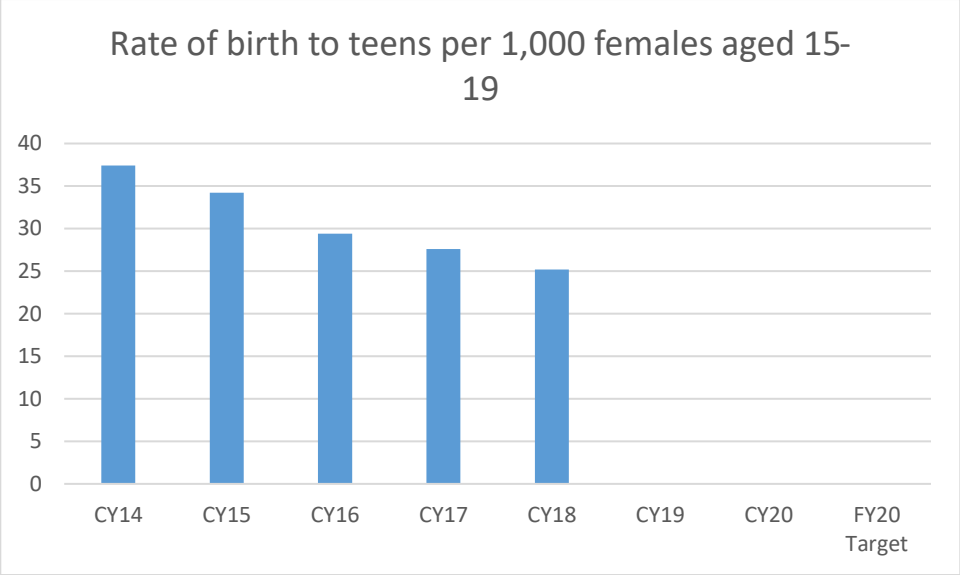
STORY BEHIND THE DATA:
Diabetes, one of the leading causes of death and disability in the U.S., is the sixth leading cause of death in New Mexico. In 2017, an estimated 220,039 NM adults, ages 18 and older (13.7%) had diabetes, and only 7 in 10 with the condition were aware of it. For people with diagnosed diabetes, the condition can be managed, and complications can be prevented or reduced through improved quality of clinical care and increased access to sustainable self-management and support services. The hospitalization rate among adults with diagnosed diabetes has been declining over the past five years because of several factors, like disease management programs provided by health care organizations and diabetes self-management education.

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

PHD PERFORMANCE MEASURE #18

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

CY14	CY15	CY16	CY17	CY18	CY19	CY20	FY20 Target
37.4	34.2	29.4	27.6	25.2	n/a	n/a	Explanatory



MEASURE DESCRIPTION:
This measure is a count of births to females aged 15-19 over the total population of females aged 15-19. This data is collected on a calendar year and the Family Planning Bureau calculates an estimated decrease of 10% per year.
DATA SOURCE/METHODOLOGY:
NM-IBIS

STORY BEHIND THE DATA:
Increased access to and availability of most- and moderately-effective contraception and evidence-based unintended teen pregnancy prevention programming can be directly linked to a decrease in the teen birth rate. Since 2013, the teen birth rate among 15-to-19-year-olds in New Mexico (NM) has declined by 41.3% to 25.2 per 1,000 in 2018 (NM-Indicator-Based Information System) and is the seventh highest in the nation (National Center for Health Statistics).

IMPROVEMENT ACTION PLAN:
Annual calendar year explanatory measure, thus no quarterly action plan results. CY2019 data will be available in late 2020.

PROGRAM #2: Epidemiology and Response Division (ERD)

Program Description and Purpose:
The Epidemiology and Response Division (ERD) monitors health, provides health information, prevents disease and injury, promotes health and health behaviors, responds to public health events, prepares for health emergencies, and provides emergency medical, trauma and vital records to New Mexicans. ERD provides services through six bureaus: Emergency Medical Systems (EMS), Environmental Health Epidemiology (EHEB), Health Emergency Management (BHEM), Infectious Disease Epidemiology (IDEB), Injury and Behavioral Epidemiology (IBEB), and Vital Records and Health Statistics (BVRHS).

Program Budget (in thousands):

FY19	General Fund	Other State Funds	Federal Funds	Other Transfers	TOTAL	FTE
200	4,199,400	463,600	9,093,000	406,700	14,162,700	203
300	1,226,900	78,100	5,073,400	133,000	6,511,400	
400	4,489,400	72,500	1,785,100	298,000	6,645,000	
TOTAL	9,915,700	614,200	15,951,500	837,700	27,319,100	

FY20	General Fund	Other State Funds	Federal Funds	Other Transfers	TOTAL	FTE
200	4,200,300	450,100	9,245,400	266,900	14,162,700	204
300	1,173,600	84,900	5,003,000	249,900	6,511,400	
400	4,541,800	79,200	1,703,100	108,300	6,432,400	
TOTAL	9,915,700	614,200	15,951,500	625,100	27,106,500	

Program Performance Measures:

Program Objective 1: Improve health status of New Mexico

1. Percent of self-reported sexual assaults per 100,000 population
2. Number of youth who have completed an evidence-based or evidence-supported sexual assault primary prevention program
3. Rate of suicide per 100,000
4. Percent of hospitals with emergency department based self-harm secondary prevention program
5. Number of community members trained in evidence-based suicide prevention program

Program Objective 2: Reduce substance use deaths

6. Rate of alcohol-related deaths per 100,000 population
7. Percent of county and tribal health councils that include in their plans evidence-based strategies to reduce alcohol-related harms
8. Percent of persons receiving alcohol screening and brief intervention (a-SBI) services
9. Percent of retail pharmacies that dispense naloxone (FY20 Key Measure)
10. Percent of opioid patients also prescribed benzodiazepines (FY20 Key Measure)

Program Objective 3: Reduce deaths among older populations

11. Rate of heat related illness hospitalizations per 100,000 population
12. Rate of cardiovascular disease (heart disease & stroke) deaths per 100,000 population
13. Percent of NM hospitals certified for stroke care (FY20 Key Measure)
14. Rate of fall-related deaths per 100,000 adults, aged 65 years or older
15. Percent of emergency department based secondary prevention of older adult fractures due to falls program

Program Objective 4: Reduce pneumonia and influenza deaths

16. Percent of the New Mexico population served during mass distribution of antibiotics and/or vaccinations through public/private partnerships in the event of a public health emergency
17. Rate of pneumonia and influenza death rate per 100,000 population

Program Objective 5: Monitor health status and provide health information

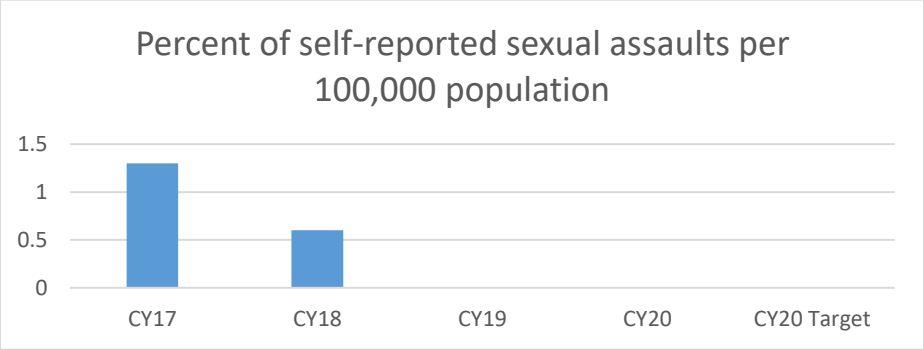
18. Rate of drug overdose deaths per 100,000 population
19. Rate of avoidable hospitalizations per 100,000 population
20. Percent of vital records front counter customers who are satisfied with the service they received

ERD PERFORMANCE MEASURE #1

Percent of self-reported sexual assaults per 100,000 population

Results

CY17	CY18	CY19	CY20	CY20 Target
1.3	0.6	Fall 2020		Explanatory



MEASURE DESCRIPTION:
Numerator: Those who answered 'Yes' to the question, "In the past 12 months, has anyone HAD SEX with you after you said or showed that you didn't want to or without your consent?"
Denominator: Number of NM residents who completed the Behavioral Risk Factor Surveillance System (BRFSS) survey for the year indicated, and who answered the question above.

DATA SOURCE/METHODOLOGY:
Questions were added to the BRFSS Survey for a period of three years to establish a baseline percentage of completed sexual assaults in NM for 2016, 2017, and 2018. Data are weighted to reflect the demographic population parameters of all NM residents. This is an annual calendar year explanatory measure.

STORY BEHIND THE DATA:
According to the 2018 BRFSS, 13.8% of women in NM have been raped during their lifetime, and of those 30.9% have been victims of rape by an intimate partner. Data from the 2018 BRFSS also shows certain populations in NM are at greater risk for sexual violence, including LGBTQ, American Indians and Alaska Natives, people living with disabilities, African-Americans, those who are foreign-born, children, and women.

BRFSS data are collected from state-level survey data, causing a delay in data acquisition. The percentage increased from CY16 to CY17 then decreased again in CY18. Because this is an explanatory measure, it is unclear how much effect Sexual Violence Prevention Program (SVPP) efforts had on this measure.

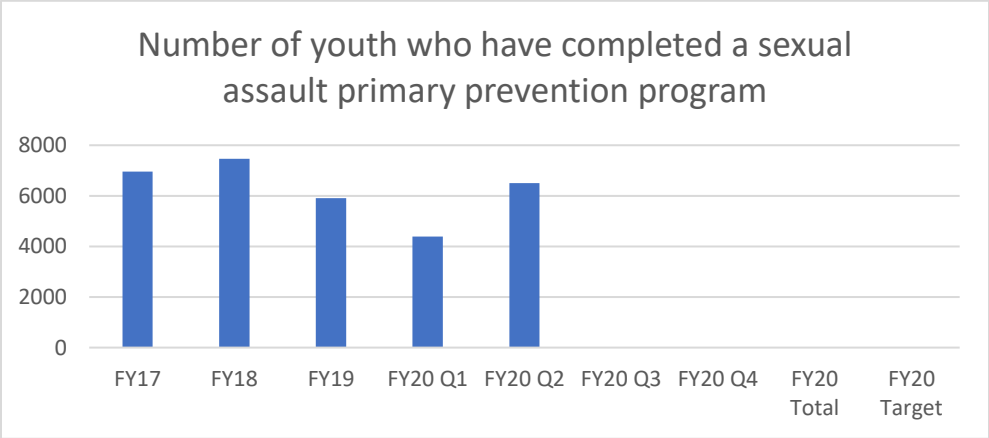
IMPROVEMENT ACTION PLAN:
The Sexual Violence Prevention Program addresses NM's high rate of sexual violence through a social-ecological approach where prevention is addressed at individual, relational, community, and societal levels with evidence-based and evidence-informed interventions. For individual and relational levels, the SVPP contractors deliver primary prevention educational programming in NM schools. At the community and societal levels SVPP contractors work with organizations and community partners to change organizational policies and lead statewide prevention initiatives.

ERD PERFORMANCE MEASURE #2

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

Results

FY17	FY18	FY19	FY20 Q1	FY20 Q2	FY20 Q3	FY20 Q4	FY20 Total	FY20 Target
6962	7470	5905	4393	6507				≥7000



MEASURE DESCRIPTION:
This output measure focuses on students and youth who have completed primary prevention programs.

DATA SOURCE/METHODOLOGY:
This information is gathered through reports submitted by Sexual Violence Prevention Program (SVPP) contractors showing participant counts of youth who completed an evidence-based sexual violence prevention program. Data are collected and evaluated to measure program reach.

STORY BEHIND THE DATA:
According to the 2017 Youth Risk Behavior Survey (YRBS), 9.9% of NM high school youth reported being forced to do sexual things (counting such things as kissing, touching, or being physically forced to have sexual intercourse) they did not want to do by anyone, one or more times during the 12 months before the survey. In 10 of 11 DOH funded programs, evaluative data showed youth to have significant decreases in attitudes that are risk factors for sexual violence perpetration.

IMPROVEMENT ACTION PLAN:

Major Quarterly Action Steps:	**Goal Completion Date**				
	Q1	**Q2**	**Q3**	**Q4**	**Target**
1) Train youth in evidence-based or supported sexual assault primary prevention	4393	6507			**7000**
2) Gather and analyze evaluation data	x	x			
3) Develop community and societal level interventions	x	x			

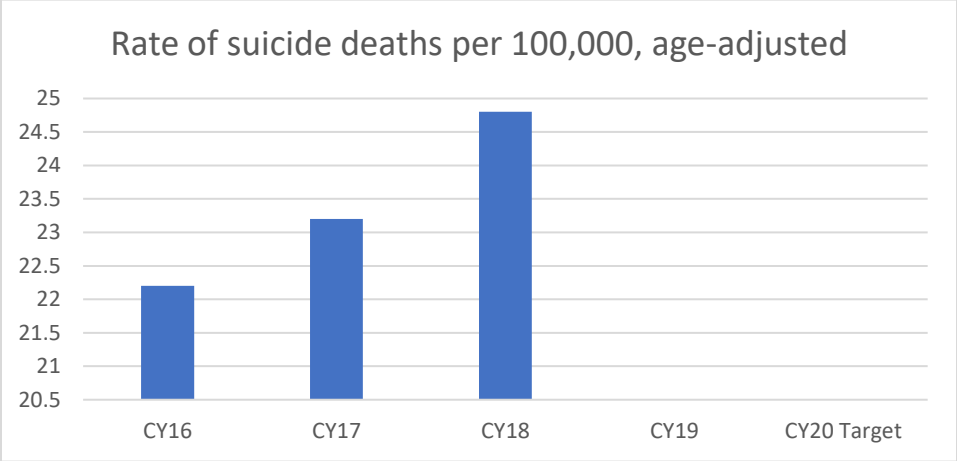
The Office of Injury Prevention (OIP) works with sexual violence contractors and community partners throughout the state to provide education to youth and adults who work with youth for the primary prevention of sexual violence. The OIP will increase the number of New Mexicans who have completed an evidence-based sexual assault primary prevention program and the Sexual Violence Prevention Program will move toward community and societal level interventions and establish performance measures reflecting this shift.

ERD PERFORMANCE MEASURE #3

Rate of suicide per 100,000 population

Results

CY16	CY17	CY18	CY19	CY20 Target
22.2	23.2	24.8	Fall 2020	Explanatory



MEASURE DESCRIPTION:
Numerator: Count of suicide deaths in 2018
Denominator: Rate is per 100,000 population, age-adjusted to U.S. 2000 population.

DATA SOURCE/METHODOLOGY:
NM Death Data: Bureau of Vital Records and Health Statistics (BVRHS), NM Department of Health; Centers for Disease Control and Prevention, National Center for Health Statistics. This is an annual calendar year explanatory measure.

STORY BEHIND THE DATA:
The suicide rate in New Mexico (NM) has consistently been more than 50% higher than national rates. In 2017, NM had the fourth highest suicide rate in the United States. From 2009-2018, deaths by suicide in NM increased by 39%. In 2018, state data showed suicide was the ninth leading cause of death in New Mexicans across all ages and the second leading cause of death for those ages 5 - 34 years.

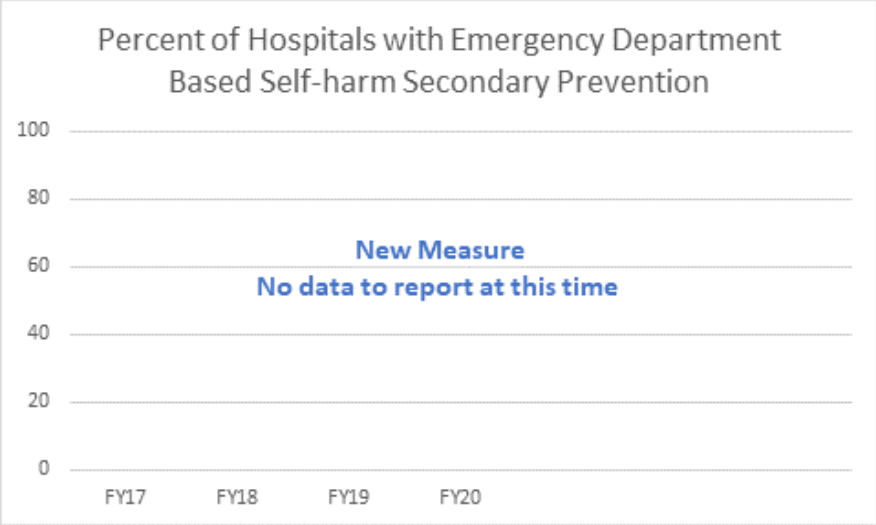
IMPROVEMENT ACTION PLAN:
The Office of Injury Prevention (OIP) will re-establish the statewide NM Suicide Prevention Coalition to build NM's Strategic Plan for Suicide Prevention. Specific strategies and activities were developed for several targeted areas to meet major suicide prevention strategic goals, which were identified by a group representative of the state's population. OIP is establishing a Secondary Prevention of Suicide Program to address the high rate of suicide by preventing suicide in individuals at particularly high risk, including those individuals seen for suicide attempts and then discharged home from emergency departments. OIP's Suicide Prevention Program serves as a resource for data and resource dissemination and collaborates with the Office of School and Adolescent Health to conduct suicide gatekeeper trainings.

ERD PERFORMANCE MEASURE #4

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

Results

FY17	FY18	FY19	FY20 Q1	FY20 Q2	FY20 Q3	FY20 Q4	FY20 Total	FY20 Target
--	--	--	0%	0%				5%



MEASURE DESCRIPTION:
Numerator: Number of emergency departments in the state with self-harm secondary suicide prevention programs.
Denominator: Number of emergency departments in NM (n=37) in 2019.

DATA SOURCE/METHODOLOGY:
The Suicide Prevention Program is working to establish self-harm secondary suicide prevention programs with emergency departments that will provide data for the numerator.

STORY BEHIND THE DATA:
Reducing the high rate of suicide in NM requires a comprehensive and multi-faceted approach involving both primary and secondary prevention. Individuals discharged from an emergency department following a suicide attempt are documented to have higher rates of suicide within the first 6-12 months following discharge. An evidence-based program to prevent subsequent suicide is being developed.

IMPROVEMENT ACTION PLAN:

Major Quarterly Action Steps:	Goal Completion Date				
	Q1	Q2	Q3	Q4	Target
1) Provide training and implementation support for 2 emergency departments	0	0			**2**
2) Support and evaluate the self-harm secondary prevention programs by developing evaluation plans, implementing them with the emergency departments, and conduct ongoing reviews.	X	X			

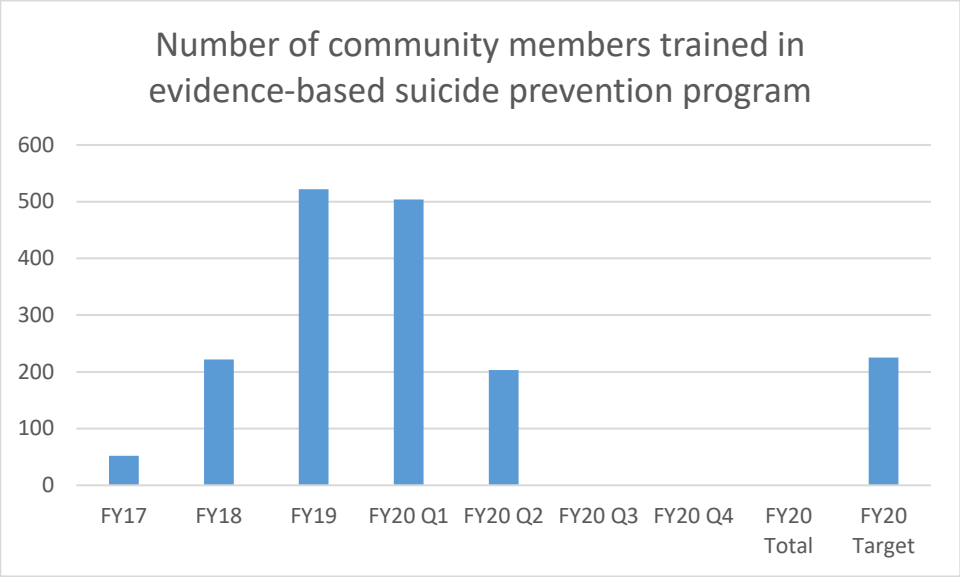
This program includes a patient-centered safety plan, a quick referral to follow-up care, and contacts to support patients during the first 6-months following the patient's discharge from an emergency department.

ERD PERFORMANCE MEASURE #5

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

Results

FY17	FY18	FY19	FY20 Q1	FY20 Q2	FY20 Q3	FY20 Q4	FY20 Total	FY20 Target
52	222	522	504	203				225



MEASURE DESCRIPTION:
The measure is a count of community members trained in suicide gatekeeper programs or in train-the-trainer suicide gatekeeper programs.

DATA SOURCE/METHODOLOGY:
The Suicide Prevention Program and Office of School and Adolescent Health (OSAH) participant records of evidence-based suicide gatekeeper trainings conducted.

STORY BEHIND THE DATA:
Evidence-based suicide gatekeeper trainings, such as the *Question, Persuade, Refer* program, have been shown to be effective in reducing suicide. NM suicide rate has been more than 50% higher than the national rate over the past decade, and in 2017, NM had the fourth highest suicide rate in the United States. The past decade saw an increase in suicide for all age groups, with the largest rate increases found in children 10-14 years and adults 65-74 years, a tripling and doubling, respectively, of the rates of suicide. Thus, continuing to increase awareness of suicide by educating community members about risk factors and warning signs is one component of a comprehensive approach to effectively address suicide. In addition, the Department of Health's Office of Injury Prevention continues to partner with the Office of School and Adolescent Health in building capacity in local communities and with other with-in- and outside-state government agencies to offer gatekeeper trainings through increasing the number of suicide gatekeeper train-the-trainer programs.

IMPROVEMENT ACTION PLAN:

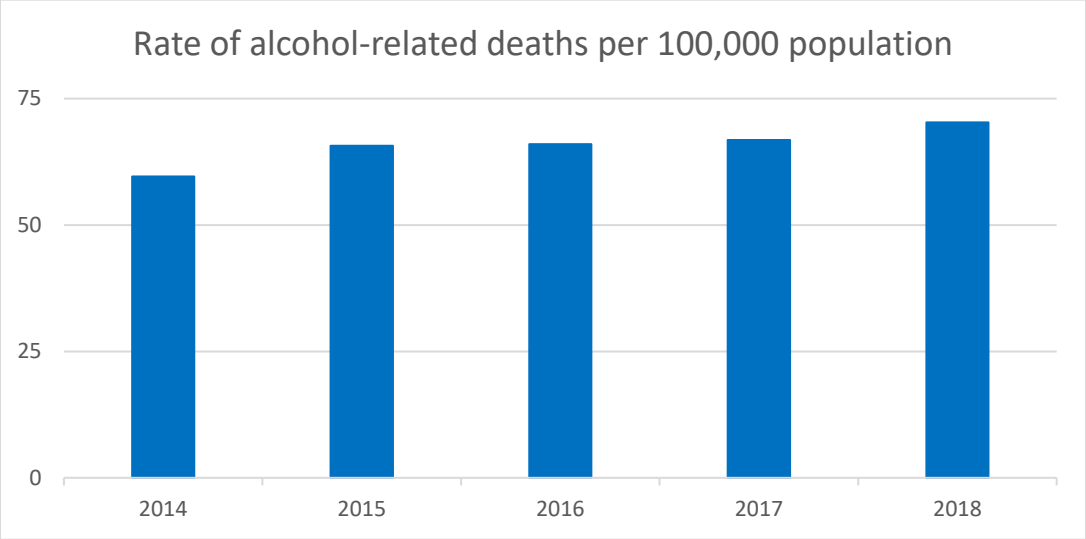
Major Quarterly Action Steps:	**Goal Completion Date**				
	Q1	Q2	Q3	Q4	Target
1) Offer Gatekeeper trainings to community members statewide	504	203			**600**

ERD PERFORMANCE MEASURE #6

Rate of alcohol-related deaths per 100,000 population

Results

CY14	CY15	CY16	CY17	CY18	CY19	CY20	FY20 Target
59.6	65.7	66.0	66.8	70.3	Fall 2020		Explanatory



MEASURE DESCRIPTION:
Numerator: Number of alcohol-related deaths.
Denominator: New Mexico population. This rate is age-adjusted to the standard 2000 US population.

DATA SOURCE/METHODOLOGY:
Death data are from NMDOH Bureau of Vital Records and Health Statistics. Population data are from UNM/GPS. Estimates of alcohol-related deaths are based on CDC Alcohol-related Disease Impact (ARDI).

STORY BEHIND THE DATA:
New Mexico has the highest alcohol-related death rate in the US. New Mexico's CY18 alcohol-related death rate is twice the US 2017 death rate (70.3 compared to 35.0). The alcohol-related death rate in New Mexico increased 5% between 2017 and 2018.

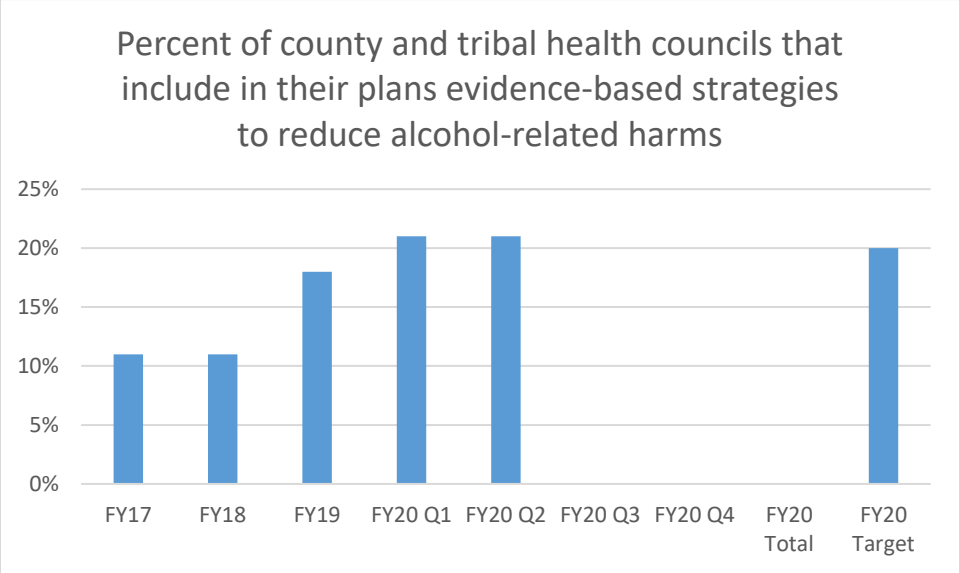
IMPROVEMENT ACTION PLAN:
While this is an annual year explanatory measure and no quarterly results action is required, NMDOH ERD staff reach out to local (county/tribal/pueblo/national) health councils about the importance of including alcohol-related strategies. Data, presentations, and support are offered to the health councils. NMDOH ERD staff are also working with HSD to get data on Medicaid paid alcohol Screening and Brief Intervention (a-SBI) services.

ERD PERFORMANCE MEASURE #7

Percent of county and tribal health councils that include in their plans evidence-based strategies to reduce alcohol-related harms

Results

FY17	FY18	FY19	FY20 Q1	FY20 Q2	FY20 Q3	FY20 Q4	FY20 Total	FY20 Target
11%	11%	18%	21%	21%				≥ 15%



MEASURE DESCRIPTION:
Numerator: Number of health councils that report evidence-based alcohol prevention strategies.
Denominator: Total number of health councils.

DATA SOURCE/METHODOLOGY:
Data for this measure comes from a survey and phone calls.

STORY BEHIND THE DATA:
The county and tribal/national/pueblo health councils, impact health outcomes in their service areas through interventions and programs. Health councils are encouraged to implement evidence-based strategies to prevent excessive alcohol consumption.

IMPROVEMENT ACTION PLAN:

Major Quarterly Action Steps:	Goal Completion Date				
	Q1	Q2	Q3	Q4	Target
1) Contacted Colfax and Eddy County Health Councils	2				**2**
2) Contacted Grant and Lincoln County Health Councils		2			**2**

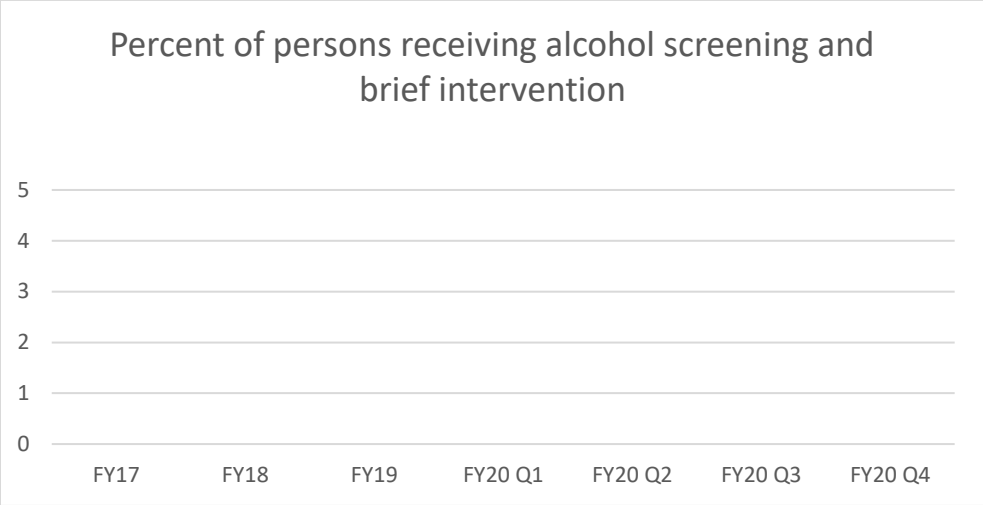
NMDOH reaches out to at least two health councils per quarter to enquire about evidence-based excessive alcohol strategies and offer data and support.

ERD PERFORMANCE MEASURE #8

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

Results

FY17	FY18	FY19	FY20 Q1	FY20 Q2	FY20 Q3	FY20 Q4	FY20 Total	FY20 Target
			Data available starting Q3	Data available starting Q3				≤5%



MEASURE DESCRIPTION:
Numerator: Number of persons receiving SBI services.
Denominator: Total number of persons 15 and up.

DATA SOURCE/METHODOLOGY:
Data is from HSD's Medicaid database.

STORY BEHIND THE DATA:
Data will be available starting Q3. Alcohol Screening and Brief intervention (a-SBI) is a clinical intervention to address excessive alcohol consumption. Particularly when combined with referral to treatment, a-SBI is an impactful strategy that can decrease excessive alcohol consumption.

IMPROVEMENT ACTION PLAN:

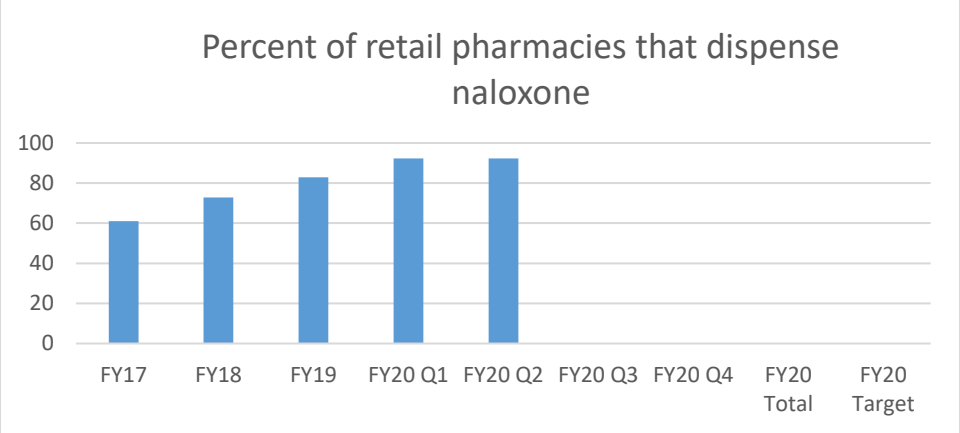
Major Quarterly Action Steps:	Goal Completion Date				
	Q1	Q2	Q3	Q4	Target
1) Obtain counts of Medicaid payments for SBI services	x	x			
2) Establish baseline data for FY17-19		x			

ERD PERFORMANCE MEASURE #9

Percent of retail pharmacies that dispense naloxone

Results

FY17	FY18	FY19	FY20 Q1	FY20 Q2	FY20 Q3	FY20 Q4	FY20 Total	FY20 Target
61	72.9	82.9	92.3	92.3				≥80%



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

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

STORY BEHIND THE DATA:
The purpose of this measure is to ensure that all New Mexicans continue to have access to naloxone, the opioid overdose reversal drug, at their local pharmacy. In FY19, DOH worked to identify retail pharmacies that had not submitted Medicaid claims for naloxone, collaborated with the Board of Pharmacy to narrow down the list, and contracted with the University of New Mexico College of Pharmacy for pharmacy training of the identified pharmacies. This work continues in FY20. In June 2019, Senate Bill 221 went into effect. This bill requires that naloxone be co-prescribed with opioid prescriptions that have a duration of 5 days or more, educate on the risk of opioid overdose and naloxone use.

IMPROVEMENT ACTION PLAN:

Major Quarterly Action Steps:	Goal Completion Date				
	Q1	Q2	Q3	Q4	
1) Provide revised list to the UNM College of Pharmacy to train on naloxone and related topics. The list was due to the increase in pharmacies dispensing naloxone.	X	X			
2) Identified pharmacies by DOH will be trained by UNM's College of Pharmacy	X	X			
3) Continue to verify data against Medicaid claims to identify gaps in training needs and updates to UNM College of Pharmacy list.	X	X			

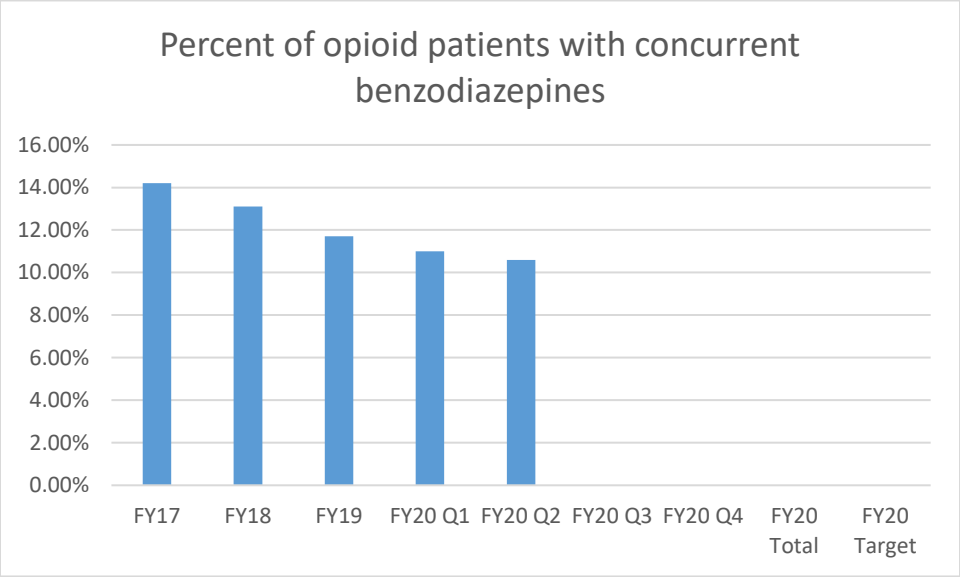
The DOH pharmacists uses Prescription Monitoring Program data and non-fatal drug overdoses case reports to check any drug overdose for recent controlled substance prescription fills. The DOH pharmacist contacts the pharmacy where the prescription was filled to encourage them to dispense naloxone to the patient the next time they come in for a prescription refill.

ERD PERFORMANCE MEASURE #10

Percent of opioid patients also prescribed benzodiazepines

Results

FY17	FY18	FY19	FY20 Q1	FY20 Q2	FY20 Q3	FY20 Q4	FY20 Total	FY20 Target
14.2%	13.1%	11.7%	11.0%	10.6%				≤5%



MEASURE DESCRIPTION:

Numerator: Number of retail pharmacy patients with concurrent prescriptions for opioids and benzodiazepines with at least 10 days of overlap.

Denominator: Number of retail pharmacy patients with any opioid prescription.

DATA SOURCE/METHODOLOGY:

New Mexico Board of Pharmacy Prescription Monitoring Program (PMP) data. Data are processed quarterly, approximately 6 weeks after the end of the quarter to ensure complete data. We continue to work with the PMP vendor to decrease this timeline, however the timeline is also impacted by the Board of Pharmacy (BOP) rules and the requirement for the complete data necessary for the reporting process. Full-year data presented are the average of the relevant quarters.

STORY BEHIND THE DATA:

Opioids and benzodiazepines both depress respiration. The risk of death increases when benzodiazepines are taken along with opioids. Prescription opioids as a drug-type are involved in more drug overdose deaths than any other drug-type, however in 2017, for the first time, a benzodiazepine drug (alprazolam) was the most common prescription drug involved in overdose deaths in New Mexico. Alprazolam remains the most common prescription drug involved in drug overdose deaths in 2018. A benzodiazepine prescribers guide was produced with the support of the Overdose Prevention and Pain Management Advisory Council. The Council includes voting representatives from several state agencies and stakeholder groups. The guide was distributed by the NM provider licensing boards to their licensees.

IMPROVEMENT ACTION PLAN:

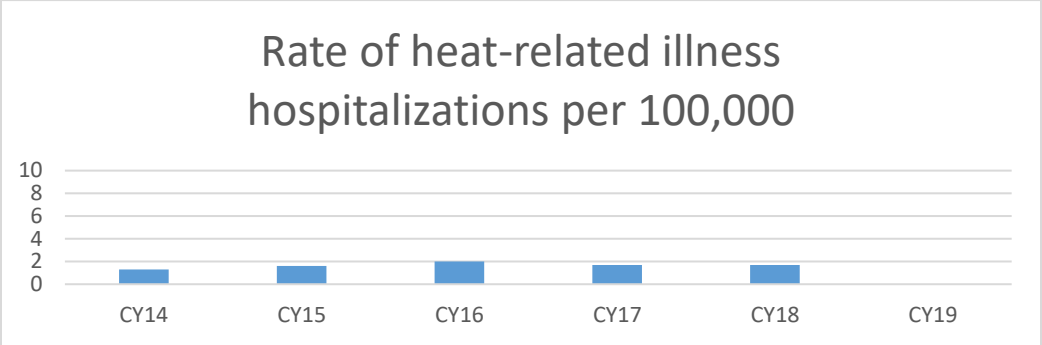
Major Quarterly Action Steps:	Goal Completion Date				
	Q1	Q2	Q3	Q4	Target
1) Provide quarterly reports to BOP including co-prescription rates for distribution to boards	12/17/19	Not available			

ERD PERFORMANCE MEASURE #11

Rate of heat related illness hospitalizations per 100,000 population

Results

CY14	CY15	CY16	CY17	CY18	CY19	CY20	FY20 Target
1.3	1.6	2	1.7	1.7	Fall 2020		Explanatory



MEASURE DESCRIPTION:
Heat-related Illness (HRI) is defined as a constellation of explicit effects of hot weather on the body, including heat stroke, and sunstroke (hyperthermia), heat syncope or collapse, heat exhaustion, heat cramps, heat fatigue, heat edema, and other unspecified clinical effects attributed to excessive heat exposure.
Numerator: Number of inpatients (NM residents) treated each year, where HRI is any primary or other diagnosis.
Denominator: Midyear New Mexico resident population

DATA SOURCE/METHODOLOGY:
Hospital Inpatient Discharge Data, made available by the Health Systems Epidemiology Program, Epidemiology and Response Division, New Mexico Department of Health.

STORY BEHIND THE DATA:
No National benchmarks were identified and our definitions for HRI are not consistent among states. The goal is to keep the rate of HRI hospitalizations at or below the average rate for the past four years. Therefore, the target was calculated by averaging 2014 – 2017 data = age adjusted rate of 1.7 HRI admissions per 100,000 NM residents. Environmental Conditions are a key issue for this measure as air temperature is one of the environmental conditions that can impact health. Older adults and children are at increased risk for heat-related disease and death with increasing temperatures. Data for CY 2019 might be available mid-late summer 2020.

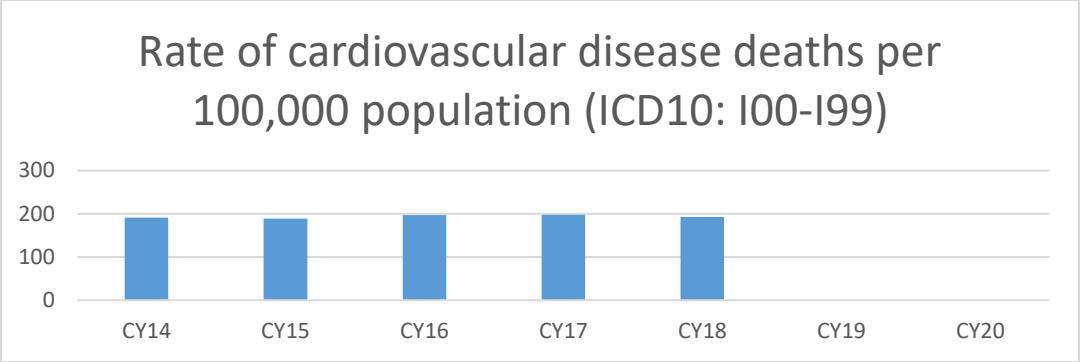
IMPROVEMENT ACTION PLAN:
The measure tracks hospitalization trends over time for heat-related illness as an emerging health effect of climate change. While this is an annual year explanatory measure and no quarterly results action is required, the Epidemiology and Response Division's Environmental Health Epidemiology Bureau is committed to developing a plan using the Building Resiliency Against Climate Effects (BRACE) framework to enhance the resiliency of New Mexicans and visitors to the health effects caused by climate change, in this case the effect of high ambient temperatures. BRACE framework is a five-step process that allows health officials to develop strategies and programs to help communities prepare for the health effects of climate change. Part of this effort involves incorporating complex atmospheric data and both short and long-range climate projections into public health planning and response activities. Combining atmospheric data and projections with epidemiologic analysis allows health officials to more effectively anticipate, prepare for, and respond to a range of climate sensitive health impacts.

ERD PERFORMANCE MEASURE #12

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

Results

CY14	CY15	CY16	CY17	CY18	CY19	CY20	FY20 Target
191.4	189.3	197.2	198.1	193	Fall 2020		Explanatory



MEASURE DESCRIPTION:
Numerator: Annual number of NM residents whose recorded primary cause of death was one of the ICD-10 Cardiovascular disease codes.
Denominator: Number of NM residents for the corresponding year.
Age-adjustment: Standardized to the distribution of 5-year age groups for NM residents.

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

STORY BEHIND THE DATA:
In 2018, NM stroke care hospitals treated >85% of patients who arrived at the hospital within 2-hours and were treated within 3-hours, an improvement from 2017 and Q1 of 2018 where the 85% goal was not met. Plus, in 2018, NM stroke care hospitals administered IV alteplase (a medication that helps dissolve blood clots) in 19.4% of patients who arrived at the hospital within the appropriate time window. This is above the national average and is increased from 16.9% in 2017. The peak time for alteplase administration in 2018 has decreased slightly from 2017 showing us that alteplase is being given faster in NM overall. Data for CY 2019 might be available mid-late summer 2020.

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

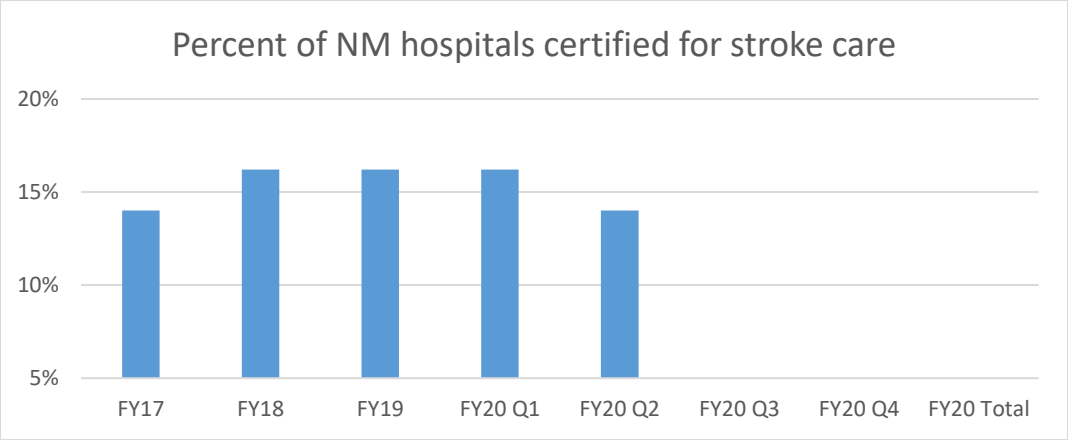
- Distribute recently purchased blood pressure cuffs to HDSPP partners: The Office of Community Health Workers for use in their clinical support trainings, Presbyterian Healthcare Services Center for Community Health, FQHCs throughout NM, and the YMCA in order to promote the importance of self-measured blood pressure monitoring.
- Hold classes starting in July, at the YMCA of Central NM in Albuquerque for their program focused on self-measured blood pressure and education about nutrition and physical health to make lifestyle changes. HDSPP is supporting the program and helping with start-up. The goal is to have 25 individuals in the initial cohort and expand from there.
- Look in to strategies on implementing interventions recommended by the Community Guide Task Force.
- Review the new recommendations made by American Stroke Association for all categories found in the establishment of stroke systems of care for implementation.
- Include TUPAC as a partner in implementing interventions to reduce tobacco use.

ERD PERFORMANCE MEASURE #13

Percent of NM hospitals certified for stroke care

Results

FY17	FY18	FY19	FY20 Q1	FY20 Q2	FY20 Q3	FY20 Q4	FY20 Total	FY20 Target
14%	16.20%	16.20%	16.20%	14%				≥20%



MEASURE DESCRIPTION:
Numerator: Number of hospitals in NM certified for stroke care.
Denominator: Number of acute care hospitals in NM.

DATA SOURCE/METHODOLOGY:
The Joint Commission's (TJC) list of certified stroke care centers, as well as DNV-GL's (accreditation agency, Det Norske Veritas-Germanischer Lloyd) list of certified stroke care centers.

STORY BEHIND THE DATA:
In the US and New Mexico (NM), stroke is the fifth leading cause of death and a leading cause of adult disability. In order to reduce the impact that strokes have on New Mexicans, hospital stroke centers have been developed. Hospitals with these certifications will have a dedicated stroke-focused program, staffed by qualified medical professionals with specific stroke care education. Seven out of 43 acute care hospitals in NM are certified for stroke care. Currently, five are designated as primary stroke centers, and one is designated as acute stroke ready. A total of 14% of hospitals in New Mexico are designated to provide stroke specific care to patients. NMDOH will continuously work with hospitals to maintain or elevate current stroke certifications, identify hospitals who could qualify for a stroke certification, and guide those hospitals toward obtaining a stroke certification.

IMPROVEMENT ACTION PLAN:

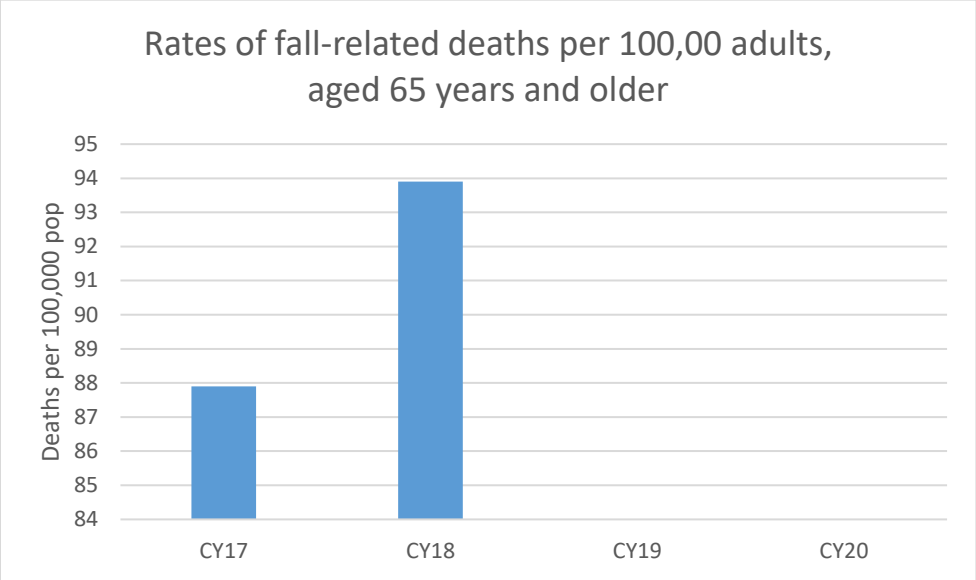
Major Quarterly Action Steps:	Goal Completion Date				
	Q1	Q2	Q3	Q4	Target
1) Work with certified hospitals to maintain or elevate their accreditation and certification level – Ongoing throughout the year	x	x			
2) Send award letters to stroke care hospitals to help with stroke data registry cost	x				
3) Pursue access to the American Heart Association's stroke data registry to facilitate system improvement					
4) Survey hospitals statewide to identify reasons hospitals do not seek stroke certification					
5) Survey the Stroke Care Card utilization to assess its usage and effectiveness in decreasing stroke care time					

ERD PERFORMANCE MEASURE #14

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

Results

CY17	CY18	CY19	CY20	CY20 Target
87.9	93.9	Fall 2020		Explanatory



MEASURE DESCRIPTION:
Numerator: Number of fall-related deaths of people aged 65 and older
Denominator: Number of NM residents aged 65 and older

DATA SOURCE/METHODOLOGY:
New Mexico's Indicator-Based Information System (NM-IBIS). This is an annual calendar year explanatory measure.

STORY BEHIND THE DATA:
Unintentional falls are the leading cause of injury in adults older than 64. In 2018, there were 5,829 hospital visits in adults 65 and older because of falls. This is up from 5,515 visits in 2017, an increase of over 5%. Intervention for patients admitted to emergency departments for a fall can be an effective tool in preventing subsequent falls. Between 36% and 50% of patients have an adverse event, such as a recurrent fall, emergency department revisit, or death within 1 year after a fall. This is a new performance measure.

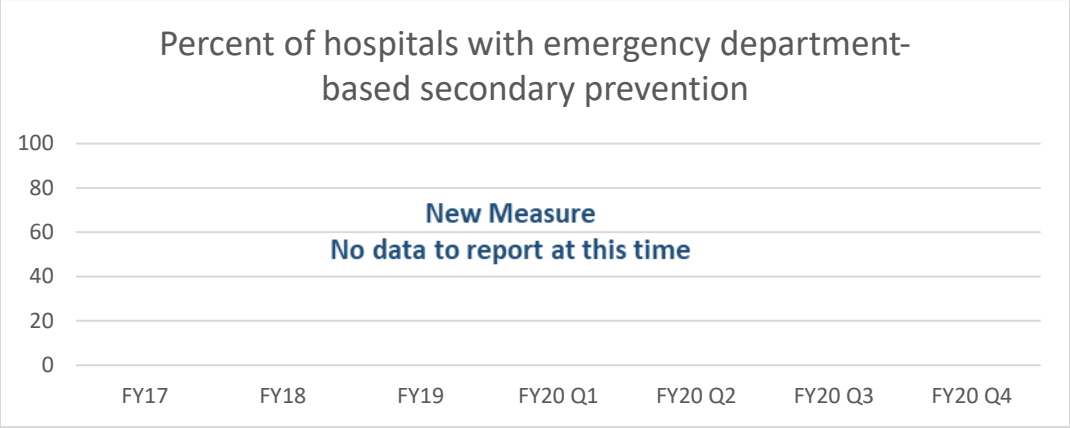
IMPROVEMENT ACTION PLAN:
The Epidemiology and Response Division will:
- Expand the network of instructors available statewide to implement evidence-based falls prevention interventions.
- Increase the number of professionals trained on the use of the STEADI Falls Prevention Toolkit to assess for fall-risk.
- Provide education on falls prevention, encourage older adults to exercise, and refer older adults to evidence-based interventions.

ERD PERFORMANCE MEASURE #15

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

Results

FY17	FY18	FY19	FY20 Q1	FY20 Q2	FY20 Q3	FY20 Q4	FY20 Total	FY20 Target
--	--	--	0%	0%				5%



MEASURE DESCRIPTION:
Numerator: Number of hospitals with emergency department-based secondary prevention of older adult fractures due to falls programs.
Denominator: Number of emergency departments in NM (n=37) in 2019.

DATA SOURCE/METHODOLOGY:
The Fall Prevention Program is working to establish self-harm secondary fall prevention programs with emergency departments that will provide data for the numerator.

STORY BEHIND THE DATA:
Unintentional falls are the leading cause of injury in adults older than 64. In 2018, there were 5,829 hospital visits in adults 65 and older because of falls. This is up from 5,515 visits in 2017, an increase of over 5%. Intervention for patients admitted to emergency departments for a fall can be an effective tool in preventing subsequent falls. Between 36% and 50% of patients have an adverse event, such as a recurrent fall, emergency department revisit, or death within 1-year after a fall.

IMPROVEMENT ACTION PLAN:

Major Quarterly Action Steps:	Goal Completion Date				
	Q1	Q2	Q3	Q4	Target
1) Provide training and implementation support for 2 emergency departments	0	0			**2**
2) Support and evaluate the self-harm secondary prevention programs by developing evaluation plans, implementing them with the emergency departments, and conduct ongoing reviews.					

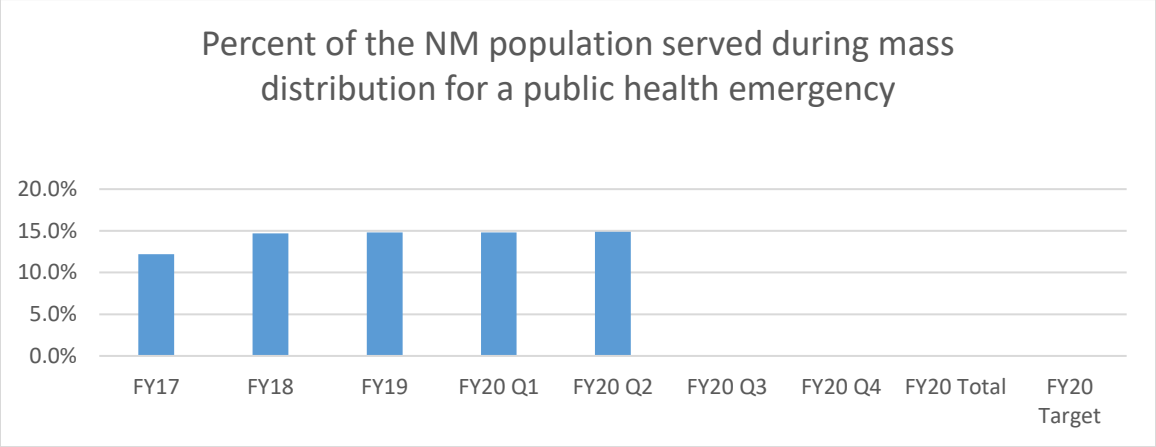
This program includes ensuring a quick referral to follow-up care and encourage patient to participate in an evidence-based falls prevention activity based on their ability and level of fall risk.

ERD PERFORMANCE MEASURE #16

Percent of the New Mexico population served during mass distribution of antibiotics and/or vaccinations through public/private partnerships in the event of a public health emergency

Results

FY17	FY18	FY19	FY20 Q1	FY20 Q2	FY20 Q3	FY20 Q4	FY20 Total	FY20 Target
12.2%	14.7%	14.8%	14.8%	14.9%				≥ 19%



MEASURE DESCRIPTION:
Numerator: Number of NM residents served during mass distribution for a public health emergency
Denominator: NM resident population

DATA SOURCE/METHODOLOGY:
Crimson Contagion was a full-scale state exercise (August 2019) that tested a pandemic influenza scenario. During Crimson Contagion, New Mexico was able to exercise the Strategic National Stockpile (SNS) capabilities. SNS exercised activating points of dispensing (PODs) and utilizing cold chain management plans.

STORY BEHIND THE DATA:
New Mexico and its citizens must be provided with primary and alternate methods to receive antibiotics and or vaccinations during a pandemic. New Mexico's primary strategy for mass prophylaxis is through Open (Public) Points of Dispensing (PODs) with existing plans to serve 100% of the population. The alternate strategy that this measure aims to achieve is that of Closed POD partnering. Closed POD partnering is achieved through rigorous research and time-intensive planning efforts that identify agencies, entities, and organizations that employ and/or serve a significant number of individuals and possess the internal resources to provide prophylaxis to their employees, family members and critical contactors.

IMPROVEMENT ACTION PLAN:

Major Quarterly Action Steps:	Goal Completion Date				
	Q1	Q2	Q3	Q4	Target
1) Continue ongoing POD planning by meeting with state agencies and their organizations	X				
2) Review open and closed POD plans for cold chain details					
3) Suggest POD plan revisions and edits to improve their cold chain planning					
4) Query POD locations to gather information on their total cold chain capacity					

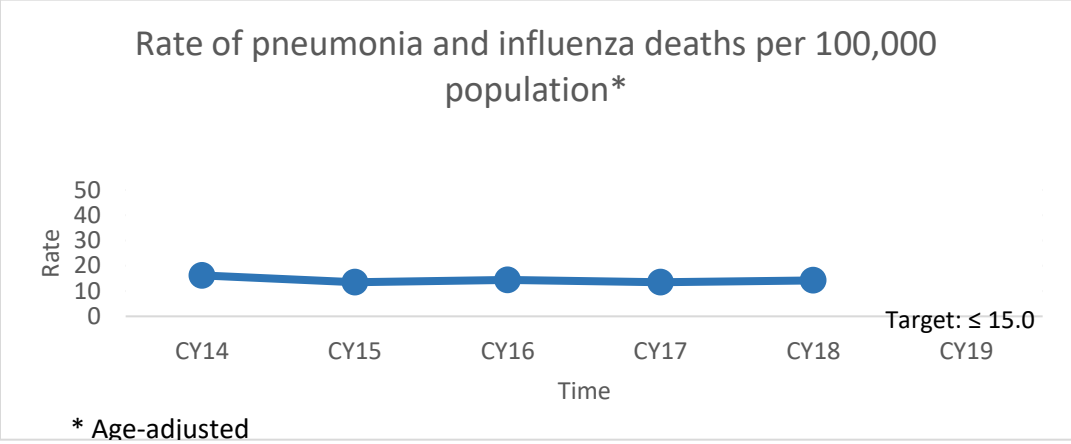
Next meetings occurring end of January and mid-February.

ERD PERFORMANCE MEASURE #17

Rate of pneumonia and influenza death rate per 100,000 population

Results

CY17	CY18	CY19	CY20	FY20 Target
13.5	14.5	Fall 2020		Explanatory



MEASURE DESCRIPTION:
Numerator: Number of cases with pneumonia or influenza as a cause of death.
Denominator: Population estimates provided by the University of New Mexico, Geospatial and Population Studies (GPS) program.
Criteria for Eligibility: Inclusion is based on death certificate data with a cause-of-death code J09-J18 (influenza death codes include J09-J11; Pneumonia death codes are J12-18).

DATA SOURCE/METHODOLOGY:
New Mexico Death Data: Bureau of Vital Records and Health Statistics (BVRHS)
New Mexico Population Estimates: University of New Mexico, Geospatial and Population Studies (GPS) Program, ttp://gps.unm.edu/

STORY BEHIND THE DATA:
Pneumonia and influenza (P&I) infections are the eighth leading cause of death in the US and 10th in New Mexico. Between 2010 and 2018, influenza causes an estimated 190,000 - 960,000 hospitalizations and 12,000 - 79,000 deaths nationally each year. P&I death rates have decreased over the last 10 years, thereby recognizing the importance of influenza antiviral medications in preventing influenza-related deaths and increasing their use among hospitalized influenza patients during outbreaks in healthcare facilities. NMDOH promotes and assures the use and availability of influenza and pneumococcal vaccines.

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

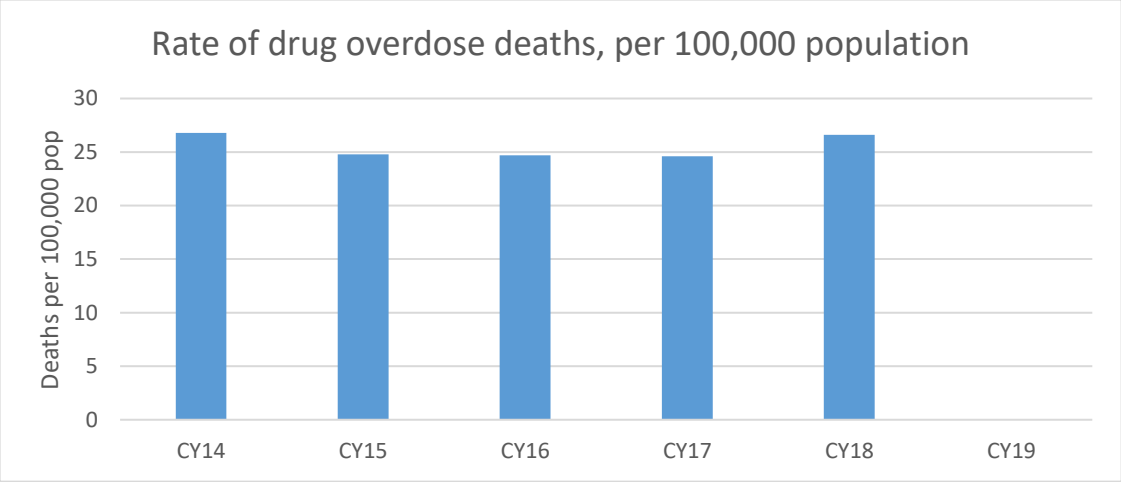
- Measure the rates of pneumococcal vaccine uptake among children, the percent of adults ≥65 years of age who receive pneumococcal vaccine, the percent of the population ≥6 months of age who receive influenza vaccine, the rate of P&I death and hospitalization, and the use of anti-viral medications among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

ERD PERFORMANCE MEASURE #18

Rate of overdose deaths per 100,000 population

Results

CY14	CY15	CY16	CY17	CY18	CY19	C20 Target
26.8	24.8	24.7	24.6	26.6	Fall 2020	Explanatory



MEASURE DESCRIPTION:
Numerator: Number of drug overdose deaths as defined by underlying cause of death ICD-10 codes X40-X44, X60-X64, X85, Y10-Y14. Denominator: New Mexico Population (UNM/GPS estimates). Age adjustment to the US 2000 standard population.

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

STORY BEHIND THE DATA:
New Mexico has long had one of the highest rates of drug overdose deaths in the US. Between 2015 and 2017 NM reported small decreases in the number of drug overdose deaths. However, the number increased in 2018. For the last few years, New Mexico has aggressively addressed opioid overdose deaths, including making naloxone more available, mandating use of the Prescription Monitoring Program (PMP), increasing the number of healthcare providers who can prescribe medication assisted treatment (MAT), paying for screening and brief intervention (SBI) services through Medicaid, increasing support for harm reduction, and including syringe services. During this time, the non-fentanyl opioid-involved death rates have been decreasing while methamphetamine-involved and fentanyl-involved death rates have increased.

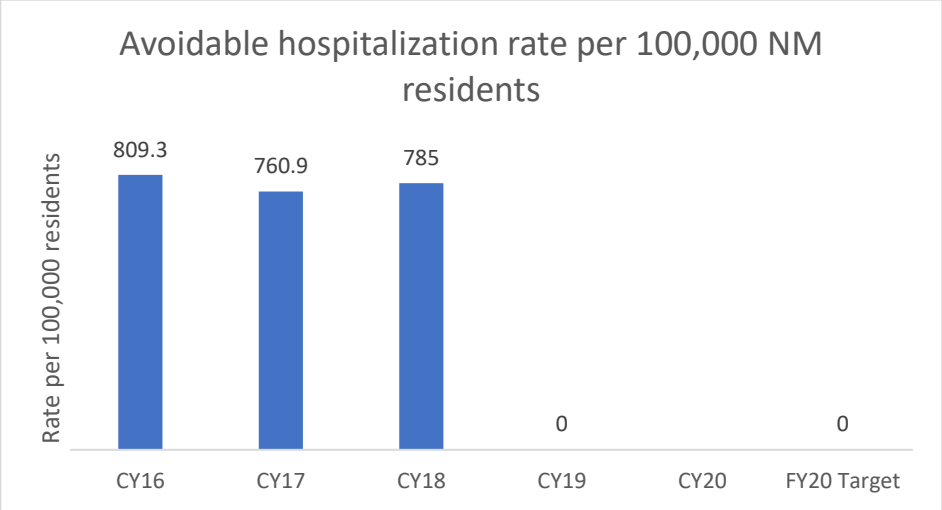
IMPROVEMENT ACTION PLAN:
While this is an annual explanatory measure and no quarterly actions are required, The Epidemiology and Response Division is working with the Behavioral Health Services Division (BHSD) in the Human Services Department (HSD) on a plan to decrease methamphetamine-involved deaths. The draft plan includes prevention, criminal justice, treatment, surveillance components and will be carried out in collaboration with DOH's sister agencies to maximize impact with limited resources. Opioid-related work (as described above) will continue.

ERD PERFORMANCE MEASURE #19

Rate of avoidable hospitalizations per 100,000 population

Results

CY16	CY17	CY18	CY19	CY20	FY20 Target
809.3	760.9	785.0	Fall 2020		Explanatory



MEASURE DESCRIPTION:
Numerator: Ambulatory Care Sensitive Condition (ACSC) related hospitalizations
Denominator: New Mexico resident population

The calculation method will follow the Agency for Healthcare Research and Quality (AHRQ) protocols for calculating ACSC hospitalization rates in their Prevention Quality Indicators (PQIs), exclusions include hospitalizations provided to NMDOH with missing values for clinical documentation/discharge diagnosis, county, or race.

DATA SOURCE/METHODOLOGY:
New Mexico's Hospital Inpatient Discharge Dataset (https://nmhealth.org/about/erd/hsep/hidd/).

STORY BEHIND THE DATA:
Avoidable hospitalizations initially began being analyzed in NM for the 2016 calendar year beginning with the implementation of ICD-10-CM coding of discharge diagnosis. The initial analysis has provided a baseline of descriptive statistics to support identification of the NM population by demographics, including age, gender, race, and geographics that is most impacted by avoidable hospitalizations. These particular hospitalizations are avoidable with proper control and management of various conditions, adequate access to primary care, and with preventative public health measures.

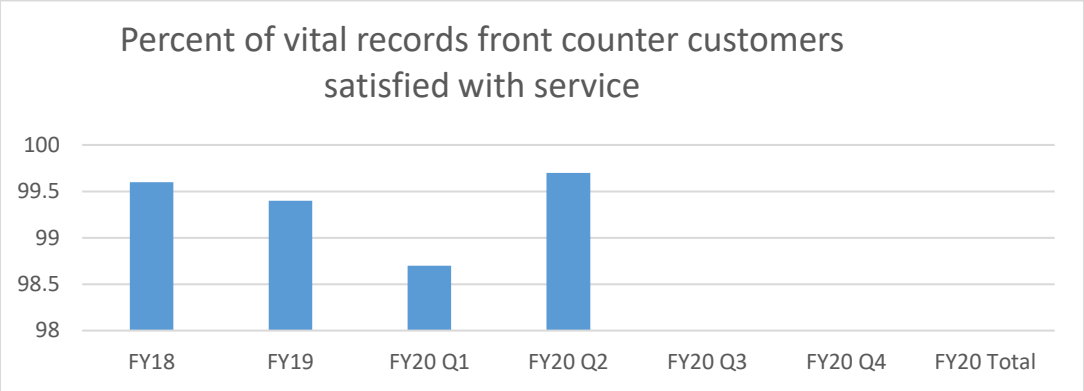
IMPROVEMENT ACTION PLAN:
The Epidemiology and Response Division's Health Systems Epidemiology Program currently analyzes avoidable hospitalization data annually upon collection of the annual hospital inpatient discharge dataset and disseminates these data via various methods, e.g., epidemiology reports, press reports, etc. The intention is to develop a communication plan that provides proper structure to the message, audience, communication channels, follow-up, and maintenance protocols.

ERD PERFORMANCE MEASURE #20

Percent of vital records front counter customers who are satisfied with the service they received

Results

FY17	FY18	FY19	FY20 Q1	FY20 Q2	FY20 Q3	FY20 Q4	FY20 Total	FY20 Target
n/a	99.6	99.4	98.7	99.7				95



MEASURE DESCRIPTION:
Numerator: Number of customers that marked excellent or good for the quality of the customer service they received.
Denominator: Total number of customers who filled out the customer survey. Exclusions would be those customers who refused to complete a survey.

DATA SOURCE/METHODOLOGY:
Counter customer survey. Total surveys for Quarter 2 is 411. Total Excellent 395, Good 15 and Fair 1

STORY BEHIND THE DATA:
Vital records are important legal documents and are key to many essential activities, so having satisfied customers who use Vital Records' service reflects positively on the state. Due to the implementation of the Real ID driver's license, the number of customers and the services they need have changed drastically, thus the amount of time needed to serve a customer has increased by up to five times the old rate due to the complexity of the services now needed. By repositioning Staff, Vital Records was able to increase Customer Satisfaction from Quarter 1, result of 98.7 to an impressive 99.7

IMPROVEMENT ACTION PLAN:

Major Quarterly Action Steps:	Goal Completion Date				
	Q1	Q2	Q3	Q4	Target
1) Conduct customer satisfaction surveys to verify the 95% goal is maintained	x	x			**95%**
2) Develop recommendations for choice of customer satisfaction survey		x			
3) Develop electronic versions of survey using computer tables					
4) Modify approach to customer service as needed, based on new process					

The Bureau is changing the customer satisfaction survey platform and has reviewed four different software options that electronically capture customer satisfaction. Some of these platforms were stand-alone systems that allowed only for the customer satisfaction survey, while others combined with customer queuing software, which can be used for other purposes. The new system will be implemented after Vital Records moves into its new facility.

PROGRAM #3: Scientific Laboratory Division (SLD)

Program Description and Purpose:

The Scientific Laboratory Division (SLD), provides a wide variety of laboratory services to programs operated by numerous partner agencies across the state of New Mexico.

SLD services include:

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

The activities of SLD in support of these State agencies are mandated in statute and are essential for the successful mission of the programs it supports in these numerous agencies.

Program Budget (in thousands):

FY19	General Fund	Other State Funds	Federal Funds	Other Transfers	TOTAL	FTE
200	$5,070,800.00	$1,227,000.00	$1,372,400.00	$118,800.00	$7,789,000.00	134
300	$380,400.00	$61,600.00	$48,100.00	$ -	$490,100.00	
400	$2,126,000.00	$642,100.00	$1,447,800.00	$689,200.00	$4,905,100.00	
TOTAL	$7,578,200.00	$1,930,700.00	$2,868,300.00	$808,000.00	$13,185,000.00	

FY20	General Fund	Other State Funds	Federal Funds	Other Transfers	TOTAL	FTE
200	$5,379,000.00	$1,272,500.00	$1,543,000.00	$119,100.00	$8,313,600.00	134
300	$170,600.00	$33,500.00	$61,200.00	$34,500.00	$299,800.00	
400	$2,193,800.00	$593,900.00	$1,551,300.00	$628,100.00	$4,967,100.00	
TOTAL	$7,743,400.00	$1,899,900.00	$3,155,500.00	$781,700.00	$13,580,500.00	

Program Performance Measures:

Program Objective 1: Provide laboratory analyses within established timeframes

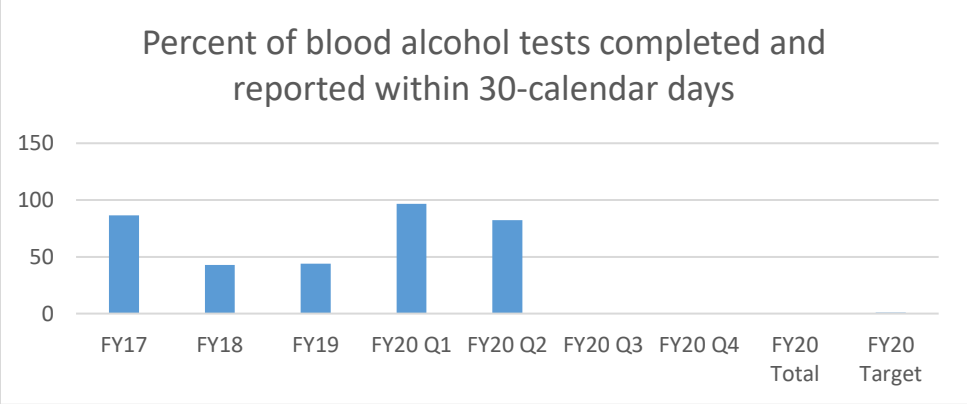
1. Percent of blood alcohol tests from driving-while-intoxicated cases that are completed and reported to law enforcement within 30-calendar days (FY20 Key Measure)
2. Percent of environmental samples for chemical contamination that are completed and reported to the submitting agency within 60-business days
3. Percent of public health threat samples for communicable diseases and other threatening illnesses that are completed and reported to the submitting agency within published turnaround times

SLD PERFORMANCE MEASURE #1

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

Results

FY17	FY18	FY19	FY20 Q1	FY20 Q2	FY20 Q3	FY20 Q4	FY20 Total	FY20 Target
86.58	42.78	44	96.52	82.15				90%



MEASURE DESCRIPTION:
Denominator: Number of cases reported out during the quarter/year.
Numerator: Number of cases reported out within 30-calendar days of receipt.
(Note: Measure previously specified reporting in 15-days and changed to 30-days in FY19-Q4).

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

STORY BEHIND THE DATA:
Nationally, New Mexico has had the highest alcohol-related death rate since 1997. New Mexico's rate has consistently been nearly twice the national rate and has been increasing more rapidly than the national rate. According to the Centers for Disease Control and Prevention, alcohol is a contributing factor in up to 49% of motor vehicle crashes. The SLD Toxicology staff analyze samples for blood alcohol concentration (BAC) and drugs to determine cause of impairment in drivers, as well as Office of Medical Investigator (OMI) samples for cause of death. SLD staff also serve as expert witnesses in court cases where alcohol or drugs are involved. Duplicate testing of each specimen is performed per accreditation requirements, which doubles testing time (started FY16-Q3). This measure was revised to extend results reporting from 15-calendar days to 30-calendar days and the results for FY20-Q2 dropped below the target with 82.15% of results reported within the 30-day turnaround time. The decrease resulted from many older cases being closed which artificially depressed the percentage closed within 30-days.

IMPROVEMENT ACTION PLAN:

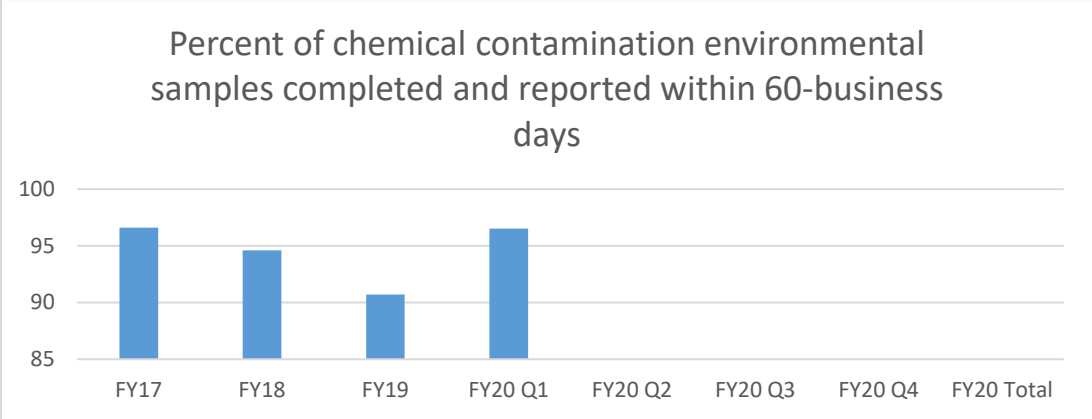
Major Quarterly Action Steps:	Goal Completion Date				
	Q1	Q2	Q3	Q4	Target
1) Conduct blood alcohol tests			>90%		**90%**
2) Recruit and hire qualified staff	Ongoing to Q4				
3) Train newly-hired staff	Ongoing to Q4				
4) Monitor and maintain testing equipment	X	X			

SLD PERFORMANCE MEASURE #2

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

Results

FY17	FY18	FY19	FY20 Q1	FY20 Q2	FY20 Q3	FY20 Q4	FY20 Total	FY20 Target
96.61	94.59	90.7	96.52	95.4				90%



MEASURE DESCRIPTION:
Denominator: Number of samples reported out during the quarter/year. These samples include chemical, radiological, and air particulate contaminants.
Numerator: Number of samples in the denominator that are reported out within 60-calendar days of receipt.

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

STORY BEHIND THE DATA:
The Scientific Laboratory Division is certified by the Environmental Protection Agency to analyze the primary regulated contaminants in water, air, and soil samples under the New Mexico Environment Department regulations. The laboratory performs analyses for organic and inorganic materials, radioactive materials, and heavy metals for tax-supported governmental agencies and municipalities to ensure that contamination by potentially toxic compounds is detected and measured. Turnaround times are based on the needs of the New Mexico Environment Department. The Chemistry Bureau exceeded the FY20 target of 90% by reporting 95.4% of results within 60-calendar days of sample receipt.

IMPROVEMENT ACTION PLAN:

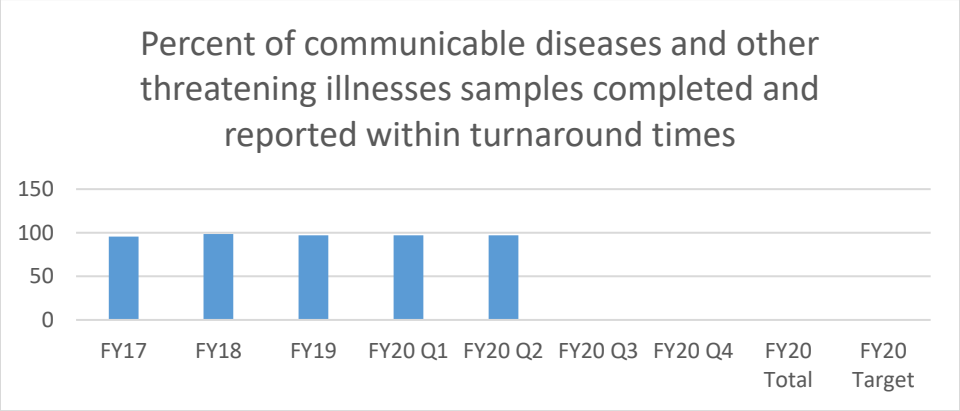
Major Quarterly Action Steps:	Goal Completion Date				
	Q1	Q2	Q3	Q4	Target
1) Conduct chemical contamination environmental samples within 60-business days	97%	95%			**90%**
2) Obtain replacement equipment for both the metals and organics testing			Feb.		

SLD PERFORMANCE MEASURE #3

Percent of public health threat samples for communicable diseases and other threatening illnesses that are completed and reported to the submitting agency within published turnaround times

Results

FY17	FY18	FY19	FY20 Q1	FY20 Q2	FY20 Q3	FY20 Q4	FY20 Total	FY20 Target
95.46	98.6	97.15	97.2	97.1				90%



MEASURE DESCRIPTION:
Denominator: Number of samples reported out during the quarter/year. These samples include animal and human diagnostic samples, as well as reference samples, food, dairy and water samples.
Numerator: Number of samples reported out within turnaround times for tests listed in SLD's DIRECTORY OF SERVICES.

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

STORY BEHIND THE DATA:
The Biological Sciences Bureau of the Scientific Laboratory Division (SLD) tests for commonly occurring and exotic infectious diseases of public health significance. The laboratory receives human and animal diagnostic specimens as well as food, dairy, and water samples for routine testing, surveillance testing, and outbreak investigation. The Bureau partners with national, state, and local agencies such as the Centers for Disease Control & Prevention, Food & Drug Administration, Veterinary Diagnostic Services, city and county agencies, epidemiologists, hospitals, and patient testing laboratories to detect and confirm bacterial and viral causes for infectious disease. Each test performed is described in SLD's Directory of Services and has a defined turnaround time for reporting results. The laboratory exceeded the target of 90%, reporting 97.2% of results within specified turnaround times.

IMPROVEMENT ACTION PLAN:

Major Quarterly Action Steps:	Goal Completion Date				
	Q1	Q2	Q3	Q4	Target
1) Conduct communicable diseases and other threatening illness samples within specified turnaround times	97%	97%			**90%**
2) Pass upcoming Environmental Protection Agency and College of American Pathologists inspections			Jan	Jun	
4) Update six testing platforms for detecting human exposure to infectious viruses			2 in Mar	1 in Jun	

PROGRAM #006: Facilities Management Division (FMD)

Program Description and Purpose:
The Facilities Management Division (FMD) fulfills the NMDOH mission by providing:

- Programs in mental health, substance abuse, long-term care, and physical rehabilitation in both facility and community-based settings; and
- Safety net services throughout New Mexico.

FMD consists of six healthcare facilities and one community program. Most individuals served by NMDOH facilities have either complex medical conditions or psychiatric disorders that manifest in violent behaviors, and private sector providers are either unable or unwilling to serve these complex individuals, many of whom are restricted to NMDOH facilities by court order. The FMD Facility and Community Program staff cares for both New Mexico adult and adolescent residents, who need continuous care 24 hours/day, 365 days/year as well as provision of a variety of behavioral health outpatient services.

Program Budget (in thousands):

FY19	General Fund	Other State Funds	Federal Funds	Other Transfers	TOTAL	FTE
200	45,029.0	44,805.6	4,834.5	736.6	95,405.7	1,793
300	4,213.3	6,248.0	119.0	734.5	11,314.8	
400	*10,353.2	7,677.8	104.8	2,960.7	21,096.5	
TOTAL	59,595.5	58,731.4	5,058.3	4,431.8	127,817.0	

*4,050.0 is for the Fort Bayard Medical Center building lease purchase

FY20	General Fund	Other State Funds	Federal Funds	Other Transfers	TOTAL	FTE
200	46,093.3	54,175.4	7,588.5	738.6	108,595.8	2,003
300	5,221.3	6,652.9	308.8	734.5	12,917.5	
400	*10,854.1	11,991.4	1,184.8	2,981.3	27,011.6	
TOTAL	62,168.7	72,819.7	9,082.1	4,454.4	148,524.9	

*4,050.0 is for the Fort Bayard Medical Center building lease purchase

Program Performance Measures:

Program Objective 1: Improve quality of care

1. Percent of long-term care residents experiencing facility acquired pressure injuries (Veterans' Home)
2. Customer overall satisfaction (Veterans' Home)
3. Number of residents requiring re-hospitalization within 30-days of admission (Veterans' Home)
4. Number of significant medication errors per 100 patients (FY20 Key Measure)
5. Percent of long-term care residents experiencing one or more falls with major injury (FY20 Key Measure)

Program Objective 2: Assure safety net services

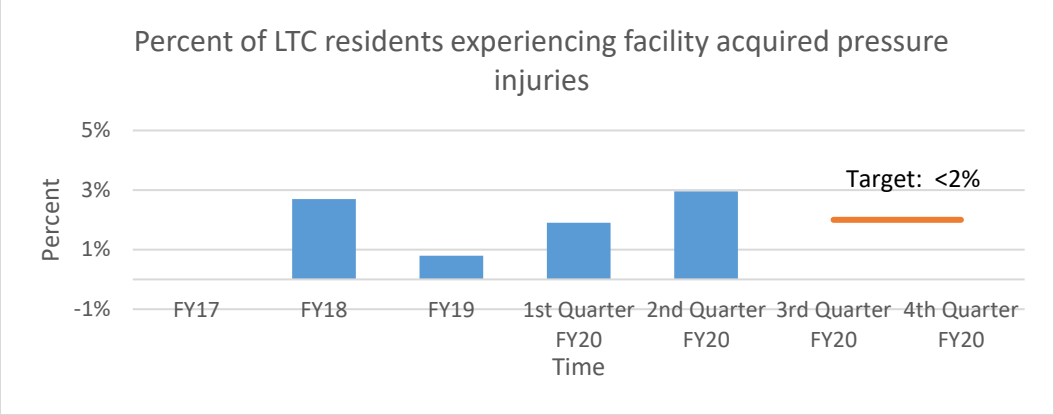
6. Percent of adolescent residents (SATC & NMBHI Care Unit) who are successfully discharged
7. Percent of priority Request for Treatment clients who are admitted to the program (TLH)
8. Rate of medical detox occupancy at Turquoise Lodge Hospital
9. Percent of eligible third-party revenue collected at all agency facilities

FMD PERFORMANCE MEASURE #1

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

Results

FY17	FY18	FY19	FY20 Q1	FY20 Q2	FY20 Q3	FY20 Q4	FY20 Total	FY20 Target
	2.70%	0.80%	1.90%	2.96%				<2%



MEASURE DESCRIPTION:
New Mexico State Veterans' Home (NMVH) facility acquired pressure injuries are tracked monthly. The calculated rate is based on the total number of LTC residents with facility acquired pressure injuries for the quarter.
Numerator: Total number of LTC residents with pressure injuries acquired in-house for the quarter.
Denominator: Average total number of LTC residents served for the quarter.

DATA SOURCE/METHODOLOGY:
Pressure injury data is compiled and reported on the facility Monthly Pressure Injury Report. The facility acquired pressure injury data is taken from the Monthly Pressure Injury Report and calculated into a facility acquired pressure injury rate by using the total number of residents served for the month.

STORY BEHIND THE DATA:
A performance action team (PAT) was developed to improve NMVH pressure injury rates. The team implemented actions to lower the facility pressure injury rate, with oversight by the Quality Assurance Performance Improvement (QAPI) Committee.

IMPROVEMENT ACTION PLAN:

Major Quarterly Action Steps:	Goal Completion Date				
	Q1	Q2	Q3	Q4	Target
1) Continue monitoring of repositioning	86%	93%			95%
2) Conduct weekly rounds to address and/or prevent skin issues related to individual residents' needs	X	X			
3) Report on performance measures to the QAPI committee monthly	X	X			
4) Reconvene the performance action team by January 31st for ongoing work on pressure injury prevention					

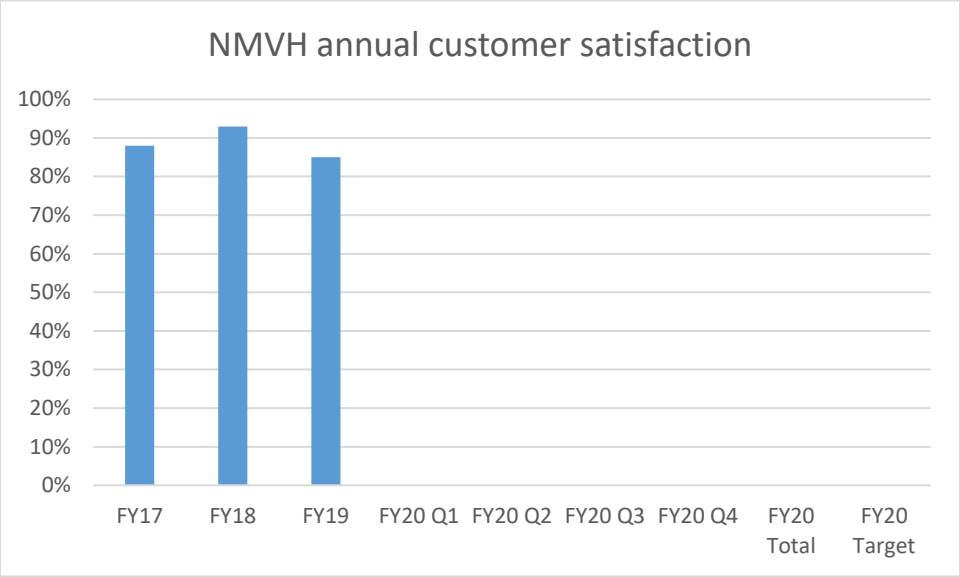
FY20 Q2: NMVH experienced an increase from QI to Q2 in residents experiencing pressure injuries. Repositioning demonstrates improvement. One resident's pressure injury was related to a blister that quickly cleared and was thought/reported to be from pressure on the ankle, heel protectors were applied. Work on pressure injury prevention is ongoing.

FMD PERFORMANCE MEASURE #2

Customer Overall Satisfaction (Veterans' Home)

Results

FY17	FY18	FY19	FY20 Q1	FY20 Q2	FY20 Q3	FY20 Q4	FY20 Total	FY20 Target
88%	93%	85%						Explanatory



MEASURE DESCRIPTION:
Annual surveys are available to the New Mexico Veterans' Home (NMVH) residents and resident families/Power of Attorney (POAs) with results based on returned surveys.
Numerator: Total number of positive survey results answering most of the time, always, and yes for the fiscal year.
Denominator: Total number of survey results answering most of the time, always, yes, no, sometimes, and never for the fiscal year.

DATA SOURCE/METHODOLOGY:
Satisfaction survey results are calculated from an internal survey tool and include residents and resident families/POA survey results.

STORY BEHIND THE DATA:
FY17 and FY18 survey results were calculated through an external vendor. The survey process changed for FY19 to an annual survey utilizing NMVH's internal survey tools. Residents and/or resident families/POAs were surveyed at the end of FY19 with 65 surveys returned.

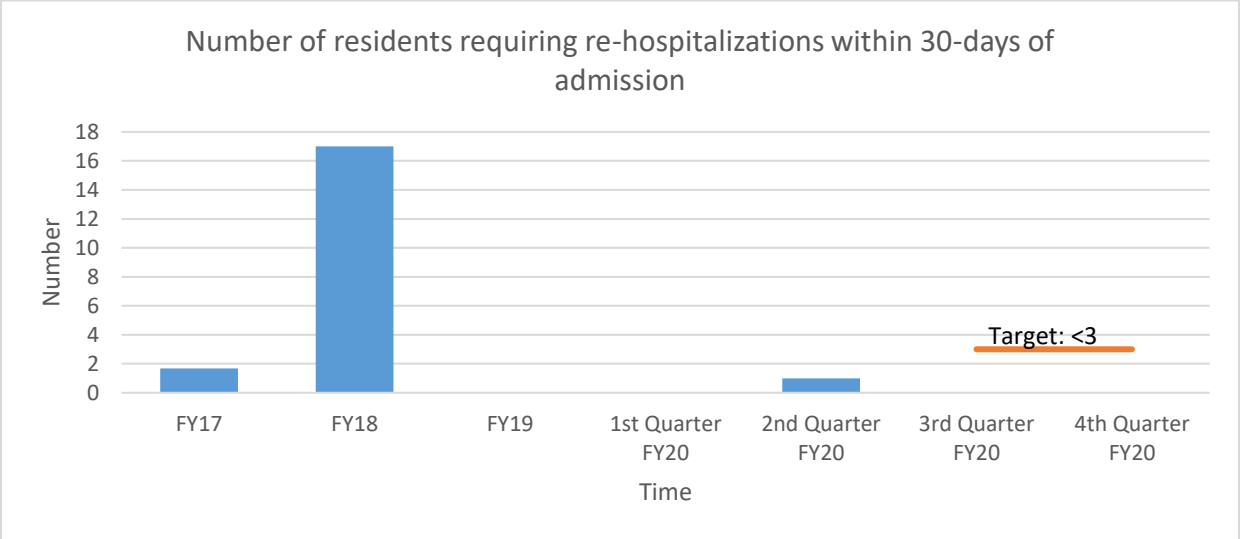
IMPROVEMENT ACTION PLAN:
While this is an annual explanatory measure and no quarterly actions are required, NMVH's Performance Action Team (PAT) was developed in FY20 Q1. The purpose of the PAT is to review survey responses and make recommendations for improvement of customer satisfaction to the Quality Assurance Performance Improvement (QAPI) Committee. FY20 Q2: The PAT is compiling data for common areas and setting priorities for improvement.

FMD PERFORMANCE MEASURE #3

Number of residents requiring re-hospitalizations within 30-days of admission (Veterans' Home)

Results

FY17	FY18	FY19	FY20 Q1	FY20 Q2	FY20 Q3	FY20 Q4	FY20 Total	FY20 Target
1.7	17	0	0	1			0	<3



MEASURE DESCRIPTION:
The performance measure is the total number of LTC residents sent back to any acute care hospital from NMVH within 30-days of admission/readmission for the quarter.

DATA SOURCE/METHODOLOGY:
NMHV uses data from the Point Click Care (PCC) Rehospitalization Report - All Payer 30-Day Rehospitalization Rate for the total number of rehospitalizations for the quarter.

STORY BEHIND THE DATA:
FY20 Q2: One (1) resident returned to the hospital within 30-days of admission/readmission. NMVH continues to be below the target of <3/quarter or <12/yr. Ongoing oversight of hospital readmissions will continue.

IMPROVEMENT ACTION PLAN:

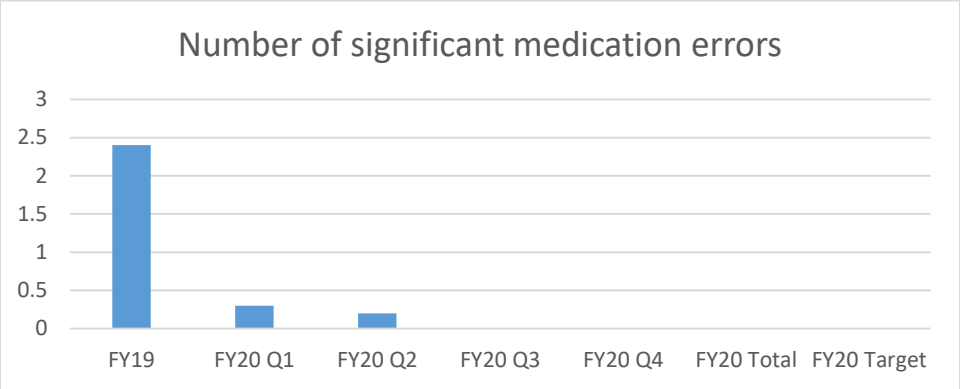
Major Quarterly Action Steps:	Goal Completion Date				
	Q1	Q2	Q3	Q4	Target
1) Monitor number of residents sent back to an acute care hospital within 30-days of admission or readmission	0	1			<3/qtr <12/yr
2) Review PCC rehospitalization report monthly and identify any change in current trend	X	X			
3) Report findings to QAPI Committee via review of the smartsheet with committee recommendations/action, as appropriate	X	X			

FMD PERFORMANCE MEASURE #4

Number of significant medication errors

Results

FY17	FY18	FY19	FY20 Q1	FY20 Q2	FY20 Q3	FY20 Q4	FY20 Total	FY20 Target
N/A	N/A	2.4	.3	.2				≤ 2.0



MEASURE DESCRIPTION:
This measure reports on the quality of patient care by measuring the accuracy of medication administration within each facility and the entire program area. Medication administration is a consistent and standard practice at each facility.
Numerator: Total number of medication errors (for all facilities).
Denominator: Total number of days/month to determine an inpatient average daily census. This average daily census is then divided by 100 to determine the denominator.

DATA SOURCE/METHODOLOGY:
Data will be provided by each facility following their determination of whether a medication error is considered "significant", which is defined as a level D or higher according to the National Coordinating Council for Medication Error Reporting and Prevention (NCC MERP) Index for Categorizing Medication Errors Index for Categorizing Medication Errors. This will be the numerator.

STORY BEHIND THE DATA:
In 1999, the Institute of Medicine published To Err Is Human: Building a Safer Health System, in which they stated that between 44,000-98,000 people die in hospitals each year as a result of preventable medication errors and laid out a strategy for reducing these errors. The DOH Facilities, each of which serve a distinct population, monitor and report the rate of significant Category D or higher medications errors, according to the NCC MERP Index for Categorizing Medication Errors. The NCC MERP addresses interdisciplinary causes of errors and promotes safe use of medications to prevent errors. A Category D or higher is an error that reaches the patient, resulting in increased patient monitoring or treatment intervention and corrective actions taken to prevent recurrence and harm.

IMPROVEMENT ACTION PLAN:

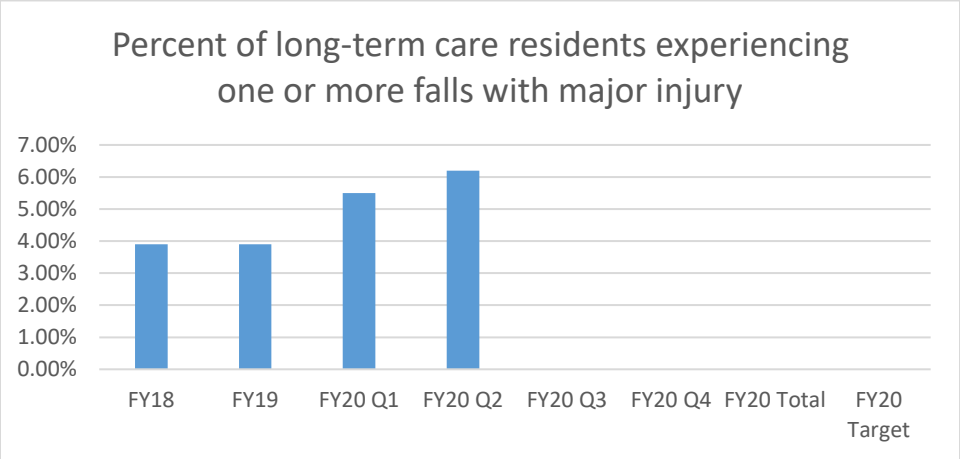
Major Quarterly Action Steps:	Goal Completion Date				
	Q1	Q2	Q3	Q4	Target
1) Foster a continuous culture of patient safety and quality improvement framework	X	X			
2) Monitor actual and potential medication errors that occur/may occur, including near misses, and investigate root causes	X	X			
3) Establish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

FMD PERFORMANCE MEASURE #5

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

Results

FY17	FY18	FY19	FY20 Q1	FY20 Q2	FY20 Q3	FY20 Q4	FY20 Total	FY20 Target
	3.9%	3.9%	5.5%	6.2%				≤ 3%



MEASURE DESCRIPTION:

This measure reports the percentage of residents within long term care facilities who have fallen with a major injury as a result of the fall. The DOH long term care facilities are the New Mexico Behavioral Health Institute, New Mexico Veterans' Home and the Fort Bayard Medical Center.

DATA SOURCE/METHODOLOGY:

Certification and Survey Provider Enhanced Reports, also known as CASPER Reports, are generated from the Centers of Medicare and Medicaid Services (CMS). All Nursing Facilities who receive any payment from Medicare or Medicaid are required to complete this process. This data collection will utilize the measure of “Falls with Major Injury” which is reported as a numerator and a denominator along with the Facility Observed Percent. The report also provides comparative data for State Average and National Average. Each Department of Health facility reports individually, so the combined outcome is an average of these facilities and this is consistent with the comparative data which is also an average.

STORY BEHIND THE DATA:

Falls are common and are a major safety concern for long-term care facilities. While not all falls and injuries can be prevented, it is critical to have a systematic process of assessment, intervention, and monitoring to minimize fall risk and prevent major injuries resulting from falls. Every new long-term care resident is assessed for fall risk. This assessment is then included in each individual resident's care plan, contributing to the success of this measure. It is, however, a significant challenge to balance each resident's need for independence with the inherent risk for falls.

IMPROVEMENT ACTION PLAN:

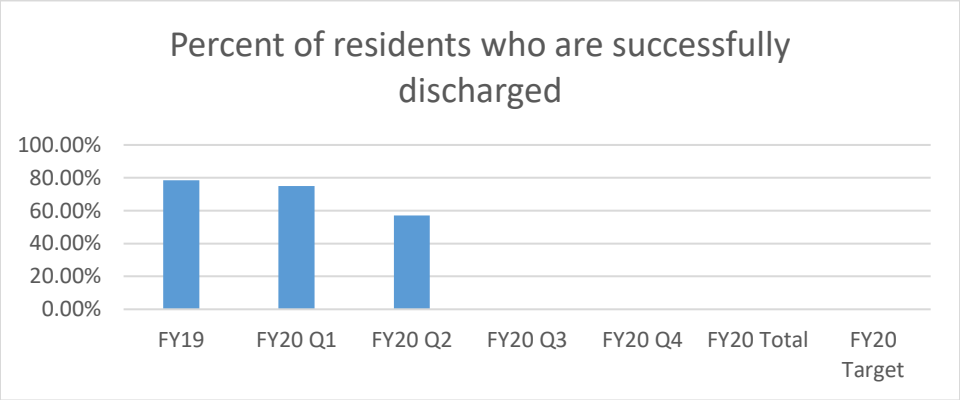
Major Quarterly Action Steps:	Goal Completion Date				
	Q1	Q2	Q3	Q4	Target
1) Educate employees, residents and family members	X	X			
2) Provide services that focus on strengthening and improving balance and mobility	X	X			
3) Develop individualized resident treatment plans, following a fall	X	X			
4)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

FMD PERFORMANCE MEASURE #6

Percent of residents who are successfully discharged

Results

FY17	FY18	FY19	FY20 Q1	FY20 Q2	FY20 Q3	FY20 Q4	FY20 Total	FY20 Target
		78.4%	75.0%	57%				≥ 80%



MEASURE DESCRIPTION:
This measure will assess and evaluate how well the adolescent residents met their treatment goals while in treatment, resulting in successful discharges. The DOH facilities with adolescent programs are the New Mexico Behavioral Health Institute (CARE Unit) and the Sequoyah Adolescent Treatment Center.
Numerator: Total number of successful discharges for the reporting period.
Denominator: Total number of discharges for the reporting period.

DATA SOURCE/METHODOLOGY:
AVATAR, which is an electronic healthcare record system.

STORY BEHIND THE DATA:
According to the June 7, 2017 Results First report presented to the NM Legislative Finance Committee:

- Behavioral health problems affect 1 out of 5 children nationally;
- New Mexico has a higher rate of individuals living at or below the poverty line than the rest of the country, putting the state at higher risk for individuals developing behavioral health problems; and
- In New Mexico, 14% of youth experienced 3 or more adverse childhood experiences, higher than the national average of 11%.

NMDOH has youth Residential Treatment programs which provide intensive services for adolescents with serious emotional and behavioral problems and this performance measure reports on the programs meeting their goal for successful discharges from the programs. A successful discharge is a resident discharged to a lower level of care or to the recommended level of care at the time of admission. An unsuccessful discharge includes a discharge to the juvenile justice system.

IMPROVEMENT ACTION PLAN:

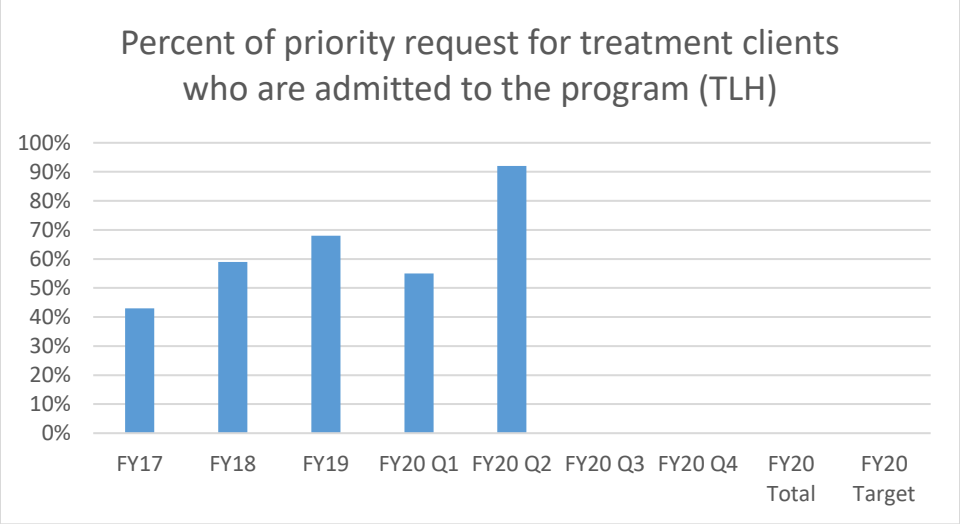
Major Quarterly Action Steps:	Goal Completion Date				
	Q1	Q2	Q3	Q4	Target
1) Provide individualized treatment and services meeting the needs of each resident	X	X			
2) Tailor program recruitment criteria to ensure availability of appropriate treatment services	X	X			
3) Review and develop ongoing program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

FMD PERFORMANCE MEASURE #7

Percent of priority Request for Treatment clients who are admitted to the program (TLH)

Results

FY17	FY18	FY19	FY20 Q1	FY20 Q2	FY20 Q3	FY20 Q4	FY20 Total	FY20 Target
43%	59%	68%	55%	92%				50% of Approvals



MEASURE DESCRIPTION:
Numerator: Number of admitted Priority Patients per month.
Denominator: Total number of Approved Priority Patients per month.

DATA SOURCE/METHODOLOGY:
AVATAR EMR, an enterprise behavioral health software program for electronic medical records and practice management.

STORY BEHIND THE DATA:
In 2016, New Mexico had the twelfth highest total drug overdose death rate in the nation, down from second in 2014. Turquoise Lodge Hospital (TLH) provides safety net services for consumers in New Mexico who are seeking detoxification from drugs and/or alcohol. TLH prioritizes admission for pregnant injecting drug users, pregnant substance users, other injecting drug users, women with dependent children, parenting women, and men and women seeking to regain custody of children. TLH has the potential to impact New Mexico's drug overdose and alcohol death rate through active engagement of priority populations.

IMPROVEMENT ACTION PLAN:

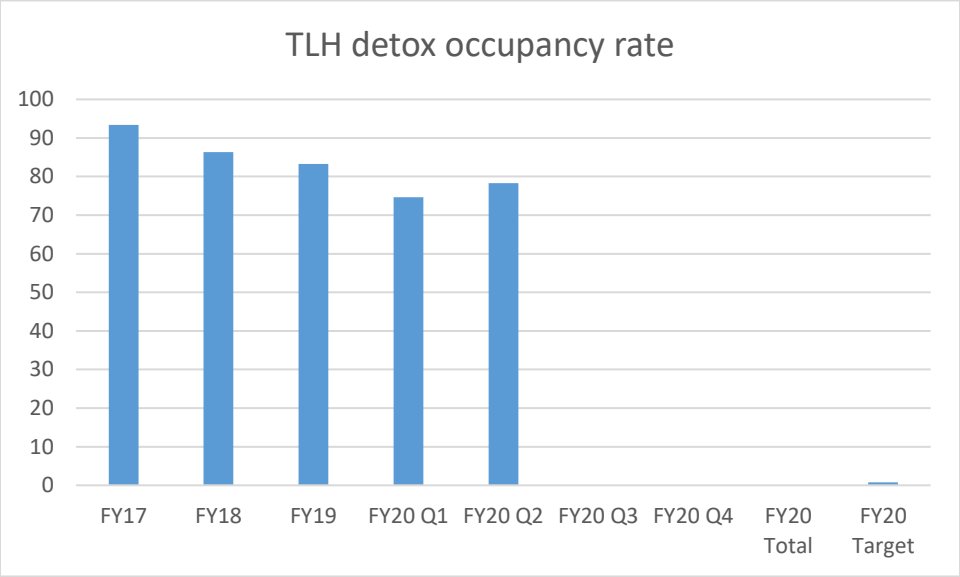
Major Quarterly Action Steps:	Goal Completion Date				
	Q1	Q2	Q3	Q4	Target
1) Utilize the Crystal Report to more quickly see intervention outcomes	X	X			
2)					

FMD PERFORMANCE MEASURE #8

Rate of medical detox occupancy at Turquoise Lodge Hospital

Results

FY17	FY18	FY19	FY20 Q1	FY20 Q2	FY20 Q3	FY20 Q4	FY20 Total	FY20 Target
93.4	86.3	83.3	74.6	78.3				75%



MEASURE DESCRIPTION:
Numerator: Total number of detox patients in hospital per day, monthly (Patient Days).
Denominator: Number of detox admissions per month.
Quarterly Data is serviced from the 3-month average of monthly data.

DATA SOURCE/METHODOLOGY:
Hospital Census Data

STORY BEHIND THE DATA:
As of 2016, New Mexico has the twelfth highest drug overdose death rate in the nation. The consequences of substance use are not limited to death, but include many medical and social consequences, including poverty and lack of adequate insurance. Turquoise Lodge Hospital (TLH) is a specialty hospital that provides safety net services for New Mexican adults with substance use disorders. Occupancy rate, or the percentage of staffed beds that are occupied, measures access to these safety net services. TLH does not make admission decisions based on an individual's insurance, the lack of insurance or the ability to pay. According to the U.S. Centers of Disease Control and Prevention (CDC), for the year 2013, the average specialty hospital occupancy rate in the United States was 63.0% and in New Mexico the average rate was 56.0%.

IMPROVEMENT ACTION PLAN:

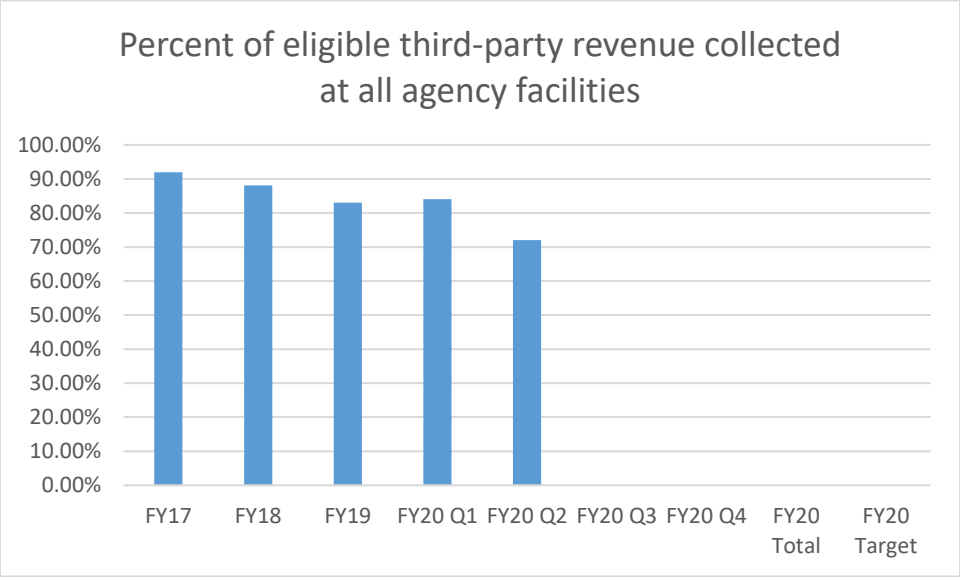
Major Quarterly Action Steps:	Goal Completion Date				
	Q1	Q2	Q3	Q4	Target
1) Schedule three to five admissions per day, five days per week	X	X			
2) Monitor processes, occupancy rate, and implement changes, as necessary	X	X			
3) Increase nursing resources to complete pre-admission assessments	X	X			

FMD PERFORMANCE MEASURE #9

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

Results

FY17	FY18	FY19	FY20 Q1	FY20 Q2	FY20 Q3	FY20 Q4	FY20 Total	FY20 Target
92.0%	88.1%	83.0%	84.1%	72.0%				≥ 93%



MEASURE DESCRIPTION:
This measure reports the percent of payments received based on the amount billed by the facilities.
Numerator: Amount of revenue collected in the reporting period.
Denominator: Amount billed in the reporting period.
Equals the percent of third-party revenue collected.

DATA SOURCE/METHODOLOGY:
The information is obtained from the Electronic Healthcare Record systems used by each Facility. Earned income (revenue) in the reporting period less adjustments for uncompensated/non-recoverable care equals the amount billed.

STORY BEHIND THE DATA:
The collection of revenue is important to maintain services across the state. Greater revenue collection allows DOH to provide an enhanced level of care to our patients. The state's revenue fluctuates each year, and as a result the amount of General Fund appropriated to NMDOH, is directly affected.

IMPROVEMENT ACTION PLAN:

Major Quarterly Action Steps:	Goal Completion Date				
	Q1	Q2	Q3	Q4	Target
1) Fill vacated billing positions and train staff to handle both current and aged accounts	X	X			
2) Ensure proper Managed Care Organization (MCO) reimbursement eligibility protocols are being followed	X	X			
3) Review services to ensure that they are billable under contracts and/or negotiate new service rates, as necessary	X	X			

PROGRAM #5: Developmental Disabilities Supports Division (DDSD)

Program Description and Purpose:
The Developmental Disabilities Supports Division (DDSD) effectively administers a system of person-centered community supports and services that promotes positive outcomes for all stakeholders. DDSD is the primary state agency that funds community services and supports for people with disabilities and their families in New Mexico. DDSD's primary focus is on assisting individuals with developmental disabilities and their families in exercising their right to make choices, grow and contribute to their community. DDSD oversees home and community-based Medicaid waiver programs and these include:

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

DDSD's Intake and Eligibility Bureau manages the Central Registry for individuals waiting for services. DDSD also provides several State General Funded Services. For all programs DDSD's vision is for people with intellectual and developmental disabilities and their families to exercise their right to make choices and grow and contribute to their community.

Program Budget (in thousands):

FY19	General Fund	Other State Funds	Federal Funds	Other Transfers	TOTAL	FTE
200	7,311.1	6,214.1	588.9	0.0	14,114.1	
300	8,425.2	1,254.3	2,158.3	207.9	12,045.7	
400	21,679.6	1,685.6	83.6	1,177.1	24,625.9	189
500	117,294.3	0.0	0.0	0.0	117,294.3	
TOTAL	154,710.2	9,154.0	2,830.8	1,385.0	168,080.0	

* 500s are waiver payments

FY20	General Fund	Other State Funds	Federal Funds	Other Transfers	TOTAL	FTE
200	7,657.1	6,413.0	607.6	0.0	14,677.7	
300	8,675.2	1,454.3	2,158.3	207.9	12,495.7	
400	26,882.6	1,663.4	83.6	1,177.1	29,806.7	188
500	131,944.3	19.2	0.0	0.0	131,963.5	
TOTAL	175,159.2	9,549.9	2,849.5	1,385.0	188,943.6	

Program Performance Measures:

Program Objective 1: Redesign waivers to eliminate the DDW waitlist

1. Number of individuals on the developmental disabilities waiver waiting list
2. Number of individuals receiving developmental disability waiver services
3. Percent of developmental disabilities waiver applicants who have a service and budget in place within 90-days of income and clinical eligibility (FY20 Key Measure)

Program Objective 2: Become a data driven decision-making organization

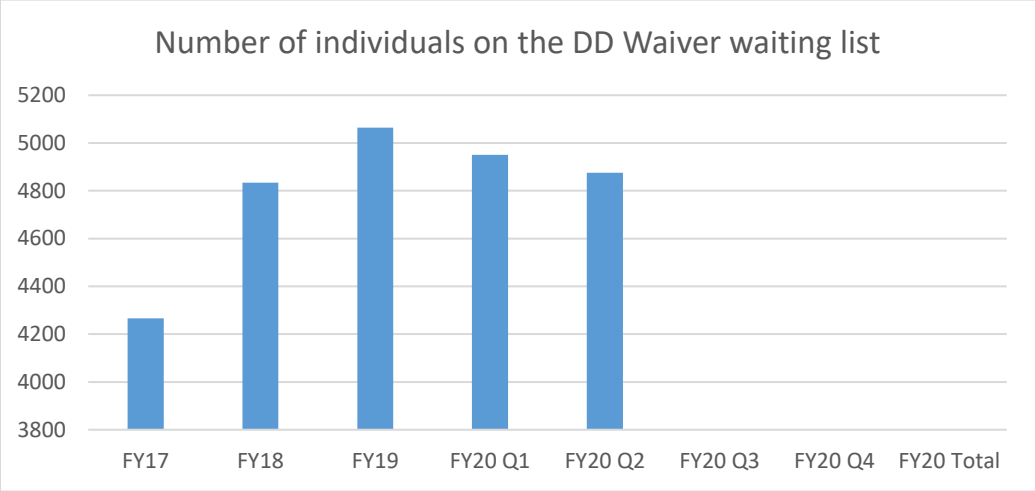
1. Percent of DD Waiver providers in compliance with General Events timely reporting requirements (2-day rule) (FY20 Key Measure)
2. Percent of adults on the DD Waiver who receive employment supports (FY20 Key Measure)

DDSD PERFORMANCE MEASURE #1

Number of individuals on the DD Waiver waiting list

Results

FY17	FY18	FY19	FY20 Q1	FY20 Q2	FY20 Q3	FY20 Q4	FY20 Total	FY20 Target
4266	4834	5064	4950	4876				Explanatory



MEASURE DESCRIPTION:
This explanatory measure indicates the number of individuals waiting for services.

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

STORY BEHIND THE DATA:
The wait time for Home and Community-Based Services (HCBS) Waivers varies widely by state. In New Mexico, the HCBS Waivers with a waiting list include the Developmental Disabilities (DD) and Mi Via Waivers. Individuals are offered waiver services as funding for allocation slots becomes available. Persons that meet the requirements can receive standard Medicaid benefits and other services while on the waiting list. As of December 31, 2019, there were 4,876 individuals on the waiting list for HCBS Waivers. These individuals have been determined to meet the definition of developmental disability. Of those individuals, 437 have placed their allocation on hold. This means these individuals were offered waiver services and have chosen to continue on the waiting list, for now. The number of individuals on the wait list decreased during FY20, as the FY20 appropriation created 355 waiver slots for individuals on the wait list. As of December 31, 2019, 309 of those slots have been filled. The remaining slots will be filled throughout the fiscal year.

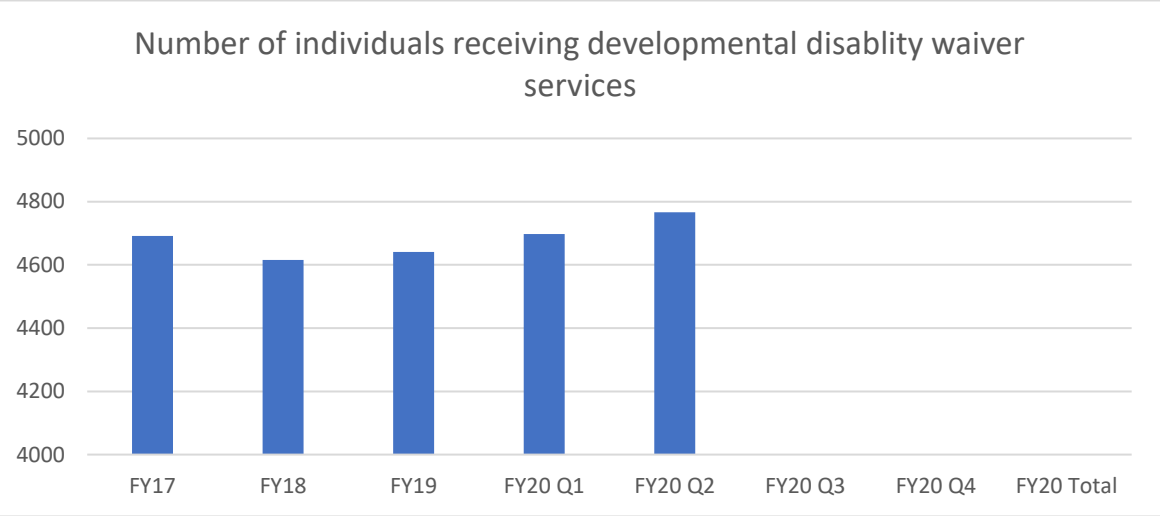
IMPROVEMENT ACTION PLAN:
While this is an annual explanatory measure and no quarterly actions are required, of course DDSD will continue to increase applicant awareness of services that are available to them while they are on the wait list such as Medicaid, State General Fund, and community-based service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

DDSD PERFORMANCE MEASURE #2

Number of individuals receiving developmental disability waiver services

Results

FY17	FY18	FY19	FY20 Q1	FY20 Q2	FY20 Q3	FY20 Q4	FY20 Total	FY20 Target
4692	4616	4641	4698	4766				Explanatory



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

DATA SOURCE/METHODOLOGY:
New Mexico Human Services Department, Client Counts and Expense Report, December 11, 2019.

STORY BEHIND THE DATA:
Every state in the nation has the option to provide home and community-based services with approval from the Centers for Medicare and Medicaid Services (CMS). Nationwide, over 44 states, and the District of Columbia, provide home and community-based Medicaid waiver services to people with Intellectual or Developmental Disabilities (I/DD).
The Developmental Disabilities Waiver program (DDW) serves as an alternative to institutional care. DDW provides a variety of services for people with I/DD to support them in living independently and participating actively in their communities.

In FY20-Q2, the Developmental Disabilities Supports Division (DDSD) had 4,766 (Human Services Department 12/11/19 Developmental Disabilities Waiver and Mi Via Waiver unduplicated count) persons receiving Developmental Disability Waiver services. The Intake and Eligibility Bureau (IEB) has developed an allocation plan for the FY19 allocations. FY19 allocation batch allows for 80 slots, with 10 reserved for expedited allocations. The IEB completes replacement and attrition allocations, with replacement as applicable, e.g., hold, no response, refuse altogether, and approximately six attrition slots each month.

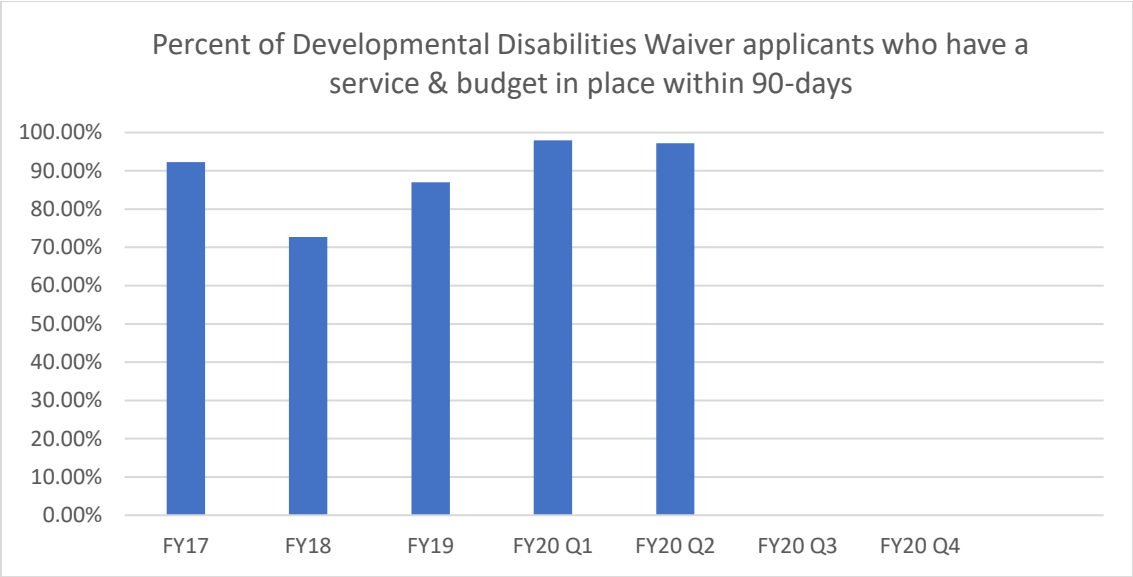
IMPROVEMENT ACTION PLAN:
While this is an annual explanatory measure and no quarterly actions are required, DDSD will continue to monitor the allocation process to ensure people receive timely DD Waiver services as allocation slots become available.

DDSD PERFORMANCE MEASURE #3

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

Results

FY17	FY18	FY19	FY20 Q1	FY20 Q2	FY20 Q3	FY20 Q4	FY20 Total	FY20 Target
92.30%	72.70%	87.00%	98.00%	97.19%				90%



MEASURE DESCRIPTION:
This indicator measures the percentage of newly allocated individuals receiving initial services in a timely manner.

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

STORY BEHIND THE DATA:
This performance measure is in response to Lewis v. New Mexico Department of Health. It is important in ensuring allocated individuals have a service plan in place within 90-days of income and clinical eligibility. The Developmental Disabilities Supports Division (DDSD) Intake and Eligibility Bureau (IEB) works closely with internal and external partners to ensure that individuals with developmental disabilities receive waiver services in a timely manner by completing the necessary application requirements. During FY20 Q2, 104 out of 107 individuals had a service plan in place within 90 days of income and clinical eligibility determination.

IMPROVEMENT ACTION PLAN:

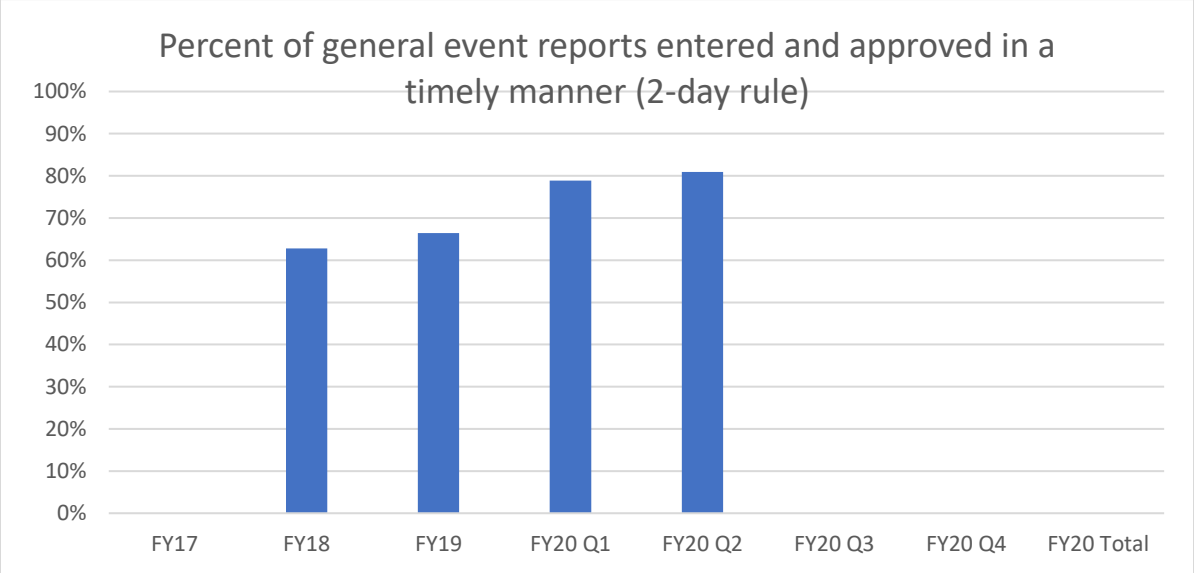
Major Quarterly Action Steps:	Goal Completion Date				
	Q1	Q2	Q3	Q4	Target
1) Review the Central Registry status reports to determine if systemic or case specific problems exist during the eligibility determination process	98%	97%			**90%**
2) Communicate with registrants/applicants to ensure contact information is current and accurate	98%	97%			**90%**
3) Increase applicant awareness of Medicaid, State General Fund, and community-based service options	98%	97%			**90%**

DDSD PERFORMANCE MEASURE #4

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

Results

FY18	FY19	FY20 Q1	FY20 Q2	FY20 Q3	FY20 Q4	FY20 Total	FY20 Target
62.8%*	66.4%*	78.9%*	80.9%				86%



MEASURE DESCRIPTION:
This measure indicates the degree to which General Events Reports are addressed in a timely manner.

DATA SOURCE/METHODOLOGY:
New Mexico Department of Health, DDSD, Therap Database, December 2019. Minor revisions (*) reflect the correction of a limited number of duplicated records.

STORY BEHIND THE DATA:
The timely submission and approval of General Events Reports is critical to DDSD's mission of ensuring the safety and wellbeing of the individuals on the traditional Developmental Disabilities Waiver (DDW). The purpose of General Events Reporting (GER) is to report, track and analyze events, which a pose a risk to adults in the DDW program, but do not meet criteria for ANE or other reportable incidents as defined by the Incident Management Bureau. According to DDSD requirements, providers must enter and approve GERs within two (2) business days, except for medication errors, of the event date.

IMPROVEMENT ACTION PLAN:

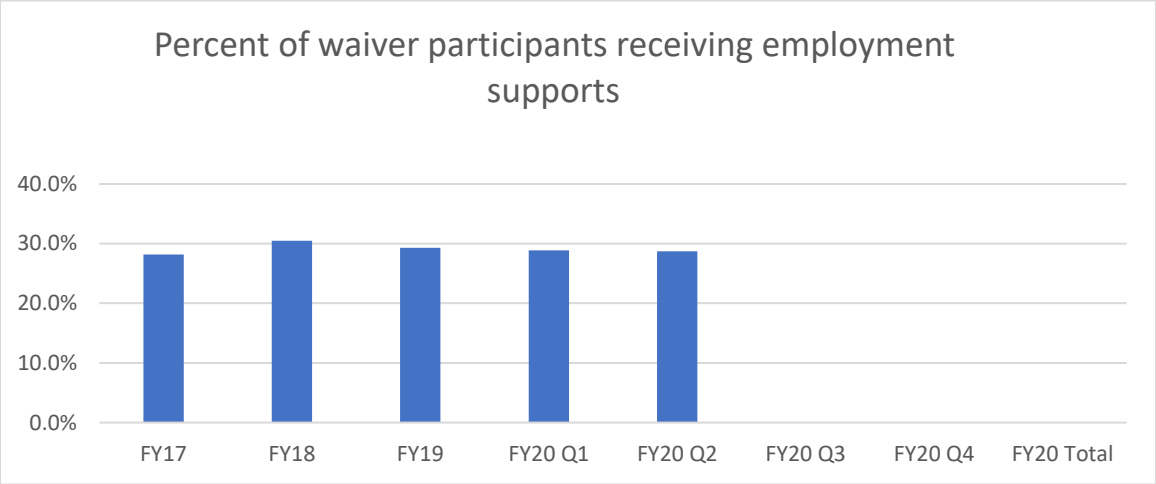
Major Quarterly Action Steps:	Goal Completion Date				
	Q1	Q2	Q3	Q4	Target
1) Conduct case review for providers who are not adhering to GER requirements	x	x			**86%**
2) Initiate appropriate interventions with provider agencies not adhering to requirements	x	x			**86%**

DDSD PERFORMANCE MEASURE #5

Percent of Waiver participants receiving employment supports

Results

FY17	FY18	FY19	FY20 Q1	FY20 Q2	FY20 Q3	FY20 Q4	FY20 Total	FY20 Target
28.2%*	30.5%*	29.3%*	28.9%*	28.7%				34%



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

DATA SOURCE/METHODOLOGY:
New Mexico Department of Health, Omnicaid Database. All figures are derived from claims paid during the period 01.01.2019 through 12.31.2019. The one-year time period (ending with FY20 Q2) is utilized to provide both recent and reliable data. This one-year time period aligns with the performance measure target (34%), which is measured over a period of one year. All figures provided are subject to revision as additional claims, are processed and adjusted. Individuals of working age include all waiver participants (both Traditional and Mi Via) between the age of 22 to 64 years inclusive. The revised data (*) above are the result of claims processing and minor age adjustments.

STORY BEHIND THE DATA:
Nationally, individuals with intellectual/developmental disabilities (I/DD) experience greater levels of unemployment, underemployment, low wages, and poverty compared to those without disabilities. New Mexico has made steady progress toward increasing community-integrated outcomes and performs above the national average of 19%. Community Integrated Employment (CIE) includes job development, so individuals with developmental disabilities may participate as active community members and realize the benefits of employment. Throughout FY17, FY18 and now into FY19, DDSD conducted presentations for Employment First (E1st). E1st expects that working age individuals with I/DD should be given the opportunity to work in the community. To date, DDSD has conducted over 100 presentations, including two train-the-trainer sessions to approximately 1445 people.

IMPROVEMENT ACTION PLAN:

Major Quarterly Action Steps:	Goal Completion Date				
	Q1	Q2	Q3	Q4	Target
1) Host College of Employment Services (CES) training statewide	x	x			**34%**
2) Host Employment First training statewide	x	x			**34%**

In FY20Q1, 28.94% and in FY20 Q2 28.69% of eligible adults received employment services.

PROGRAM #6: Health Certification Licensing and Oversight (DHI)

Program Description and Purpose:
The Division of Health Improvement (DHI) ensures that healthcare facilities, community-based Medicaid waiver providers and community support services deliver safe and effective healthcare and community services in accordance with laws, regulations, and standards of practice. DHI works closely with key stakeholders to promote and protect the health, safety, and quality of life of New Mexicans. Key DHI enforcement activities include:

- Conducting various health and safety surveys for both facilities and community-based programs;
- Conducting investigations of alleged abuse, neglect, exploitation, death or environmental hazards; and
- Processing over 44,000 caregiver criminal history screenings annually.

Program Budget (in thousands):

FY19	General Fund	Other State Funds	Federal Funds	Other Transfers	TOTAL	FTE
200	4,461.30	1,514.60	1,821.70	3,621.00	11,418.60	173
300	85	330.4	82.7	311.2	809.3	
400	463.7	116.7	518.4	471.8	1,570.60	
TOTAL	5,010.00	1,961.70	2,422.80	4,404.00	13,798.50	

FY20	General Fund	Other State Funds	Federal Funds	Other Transfers	TOTAL	FTE
200	4,271.60	1,699.60	2,076.40	4,350.60	12,398.20	183
300	609.5	139.1	96	170.5	1,015.10	
400	510.2	208	584.2	452	1,754.40	
TOTAL	5,391.30	2,046.70	2,756.60	4,973.10	15,167.70	

Program Performance Measures:

Program Objective 1: Ensure safe healthcare services

1. Percent of Caregiver Criminal History Screening (CCHS) Appeal Clearance recidivism/re-offense (conviction) after a successful appeal
2. Percent of improved accuracy in nursing home Incident Reports (IRs) submitted following participation in a DHI quality training on reporting requirements
3. Percent of Assisted Living Facilities (ALFs) compliance with background checks
4. Rate of abuse for developmental disability waiver and mi via waiver clients
5. Rate of re-abuse for developmental disability waiver and mi via waiver clients

Program Objective 2: Provide timely completion of oversight activities

1. Percent of health facility survey of statement of deficiencies (CMS form 2567/state form) distributed to the facility within 10-days of survey exit (DOB-LTC)
2. Percent of health facility survey statement of deficiencies (CMS form 2567/state form) distributed to the facility within 10-days of survey exit (POB-NLTC)
3. Percent of abuse, neglect and exploitation investigations completed within required timeframes (FY20 Key Measure)
4. Percent of Quality Management Bureau (QMB) 1915c Home and Community-Based Service Waiver (HCBS-DDW, Mi Via and Med Frag.) report of findings distributed within 21 working days from end of survey

Program Objective 3: Provide timely initiation of oversight activities

1. Percent of (IMB) assigned investigations initiated within required timelines
2. Percent of Assisted Living Facilities (ALF) complaint surveys initiated within timeframes

Program Objective 3: Pursue organizational excellence

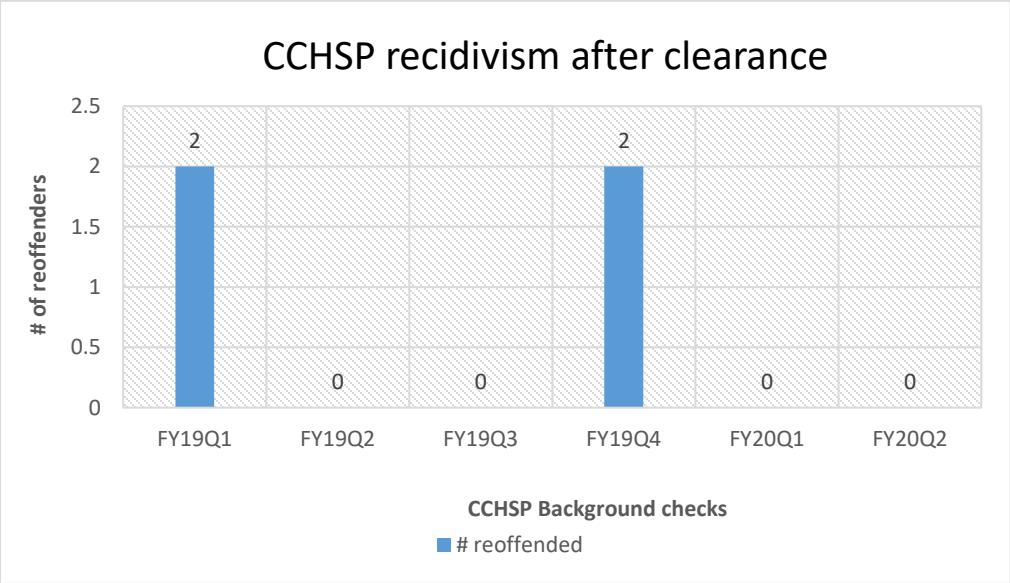
1. Percent of Nursing Home (NH) survey citation(s) upheld as valid when reviewed by the Centers of Medicare and Medicaid Services (CMS) and through Informal Dispute Resolution (IDR)

DHI PERFORMANCE MEASURE #1

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

Results

FY19	FY20 Q1	FY20 Q2	FY20 Q3	FY20 Q4	FY20 Total	FY20 Target
4	0	0				<12 annually



MEASURE DESCRIPTION:
This measure applies to "Employee Caregivers" as defined by NMAC 7.1.9. The CCHS database collects and records the date a background check is received (start date) and the date the background check is completed and closed (completion date).

DATA SOURCE/METHODOLOGY:
CCHSP database at: https://nmhealth.cchsp.com

STORY BEHIND THE DATA:
When a caregiver is disqualified at screening they can appeal for reconsideration, this performance measure looks at those individuals who reoffend after being cleared following an appeal. This measure counts the individuals who are currently employed and offend or reoffend resulting in a disqualification event, regardless of the date of their original clearance.

IMPROVEMENT ACTION PLAN:

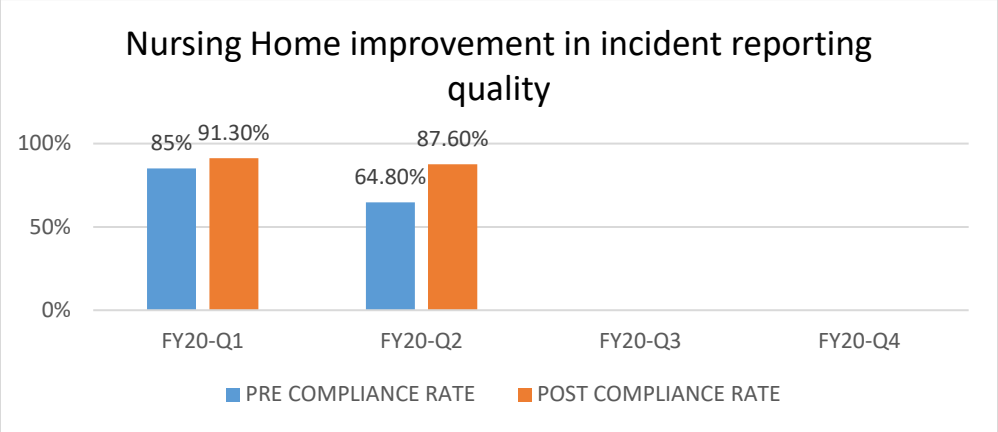
Major Quarterly Action Steps:	Goal Completion Date				
	Q1	Q2	Q3	Q4	Target
1) Monitor recidivism when appeals received	n/a	n/a			**<12**

DHI PERFORMANCE MEASURE #2

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

Results

FY17	FY18	FY19	FY20 Q1	FY20 Q2	FY20 Q3	FY20 Q4	FY20 Total	FY20 Target
			91.3%	87.6%				85%



MEASURE DESCRIPTION:
Numerator: Total number of IR components that meet criteria per incident.
Denominator: Total number of IR components per incident.

DATA SOURCE/METHODOLOGY:
Part 1: Baseline prior to training.
Part 2: Change post training.
Part 3: Percent of change (improvement) in IR accuracy and quality.
Percent of accurate IR components post DHI training Minus (-) Percent of accurate IR components prior to DHI training Equals (=) percent of change (improvement) in IR accuracy and quality.

STORY BEHIND THE DATA:
Receiving an accurate and complete incident report (IR) and a 5-day (calendar days) follow-up investigation summary from a licensed nursing home health facility is a state and federal requirement. This information is an important first step in triaging an incident to determine potential assignment for onsite survey. When incomplete IRs are submitted it can delay the triage process while additional information is requested and collected, adding additional staff time. This performance measure looks at the impact (outcome) of DHI's quality training to nursing homes, specifically whether they improve the accuracy and quality of their IRs and follow-up investigations. The data compares the quality and accuracy of a nursing home against itself over time, as well as their follow-up investigations and summary of corrective and preventive actions taken. There are 25 components to a complete IR and each IR is scored for completeness. Already DHI is seeing improvement in nursing home incident reporting for participating facilities.

IMPROVEMENT ACTION PLAN:

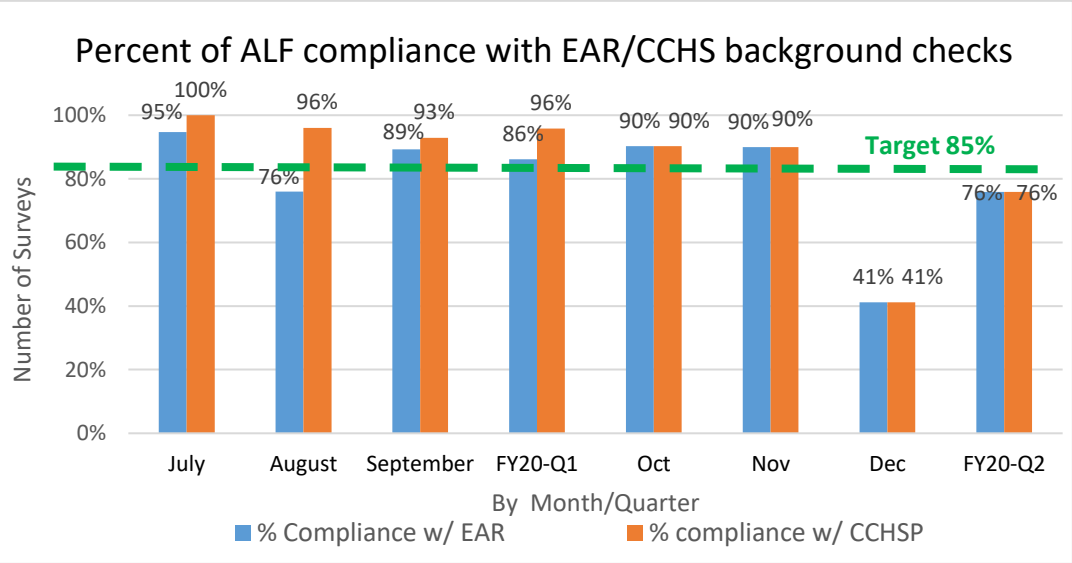
Major Quarterly Action Steps:	Goal Completion Date				
	Q1	Q2	Q3	Q4	Target
1) Conduct facility trainings	n/a	n/a			**85%**
2) Continue facility trainings, Monitor for improvement	n/a	n/a			**85%**

DHI PERFORMANCE MEASURE #3

Percent of Assisted Living Facilities (ALFs) compliant with background checks

Results

FY17	FY18	FY19	FY20 Q1	FY20 Q2	FY20 Q3	FY20 Q4	FY20 Total	FY20 Target
			86.2% EAR 96% CCHS	76% EAR 76% CCHS				85%



MEASURE DESCRIPTION:

This measure monitors the compliance of Assisted Living Facilities (ALFs) with completing background checks for all caregivers with the Employee Abuse Registry (EAR) and Caregiver Criminal History Screening Program (CCHSP).
Numerator: Number of ALFs cited for CCHS in a survey.
Denominator: Number of ALFs surveyed.

DATA SOURCE/METHODOLOGY:

Data Source: HTTPS://HFLCShared (\\dhirndcolm002) H:\Review Office\Reviewer\LTC TRACKING LOG\Licensed Only

STORY BEHIND THE DATA:

This performance measure reports on the compliance of assisted living facilities with caregiver criminal history screening requirements. Historical compliance has been poor due to limited oversight by DHI. Improved compliance is expected with increased oversight from new DHI survey teams.

IMPROVEMENT ACTION PLAN:

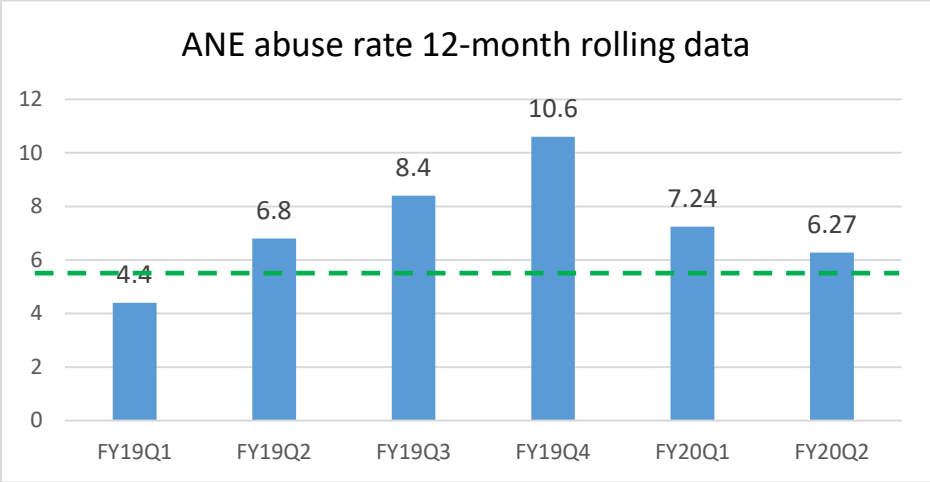
Major Quarterly Action Steps:	Goal Completion Date				
	Q1	Q2	Q3	Q4	Target
1) Hire and train additional ALF surveyors	n/a	n/a			**85%**
2) Complete all ALF compliant surveys within timeframes	n/a	n/a			**85%**
3) Complete all ALF annual surveys	n/a	n/a			**85%**

DHI PERFORMANCE MEASURE #4

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

Results

FY17	FY18	FY19	FY20 Q1	FY20 Q2	FY20 Q3	FY20 Q4	FY20 Total	FY20 Target
6.80%	7.50%	10.60%	7.24%	6.27%				≤ 7%



MEASURE DESCRIPTION:

Numerator: Number of persons who have had one or more substantiated allegations of abuse, neglect or exploitation (ANE) within a twelve-month (calendar year) period as tracked by the IMB database.

Denominator: Total individuals served by the New Mexico traditional Developmentally Disabled Waiver (DDW), Medically Fragile Waiver (MFW) (adults only) and Mi Via waiver.

DATA SOURCE/METHODOLOGY:

This data comes from the IMB computer database. The four quarterly reports are summed and divided by 4 to reach an average population for the 12-month period.

Eligibility: Individuals eligible for the DDW, MFW (adult only) and Mi Via waivers, calculated from quarterly reports of populations from DDSD at the end of each quarter, as tracked by the UNM Continuum of Care database. The four quarterly reports are summed and divided by 4 to reach an average population for the 12-month period.

Time Period: Due to the length of investigations, the quarterly data will always be presented from the previous quarter.

STORY BEHIND THE DATA:

Abuse, neglect, and exploitation (ANE) of individuals with intellectual/developmental disabilities (I/DD) has a direct impact on their quality of life and results in increased emergency room visits, additional medications, and related medical treatment. Neglect is the most common allegation. Lack of adequate supervision, failure to follow health care plans, and insufficient staff training are the most common reasons for substantiated neglect. Many adults with I/DD are unable to recognize danger, understand their rights, and protect themselves, and neglect is the leading cause of premature death for this population.

IMPROVEMENT ACTION PLAN:

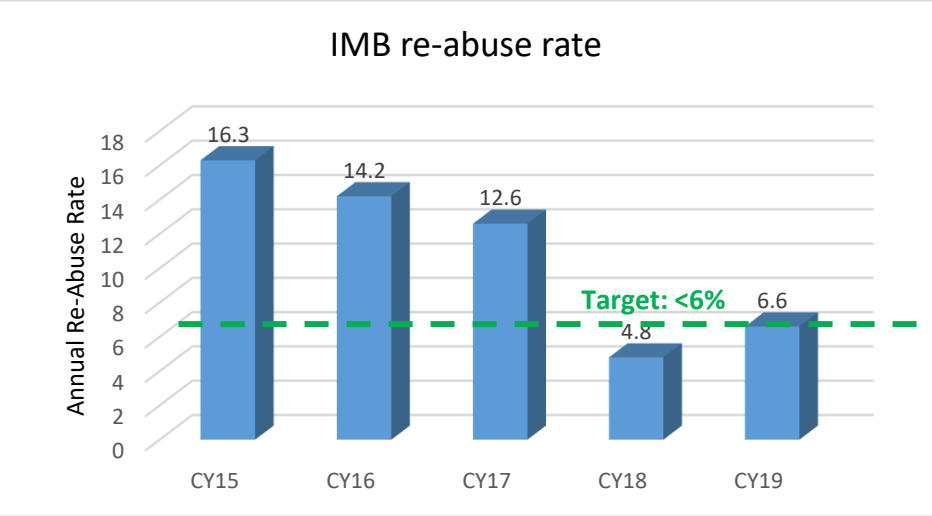
Major Quarterly Action Steps:	Goal Completion Date				
	Q1	Q2	Q3	Q4	Target
1) Maintain completion of backlog cases	n/a	n/a			<7
2) Continue training of new investigators	n/a	n/a			<7

DHI PERFORMANCE MEASURE #5

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

Results

CY2015	CY2016	CY2017	CY2018	CY2019	CY2020	CY2021	FY20 Total	FY20 Target
16.3%	14.2%	12.6%	4.8%	6.6%				≤ 6%



MEASURE DESCRIPTION:
Numerator: Number of repeat substantiated cases involving the same consumer over a 12-month period.
Denominator: Total number of substantiated cases.

DATA SOURCE/METHODOLOGY:
This annual data comes from the IMB Database. This data measures the number of repeat substantiated cases involving the same consumer over a 12-month period (calendar year). Data prior to 2016 has limitations and does not represent the current level of detail for comparison.

STORY BEHIND THE DATA:
It is important to measure repeat abuse, neglect, and exploitation (ANE) because many individuals are unable to recognize danger, understand their rights, and protect themselves. Lack of adequate supervision, failure to follow health care plans, and staff training are the most common reasons for substantiated neglect. Incidents are tracked through the Incident Management Bureau (IMB) incident management data system.

IMPROVEMENT ACTION PLAN:

Major Quarterly Action Steps:	Goal Completion Date				
	Q1	Q2	Q3	Q4	Target
1) Track the re-abuse rate, including ANEs	X	X			
2) Determine the effectiveness of corrective & preventive action plans	X	X			
3) Make improvements to database functionality	X	X			

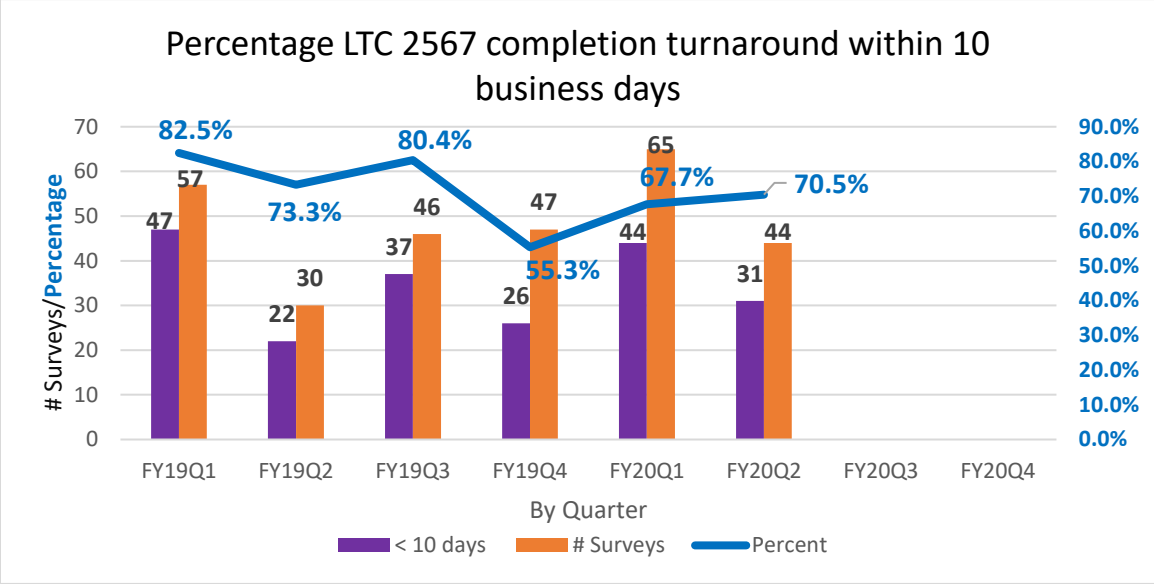
By tracking the re-abuse rate, (which includes ANE), IMB can determine the effectiveness of Corrective and Preventive Action Plans and strategies intended to reduce the rate of abuse. IMB continues to make improvements to its database functionality to improve the quality of the data.

DHI PERFORMANCE MEASURE #6

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

Results

FY17	FY18	FY19	FY20 Q1	FY20 Q2	FY20 Q3	FY20 Q4	FY20 Total	FY20 Target
89%	89%	73.3%	67.7%	70.5%				85%



MEASURE DESCRIPTION:

Numerator: Number of health facilities receiving a CMS form 2567 and/or state form (statement of deficiencies), within 10 business days of survey exit.

Denominator: Number of long-term care, non-long-term care, and licensed only health facilities receiving a CMS form 2567 and/or state form (statement of deficiencies).

DATA SOURCE/METHODOLOGY:

DHI management manually tracks this data using three spreadsheets: "The Long-Term Care Tracking log", "The Non-Long-Term Care Tracking Log" and "The Licensed Only Tracking Log".

STORY BEHIND THE DATA:

Providing regulatory oversight to health facilities is key to DHI's mission to ensure that safe healthcare services are being provided to all New Mexicans. Timely feedback following a survey is critical to ensure health facilities make necessary corrections and improvements to ensure safe healthcare services are being provided. DHI has a federal requirement to issue 2567s within 10-days. A high vacancy rate has impacted DHI's timeliness of reports and DHI has experienced a significant increase in survey workload and complaint surveys. During FY19 Q4, there was a delay in sending compliance letters for deficiency free surveys.

IMPROVEMENT ACTION PLAN:

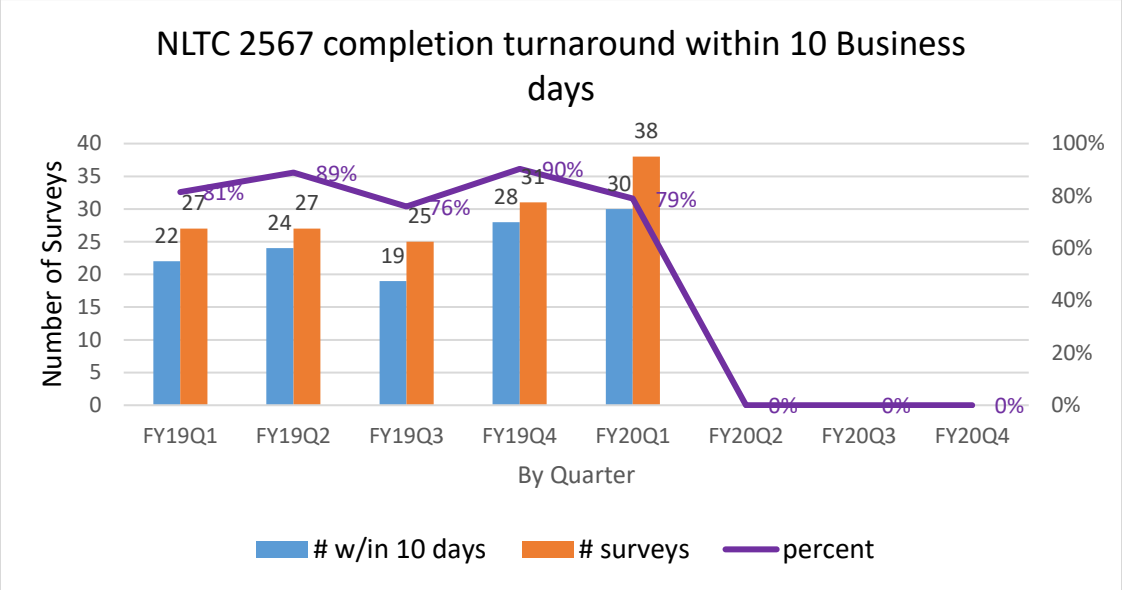
Major Quarterly Action Steps:	Goal Completion Date				
	Q1	Q2	Q3	Q4	Target
1) Recruit and train vacant surveyor positions	n/a	n/a			**85%**
2) Implement workflow management improvements	n/a	n/a			**85%**

DHI PERFORMANCE MEASURE #7

Percent of health facility survey statement of deficiencies (CMS form 2567/state form) distributed to the facility within 20-days of survey exit (POB-NLTC)

Results

FY19	FY20 Q1	FY20 Q2	FY20 Q3	FY20 Q4	FY20 Total	FY20 Target
84.50%	79%					90%



MEASURE DESCRIPTION:
Numerator: Number of health facilities receiving a CMS form 2567 and/or state form (statement of deficiencies) within 10-days.
Denominator: Total number of surveys.

DATA SOURCE/METHODOLOGY:
Data Source: HTTPS://HFLCShared (\\dhirndcolm002)(H:)\Review Office\Reviewer\NLTC TRACKING LOGH:\Review Office\Reviewer\NLTC TRACKING LOG. There is a one quarter data lag in reporting.

STORY BEHIND THE DATA:
Providing regulatory oversight to health facilities is key to DHI's mission to ensure that safe healthcare services are provided to all New Mexicans. Timely feedback following a survey is critical to ensure health facilities make necessary corrections and improvements to ensure safe healthcare services are being provided. DHI has a federal requirement to issue 2567s within 10-days. A high vacancy rate has impacted DHI's timeliness of reports and DHI has experienced a significant increase in survey workload and complaint surveys. During FY19 Q4, there was a delay in sending compliance letters for deficiency free surveys. The change in the complaint process has created an influx of assigned surveys.

IMPROVEMENT ACTION PLAN:

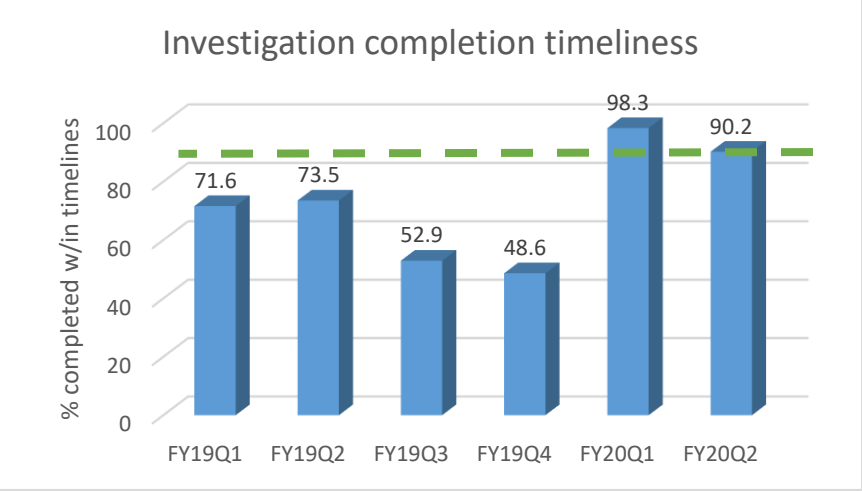
Major Quarterly Action Steps:	Goal Completion Date				
	Q1	Q2	Q3	Q4	Target
1) Recruit and train vacant surveyor positions	n/a	n/a			**90%**
2) Implement workflow management improvements	n/a	n/a			**90%**
3) Meet with CMS consultants to review and improve the complaint triage process	n/a	n/a			**90%**

DHI PERFORMANCE MEASURE #8

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

Results

FY17	FY18	FY19	FY20 Q1	FY20 Q2	FY20 Q3	FY20 Q4	FY20 Total	FY20 Target
		48.60%	98.3%	90.2%				90%



MEASURE DESCRIPTION:
Completing investigations within the prescribed 45-day timeline is important to ensure the health and safety of the consumer we serve. Therefore, this is a high priority.
Numerator: Number of IMB investigations completed within 45-days or less, or with an approved extension.
Denominator: Total number of investigations completed in the Quarter.

DATA SOURCE/METHODOLOGY:
This data comes from DHI's Investigation Management Bureau database.

STORY BEHIND THE DATA:
Abuse, neglect, and exploitation (ANE) of individuals with intellectual/developmental disabilities (I/DD) has a direct impact on their quality of life and results in increased emergency room visits, additional medications, and related medical treatment. Neglect is the most common allegation. Lack of adequate supervision, failure to follow health care plans, and insufficient staff training are the most common reasons for substantiated neglect. Completing investigations within the prescribed 45-day timeline is important to ensure the health and safety of the consumer we serve. The decrease at the end of FY19 was a result of completing and closing the backlog of old cases.

IMPROVEMENT ACTION PLAN:

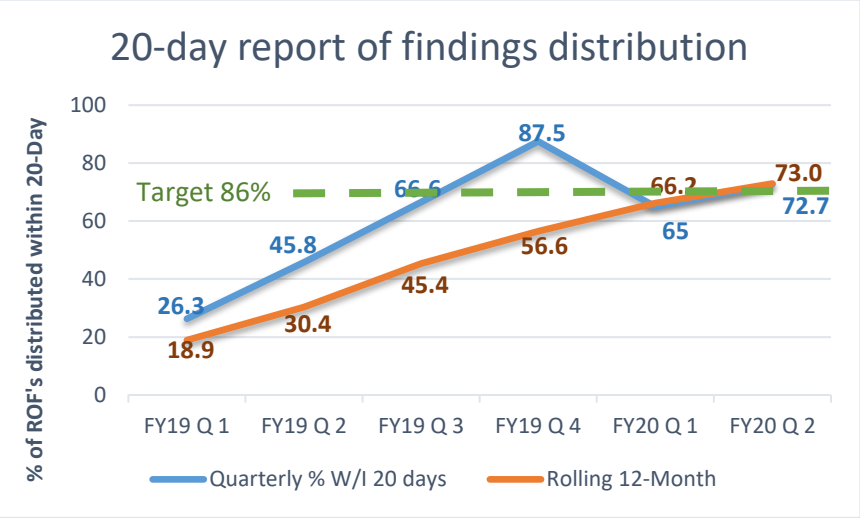
Major Quarterly Action Steps:	Goal Completion Date				
	Q1	Q2	Q3	Q4	Target
1) Review employee productivity and retention	n/a	n/a			**90%**
2) Evaluate the need for additional resources	n/a	n/a			**90%**

DHI PERFORMANCE MEASURE #9

Percent of Quality Management Bureau (QMB) 1915c Home and Community-Based Service Waiver (HCBS-DDW, Mi Via and Med Frag.) report of findings distributed within 21 working days from end of survey

Results

FY17	FY18	FY19	FY20 Q1	FY20 Q2	FY20 Q3	FY20 Q4	FY20 Total	FY20 Target
54.90%	12.50%	49.20%	87.50%					86%



MEASURE DESCRIPTION:

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

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

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

DATA SOURCE/METHODOLOGY:

QMB Output Indicator Report. QMB manually collects data from each completed survey using an excel spreadsheet. This data source is then used to create the monthly "Output Indicator Report." Data is compiled and reported quarterly. QMB will measure the percentage of compliance with this internal requirement

STORY BEHIND THE DATA:

A high vacancy rate has impacted DHI's timeliness of reports and the Quality Management Bureau (QMB) has experienced a 100% turnover in surveyor staff during the past 24-months. The resulting vacancies required survey teams to schedule back to back provider surveys, which was further complicated by a prohibition to use overtime for report writing, causing a significant backlog of survey reports pending completion. Turnover in 2 program manager positions who are responsible for editing reports was an also delayed the completion of reports, as well as ongoing technical issues with the development of the QMB database and e-survey tools. At this time, QMB has an 11% vacancy rate and is working to get new surveyors and managers fully trained.

IMPROVEMENT ACTION PLAN:

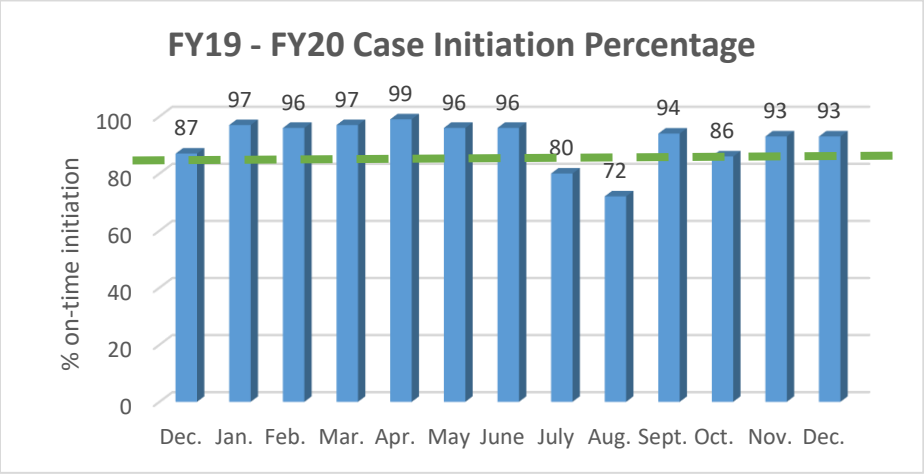
Major Quarterly Action Steps:	Goal Completion Date				
	Q1	Q2	Q3	Q4	Target
1) Recruit and train vacant surveyor positions	n/a	n/a			**86%**

DHI PERFORMANCE MEASURE #10

Percent of (IMB) assigned investigations initiated within required timelines

Results

FY19	FY20 Q1	FY20 Q2	FY20 Q3	FY20 Q4	FY20 Total	FY20 Target
	79%	91%				86%



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

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

STORY BEHIND THE DATA:
A critical component of keeping individuals safe is the timely initiation of investigations of ANE. Case initiation is defined as the Investigator making direct contact with someone identified in the case, e.g., reporter, alleged victim, case manager, incident coordinator, etc.). IMB uses the same case initiation priority levels as Adult Protective Service and the Children, Youth and Families Department. An Emergency Priority requires initiation within three hours, a Priority One requires initiation within 24-hours and a Priority Two requires initiation within five-days.

IMPROVEMENT ACTION PLAN:

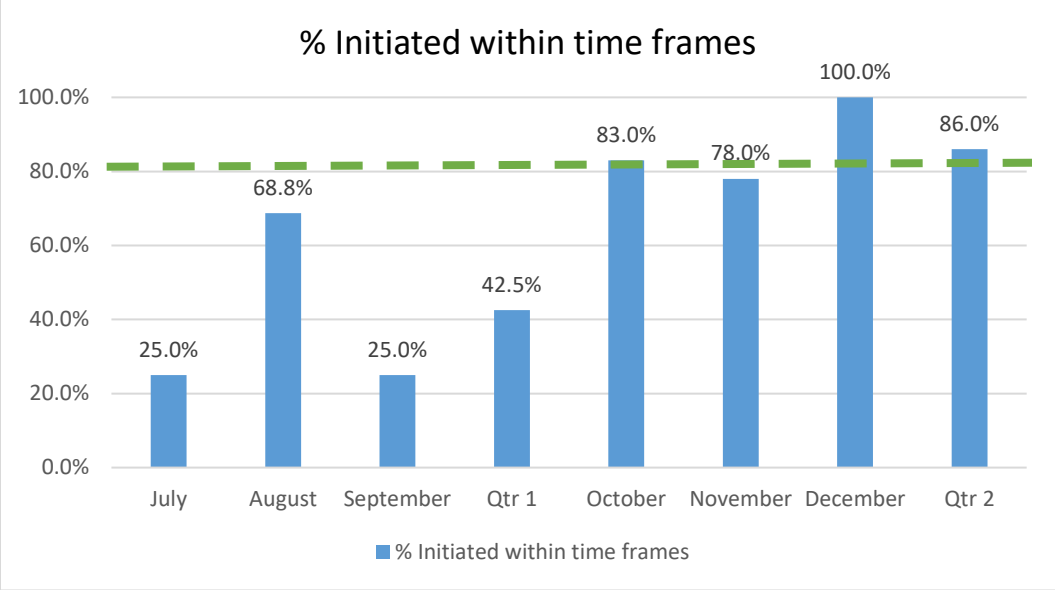
Major Quarterly Action Steps:	Goal Completion Date				
	Q1	Q2	Q3	Q4	Target
1) Hire additional investigators to manage workload	0	0			
2) Conduct timely ANE initiation investigations					**86%**

DHI PERFORMANCE MEASURE #11

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

Results

FY19	FY20 Q1	FY20 Q2	FY20 Q3	FY20 Q4	FY20 Total	FY20 Target
	42.50%					85%



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

DATA SOURCE/METHODOLOGY:
Data Source: HTTPS://HFLCShared (\\dhirndcolm002)H:\Review Office\Reviewer\LTC TRACKING LOG\Licensed Only

STORY BEHIND THE DATA:
This performance measure reports on the percent of Assisted Living Facilities (ALF) complaints initiated within timeframes. Improved compliance is expected with increased new DHI ALF survey teams. There has been a historical backlog of complaints pending a survey review, with the addition of new surveyor staff, old complaints have been completed and the teams are now current with workload.

IMPROVEMENT ACTION PLAN:

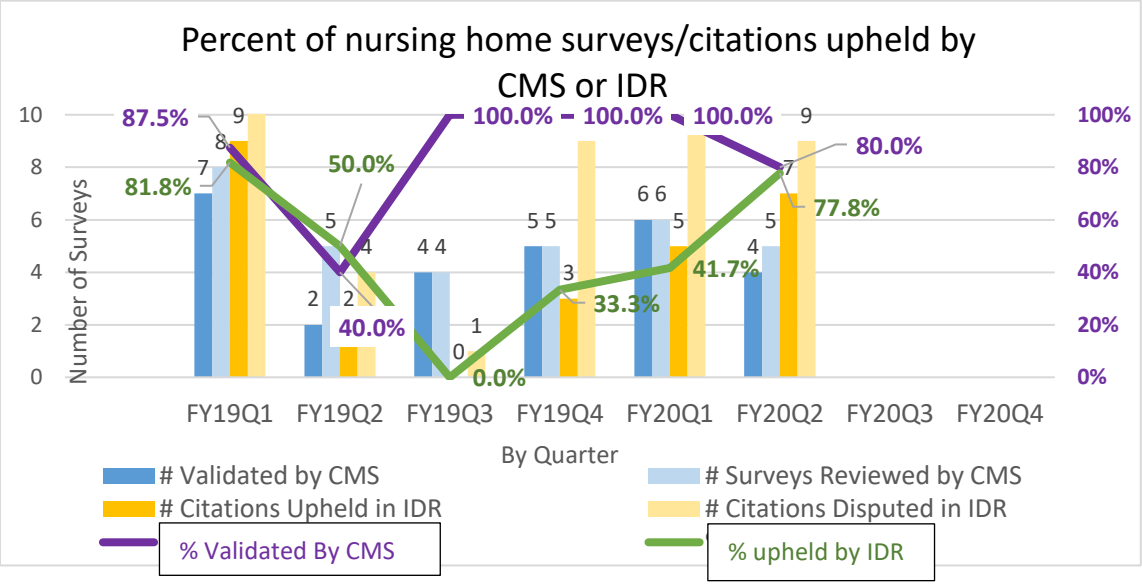
Major Quarterly Action Steps:	Goal Completion Date				
	Q1	Q2	Q3	Q4	Target
1) On-going monitoring	n/a	n/a			**85%**
2) Hire and train additional ALF surveyors					
3) Maintain complaint survey reviews completion status, to avoid backlog					

DHI PERFORMANCE MEASURE #12

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

Results

FY17	FY18	FY19	FY20 Q1	FY20 Q2	FY20 Q3	FY20 Q4	FY20 Total	FY20 Target
		85% CMS 47% IDR	100% CMS 41.7% IDR	80% CMS 77.8% IDR				90%



MEASURE DESCRIPTION:
This performance measure reports evidential validity and defensibility, supporting non-compliance with federal regulations when DHI has recommended a remedy or sanction. These reports are used for CMS citation reviews as well as nursing home requests for cited Informal Dispute Resolution (IDR) of deficiencies. IDRs can be requested when no remedy/sanction has been imposed.
Numerator: Number of Citations validated.
Denominator: Number of citations under review (date of CMS review/IDR).

DATA SOURCE/METHODOLOGY:
Data Source: HTTPS://HFLCShared (\\dhirndcolm002)(H:)\NHquality (Quality Indicator)

STORY BEHIND THE DATA:
Writing valid and defensible citations is critical to the survey process. This includes the evidence to support non-compliance with federal regulations when DHI has recommended a remedy or sanction, which triggers a review of the citation by CMS or when a nursing home requests an Informal Dispute Resolution (IDR) of deficiencies cited. The measure is a useful quality improvement tool for writing of citations that are thus supportable when challenged.

IMPROVEMENT ACTION PLAN:

Major Quarterly Action Steps:	Goal Completion Date				
	Q1	Q2	Q3	Q4	Target
1) Utilize the Crystal Report to more quickly see intervention outcomes	n/a				90%
2) Increase valid and defensible written citations					

PROGRAM #7: Medical Cannabis Program (MCP)

Program Description and Purpose:
The Medical Cannabis Program (MCP) was created in 2007 under the Lynn and Erin Compassionate Use Act (the Act). The purpose of this Act is to allow the beneficial use of medical cannabis in a regulated system for alleviating symptoms caused by debilitating medical conditions. The Program enables the provision of compassionate care for people that have certain illnesses who prefer to use cannabis to alleviate symptoms related to their diagnosis. The Program serves New Mexicans with qualifying medical conditions diagnosed by a health care provider. There are currently 28 qualifying medical conditions.

Program Budget (in thousands):

FY19	General Fund	Other State Funds	Federal Funds	Other Transfers	TOTAL	FTE
200				$1,949,700.00	$1,949,700.00	28
300				$793,500.00	$793,500.00	
400				$586,800.00	$586,800.00	
TOTAL				$3,330,000.00	$3,330,000.00	

FY20	General Fund	Other State Funds	Federal Funds	Other Transfers	TOTAL	FTE
200				$1,747,200.00	$1,747,200.00	28
300				$503,500.00	$503,500.00	
400				$973,200.00	$973,200.00	
TOTAL				$3,223,900.00	$3,223,900.00	

Program Performance Measures:

Program Objective 1: Allow the beneficial use of medical cannabis to New Mexicans

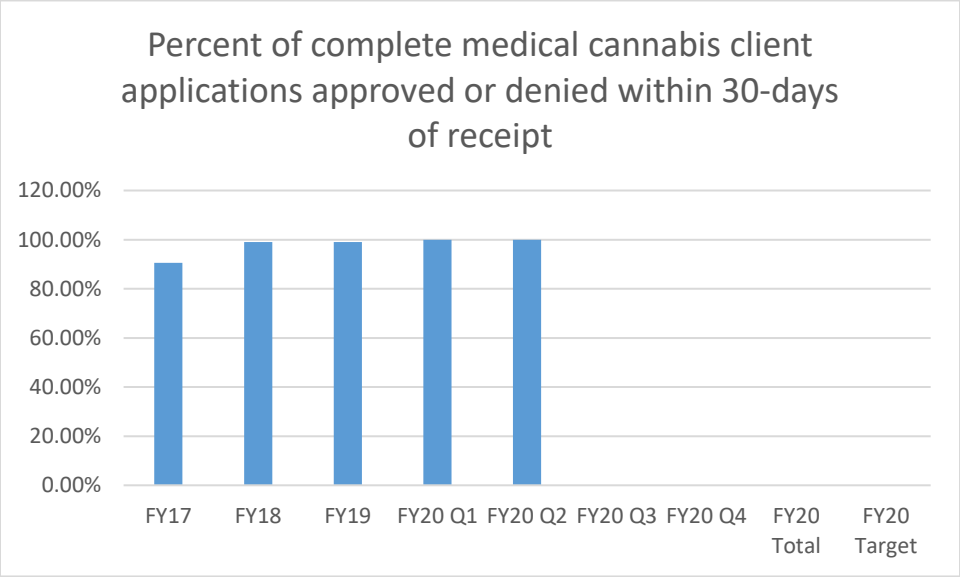
1. Percent of complete medical cannabis client applications approved or denied within thirty calendar days of receipt
2. Percent of registry identification cards issued within 5 business days of application approval

MCP PERFORMANCE MEASURE #1

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

Results

FY17	FY18	FY19	FY20 Q1	FY20 Q2	FY20 Q3	FY20 Q4	FY20 Total	FY20 Target
90.50%	99.00%	99.00%	99.96%	100%				≥99%



MEASURE DESCRIPTION:
Percent of complete Medical Cannabis client applications approved or denied within 30 calendar days of receipt.

DATA SOURCE/METHODOLOGY:
The data is obtained through the electronic records system used by the Medical Cannabis Program - Bio-Track. This program allows the gathering of data based on date completed application is received by the program, entry date, approval date, and card print date.

STORY BEHIND THE DATA:
Processing applications in a timely manner helps ensure medical cannabis patients have safe access to safe medicine and protections offered under the Lynn and Erin Compassionate Use Act. In FY19-Q4, 99 percent of completed patient applications were processed in 30-days.

IMPROVEMENT ACTION PLAN:

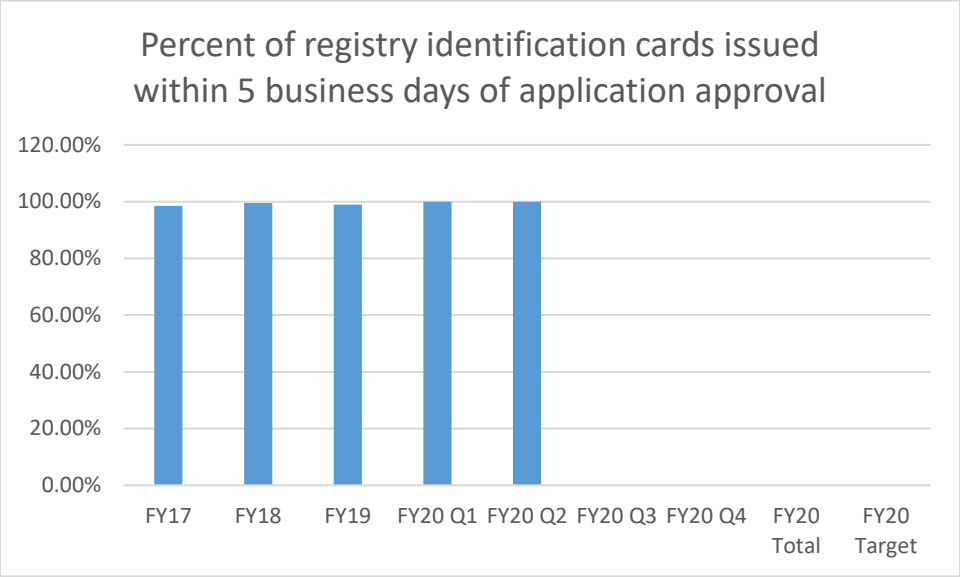
Major Quarterly Action Steps:	Goal Completion Date				
	Q1	Q2	Q3	Q4	Target
1) Streamline patient applications by making forms clearer and easier to read					**Q4**
2) Implement operational changes	X	X			
3) Revise letters for deficient applications					**Q4**
4) Review, change and/or upgrade existing software systems for electronic application submissions					**Q4**

MCP PERFORMANCE MEASURE #2

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

Results

FY17	FY18	FY19	FY20 Q1	FY20 Q2	FY20 Q3	FY20 Q4	FY20 Total	FY20 Target
98.50%	99.50%	99%	99.98	99.98				≥95%



MEASURE DESCRIPTION:
This measure provides the percentage of Medical Cannabis Program Patient Registry Identification cards, which have been issued within five business days of the approval of a completed application to the program.

DATA SOURCE/METHODOLOGY:
The data is obtained through the electronic records system used by the Medical Cannabis Program - Bio-Track. This program allows the gathering of data based on date completed application is received by the program, entry date, approval date, and card print date.

STORY BEHIND THE DATA:
Mailing patient registry ID cards in a timely manner helps ensure medical cannabis patients have access to safe medicine and protections offered under the Lynn and Erin Compassionate Use Act. In FY19-Q4, the Medical Cannabis Program exceeded its target by printing and mailing 99 percent of patient registry ID cards within 5-days of application approval.

IMPROVEMENT ACTION PLAN:

Major Quarterly Action Steps:	Goal Completion Date				
	Q1	Q2	Q3	Q4	Target
1) Streamline patient applications by making forms clearer and easier to read					Q4
2) Implement operational changes	X	X			
3) Revise letters for deficient applications					Q4
4) Review, change and/or upgrade existing software systems for electronic application submissions					Q4