Strategic Plan
Fiscal Year 2014

State of New Mexico
Susana Martinez, Governor

New Mexico Department of Health
Catherine D. Torres, MD, Cabinet Secretary

September 1, 2012
Vision
A healthy state of mind!

Mission
Provide leadership to guide public health and to protect the health of all New Mexicans.

New Mexico Department of Health Guiding Principles
The Department of Health will succeed in its mission by committing to and practicing these guiding principles every day:

- We will continue to build trust with our community leaders, constituents, and each other by holding ourselves accountable for our actions and decisions.
- We will continue to honor the contribution of each of our employees and to communicate effectively throughout the Department to better serve our constituents.
- We will continue to be mindful that our work is intended to improve the lives of New Mexicans and the health of all communities.

Integrity  Compassion  Respect
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Appendices: Required Reports

A. FY12 Final Quarterly Performance Report

B. PBB FY12 End of Year Performance Report

   Performance Measure Summary

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D. LFC Performance Audit Update - Public Health Division

   LFC Public Health Audit Matrix
The Department of Health is focused on being accountable to the people of New Mexico. As you look over the strategic plan for state fiscal year 2014, you will see from the content that we are emphasizing health promotion and health protection. We are also aligning our work to eliminate health disparities.

The foundation for this new perspective is Public Health Accreditation, my Centennial initiative. By becoming accredited, the department will demonstrate our commitment to improve and protect the public’s health. Accreditation will drive the Department of Health to strengthen the quality of services we deliver to the community. We will demonstrate that this agency has the capacity to meet and sustain each of the 32 public health standards that are aligned with public health essential services, business practices, and governance. I invite you to learn more by visiting the Public Health Accreditation Board website at phaboard.org.

The work toward accreditation will help us prepare for the transformation of our services to meet the challenges of health system reform. The Affordable Care Act offers our agency an opportunity to work with federal, state, local and tribal partners to improve health status. We are focusing on assessing local health systems, assisting with plans to integrate preventive health into the health care delivery system, ensure population health improvement, and promote health equity for all New Mexicans.

Our partnerships with our tribal sovereign nations and rural and urban communities are vital in our efforts to eliminate disparities. We will continue to host preventive health weeks around the state to address health disparities as well as One World One Health concept. Recently, Governor Susana Martinez has selected the department’s Healthy Kids 5 - 2 - 1 - O Challenge as one of her Centennial priorities. We want to create excitement for good health practices in individuals, families, schools, and in the workplace.

Be Healthy!

Catherine D. Torres, MD
It is important to frame the surrounding influences on public health. By identifying and anticipating the factors that individuals, families, communities, public and private organizations, and the Department of Health are facing, we are better able to effectively prepare for a changing health system.

**HEALTH DISPARITY**

“Health disparities” was first officially defined as “differences in the incidence, prevalence, mortality and burden of disease and other adverse health conditions that exist among specific population groups in the United States”. Health disparities are relative, and are identified by comparing the health status, access to services and/or health outcomes of population groups. Characteristics such as race/ethnicity, limited English proficiency, disabilities, sexual orientation, economic status and geographic location may affect one’s ability to achieve good health.

Although there have been national efforts to reduce health disparities and achieve health equity during the past two decades (Healthy People 2000, 2010, 2020 and the National Partnership for Action to End Health Disparities), these efforts have been hampered by a lack of consistency in collecting and reporting health data. The Patient Protection and Affordable Care Act passed in 2010 not only addresses access to care, it also addresses the need for improved data to identify significant health differences that often exist between segments of the population. As a result the Office of Minority Health in the United States Department of Health and Human Services has released new minimum data standards for Race and Ethnicity, Sex, Primary Language and Disability Status. Improved data will assist in efforts to target affected populations and monitor efforts to reduce health disparities and move the United States to a status of health equity — “the attainment of the highest level of health for all people”.

**WHO WE ARE**

The concept of health disparities is important for all but is especially relevant for a state such as New Mexico. New Mexico is a minority-majority state with Hispanics and American Indians accounting for over fifty percent of the population. Although the United States is increasingly diverse, Whites who are not Hispanic comprise over sixty percent of the national population compared to forty percent of New Mexico’s population. Although New Mexico has a slightly smaller percentage of foreign-born residents (NM 9.7%, US 12.7%), it has a larger percentage of individuals who speak a language other than English at home (36%) than is true nationally (20.1%). New Mexico has a lower unemployment rate than the nation (NM 6.5%, U.S. 8.2%), higher rates of individuals without health insurance (NM 21%, US 16%), and higher rates of individuals living below 100% of poverty (NM 23.8%, US 20.2%).
In summary:

- 6 of 10 New Mexicans belong to racial/ethnic minorities.
- 36 of 100 speak a language other than English at home.
- 1 of 5 are without health insurance, and
- 24 of 100 live below the poverty level.

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

**ACCESS**
The National Healthcare Disparities Report identifies American Indians/Alaska Natives, Hispanics and people with low incomes as experiencing disparities in access to care. As the above data demonstrate, a substantial proportion of New Mexicans fall into these categories. In addition, New Mexico has the fifth largest land area among the fifty states but contains only four cities with populations of 50,000 or more. Thirty-two of New Mexico’s thirty-three counties contain health professional shortage areas. Over forty percent of the state’s population is estimated to live in a Primary Care Health Professional Shortage Area.

**EDUCATION**
Education influences health. Forty-seven percent (47%) of 4th graders were reading below basic achievement levels in 2011. In 2010, 67% graduated from high school. In 2010, it was estimated that 16% of school children were living in crowded housing and 12% were being cared for by grandparents living in poverty.

New Mexico continues to have the 2nd highest rate of teen births in the nation at 46.2 births per 1,000 females ages 15-19 years; and, the 2010 death rate for teens 15-19 years is 70.8 per 100,000 compared to 53 per 100,000 in the US in 2009. These data are staggering and represents the many challenges to good health faced by a large number of young people in this state.
**EMERGING THREATS**

There are a number of threats to public health on the horizon for New Mexico, particularly those due to the aging of the population, chronic disease and emerging infectious diseases.

The aging of the population increases the likelihood of falls, Alzheimer’s Disease and health-care associated infection. In New Mexico the aging of the population along with the increased availability of opioid painkillers, which a greater percentage of elderly use than any other age group, may lead to increases in falls deaths in this population. Increases in the percentage of our population with Alzheimer’s and in institutional care will provide significant challenges for society.

Synergistic with the aging of the population, obesity leads to increased chronic disease rates. Both obesity and morbid obesity, typically 100 pounds or more overweight, have markedly increased with morbid obesity in NM doubling over the last decade. More obesity contributes to more diabetes and more arthritis.

Because infectious diseases can become more common over time, it is important to conduct surveillance for current vectors of human disease and those that may emerge in the future. For example, mosquito surveillance currently provides information about the seasonal threat of West Nile virus infection in New Mexicans and the potential future threats of Dengue Fever and Rift Valley Fever. Through rabies surveillance of wild animals we have tracked the emergence of rabies among the fox population of southwestern NM and increases in rabies cases among the skunk population of the Carlsbad area. The growing feral hog population in NM has tested positive for leptospirosis, swine brucellosis and other diseases. Furthermore, a new influenza virus, H3N2v, has emerged from swine in the Midwest and has infected people in close contact with them. This new virus is being tracked to see if it arrives in NM and to assure that it does not easily spread from person to person.

**WORKFORCE**

The Bureau of Labor Statistics reported that job growth in the healthcare sector is outpacing other industries and accounts for 1 out of every 5 new jobs created in 2012. Employment in healthcare-related occupations is expected to continue to grow. However shortages in the healthcare workforce are expected to be driven by two competing factors: increased demand and insufficient supply.

One factor that places demands on the workforce is growth in the population over the age of 65 years with its increased need for medical care. Another factor is the effect of the Patient Protection and Affordable Care Act in increasing access to medical care.

According to the American Association of Colleges of Nursing the shortage of registered nurses is expected to intensify because nursing school enrollment is not growing fast enough. Nursing schools are turning away qualified applicants due to shortages in faculty, clinical sites, classroom space and clinical preceptors.

The aging of the population increases the demand for medical care, it also affects the supply of health care professionals. Particularly affected are the nursing and primary care fields with the average age of nurses increasing to the mid-forties and more than a quarter of primary care physicians near retirement.
In addition the health workforce is not equitably distributed. Rural areas are even more likely than urban areas to face a health care workforce shortage. In addition to the aging of primary care physician and nurse populations, the Rural Assistance Center cites the lack of educational and training opportunities, lack of opportunities for career advancement, financial concerns and an increased workload as contributing to workforce shortages in rural areas. In New Mexico only Los Alamos County does not contain a health professional shortage area.
WHY IS PUBLIC HEALTH ACCREDITATION A PRIORITY FOR THE DEPARTMENT OF HEALTH?

Accreditation is a voluntary, national program overseen by the Public Health Accreditation Board, an independent oversight body. The goal of the national public health accreditation program is to improve and protect the health of the public by advancing the quality and performance of all health departments in the country – state, local, territorial and tribal. By accomplishing accreditation, it’s delivery of public health core functions will be evaluated according to a set of national standards and measures. The Department of Health’s (DOH) efforts to attain Public Health Accreditation (Accreditation) are in full swing. We believe that accreditation will create a culture of continuous quality improvement of the essential services we provide to the people of New Mexico.

The Department of Health must demonstrate compliance with a set of standards and measures aligned with the well established ten (10) essential public health services, which are also Accreditation Domains 1-10:

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Accreditation includes two additional Domains: 11. Administrative and Management Capacity and 12. Governance. The Department submitted an Accreditation Statement of Intent to apply in May of this year and intends on submitting the application by early 2013. The Accreditation application consists of several requirements, including submission of a letter of support from Governor Susana Martinez and 3 documents:

- State Health Assessment
- State Health Improvement Plan
- Department Strategic Plan with Quality Improvement Plan

Accreditation standards emphasize the use of evidence-based/promising practices and evaluation of health improvement interventions by Department programs, their contractors, and partners when determining health improvement strategies.

Public Health Accreditation is relevant to the majority of DOH organizational units (divisions and offices). The Department’s Health Facilities are not directly affected because the standards that they rely on align with The Joint Commission. However, they will have the opportunity to benefit from the performance improvement system.

Accreditation activities are coordinated by the Office of Policy and Accountability (OPA). The Office convenes the Public Health Accreditation Leadership Team comprised of the Department’s senior managers. This team ensures that program staff remain on track for accomplishing the Accreditation process goals and timelines. Goals and timelines are included in a project plan for managing the completion of the final health assessment and plans and the collection of documentation to demonstrate the Department’s ability to comply with the Accreditation standards.
A key element of Accreditation relates to the Department’s investment in a Quality Improvement and Performance Improvement culture (Domain 9: Evaluate health services). DOH has selected Results-Based Accountability (RBA) as its key framework for achieving these standards. Over 50 Department employees and partners have been trained as RBA coaches and are currently applying this method in their programs. This evaluation and continuous improvement method is being applied to internal business processes, for planning and evaluating programs, and to evaluate community health improvement strategies. The Department initiated a series of Turn the Curve on Health events during FY12 to develop a partner-centered approach to population health improvement to compliment its programmatic approach to targeted health improvement. Partner Handshake agreements were collected from individuals and organizations around the State. Their efforts continue to expand these agreements to further health improvement at the local level. The State Health Improvement Plan will reflect these activities with community partners. The results for these combined efforts aim to improve population health in nine (9) priority health areas:

**Child and Adolescent Obesity**
- Diabetes
- Tobacco Use
- Teen Births
- Adult Immunizations (≥ 65 years)

**Oral Health**
- Elderly Falls (≥ 65 years)
- Drug Overdose Deaths
- Alcohol-Related Deaths

Accreditation includes Domain 9, that requires the Department to evaluate preventive health interventions and health services. In order to do that, OPA has acquired the RBA companion scorecard. The Results for People scorecard is a web based dashboard that reflects both community and program activities related to the 9 priority health areas, and health improvement performance at the program level. Results for People will be available for use at the state and local levels to track performance. It will be available to the public by the end of 2012.

The policy and accountability function has a strong epidemiology focus to ensure the use of health data, a core concept of Results-Based Accountability, to guide health improvement activities, quality and performance improvement, program evaluation, and to inform health policy. The Office has a Chief epidemiologist and 2 Epidemiologists. OPA also produces the Health Disparities Report and the American Indian Health Disparities Report, which has resulted in New Mexico being recognized as one of the leading states in the documentation of health disparities.

OPA, in partnership with the Healthy Kids NM Program, established an elementary school BMI surveillance system in New Mexico. OPA’s Chief epidemiologist is responsible for on-going support of the project which includes selecting the statewide sample, providing data analysis and reporting functions. The Office has also consulted on program evaluation and on population sampling.

The Office will also continue to focus on health policy (Domain 5) by coordinating legislative activities under the direction of the Cabinet Secretary of Health. This role includes the development of performance measures, coordination of program policy recommendations to the Secretary, legislative bill analysis, and various other duties.

The Federal Centers for Disease Control and Prevention awarded a 5-year cooperative agreement to the Department to strengthen public health infrastructure. Public Health Accreditation is a top priority for the National Public Health Improvement Initiative grant.
TRANSFORMING THE PUBLIC HEALTH SYSTEM

The Affordable Care Act will effect public health arena. Secretary Torres is creating a working group to oversee the transformation of the public health system in New Mexico in order to better provide the 10 essential public health services and effectively address health inequities.

We recognize that health promotion staff are key to improving health throughout our state. In some regions there are very few of these health professionals. The Public Health Division is working to create 11 new health promotion positions to be placed throughout the state. These individuals will increase our ability to improve health outcomes in collaboration with our community partners.

AFFORDABLE CARE ACT

This is an unprecedented period of change and opportunity for the Department of Health and it’s many partners. The Affordable Care Act (ACA) requires us to address an evolving health system:

☆ A need to create integrated approaches to prevention, primary care, and overall health to be more efficient and effective;

☆ Health challenges are increasingly related to chronic disease and require a greater focus on systems, policies, and program changes that will reduce the prevalence of chronic diseases;

☆ Increased recognition that place matters! Where people live, learn, work, and play can be as important to health outcomes as medical interventions. This means that public health is working with diverse partners to improve access to healthy foods and walkable communities as priority public health interventions; and,

☆ Health information technology presents new opportunities for understanding and improving the public’s health.
The Responsibility of Leadership
In December of 2011, Dr. Catherine Torres welcomed over 100 state health leaders and asked for their help to improve health outcomes in 9 areas (page 12). Participants selected the indicator they wanted to focus on for that day. Each group engaged in a Results-Based Accountability (RBA) process that started with the presentation of a data baseline for each of the health indicators. They contributed to the story behind the data and identified partners who would be important in any effort to improve on health status. Each group then examined the strategies that work to improve health in each of the 9 areas and identified actions they could contribute to improve health in their health area of choice. This process was repeated during the months of April and May, 2012 in 5 regional events.

In the regional events, participants were asked to join the Department in a Partnership Handshake that represented a health improvement contribution. The Department signed on to provide support and technical assistance while each partner selected a strategy from a list of evidence-based and promising practices to contribute to the collective health improvement effort.

The Department gathered handshakes from multiple partners in each region and is developing a process to ensure that the State Health Improvement Plan is action oriented with follow through by both partners. The State Health Improvement Plan is a required submission for the Public Health Accreditation Application. Handshake agreements will be included in the Results for People Scorecard, a web based performance tracking system.

Program Accountability
Department of Health programs are using the RBA process to determine interventions and to evaluate whether or not anyone is better off because of their health improvement efforts. The development of performance measures takes on new meaning when accountability is involved. The following section includes information at the population and performance accountability levels, including strategies applied by DOH programs. The first objective provides a foundation for all public health essential services - Public Health Accreditation.

Infrastructure Objective
Achieve Public Health Accreditation for the New Mexico Department of Health and the People We Serve

Strategies
- Submit a successful Public Health Accreditation application to the national accreditation board.
- Submit complete documentation in support of Public Health Accreditation standards.
- Successfully complete the site visit review in support of a Public Health Accreditation award.
A FOCUS ON HEALTH ISSUES

New Mexico’s Turn the Curve on Health Priorities

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

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

WHAT DOES TURN THE CURVE MEAN?

Public Health Accreditation requires the Department of Health to establish a culture of performance and quality improvement (PI/QI). The Department examined several different PI/QI models and selected Results-Based Accountability to improve both population health efforts and program performance. In a nutshell:

Population Accountability: Is working together with a variety of partners to accomplish a result or outcome that improves a condition of well-being for children, adolescents, families, or communities in a geographic area.
Performance Accountability: A measure of how well a program, agency or service system is working:
☆ How much did we do?
☆ How well did we do it?
☆ Is anyone better off?

Turn the Curve means moving the data in the right direction!
Healthy Eating/Active Lifestyles (Child and Adolescent Obesity)

**Result:** Healthy Children, Youth, and Adults

- Obesity is a growing problem and occurs at very young ages. In 2011, 15% of kindergarten and 22% of third grade students were obese.
- American Indians have the highest rate of obesity among all age groups in New Mexico. By third grade one in two American Indian students are obese or overweight.
- Obese children are more likely to be obese adults and suffer from heart disease and diabetes.
- Healthy eating and active living are two lifestyle choices that can prevent obesity but social and environmental factors make it difficult for many to eat healthy or be physically active.
- Kids no longer want to play outside. Rather they want to sit and play video games or watch TV.
- Increased access to inexpensive high fat, high calorie and high sodium foods make healthy eating more difficult.

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Story Behind the Data

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

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**What Works**

- Provide technical assistance and training to NM licensed and registered childcare centers and homes to support healthy eating.
- Provide technical assistance and training to schools and school districts to support walking school buses and safe routes to school.
- Provide technical assistance and training to schools and school districts to support safe, active and welcoming outdoor school space for community use.
- Provide technical assistance and training to schools and school districts to support the purchase of locally grown food for school meals.
- Provide technical assistance and training to rural and frontier communities to support increased access to an affordable and healthy food supply.

**New Mexico Children’s Cabinet Strategies**

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

- Federally Qualified Health Centers
- NM Primary Care Association
- Diabetes Self-Management Education (DSME) programs
- NM Hospitals
- Tribal and community diabetes programs
- Physical activity and nutrition organizations
- Zia Association of Diabetes Educators
- American Heart Association
- NM Medical Review Association

**What Works**

- Intensive management of diabetes and co-morbid conditions by hospital, primary care staff and by individuals and their families through improving glycemic control, provider monitoring of A1c (average blood glucose control for the past 2 to 3 months) and diabetic retinopathy screening.
- Diabetes self-management education in community gathering places for adults in the home for adolescents.
- Case management.
- Lifestyle change programs for people at high risk for type 2 diabetes.

**Program Strategies**

- Support health care organizations to assess and implement practice changes to improve quality of care for people with and at risk for diabetes through use of the Planned Care Model and/or Patient Centered Medical Home and supported by provider education.
- Produce consistent guidelines to interpreting glucose levels, developing treatment plans and providing patient education including the use of group education.
- Expand My CD peer training to improve self-management of diabetes.

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**Result:**
**Healthy Children, Youth, and Adults**

**Story Behind the Data**

- Hospitalization represents the most severe cases of disease and indicates that the disease is **not well-controlled.**
- Lack of **follow-up** on A1c results or the importance of monitoring A1c.
- Language and cultural **barriers exist** between patients and providers.
- Patient denial or fear can lead to non-compliance with medication and treatment plan and poor eating habits because of a **lack of knowledge** on adapting cultural/traditional foods.
- **Lack of resources** affects both access to care and ability to make lifestyle changes.
- **Inadequate links** between healthcare providers and between providers and community programs affect care.
Tobacco

Partners

Local, regional, and statewide TUPAC-funded grantees, including media, 1-800-QUIT NOW, and evaluation services providers
NMHSD (Office of Substance Abuse Prevention, Synar Program);
Public Education Department Navajo Nation

American Cancer Society—Cancer Action Network;
American Lung Association

What Works

• Regulating the time, place, and manner in which tobacco can be advertised and sold in order to prevent youth from initiating tobacco use.
• Supporting the development of policies to protect all New Mexicans from secondhand smoke exposure, including locations not covered by Dee Johnson Clean Indoor Air Act.
• Screening all patients in healthcare settings for tobacco use and providing brief interventions or referrals to 1-800-QUIT NOW and www.quitnownm.com.
• Promoting non-smoking policies for multi-housing units.
• Promote a new tobacco cessation media campaign called, “THRIVE” that carries an inspiring message that the world is a more beautiful place without tobacco. The ad encourages tobacco users to

“QUIT NOW and Thrive.”

Program Strategies

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

Result:
Healthy Children, Youth, and Adults

Story Behind the Data

• Despite decreases in overall adult smoking in NM, rates are still significantly higher among adults who have lower education, lower income, are unemployed, or uninsured.
• Smoking initiation begins in middle and high schools. Especially high smoking rates are seen among youth with poor academic grades, American Indian youth, and youth experiencing food insecurity.
• About 92% of New Mexicans are protected from secondhand smoke exposure by the 2007 Dee Johnson Clean Indoor Air Act.
• Access to services, exposure to media messages, and cultural differences related to use of tobacco may vary in rural compared to urban areas.
Story Behind the Data

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

Poverty is a cause as well as a consequence of early childbearing.

- Hispanics have the highest rate among all populations in NM accounting for 69% of all births to teen girls age 15-17.
- Sexually active Hispanic teens are less likely to use contraception than other teens.
- Many NM teens do not have immediate access to family planning or birth control services. Barriers include socioeconomic status, clinic location and transportation. Services at community clinics are often not available at teen friendly hours, e.g. after-school.
- Increased awareness and accountability for a male’s role in birth control and teen pregnancy is needed.
- Parents often find it difficult to talk with teens about sensitive issues such as sex and reproductive health.
- There is a lack of support services and systems for youth such as prevention services and early intervention to prevent unintended and unplanned pregnancies.

What Works

Evidence-Based Interventions:
- Confidential Clinical Services including School Based Health Centers.
- Service Learning Programs/Youth Development (All4You, Teen Outreach Program, CAS-Carrera).
- Comprehensive Sex Education Programs (Cuídate!, Draw the Line/Respect the Line, Making a Difference, Making Proud Choices, Safer Choices).
- Male Involvement Programs (Reproductive Health Counseling for Young Men).

Promising Practices include:
- Male Involvement Programs (Wise Guys Male Responsibility Curriculum).
- Adult-Teen Communication Programs (Plain Talk, Raíces y Alas).
- Natural Helpers and Teens Listening to Teens (Peer-to-peer leadership).
- Peer group education.
- Early Childhood intervention programs.
- Mentorship Program for Males and Females.
- Community Health Workers.

Program Strategies

- Provide clinical services that accommodate teens by means of accessible locations (e.g. SBHCs) and clinical practices (e.g. providing teen-friendly methods including long-acting reversible contraceptives (LARC).
- Provide opportunities for community education programs with service learning and adult-teen communication.
Adult Immunization

**Partners**

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<td>Senior/community centers</td>
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**What Works**

- Expanded access in health care settings.
- Reduced client out-of-pocket costs.
- Standing orders, provider reminder systems, assessment and feedback in provider settings.
- Patient reminder systems and education.
- Mass and small media, educational activities for both consumers and health care providers.
- Outreach beyond the traditional health care settings.

**Program Strategies**

- Collaborate with community organizations and local/regional health partners to increase the number of access points for adults seeking immunizations.
- Assist WIC in developing educational and informational materials in order to increase awareness among adults about vaccines and immunization services.
- Increase advocacy in the community through education of providers (i.e., healthcare providers, WIC staff) by developing and preparing an educational “sound-byte” to be used during patient encounters.
- Outreach through bilingual media campaign.

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**Result:**

Healthy Adults

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**Story Behind the Data**

**Influenza and Pneumonia**

- Over 200,000 influenza hospitalizations and **40,000 cases** of invasive pneumonia occur each year nationally.
- Nearly 3,000 hospitalizations for pneumonia and influenza occur among individuals age **65 and older** in New Mexico annually.
- Influenza and pneumonia account for approximately **300 deaths per year** in New Mexico and over 70% of these deaths occur to individuals age 65 and older.
- Medicare **covers the cost** of an annual influenza vaccination.
- One pneumonia vaccination at age 65 generally provides coverage for a **lifetime** and Medicare covers the cost.
- **Pertussis (Whooping Cough)** is on the increase in New Mexico and in the U.S. and poses a serious threat to young children. Therefore, adults of any age in close contact with an infant should be vaccinated.

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**A MI ABUELITO VA LO VACUNARON CONTRA LA NEUMONÍA Y LA GRIPA ...Y AL SUYO?**
Oral Health

Result: Healthy Children, Youth, and Adults

- Hispanics and Native Americans have higher rates of tooth decay among all populations in New Mexico experiencing tooth decay.
- Hispanic and American Indian adults are less likely than Whites to have a dental visit within the last year.
- Less than half of adults with an annual income below $15,000 have had a dental visit within the last year.
- 18.5% of those aged 65+ had their teeth extracted in 2010.
- 67.2% of adults saw a dentist in 2010.
- 21% of New Mexicans did not have health insurance in 2010.
- NM ranks 49th in the dentist shortage crisis in the US in 2011.
- Union and Harding Counties do not have a dentist in residence in 2012.
- 77% of New Mexico water systems are fluoridated.

Story Behind the Data

Partners

- UNM medical school
- Hygienist Training Programs
- Community Health Workers – dental case management
- Nursing Home Association
- NM Veteran Association
- Dental insurance companies
- NM Dental Association
- Local Dental Societies
- NM Medical Association
- NM Senior Olympics
- NM Long Term Care Association
- NM Dental Hygiene Association
- NM Hospital Association
- Community College Association
- Dept. of Long Term Care and Aging
- NM AARP
- Tribal Government

What Works

- Connecting primary care with dental care.
- Increasing the number of Medicaid dental providers.
- Promotion of fluoridated water consumption.
- Increasing the number of Medicaid provider providing preventive services.
- Increasing the number of Medicaid providers serving adults.
- Increasing the number of Medicaid dental clients.

Program Strategies

- Develop a culturally appropriate and bilingual prevention campaign that targets adults
- Develop and implement a NM Oral Health Surveillance System.
- Increase access to oral health care for those living in LTC facilities, nursing homes, and seniors overall.
- Develop and implement an Oral Health Strategic Plan.
**Elderly Falls (65 Years and Older)**

**Partners**
- Indian Health Services
- Native American communities
- Hospitals
- Universities/Colleges
- Healthy Aging Collaborative
- Triple Area Agencies on Aging and Senior Centers
- Geriatric Education Center
- Native American Communities
- Healthy Aging Collaborative
- Geriatric Education Center

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

**Program Strategies**
- Reduce adult falls and associated injury rates by increasing the number of instructors for, and participation in, Tai Chi: Moving for Better Balance classes.
- Raise awareness of the risk of elderly falls.

**Story Behind the Data**
- In NM, falls are the leading cause of injury-related death and hospitalizations among adults 65 years and older.
- NM had the second-highest fall-related death rate among states in 2008.
- NM’s fall-related death rate was 2.3 times higher than the national rate in 2008.
- NM’s fall-related death rate among people 65+ years of age and over increased 115% from 1999 to 2008, and decreased 22% from 2008-2010.
- Over 2,100 unintentional fall-related hospitalizations occurred among adults 65+ in 2009.

**Result:**
Healthy Elders
Drug Overdose Deaths

Result: Healthy Children, Youth, and Adults

Story Behind the Data
- In 2009, New Mexico had the highest drug overdose death rate in the nation.
- The consequences of drug use continue to burden New Mexico communities.
- Drug use can result in overdose death and is also associated with other societal problems including crime, violence, homelessness, loss of productivity and spread of blood-borne disease.
- Unintentional overdose, or poisoning, accounts for 80-85% of drug-induced deaths in New Mexico.
- High rates among Hispanic males drive the overall high state rates.
- A primary risk factor is excessive prescription drug misuse.
- Poisoning from drug overdoses has surpassed motor vehicle deaths as the major cause of unintentional injury in New Mexico.

What Works
- Screening by health care providers for those with potential drug-related problems.
- Increasing access to behavioral health care and treatment, including school-based health centers.
- Increasing accessibility to medication-assisted therapy, such as methadone or Suboxone.

Promising practices include:
- Support of the Good Samaritan Law.
- Promulgating clinical opioid prescribing guidelines for pain treatment.
- Tracking drug data and overdoses in New Mexico to identify issues related to prescription drugs.
- Implementing comprehensive harm reduction policies and practices statewide, targeting prescription pain medication use/misuse and illicit drug use, including expanded access to overdose rescue medication for both at-risk populations.

Program Strategies
- Encourage and provide support for the establishment of community-based prescription opioid drug overdose prevention initiatives.
- Make naloxone (narcan, which reverses the effects of narcotic overdose) and associated overdose rescue training available to reduce overdose death associated with prescription opioid misuse.
- Implement a community-based prevention pilot project in response to prescription drug misuse and overdose in Taos, Santa Fe, Truth or Consequences, Roswell, and Gallup modeled after Project Lazarus, an evidence-based strategy.
Alcohol Related Deaths

Partners

NMHSD (Office of Substance Abuse Prevention), NMDOT, NMDF, NMRLD, NMPS
PIRE/Behavioral Health Research Center of the Southwest
Community Coalitions: Partnership for Community Action; Santa Fe Underage

Drinking Prevention Alliance; Local government agencies
New Mexico Association of Counties and Local DWI Programs
UNM: Prevention Research Center; Center for Health Policy; Center on Alcoholism, Substance Abuse, and Addictions

What Works

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

Program Strategies

- Conduct alcohol-misuse screening and brief interventions (SBI) in clinical settings to reduce excessive alcohol consumption, alcohol dependence and abuse, and alcohol-related injury and chronic disease.
- Promote regulation of the physical availability of alcoholic beverages (e.g., enhanced enforcement of on-premise laws; increase server liability and social host liability) to reduce excessive alcohol consumption and prevent alcohol-related injury and chronic disease.
- Promote comprehensive drinking/driving countermeasures (e.g., DWI law enforcement in the form of sobriety checkpoints, accompanied by a public awareness campaign).

Result: Healthy Children Youth and Adults

- New Mexico had the highest alcohol-related (AR) death rate in the nation from 2001 through 2007 (most recent year other state rates available).
- From 2001-2008, NM’s alcohol-related chronic disease death rate was 1.8 to 2.2 times the US rate; the US rate declined 4%, but NM’s rate increased 1%.
- From 2001-2008, NM’s alcohol-related injury death rate was 1.7 times the US rate; and increased by 21% while the US rate increased 14%.
- Male alcohol-related death rates are > 2x female rates.
- More than 75% of alcohol-related deaths in NM occur before age 65.
- High rates among American Indian males and females and Hispanic males drive the overall high state rates.
- Excessive alcohol consumption (binge and heavy drinking) is primary risk factor.
Laboratory Services

Objective
Ensure the provision of quality laboratory practices by private sector analytical laboratories

Strategy
- Conduct certification inspections of private water, dairy and DWI testing laboratories in NM on behalf of the state regulatory authorities: NM Environment Department, NM Agriculture Department, and NM Department of Health, respectively.

Objective
Provide accessibility to specialty analytic services to the private sector health providers to support patient care

Strategy
- Offer accredited reference laboratory services for NM notifiable and emerging disease threats.

Objective
Improve the speed of tuberculosis diagnosis in NM

Strategy
- Develop and implement a PCR method for rapid diagnosis of tuberculosis within SLD (it is currently sent out of state).
**Public Health**

**Objective**
Develop and implement an assessment process to determine clinical service gaps in a community

**Strategies**
- Provide training to Public Health staff on how to conduct the assessment process in local communities.
- Incorporate the results of the clinical service gap assessment into decision-making about the role of Public Health as a safety-net provider.
- Work with partners to assure that clinical service gaps are filled.

---

**Epidemiology & Response**

**Objective**
Identify ongoing processes to improve Emergency Medical Systems and Trauma Care in New Mexico

**Strategies**
- Develop a plan to improve EMS Response through better use and sharing of local resources through regionalization of independent response agencies statewide.
- Utilize EMS examinations through the National Registry of EMT's, to assure that the national EMS education standards are met.
- Acquire 100% of EMS pre-hospital run data to evaluate training and administrative needs for emergency medical systems needs.
- Increase the percent of emergency department and intensive care unit licensed medical staff at developing and existing trauma centers who have received training in traumatic injury care.

---

**Objective**
Lead an evidence-based prevention initiative to reduce Clostridium Difficile Infections (CDI) in San Juan County. CDI is a health-care associated infection remaining at historically high levels

**Strategies**
- Recruit a minimum of one acute care hospital, one clinical diagnostic laboratory, one long term care facility, and one community provider to participate in all components of the regional initiative.
- Establish a baseline of CDI for future comparisons.
- Develop a written standardized *Clostridium Difficile* laboratory protocol that is adopted by a minimum of one clinical diagnostic laboratory.
- Facilitate standardized patient transfer communication tools and improved transfer processes to be adopted by a minimum of one acute care hospital, one long term care facility, and one community provider.
- Provide training on National Healthcare Safety Network (NHSN) CDI surveillance protocols and CDI prevention measures and monitor the quantity and quality of the trainings.
Objective
Through the New Mexico Department of Health Morbidity Surveillance Program provide information on the quality of care offered by healthcare providers in the state

Strategies
- Produce an annual report identifying patterns of care for patients with various demographic and clinical characteristics, and examining state-specific trends in hospital and emergency department utilization, access, charges, and outcomes.
- Perform and report on analyses of trends, and create consumer-friendly reports, for the following topics: injury, access to health care, trends and correlations between emergency department use and environmental events, emerging infections, occurrence of non-fatal, preventable illness, and community assessment and planning.
- Include ambulatory care sensitive conditions (conditions for which good outpatient care can potentially prevent the need for hospitalization) in the IBIS Hospital Data Query.
- Pilot test a publicly available website which shares healthcare quality information by quality indicators (such as readmission rates in the last 30 days and/or potentially preventable hospitalizations) to allow for consumer comparisons.
- Participate in national, regional and state publicly available on-line and print quality reporting forums, including the Agency for Healthcare Quality’s (AHRQ) National Healthcare Quality Report (NHQR) and the National Healthcare Disparities Report (NHDR).

Office of General Counsel

Objective
Develop training module for clinical staff on different types of guardianship/agents recognized by New Mexico law and the scope of another person’s authority to consent to treatment on behalf of a patient, client or resident

Strategies
- Review old presentation and handouts and update as necessary to reflect any changes in the law.
- Research training materials available from other agencies online.
- Draft training module.

Objective
Identify policies regarding clinical care (such as peer review or sentinel events) that need implementation or review

Strategies
- Review requests for legal services to identify possible system issues.
- Discuss issues faced by DOH at Office of General Counsel staff meetings.
- Discuss risk management cases to identify possible systems issues.
Objective
Identify laws or regulations that require creation or amendment to better provide services to the citizens of New Mexico

Strategies
- Continue work with the State Tribal Judicial Consortium.
- Continue work Task Force groups formed through legislative memorials or other mechanisms.
- Review requests for legal services to identify possible system issues.

Objective
Conduct timely investigations and produce timely findings on allegations of abuse, neglect and exploitation

Strategies
- Use of the Therap system by investigators to obtain relevant documents for investigations to reduce turn-around time from providers and to expedite examination of evidence.
- Assign investigators to cases across regions throughout the state when caseloads are disproportionate in order to meet investigation timelines.
- Continue collaboration with the Aging and Long Term Services Department, Adult Protective Services Division and Human Services Department, Medical Assistance Division to ensure incidents reports are routed to the responsible agency quickly so they can be triaged and investigated in a timely manner.
- Explore technology options to reduce the amount of time it takes to write investigation reports and process evidence such as speech-recognition software, electronic storage of documents, etc.

Objective
Reduce the number of days from survey exit to the distribution of facility survey results

Strategies
- Explore strategies to improve the efficient implementation of the Centers for Medicare and Medicaid required QIS survey process for nursing facilities and other survey processes, such as, writing relevant findings for a negative response during the Quality Indicator Survey process, completing 2567 reports immediately following the exit and scheduling surveys to allow staff time to write immediately following the exit as much as possible.
- Explore options to improve recruitment of qualified surveyors especially nurse surveyors.
- Continue consistent enforcement of regulations, follow-up on corrective action plans and implementation of sanctions for non-compliance.
**Objective**
Conduct timely reviews of facility building plans for compliance with required standards

**Strategies**
- Consistently enforce regulations and other requirements in plan reviews.
- Schedule at least 3-5 plan reviews per week and create a response letter at the completion of the review.
- Explore strategies to improve communication about required elements of a completed packet with facility architects and administrators to expedite the plan approval process.
- Pursue options to increase the number of Life Safety Code staff in order to further reduce the turnaround time.

---

**Objective**
Reduce the number of days from survey exit to the distribution of community program survey results

**Strategies**
- Continue refinement of the Conditions of Participation for the Developmental Disabilities Waiver based on changes to the Waiver requirements and new Service Standards.
- Continue consistent enforcement of regulations, follow-up on corrective action plans and consideration of sanctions for non-compliance.
- Pursue options to reduce the turnaround time to 10 days or less.

---

**Developmental Disabilities Supports Division**

**Objective**
Fully implement the redesign of the Developmental Disabilities Waiver Program (DDW)

**Strategies**
- Assess all eligible waiver participants 18 years and older using the NM SIS (Supports Intensity Scale) for the purpose of person centered planning and developing individual budgets.
- Transition eligible individuals 18 years and older into the new resource allocation system.
- Implement new rates and service models.

---

**Objective**
Promote the developmental progress of infants and toddlers (birth to age 3) in the Family Infant Toddler (FIT) Program and promote the ability of parents to support their child’s development.

**Strategies**
- Review and revise the current process for measuring the child’s developmental levels when they exit compared to when they entered.
- Develop a quality audit of Individualized Family Service Plans (IFSPs) to promote learning within the daily routines and activities of each child and family.
- Revise online and classroom training for Family Service Coordinators, developmental specialists and other early intervention staff to incorporate changes from the revised FIT regulations, include key principles of effective early intervention and promote the Transdisciplinary Team Approach.
Objective
Increase the percentage of counties participating in the “What Does Public Health Do for You?” program, a public information campaign on public health activities and services

Strategies
- Work with Regions to implement the “What Does Public Health Do for You?”
- Use the program to introduce new names of regions and to report progress on local efforts such as Community Transformation Grant.
- Document the distribution of the products of the “What Does Public Health Do for You?” program.

Epidemiology & Response
Objective
Develop a campaign in New Mexico for public health branding

Strategies
- Identify effective strategies to promote the “public health brand,” potentially including web content on NM-Tracking and NM-IBIS and other DOH websites.
- Research social marketing and other techniques to increase public awareness and perceived benefits/value of public health activities and services.
- Highlight success stories of how public health data and health promotion activities have been used by communities to improve health literacy, behaviors, funding and status.
Objective
Inform the public

Strategies
- Develop and distribute press releases and conduct press conferences to ensure awareness and knowledge about public health threats, community health activities, and DOH program information.
- Collaborate with DOH programs to ensure that all DOH information and health education materials are readable and accessible.
- Coordinate DOH program public information and education efforts to ensure that they have the greatest benefit to the public.
- Coordinate with DOH programs around community health improvement events to ensure that they have the greatest benefit to the public.
- Explore innovative methods of providing information to the public.

Healthy Me
This image by artist Toni Truesdale is one of four she created for posters to be displayed at New Mexico child care centers. Each carries “Healthy Me” messages to “Eat Fruits and Veggies,” “Play Outside,” “Drink Water” and “Move More.” Healthy Kids New Mexico is giving the posters to the Children, Youth and Families Department, which will hand them out at trainings and licensing reviews.
Public Health

Objective
Develop a statewide competency based community health worker training program and associated voluntary certification process

Strategy
- Work with New Mexico Board of Licensing to establish a training program that meets New Mexico legal requirements for certification.

Public Health & Administration

Objective
Maintain the Public Health Learning Collaborative (PHLC) with Department of Health, academic and community partners

Strategies
- Include Department of Health staff members on the PHLC to inform course content and build core public health competencies among the workforce.
- Include faculty and students from the University of New Mexico and New Mexico State University on the PHLC to inform the development of course content and deliver courses statewide.
- Include individuals representing community-based public health efforts on the PHLC to inform course content and deliver to community groups statewide.
**Objective**
Increase public health core competencies for the Department of Health and health system partner workforce


**Strategies**
- Offer free Introduction to Public Health courses statewide.
- Develop a team of Introduction to Public Health course facilitators.
- Build Introduction to Public Health learning opportunities into health conferences and other venues when possible.
- Develop a Public Health Practice I course and offer statewide.
- Develop a Public Health Practice II course and offer statewide.

**Objective**
Increase population and performance accountability competencies among the Department of Health and key partner workforce

**Strategies**
- Provide Results-Based Accountability Training for Trainers and Coaches to Department of Health and health improvement partners.
- Provide coaching to Department of Health programs to ensure Results-Based Accountability application for improvement and performance.
- Develop improved performance measures using Results-Based Accountability method department-wide.

**Administration**

**Objective**
Strengthen the workforce by filling vacancies

**Strategies**
- Use more aggressive recruiting techniques such as strategic media and web advertising.
- Hold quarterly interactive job fairs in strategic locations.

**Objective**
Ensure that all employees and supervisors have received necessary training for their positions

**Strategies**
- Hire a training supervisor to monitor, evaluate, implement, and track training department wide.
- Implement new training tracking software to determine what employees and supervisors have received training, still need training, and what specific training courses are required of each employee or supervisor.
- Assess staff education and training in public health needs.
- Increase the percentage of staff who have formal public health training.
**Epidemiology & Response**

**Objective**
Provide relevant, up-to-date information in engaging and inviting online formats on an annual basis through New Mexico’s Indicator Based Information System (NM-IBIS)

**Strategies**
- Develop a single web portal to give a unified presence and single entry point for both NM-IBIS and NM-Tracking online query and data reporting systems.
- Work with data stewards to obtain data for existing query modules as soon as possible and program the new data within 2 weeks of getting the data.
- Work with DOH programs to maintain, update and enhance online public health indicator reports.
- Continue the successful integration of IBIS and Tracking web-based applications to develop a unified approach to interactive mapping for DOH.

**Objective**
Improve the availability of healthcare information for consumer decisions

**Strategies**
- Facilitate the submission of emergency department data using state of the art healthcare IT techniques.
- Investigate new and upcoming technologies to make healthcare quality information more readily available to healthcare consumers.
- Create capacity and develop a plan to report on emergency department encounter trends.
- Create a system of public reporting of hospital quality indicators readily available for use by the general public.
**Public Health**

**Objective**
Improve the New Mexico Statewide Immunization Information System (NMSIIS)

**Strategies**
- Provide education to VFC providers about the benefits of submitting immunizations electronically to NMSIIS.
- Provide technical assistance to VFC providers that want to begin to submit immunizations electronically to NMSIIS.
- Provide training to Public Health Division staff on correct entry of client and immunization information so that data can be successfully incorporated into NMSIIS.
- Incorporate immunization information from the Billing and Electronic Health Record into NMSIIS.

**Administration**

**Objective**
Improve Information Technology Network Infrastructure

**Strategies**
- Document and assess current resource intensive processes for efficiency.
- Conduct a comprehensive network needs assessment.
- Develop a 5-year network improvement action plan.

**Objective**
Improve Information Technology Processes

**Strategies**
- Establish an information technology steering committee at the senior management level.
- Research and select process management methodology.
- Develop a process improvement action plan for information technology.

**Administration & Facilities**

**Objective**
Improve the efficiency and effectiveness of the electronic health record system for DOH facilities

**Strategies**
- Establish a user group to inform Electronic Health Record system functioning.
- Increase workforce knowledge and skills to improve use of current EHR system.
- Establish and implement an Electronic Health Record system improvement action plan.
**Administration & Epidemiology and Response**

**Objective**
Provide timely information and education to the public

**Strategies**
- Post press releases and other DOH information on the DOH website.
- Collaborate with the Governor’s Office, the Department of Homeland Security and Emergency Management, and other state agencies to ensure the availability of accurate and vital information for the public during health emergencies.

---

**Laboratory Services**

**Objective**
Make all infectious disease laboratory information on humans and animals available electronically to public health partners

**Strategies**
- Expand linkages of analytical instrumentation with Laboratory Information Management System at state public health laboratory.
- Update the mapping of electronic messaging (Health Level-7) of laboratory results to the NM Health Information Collaborative.
- Implement new rapid technologies for characterizing emerging infectious diseases and toxic chemical hazards.
The newly created DOH Office of Financial Accountability (OFA) has been established to ensure that the Department’s finances are administered and managed at the highest possible levels, with a particular emphasis on maintaining and increasing accountability and compliance with financial laws, rules, and regulations.

As a health care organization that expends more than a half-billion dollars annually, the Department of Health expends a significant amount of financial resources in working toward meeting its programmatic goals. As such, DOH is committed to providing the highest levels of fiscal compliance and accountability for its state and federal funding partners and other payers. At the direction of the Cabinet Secretary, OFA will focus on reviewing, evaluating, and reporting on the Department’s finances and their management; identifying areas that need attention and remediation; and overseeing the implementation of revised procedures and processes that correct past deficiencies and inefficiencies and that improve upon processes that have proven effective and efficient in the administration of DOH’s programs.

Cognizant of DOH’s primary mission of improving health by providing effective public health and health care services and ensuring a sound health care delivery system, OFA will work to ensure that all possible steps are taken to increase the amount of services provided for a given amount of financial resources; streamline and minimize red tape while ensuring accountability; leverage services with limited financial resources; maximize revenue for services provided; oversee the application of sanctions for violations of financial requirements; and coordinate corrective actions for identified weaknesses.
Objective
Oversee implementation of corrective actions

Strategies

- Review and resolve audit findings.
- Identify individuals and processes responsible for corrective actions.

Performance Improvement Focus: Reduce repeat audit findings.

Objective
Ensure compliance with financial laws, rules, and regulations

Strategies

- Review status of current and/or updated policies and procedures.
- Identify and update areas needing attention.

Performance Improvement Focus: Reduce number of audit findings.

Objective
Identify areas of significant financial risk

Strategies

- Review revenue and expenditure data for each facility and program area.
- Identify shortfalls, if any, of revenue versus expenditure and reasons.
- Work with fiscal directors to develop a plan to minimize risk and ensure that sufficient revenue is collected to cover all expenses.

Objective
Review and refine policies and procedures to increase financial accountability and minimize financial risk

Strategies

- Identify and review policies covering financial compliance.
- Identify and list known instances of non-compliance and violations.
- Review instances with financial directors in programs and facilities and determine whether policies and procedures are sufficient.
- Identify and implement needed revisions to policies and procedures.

Performance Improvement focus: Revise and strengthen financial policies and procedures.
**Objective**
Reduce waste, fraud, theft, and abuse

**Strategies**
- Review facility and program loss prevention plans and practices.
- Compile and review number and type of instances of loss, including theft, fraud, waste, and abuse.
- Review findings with facility and program finance staff.

Performance Improvement focus: Reduce instances of waste, fraud, or abuse.

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**Administration & Facilities**

**Objective**
Coordinate efforts to maximize third-party revenue

**Strategies**
- Work with facility financial staff to identify current and potential payors and revenue sources.
- Coordinate re-billing efforts.
- Reduce delinquent accounts by implementing improved collection strategies.

Performance Improvement Focus: Increase revenue collected from third-party payors.
DATA SOURCES
www.healthypeople.gov/2020/about/disparitiesAbout.aspx
New Mexico QuickFacts from the US Census Bureau: www.quickfacts.census.gov/qfd/states/35000.html.
www.statehealthfacts.org
U.S. Census Bureau, Population Division, June 2012.
www.hpsafind.hrsa.gov/HPSASearch.aspx
American Association of Colleges of Nursing: Nursing Shortage Fact Sheet
Rural Assistance Center: Health Care Workforce Frequently Asked Questions.
Rural Health Research and Policy Centers, “The Aging of Primary Care Physician Workforce: Are Rural Locations Vulnerable?” June 2009
Find Shortage Areas: HPSA by State and County: www.hpsafind.hrsa.gov/
Bureau of Vital Records and Health Statistics, NMDOH
Appendix A

- FY12 Final Quarterly Performance Report
FY12 Quarter Four Performance Report

April 1, 2012–June 30, 2012

New Mexico Department of Health
Catherine D. Torres, MD, Cabinet Secretary
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NEW MEXICO DEPARTMENT OF HEALTH

VISION:
A healthy state of mind!

MISSION:
Provide leadership to guide public health and to protect the health of all New Mexicans.

FY12 OPERATING BUDGET:

General Funds: 288,707.1
Federal Funds: 103,570.2
Other State Funds: 113,781.2
Other Transfers: 27,110.8

CONTACT INFORMATION

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(505) 827-2613

Public Information Office  
(505) 827-2619

Administration and Finance  
(505) 827-2555

Border Health  
(800) 784-0394

Policy and Accountability  
(505) 827-1052

Information Technology Services  
(505) 827-2744

Public Health  
(505) 827-2389

Immunization Program  
(888) 231-2367

Epidemiology and Response  
(505) 827-0006

Scientific Laboratory  
(505) 841-2500

Facilities Management  
(505) 827-2701

Developmental Disabilities Supports Services  
(800) 283-5548

Health Certification Licensing Oversight  
(505) 476-9093
PROGRAM AREA 1: ADMINISTRATION

PURPOSE:
The Administration Program fulfills the DOH mission by providing: leadership, policy development, information technology, and administrative and legal support, so that we achieve a high level of accountability and excellence in services provided to the people of New Mexico.

FY12 OPERATING BUDGET:

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<th>Source</th>
<th>Amount</th>
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<td>General Funds</td>
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<tr>
<td>Federal Funds</td>
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<td>Other State Funds</td>
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<tr>
<td>Other Transfers</td>
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SUMMARY AND RESULTS AT A GLANCE

Q4 Administration Summary: Administration has two quarterly measures. The days between expenditure of federal funds and request for reimbursement is not likely to meet the target this fiscal year. The result for percent of payment vouchers paid exceeded target.

<table>
<thead>
<tr>
<th>Performance Measure</th>
<th>Reporting Frequency</th>
<th>FY11 Actual</th>
<th>FY12 Target</th>
<th>FY12 Q1</th>
<th>FY12 Q2</th>
<th>FY12 Q3</th>
<th>FY12 Q4</th>
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</thead>
<tbody>
<tr>
<td>Number of working days between expenditure of federal funds and request for reimbursement</td>
<td>Quarterly</td>
<td>30 days</td>
<td>5 days</td>
<td>30 days</td>
<td>30 days</td>
<td>30 days</td>
<td>30 days</td>
</tr>
<tr>
<td>Percent of payment vouchers paid within thirty days of acceptance of goods and services</td>
<td>Quarterly</td>
<td>92.1%</td>
<td>87%</td>
<td>84.9%</td>
<td>100%</td>
<td>92.3%</td>
<td>92.5%</td>
</tr>
</tbody>
</table>

Total: 94.9%  Total: 93.9%  Total: 93.5%
IMPROVE ACCOUNTABILITY AND RESPONSIVENESS OF OUR SERVICES WITHIN DOH:

**Data Reported Quarterly**

**Data Source:**
Grant Management System

**Goal:**
To decrease the number of days between expenditure of federal funds and request for reimbursement.

---

**MEASURE HISTORY:**
- Processing time between expenditures of federal funds and request for reimbursement varies dramatically based on the type of expenditure, when in the quarter it was processed and how the process is managed by all agencies involved. Our goal is always to request reimbursement as quickly as possible.

---

**QUARTER FOUR ACTIVITIES:**
- Draw all expenditures on a monthly basis for all federal grants.
- There is a monthly draw on the 20th of each month.
In FY07, the SHARE system was implemented and ASD financial personnel were not sure how to calculate the percent of payment vouchers paid within 30 days, so no data was reported. The Office of Policy and Accountability has been assisting by entering the data and calculating the result from a monthly sample drawing from all areas of the Department.

Since FY09-Q3 when an internal data quality process was started, this measure has shown continuous improvement.

**ACTION PLAN**

- Continue to evaluate the payment voucher process and carefully monitor encumbrances.
- Provide training to DOH staff in processes that will improve turnaround time.
PROGRAM AREA 2: PUBLIC HEALTH

MISSION/PURPOSE:
Public Health fulfills the DOH mission by working with individuals, families, and communities in New Mexico to improve health status, eliminate disparities, and ensure timely access to quality, culturally competent health care. Public Health provides leadership by assessing the health status of the population; responding to outbreaks and health concerns in the population; developing sound public health policy; promoting healthy behaviors to prevent disease, injury, disability, and premature death; educating, empowering, and providing technical assistance to create healthy communities; mobilizing community partnerships to identify and solve health problems; assuring access to health care through recruitment and retention activities such as the J-1 Visa Program, licensing midwives, tax credits for rural health providers, as well as administering funding for rural primary health care providers serving populations in need throughout the state; and providing safety net clinical services.

<table>
<thead>
<tr>
<th>FY12 OPERATING BUDGET:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>General Funds</strong>: 66,536.0</td>
</tr>
<tr>
<td><strong>Federal Funds</strong>: 77,321.4</td>
</tr>
<tr>
<td><strong>Other State Funds</strong>: 29,481.1</td>
</tr>
<tr>
<td><strong>Other Transfers</strong>: 13,293.7</td>
</tr>
</tbody>
</table>
### SUMMARY AND RESULTS AT A GLANCE

**Q4 Public Health Summary:** Public Health has a total of eleven measures: one semi-annual measure and ten quarterly measures. The measures for individuals not sharing syringes, receiving HIV services, the percent of individuals diagnosed with primary or secondary syphilis and suicide prevention are four that have exceeded the target. Seven did not meet the fiscal year target.

<table>
<thead>
<tr>
<th>Performance Measures</th>
<th>Reporting Frequency</th>
<th>FY11 Actual</th>
<th>FY12 Target</th>
<th>FY12 Q1</th>
<th>FY12 Q2</th>
<th>FY12 Q3</th>
<th>FY12 Q4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percent of preschoolers fully immunized</td>
<td>Semi-Annual</td>
<td>65.4%</td>
<td>81%</td>
<td>NA</td>
<td>Available 3-12</td>
<td>Not yet available</td>
<td>76.1% preliminary</td>
</tr>
<tr>
<td>Number of teens ages 15 to 17 receiving family planning services in agency-funded family planning clinics</td>
<td>Quarterly</td>
<td>4,851</td>
<td>6,874</td>
<td>1,811</td>
<td>Revised: 1,310 Total: 2,959</td>
<td>1,271 Total: 4,925</td>
<td>1,490 Total: 5,631</td>
</tr>
<tr>
<td>Number of WIC eligible persons receiving services</td>
<td>Quarterly</td>
<td>112,324</td>
<td>120,786</td>
<td>79,705</td>
<td>79,052</td>
<td>79,052</td>
<td>79,052 Total: 110,027</td>
</tr>
<tr>
<td>Number of calls to the 1-800-Quit Now tobacco cessation help line</td>
<td>Quarterly</td>
<td>11,944</td>
<td>13,748</td>
<td>1,802</td>
<td>1,699 Total: 3,501</td>
<td>2,852 Total: 6,353</td>
<td>3,289 Total: 9,642</td>
</tr>
<tr>
<td>Number of HIV/AIDS prevention interventions</td>
<td>Quarterly</td>
<td>14,047</td>
<td>21,604</td>
<td>4,827</td>
<td>3,427 Total: 8,254</td>
<td>4,195 Total: 12,449</td>
<td>3,100 Total: 15,549</td>
</tr>
<tr>
<td>Person’s enrolled in the agency’s HIV services and receiving combination therapy who demonstrate an undetectable viral load</td>
<td>Quarterly</td>
<td>90.2%</td>
<td>74%</td>
<td>89.5%</td>
<td>90.1%</td>
<td>90.4%</td>
<td>90.6%</td>
</tr>
<tr>
<td>Percent of individuals re-enrolling in the syringe exchange program who are not sharing syringes</td>
<td>Quarterly</td>
<td>82%</td>
<td>69%</td>
<td>82.8%</td>
<td>87.13%</td>
<td>96.1%</td>
<td>100%</td>
</tr>
<tr>
<td>Number of syringes that are returned to syringe exchange program</td>
<td>Quarterly</td>
<td>2,802,426</td>
<td>3,142,400</td>
<td>559,022 Revised to 567,807</td>
<td>644,012 Revised to 716,358</td>
<td>560,601 Revised to 556,999</td>
<td>455,987 Total: 2,317,151</td>
</tr>
<tr>
<td>Percent of individuals diagnosed with primary or secondary syphilis treated within thirty days of diagnosis</td>
<td>Quarterly</td>
<td>100%</td>
<td>88%</td>
<td>94%</td>
<td>91%</td>
<td>94%</td>
<td>100%</td>
</tr>
<tr>
<td>Number of visits to agency-funded school-based health centers</td>
<td>Quarterly</td>
<td>55,616</td>
<td>49,100</td>
<td>4,490</td>
<td>15,906 Total: 19,586</td>
<td>14,045 Total: 33,631</td>
<td>9,346 Total: 42,977</td>
</tr>
<tr>
<td>Number of participants in youth suicide prevention awareness and outreach activities</td>
<td>Quarterly</td>
<td>NA</td>
<td>2,500</td>
<td>2,792</td>
<td>1,352 Total: 4,144</td>
<td>6,891 Total: 11,035</td>
<td>13,658 Total: 24,693</td>
</tr>
</tbody>
</table>
INCREASE IMMUNIZATIONS FOR ALL NEW MEXICANS:

Data Reported Semi-Annually

Data Source:
National Immunization Survey

Goal:
To increase the percent of preschoolers immunized.

![Percent of Preschoolers Fully Immunized](image)

MEASURE HISTORY:

- CDC frequently changes the standard series of vaccines by which preschool children's rates of immunization are measured. Previously, the standard series was 4:3:1:3:3:1 (4 DTaP:3 Polio:1MMR:3 doses Hib:3 doses of Hep B:1 dose of varicella). Beginning FY11, the new standard of measurement became 4:3:1:3:3:1:4 (4 DTaP:3 Polio:1MMR:3 doses Hib:3 doses of Hep B:1 dose of varicella:4 doses pneumococcal). Because of this change and the shortage of Hib Vaccine during the measurement period, rates nationwide, and in most states, have decreased.

- Preliminary data was released during the 4th quarter but the final FY12/CY11 result will not be available until after CDC's final immunization survey results are announced.

NATIONAL COMPARISON:

<table>
<thead>
<tr>
<th>Percent of Preschoolers Fully Immunized</th>
<th>CY07</th>
<th>CY08</th>
<th>CY09</th>
<th>CY10</th>
</tr>
</thead>
<tbody>
<tr>
<td>New Mexico</td>
<td>76%</td>
<td>77%</td>
<td>70.2%</td>
<td>65.1%</td>
</tr>
<tr>
<td>United States</td>
<td>77.4%</td>
<td>76.1%</td>
<td>63.6</td>
<td>70.2</td>
</tr>
</tbody>
</table>

ACTION PLAN:

- Work directly with almost 500 immunization providers and partners statewide that serve children zero to three years of age to improve their immunization practices, minimize missed immunization opportunities and increase rates of completed childhood immunizations.

- Reach the state's low immunization zones by researching and creating new opportunities, processes and systems with less-used resources such as promotoras, medical assistants and other community health workers.
REDUCE TEEN BIRTHS:

Data Reported Quarterly
Data Source: Provider databases/INPHORM/BEHR
Goal: To increase the number of teens ages 15-17 receiving family planning services.
Note: Unduplicated numbers cannot be added from one quarter to the other quarters for the cumulative number

MEASURE HISTORY:
- The results include numbers from Family Planning Program (FPP) and Office of School and Adolescent Health.
- The lower number of clients is most likely due to the midyear retirement of several Certified Nurse Practitioners in the two most productive Regions. The two Regions are now recruiting and FPP is paying for contracted clinicians. There is also a reduction in clients at contract sites. This is a combination of a contractor (El Centro) terminating their contract; and, because a number of School Based Health Centers are in transition and are not able to continue their contract at this time. FPP has added other SBHCs (e.g. UNM) that will begin this fiscal year.

ACTION PLAN:
- The Family Planning Program funded clinics will continue to provide confidential, family planning services to teen clients aged 15-17 at over 100 sites in Public Health Offices, Primary Care Clinics & SBHCs.
- Continue to promote four population-based strategies (service learning programs, adult-teen communication programs, comprehensive sex education and male involvement programs) to work in concert with the clinical family planning direct services to prevent teen pregnancy.
- Fund and provide technical assistance for community education with the Teen Outreach Program (TOP). TOP, a service learning program designed to decrease teen pregnancy and increase school success, combines community service with curriculum-based activities throughout the school year. TOP students complete service learning projects such as knitting winter clothing for domestic violence victims and distributing food baskets to needy families.
- Fund and provide technical assistance for community based organizations to implement comprehensive sex education programs. Organizations will implement Cuidate, targeting Hispanic youth 13-18 years of age with the theme of taking care of oneself and one’s partner, family and community.
QUARTER FOUR ACTIVITIES:

- Continue to support the adult-teen communication program Plain Talk, and provide training for Raices y Alas, a two-hour workshop for parents of adolescents designed to increase parents' confidence in talking with their children about sex and sexual health topics.

- Mary Stoecker, Health Promotion Specialist from the Grant PHO in Silver City, Amanda Lujan, Clerk from the Socorro PHO, and Ruth Guin, RN DNS Region 5, attended the Catron County Teen Health Fair at Reserve High School. The teen health fair was set around the game of monopoly, and Mary Stoecker presented nutrition while Ruth Guin and Amanda Lujan had games to play with the students around birth control and sexually transmitted diseases. There were middle and high school students from the two school districts in Catron County along with a few students from a private school. A total of 73 students were seen at the birth control/STD stop and 83 students were seen at the nutrition stop.

- Patti Collins, coordinator of the Lea County Community Transformation Grant, sent four UNM BA/MD students to tour the public health, WIC and CMS offices to gather information on the programs. The students are in Lea County for a month, working on teen pregnancy as their summer project for school.
REDUCE OBESITY AND DIABETES:

Data Reported Quarterly

Data Source:
WIC database

Goal:
To increase the number of WIC eligible persons receiving services.

Note:
In FY12, 110,027 were served through the WIC program.

MEASURE HISTORY:

- In FY12, the report used for this performance measure will be validated for accuracy.
- Quarterly results are estimates and include duplicate persons. A more accurate result can be reported annually.

QUARTER FOUR ACTIVITIES:

- The Autodialer was implemented statewide in November and has been extremely effective in significantly decreasing the demand for staff manual labor for contacting WIC participants.
- The nightly automated client appointment reminder service continues to be used for clients who miss their WIC appointments. The automated appointment reminder calls all clients who miss a scheduled appointment. A list is generated for WIC staff to provide a follow-up call.
- The WIC Regions statewide have shared positive feedback about the Autodialer and are utilizing reports to review and provide a follow-up call to reschedule a missed appointment.
- The WIC outreach poster "Your family has you, and you have WIC" was distributed statewide. The poster was printed in English and Spanish and WIC programs utilized the poster in a variety of ways, such as posting in laundromats, doctor's offices, head start programs, child care centers, etc.
- The Regions have planned several initiatives such as mass screening days, outreach at health fairs, and connecting with partners in their communities. These activities have reached out to serve potentially eligible clients.
- The assessment of locations of need was effective in order for the WIC Program to serve clients and potential clients. This infrastructure initiative provides increased assistance for families and referrals.
REDUCE THE ABUSE OF TOBACCO:

Data Reported Quarterly

Data Source: TUPAC Program

Goal: To increase the number of calls to the 1-800-Quit Now tobacco cessation helpline.

MEASURE HISTORY:

- The biggest factor in quitline call volume is media promotion.
- Based on 2010 BRFSS data, NM's adult smoking rate went up to 18.5% from 17.9%. This is the first time BRFSS data has shown an increase in adult tobacco use since the Tobacco Use Prevention and Control (TUPAC) program began.
- In 2010, as a result of budget cuts, TUPAC eliminated 20 contracts and reduced services for tobacco use prevention and control. Since 2006, program funding has been reduced by $3.5 million. National studies have demonstrated that reductions in funding for comprehensive tobacco prevention and control programs have led to a leveling off or increase in tobacco use.
- In December, TUPAC's population-based cessation services began including web-based cessation services, in addition to the telephone-based services. The result submitted for Q3 & Q4 includes participants in our web-based and telephone-based cessation services. Web and telephone-based services are provided by the same vendor.

ACTION PLAN:

- Provide free smoking cessation services in English and Spanish to New Mexico Smokers through the tobacco cessation help line service, 1-800-QUIT NOW and online tobacco cessation service.
- Continue media campaign to promote availability of free cessation services through 1-800-QUIT NOW and online tobacco cessation services.
- 1-800-QUIT NOW and the online tobacco cessation service will continue to provide free nicotine patch, gum, or lozenge therapy (Nicotine Replacement Therapy-NRT) to every participant for whom NRT is an appropriate therapy.
DECREASE THE TRANSMISSION OF INFECTIOUS DISEASE CASES AND EXPAND SERVICES FOR PERSONS WITH INFECTIOUS DISEASES:

MEASURE HISTORY:

- FY11 was the first year that the HIV Prevention Program had not exceeded target for this performance measure. The decline in the number of HIV/AIDS prevention interventions is caused by ongoing cuts to HIV prevention contracts over the past three years and a shift to more costly and intensive interventions that have been demonstrated to have impact on behavior change, but impact less numbers of people served. In FY12 the HIV Prevention Program did not meet its target but did report an increase over FY 11.

ACTION PLAN:

- One major goal of the HIV Prevention Program is to prevent new HIV infection by decreasing risky sexual and drug-using behaviors within the populations at greatest risk for HIV infection.

- Target populations and effective interventions are defined and prioritized through a mandated community-based process implemented by the New Mexico HIV Prevention Community Planning and Action Group (CPAG).

- This figure reflects an increase of 11% over the 14,047 units of evidence-based HIV prevention interventions delivered during SFY2011, though funding remains flat. This reflects increased stability of community-based providers and enhanced expertise of their staff in delivering these complex models.

- The total is less than the SFY2012 target. This is due to a significant shift in HIV prevention priorities over the past 5 years, both in terms of statewide priorities and direction from the Centers for Disease Control and Prevention (CDC), which funds roughly 70% of this program. Instead of providing a high volume of low-intensity activities such as outreach that have limited impact on reducing risk behaviors, the program is funding a smaller volume of high-intensity and higher-cost evidence based models that reduce HIV risk. Community-based contractors are largely using evidence-based effective models that are recommended and promoted by CDC.
**Data Reported Quarterly**

**Data Source:**
CareWare

**Goal:**
To increase the number of persons enrolled in the agency’s HIV services and receiving combination therapy who demonstrate an undetectable viral load.

**Note:** * Target has been exceeded in every quarter

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**MEASURE HISTORY:**

- DOH began reporting on this measure in FY11 because it shows a positive outcome of services provided.
- Viral load is a key indicator for two reasons. HIV patients with undetectable viral loads are likely to be healthy, and they are unlikely to be infectious.

**ACTION PLAN:**

- The HIV Services Program will use its CQM (Clinical Quality Management) Committee to focus on this important performance measure and seek to improve it.
- Components of improvement are data capture, making sure that viral load results are captured in the program data base, and making low performing sites aware that they are functioning below others so that they are motivated to improve.
- Additionally, annual clinical audits by the Infectious Disease Medical Director highlight this and other key measures and publicize them to all clinics. This creates a peer pressure to improve performance.
- Consequently, in the 4th quarter 608 of the 671 individuals enrolled in agency HIV services and on HAART medications demonstrated an undetectable viral load.
MEASURE HISTORY:

- This measure is reported one quarter behind.
- Reducing the sharing of syringes among injection drug users reduces the likelihood of transmitting blood borne pathogens such as HIV and Hepatitis C.
- The FY11 target was exceeded due to the continued education of participants in the program by the Harm Reduction specialists in each of the participating local Public Health Offices and designated Harm Reduction programs.
- In FY12, the target was exceeded.

ACTION PLAN:

- Continue training staff and volunteers at Local Public Health Offices (PHO) and Community Based Offices (CBO) on correct outreach methodologies and practices.
- Through the education of participants during the exchange of used syringes for clean syringes, the program aims at having 70% or more of the re-enrollees respond that they are not sharing their syringes with other individuals on their re-enrollment survey.
- The target was exceeded in every quarter for FY12

QUARTER FOUR ACTIVITIES:

- In the first two quarters combined, 484 of 566 clients being re-enrolled reported on their survey that they did not share syringes.
- In the third quarter, 604 of 627 clients reported that they did not share syringes.
- For the year, 1,348 of the 1,453 clients being re-enrolled reported that they did not share syringes.
MEASURE HISTORY:

- Results are one quarter behind due to the reporting process. The FY12-Q1 result completes the FY11 result which was preliminary. The revised FY11 result is 3,361,448, which exceeds target by 161,448.
- Numbers are calculated for each quarter and then reported. In the following quarter, when these figures are re-checked, they always increased by at least 20 percent. This reflects the fact that some busy providers take up to 6 months to submit data reports to the Harm Reduction Program.
- The importance of returning reports on a monthly basis is emphasized during Harm Reduction program provider meetings (2-3 times per year)/ Numerous email reminders are also sent.

ACTION PLAN:

- Encourage injection drug users to return used syringes to the syringe exchange programs for proper biohazard disposal. This reduces the likelihood of accidental needle sticks by non-injection drug users and injection drug users themselves. The proper destruction of used syringes keeps the community safer.
- Continue to train staff and volunteers at Local Public Health Offices (LPHO) and Community Based Offices (CBO) in order to engage participants in their programs in harm reduction principles. This activity will help to inform staff and volunteers about the services offered within syringe exchange and refer appropriate participants to the program.
- To reach out to populations that may not be able to make it to clinics and other fixed site locations, such as those experiencing homelessness, or without transportation.
Data Reported Quarterly

Data Source: PRISM

Goal:
To increase the percent of individuals diagnosed with primary or secondary syphilis treated within thirty days of diagnosis.

Note:
Data is reported with a lag time of one quarter; Target has been exceeded in every quarter.

**MEASURE HISTORY:**

- The STD Program always reports with a lag time of one quarter due to the time needed to finish investigations and enter results. The data system was changed in FY11-Q3 resulting in the improved ability of program managers to get useful surveillance and management reports to improve program efforts.

- 71 of 74 cases were treated within 30 days for the year. 22 of 22 were treated within 30 days for the 4th quarter.

**ACTION PLAN:**

- Conduct partner notification interviews of all reported cases of early syphilis and pursue the goal of improving the number of partners and associated individuals for each case. This is a key strategy because with only about 100 cases of early syphilis (the only time it is infectious is in primary or secondary stages) it is very difficult to find the disease by screening. So for every case, it is necessary to find as many people as possible who may have also been exposed, and as soon as possible to stop the spread of disease.

- Identify, locate and appropriately treat partners of individuals with syphilis, in an effort to control the disease. Early treatment means less duration and fewer exposures to the infection.

- Use the STD Program’s case management database, to monitor the status and outcomes of these investigations. This data is used to identify the relative strengths and weaknesses of program performance and to make recommendations for improvement in both the number and percent of favorable outcomes of partner notification investigations.

- Analyze data quarterly to determine statewide and regional performance as outlined in the Disease Prevention Specialist Performance Standards. Emphasis will be placed on measures referencing interviewing standards and partner investigations.

- Disease Prevention Team is working to improve re-interviews and cluster interviews. These are both designed to find more people who are at risk or may have been exposed to syphilis. This is a statewide effort and should result in more cases being identified and treated at an early stage.
EXPAND HEALTH CARE FOR SCHOOL-AGE CHILDREN AND YOUTH THROUGH SCHOOL-BASED HEALTH CENTERS:

**Data Reported Quarterly**

**Data Source:** SBHC Pro database

**Goal:** To increase the number of visits to SBHCs.

**Number of Visits to Agency Funded School-Based Health Centers**

![Number of Visits to Agency Funded School-Based Health Centers](chart)

**MEASURE HISTORY:**

For the first time in history the SBHC program did not meet its performance target. The SBHC Program implemented a restructure during the fiscal year to strengthen compliance with HIPAA which included securing new entities to operate each of the centers. As a result of the restructure, the first quarter was spent on reorganizing day-to-day operations, coordinating partnerships with the school administration and negotiating contracts with primary care and behavior health providers to deliver services.

**QUARTER FOUR ACTIVITIES:**

- Two sites successfully identified a sponsoring entity, Cuba and Raton, leaving two sites without sponsors. Work continues to find sponsorship for Belen and Socorro. A preliminary meeting was held with First Choice and Presbyterian Hospital. Both entities are reviewing operational requirements and considerations. The Office of School and Adolescent Health (OSAH) is hopeful a sponsor will be found before the end of the fiscal year.

- The New Mexico Alliance for School-Based Health Care updated the SBHC on-line directory. The database includes contact information, days/times of services and types of services available at each SBHC. For a complete listing, visit www.nmasbhc.org.

- Implement year long Quality Improvement interventions to promote best practices within school-based health centers focused on supporting clinical services and systems necessary to improve identification, treatment of pediatric overweight, improved clinical practices to support Early and Periodic Screening, Diagnostic and Treatment (EPSDT) exams, and early identification, screening and intervention of depression and anxiety.

- Seventeen SBHC sites are currently involved with ENM in some aspect of demonstration quality improvement. All initial site visits for engaged sites will occur by the end of January.
QUARTER FOUR ACTIVITIES:

- Partner with Human Services Division and managed care organizations to implement effective Medicaid and/or commercial insurance systems to support SBHC sustainability.

- Thirty-two SBHCs are currently credentialed with the managed care organizations for Medicaid eligible services. All SBHCs are required to implement PE/MOSSA activities to ensure youth are enrolled in services.

- OSAH, in partnership with HSD – School Medicaid Staff, continue to provide on-going technical assistance and oversight to ensure all SBHCs participating in the SBHC Medicaid Program are in compliance with federal and state policies. Activities include facility and site audits, training on billing/coding procedures and advocacy with managed care organizations to complete credentialing process.

- Medicaid site re-credentialing visits were conducted at Maxwell, Carlos Vigil, Espanola High School School-based Health Centers in April. Site visits were conducted at Roswell, Goddard, and Mesa Middle Schools in June. During the 2011-2012 school year, a total of 20 site re-credentialing visits were made.

- UNM-Envision continues to conduct quality improvement activities statewide. A total of 20 SBHCs are actively engaged in activities that include on-site coaching, participation in webinars and training, and implementation of new tools and resources specifically designed for SBHCs. Specific activities included Motivational Interviewing for Las Cruces SBHC staff, youth engagement practices with sites in Espanola, Pojoaque and Silver City, development and implementation of patient registry for depression and anxiety with Pojoaque and several webinar and case consultation conference calls focused on the following topics: advanced screening and assessment tools for behavior health, model of improvement in healthcare, immunizations and coordination with school and public health, treatment of depression in children who are overweight, nutrition education and therapy, diabetes, evaluation and treatment, and asthma management.

- A focus for quality improvement is on strengthening the components of the EPSDT using a Proficiency Model which characterizes the elements of the EPSDT, as a comprehensive screening exam. The model breaks components into proficiency levels and is based on the percent of all EPSDT exams that have all the elements in each tier. This format allows SBHCs to address infrastructure and clinic processes that impact completion of the full exam and focuses quality improvement with sites on more discreet elements at each level before moving on to more complex elements. This approach allows quality improvement coaches to make rapid assessments of the needs at each level and enables sites to focus on the elements at each level.

- SBHCs located in Silver City, Cobre, Pojoaque and Espanola High Schools continue to participate in the demonstration project. Onsite coaching visits have resulted in an increase in EPSDT and overall productivity. Findings from the project are part of a national demonstration project which will continue through 2015.
QUARTER FOUR ACTIVITIES:

- Four additional sites were identified for FY '13, including Carlos Vigil Middle School in Espanola sponsored by El Centro, Mesa Vista Middle School in Ojo Caliente sponsored by Las Clinicas Del Norte, Van Buren Middle School in Albuquerque sponsored by UNM-Family and Community Medicine and Mesa Middle School in Roswell sponsored by Eastern New Mexico University.

- All DOH funded SBHCs successfully implemented 4 health promotion and risk reduction projects campus-wide. In these projects they were also asked to engage youth in meaningful ways, including planning, developing and implementing activities and participating in School Health Advisory Council. Over 200 health promotion activities were completed addressing issues such as obesity prevention, asthma, depression, physical activity and nutrition, bullying and school climate, suicide prevention, STD awareness, tattooing, prescription drug awareness, immunization, oral health, stress reduction, teen dating violence, reproductive health, and teen parenting.

- Support the ongoing coordination of SBHC and school health programs, including provider recruitment and training, statewide social marketing, development of advocacy strategies aimed at increasing awareness and effectiveness of SBHCs, school nursing and school health initiatives.

- Major updates to the School Health Manual were completed. The school health manual is now a "fluid" document and OSAH will post a current listing of updates for all school health personnel.

- A new standardized New Mexico School Asthma Action Plan form was developed by OSAH staff with approval of the NM Asthma Coalition, NM Pediatric Society, NM Health Plans, and the NM School Nurse Advisory Council. Updates to the Plan were completed for the School Health Manual. Also a Spanish version of the Asthma Action Plan has been developed and will be ready for this next school year.

- Support ongoing effective SBHC data collection, monitoring and reporting systems necessary to demonstrate the impact of school-based health centers on improving health and academic outcomes for youth.

- Apex Education is partnering with OSAH to expand utilization of the electronic version of the Student Health Questionnaire (eSHQ) currently utilized by SBHCs to assess risk behaviors. Currently a team is developing a middle school version. Apex deployed an iPad application in five demonstration sites. Immediate feedback from the SBHC sites includes improved student care and integration with patient registries. Site participating in the demonstration project fully implemented the electronic student health questionnaire (eSHQ). Sites participating in the demonstration include Silver City, Cobre, Pojoaque and Espanola (all high schools). Additionally, sites began the process of identifying processes and approaches necessary to fully implement medical home strategies. First step is identification of each SBHCs strengths and weaknesses and development of patient registry/follow up activities. Each of the SBHCs have all agreed to participate in a national evaluation and are working closely with coaches and evaluators to record progress.
QUARTER FOUR ACTIVITIES:

- Support the ongoing coordination of SBHC and school health programs, including provider recruitment and training, statewide social marketing, development of advocacy strategies aimed at increasing awareness and effectiveness of SBHCs, school nursing and school health initiatives.

- OSAH supported the inclusion of school injury subcategories (accidental and due to violence) to the Annual School Health Services Report on a voluntary basis for FY 12. This will become a mandatory report for next school year. This information will provide data on the type and number of student injuries school nurses care for annually.

- The Save Our Children’s Sight Fund was fully implemented. Information on the program and eligibility requirements were sent out to school nurses statewide. Approximately 30 youth received assistance with vision care and glasses.

- The 16th annual Head to Toe Conference was held April 17-20 at the Albuquerque Convention Center with a total attendance of 554. A total of 58 breakout sessions were available with a specific track focusing on Opioid Dependency.

- The Office of School and Adolescent Health assisted as hosts for the National School-Based Health Center Alliance Convention, held June 24 – 27, 2012 at the Hyatt Regency. There were 750 registered participants from across the country, including representatives from Puerto Rico and Hawaii. The convention featured a youth track. Forty diverse youth from across the country, 20 specifically from NM, attended special leadership training, including a site visit to Laguna/Acoma Pueblo. The site visit included a workshop with the ACL Youth Action Group, native dances and a meal. The trip provided a once in a lifetime opportunity for youth to visit a Pueblo and to learn firsthand about Native culture and tradition. This was the first year for New Mexico to host the national convention. Highlights included an opening convocation from Governor Luarkie of Laguna Pueblo that included remarks about his personal experiences as a patient of the ACL Teen Center when he was in high school. Presentations from New Mexico included highlights of the proposed Centennial Care reform and its impact on SBHCs from HSD, social marketing campaign and SBHC sustainability, youth engagement in health services, SBHCs and the patient centered home approach and an update on the federally funded quality improvement project currently underway in partnership with Colorado. New Mexico had 156 registered participants, primarily consisting of SBHC providers and staff and key stakeholders partnering with OSAH to implement SBHCs statewide.
QUARTER FOUR ACTIVITIES:

STORIES FROM SBHCS

- Katishtya School-Based Health Clinic – Pueblo of San Felipe: In response to the growing concern of reports of depression and social isolation among students at the school, the Katishtya SBHC Counselor developed a series of intervention and prevention support groups for students at the school including two weekly lunch groups focused on social growth and development and one group specifically for 6th, 7th and 8th grade girls. The SBHC Nurse expanded the focus of the groups by including multiple topics associated with healthy living and personal care. The groups explored team building through experiential learning activities such as bowling, eating out together, and playing games. The groups helped students build healthy relationships with one another and taught students about healthy alternatives to address depression, social isolation and conflicts. By end of the year, it was reported that students involved in the groups had improved attendance, improved grades, and decreased reports of conflicts on campus.

- Dulce SBHC: The SBHC Prevention Specialist spoke to a student who had been in a fight and discovered that the student was feeling suicidal. One of his parents had committed suicide. The Prevention Specialist contacted the Counselor and together they all met with the student’s remaining parent and developed a plan to keep the student safe. The student is seeing the counselor on a regular basis and is doing much better.

- Albuquerque HS: An obese student, concerned about her weight because of a family history of diabetes, went to the AHS SBHC for help. The nurse practitioners at the clinic met with the student on a regular basis and discussed nutrition options, food diary logs, and exercise options for her. The nurse practitioners provided bi-weekly feedback to the student and helped keep the student motivated about her weight loss success. The student started a regular exercise program, modified recipes at home and her family started walking with her. To date, the student has lost 50 pounds and has established a lifetime of healthy habits and goals to keep the weight off.

- Carlsbad HS: A young female student was experiencing severe abdominal pains and missing a lot of school. Her current physician thought it was psychosomatic and her complaints were not taken seriously. Her mother brought her to the SBHC to avoid her missing more school. The nurse practitioner listened to the student, ran tests and identified that she did have a medical problem. The child was sent to specialists who discovered that she had a heart condition and only had one kidney and discovered and treated the cause of her pain. The student has minimized her school absences, her grades have improved, and she can actively participate in most activities at school now.
MEASURE HISTORY:

There is no historical data for this measure as data was collected for the first time in FY12.

QUARTER FOUR ACTIVITIES:

- Enhance statewide crisis response by the operation of statewide telephone call/talk/crisis lines, networked with the National Lifeline.
- Increase community capacity to identify suicide risk factors and implement evidence-based practices among at-risk adolescents and their families.
- During fiscal year 2011-2012, OSAH funded a total of 18 programs focused on positive youth development and adolescent health. The goal for all contractors was to promote the positive youth development approach and adolescent health via peer to peer education and/or youth-adult partnership. Majority of the contracts implemented the Natural Helper program, a school-based peer support program based on the premise: Within every school, an informal "helping network" already exists. Students with problems naturally seek out other students and also adults whom they trust. All Natural Helper programs participated in an annual retreat, were trained on various adolescent health topics and implemented health promotion activities. Other projects included a variety of topics including, implementation of the Teen Outreach Program (TOPs), Teaching 21st Century Kids, Rez Hope and Youth Development Pathways to Health in Rural NM. Youth gained experience in the public health approach, prevention and health promotion, strategies to organize community to address health needs. In summary, $200,000 supported 16 contractors who recruited 300 youth leaders who then impacted approximately 8500 youth statewide. 12 Natural Helper programs were implemented, 6 Youth Action Groups were developed, more than 75 health promotion activities were completed, 10 youth-led health promotion mini grants were funded and 4 toolkits were created.
QUARTER FOUR ACTIVITIES:

- The National Suicide Prevention Lifeline, PMS, and Agora fielded crisis calls.
- UNM Agora Crisis Line developed and implemented a chat line with over 500 chats received from teens during the first month. Informational posters will be distributed to school campuses in the Fall.
- The PMS Crisis Line completed 17 assessments and made referrals for those youth deemed at risk for suicide.
- NMSU "The Call" provided promotional material to over 2,600 students and community members during this fiscal year. They also hosted ASIST suicide prevention programs for 57 students.
- The New Mexico Coalition for Health and Resilient Youth is implementing a peer-to-peer youth group that is responsible for implementing suicide awareness activities in two high schools. To-date the students have provided training for students and teachers, are involved in producing a video on teen dating violence and drug abuse, and are activity engaged in identifying and referring youth at-risk for depression to the SBHC. The schools are happy to report there has not been an incident of suicide during his school year.
- NM Suicide Prevention Coalition conducted QPR (gatekeeper awareness training) statewide reaching 772 people statewide. The Coalition also coordinated a public television program about suicide featuring Dr. Torres, Senator Lovejoy, behavioral health experts and youth who had attempted suicide.
- New Suicide Intervention Project provided implemented a peer-to-peer program for 84 students and 8 adults, provided clinical training at Highlands University for 40 graduate school social work students and tested an on-line suicide prevention/awareness training for 11 faculty staff and administrators. They also provided suicide awareness training at St. Michaels and Capital High Schools in Santa Fe.
- Programs for Adolescents provide training and technical assistance for two new additional Natural Helper groups in Albuquerque and Espanola.
- Pojoaque Valley Schools–Natural Helper program implemented a program called "iGenconnect" which allows students to send text messages of encouragement and positive health information campus-wide.
QUARTER FOUR ACTIVITIES:

- Increase culturally relevant knowledge of signs of suicide, risk and protective factors and identification of resources among youth.
- Reduce the risk of suicide for LGBTQ youth by supporting the formation of a new Gay-Straight Alliance for LGBTQ students.
PROGRAM AREA 3: EPIDEMIOLOGY & RESPONSE

MISSION/PURPOSE:
Epidemiology and Response fulfills the DOH mission by monitoring health, providing health information, preventing disease and injury, promoting health and healthy behaviors, responding to public health events, preparing for health emergencies, and providing emergency medical, trauma, vital registration, and sexual assault-related services to New Mexicans.

<table>
<thead>
<tr>
<th>FY12 OPERATING BUDGET:</th>
</tr>
</thead>
<tbody>
<tr>
<td>General Funds: 8,051.6</td>
</tr>
<tr>
<td>Federal Funds: 15,455.7</td>
</tr>
<tr>
<td>Other State Funds: 1,314.3</td>
</tr>
<tr>
<td>Other Transfers: 493.2</td>
</tr>
</tbody>
</table>

SUMMARY AND RESULTS AT A GLANCE

**ERD Q4 Summary:** In FY12, ERD has two quarterly measures. Both measures had exceeded the FY12 target.

<table>
<thead>
<tr>
<th>Performance Measures</th>
<th>Reporting Frequency</th>
<th>FY11 Actual</th>
<th>FY12 Target</th>
<th>FY12 Q1</th>
<th>FY12 Q2</th>
<th>FY12 Q3</th>
<th>FY12 Q4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of health emergency exercises conducted to assess and improve state and local capability</td>
<td>Quarterly</td>
<td>106</td>
<td>59</td>
<td>12</td>
<td>30</td>
<td>34</td>
<td>53</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Total: 42</td>
<td>Total: 76</td>
<td>Total: 129</td>
<td></td>
</tr>
<tr>
<td>Number of designated trauma centers in the state</td>
<td>Quarterly</td>
<td>9</td>
<td>9</td>
<td>9</td>
<td>9</td>
<td>10</td>
<td>10</td>
</tr>
</tbody>
</table>
ENSURE PREPAREDNESS FOR HEALTH EMERGENCIES, INCLUDING PANDEMIC INFLUENZA:

Data Reported Quarterly

Data Source: Exercise Database

Goal: To increase the number of pandemic influenza plan exercises.

MEASURE HISTORY:

- This measure exceeded target since FY10. The reporting of exercises is done by the Bureau of Health Emergency Management (BHEM) and its preparedness partners, including public health regions, hospitals, clinics and others. The Public Health Emergency Response Coordinators located in the regions report monthly to BHEM all preparedness activities of significance including participation and conduct of exercises. Also, Hospital Preparedness Program (HPP) participating healthcare partners (hospitals and clinics) report activity.

ACTION PLAN:

- Activities related to the measures that were planned for this fiscal year, July 2011 - June 2012, include: Quarterly drills for the Strategic National Stockpile (SNS), Cities Readiness Initiative (CRI) and the Hospital Preparedness Program (HPP); Table Top Exercises for SNS and the HPP; Functional Exercises for SNS and HPP; DOH participation with the Department of Homeland Security and Emergency Management in the NM Training and Exercise Workshop in late October; and multiple regional and local hospital drills and exercises to be conducted statewide.

QUARTER FOUR ACTIVITIES:

- During the fourth quarter of FY12, fifty-three drills and exercises were reported to the NM Department of Health. Exercises include 12 weekly radio drills statewide, 12 HAVBed drills, 9 Government Emergency Telecommunication System drills, real time Pertussis vaccination clinics, and 1 table top exercise. Additionally, the Hospital Preparedness Program (HPP) conducted its statewide quarterly exercise which tested on interoperable communication systems, bed tracking, ESAR-VHP, fatality management and hospital evacuation plans. In this exercise, 4 hospitals fully participated with additional facilities participating in interoperable communications and bed tracking.

- In addition to the continuing training of public health staff with emergency response codes, trainings were conducted related to the Strategic National Stockpile points of dispensing, operations centers and the incident command system.
IMPROVE EMERGENCY MEDICAL SERVICES AND TRAUMA CARE ACROSS THE STATE.

MEASURE HISTORY:
- Designation of trauma centers is a two year process.
- Two facilities that were originally scheduled for FY11 requested an extension to designate during FY12. One additional facility was added during FY12.

QUARTER FOUR ACTIVITIES:
- Gallup Indian Medical Center continues to work towards Level III Trauma Center status with the guidance of the EMSB Trauma Program.
- Christus- St. Vincent Regional Medical Center has applied to the American College of Surgeons for a Focus review, which is anticipated to occur in December of 2012.
- The EMS Bureau has received two funding applications for Trauma System Fund Authority to develop as a trauma center;
  Sandoval County Regional, UNM in Rio Rancho
  Union County General Hospital
- The EMS Bureau continues to work with all Designated and Developing trauma centers to evaluate their programs, and assisting with their trauma data submission to the State Trauma Registry.
PROGRAM AREA 4: LABORATORY SERVICES

MISSION/PURPOSE:
Laboratory Services fulfills the DOH mission by providing laboratory analysis and scientific expertise for public health policy development, environment and toxicology programs in New Mexico. The laboratory provides timely identification in order to prevent, identify, and respond to threats to public health and safety from emerging and unusual infectious diseases in humans, animals, water, food, and dairy, as well as chemical and radiological hazards in drinking water systems and environmental water, air, and soil. The laboratory also performs drug testing and provides expert witness testimony for forensic investigations of DWI/DUID and cause of death from drugs and infectious disease. The laboratory is the primacy bioterrorism and chemical terrorism response laboratory for the state and provides training for clinical laboratories throughout New Mexico. New Mexico statute dictates that SLD is the primacy laboratory for the New Mexico Department of Health, the New Mexico Office of the Medical Investigator, the New Mexico Environment Department, and the New Mexico Department of Agriculture.

FY12 OPERATING BUDGET:
- General Funds: 6,445.1
- Federal Funds: 1,709.3
- Other State Funds: 2,977.0
- Other Transfers: 0.0

SUMMARY AND RESULTS AT A GLANCE

SLD Summary: SLD has three measures in FY12. The target was met in quarter 4 on the public health threat samples but missed on the other two although q4 showed substantial improvement on the blood alcohol test measures.

<table>
<thead>
<tr>
<th>Performance Measures</th>
<th>Reporting Frequency</th>
<th>FY11 (cumulative)</th>
<th>FY12</th>
<th>FY12</th>
<th>FY12</th>
<th>FY12</th>
<th>FY12</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percent of public health threat samples illnesses that are analyzed within specified turnaround times</td>
<td>Quarterly</td>
<td>93%</td>
<td>89.63%</td>
<td>90.8% Total: 90.16%</td>
<td>92.6% Total: 90.9%</td>
<td>95.8% Total: 92.2%</td>
<td></td>
</tr>
<tr>
<td>Percent of blood alcohol tests from driving-while-intoxicated cases that are analyzed and reported within ten business days</td>
<td>Quarterly</td>
<td>74%</td>
<td>46.10%</td>
<td>34.76% Total: 40.09%</td>
<td>40.9% Total: 40.4%</td>
<td>57.4% Total: 44.6%</td>
<td></td>
</tr>
<tr>
<td>Percent of office of medical investigator toxicology cases completed within ninety days</td>
<td>Quarterly</td>
<td>88%</td>
<td>46.51%</td>
<td>15.08% Total: 19.87%</td>
<td>27.8% Total: 24.5%</td>
<td>63.09% Total: 33.85%</td>
<td></td>
</tr>
</tbody>
</table>
IMPROVE THE SCIENTIFIC LABORATORY’S ABILITY TO PROVIDE LABORATORY ANALYTICAL SERVICES TO STATE PROGRAMS:

Data Reported Quarterly

Data Source:
Laboratory Information Management System (LIMS) and ACCESS data files

Goal:
To meet the target of 93% of public health threat samples tested in the specified turn-around times.

![Percent of public health threat samples illnesses that are analyzed within specified turnaround times](image)

- **FY11**: 94.7%
- **FY12-Q1**: 89.6%
- **FY12-Q2**: 90.8%
- **FY12-Q3**: 92.6%
- **FY12-Q4**: 95.8%
- **FY12 Target**: 93%

MEASURE HISTORY:

- This measure combines reporting from the Biological Sciences and Chemistry Bureaus including environmental samples. The method of calculation was revised in FY11 to more accurately reflect all threats to public health.

QUARTER FOUR ACTIVITIES:

- This is a reporting measure for both the Biological Sciences Bureau and the Chemistry Bureau. Although the target was met for the fourth quarter, the yearly target was not quite met (92.2%) for the following reasons.

- The Chemistry Bureau was implementing the new Laboratory Information Management System (LIMS) during the first two quarters and went live during the third quarter. The requirement gathering, configuration and implementation resulted in a double workload for the staff which resulted in delayed turnaround times. Once the staff was able to learn the system, turn-around times improved during the 4th quarter.

- The Water Chemistry section had a supervisor retire at the end of the second quarter, leaving the section with 60% staffing, which, along with instrument failures, and working with the new LIMS, resulted in increased turnaround times. However, with increased familiarity with LIMS and resolution of instrumental issues, the turnaround times improved during the fourth quarter.

- While the improvement in these areas was not quite enough to lift the cumulative result, it is a strong indication for success in FY13.
Data Reported Quarterly

Data Source:
Laboratory Information Management System (LIMS)

Goal:
To meet the goal of 74% of blood alcohol tests analyzed within 10 business days.

MEASURE HISTORY:

- In FY11, the number of days was changed from seven to ten days. However results for this measure were negatively impacted due to the move, lack of fully trained staff and a continued high volume of subpoenas and discovery orders.

- A series of court decisions beginning with Melendez-Diaz v Massachusetts (June 2009) and Bullocking v New Mexico (June 2010) have led to increasing demand for analyst’s court testimony on sample results.

- In the Melendez-Diaz v Massachusetts (2009) case, lab reports are no longer considered a business record; the lab analyst is an accuser of the defendant and the accused has the constitutional right to confront his/her accuser.

- In the Bullocking v New Mexico (2010 case), the person appearing in court to be confronted by the accused had to be involved in the generation of that specific result; the lab cannot send other lab staff trained in the same analysis to face the accused.

ACTION PLAN:

- Continue training new employees. It takes from 6 months to one year for employees to become proficient in analysis of samples, depending on the type of testing being done. DWI testing looks at 19 categories of drugs which covers approximately 90 different drugs.

- Continue to encourage the use of video testimony. Video testimony allows the analysts to stay in the laboratory building to testify and therefore be available to continue testing samples. When an analyst travels to court, the analyst can be out of the laboratory for two days just for travel time.

QUARTER FOUR ACTIVITIES:

- The target of 74% of blood alcohol tests reported within 10 days was not met for the following reasons although quarter four showed improvement despite an increase in Discovery Order requests. There was also an emphasis on getting older impaired driving cases cleared.

- It takes about one year for analysts to become proficient on the drug screening assay. 50% of the new analysts are not yet proficient.

- Discover Order requests increased 37.5% from the third quarter. These requests pull analysts off the laboratory bench in order to meet these demands. In addition the number of subpoenas (1,743) received in FY12 was a 19.3% increase from FY11.
MEASURE HISTORY:

- The cause of death cases completed within 90 days in FY12 was affected by the volume of subpoenas for impaired driving cases coupled with staff vacancies. The same scientists who analyze the cause of death samples, analyze impaired driving samples, and are subpoenaed to testify in court.

- Through FY10 and early FY11 OMI cases received priority. By second quarter the priority shifted to DWI cases.

- New staff are being trained and are becoming proficient. However, it takes approximately two years to become fully proficient due to the complexities of drug testing and the samples received from the Office of the Medical Investigator.

ACTION PLAN:

- Continue training of new staff. New staff have been hired and training is needed to bring them up to the level required for the American Board of Forensic Toxicologists. This can take from 6 months to 2 years depending on the drug analysis.

QUARTER FOUR ACTIVITIES:

- The target of 88% of samples reported out within 90 days was not met for the following reasons:
  - The same analysts test both OMI and driving-under-the-influence samples.
  - Subpoenas for expert testimony for driving-under-the-influence samples increased 19.3% from FY12 which pulled scientists from the laboratory to testify in courts throughout the state.
  - During the second and third quarters of FY12 emphasis was placed on reducing the backlog of older driving-while-under-the-influence samples that had drug analyses.
  - As DWI backlog was reduced by February 2012 as a result of the overtime work, SLD Toxicology staff resumed work on OMI cases and this improved the OMI case completion measures.
FY12 SUCCESS STORIES

Biological Sciences Bureau (BSB):
The Virology/Serology Section has validated the Architect i1000 platform for HIV and Hepatitis testing. This automated platform has helped the section improve turnaround times as well as freeing up staff for other testing.

Chemistry Bureau:
Radiochemistry Section has worked to improve their turnaround times from 13.04% from FY’12 Q2 to 55.25% in FY12Q3. This was accomplished through a concerted team effort by the staff; a new scientist coming up to speed quickly; as well as instrument issues being resolved.

Toxicology Bureau:
The Toxicology Bureau officially received its re-accreditation certificate from the American Board of Forensic Toxicology (ABFT) on Tuesday, April 4. This followed its most recent on-site biennial audit which took place last September. The SLD has held ABFT accreditation since 2001 and is one of only 30 laboratories in the US to hold this accreditation.
PROGRAM AREA 6: FACILITIES MANAGEMENT

MISSION/PURPOSE:
Facilities Management fulfills the DOH mission by overseeing six health care facilities and one community program; the safety net services provided throughout New Mexico include programs in mental health, substance abuse, long term care, and physical rehabilitation in both facility and community-based settings. Facility staff care for both New Mexico adult and adolescent residents who need continuous care 24 hours-a-day, 365 days-a-year. Most individuals served by DOH facilities have either complex medical conditions or psychiatric disorders that manifest in violent behaviors, and private sector providers are either unable or unwilling to serve these complex individuals, many of whom are remanded to DOH facilities by court order.

### FY12 OPERATING BUDGET:

<table>
<thead>
<tr>
<th>Source</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>General Funds:</td>
<td>62,477.0</td>
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<tr>
<td>Federal Funds:</td>
<td>0.00</td>
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<tr>
<td>Other State Funds:</td>
<td>76,178.8</td>
</tr>
<tr>
<td>Other Transfers:</td>
<td>713.8</td>
</tr>
</tbody>
</table>

### SUMMARY AND RESULTS AT A GLANCE

Facilities Summary: Facilities has four performance measures in FY12. The amount of uncompensated care met the target for fiscal year 2012 showing a decrease of over 5 million from FY11.

<table>
<thead>
<tr>
<th>Performance Measures</th>
<th>Reporting Frequency</th>
<th>FY11 Actual</th>
<th>FY12 Target</th>
<th>FY12 Q1</th>
<th>FY12 Q2</th>
<th>FY12 Q3</th>
<th>FY12 Q4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of substantiated cases of ANE per one hundred residents in agency-operated long-term care programs confirmed by the division of health improvement</td>
<td>Quarterly</td>
<td>.24</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0.28</td>
</tr>
<tr>
<td>Percent of operational beds filled at all agency facilities</td>
<td>Quarterly</td>
<td>93.5%</td>
<td>89%</td>
<td>91.4%</td>
<td>95%</td>
<td>87.9%</td>
<td>87.0%</td>
</tr>
<tr>
<td>Percent of billed third party revenues at all agency facilities</td>
<td>Quarterly</td>
<td>60%</td>
<td>74%</td>
<td>74%</td>
<td>60%</td>
<td>60%</td>
<td>59.8%</td>
</tr>
<tr>
<td>Total dollar amount of uncompensated care at all facilities</td>
<td>Quarterly</td>
<td>$41,377,947</td>
<td>$38,684,000</td>
<td>$7,294,196</td>
<td>$8,658,536</td>
<td>$8,172,742</td>
<td>$11,867,028</td>
</tr>
</tbody>
</table>
IMPROVE RESIDENT CARE AND SERVICES IN DOH FACILITIES.

Data Reported Quarterly

Data Source: Incident Management System

Goal:
To maintain zero substantiated cases of abuse, neglect and exploitation.

Number of Substantiated Cases of Abuse, Neglect and Exploitation per 100 Residents in DOH Operated Long Term Care Programs

MEASURE HISTORY:
- The long term care facilities continue to focus on preventing abuse, neglect and exploitation.
- In FY12-Q4, there were two substantiated cases of abuse, neglect or exploitation, confirmed in agency operated long term care programs.

ACTION PLAN:
- Decrease the number of substantiated cases of abuse, neglect and exploitation by increasing the number of unannounced surveys.
- Provide mandatory annual training for all staff members on incident management. Update any changes in the process, review definitions and requirements for reporting and dealing with incidents.
Data Reported Annually

Data Source:
Minimum Data Set

Goal:
To increase the percent of operational capacity beds filled at all agency facilities.

MEASURE HISTORY:
- This measure exceeded target in FY12 for three of the 4 quarters.

Data Reported Quarterly

Data Source:
Minimum Data Set

Goal:
To increase the percent of billed third party revenues at all agency facilities.

MEASURE HISTORY:
- Facilities continue to have difficulties with collections from some private pay revenues.

QUARTER FOUR ACTIVITIES:
- To improve revenue collections, some facilities have implemented electronic billing and dragon speak transcription service and upgraded computers for faster processing. There is also a focus on hiring administrative (billing related) positions at Fort Bayard and Las Vegas.
- Improve reporting by ensuring accurate billing data.
- Initiated ongoing monthly meetings with third-party payors to improve revenue.
**Data Reported Annually**

**Data Source:**
Minimum Data Set

**Goal:**
To decrease the total dollar amount of uncompensated care at all facilities.
Note: Data has been corrected for Quarters 2 and 3. The cumulative was previously reported as the quarterly amount.

**MEASURE HISTORY:**
- In FY11, the total dollar amount of uncompensated care at all facilities missed the target by $1.3 million.
- In FY12 the target was met with $35,992,502 for the total amount of uncompensated care at all facilities showing a decrease of over 5 million from FY11.
- Please note that there was miscommunication about the quarterly reporting in Quarters 2 and 3 so that the year to date amount was reported as the quarterly amount.
PROGRAM AREA 7:  
DEVELOPMENTAL DISABILITIES SUPPORTS

MISSION/PURPOSE:
Developmental Disabilities Supports (DDSD) fulfills the DOH mission by effectively administering a system of person-centered community supports and services that promotes positive outcomes for all stakeholders with a primary focus on assisting individuals with developmental disabilities and their families to exercise their right to make choices, grow and contribute to their community.

<table>
<thead>
<tr>
<th>FY12 OPERATING BUDGET:</th>
</tr>
</thead>
<tbody>
<tr>
<td>General Funds: 129,085.6</td>
</tr>
<tr>
<td>Federal Funds: 2,596.3</td>
</tr>
<tr>
<td>Other State Funds: 1,400.0</td>
</tr>
<tr>
<td>Other Transfers: 7,704.0</td>
</tr>
</tbody>
</table>

SUMMARY AND RESULTS AT A GLANCE

**Developmental Disabilities Summary:** DDSD has five quarterly measures in FY12. Two DD Waiver measures are informational only.

<table>
<thead>
<tr>
<th>Performance Measures</th>
<th>Reporting Frequency</th>
<th>FY11 Actual</th>
<th>FY12 Target</th>
<th>FY12 Q1</th>
<th>FY12 Q2</th>
<th>FY12 Q3</th>
<th>FY12 Q4</th>
<th>FY12 Q4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percent of adults receiving developmental disabilities day services who are engaged in community-integrated employment</td>
<td>Quarterly</td>
<td>32%</td>
<td>29%</td>
<td>29.24%</td>
<td>Available in Q3</td>
<td>29.2</td>
<td>36%</td>
<td></td>
</tr>
<tr>
<td>Percent of developmental disabilities waiver applicants who have a service plan in place within ninety days of income and clinical eligibility determination</td>
<td>Quarterly</td>
<td>90%</td>
<td>93%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>98.3</td>
<td></td>
</tr>
<tr>
<td>Percentage of requests to increase level of care (from level 3 to level 2 or from level 2 to level 1) reviewed by DOH</td>
<td>Quarterly</td>
<td>NA</td>
<td>39%</td>
<td>75%</td>
<td>75%</td>
<td>67%</td>
<td>57%</td>
<td></td>
</tr>
<tr>
<td>Number of individuals on the developmental disabilities waiver receiving services</td>
<td>Quarterly</td>
<td>3,801</td>
<td>3,792</td>
<td>3,815</td>
<td>3,793</td>
<td>3,768*</td>
<td>3,888</td>
<td></td>
</tr>
<tr>
<td>Number of individuals on the developmental disabilities waiver waiting list</td>
<td>Quarterly</td>
<td>5,401</td>
<td>4,720</td>
<td>5,542</td>
<td>5,643</td>
<td>5,876</td>
<td>5,911</td>
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</tr>
</tbody>
</table>


ENSURE QUALITY DEVELOPMENTAL DISABILITIES SERVICES FOR NEW MEXICANS.

Data Reported Quarterly

Data Source:
Supported Employment Unit,
Community Programs Bureau

Goal:
To increase the percent of adults
receiving DD day services who are
engaged in community integrated
employment.

Note: * Results were met or ex-
cceeded every quarter

MEASURE HISTORY:

* The data for this measure is reported one quarter behind.

In the fourth quarter 1,167 out of the 3,241 adults receiving day services were engaged in community integrated employment

DDSD exceeded the target of 29% through continuing technical assistance to supported employment providers; providing trainings from national speakers, utilization of NMEI and other consultants and emphasis on Employment First by DDSD staff.

QUARTER FOUR ACTIVITIES:

* Continue to utilize the New Mexico Employment Institute in areas of job development and technical assistance to train and assist providers.

* Continue to schedule and conduct local Employment Leadership Network meetings to support employment efforts among providers, employers and individuals served.

* Also continue to work closely with the National Supported Employment Network of which we are a mentor state. Medicaid Infrastructure Grant funding has been secured to facilitate training of providers.
**MEASURE HISTORY:**
- In FY12, only one applicant during the entire year did not have a service plan in place within 90 days of income and clinical eligibility determination.

**ACTION PLAN:**
- Eligibility workers request bi-weekly status reports from Case Managers (or from applicants if choosing the Mi Via option). Status reports are monitored to identify barriers, and potential barriers, to completion of eligibility determinations. Information obtained from monitoring is provided to appropriate DDSD personnel as indicated.

**QUARTER FOUR ACTIVITIES:**
- Percent of DD waiver applicants who have a service plan in place within 90 days of income and clinical eligibility determination was 98.3% for quarter four. The number of days was calculated by comparing the date of income/clinical eligibility determination (LOC/MAW) and the start date of the individual service plan (ISP). The data is collected from Case Management agencies and Income Support Division documents.
QUARTER FOUR ACTIVITIES:

- Regional office staff members determine the number of Level of Care requests that were approved for increases. This is related to the current DDSD funding formula for waiver services. The data being reported is the percent of requests which are reviewed and approved. An individual's level of care cannot increase without Department of Health review.

- During quarter four a new system for determining services was implemented.
QUARTER FOUR ACTIVITIES:

In quarter four the number of individuals on the developmental disabilities waiver receiving services increased. 3,693 are on the traditional DD Waiver and 195 are on the Mi Via DDW list. The total given is a combined total 3,888. Both the traditional DD Waiver and Mi Via show an increase.

In quarter four the increase in the number receiving services was greater than the increase in the number on the waiting list.

Data Reported Quarterly

Data Source:
Central Registry

Goal:
To decrease the number of individuals on the developmental disabilities waiver waiting list.

Note:
Measure is non-AGA, informational only.

QUARTER FOUR ACTIVITIES:

- The number of persons waiting for DD Waiver services continues to increase. There are two major factors leading to the increase. First, the number of persons added to the DD waiver is limited because of funding availability. The second factor is that people continue to apply for DD waiver services. It is likely the number of people on the wait list will continue to increase until funding availability allows for substantial numbers to move from the wait list into DD waiver services.
**PROGRAM AREA 8: HEALTH CERTIFICATION, LICENSING AND OVERSIGHT**

**MISSION/PURPOSE:**
The Health Certification, Licensing and Oversight program provides health facility licensing and certification surveys, community-based oversight and contract compliance surveys and a statewide incident management system, so that people in New Mexico have access to quality health care and that vulnerable populations are safe from abuse, neglect and exploitation.

**FY12 OPERATING BUDGET:**
- General Funds: 4,393.0
- Federal Funds: 1,929.6
- Other State Funds: 2,290.9
- Other Transfers: 3,427.7

**SUMMARY AND RESULTS AT A GLANCE**

**Q4 Health Certification Licensing and Oversight Summary:** HCLO has three quarterly measures in FY12 and met target on two of the three.

<table>
<thead>
<tr>
<th>Performance Measures</th>
<th>Reporting Frequency</th>
<th>FY11 Actual</th>
<th>FY12 Target</th>
<th>FY12 Q1</th>
<th>FY12 Q2</th>
<th>FY12 Q3</th>
<th>FY12 Q4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percent of developmental disabilities, family infant toddler, medically fragile and behavioral health providers receiving a survey by the quality management bureau</td>
<td>Quarterly</td>
<td>67.6%</td>
<td>49%</td>
<td>14.28%</td>
<td>16.5%</td>
<td>19.1%</td>
<td>20.2%</td>
</tr>
<tr>
<td>Percent of required compliance surveys completed for adult residential care and adult day care facilities</td>
<td>Quarterly</td>
<td>44.5%</td>
<td>74%</td>
<td>9%</td>
<td>14%</td>
<td>13%</td>
<td>9%</td>
</tr>
<tr>
<td>Percent of abuse, neglect and exploitation incidents for community-based programs investigated within 45 days</td>
<td>Quarterly</td>
<td>92.04%</td>
<td>93%</td>
<td>95.16%</td>
<td>97.15%</td>
<td>94.85%</td>
<td>95.1%</td>
</tr>
</tbody>
</table>
ELIMINATE ABUSE, NEGLECT, OR EXPLOITATION OF SENIORS AND VULNERABLE ADULTS:

![Chart showing percent of Developmental Disabilities, Family Infant Toddler, Medically Fragile and Behavioral Health Providers Receiving a Survey by the QMB.](chart)

**Data Reported Quarterly**

**Data Source:**
QMB and HFLC Systems

**Goal:**
To increase the percent of DD, FIT, MF and behavioral health providers receiving a survey from QMB. Target for FY12 was exceeded.

**MEASURE HISTORY:**
- The total number of community providers was 224 at the beginning of the year. During the year the number decreased to 208. The purpose of community provider surveys is to ensure compliances with state and federal regulations, statues, requirements, standards and policies in order to protect the health and safety of people served.
- Division of Health Improvement’s Quality Management Bureau conducts compliance surveys of community based providers for the following services: The CMS Medicaid Waivers for Developmental Disabilities (DDW) and Medically Fragile (MFW), the Family Infant Toddler (FIT) Program, Behavioral Health Services (BH), Community Mental Health Centers (CMHC), and Comprehensive Community Support Services (CCSS).
- The frequency of provider surveys is based on their historical/current performance or service type. DDW, MFW, FIT providers are surveyed based on the previous determination of compliance, Substantial Compliance, (3 year) Partial compliance (2 year), or Non compliance (1 year). BH surveys are conducted on an 18-24 month review cycle for each service, CMHC and CCSS.

**ACTION PLAN:**
- In FY12, QMB made significant changes to its survey processes to realign survey tools and processes with the new DDW standards and requirements (including Conditions of Participation CoPs) and with BH guidelines for a single compliance tool for youth and adult services.
- The SFY12 data will be used to create a new benchmark for the QMB performance measure data.

**QUARTER FOUR ACTIVITIES:**
- In the fourth quarter of SFY12 QMB conducted 42* surveys of community based providers. 28 DDW surveys of 23 providers (6 were repeat surveys of same provider) ; MF surveys completed 2 of 11; FIT surveys completed 4 of 36; CMHC 2 verification surveys; CCSS surveys 6 of 25.
Data Reported Quarterly

Data Source:
Incident Management Bureau database

Goal:
To increase the percent of compliance surveys completed for adult residential care and adult day care facilities.

![Percent of Required Compliance Surveys Completed for Adult Residential Care and Adult Day Care Facilities](image)

**MEASURE HISTORY:**
- Survey oversight of assisted living and adult day care facilities is statutorily required as well as needed to protect our vulnerable NM residents living in these settings. We survey for health and safety in accordance with our regulations 7.8.2 NMAC.

**ACTION PLAN:**
- Hiring and training new surveyors.
- Improve over-all program performance to ensure quality oversight of facilities.
- Increase monitoring by chief nursing officer.
- Increase customer satisfaction.
- Conduct unannounced state licensing surveys of assisted living and adult day care facilities to ensure the health and safety of vulnerable NM residents.
- HFL&C is conducting Complaint Based Surveys on these facility types to ensure the health and safety of residents residing and receiving services is ensured.

**QUARTER FOUR ACTIVITIES:**
- HFL&C is conducting Complaint Based Surveys on these facility types to ensure the health and safety of residents residing and receiving services is ensured. During the months of April, May, and June, 15 complaint surveys, 3 revisit surveys and 3 initials were completed. 21 total surveys were conducted in the 4th quarter.
**MEASURE HISTORY:**

- To protect consumers that receive community-based services from abuse, neglect and exploitation perpetrated by paid caregivers.

- In order to protect the health and safety of covered populations, home and community-based service providers are required to file Incident Reports (IR) of abuse, neglect, exploitation and other reportable incidents with the Incident Management Bureau (IMB), as required by regulation. Covered populations include people served through: the Developmental Disabilities (DD) Waiver; Medically Fragile Waiver; Family, Infant, Toddler Program, DD State General Fund; Traumatic Brain Injury Crisis Interim Fund; and some people served through the DD Mi Via Waiver.

- The FY 12 target has been exceeded in each quarter.

**ACTION PLAN:**

- Incident reports are received from community based providers of service who contract with the Department of Health and the Aging and Long Term Services Traumatic Brain Injury program. Incidents reported include abuse, neglect, exploitation, death, emergency services, law enforcement and environmental hazards. Incident Management Intake triages all incident reports received to determine priority, severity and assignment of case. Incident Management Bureau has no control over the number of incidents received. Factors that impact the actual number of incidents received may include the number of individuals receiving services, the number of enrolled providers, the number of incidents that occur, etc.
ACTION PLAN:
- Investigators are assigned to review incidents reporting use of emergency services and law enforcement involvement to determine if the services were utilized appropriately and to determine if abuse, neglect or exploitation could also be alleged and confirmed. Finally, investigators are also assigned reports of environmental hazards and unexpected deaths to determine if abuse, neglect or exploitation may be alleged and confirmed.

QUARTER FOUR ACTIVITIES:
- Percentages were impacted by extended leave by three investigators, and a vacancy during the third quarter. This increased the case load averages for working investigators which resulted in slight delay in case closure rates.
Appendix B

- PBB End of Year Performance Report
- Full Program Report (FY12 results, FY13 approved measures and FY14 requested targets).
- Performance Measure Summary
- Performance Monitoring Plan
### Program: PO02
**Public Health**

#### Program Description
Prevention and health promotion programs should be designed to improve health status and reduce disease and injury. Access to quality, culturally competent health care.

### Public Health Measures

<table>
<thead>
<tr>
<th>Measure</th>
<th>Target</th>
<th>Year-End Estimate</th>
<th>Percent Met</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>91.5%</td>
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</table>

#### Efficiency

<table>
<thead>
<tr>
<th>Efficiency</th>
<th>Annual Report</th>
<th>Net Increase</th>
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<tbody>
<tr>
<td></td>
<td>79%</td>
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</table>

### Program: PO01
**Administration**

#### Program Description
The purpose of the administration program is to provide leadership, policy development, information technology, and fiscal management.

### Administration Measures

<table>
<thead>
<tr>
<th>Measure</th>
<th>Target</th>
<th>Year-End Estimate</th>
<th>Percent Met</th>
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<tbody>
<tr>
<td></td>
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<td>79%</td>
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</table>

#### Agency: 66500
**Department of Health**

### AnnualPerformanceReport

**DFP Performance Based Budgeting Data System**
<table>
<thead>
<tr>
<th>Measure</th>
<th>Type</th>
<th>Year-End</th>
<th>Target</th>
<th>Meets</th>
<th>Result</th>
<th>FE/12</th>
<th>Target</th>
<th>Meets</th>
<th>Result</th>
<th>FE/12</th>
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<tbody>
<tr>
<td>PSA HIV Prevention Services to New Mexico</td>
<td></td>
<td>110.07%</td>
<td>113.00</td>
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<td>123.00</td>
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<tr>
<td>% of eligible women, urban and children (WIC) persons receiving CFS, health immunization results are announced</td>
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<tr>
<td>Health providers to deliver services that will not be at risk and will be eligible to receive CFS, health immunization and newborn screening services through school immunizations and newborn screen programs that are respectful to adolescents, and in accordance with HIPAA and Title X confidentiality provisions.</td>
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<td>Number of girls who have not had sex, who identified as lesbian, gay, or bisexual</td>
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</tbody>
</table>
The purpose of the public health services program is to provide laboratory and scientific expertise for policy development and assist in developing public health, infection, and toxicology programs in the state of New Mexico to provide effective and efficient public health services.

**Facilities Management**

**Program:** P009

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Measure</th>
<th>Type</th>
<th>Year-End Results</th>
<th>Met</th>
<th>Target</th>
<th>Result</th>
<th>FY12</th>
<th>FY12</th>
</tr>
</thead>
<tbody>
<tr>
<td>Efficiency</td>
<td>Percent of all state agencies and contracts with individual contracts for expenditures of all state agencies</td>
<td>Effort</td>
<td>95%</td>
<td>94%</td>
<td>93%</td>
<td>95%</td>
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<tr>
<td>Outcome</td>
<td>Percent of operational capacity fully utilized at all agencies</td>
<td>Outcome</td>
<td>94%</td>
<td>94%</td>
<td>93%</td>
<td>95%</td>
<td>94%</td>
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</tr>
</tbody>
</table>

**Laboratory Services**

**Program:** P004

**Measure:** DFA Performance Based Budgeting Data System

**Annual Performance Report**
<table>
<thead>
<tr>
<th>Measure</th>
<th>Type</th>
<th>FY12</th>
<th>FY11</th>
<th>Result</th>
<th>Target</th>
<th>Target</th>
<th>Year-End</th>
<th>FY12</th>
<th>FY11</th>
<th>Result</th>
<th>FY12</th>
<th>FY11</th>
<th>Result</th>
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</tbody>
</table>
### Performance Indicators

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Percent of Medicaid Eligible Populations</th>
<th>Percent of Non-Medicaid Eligible Populations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preventive care services received by health care providers</td>
<td>96%</td>
<td>90%</td>
</tr>
<tr>
<td>Preventive care services received by non-medicaid health care providers</td>
<td>96%</td>
<td>90%</td>
</tr>
<tr>
<td>Preventive care services received by community health centers</td>
<td>96%</td>
<td>90%</td>
</tr>
</tbody>
</table>

### Health Certification, Licenses, and Oversight

**Program:** Health Certification, Licenses, and Oversight

**Measure:** 90%

**Efficiency:** 90%
DFA Performance Based Budgeting Data System  
Full Program and Measure Report

### Administration

**BusUnit:** Department of Health  
**Code:** 66500

**Program Name:** Administration  
**Code:** P001

**Authority:** Sections 9-7-1 through 9-7-16 NMSA 1978.

**Users:** Department of Health programs, staff, contractors, suppliers and vendors, individuals and communities of New Mexico.

**Purpose:** The purpose of the administration program is to provide leadership, policy development, information technology, administrative and legal support to the department of health so it achieves a high level of accountability and excellence in services provided to the people of New Mexico.

**Performance Measures:**

<table>
<thead>
<tr>
<th>Performance Measures</th>
<th>FY12 Result</th>
<th>FY13 Target</th>
<th>FY14 Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>Efficiency</td>
<td>Percent of payment vouchers paid within thirty days of acceptance of goods and services</td>
<td>93.5%</td>
<td>100%</td>
</tr>
<tr>
<td>Output</td>
<td>Number of working days between expenditure of federal funds and request for reimbursement</td>
<td>30</td>
<td>5</td>
</tr>
<tr>
<td>Efficiency</td>
<td>Percent of responses to Requests for Legal Services initiated within two weeks</td>
<td>100%</td>
<td>*</td>
</tr>
<tr>
<td>Efficiency</td>
<td>Percent of disciplinary actions reviewed, approved and returned within three working days</td>
<td>100%</td>
<td>*</td>
</tr>
<tr>
<td>Output</td>
<td>Percent of Hispanic adults age 65 and older that receive a pneumonia and/or influenza vaccination</td>
<td>75%</td>
<td>75%</td>
</tr>
</tbody>
</table>

### Public Health

**Authority:** Sections 24-1-1 through 24-1-21; 24-1-1 through 24-1A-1 through 24-1A-4 NMSA 1978.

**Users:** Mothers and children, particularly those with no other funding source; people living with HIV/AIDS; children and adults with chronic or infectious disease, or other special health needs; uninsured, low-income individuals needing primary care and dental services, school-aged children and their families, people living along the U.S.-Mexico border, individuals and communities in New Mexico.

**Purpose:** The purpose of the public health program is to provide a coordinated system of community-based public health services focusing on disease prevention and health promotion to improve health status, reduce disparities and ensure timely access to quality, culturally competent health care.

**Performance Measures:**

<table>
<thead>
<tr>
<th>Performance Measures</th>
<th>FY12 Result</th>
<th>FY13 Target</th>
<th>FY14 Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>Output</td>
<td>Number of syringes returned to the syringe exchange program</td>
<td>2,317,151</td>
<td>*</td>
</tr>
<tr>
<td>Quality</td>
<td>Percent of QUIT NOW enrollees who successfully quit using tobacco at 7-month follow-up</td>
<td>*</td>
<td>40%</td>
</tr>
<tr>
<td>Outcome</td>
<td>Number of teen births averted among 15-17 year old females seen in the department of health funded clinics</td>
<td>*</td>
<td>850</td>
</tr>
<tr>
<td>Outcome</td>
<td>Percent of individuals re-enrolling in the syringe exchange program who are not sharing syringes</td>
<td>92.8%</td>
<td>*</td>
</tr>
<tr>
<td>Output</td>
<td>Number of calls to 1-800-Quit Now tobacco cessation helpline</td>
<td>9,642</td>
<td>14,000</td>
</tr>
<tr>
<td>Output</td>
<td>Number of teens ages fifteen to seventeen receiving family planning services in agency-funded family planning clinics</td>
<td>5,631</td>
<td>7,000</td>
</tr>
</tbody>
</table>

---

* Tuesday, September 04, 2012

Page 1 of 5
### DFA Performance Based Budgeting Data System

#### Full Program and Measure Report

<table>
<thead>
<tr>
<th>Output</th>
<th>Number of human immunodeficiency virus/acquired immune deficiency syndrome prevention interventions</th>
<th>15,549</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outcome</td>
<td>Persons enrolled in the agency’s HIV services and receiving combination therapy who demonstrate an undetectable viral load</td>
<td>90.1%</td>
</tr>
<tr>
<td>Outcome</td>
<td>Percent of individuals diagnosed with primary or secondary syphilis treated within thirty days of diagnosis</td>
<td>95.9%</td>
</tr>
<tr>
<td>Output</td>
<td>Number of participants in youth suicide prevention awareness and outreach activities</td>
<td>24,693</td>
</tr>
<tr>
<td>Output</td>
<td>Number of visits to agency-funded school-based health centers</td>
<td>42,977</td>
</tr>
<tr>
<td>Output</td>
<td>Percent of preschoolers (nineteen to thirty-five months) fully immunized</td>
<td>76.1%</td>
</tr>
<tr>
<td>Outcome</td>
<td>Percent of children enrolled in Medicaid that receive dental screening and fluoride sealants or varnish</td>
<td>75%</td>
</tr>
<tr>
<td>Output</td>
<td>Number of eligible women, infant and children (WIC) persons receiving services</td>
<td>110,027</td>
</tr>
</tbody>
</table>

**Program Name:** Epidemiology and Response  
**Code:** P003

**Authority:** Sections 24-1-1 through 24-1-21; 24-10A-1 through 24-10A-10; 24-14-1 through 24-14-3; and 24-10B-1 through 24-10B-12 NMSA 1978.

**Users:** Individuals requiring emergency medical services, individuals needing data and reports on health status of New Mexicans, individual requiring vital records; individuals concerned about bioterrorism preparedness and individuals in New Mexico.

**Purpose:** The purpose of the epidemiology and response program is to monitor health, provide health information, prevent disease and injury, promote health and healthy behaviors, respond to public health events, prepare for health emergencies and provide emergency medical and vital registration services to New Mexicans.

**Performance Measures:**

<table>
<thead>
<tr>
<th>Performance Measure</th>
<th>FY12 Result</th>
<th>FY13 Target</th>
<th>FY14 Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quality</td>
<td>Percent of emergency medical services agencies that comply with the standards of certification as outlined in the NMAC Rule 7.27.10</td>
<td>100%</td>
<td>*</td>
</tr>
<tr>
<td>Efficiency</td>
<td>Average time from initial report to final review and transmission by agency to the centers for disease control and prevention of foodborne pathogens: salmonella, shigella and campylobacter</td>
<td>12 days</td>
<td>*</td>
</tr>
<tr>
<td>Efficiency</td>
<td>Percent of birth certificates issued or searched for within seven days of receipt of an approved birth search application and fee</td>
<td>100%</td>
<td>*</td>
</tr>
<tr>
<td>Output</td>
<td>Number of designated trauma centers in the state</td>
<td>10</td>
<td>*</td>
</tr>
<tr>
<td>Output</td>
<td>Number of health emergency exercises conducted to assess and improve state and local capability</td>
<td>129</td>
<td>*</td>
</tr>
<tr>
<td>Output</td>
<td>Percentage of emergency department and intensive care unit licensed staff at developing and existing trauma centers who have received training in traumatic injury care</td>
<td>80%</td>
<td></td>
</tr>
<tr>
<td>Output</td>
<td>The number of naloxone prescriptions provided in conjunction with prescription opioids</td>
<td>1,000</td>
<td></td>
</tr>
</tbody>
</table>
### DFA Performance Based Budgeting Data System

**Full Program and Measure Report**

<table>
<thead>
<tr>
<th>Program Name:</th>
<th>Laboratory Services</th>
<th>Code:</th>
<th>P004</th>
</tr>
</thead>
<tbody>
<tr>
<td>Authority:</td>
<td>Sections 24-1-1 through 24-1-21, §9-7-3, §24-1-3 P, §25-7(A)1-19, - § 25-7A-19, , §24-1-6, §9-7-6, §66-8-107 through 113, 66-8-105 to 66-8-112 , 24-1-22 , §24-1-22, §30-31-1 through 41, §24-11-1 through 12, §60-1-22, §74-6-1 et seq. -NMSA 1978;21 NMAC 34.2 [74-4G-1 to 74-4G-12 ], 40 CFR 116-140, 40 CFR 141-143, 10 CFR 1-171, 10 CFR Subchapter C,</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Users:</td>
<td>Law enforcement agencies and personnel, the Office of the Medical Investigator, Agriculture Department and Environment Department</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Purpose:</td>
<td>The purpose of the laboratory services program is to provide laboratory analysis and scientific expertise for policy development for tax-supported public health, environment and toxicology programs in the state of New Mexico to provide timely identification of threats to the health of New Mexicans.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Performance Measures:</th>
<th>FY12 Result</th>
<th>FY13 Target</th>
<th>FY14 Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outcome</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Effeciency</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Outcome</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Program Name:</th>
<th>Facilities Management</th>
<th>Code:</th>
<th>P006</th>
</tr>
</thead>
<tbody>
<tr>
<td>Authority:</td>
<td>Constitution of New Mexico, Article 14, Section 1; 23-1-1 through 23-1-13; 23-4-1 through 23-4-7; 23-5-1 through 23-5-2 ; 27-9-11 NMSA 1978.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Users:</td>
<td>Elderly persons with specialized support needs, medically fragile persons, persons in need of mental health and substance abuse treatment, and veterans requiring long-term care.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Purpose:</td>
<td>The purpose of the facilities management program is to provide oversight for department of health facilities that provide health and behavioral healthcare services, including mental health, substance abuse, nursing home and rehabilitation programs in both facility- and community-based settings, and serve as the safety net for the citizens of New Mexico.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Performance Measures:</th>
<th>FY12 Result</th>
<th>FY13 Target</th>
<th>FY14 Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>Output</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Efficiency</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Explanatory</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Outcome</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Outcome</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Output</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Note: The results for FY14 are not available as of the date of this report.*

*Tuesday, September 04, 2012*
### DFA Performance Based Budgeting Data System

#### Full Program and Measure Report

| Efficiency | Percent of collectable third-party revenues at agency facilities | 59.8% |
| Explanatory | Total dollar amount, in millions, of uncompensated care at all agency facilities | $36 |
| Outcome | Number of substantiated cases of abuse, neglect and exploitation per one hundred residents in agency-operated long-term care programs confirmed by the division of health improvement or adult protective services | 0.28 |

#### Program Name: Developmental Disabilities Support

**Code:** P007

**Authority:** 28-16A-1 through 28-16A-18 NMSA 1978.

**Users:** Children and adults with developmental disabilities and children at risk of developmental delays

**Purpose:** The purpose of the developmental disabilities support program is to administer a statewide system of community-based services and support to improve the quality of life and increase the independence and interdependence of individuals with developmental disabilities and children with or at risk for developmental delay or disability and their families.

### Performance Measures:

<table>
<thead>
<tr>
<th>Performance Measures</th>
<th>FY12 Result</th>
<th>FY13 Target</th>
<th>FY14 Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outcome</td>
<td>Percent of adults receiving developmental disabilities day services who are engaged in community-integrated employment</td>
<td>36%</td>
<td>38%</td>
</tr>
<tr>
<td>Efficiency</td>
<td>Percent of developmental disabilities waiver applicants who have a service plan in place within ninety days of income and clinical eligibility determination</td>
<td>98.3%</td>
<td>100%</td>
</tr>
<tr>
<td>Explanatory</td>
<td>Number of individuals on developmental disabilities waiver receiving services</td>
<td>3,888</td>
<td>3,997</td>
</tr>
<tr>
<td>Explanatory</td>
<td>Number of individuals on developmental disabilities waiver waiting list</td>
<td>5,911</td>
<td>4,535</td>
</tr>
<tr>
<td>Efficiency</td>
<td>Percent of requests to increase a level of care reviewed by the department of health</td>
<td>69.8</td>
<td>*</td>
</tr>
</tbody>
</table>

#### Program Name: Health Certification Licensing and Oversight

**Code:** P008

**Authority:** Section 24-1-1 through 24-1-22; 29-17-2 through 29-17-5; 9-7-16 NMSA 1978

**Users:** Health care providers requiring licensing and certification their patients and consumers of health care services

**Purpose:** The purpose of the health certification, licensing and oversight program is to provide health facility licensing and certification surveys, community-based oversight and contract compliance surveys and a statewide incident management system so that people in New Mexico have access to quality health care and that vulnerable populations are safe from abuse, neglect and exploitation.

### Performance Measures:

<table>
<thead>
<tr>
<th>Performance Measures</th>
<th>FY12 Result</th>
<th>FY13 Target</th>
<th>FY14 Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>Output</td>
<td>Percent of abuse, neglect and exploitation incidents for community-based programs investigated within 45 days</td>
<td>95.5%</td>
<td>100%</td>
</tr>
<tr>
<td>Output</td>
<td>Percent of developmental disabilities, medically fragile, behavioral health and family, infant, toddler providers receiving a survey by the quality management bureau</td>
<td>71%</td>
<td>100%</td>
</tr>
<tr>
<td>------------------------------------------------------------------------</td>
<td>------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>-----</td>
<td>------</td>
</tr>
<tr>
<td>Output</td>
<td>Percent of required compliance surveys completed for adult residential care and adult daycare facilities</td>
<td>45%</td>
<td></td>
</tr>
<tr>
<td>Output</td>
<td>Percent of intermediate care facilities for the mentally retarded (ICFMR) receiving an unannounced survey by Health Facility and Licensing</td>
<td>97%</td>
<td></td>
</tr>
<tr>
<td>Purpose/Measure</td>
<td>FY11 Actual</td>
<td>FY12 Actual</td>
<td>FY13 Budget</td>
</tr>
<tr>
<td>----------------</td>
<td>-------------</td>
<td>-------------</td>
<td>-------------</td>
</tr>
<tr>
<td><strong>P002 Public Health</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Outcome</td>
<td>Percent of children enrolled in Medicaid that receive dental screening and fluoride sealants or varnish</td>
<td>75%</td>
<td>75%</td>
</tr>
<tr>
<td>Output</td>
<td>Number of calls to 1-800-Quit Now tobacco cessation helpline</td>
<td>11,944</td>
<td>9,642</td>
</tr>
<tr>
<td>* Output</td>
<td>Number of teens ages fifteen to seventeen receiving family planning services in agency-funded family planning clinics</td>
<td>4,851</td>
<td>5,631</td>
</tr>
<tr>
<td>Output</td>
<td>Number of visits to agency-funded school-based health centers</td>
<td>55,616</td>
<td>42,977</td>
</tr>
<tr>
<td>* Output</td>
<td>Percent of preschoolers (nineteen to thirty-five months) fully immunized</td>
<td>65.4%</td>
<td>76.1%</td>
</tr>
<tr>
<td>Outcome</td>
<td>Number of teen births averted among 15-17 year old females seen in the department of health funded clinics</td>
<td>850</td>
<td></td>
</tr>
<tr>
<td>Outcome</td>
<td>Percent of individuals re-enrolling in the syringe exchange program who are not sharing syringes</td>
<td>82%</td>
<td>92.8%</td>
</tr>
<tr>
<td>Outcome</td>
<td>Persons enrolled in the agency’s HIV services and receiving combination therapy who demonstrate an undetectable viral load</td>
<td>90.2%</td>
<td>90.1%</td>
</tr>
<tr>
<td>Outcome</td>
<td>Percent of individuals diagnosed with primary or secondary syphilis treated within thirty days of diagnosis</td>
<td>100%</td>
<td>95.9%</td>
</tr>
<tr>
<td>Output</td>
<td>Number of syringes returned to the syringe exchange program</td>
<td>2,802,426</td>
<td>2,317,151</td>
</tr>
<tr>
<td>Output</td>
<td>Number of human immunodeficiency virus/acquired immune deficiency syndrome prevention interventions</td>
<td>14,047</td>
<td>15,549</td>
</tr>
<tr>
<td>Output</td>
<td>Number of eligible women, infant and children (WIC) persons receiving services</td>
<td>112,324</td>
<td>110,027</td>
</tr>
<tr>
<td>Quality</td>
<td>Percent of QUIT NOW enrollees who successfully quit using tobacco at 7-month follow-up</td>
<td>40%</td>
<td></td>
</tr>
<tr>
<td><strong>P003 Epidemiology and Response</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Quality</td>
<td>Percent of emergency medical services agencies that comply with the standards of certification as outlined in the NMAC Rule 7.27.10</td>
<td>100%</td>
<td></td>
</tr>
<tr>
<td>Efficiency</td>
<td>Average time from initial report to final review and transmission by agency to the centers for disease control and prevention of foodborne pathogens: salmonella, shigella and campylobacter</td>
<td>12 days</td>
<td></td>
</tr>
<tr>
<td>Efficiency</td>
<td>Percent of birth certificates issued or searched for within seven days of receipt of an approved birth search application and fee</td>
<td>100%</td>
<td></td>
</tr>
<tr>
<td>Output</td>
<td>Number of designated trauma centers in the state</td>
<td>9</td>
<td>10</td>
</tr>
<tr>
<td>Output</td>
<td>Number of health emergency exercises conducted to assess and improve state and local capability</td>
<td>106</td>
<td>129</td>
</tr>
<tr>
<td>Output</td>
<td>Percentage of emergency department and intensive care unit licensed staff at developing and existing trauma centers who have received training in traumatic injury care</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* - recommended for General Appropriation Act
### TABLE 2

**Department of Health Performance Measures Summary**

<table>
<thead>
<tr>
<th>Purpose/Measure</th>
<th>FY11 Actual</th>
<th>FY12 Actual</th>
<th>FY13 Budget</th>
<th>FY14 Request</th>
<th>FY14 Recomm</th>
</tr>
</thead>
<tbody>
<tr>
<td>Output</td>
<td>The number of naloxone prescriptions provided in conjunction with prescription opioids</td>
<td>1,000</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**P004 Laboratory Services**

The purpose of the laboratory services program is to provide laboratory analysis and scientific expertise for policy development for tax-supported public health, environment and toxicology programs in the state of New Mexico to provide timely identification of threats to the health of New Mexicans.

<table>
<thead>
<tr>
<th>Outcome</th>
<th>FY11 Actual</th>
<th>FY12 Actual</th>
<th>FY13 Budget</th>
<th>FY14 Request</th>
<th>FY14 Recomm</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percent of Office of Medical Investigator toxicology cases completed within ninety days</td>
<td>65.55%</td>
<td>33.85%</td>
<td>95%</td>
<td>*</td>
<td></td>
</tr>
</tbody>
</table>

* Efficiency Percent of blood alcohol tests from driving-while-intoxicated cases analyzed and reported within ten business days | 16.33% | 44.6% | 95% | 95% |

<table>
<thead>
<tr>
<th>Outcome</th>
<th>FY11 Actual</th>
<th>FY12 Actual</th>
<th>FY13 Budget</th>
<th>FY14 Request</th>
<th>FY14 Recomm</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percent of public health threat samples for communicable diseases and other threatening illnesses analyzed within specified turnaround times</td>
<td>93.42%</td>
<td>92.2%</td>
<td>*</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**P006 Facilities Management**

The purpose of the facilities management program is to provide oversight for department of health facilities that provide health and behavioral healthcare services, including mental health, substance abuse, nursing home and rehabilitation programs in both facility- and community-based settings, and serve as the safety net for the citizens of New Mexico.

<table>
<thead>
<tr>
<th>Outcome</th>
<th>FY11 Actual</th>
<th>FY12 Actual</th>
<th>FY13 Budget</th>
<th>FY14 Request</th>
<th>FY14 Recomm</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of patient falls with injury per thousand patient days at all agency facilities</td>
<td>0</td>
<td>*</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* Output Percent of operational capacity beds filled at all agency facilities | 93.5% | 87.0% | 100% | 100% |

* Efficiency Percent of collectable third-party revenues at all agency facilities | 62% | 59.8% | 90% | 90% |

* Explanatory Total dollar amount, in millions, of uncompensated care at all agency facilities | $41.4 | $36 | $38 | $38 |

<table>
<thead>
<tr>
<th>Outcome</th>
<th>FY11 Actual</th>
<th>FY12 Actual</th>
<th>FY13 Budget</th>
<th>FY14 Request</th>
<th>FY14 Recomm</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of substantiated cases of abuse, neglect and exploitation per one hundred residents in agency-operated long-term care programs confirmed by the division of health improvement or adult protective services</td>
<td>0.24</td>
<td>0.28</td>
<td>*</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Outcome</th>
<th>FY11 Actual</th>
<th>FY12 Actual</th>
<th>FY13 Budget</th>
<th>FY14 Request</th>
<th>FY14 Recomm</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of substantiated cases of abuse, neglect and exploitation per one hundred residents in agency-operated long-term care programs confirmed by the division of health improvement or adult protective services</td>
<td>.24</td>
<td>0.28</td>
<td>*</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Outcome</th>
<th>FY11 Actual</th>
<th>FY12 Actual</th>
<th>FY13 Budget</th>
<th>FY14 Request</th>
<th>FY14 Recomm</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percent of operational capacity beds filled at all agency facilities</td>
<td>93.5%</td>
<td>87%</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Efficiency Percent of collectable third-party revenues at all agency facilities | 60% | 59.8% | |

Explanatory Total dollar amount, in millions, of uncompensated care at all agency facilities | $41.3 | $36 | |

**P007 Developmental Disabilities Support**

The purpose of the developmental disabilities support program is to administer a statewide system of community-based services and support to improve the quality of life and increase the independence and interdependence of individuals with developmental disabilities and children with or at risk for developmental delay or disability and their families.

<table>
<thead>
<tr>
<th>Outcome</th>
<th>FY11 Actual</th>
<th>FY12 Actual</th>
<th>FY13 Budget</th>
<th>FY14 Request</th>
<th>FY14 Recomm</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percent of adults receiving developmental disabilities day services who are engaged in community-integrated employment</td>
<td>32%</td>
<td>36%</td>
<td>38%</td>
<td>50%</td>
<td></td>
</tr>
</tbody>
</table>

* Efficiency Percent of developmental disabilities waiver applicants who have a service plan in place within ninety days of income and clinical eligibility determination | 90% | 98.3% | 100% | 100% |

* Explanatory Number of individuals on developmental disabilities waiver receiving services | 3,812 | 3,888 | 3,997 | no target |

* - recommended for General Appropriation Act
<table>
<thead>
<tr>
<th>Purpose/Measure</th>
<th>FY11 Actual</th>
<th>FY12 Actual</th>
<th>FY13 Budget</th>
<th>FY14 Request</th>
<th>FY14 Recomm</th>
</tr>
</thead>
<tbody>
<tr>
<td>* Explanatory Number of individuals on developmental disabilities waiver waiting list</td>
<td>5,401</td>
<td>5,911</td>
<td>4,535</td>
<td>no target</td>
<td></td>
</tr>
</tbody>
</table>

**P008 Health Certification Licensing and Oversight**

The purpose of the health certification, licensing and oversight program is to provide health facility licensing and certification surveys, community-based oversight and contract compliance surveys and a statewide incident management system so that people in New Mexico have access to quality health care and that vulnerable populations are safe from abuse, neglect and exploitation.

**Output** Percent of abuse, neglect and exploitation incidents for community-based programs investigated within 45 days

- 92.04% 95.5% 100% *

**Output** Percent of developmental disabilities, medically fragile, behavioral health and family, infant, toddler providers receiving a survey by the quality management bureau

- 67.6% 71% 100% 85%

**Output** Percent of required compliance surveys completed for adult residential care and adult daycare facilities

- 44.5% 45% *

**Output** Percent of intermediate care facilities for the mentally retarded (ICFMR) receiving an unannounced survey by Health Facility and Licensing

- 100% 97% *

**P001 Administration**

The purpose of the administration program is to provide leadership, policy development, information technology, administrative and legal support to the department of health so it achieves a high level of accountability and excellence in services provided to the people of New Mexico.

**Output** Number of working days between expenditure of federal funds and request for reimbursement

- 5 30 5 *

**Output** Percent of Hispanic adults age 65 and older that receive a pneumonia and/or influenza vaccination

- 75% 75%

**Efficiency** Percent of payment vouchers paid within thirty days of acceptance of goods and services

- 92.1% 93.5% 100% *

**Efficiency** Percent of responses to Requests for Legal Services initiated within two weeks

- 100% *

**Efficiency** Percent of disciplinary actions reviewed, approved and returned within three working days

- 100% *

* - recommended for General Appropriation Act
DFA Performance Based Budgeting Data System
Performance Monitoring Plan

<table>
<thead>
<tr>
<th>Agency: Department of Health</th>
<th>BusUnit: 66500</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Program Name: Administration</th>
<th>PCode: P001</th>
</tr>
</thead>
<tbody>
<tr>
<td>The purpose of the administration program is to provide leadership, policy development, information technology, administrative and legal support to the department of health so it achieves a high level of accountability and excellence in services provided to the people of New Mexico.</td>
<td></td>
</tr>
</tbody>
</table>

| Measure: Percent of Hispanic adults age 65 and older that receive a pneumonia and/or influenza vaccination |
| Strategic Goal: Improved Health Outcomes for the People of New Mexico |
| Definition: The number of adults who identify themselves as Hispanic and age 65 and older who respond yes to the questions on whether they have ever received a pneumonia vaccination or yes to the question on whether they have received an influenza vaccination in the past year divided by the total number of adults who identify as Hispanic and age 65 or older |

| Data Sources and Methodology: Behavioral Risk Factor Surveillance System |
| Data Validity: The data will be as accurate as the self reports by respondents to the questions on whether they have received the vaccinations |
| Data Reliability: Population based random telephone surveys are a widely accepted method of conducting surveillance of health behaviors. |

<table>
<thead>
<tr>
<th>Program Name: Public Health</th>
<th>PCode: P002</th>
</tr>
</thead>
<tbody>
<tr>
<td>The purpose of the public health program is to provide a coordinated system of community-based public health services focusing on disease prevention and health promotion to improve health status, reduce disparities and ensure timely access to quality, culturally competent health care.</td>
<td></td>
</tr>
</tbody>
</table>
DFA Performance Based Budgeting Data System

Performance Monitoring Plan

**Measure:** Percent of QUIT NOW enrollees who successfully quit using tobacco at 7-month follow-up

**Strategic Goal:** Improved Health Outcomes for the People of New Mexico

**Definition:** Number of Quit Now enrollees who consented to evaluation, are reached, and report they have not used any form of tobacco in the past thirty days divided by the total number of Quit Now enrollees who consented to evaluation, are reached and provide a response to the question on tobacco use.

**Data Sources and Methodology:**
A random sample of Quit Now enrollees who have consented to be evaluated are called by telephone seven months after enrollment in cessation services and asked whether they have used tobacco in the last thirty days. There is a target of 150 completed surveys per month.

**Data Validity:**
The follow-up survey used for this measure includes questions from the Minimal Data Set (MDS) created by the North American Quitline Consortium (NAQC). The MDS provides a set of standard questions for evaluating quitlines and allows for the comparison of findings across states.

**Data Reliability:**
In developing the Minimal Data Set, the North American Quitline Consortium gave preference to measures with acceptable reliability and validity, endorsed by scientific bodies or used in national surveys.

**Measure:** Number of teen births averted among 15-17 year old females seen in the department of health funded clinics

**Strategic Goal:** Improved Health Outcomes for the People of New Mexico

**Definition:** Number of births prevented for females, age 15-17, through the provision of contraceptive care

**Data Sources and Methodology:**
The number of females ages 15-17 served in Family Planning Program funded clinics is obtained through the Billing and Electronic Health Record System and reporting from contracted sites. The contraceptive methods dispensed to clients are collected by nurses and clinicians. The number of averted pregnancies is calculated by multiplying the number of teens using contraceptive methods by an estimated ratio of 242 prevented pregnancies per 1,000.

**Data Validity:**
The data are as valid as the reporting. With the exception of insured clients, client's ages are self-reported.

**Data Reliability:**
The Family Planning collection of numbers served and methods dispensed is consistent with national methodology. The ratio of pregnancy prevented comes from the Alan Guttmacher Institute.
DFA Performance Based Budgeting Data System
Performance Monitoring Plan

Measure: Percent of preschoolers (nineteen to thirty-five months) fully immunized

Strategic Goal: Improve public health outcomes through public and private partnerships

Definition: The percent of children ages 19-35 months who have received all the CDC recommended vaccinations

Data Sources and Methodology:
Data for the NIS are collected through a random digit dialing telephone survey of households. Interviewers first determine if there are children ages 19 months to 35 months in the household, then proceed to ask household respondents for information regarding children’s vaccinations. The NIS also includes a mail survey (with consent) that asks the children’s medical providers to report the vaccinations in the child’s medical record. The limitations of the data are that it is survey data and neither county-specific nor real time – that is, the data reflect the immunization status of children who were ages 19 months to 35 months one year ago. Additionally, the data are obtained only from those households with telephones. The data are subject to recall bias (parents without written records are asked to recall their children’s immunization status); and data from providers’ offices may be incomplete.

Data Validity:
An area’s vaccination coverage estimate is based on both: a) parental response regarding the vaccination status of the children who live in the household; and b) provider-verification of vaccination status. Complex statistical methods are used to adjust for children whose parents refuse to participate, those who live in households without telephones, or those whose immunization histories cannot be verified through their providers. NIS data have been compared to other national data sources such as WIC, National Health Interview Survey, decennial census information and vital statistics to further check for reliability. Additionally, New Mexico county-level clinic data has been initiated to corroborate NIS and use as basis for local performance level.

Data Reliability:
Data for the NIS are collected from population samples large enough to provide reliable estimates for statewide immunization rates within a 95% confidence interval. This, coupled with a centrally operated data collection system continuously monitored using state-of-the-art quality-assurance techniques, strengthens the reliability of data collection to enable comparisons of estimated immunization coverage rates among states as well as immunization rates over time.

Measure: Percent of children enrolled in Medicaid that receive dental screening and fluoride sealants or varnish

Strategic Goal: Improved Health Outcomes for the People of New Mexico

Definition: The number of paid claims for dental screening and fluoride sealants or varnish for children divided by the total number of children enrolled in Medicaid

Data Sources and Methodology:

Data Validity:
The data is as accurate as the claim information

Data Reliability:
The data is as reliable as any information coming from payment for medical services
DFA Performance Based Budgeting Data System
Performance Monitoring Plan

Program Name: Epidemiology and Response  
PCode: P003

The purpose of the epidemiology and response program is to monitor health, provide health information, prevent disease and injury, promote health and healthy behaviors, respond to public health events, prepare for health emergencies and provide emergency medical and vital registration services to New Mexicans.

Measure: Percentage of emergency department and intensive care unit licensed staff at developing and existing trauma centers who have received training in traumatic injury care

Strategic Goal: Improved Health Care Quality

Definition: Number of licensed staff at trauma centers (emergency department & intensive care unit) who have received specific training in trauma care divided by the total number of licensed personnel in the emergency department and intensive care unit

Data Sources and Methodology:
Each trauma center will provide the total number of licensed personnel and the number who have received specific training in trauma care along with copies of completion certificates for the trained personnel.

Data Validity:
The reported information will be documented through the submission of completion certificates, course rosters, and other documentation.

Data Reliability:
Data will be reported in the same manner by each trauma center.

Measure: The number of naloxone prescriptions provided in conjunction with prescription opioids

Strategic Goal: Improved Health Outcomes for the People of New Mexico

Definition: Simple count of the number of prescriptions for naloxone

Data Sources and Methodology:
Patient names are shown on invoices from pharmacies for payment for naloxone kits. Names will be retrieved from invoices to determine number of prescriptions.

Data Validity:
There may be more dispensing than is reported because some invoices may be late, pharmacies may fail to invoice or other organizations may pay some of the costs.

Data Reliability:
Reliability will be very high.

Program Name: Laboratory Services  
PCode: P004

The purpose of the laboratory services program is to provide laboratory analysis and scientific expertise for policy development for tax-supported public health, environment and toxicology programs in the state of New Mexico to provide timely identification of threats to the health of New Mexicans.
DFA Performance Based Budgeting Data System
Performance Monitoring Plan

Measure: Percent of blood alcohol tests from driving-while-intoxicated cases analyzed and reported within ten business days

Strategic Goal: Improved Health Outcomes for the People of New Mexico

Definition: Percent of DWI cases for which results are calculated and reported to requesting agency within 10 business days

Data Sources and Methodology:

Data Validity:
The section supervisors are generating the data and reviewing before giving to the bureau chiefs. They work intimately with the samples and know when the numbers are ‘off.’ This is the only method available to measure sample testing turn-around times.

Data Reliability:
The data is compiled using a query, so the general indication is that the data are accurate within a few percent of the actual number. The data are reliable (probably within 5%). Results may vary if further work completed. While the process is more accurate and efficient with the new LIMS, staff, both analytical and IT, are learning the new LIMS process. A potential limitation would be that because this is a new system, there is a learning curve in developing queries.

Program Name: Facilities Management

The purpose of the facilities management program is to provide oversight for department of health facilities that provide health and behavioral healthcare services, including mental health, substance abuse, nursing home and rehabilitation programs in both facility- and community-based settings, and serve as the safety net for the citizens of New Mexico.

Measure: Percent of operational capacity beds filled at all agency facilities

Strategic Goal: Improved Health Care Quality

Definition: Average number of staffed beds occupied

Data Sources and Methodology:

Data Validity:
Census is taken daily at midnight in all facilities. Census is reviewed daily by Facility Administrators and managers and reviewed at least monthly by OFM. Constant review of census is necessary for staffing, admissions and billing/revenue generation. Census is initially captured on a paper form once a day and entered into Avatar (Electronic Medical Record System). This has been an effective mechanism for capturing this data.

Data Reliability:
Capturing census data is not complicated. Numbers are reviewed on a daily basis as they drive staffing, admissions and revenue generation. This data is reliable, both on an intra-rater and inter-rater reliability basis. Final data is likely to be 100% reliable when OFM receives it. Any errors would be caught in reviewing the next day’s census or in calculating patient days. There are no limitations or shortcomings of the data.
DFA Performance Based Budgeting Data System
Performance Monitoring Plan

Measure: Percent of collectable third-party revenues at all agency facilities

Strategic Goal: Improve Fiscal Accountability

Definition: Amount of charges billed to third party (private and public) insurance companies for care of individuals residing in DOH facilities

Data Sources and Methodology:
Billing data.

Data Validity:
Billing data is straightforward. This data was chosen to monitor the facilities’ ability to optimize revenue. The percentage of third-party billings collected will be captured and calculated on a spreadsheet. Both the method of capture and calculation are appropriate.

Data Reliability:
The methodology is uncomplicated and captured directly from billing data. The measure is indicative of facilities’ ability to optimize revenue. This data is reliable, both on an intra-rater and inter-rater reliability basis. It is not complex and it is very straightforward. There are no limitations or shortcomings of the data. Data will be captured on an ongoing basis and tallied monthly. Monthly totals will be reported to OFM.

Measure: Total dollar amount, in millions, of uncompensated care at all agency facilities

Strategic Goal: Improve Fiscal Accountability

Definition: Amount of uncompensated care (care for which there is no payment) provided by agency facilities

Data Sources and Methodology:

Data Validity:
The financial data is relatively straightforward. The cost of care will be determined for each individual for whom there is no payor source for each day in the facility based on the current reimbursement rates. This is a good measure of the state’s provision of indigent care and its ability to operate safety net services. The amount of uncompensated care is an appropriate measure of the state’s ability to provide safety net services.

Data Reliability:
The methodology is uncomplicated and captured directly from billing data. The measure and data collected is reliable. The data is derived by calculating reimbursement rates. This methodology should remain consistent. There are no limitations or shortcomings of the data.

Program Name: Developmental Disabilities Support

PCode: P007

The purpose of the developmental disabilities support program is to administer a statewide system of community-based services and support to improve the quality of life and increase the independence and interdependence of individuals with developmental disabilities and children with or at risk for developmental delay or disability and their families.
DFA Performance Based Budgeting Data System
Performance Monitoring Plan

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

Strategic Goal: Improve Health Care Quality

Definition: The numerator comes from Department of Labor Wage and Hour Reports submitted by community providers to the Regional Community Inclusion Coordinators, Supported Employment. The denominator is derived from the DD waiver billings for the total number of adults receiving supported employment, adult habilitation, or community access services plus the number of state general fund day service slots for the quarter.

Data Sources and Methodology:
Number of Adults receiving DD Waiver + State General Fund day services reported on Wage and Hour Forms as employed in integrated community employment (in a community job, not a sheltered workshop) = Numerator
Report from the Supported Employment Database, using data entered from provider ‘Wage and Hour’ reports. Parameters for the data collected are defined by the Jackson Lawsuit Plan of Action and the DC Waiver Standards. Total number of adults receiving DDSD day services (Supported Employment + Adult Habilitation + Community Access: DD Waiver billed for this quarter + State General Fund day service slots for this quarter) = Denominator=% in Community Integrated Employment. The major limitation is that the process is manual and thus there is a time lag with data being reported a quarter behind the current reporting period (FY09 Quarter 1 data will not be available until January 2009).

Data Validity:
The data base is the collection point for quantitative information on specific individuals that states the amount of hours worked and wages paid. Data is entered into the source documents (wage and hour reports) based on established written definitions.

Data Reliability:
Regional Supported Employment Coordinators verify that data is correct though individual specific monitoring activities. At the regional and state level, anomalies in the data are noted and investigated to assure accuracy. Agency and individual follow-up at the regional level is used to address inconsistencies and or errors in reporting.
## DFA Performance Based Budgeting Data System

### Performance Monitoring Plan

<table>
<thead>
<tr>
<th>Measure</th>
<th>Percent of developmental disabilities waiver applicants who have a service plan in place within ninety days of income and clinical eligibility determination</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strategic Goal</td>
<td>Improve Health Care Quality</td>
</tr>
<tr>
<td>Definition</td>
<td>The number of DD waiver applicants who have a service plan in place within 90 days of eligibility determination divided the total number of applicants who have a service plan in place.</td>
</tr>
</tbody>
</table>

### Data Sources and Methodology:

Information from NM HSD Income Support Division Medical Assistance (MAW) forms and Level of Care (LOC) forms is entered into the Central Registry database. A query produces a report from the system listing the individual, the dates, the number of days for the completion of the eligibility process, the number of days to institute a Service Plan, and if applicable the adjusted number of days and the reason(s) for the adjustment.

### Data Validity:

Staff uses appropriate database that collects information pertinent to timeframes of individuals allocated to the DD waiver services.

### Data Reliability:

Quality assurance reviews are conducted quarterly by reviewing a 10% random sample of allocation records being processed.

<table>
<thead>
<tr>
<th>Measure</th>
<th>Number of individuals on developmental disabilities waiver receiving services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strategic Goal</td>
<td>Improve Health Care Quality</td>
</tr>
<tr>
<td>Definition</td>
<td>Count of individuals receiving services paid by the DD waiver</td>
</tr>
</tbody>
</table>

### Data Sources and Methodology:

The number of paid claims for all clients in service are compared to the number of unduplicated individuals in service to determine validity of count (i.e., that the reported number of people served is actually the number of people served on the waiver). There is a direct relationship between services rendered to clients on the DD Waiver and the associated costs recorded into both databases, yielding actual numbers served on the waiver.

### Data Validity:

Reliability is difficult to achieve since both databases yield point-in-time measurements. Since this is a point-in-time measurement, no two measurements would ever be the same, due to the ever-changing nature of individuals' service deliveries. Therefore, reliability is difficult to establish. Client counts reflect point-in-time measurements.
DFA Performance Based Budgeting Data System
Performance Monitoring Plan

Measure: Number of individuals on developmental disabilities waiver waiting list

Strategic Goal: Improve Health Care Quality

Definition: Count of individuals who have been determined eligible for services but have not yet received any services

Data Sources and Methodology:

Data Validity:
Established Central Registry Data Verification Reports are reviewed on a monthly basis by bureau staff to determine that numbers of individuals waiting for services reported are actually the number of individuals waiting for services. The instrument was developed specifically to verify the database information for individuals waiting for services.

Data Reliability:
Since this is a point-in-time measurement, no two measurements would ever be the same, due to the ever-changing quantity of individuals waiting for services. Therefore, reliability is difficult to establish. Client counts reflect point-in-time measurements based upon current updates from waiver wait list applicants (database manager must rely on communication from individuals waiting for services).

Program Name: Health Certification Licensing and Oversight

PCode: P008

The purpose of the health certification, licensing and oversight program is to provide health facility licensing and certification surveys, community-based oversight and contract compliance surveys and a statewide incident management system so that people in New Mexico have access to quality health care and that vulnerable populations are safe from abuse, neglect and exploitation.

Measure: Percent of developmental disabilities, medically fragile, behavioral health and family, infant, toddler providers receiving a survey by the quality management bureau

Strategic Goal: Improve Health Care Quality

Definition: Percent of DD, FIT, medically fragile and behavioral health providers receiving a site visit by quality management staff to document conditions at the facility

Data Sources and Methodology:

Data Validity:
The data is a simple percentage. The numerator is the number of surveys conducted with a report completed and sent to the provider by the end of the quarter. The denominator is the number of surveys scheduled for the quarter. The measure indicates the number of providers that received a compliance monitoring survey versus the number of surveys scheduled.

Data Reliability:
This is a quantitative measure, a simple percent. The performance measure is only counting the number of reviews conducted and the number scheduled. The data is a simple count. Note, the data may be under reported when a scheduled survey was completed within the reporting period, but the report was not sent to the provider within the reporting period. This measure only indicates the percentage of reviews completed by QMB. It does not indicate the findings of the reviews (the amount of compliance a provider had). The data does not indicate system trends or issues or how many providers received a sanction for poor performance. This data only counts QMB-monitored providers and does not include community-based providers not monitored by QMB.

Tuesday, September 04, 2012
Appendix C

☐ Final Program Summary
Authority: NMSA 1978, §§ 9-7-1 to 16 (1977), as amended.

Constituents: All New Mexicans, especially DOH programs, staff, contractors, suppliers and vendors, individuals, and communities throughout the state.

Program Purpose Statement: The Administration Program fulfills the DOH mission by providing: leadership, policy development, information technology, and administrative and legal support, so that we achieve a high level of accountability and excellence in services provided to the people of New Mexico.

<table>
<thead>
<tr>
<th>Performance Measure</th>
<th>FY12 Actuals</th>
<th>FY13 Target</th>
<th>FY14 Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percentage of Hispanic adults age 65 and older that receive a pneumonia and/or influenza vaccinations</td>
<td>NA</td>
<td>75%</td>
<td>75%</td>
</tr>
</tbody>
</table>
Public Health


Constituents: All New Mexicans, especially mothers and children, particularly those with no other funding source; people living with HIV/AIDS; children and adults with chronic or infectious disease, or other special health needs; uninsured, low-income individuals needing primary care and dental services; school-age children and their families; people living along the U.S.-Mexico border.

Program Purpose Statement: Public Health fulfills the DOH mission by working with individuals, families, and communities in New Mexico to improve health status, eliminate disparities, and ensure timely access to quality, culturally competent health care. Public Health provides leadership by assessing the health status of the population; responding to outbreaks and health concerns in the population; developing sound public health policy; promoting healthy behaviors to prevent disease, injury, disability, and premature death; educating, empowering, and providing technical assistance to create healthy communities; mobilizing community partnerships to identify and solve health problems; assuring access to health care through recruitment and retention activities such as the J-1 Visa Program, licensing midwives, tax credits for rural health providers, as well as administering funding for rural primary health care providers serving populations in need throughout the state; and providing safety net clinical services.

<table>
<thead>
<tr>
<th>Performance Measure</th>
<th>FY12 Actuals</th>
<th>FY13 Target</th>
<th>FY14 Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percentage of Quit Now enrollees who successfully quit using tobacco at 7-month follow-up</td>
<td>NA</td>
<td>NA</td>
<td>40%</td>
</tr>
<tr>
<td>Number of teen births averted among 15-17 females seen in the department of health funded clinics</td>
<td>NA</td>
<td>NA</td>
<td>850</td>
</tr>
<tr>
<td>Percent of children enrolled in Medicaid that receive dental screening and fluoride sealants or varnish</td>
<td>NA</td>
<td>75%</td>
<td>75%</td>
</tr>
<tr>
<td>Percent of preschoolers (19-35 months) fully immunized</td>
<td>76.1%*</td>
<td>90%</td>
<td>90%</td>
</tr>
</tbody>
</table>
Epidemiology & Response

**Authority:** NMSA 1978, §§ 24-1-1 to 21 (1973), as amended, 24-10A-1 to 10 (1978), as amended, 24-10B-1 to 12 (1983), as amended, 24-14-1 to 3 (1961), as amended.

**Constituents:** All New Mexicans, especially individuals requiring emergency medical services, individuals needing data and reports on health status of New Mexicans, individuals requiring vital records, and individuals concerned about bioterrorism preparedness.

**Program Purpose Statement:** Epidemiology and Response fulfills the DOH mission by monitoring health, providing health information, preventing disease and injury, promoting health and healthy behaviors, responding to public health events, preparing for health emergencies, and providing emergency medical, trauma, vital registration, and sexual assault-related services to New Mexicans.

<table>
<thead>
<tr>
<th>Performance Measure</th>
<th>FY12 Actuals</th>
<th>FY13 Target</th>
<th>FY14 Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percentage of emergency department and intensive care unit licensed staff at developing and existing trauma centers who have received training in traumatic injury care</td>
<td>NA</td>
<td>NA</td>
<td>80%</td>
</tr>
<tr>
<td>The number of naloxone prescriptions provided in conjunction with prescription opioids</td>
<td>NA</td>
<td>NA</td>
<td>1,000</td>
</tr>
</tbody>
</table>
**Laboratory Services**


**Constituents:** All New Mexicans, especially state, federal, and local law enforcement agencies and personnel, the Office of the Medical Investigator, New Mexico Department of Agriculture, Environment Department, Department of Public Safety, dairy industry, New Mexico tribes, and New Mexico hospitals and clinical laboratories.

**Program Purpose Statement:** Laboratory Services fulfills the DOH mission by providing laboratory analysis and scientific expertise for public health policy development, environment and toxicology programs in New Mexico. The laboratory provides timely identification in order to prevent, identify, and respond to threats to public health and safety from emerging and unusual infectious diseases in humans, animals, water, food, and dairy, as well as chemical and radiological hazards in drinking water systems and environmental water, air, and soil. The laboratory also performs drug testing and provides expert witness testimony for forensic investigations of DWI/DUID and cause of death from drugs and infectious disease. The laboratory is the primacy bioterrorism and chemical terrorism response laboratory for the state and provides training for clinical laboratories throughout New Mexico. New Mexico statute dictates that SLD is the primacy laboratory for the New Mexico Department of Health, the New Mexico Office of the Medical Investigator, the New Mexico Environment Department, and the New Mexico Department of Agriculture.

<table>
<thead>
<tr>
<th>Performance Measure</th>
<th>FY12 Actuals</th>
<th>FY13 Target</th>
<th>FY14 Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percent of blood alcohol tests from driving-while-intoxicated cases analyzed and reported within ten business days</td>
<td>44.6%</td>
<td>95%</td>
<td>95%</td>
</tr>
</tbody>
</table>
Facilities Management

Authority: N.M. Const. art. XIV, § 1; NMSA 1978, §§ 23-1-1 to 13 (1903), as amended, 23-5-1 to 2 (1959).

Constituents: All New Mexicans, especially elderly persons with specialized support needs, medically fragile persons, persons in need of mental health and substance abuse treatment, and veterans requiring long-term care.

Program Purpose Statement: Facilities Management fulfills the DOH mission by overseeing six health care facilities and one community program; the safety net services provided throughout New Mexico include programs in mental health, substance abuse, long term care, and physical rehabilitation in both facility and community-based settings. Facility staff care for both New Mexico adult and adolescent residents who need continuous care 24 hours-a-day, 365 days-a-year. Most individuals served by DOH facilities have either complex medical conditions or psychiatric disorders that manifest in violent behaviors, and private sector providers are either unable or unwilling to serve these complex individuals, many of whom are remanded to DOH facilities by court order.

<table>
<thead>
<tr>
<th>Performance Measure</th>
<th>FY12 Actuals</th>
<th>FY13 Target</th>
<th>FY14 Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percent of operational capacity beds filled at all agency facilities</td>
<td>87.0%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Percent of collectable third-party revenues at all agency facilities</td>
<td>59.8%</td>
<td>90%</td>
<td>90%</td>
</tr>
<tr>
<td>Total dollar amount, in millions, of uncompensated care at all agency facilities</td>
<td>$36</td>
<td>$38</td>
<td>$38</td>
</tr>
</tbody>
</table>

Constituents: All New Mexicans, especially children and adults with developmental disabilities and children at risk of developmental delays.

Program Purpose Statement: Developmental Disabilities Supports (DDSD) fulfills the DOH mission by effectively administering a system of person-centered community supports and services that promotes positive outcomes for all stakeholders with a primary focus on assisting individuals with developmental disabilities and their families to exercise their right to make choices, grow and contribute to their community.

<table>
<thead>
<tr>
<th>Performance Measure</th>
<th>FY12 Actuals</th>
<th>FY13 Target</th>
<th>FY14 Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percent of adults receiving developmental disabilities day services who are engaged in community integrated employment</td>
<td>36%</td>
<td>38%</td>
<td>50%</td>
</tr>
<tr>
<td>Percent of developmental disabilities waiver applicants who have a service plan in place within ninety days of income and clinical eligibility determination revenues at all agency facilities</td>
<td>98.3%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Number of individuals on developmental disabilities waiver receiving services</td>
<td>3,888</td>
<td>Explanatory</td>
<td>Explanatory</td>
</tr>
<tr>
<td>Number of individuals on developmental disabilities waiver waiting list</td>
<td>5,911</td>
<td>Explanatory</td>
<td>Explanatory</td>
</tr>
</tbody>
</table>
Health Certification, Licensing and Oversight


Constituents: All New Mexicans, especially health care providers requiring licensing and certification, their patients, and consumers of health care services.

Program Purpose Statement: Health Certification, Licensing, and Oversight fulfills the DOH mission by conducting health facility licensing and certification surveys, community-based oversight and contract compliance surveys, and a statewide incident management system so that people in New Mexico have access to quality health care and vulnerable populations are safe from abuse, neglect, and exploitation.

<table>
<thead>
<tr>
<th>Performance Measure</th>
<th>FY12 Actuals</th>
<th>FY13 Target</th>
<th>FY14 Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percent of developmental disabilities, medically fragile, behavioral health and family, infant, toddler providers receiving a survey by the quality management bureau</td>
<td>71%</td>
<td>70%</td>
<td>85%</td>
</tr>
</tbody>
</table>
Authority: NMSA 1978 26-2B-1 to 26-2B-7

Constituents: The Medical Cannabis Program provides services to patients who are residents of New Mexico and who meet the qualifying eligibility criteria for one of 16 qualifying conditions for the program. In order to enroll patients, program staff review and verify information in patient applications, print enrollment cards and communicate with patients regularly. As of August 21, 2012, the Program has enrolled 9,812 patients, with 7,456 currently active. In addition, the Program has 23 licensed non-profit cannabis producers, which require regular site visits and periodic audits. The Program regularly processes additional amendments and new applications as required by patients’ needs for medical cannabis.

Program Purpose Statement: The Medical Cannabis Program was established on July 1, 2007 in accordance with the Lynn and Erin Compassionate Use Act and is charged with enrolling patients into the medical cannabis program and regulating a system of production and distribution of medical cannabis for patients in order to ensure an adequate supply.

<table>
<thead>
<tr>
<th>In Construction</th>
<th>To Be Determined</th>
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<th>To Be Determined</th>
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<tr>
<td>To Be Determined</td>
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</tr>
</tbody>
</table>
Appendix D

- LFC Performance Audit Update - Public Health Division
- LFC Public Health Audit Matrix
May 16, 2012

David Abbey, Director
Legislative Finance Committee
325 Don Gaspar
Santa Fe NM 87501

Dear Mr. Abbey:

Thank you for allowing us the opportunity to respond to the Legislative Finance Committee (LFC) report on the Public Health Division. We would again like to express our deep appreciation to Ms. Pam Galbraith and the LFC for their professionalism and expertise offered during this evaluation. Attached is the “Review Follow-Up Matrix” provided to us by Ms. Galbraith requesting Target Completion Dates for the significant findings. The Department has determined representative completion dates for each of these findings as referenced on the spreadsheet. The Department will monitor progress on each of these items and evaluate the results.

If you have any comments of questions related to information provided on the spreadsheet, please contact me.

Sincerely,

[Signature]
Catherine D. Torres, MD
Cabinet Secretary of Health
March 16, 2012

David Abbey, Director
Legislative Finance Committee
325 Don Gaspar
Santa Fe NM 87501

Dear Mr. Abbey:

Thank you for allowing us the opportunity to respond to the Legislative Finance Committee (LFC) report on the Public Health Division. We would like to express our deep appreciation to Ms. Pam Galbraith and the LFC for their professionalism and expertise offered during this evaluation. The Department cooperated with the tight schedule arranged by the LFC staff as they traveled many miles across the State to try to absorb and understand the complexity of the public health system as it is today.

The Department of Health (DOH) received a preliminary draft of the Report to the Legislative Finance Committee: Cost Effectiveness of Public Health Offices on March 9, 2012. The report describes the results of the evaluation conducted by the Legislative Finance Committee Program Evaluation Team. The objective of the program evaluation was to measure the cost effectiveness of the Division Public Health Offices.

The draft report recognizes the challenges involved in operating 54 local public health offices spread across the fifth largest state in the United States and assuring compliance with the mandates related to Public Health in New Mexico. The Department agrees with some of the findings and had previously identified and is focusing on some of the same issues.

The report was thorough in the visitation of public health offices and in the review of public health office staffing issues related to the recent challenges to efficient public health operations, i.e. impacts of the hiring freeze and impact of the implementation of NeoGov.

After reviewing the report, we note that the evaluation did not fully consider all the functions of the Public Health Division, specifically the Bureaus that support the Public Health Offices. Given the short timeframe this is quite impossible, and so the evaluators might not have fully understood how intrinsically related the Regions and Bureaus are in the delivery of services as

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one centralized entity. It is not helpful to view the local public health function as a separate independently functioning component, without missing the depth of both technical expertise and program support required of the Bureaus for adequate functioning of the public health programs offered within local offices. The Bureaus offer required data collection, technical assistance, supplies provision, and federal program management within the structure of a public health office. Without this assistance, it would be literally impossible, without a substantial and duplicative administrative structure, to meet compliance with federal regulations, on categorical grants such as the Supplemental Nutrition Program for Women, Infants, and Children (WIC) while trying to administer over 21 differing public health programs at the local level (Please refer to the STAR Guide for WIC by USDA).

With regard to the Public Health statute designating counties as responsible for providing space for public health, both the historical perspective and the future perspective are needed as we re-evaluate the most efficient infrastructure for provision of public health services. Public Health currently covers infrastructure costs that cross counties, not possible for small rural counties to cover to assure health of their citizens. Historically, public health has grown as the population for which it is responsible has grown. When large federal programs were implemented during the 1980's and 1990's, Public Health had to locate the facilities to house those new large federal programs. In many cases, the funding did not categorically provide for the cost of space in those facilities, although a formal allocation of operational costs is used for these federal programs. Looking toward the future, Public Health provides services that will not be replaced by Health Care Reform. Another significant DOH concern is whether the high risk pool (NMMIP) will remain after 2014 when the health insurance exchange is implemented. This would be a huge loss to DOH programs such as CMS and the HIV Treatment Program as NMMIP is utilized to purchase insurance coverage for New Mexico’s very ill, high cost populations, many of whom will not be eligible to participate in the Health Insurance Exchange. This would leave several hundred very ill New Mexicans without comprehensive healthcare coverage.

The Department concurs with a number of recommendations in the report. However, there are other recommendations with which we do not concur. Reasons for which we do not concur include sufficient information has not been considered, a few yet important inaccurate conclusions were drawn, and ramifications of some recommendations were not understood. The following provides a high level response on the findings and the recommendations contained in the report.

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A. LACK OF OUTCOME-FOCUSED EFFORTS AND FUNDING REDUCTIONS MAY COMPROMISE PHD'S ABILITY TO IMPLEMENT SOLUTIONS TO HEALTH ISSUES FACING NEW MEXICO.

1. Numerous and sometimes competing health challenges and federal and state requirements complicate the efficient and effective public health service delivery function.

*Neither the regional administrative span of control nor the allocation of resources appears to relate to geographic size or population.*

The Division has spent considerable time assessing the distribution of resources across the state to determine the most effective distribution of these limited resources. Population size alone cannot be used to allocate resources since a basic level of infrastructure must be in place in each county to meet statutory requirements as well as be able to deliver public health services and respond to public health emergencies. In addition to geographic size and population, the state has analyzed and monitors the burden of disease in each Region as well as the demand for services in each Region. The Division adjusts staffing by relocating positions as needed to meet changing demands. All movement of positions is done via attrition.

*DOH is beginning the process to gain national public health accreditation.*

Agree.

*Statutes exist which dictate specific public health services.*

Agree; however, in the case of needing to place a patient in a facility for treatment of TB, PHD is the payor of last resort. PHD staff work to determine if the patient has insurance, Medicaid or other coverage (Indian Health Service). If the patient is eligible for Medicaid but is not enrolled, staff work with the patient to complete the application process to cover payment for these services.

2. *Performance monitoring for public health does not adequately investigate program outcomes.*

Disagree. Please refer to the document attached entitled, "NMDOH Performance Management to Improve Health (Attachment A) that establishes the principles for performance measures. A sample of the outcomes that are measured by programs include:

- The Title V Program is required to assess, establish State performance measures and track outcomes on 18 National Performance Measures as well as 9 state performance measures (Attachment B).
- Family Planning Program tracks teen birth rates.
- The WIC Program tracks initiation and duration of breastfeeding as well as children’s weight status, mother's weight gain during pregnancy, smoking, drug use, and birth weights.
• The TB Program tracks the number of patients with TB that completed treatment, the number of persons who were exposed to someone with TB that were screened, of those the number that were recommended to be treated and of those how many completed treatment.
• The STD Program tracks the number of individuals identified with an STD, and the number of persons exposed to someone with an STD who were contacted, screened and treated in a timely manner.
• The Office of School and Adolescent Health tracks the number of individuals served in School-Based Health Centers funded by the department by the type of service received.
• The Tobacco Use Prevention and Control Program monitors the calls to the Quitline and is able to link those activities to smoking prevalence reported from population survey (Behavioral Risk Factor Surveillance System).

State performance measures reported to LFC are reported quarterly. Some measures such as immunization coverage of preschoolers are available on a quarterly basis but are reported annually. Please see list of performance measures (Attachment C) tracked by PHD. PHD is reevaluating performance measures and training staff to assure appropriate of program outcomes.

3. Given the state's diverse health challenges and resource constraints, the Public Health Division needs to improve resource allocation and budget management.

Budget dollars are allocated to regional offices, not directly to local public health offices.

Disagree. State is a centralized entity that operates through Regions as one venue. There are no financial resources at the local public health office level to manage or track budgets. Budgets are built based on historical data and identified needs at the region level. Regional Directors are responsible for planning, managing, and monitoring operational budget allocations to all Public Health offices in the region. This gives Regional Directors the flexibility required to allocate resources needed to operate and manage services in the local offices. Certain costs are specific to the local office, for example salary and benefit and fixed operating costs are specific to certain locations. Some operating costs such as travel, office supplies, equipment and some medical supplies are managed by the region. Vaccine, family planning supplies and certain clinical supplies are managed by Programs, purchased by the Pharmacy and shipped to local offices based on need. Food delivery and distribution is managed by the Programs as are programmatic issues, such as technical assistance, vendor management, program fiscal management and program IT systems. Federal funding, obtained through grants, is managed by the Bureau's with funding allocated to staff in bureau's and regions. Staffing focus in the local areas are on delivery of clinical services not administrative and fiscal functions.

Division-generated financial data is not useful for regional and local office budget management.

Local health offices do not manage their own operational budgets and these are managed by the Regions. The Salaries and Benefits budget for all clinical health
services is primarily managed at the division level with advice from the Leadership Team which is comprised of the Public Health Director, Regional Directors, and Bureau Chiefs, and Regional Health Officers. Each Bureau takes direction from the division and manages its programs' budgets centrally and is responsible to the funding entities. In such a small state, scarce resources demand that PHD have the flexibility to respond to national initiatives quickly to avoid handing back significant amounts of federal dollars.

PHD acknowledges that we need to refine the way that regions collect Units of Service data which at this time is not standardized which is based only on the general fund allocated to each region and does not include the federal funds which support work in the regions that is tracked by the Bureaus. Regional Directors are working together to address this issue. The Bureaus also track Units of Service for all federal grants which are used to track federal program investment and units of service produced. The Units of Service tracked by Bureaus is consistently measured.

**PHD must be judicious in the pursuit of federal dollars.**

Agree. However, approximately 42 % of the PHD budget is made up of federal dollars that pay for core programming for public health. State funding cannot replace the sizable infrastructure necessary to perform the functions addressed by federal programs. Without these federal dollars, the division would not be able to deliver essential public health services.

4. **Staffing cuts over the past three years have made it difficult for PHD to sustain programs in public health offices.**

Agree.

5. **The local public health offices are not persistent or consistent in determining a client's Medicaid eligibility, or collecting third party payments.**

Adherence to procedures for verification of Medicaid eligibility is inconsistent across the system.

*Billings to the Medicaid program do not identify sites, but are billed only as “PHD”.*

Public health office staff are trained to assess whether each client being seen for clinical services is enrolled in Medicaid, or has other insurance coverage. This is accomplished by asking the client as well as checking eligibility online. There are not sufficient public health office staff in most locations to complete a PE/MOSAA for clients that are not currently enrolled in Medicaid but that may be eligible. Clients seen for Families FIRST services are screened and enrolled if eligible for Medicaid.

All billing for clinical services provided in public health offices is done centrally, not by each local office. Although the revenue received and the remittance advice do not identify the location of services provided, the claim form does. When this information is entered into the Billing and Electronic Health Record (BEHR) system, we can generate reports of revenue received by site. Revenue received for clinical services is credited to

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the programs (Family Planning, TB, Refugee Health, Immunization, etc), not to a local health office or region because the budget is managed at the program level not at the local public health office. Billing for program services are credited to those programs as those programs are responsible for balancing their budgets and to meet federal requirements.

*Although sliding fee scales and procedures are in place, public health offices place nearly all clients at a zero pay level.*

The reality of New Mexico’s poverty is evident in our public health offices. Approximately 50% of families qualify for Medicaid in this State. The WIC Program, the Family Planning Program, CMS, and Families FIRST all have unique financial eligibility determination and requirements for their services. Health Office staff follow the Title X guidelines in gathering income information from clients to determine the sliding fee scale. Other programs such as STD and Harm Reduction do not require clients to be put on a sliding fee scale; however, public health staff gather income information to be able to describe the income level of the clients we serve.

*Other than Children’s Medical Services, PHD does not bill commercial insurance plans for services rendered to plan members.*

PHD recognizes the need to bill commercial insurance for services provided to clients who have commercial insurance. Less than 10% of clients served in public health offices have commercial insurance. Currently the PHD does not have sufficient resources to allocate to this initiative. One FTE in the Director’s office processes billings for clinical services provided in public health offices across the state. This need may be better served as a Department initiative.

It needs to be noted that the Immunization does receive quarterly payments from commercial insurers (Presbyterian, Lovelace and BCBS) for immunizations provided through the Vaccines for Children (VFC) Program to children covered by their insurance.

**Recommendations**

PHD should:

1. Develop AGA performance measures which relate to the state’s health status and PHD service activity performance.

Agree. PHD currently tracks performance measures on all programs but all of these measures are not reported to the LFC. PHD sets specific performance standards, targets, and goals for the each program. Bureaus submit their proposed additional performance measures to the division and these are approved for use in contracts. These standards are determined by national entities in some cases, and state programs in other cases. These standards are reviewed by the department once a year. Programs are encouraged to use national, state, or scientific guidelines. Established performance standards and targets are measured through collection and reporting of data reflecting the capacities, processes, or outcomes of established performance standards and targets. Three of these are collected for the AGA performance measures and reported to LFC. Other measures are reported yearly, as
required, to federal funders. All PHD contractors must report performance on deliverables quarterly to the Secretary of Health. In the future, contractors will also report performance measurement contributions using a Results Based Accountability approach, focused on not only how much service is delivered, but how well it was delivered and what impact was produced, and what the quality of the effect was where appropriate. Accreditation will improve the quality improvement processes within the Division.

2. Collaborate with the New Mexico Primary Care Association to expand eligibility screenings to other public health offices, as a pilot program, to determine the financial value of increased screenings;

HSD currently has a contract with New Mexico Primary Care Association (NMPCA) to support expansion of eligibility screenings. While some eligibility workers are supplied to PHD from this contract, it does not meet the need for PE/MOSAA eligibility determination in public health offices. PHD has agreed to collaborate with NMPCA, as a pilot program to expand eligibility screenings using staff provided through that contract, to determine the financial value of increased screening. This is an HSD function which must be afforded by the HSD budget.

3. Refine the budget reporting systems so useful information is generated with which to manage regional and local offices budgets;

Disagree. PHD disagrees that reporting systems are not providing sufficient, useful information currently, given the scarce resources available for additional administrative costs. PHD however, will investigate the capability of SHARE’s use of a reporting category or other functionality for local health offices to track local expenditures. This would entail a dramatic addition of coding and may be too laborious given the benefits.

4. Conduct routine audits of regional and local offices to evaluate business practices;

Disagree. Routine audits are done of business practices within the health services components of Local Public Health Offices as much as quarterly in Regions by Director of Nursing Services. Pharmacy staff visit each clinical office bi-annually to audit management of drug rooms. Family Planning, WIC and Families FIRST staff perform clinical operations audits using complex tools to evaluate business and clinical practices and require corrective action when business and clinical practice is not in compliance with standards. Detailed tools were submitted to LFC describing this process. Contractors are required to submit independent audits of their businesses to the WIC Program. The Family Planning Program uses the same tool as the Federal Auditors when they audit contractors. Families FIRST uses the same auditing tool the MCO’s use to audit the program to remain consistent with standards.

5. Work with the State Personnel Office to ensure that job descriptions and qualifications are current to the needs of PHD and salaries are competitive with market competitors;

Agree. PHD would welcome the opportunity to work more closely with SPO to match salaries that are competitive with market competitors. PHD staff are currently working
with our Administrative Services Division Human Resource Bureau, providing job descriptions and qualifications of health professionals so that nurses can be found and placed upon lists for the hiring process. An effort is being made to market State nursing jobs and retirement benefits.

6. Complete the accreditation process which will provide PHD with better tools by which to evaluate their mission and strategic objectives.

Agree. DOH has supported the kickoff and first steps of the Public Health Accreditation process. Additional resources will be needed to complete the public health assessment and the entire process.

B. CONTRACT MANAGEMENT WITHIN THE PHD LACKS A STRATEGIC PLAN TO DEPLOY $50 MILLION IN RESOURCES AND ACCURATELY MEASURE THE EFFECTIVENESS OF MORE THAN 300 VENDORS IN PROVIDING PUBLIC HEALTH SERVICES.

1. The PHD maintained 288 contracts and memoranda of agreement in FY12 for a total of $41.8 million, a decrease of 8 percent over FY11.

Agree. PHD contract dollars decreased from FY11 to FY12 by approximately $7,100.0. General fund contracts decreased by approximately $1,570.0.

2. PHD contracts focus on compliance reporting and not on outcomes and measuring achievement towards health goals.

The health outcomes that PHD and DOH monitor are population indicators that are generally for the state as a whole (e.g., rate of teen births, rate of low birthweight babies born, percent of 2-year-olds fully immunized). As such, they are bigger than any one agency, contractor or department, and many partners have a role.

Explanations for examples noted are as follows:
Tobacco Cessation and Awareness Activities - Performance of the contract with National Jewish Health (NJH) was monitored through weekly and monthly reports. The reports delivered data including the number of calls, demographic information and evaluation of quit attempts after six months. NJH met with the program’s contract monitor once a week by phone to be informed of call volume, NRT purchase and distribution. NJH also sent Quarterly Summary Reports and assisted the contract monitor with reporting to the CDC National Data Warehouse which gathers state Quit line data from all states and reports back to all states with the information thru the CDC project officer and the National Quit line Consortium. All reports from NJH are on file with the Tobacco Use Prevention and Control Program. Internal meetings were held weekly with the media specialist, program manager, and the contract monitor to review reports and strategize to adjust media to control call volume to maximize remaining resources for the contract year. The following performance measure has been added to the Quit line contract which is now: Number of callers to the 1-800-QUIT-NOW cessation line

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Caller volume to 1-800-QUIT NOW is driven by brand awareness and mass media campaigns. Data shows that increases in caller volume are immediately and directly proportionate to mass media placement. Attachment D is a graph that shows the correlation between media efforts and caller volume for the first two quarters of FY11. Data for other quarters are available and show the same immediate and proportionate relationship between mass media placement and caller volume.

All registered callers to the New Mexico quitline are asked how they heard about the 1-800-QUIT NOW service. Callers reported the following “How Heard About.” in FY11.

- TV ads: 46.8%
- Billboard: 3.6%
- Radio: 3.5%
- Website: 2.2%
- Brochure: 2.1%
- Plastic Quit Card: 1.4%
- Newspaper/Magazine: 0.5%

19.8% Callers reported hearing about 1-800-QUIT NOW from friends or family members. It is impossible to know how many of the friends and family members gained their awareness of the quitline from TUPAC’s mass media and marketing efforts, but TUPAC believes it would be similar to the responses provided by the quitline callers. It is estimated that the tobacco industry spends for $39.7 million for New Mexico marketing each year, which is nearly 30 times the amount spent on tobacco counter-marketing by New Mexico.

HIV Prevention - Evaluation of HIV Prevention contractors follows and exceeds guidelines set by CDC, which provides roughly 2/3 of contract funding. CDC requires process monitoring and recommends outcome monitoring. Process monitoring includes monthly reporting of interventions and participant demographics, as well as annual site visits which observe program delivery. Given that contractors are primarily delivering evidence-based HIV prevention models from CDC’s Diffusion of Effective Behavioral Interventions (DEBI) project, if the site visit observation shows that they are delivered with fidelity to their design, it is assumed that the research-based outcomes will result. Outcome monitoring can be tailored by each agency, but at minimum they must conduct pre-test and post-test surveys of participants in at least one evidence-based intervention to show changes in knowledge, attitudes and intended/reported behaviors. CDC accepts such outcome monitoring as a strong proxy for the intended result of risk reduction. Given the modest scope of most programs, CDC does not expect or recommend outcome monitoring, meaning a demonstration that participants have changed their risk behaviors or HIV/STD infection rates over time. In addition to needing comprehensive baseline data, such an evaluation would require university-level researchers and would be very costly.

UNM Prenatal Services – In future contracts number of patients services will be added as a reporting requirement.
PHD oversight of contract deliverables focuses on validating task reporting and not analyzing impact to overall program and department initiatives.

Disagree. Explanations for examples noted are as follows:

UNM Breast and Cervical Cancer Early Detection Program— Contractors submit required data to the program which is entered into the Cancer Screening and Treatment System (CaST), B&CC’s billing tracking system. This process determines that appropriate and timely quality services are performed. This information is the required back-up that accompanies the billing for each patient obtaining services. The B&CC program has quality indicators that it must meet and each provider is also required to meet (Attachment E). These indicators are not solely based on invoices but also on clinical documentation.

Teen Outreach Program— The impact of the Teen Outreach Program (TOP) on the Family Planning Program’s long term impact of reducing the teen birth rate among female teens ages 15-17 is evaluated with a pre and post survey. Each participant in TOP completes a pre and post survey at the beginning and ending of a 9 month period. Data collected on the pre and post survey contribute to the goal of reducing teen birth rates. Questions asked to evaluate this impact include:
- During the last school year, have you ever been pregnant or caused a pregnancy?
- During the last school year, have you ever had a baby or fathered a baby?
- Where did you learn the skills to say no to sex?
- Do you know where to get birth control methods to prevent teen pregnancy?
- Is there anything that would keep you from using birth control methods?
- What problems did you have when you tried to get birth control methods?
- How likely is it that you will have sex within the next 6 months?

Participants are followed the entire time they participate in TOP. TOP facilitators are required to fill out a midyear and end of year survey that asks them if they are aware of any pregnancies that occurred during this program year that involved TOP members from their club. In addition, each TOP club is required to visit a local Public Health Office or School Based Health Center that dispenses birth control so participants are educated on where to access reproductive health services.

**PHD-contracted services may duplicate services subsidized by other programs such as Medicaid and county indigent care programs.**

Disagree. Explanations of examples noted are as follows:

Breast and Cervical Cancer Screening - UNMH provides diagnostic services for women from all over the state who have received an abnormal cancer screening result and are in need of followed up services. If the women is not screened and diagnosed through a participating B&CC program provider the women would not be eligible for Medicaid. Funding for the B&CC program is sufficient to serve only 15-18% of the potentially eligible women statewide. Many screening clinics cannot provide the diagnostic services...
needed once a woman has a screening test that indicates that they are at risk for cancer. UNMH provides these diagnostic services. B&CC is always the payor of last resort. These are not duplicative services.

Pre-natal Care – Access to county indigent funds are limited for undocumented women. Emergency Medicaid covers delivery but not prenatal care. It is to the benefit of the State that women have prenatal care to assure the best possible birth outcome. PHD Title V funding for high risk prenatal services is payor of last resort and is not duplicative.

**Contract management does not include a process to identify high performing contracts or protect contracts from funding cuts.**

Disagree. PHD follows the State Procurement process and Department of Finance and Administration (DFA) guidelines in procuring professional services. Selection of contractors is based on a response to proposals and/or expertise and prior performance. When cutting contracts PHD followed mandates by DFA and executive management as well as prior performance. In most cases cuts were made equitable across the board and in certain instances cuts were based on CDC best practice guidelines. In the case where PHD was compelled to cut all health education contracts this was due to the extreme 40% budget cut to contracts in FY11. This was an unprecedented cut to PHD contracts in a single year. The decision by the administration was to minimize cuts to direct client care.

**3. Primary care is the largest contractual function of PHD, without a strategic plan to address service needs.**

**Primary care accounted for $11.9 million in contractual spending, or 28 percent of total contract dollars, without a single performance measure related to health outcomes.**

The performance measure listed in all primary care contracts was to increase access to primary health care which directly contributes to better health outcomes. The legislative intent for RPHCA dollars is to "assist in the provision of primary health care services through eligible programs in underserved areas of the state in order to better serve the health needs of the public". This legislative language has been interpreted as "increasing access to primary health care". The RPHCA regulation, 7.29.3 NMAC, states "...the Department... shall provide for the distribution of financial assistance to eligible programs which have applied for and demonstrated a need for assistance in order to sustain the delivery of a minimum level of primary health care services". The RPHCA RFP process addresses projected primary care needs for the upcoming fiscal year. Significant strategizing and assessing occurs during every RPHCA RFP process.
Recommendations

1. The PHD should strategically manage their contract budget to match public health priorities as described in the DOH Strategic Plan.

   Agree. The department has invested in the Results Based Accountability methodology to better judge effectiveness against DOH strategic goals.

2. The PHD should reassess contract performance measures to also require measureable health data to better judge service effectiveness against DOH strategic goals.

   Contract performance measures reflect the priorities of the Secretary of DOH.

3. The PHD should partner with other agencies providing similar services, such as the HSD, to determine if duplication of services exist, as well as assess if programs can be reallocated to better leverage federal dollars and reduce burden on state general funds.

   All PHD programs seek to work with public and private partners to maximize limited resources. This is evidenced by the great number of advisory boards and councils in which PHD staff participate. (Attachment F).

   As an example, DOH programs have partnered with other Health and Human Service Programs since 2005 to track 5 major outcomes for children in New Mexico through a federal grant to realign state children’s programming. The product of that work was the Children’s Report Card and one of the first Children’s Budgets in the country. Through Results Based Accountability, these outcomes were listed, the stories behind the measure were featured, implications of the data were explained to the average New Mexican in an effort to involve them in the outcome data behind all children’s programs in New Mexico. Programs were listed and budgets were compared and analyzed. Duplication of services was not evident during that analysis.

   All contracts from the Title V Grant use 18 National Performance Measures as their basis of contracting.

4. The PHD should build a strategy to address future primary care needs, assessing how best to use RPHCA dollars to assist clinics in further addressing high need for services in light of changes in population growth in rural New Mexico.

   The legislative intent for RPHCA dollars is to "assist in the provision of primary health care services through eligible programs in underserved areas of the state in order to better serve the health needs of the public". This legislative language has been interpreted as "increasing access to primary health care". The RPHCA regulation, 7.29.3 NMAC, states "...the Department... shall provide for the distribution of financial assistance to eligible programs which have applied for and demonstrated a need for assistance in order to sustain the delivery of a minimum level of primary
health care services". The RPHCA RFP process addresses projected primary care needs for the upcoming fiscal year. Significant strategizing and assessing occurs during every RPHCA RFP process.

5. PHD should mirror reporting requirements and performance measures to what HRSA requires of federally-qualified health centers (FQHCs), and use health data to measure effectiveness of this core public health function.

The RPHCA contracts have a DOH performance measure related to increasing access to health care, which is the legislative intent of the program. FY12 Supplemental Performance Measures for the Health Systems Bureau includes: Task 6: Expand health care access in rural and underserved areas. Measured by: Number of medical and dental encounters at primary care clinics supported by DOH.

The LFC recommendation to “mirror” HRSA clinical reporting has significant limitations and significant challenges for non-FQHC RPHCA funded clinics, and uncertain/limited usefulness. HRSA clinical reporting is designed to compare states, and is not designed to address specific clinics within contracted organizations. RPHCA program also does not have adequate staffing to effectively monitor clinical performance measures.

C. IMPROVED PARTNERSHIPS LOCALLY ARE NEEDED TO CUT COSTS AND IMPROVE SERVICE DELIVERY AT PUBLIC HEALTH OFFICES.

1. Local governments are not providing their share of resources to support public health offices.

PHD interprets the statute to mean counties are responsible for providing one public health office in each county and office space for the regional health officer. Although the statute states that counties are responsible for providing office and other expenses, including utilities and maintenance, over the years, certain costs have been absorbed by PHD. These rental, utility and maintenance costs have been appropriated to PHD in the General Appropriations Act (GAA). PHD does not interpret the statute to mean counties are responsible for providing staffing costs associated with public health offices. All 957 FTE are included in the GAA and are funded thought State General Fund, Other State Funds or Federal Funds.

There is no consistency in which governmental entity assumes responsibility for lease or other associated costs.

Over the years, PHD has assumed rental costs in counties where there is more than one location. In these instances the county met the requirement for the local health office. In some counties, there is more than one office space provided in more than one location. For example in the case of Dona Ana, the County provides East Mesa, Anthony, Chaparral, Dona Ana Village, West Las Cruces, and Sunland Park. All of this space is granted to Public Health free of charge, and Public Health in turn pays for janitorial services. Dona Ana Health County Health Center is a Regional Office for PHD. This office serves all the counties in Region 5 and houses staff to do so. Other counties do
not contribute to the operational costs for the Regional Offices, so historically, PHD has covered these costs. In Roswell, the county provided the space for the Regional Health Office and Clinic at the same location. This location was cramped as the Division Programs grew (WIC added some 200 FTE across the State). PHD decided that it was necessary to move to maintain adequate facilities for both the clinical services and the Regional administrative offices. Since the County was already providing a space, PHD absorbed the added costs. PHD has assumed janitorial costs in most counties since there is a need for a more thorough cleaning service in a health clinic to meet clinical standards. Utility costs have been absorbed in five public health locations: Otero/Tularosa, Dona Ana/Las Cruces, Valencia/Belen, and San Juan/Bloomfield, and East Mesa. This was a negotiation based upon need. All costs absorbed by PHD are budgeted in the GAA.

*In some cases, the state is paying lease rates or associated costs that exceed market values.*

Rental costs associated with the Moriarty lease were negotiated with the landlord and processed through the Property Control Division of the General Services Department. Leasing procedures prescribed by Property Control were followed. Utility costs are paid based on utility company billings as there is no avenue for price negotiation. PHD follows the State Procurement process when procuring building maintenance services which depending on price level requires a bid sheet with three quotes, three written quotations or an Invitation to bid through State Purchasing. In all cases PHD must give first right of refusal to New Mexico Abilities and will negotiate cost proposals based on historical cost or existing price quotations.

2. **DOH is seeking partnerships with community groups to expand the capacity for services and education to New Mexicans.**

Agree.

3. **Patient records in the public health system are not integrated.**

*An comprehensive medical record does not exist for clients served within the public health system.*

PHD recognizes the value of having an integrated, single record for clients served by the division (and department). Prior to the implementation of the electronic medical record system, BEHR, in health offices, a client seen in more than one health office would have a unique medical record at each site where they were seen. With the implementation of BEHR, clients have a single medical record and staff can readily determine clinical services clients have received at any public health clinic site. In addition to BEHR, there are multiple data systems for tracking services provided to clients including WIC, the New Mexico statewide immunization information system (NMSIIS), as well as laboratory and disease surveillance data systems. As resources permit, PHD is working to interface the various systems to gain efficiency and eliminate duplicate data entry.
The data entry process in the BEHR system does not allow for easy recovery of data.

Our ability to report on the clinical services provided has been greatly enhanced by the implementation of the electronic medical record system, BEHR, compared to when the medical records were on paper. BEHR is first and foremost the medical record for clinical services provided in local public health offices. The system is designed for "point and click", although staff have the ability to type in additional details. Some staff prefer to type in their documentation to mirror the way they charted on paper. Changing this behavior requires time, experience with the system and training.

Claim data is available from the system through the reporting capabilities in the system. Additionally, on a monthly basis, the division receives a file of all services received with diagnoses, services provided (via CPT codes), charges associated with those services, office location, provider, etc. This data is available for analysis. This fiscal year, the Family Planning Program is purchasing software and training that will allow ad hoc reporting from the medical record for information that is captured via "point and click", and much less so for information texted into the record.

No centralized state system exists to monitor the practice of public-funded health care providers.

Although PHD agrees there is no centralized state system, PHD has implemented monitoring services provided by CMS health care providers through Medicaid reports. HSD has the responsibility to monitor publicly funded health care providers.

Recommendations

1. The Legislature should modify the statute to accurately reflect state and county financial responsibilities for facility and personnel costs associated with public health facilities,

   PHD agrees that modification to the existing statute may be necessary to clarify state and county responsibilities.

2. The PHD should clarify state and county governments' financial responsibilities for public health offices through changes in regulations;

   PHD agrees that modification to the existing regulations may be necessary to clarify state and county responsibilities.

3. The PHD should require written agreements between property owners or local governments and DOH for all facilities housing public health entities and obtain Property Control Division evaluation of the terms prior to completing the agreement.

   Agree. PHD will begin working with each county to implement standard agreements.
Wherever Ms. Galbraith traveled, the local staff commented on her sincere interest in their activities. This was greatly appreciated. Again, we appreciate the opportunity you have given us to respond to the report as well as the professional and considerate manner in which this evaluation was conducted.

Sincerely,

Catherine D. Torres, M.D.
Cabinet Secretary
New Mexico Department of Health

(Signature on File)
Attachment A -- NMDOH Performance Management to Improve Health
(7/7/2011)

Performance management—the practice of actively using performance data to improve the public's health. Reviewed performance management materials from/about Results-Based Accountability, Modular kaizen, MAPP, King County Washington, Turning Point, Baldrige, Institute for Healthcare Improvement, CDC, Washington DOH and Washington State Management Framework. There are common tools, vocabulary and approaches throughout these which are the basis for the following recommendations.

Principles for NM DOH
1. Performance management to improve health requires tools, vocabulary and approaches that are aligned and consistent.
2. As long as performance management tools, vocabulary and approaches are aligned and consistent, flexibility is preferred when trying to get different groups to work on the same health priorities over time periods long enough to improve health. If a program or agency is already successfully using an approach that is consistent with these principles there would be no need to change the approach.
3. Experimental evidence for choosing one particular performance management approach over another does not exist. The evidence that does exist is at the level of practice guidelines and consensus documents.
4. Logic models, community indicators, performance measures, baselines, targets, scorecards, and quality improvement tools are all tools that can support performance management.
5. Logic models should be used and scorecards can be used to align the work of different agencies around the same health priority and can be individualized to the specific work of that agency or program.
6. Population health indicators (community or state indicators) should be distinguished from agency or program data (performance measures).
7. IBIS/Tracking is NM DOH's main vehicle for disseminating health indicator data at the various population (state, county, and small area) levels. IBIS/Tracking does not provide performance measure data.
8. Complementary performance management tools, vocabulary, and approaches should be used for the NM Comprehensive Strategic Plan, the NM DOH Strategic Plan, public health accreditation and program evaluation.
## Attachment B Title V Assessment and Performance Measures

### MATERNAL & CHILD HEALTH (MCH) MEASURES

<table>
<thead>
<tr>
<th>Title V: Maternal Child Health National Performance Measures</th>
<th>State 2010 Results</th>
<th>State 2015 Goal</th>
</tr>
</thead>
<tbody>
<tr>
<td>The percent of Screen positive newborns who received timely follow up to definitive diagnosis and clinical management for condition(s) mandated by their State-sponsored newborn screening programs.</td>
<td>100.0%</td>
<td>100%</td>
</tr>
<tr>
<td>The percent of children with special health care needs age 0 to 18 years whose families partner in decision making at all levels and are satisfied with the services they receive. (CSIHC Survey)</td>
<td>53.2%</td>
<td>55%</td>
</tr>
<tr>
<td>The percent of children with special health care needs age 0 to 18 who receive coordinated, ongoing, comprehensive care within a medical home. (CSIHC Survey)</td>
<td>41.6%</td>
<td>43%</td>
</tr>
<tr>
<td>The percent of children with special health care needs age 0 to 18 whose families have adequate private and/or public insurance to pay for the services they need. (CSIHC Survey)</td>
<td>50.6%</td>
<td>59%</td>
</tr>
<tr>
<td>Percent of children with special health care needs age 0 to 18 whose families report the community-based service systems are organized as they can use them easily. (CSIHC Survey)</td>
<td>80.7%</td>
<td>90%</td>
</tr>
<tr>
<td>The percentage of youth with special health care needs who received the services necessary to make transitions to all aspects of adult life, including adult health care, work, and independence.</td>
<td>33.7%</td>
<td>36%</td>
</tr>
<tr>
<td>Percent of 19 to 35 month olds who have received full schedule of age appropriate immunizations against Measles, Mumps, Rubella, Polio, Diptheria, Tetanus, Pertussis, Haemophilus influenzae type B.</td>
<td>70.9%</td>
<td>75%</td>
</tr>
<tr>
<td>The rate of birth (per 1,000) for teenagers aged 15 through 17 years.</td>
<td>25.8</td>
<td>24</td>
</tr>
<tr>
<td>Percent of third grade children who have received protective sealants on at least one permanent molar tooth.</td>
<td>48%</td>
<td>50%</td>
</tr>
<tr>
<td>The rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children.</td>
<td>4.6</td>
<td>2</td>
</tr>
<tr>
<td>The percent of mothers who breastfeed their infants at 6 months of age.</td>
<td>49%</td>
<td>52%</td>
</tr>
<tr>
<td>Percentage of newborns who have been screened for hearing before hospital discharge.</td>
<td>*</td>
<td>97%</td>
</tr>
<tr>
<td>Percent of children without health insurance.</td>
<td>11.9%</td>
<td>10%</td>
</tr>
<tr>
<td>Percentage of children, ages 2 to 5 years, receiving WIC services with a Body Mass Index (BMI) at or above the 85th percentile.</td>
<td>25.4%</td>
<td>20%</td>
</tr>
<tr>
<td>Percent of women who smoke in the last three months of pregnancy.</td>
<td>9.3%</td>
<td>6%</td>
</tr>
<tr>
<td>The rate (per 100,000) of suicide deaths among youths aged 15 through 19.</td>
<td>15.8</td>
<td>12</td>
</tr>
<tr>
<td>Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.</td>
<td>*</td>
<td>70%</td>
</tr>
<tr>
<td>Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.</td>
<td>64.0%</td>
<td>72%</td>
</tr>
</tbody>
</table>

### Title V: Maternal Child Health National Outcomes Measures

<table>
<thead>
<tr>
<th>Title V: Maternal Child Health National Outcomes Measures</th>
<th>State 2010 Results</th>
<th>State 2015 Goal</th>
</tr>
</thead>
<tbody>
<tr>
<td>The infant mortality rate per 1,000 live births.</td>
<td>5.8</td>
<td>5.5</td>
</tr>
<tr>
<td>The ratio of the black infant mortality rate to the white infant mortality rate.</td>
<td>1.9</td>
<td>1.7</td>
</tr>
<tr>
<td>The neonatal mortality rate per 1,000 live births.</td>
<td>2.4</td>
<td>3.1</td>
</tr>
<tr>
<td>The postneonatal mortality rate per 1,000 live births.</td>
<td>2.2</td>
<td>1.9</td>
</tr>
<tr>
<td>The perinatal mortality rate per 1,000 live births plus fetal deaths.</td>
<td>*</td>
<td>*</td>
</tr>
<tr>
<td>The child death rate per 100,000 children aged 1 through 14.</td>
<td>20.1</td>
<td>17</td>
</tr>
</tbody>
</table>

### Title V: Maternal Child Health State Performance Measures

<table>
<thead>
<tr>
<th>Title V: Maternal Child Health State Performance Measures</th>
<th>State 2010 Results</th>
<th>State 2015 Goal</th>
</tr>
</thead>
<tbody>
<tr>
<td>Decrease the percent of women with a live birth who had no health care coverage for prenatal care.</td>
<td>8.4%</td>
<td>5%</td>
</tr>
<tr>
<td>Increase the percent of pregnant women and new mothers receiving support services through community home visiting programs.</td>
<td>10.4%</td>
<td>15%</td>
</tr>
<tr>
<td>Reduce unintended pregnancy in New Mexico to less than 20% of births</td>
<td>46.5%</td>
<td>42%</td>
</tr>
<tr>
<td>Decrease the percent of women initiating prenatal care after 10 weeks that did not get care as early as they wanted</td>
<td>48.5%</td>
<td>45%</td>
</tr>
<tr>
<td>Decrease the percent of middle school students who report using alcohol within the past 30 days</td>
<td>10.2%</td>
<td>15%</td>
</tr>
<tr>
<td>Reduce the proportion of women who report being physically abused by husband or partner during pregnancy.</td>
<td>3.9%</td>
<td>2%</td>
</tr>
<tr>
<td>Increase the proportion of women who exclusively breastfed their babies through six months.</td>
<td>18.7%</td>
<td>20%</td>
</tr>
</tbody>
</table>

**Note:** Statistics for the annual reporting year may be unavailable or provisional at the time of reporting and may be updated or revised throughout the year. Please contact the State for details about the indicator data.

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## Attachment C—Performance Measures Tracked by the Public Health Division

<table>
<thead>
<tr>
<th>Performance Measure</th>
<th>Reporting Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percent of preschoolers fully immunized</td>
<td>Semi-annually</td>
</tr>
<tr>
<td>Number of teens ages 15 to 17 receiving family planning services in agency-funded family planning clinics</td>
<td>Quarterly</td>
</tr>
<tr>
<td>Number of WIC eligible persons receiving services</td>
<td>Quarterly</td>
</tr>
<tr>
<td>Number of calls to the 1-800-Quit Now tobacco cessation help line</td>
<td>Quarterly</td>
</tr>
<tr>
<td>Number of HIV/AIDS prevention interventions</td>
<td>Quarterly</td>
</tr>
<tr>
<td>Person's enrolled in the agency's HIV services and receiving combination therapy who demonstrate an undetectable viral load</td>
<td>Quarterly</td>
</tr>
<tr>
<td>Percent of individuals re-enrolling in the syringe exchange program who are not sharing syringes</td>
<td>Quarterly</td>
</tr>
<tr>
<td>Number of syringes that are returned to syringe exchange program</td>
<td>Quarterly</td>
</tr>
<tr>
<td>Percent of individuals diagnosed with primary or secondary syphilis treated within thirty days of diagnosis</td>
<td>Quarterly</td>
</tr>
<tr>
<td>Number of visits to agency-funded school-based health centers</td>
<td>Quarterly</td>
</tr>
<tr>
<td>Number of participants in youth suicide prevention awareness and outreach activities</td>
<td>Quarterly</td>
</tr>
</tbody>
</table>
Attachment D—Caller Volume to DOH Tobacco Quitline

1-800-QUIT NOW Caller Volume
FY11 - Q1&2

Number of Callers

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## Core Program Performance Indicators from the Data Quality Indicator Guide (DQIG)

October 2011 MDE Submission, Results from January 2010 - December 2010

Refer to the DQIG Report for additional information on these and other indicators.

<table>
<thead>
<tr>
<th>CORE</th>
<th>PROGRAM</th>
<th>PERFORMANCE</th>
<th>INDICATORS</th>
<th>CDC Standard</th>
<th>Percentage</th>
<th>Standard Met?</th>
<th>*</th>
<th>Percentage</th>
<th>Standard</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6.a</td>
<td>Screening</td>
<td>Initial Program Pap Tests; Rarely or Never Screened</td>
<td>† 20%</td>
<td>22.7% (805/3,548)</td>
<td>YES</td>
<td>29.1%</td>
<td>YES</td>
<td></td>
<td></td>
</tr>
<tr>
<td>19.e</td>
<td>Screening</td>
<td>Mammograms Provided to Women ‡ 50 Years of Age</td>
<td>‡ 75%</td>
<td>75.0% (3,836/5,112)</td>
<td>YES</td>
<td>85.8% (285,209/332,273)</td>
<td>YES</td>
<td></td>
<td></td>
</tr>
<tr>
<td>11.a</td>
<td>Cervical</td>
<td>Abnormal Screening Results with Complete Follow-Up</td>
<td>† 90%</td>
<td>94.3% (99/105)</td>
<td>YES</td>
<td>93.0%</td>
<td>YES</td>
<td></td>
<td></td>
</tr>
<tr>
<td>16.d</td>
<td>Cervical</td>
<td>Abnormal Screening Results; Time from Screening to Diagnosis</td>
<td>† 25%</td>
<td>25.0% (24/96)</td>
<td>YES</td>
<td>12.4% (556/4,491)</td>
<td>YES</td>
<td></td>
<td></td>
</tr>
<tr>
<td>17.</td>
<td>Diagnostic</td>
<td>Treatment Started for Diagnosis of HSIL, CIN2, CIN3, CIS,</td>
<td>† 90%</td>
<td>93.6% (88/94)</td>
<td>YES</td>
<td>91.9%</td>
<td>YES</td>
<td></td>
<td></td>
</tr>
<tr>
<td>18.d</td>
<td>Diagnostic</td>
<td>HSIL, CIN2, CIN3, CIS; Time from Diagnosis to Treatment &gt;</td>
<td>† 20%</td>
<td>18.1% (15/83)</td>
<td>YES</td>
<td>8.4% (310/3,678)</td>
<td>YES</td>
<td></td>
<td></td>
</tr>
<tr>
<td>18.g</td>
<td>Diagnostic</td>
<td>Invasive Carcinoma; Time from Diagnosis to Treatment &gt; 60</td>
<td>† 20%</td>
<td>20.0% (1/5)</td>
<td>YES</td>
<td>9.8% (25/256)</td>
<td>YES</td>
<td></td>
<td></td>
</tr>
<tr>
<td>20.a</td>
<td>Breast</td>
<td>Abnormal Screening Results with Complete Follow-Up</td>
<td>† 90%</td>
<td>91.6%</td>
<td>YES</td>
<td>95.1%</td>
<td>YES</td>
<td></td>
<td></td>
</tr>
<tr>
<td>25.d</td>
<td>Breast</td>
<td>Abnormal Screening Results; Time from Screening to Diagnosis</td>
<td>† 25%</td>
<td>8.4% (163/1,950)</td>
<td>YES</td>
<td>7.7%</td>
<td>YES</td>
<td></td>
<td></td>
</tr>
<tr>
<td>26.</td>
<td>Diagnostic</td>
<td>Treatment Started for Breast Cancer</td>
<td>† 90%</td>
<td>91.4% (106/116)</td>
<td>YES</td>
<td>97.7%</td>
<td>YES</td>
<td></td>
<td></td>
</tr>
<tr>
<td>27.d</td>
<td>Diagnostic</td>
<td>Breast Cancer; Time from Diagnosis to Treatment &gt; 60 Days</td>
<td>† 20%</td>
<td>18.9% (20/106)</td>
<td>YES</td>
<td>7.1% (373/5,229)</td>
<td>YES</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

For percentages with a denominator ‡ 10, a one-sided hypothesis test was used in determining if a program failed to meet a DQIG standard.

"Small #": The denominator is less than 10. The one-sided hypothesis test was not conducted.

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# Attachment F—List of Advisory Boards and Councils in which PHD Staff Participate

<table>
<thead>
<tr>
<th>NAME</th>
<th>Brief Description of the Purpose of the Group</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>PHD Director's Office</strong></td>
<td></td>
</tr>
<tr>
<td>Governor's Early Learning Advisory Council</td>
<td>Created by Senate Bill 120 (2011), a state-private partnership to establish a comprehensive early childhood care and education system through an aligned continuum of state and private programs, including home visitation, early intervention, child care, early head start, head start, early childhood special education, family support and prekindergarten, and to maintain or establish the infrastructure necessary to support quality in the system's programs.</td>
</tr>
<tr>
<td>Nurse Advice NM Advisory Committee</td>
<td>Provides information and advice to further the mission of NurseAdvice New Mexico. The NANNM Advisory Committee reviews NANNM's policies and metric reports, and makes recommendations for improvements and enhancements. The recommendations of the Advisory Committee are not final or decisive actions, but are rather taken to the NANNM Board of Directors for consideration.</td>
</tr>
<tr>
<td>New Mexico Public Health Association</td>
<td>To promote public health practice, policies, and systems that support health equity in New Mexico. We accomplish our mission by providing a forum for sharing research and practices, and serving as a base for leadership development, networking, and action.</td>
</tr>
<tr>
<td><strong>Family Health Bureau</strong></td>
<td></td>
</tr>
<tr>
<td>Certified Nurse Midwifery Advisory Board</td>
<td>The CNM advisory board makes recommendations to the department regarding the regulation of CNMs.</td>
</tr>
<tr>
<td>Child Fatality Review</td>
<td>Review child deaths</td>
</tr>
<tr>
<td>CMS Advisory Board</td>
<td>Advise the CMS Children and Youth with Special Health Care Needs program</td>
</tr>
<tr>
<td>CMS Newborn Genetic Screening Advisory Board</td>
<td>Advise the CMS Newborn Genetic Screening program</td>
</tr>
<tr>
<td>CMS Newborn Hearing Screening Advisory Board</td>
<td>Advise the CMS Newborn Hearing Screening program</td>
</tr>
<tr>
<td>Community Data Collaborative</td>
<td>Make data more widely available, data-to-action</td>
</tr>
<tr>
<td>Early Childhood Action Network (ECAN)/Early Childhood Comprehensive Systems (ECCS) State Team</td>
<td>A State Team is required to steer/advice the work of the ECCS grant. ECAN/ECCS State Team has been a leader in early childhood work in NM for many years bringing in all sectors to build strong collaboration, networking, coordination, infrastructure, and policy recommendations.</td>
</tr>
<tr>
<td>Family Planning Advisory Committee (FPAC)</td>
<td>The purpose of FPAC is to review and approve information and educational materials used by clinics and projects supported by the Family</td>
</tr>
<tr>
<td>Committee/Board</td>
<td>Description</td>
</tr>
<tr>
<td>-------------------------------------------------------------------------------</td>
<td>----------------------------------------------------------------------------</td>
</tr>
<tr>
<td><strong>Folic Acid Committee/Media Campaign</strong></td>
<td>Strategic planning for preconception health-related media and education; partners include HSD Medicaid and March of Dimes</td>
</tr>
<tr>
<td><strong>Geospatial Advisory Committee</strong></td>
<td>Integrate data and geospatial technologies for state government.</td>
</tr>
<tr>
<td><strong>Licensed Midwifery Advisory Board</strong></td>
<td>The LM advisory board makes recommendations to the department regarding current standards and conduct of LM practice of LMs.</td>
</tr>
<tr>
<td><strong>Maternal Mortality Review</strong></td>
<td>Review maternal deaths</td>
</tr>
<tr>
<td><strong>Multi-Agency Team: Council on Young Child Wellness (MAT)</strong></td>
<td>A Young Child Wellness Council is required to guide the state-level work of Project LAUNCH. Using the five LAUNCH Prevention and Promotions Strategies, the MAT focuses on early childhood systems building and sustainability.</td>
</tr>
<tr>
<td><strong>New Mexico Pregnancy Risk Assessment Monitoring System Steering Committee</strong></td>
<td>Provide guidance for PRAMS survey revision, data dissemination and translating data to policy and program improvements</td>
</tr>
<tr>
<td><strong>Health Systems Bureau</strong></td>
<td></td>
</tr>
<tr>
<td><strong>New Mexico Area Health Education Centers (AHEC) Advisory Workgroup</strong></td>
<td>To purpose is to review information about what the AHEC’s strategies are for students wanting to participate in programs that encourages rural and undeserved community involvement.</td>
</tr>
<tr>
<td><strong>J-1 Visa Waiver Program Advisory Workgroup</strong></td>
<td>To purpose is to review applications for physicians to obtain a waiver to reside in the USA, in turn they must be willing to work in designated underserved areas of NM.</td>
</tr>
<tr>
<td><strong>New Mexico TeleHealth Alliance Advisory Committee</strong></td>
<td>The Alliance meets to provide technical, program support to members, and enable them to effectively share resources.</td>
</tr>
<tr>
<td><strong>New Mexico Health Service Corps (NMHSC) Advisory Committee</strong></td>
<td>To purpose is to review stipends to support health professionals in training during their last two years of residency, and to support the retention of health professionals at existing eligible practice sites that are located in rural and other medically underserved areas of the state.</td>
</tr>
<tr>
<td><strong>New Mexico Higher Education Department (HED) State Loan Payment Advisory Committee</strong></td>
<td>The purpose is to review finical support for health care professionals willing to practice rural and other medically underserved areas of the state as part of their loan obligations. In addition, this group assists HED by making policy recommendations and provides advisement for those that default on their finical obligations.</td>
</tr>
<tr>
<td><strong>New Mexico Oral Health Advisory Council</strong></td>
<td>The council offers input to issues affecting oral health and provides information. The council will at times collaborate and share resources when a greater oral health presence is warranted.</td>
</tr>
<tr>
<td><strong>New Mexico Primary Care Association Board</strong></td>
<td>OPCRH is an Ex-officio Board Member.</td>
</tr>
<tr>
<td><strong>New Mexico Health Resources, Inc Board</strong></td>
<td>OPCRH is an Ex-officio Board Member.</td>
</tr>
<tr>
<td><strong>New Mexico Dental Support Center Dental Provider Meeting</strong></td>
<td>The purpose is to provide information to rural and</td>
</tr>
</tbody>
</table>

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<table>
<thead>
<tr>
<th>Committee Name</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community Health Clinic Dental Providers' Group</td>
<td>The purpose is to provide information to NMPCA members on clinical performance improvement, and to share best practices from their own organizations. Different topics are highlighted at each meeting. These are presented either by expert speakers, community partners or by our own NMPCA staff. Updates on various oral health topics from statewide and national meetings. Data are also presented from UDS results, Patient Satisfaction Surveys and any other clinical surveys that are done.</td>
</tr>
<tr>
<td>Clinical Performance Improvement Committee</td>
<td></td>
</tr>
<tr>
<td>New Mexico Provider Retreat Planning Committee</td>
<td>The purpose of these calls is to identify and discuss planning needs for the upcoming retreat, in which federal funds are used to support parts of the retreat for retention of health care providers.</td>
</tr>
<tr>
<td>Health Homes and Primary and Behavioral Health Care Integration Committee</td>
<td>The purpose of committee is provide guidance for the integration of primary and behavioral health care, to build a person-centered health home that results in improved outcomes for beneficiaries and better services and value for State Medicaid and other programs, including mental health and substance abuse agencies.</td>
</tr>
<tr>
<td>State Office of Rural Health Region D Committee</td>
<td>The purpose of these calls is to identify and discuss planning needs for the upcoming regional meeting. In addition other State Office of Rural Health and FLEX programmatic concerns and policy updates. There are expectations to participate based on receiving grant funding from HRSA.</td>
</tr>
<tr>
<td>Quarterly Office of Primary Care Region VI Conference Calls</td>
<td>The purpose of these calls is to identify and discuss priorities, needs, opportunities, and share information on programs and resources within our HRSA region. There are expectations to participate based on receiving grant funding from HRSA.</td>
</tr>
<tr>
<td>Monthly Office of Primary Care Conference Calls</td>
<td>The purpose of these calls is to identify and discuss priorities, needs, opportunities, and share information on state offices of primary care, our participation is required as part of our grant funding from HRSA.</td>
</tr>
<tr>
<td>New Mexico State Team Conference Call</td>
<td>The purpose of these calls is to identify and discuss priorities, needs, opportunities, and share information on how HRSA programs and...</td>
</tr>
<tr>
<td>Organization</td>
<td>Description</td>
</tr>
<tr>
<td>--------------------------------------------------</td>
<td>-----------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Healthy Aging Collaborative</td>
<td>Promote senior wellness. Staff volunteers to participate on the Executive Committee.</td>
</tr>
<tr>
<td>Hispanic Advisory Committee - Optum Health</td>
<td>Promotes Hispanic needs for behavioral health.</td>
</tr>
<tr>
<td>NM Immunization Coalition</td>
<td>Increase awareness and advocacy for school immunizations</td>
</tr>
<tr>
<td>NM Coalition on Asthma</td>
<td>Increase awareness and advocacy for asthma</td>
</tr>
<tr>
<td>APS School Health Advisory Council</td>
<td>Helps guide health practices of the schools within APS</td>
</tr>
<tr>
<td>School Based Health Center Partners</td>
<td>Technical assistance and training guidance for school based health centers statewide</td>
</tr>
<tr>
<td>School Nurse Advisory Council</td>
<td>Training and technical assistance in clinical best practices for school nurses statewide</td>
</tr>
<tr>
<td>Child Fatality Review Board</td>
<td>Review of all suicide related adolescent fatalities, provide recommendations for improving outcomes</td>
</tr>
<tr>
<td>Prevention Policy Consortium</td>
<td>Planning and coordinating substance abuse prevention efforts statewide</td>
</tr>
<tr>
<td>NM Youth Risk and Resiliency Survey Steering Committee</td>
<td>Plan, conduct and oversee the implementation of the bi-annual NM Youth Risk and Resiliency Survey.</td>
</tr>
<tr>
<td>Managed Care Organizations Planning Council</td>
<td>Review and improve MCO and SBHC relationship and work.</td>
</tr>
<tr>
<td>NM Health Equity Workgroup</td>
<td>Promote health equity in NM, inform our communities, connect individuals, communities and organizations and act to improve health equity in NM.</td>
</tr>
<tr>
<td>Head to Toe Conference Steering Committee</td>
<td>Planning and implementation of the annual conference for school health personnel</td>
</tr>
<tr>
<td>School Health Educators Institute Planning</td>
<td>Planning and implementation of the annual conference for school health education teachers</td>
</tr>
<tr>
<td>National Assembly of School Based Health Centers Annual Conference Planning Committee</td>
<td>Planning and implementation of the annual conference for school based health center personnel</td>
</tr>
<tr>
<td>Native American Youth Suicide Prevention Task Force</td>
<td>Training and technical assistance on Native American youth suicide prevention.</td>
</tr>
<tr>
<td>Healthy Weight Council</td>
<td>Training, technical assistance and promotion of obesity prevention</td>
</tr>
<tr>
<td>Youth Intervention, Prevention and Education in School/Communities Workgroup</td>
<td>Increasing positive youth development opportunities in schools and communities statewide</td>
</tr>
<tr>
<td>National Network of Adolescent Health Coordinators</td>
<td>Planning and coordination of adolescent health activities nationwide</td>
</tr>
<tr>
<td>New Mexico/Colorado CHIPRA grant leadership team</td>
<td>Leadership and guidance for the collaborative school based health center, quality improvement grant</td>
</tr>
<tr>
<td>Organization</td>
<td>Description</td>
</tr>
<tr>
<td>------------------------------------------------------------------------------</td>
<td>-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>New Mexico CHIPRA grant team</td>
<td>Leadership and guidance for the NM portion of the school based health center, quality improvement grant</td>
</tr>
<tr>
<td>New Mexico Community Health Worker Advisory Council</td>
<td>Established in 2006 as a result of senate Joint Memorial 076. Community group that advises OCHW on design &amp; implementation of a statewide, voluntary, competency-based training &amp; certification process for CHWs. 25 members represent all regions of the state and diverse experience in practice, training, &amp; support of CHWs.</td>
</tr>
<tr>
<td>University of New Mexico Masters of Public Health Acceptance Committee</td>
<td>Review and recommend MPH candidates for acceptance into the UNM MPH Program</td>
</tr>
<tr>
<td>New Mexico/Southern Colorado Community Health Representative (CHR) Association</td>
<td>Promote collaboration, skill development and networking among CHR programs and stakeholders</td>
</tr>
<tr>
<td>Indian Health Services (IHS) Health Promotion Disease Prevention Health Council</td>
<td>Share within IHS programs and strategize around collaborative opportunities towards tribal health</td>
</tr>
<tr>
<td>Northern Promotora Committee</td>
<td>Promote collaboration, skill development and networking among Northern New Mexico Promotora programs and stakeholders.</td>
</tr>
<tr>
<td>Diabetes Advisory Council Native American Partnership</td>
<td>Promote skill development and knowledge for CHRs and other health care workers in tribal communities concentrating on diabetes prevention and control.</td>
</tr>
<tr>
<td>Southern NM Promotora Committee</td>
<td>To give recognition to Promotor/ as/ CHWs as highly trained, educated and valued partners in the health care system within the community. To link communities with the health care system and act as the bridge to access needed services.</td>
</tr>
<tr>
<td>New Mexico Community Health Worker Association</td>
<td>Promote and support recognition and the professional development of community health workers across the state.</td>
</tr>
<tr>
<td><strong>Infectious Disease Bureau</strong></td>
<td></td>
</tr>
<tr>
<td>Community Planning and Action Group</td>
<td>Statewide advisory and workgroup to develop strategic plan for HIV and hepatitis prevention. Required by federal funders to advise the program.</td>
</tr>
<tr>
<td>Clinical Preventive Initiative—Immunization Workgroup</td>
<td>Work with NMMS and community providers to address clinical issues related to promoting immunizations.</td>
</tr>
<tr>
<td>HIV Advisory Council</td>
<td></td>
</tr>
<tr>
<td>New Mexico HIV/AIDS Treatment &amp; Services Program</td>
<td>Statewide advisory and workgroup to develop strategic planning for HIV/AIDS Treatment and Services. Required by federal funders to advise the program.</td>
</tr>
<tr>
<td>Medical Advisory Board</td>
<td></td>
</tr>
<tr>
<td>New Mexico Medical Cannabis Program</td>
<td>Make recommendations to Secretary of Health about conditions to be covered by the Medical Cannabis Program.</td>
</tr>
<tr>
<td><strong>Chronic Disease Prevention and Control Bureau</strong></td>
<td></td>
</tr>
<tr>
<td>Breast and Cervical Cancer Early Detection Quality Assurance Committee</td>
<td>Assure quality delivery of program services consistent with clinical guidelines and CDC</td>
</tr>
</tbody>
</table>

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March 21, 2012  
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<table>
<thead>
<tr>
<th>Organization</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>New Mexico Chronic Disease Prevention Council</td>
<td>Coordinate chronic disease activities statewide in order to effectively address chronic disease approaches and strategies with community partners. Provide support and participation. Federal grant required.</td>
</tr>
<tr>
<td>New Mexico Arthritis Advisory Council</td>
<td>Coordinate arthritis activities statewide in order to effectively address arthritis approaches and strategies with community partners. Provide support and participation. Federal grant required.</td>
</tr>
<tr>
<td>New Mexico Cancer Council</td>
<td>Coordinate cancer activities statewide in order to effectively address cancer approaches and strategies with community partners. Provide support and participation. Federal grant required.</td>
</tr>
<tr>
<td>New Mexico Diabetes Advisory Council</td>
<td>Coordinate diabetes activities statewide in order to effectively address diabetes approaches and strategies with community partners. Provide support and participation. Federal grant required.</td>
</tr>
<tr>
<td>Colorectal Cancer Medical Advisory Committee</td>
<td>Assure quality delivery of program services consistent with clinical guidelines and CDC requirements. Facilitation provided by the Colorectal Program (federally-funded) Federal grant requirement.</td>
</tr>
</tbody>
</table>

**Region 1/3**

<table>
<thead>
<tr>
<th>Organization</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Belen School District</td>
<td>SHAC (school health advisory council) is an committee of school officials, local healthcare providers, parents, students and other stakeholders who meet quarterly to discuss health issues in the Belen Consolidated School District and to set the agenda for school based health initiatives. The council was formed to oversee the district's school based health center, which has not been operational this school year.</td>
</tr>
<tr>
<td>Resiliency Corps</td>
<td>The Resiliency Corps is a grassroots organization of community members and local leaders committed to evidence-based injury prevention. Previous project local health office employees have participated include pedestrian safety and community walk ability projects, networking our harm reduction services with other local organizations addressing substance abuse, and expanding access to suicide prevention gatekeeper trainings in both Valencia County School Districts.</td>
</tr>
<tr>
<td>Midwest NM CAP</td>
<td>Midwest NM CAP Health Services Advisory Committee that offer services to children ages 3-5 years from counties; Valencia, Cibola, Socorro, McKinley and Catron, which include: Support Services, education, Nutrition,</td>
</tr>
<tr>
<td>Task Force</td>
<td>Description</td>
</tr>
<tr>
<td>------------------------------------</td>
<td>----------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>PMS Advisory Committee</td>
<td>Health Services Advisory Committee through Presbyterian Medical Services (PMS). The committee is comprised of PMS staff pediatricians, dental providers, community health workers from other agencies. We discuss ways to address these issues in a holistic approach so clients are receiving the same message.</td>
</tr>
<tr>
<td>McKinley County Breastfeeding Taskforce</td>
<td>McKinley County Breastfeeding Taskforce meets monthly with staff from Local Hospitals including IHS, Navajo WIC, and Zuni WIC to create ways to work together to influence local providers in promoting &amp; raising Breastfeeding rates in McKinley County.</td>
</tr>
<tr>
<td>Valencia County Breastfeeding Task Force</td>
<td>The Valencia County Breastfeeding Task Force promotes, supports and encourages breastfeeding in our community through outreach projects and monthly meetings. We are made up of professionals, breastfeeding moms, and others in the area who are interested in furthering breastfeeding.</td>
</tr>
<tr>
<td>San Juan Breastfeeding Task Force</td>
<td>The San Juan Breastfeeding Task Force meets on a quarterly basis to help health providers such as San Juan Regional, WIC, San Juan Partners Pediatrics, Northern Navajo Medical Center in Shiprock and local specialized baby stores to network among each other to increase healthful breastfeeding outcomes.</td>
</tr>
</tbody>
</table>
APPENDIX A: EVALUATION INFORMATION

Evaluation Information

Program Evaluation Objectives.
• Evaluate use of resources by public health offices to meet public health policy goals and public needs and avoid duplication of services within communities.
• Assess public health office financial business practices, including coordination with the state Medicaid program.
• Assess the use of contract services and community partnerships to meet public health goals.

Scope and Methodology.
• Reviewed state statutes, departmental, division and regional policies, procedures, and internal management documents.
• Conducted structured interviews with Departments of Health and Human Services agency staff, local public health staff and other nonparticipating public entities.
• Reviewed financial, utilization, performance, and program and quality data from the department.
• Conducted web search for information relevant to the evaluation.
• Site visits and staff interviews at 20 regional or local public health offices.

Evaluation Authority. The committee has authority under Section 2-5-3 NMSA 1978 to examine laws governing the finances and operations of departments, agencies, and institutions of New Mexico and all of its political subdivisions, the effect of laws on the proper functioning of these governing units, and the policies and costs of government. Pursuant to its statutory authority, the committee may conduct performance reviews and inquiries into specific transactions affecting the operating policies and costs of governmental units and their compliance with state law.

Evaluation Team.
Charles Sallee, Deputy Director
Pamela Galbraith, Lead Evaluator
Maria D. Griego, Evaluator

Exit Conference. The contents of this report were discussed with Department of Health senior department staff and LFC staff on March 15, 2012.

Report Distribution. This report is intended for the information of the Office of the Governor, the Department of Health, the State Auditor, and the Legislative Finance Committee. This restriction is not intended to limit distribution of this report which is a matter of public record.

Charles Sallee
Deputy Program Director for Evaluation

Department of Health
Cost Effectiveness of Public Health Offices
March 21, 2012
<table>
<thead>
<tr>
<th>Significant Findings (Brief Description)</th>
<th>Significant Recommendations (Brief Description)</th>
<th>Department Responses (Brief Description)</th>
<th>Corrective Action (Brief description with who, how and when)</th>
<th>Target Completion Date</th>
<th>Did implementation of recommendation provide improvement. If no, explain.</th>
<th>Reasons For Non-Implementation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Performance monitoring for PHD does not adequately investigate program outcomes. Performance measures focus on output (number of activities/interventions) rather than outcome of interventions/activities</td>
<td>PHD should develop AGA performance measures that relate to health status in addition of service activities for reporting to the Legislature.</td>
<td>PHD disagrees. There are processes and procedures in place that establishes the principles for performance measures. Health outcomes are measured by programs and reported to various entities. Often these outcomes are not tracked for each contract, but rather at the program or state level.</td>
<td>The Leadership Team has been instructed in Results Based Accountability and will start including a Program Performance Measure in all Contracts, as appropriate, July 1, 2012</td>
<td>1-Jul-12</td>
<td>Yes. The Leadership Team has been instructed in Results Based Accountability and started including a Program Performance Measures in all Contracts, as appropriate, July 1, 2012. This is an improvement.</td>
<td>PHD is currently reorganizing Regions so until this is done, we cannot pursue the next step which would be exploring this functionality.</td>
</tr>
<tr>
<td>Financial and personnel data (with a focus on cost allocation) does not accurately reflect total costs for regions or local health offices.</td>
<td>PHD should refine the financial reporting system so useful and accurate information is generated for the regional and local offices.</td>
<td>PHD disagrees that reporting systems are not providing sufficient, useful information currently, given the scarce resources available for additional administrative costs.</td>
<td>PHD will investigate the capability of SHARE’s use of a reporting category or other functionality for local health offices to track local expenditures.</td>
<td>30-Sep-12</td>
<td>Not yet implemented.</td>
<td></td>
</tr>
<tr>
<td>DOH is pursuing national accreditation for public health</td>
<td>Progress report in implementation plan response in September.</td>
<td>The Department agrees to submit a progress report.</td>
<td>The Department agrees to submit a progress report in September implementation response.</td>
<td>30-Sep-12</td>
<td>Yes. The Department of Health’s (DOH) effort to attain Public Health Accreditation (Accreditation) is in full swing. Accreditation is a voluntary, national program overseen by the Public Health Accreditation Board, an independent oversight body. Accreditation will drive the department to continuously improve the quality of the services we deliver to the community. This will be an improvement when the Department is accredited.</td>
<td></td>
</tr>
</tbody>
</table>

**To Be Completed By Auditor-In-Charge Of The Original Report**

**Department of Health, Public Health Division**

**Cost Effectiveness of Public Health**

**Follow Up Date: September 2012**

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**REVIEW FOLLOW-UP MATRIX**

**Follow Up Date: September 2012**
<table>
<thead>
<tr>
<th>Area</th>
<th>Action</th>
<th>Department's Position</th>
<th>Date</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Recruitment is hindered by delayed recruitment</td>
<td>PHD should work with SPC to ensure job qualifications and descriptions match responsibilities. Share comparison salary info with SPO for their research.</td>
<td>The Department agrees to work on matching job qualifications with responsibilities and to work with SPO to share comparison salary information for SPO research as appropriate.</td>
<td>15-Dec-12</td>
<td>Yes, the Department has implemented a new meeting weekly with HRB's assistance to address the delayed recruitment and strategies to change job descriptions to reflect job duties. The meetings have resulted in a number of changes to how DOH is using certain positions and this has affected how much DOH can offer hard to recruit positions. Other options are still being considered for recruitment and retention initiatives. This is an improvement.</td>
</tr>
<tr>
<td>Local offices are not persistent or consistent in determining a client's Medicaid eligibility or other third party insurers.</td>
<td>PHD should collaborate with New Mexico Primary Care Association to expand pilot studies of PEMOSA screenings.</td>
<td>The Department agrees PHD has consented to work with New Mexico Primary Care Association to expand pilot studies of PEMOSA screenings in 2 sites.</td>
<td>15-Sep-12</td>
<td>Yes, the NMPCA has contracted with two entities for these pilots; Families &amp; Youth, Inc. sends a staff member to the Sunland Park Public Health Office and Youth Development Institute (YDI) has a staff member participating at the Stanford Public Health Office.</td>
</tr>
<tr>
<td>Most clients are placed at a zero pay on the sliding fee scales and income verification is not established using verifiable documentation.</td>
<td>PHD should collaborate with New Mexico Primary Care Association to expand pilot studies of PEMOSA screenings.</td>
<td>The Department disagrees with this finding. All federal programs are reviewed federally and there have not been findings related to this assertion. Our largest program is WIC, then Family Planning. Both have been successfully reviewed for use of financial screening and have been found to be correct. The reason that a majority of clients are placed at a zero pay on the sliding fee scale is because income verification indicates that they belong there.</td>
<td>1-Jul-12</td>
<td>Site visits were made to 6 PHO's from May – Aug 2012. Offices visited include Taos PHO, Cuba PHO, Sandoval PHO, SW Valley PHO, Alamosa PHO and Las Vegas PHO. As part of the Site Visits, financial chart audits are done to ensure that clients are completing the income assessment themselves and that information is entered in the BEHR Practice Management application accurately. For each office, 10 client charts are chosen randomly from a BEHR Patient Analysis Report. Each scanned Income Assessment document is reviewed and calculated by the FPP Fee Collection Liaison to ensure that income was assessed correctly. The information from the Income Assessment is entered accurately in the Sliding Fee Scale tab of BEHR. As part of the Site Visits, financial chart audits are done to ensure that clients are completing the income assessment and that information is entered in the BEHR Practice Management application accurately. Findings from each site are documented in a letter and sent to each health office and administrative staff in that Region. To date, findings from only one PHO demonstrated that some Income Assessments were incomplete and the information was not entered in BEHR system. Clerk training was done immediately, at the time of the visit and included insurance verification using both Medicaid and HealthXnet, sliding fee scale entry and ensuring completion of the Income Assessment by the client.</td>
</tr>
</tbody>
</table>

**Note:** The table above outlines various initiatives and responses to concerns raised regarding recruitment, local office consistency in Medicaid eligibility determinations, and income verification. Each entry includes the action taken, the department's agreement or disagreement, the date, and additional notes or details about the implementation and impact of these actions.
<p>| <strong>PHD should conduct routine audits of business practices within local public health offices:</strong> Medicaid eligibility referrals, follow up on client compliance with screenings, determination of sliding fee payments. Recommendation applies to lines 11, 14, and 15. | The Department agrees | The division will work with regional management teams to conduct routine audits of business practices within local public health offices. 1-Jul-12 | Yes. PHD Program staff and regional management review processes in local health offices to identify opportunities for improvement. Reviews include assessment of documentation of income and insurance eligibility, and accurate entry of this information in the electronic medical record. PHD has set up a workgroup to begin review of all business practices within the Division. |
| PHD's contracts focus on compliance rather than outcome and achievement outcomes. PHD should strategically manage their contract dollars to match Public Health priorities as described in DOH strategic plan. | The Department disagrees that it does not strategically manage GF contract dollars to match PH priorities as described in the Strategic Plan. Federal dollars are required to be directed at federal priorities. State dollars are directed at meeting the 10 essential functions of public health which include the Strategic Plan priorities. Citing only General Fund Contracts, the Department has allocated contracts 1) as required by statute, 2) as required to meet clinical priorities within budget. With a 40% cut to PHD contracts in FY11 hard decisions were made to eliminate health ed contracts to minimize impact to direct services provided to clients. | PHD carried out a Results Based Accountability training of all leadership and some Regional Staff while doing the Comprehensive Strategic Health Plan statewide this year. The meetings were based on the DOH health status priorities as related to data, actions to take to address these priorities have been assimilated into the Strategic Plan and Indicator Leads continue to work with communities on their strategies locally. The fact remains that allocation of funding is greatly affected by federal priorities and is greatly affected by the frontier nature of the State and the need for safety net services. |
| PHD's oversight of contract deliverables focuses on validating task reporting and not analyzing program impact. | PHD disagrees. There are processes and procedures in place that establishes the principles for performance measures. Health outcomes are measured by programs and reported to various entities. Often these outcomes are not tracked for each contract, but rather at the program or state level. | The Leadership Team has been instructed in Results Based Accountability and will start including a Program Performance Measure in program evaluations, as appropriate, July 1, 2012 1-Jul-12 | Yes. All FY13 professional service contracts now contain a program performance measure that is based upon Results Based Accountability principles. |</p>
<table>
<thead>
<tr>
<th>PHD's contracted services might duplicate services subsidized by other programs.</th>
<th>PHD should partner with other agencies providing similar services to determine if duplication exists, as well as assess if program can be reallocated to better leverage federal dollars and reduce the burden on SGF.</th>
<th>The Department disagrees. We do partner with other agencies whenever possible to reserve the limited funds that the division has to provide services not provided by others.</th>
<th>The Department disagrees with this assertion, and we continue to work with partners in the community to share scarce resources and avoid duplication of services wherever possible.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary care is the largest contractual function of PHD, but PHD does not have a strategic plan to address service needs.</td>
<td>PHD should build a strategy to address future primary care needs, assessing how to best use RPHCA dollars.</td>
<td>The Department disagrees. The legislative intent for Rural and Primary Health Care Act (RPHCA) dollars is to increase access to health care throughout the state. The RPHCA RFP process addresses projected primary care needs for the upcoming fiscal year. Significant strategizing and assessing occurs during every RPHCA RFP process to determine best how to use these funds.</td>
<td>DOH considered this recommendation and is exploring the impact of the ACA on public health and how to best support the changes involved in Primary Care.</td>
</tr>
<tr>
<td>Not a single performance addressing health outcomes is included in primary care clinic contracts.</td>
<td>PHD should reassess contract performance measures to also require measurable health data to better judge service effectiveness.</td>
<td>Disagree. The RPHCA contracts have a DOH performance measure related to increasing access to health care, which is the legislative intent of the program. FY12 Supplemental Performance Measures for the Health Systems Bureau includes: Task 6: Expand health care access in rural and underserved areas. Measured by: Number of medical and dental encounters at primary care clinics supported by DOH.</td>
<td>DOH considered this recommendation and felt it would be counterproductive to implement it.</td>
</tr>
<tr>
<td>Which governmental entity assume responsibility for leases and other associated costs is inconsistent.</td>
<td>Either the Legislature should modify the statute to accurately reflect the state's intent OR PHD should clarify state and local governmental entities financial responsibilities for leases and associated costs of PH offices.</td>
<td>The Department agrees that the Legislature should modify the statute to reflect the requirement to house public health and the WIC Program sufficiently to provide services. Counties have depended on DOH to provide some facilities for administrative offices and expanded clinics due to expanded programs. In some cases it was necessary to provide additional maintenance services, as the county's were inadequate for clinic facilities meeting CLIA guidelines. The WIC Program has required offices to house 150 staff in the Regions. WIC is not funded to pay for facilities, with a few exceptions.</td>
<td>Work with the LFC to bring about an update to the current statute regarding Public Health facilities.</td>
</tr>
<tr>
<td>In some cases, the state is paying lease or associated costs that exceed market values.</td>
<td>The PHD should require written agreements with landlords clarifying responsibilities of the tenant and the landlord, even in cases where the state is only paying associated costs. PHD should seek Property Control Division counsel with associated cost agreements to evaluate market comparisons.</td>
<td>The Department agrees</td>
<td>PHD is working on written agreements statewide with Landlords clarifying responsibilities of the tenant and the landlord and will work with Property Control on evaluation of market comparisons for space.</td>
</tr>
</tbody>
</table>