Report
to
The LEGISLATIVE FINANCE COMMITTEE

Department of Health
Cost Effectiveness of Public Health Offices
March 21, 2012

Report #12-02

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David Abbey
Director

March 21, 2012

Dr. Catherine Torres, Secretary
Department of Health
1190 St. Francis Drive Suite S1310
Santa Fe, New Mexico 87502

Dear Secretary Torres:

On behalf of the Legislative Finance Committee (Committee), I am pleased to transmit the *Cost Effectiveness of Public Health Offices* Program Evaluation. The evaluation team assessed resources, business practices, contract services, and community partnerships used to meet public health policy goals by the Public Health Division of the Department of Health. An exit conference was conducted with the Department of Health to discuss the contents of the report. The Committee would like a plan to address the recommendations within this report within 30 days.

I believe this report addresses issues the Committee asked us to review and hope your department will benefit from our efforts. We very much appreciate the cooperation and assistance we received from your staff.

Sincerely,

David Abbey, Director

DA:MG/am

Cc: Senator John Arthur Smith, Chairman, LFC
Representative Luciano "Lucky" Varela, Vice-Chairman, LFC

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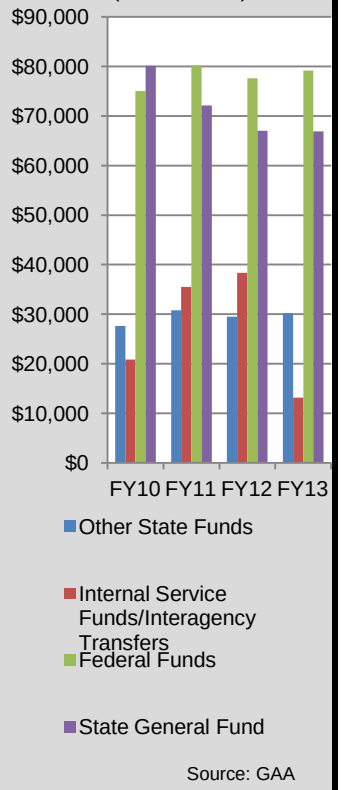
PHD Bureaus Contributing Staff to Regional and Local Offices:

- ***Chronic Disease***
- ***Family Health***
- ***Infectious Disease***
- ***Pharmacy***
- ***Health Systems***

PHD All Funding Sources FY10-FY12

(in thousands)



Source: GAA

In FY12, the total operating budget for PHD was $187.6 million.

Most New Mexico residents are likely unaware of the broad array of services provided by the Division of Public Health (PHD), services to protect us from disease and improve our health.

State and federal mandates, the Department of Health (DOH) strategic plan, the pursuit of national accreditation, core functions, and essential services are the driving forces in the state's public healthcare delivery system. Piecing together all these directives into a comprehensive plan of service, to provide the greatest positive impact to the greatest number, is a daunting task for the PHD.

State statutes dictate specific public health services, impacting the PHD's workload and priorities. The state Public Health Act serves as the foundation for establishing the organizational structure for public health, and mandates counties play a role in the public health system by contributing financial support for office space and associated expenses.

Although the federal government does not direct an organizational structure for public health, strategic objectives are driven by access to special program dollars from federal health agencies. In FY12, the total operating budget for PHD was $187.6 million with $77.6 million coming from federal funding.

The system to provide services includes five regional and 54 local public health offices which span the state, and, in some situations, are the only providers of health services in a locality.

The PHD's extensive assortment of services and programs requires a diverse collection of subject experts. The expertise comes from staff in other PHD bureaus. These individuals are dedicated to program administration, contract management, and direct services for specified health programs.

The work of the PHD is also supplemented by vendor contracts for the delivery of primary care, education, and outreach services.

To assess the cost effectiveness of the public health offices system, this Legislative Finance Committee evaluation focuses on the business practices, specifically on the PHD's revenue generation and resource allocation, issues relating to contract and lease management, and the usefulness of the PHD performance monitoring process in measuring the program and intervention value to clients serviced and the state.

KEY FINDINGS

In FY11, PHD received over $77 million in federal funding.

New Mexico ranks 2nd in the nation for births to girls ages 15 to 17 years of age.

Prescription drug overdose deaths are on a steady incline in New Mexico.

FY11 Cost per Unit of Service

Region I & III	$14.18
Region II	$11.81
Region IV	$13.18
Region V	$22.17

Source: PHD

Lack of outcome-focused efforts and funding reductions may compromise the PHD's ability to implement solutions to health issues facing New Mexico. Faced with funding uncertainties from all funding sources, the DOH and the PHD must critically assess priorities to ensure the greater needs of the general public and specifically vulnerable populations are being met. Overall funding decreased by 5 percent from FY11 to FY12. In previous years, decreases in state general fund could be accommodated by stable or increased funding from other sources, which is no longer an option. The PHD is extended beyond what might be possible.

Numerous and sometimes competing health challenges and federal and state requirements complicate the efficient and effective public health service delivery function. New Mexico has several health issues and ranks poorly compared to other states. These issues deserve strong attention and intervention: teen births, drug-induced deaths, and deaths from chronic diseases. The PHD must increase reliance on other health providers and community partners to participate in the health of their communities so the PHD can focus their attention on filling system gaps and providing policy leadership.

Performance monitoring for public health does not adequately investigate program outcomes. The emphasis in the PHD's performance monitoring is on process, and not outcomes. This approach is prevalent throughout all performance monitoring by the PHD. This is evidenced by the twelve performance measures in the FY13 DOH Strategic Plan, all of which measure number of incidents rather than changes in health status of populations served.

The PHD needs to improve resource allocation and budget management given the state's diverse health challenges and resource constraints. The PHD is funded by state general fund, other state funds, Medicaid, and federal grants. In the past four years, state general fund appropriations have decreased 20 percent. Federal funding is targeted to specific programs, with no or limited opportunity for discretionary use. The PHD must be judicious in the pursuit of federal dollars. If federal program funding decreases, the PHD faces the dilemma of reallocating funds from other existing programs, reducing the scale of the federally-funded program, or eliminating programs.

To effectively manage budgets, the PHD must have financial and personnel data which is accurate and current. Regional offices receive funding to support the regional office and the assigned local sites. Staff

for the other bureaus are assigned to regions, but the cost allocation remains with the bureau. The PHD could not provide budget information for local public health offices and costing out bureau support to the regional offices, although possible, is not easily supported through the current reporting system. The cost allocation process limits the PHD's ability to accurately state cost per unit of service, a key factor in budget management.

As of March 1, 2012, there were 15 clinical social worker vacancies.

Staffing cuts over the past three years have made it difficult for the PHD to sustain programs in public health offices. The status of the state's budget did require curbing personnel costs in the PHD. This was done by eliminating positions, placing a hiring freeze on positions, and mandating a 12 percent general fund vacancy rate. However, the ability to maintain services is contingent upon clinical personnel to perform individual client services. During the past three years, clinical social worker and nursing positions were not protected from the cost-saving measures. These decreases did not allow sites to maintain workload and created delays in service. Recovery from these actions is prolonged by applicant perception of system instability and a complex recruitment system.

The local public health offices are not persistent or consistent in determining a client's Medicaid eligibility, or collecting third-party payments. Increasing Medicaid reimbursement is an option which the PHD has not actively pursued. All public health offices are eligible to bill for Medicaid services. Since the PHD does not bill Medicaid by site, but as a division, they cannot identify where interventions would eliminate existing billing issues.

Sliding fee scales allow for variable costs for services based upon an individual's ability to pay.

Although sliding fee scales exist for public health office billings, nearly all clients are placed at a zero-pay level. Verifying income to determine a client's financial means to participate in payment for services is done either through a self-completed affidavit or a verbal verification from the client. Most clients are placed at a zero pay level. Other clients, in the harm reduction and hepatitis prevention programs, have no financial screening per PHD procedure.

Other than Children's Medical Services, the PHD does not bill commercial insurance plans for services rendered to plan members. For convenience or confidentiality, insured clients receive services at public health offices. The PHD does not have commercial plan contracts, but also does not pursue single case agreements to receive reimbursement from commercial plan insurers.

The PHD maintained 288 contracts and memoranda of agreement in FY12 for a total of $41.8 million.

Top 3 Contract Categories:

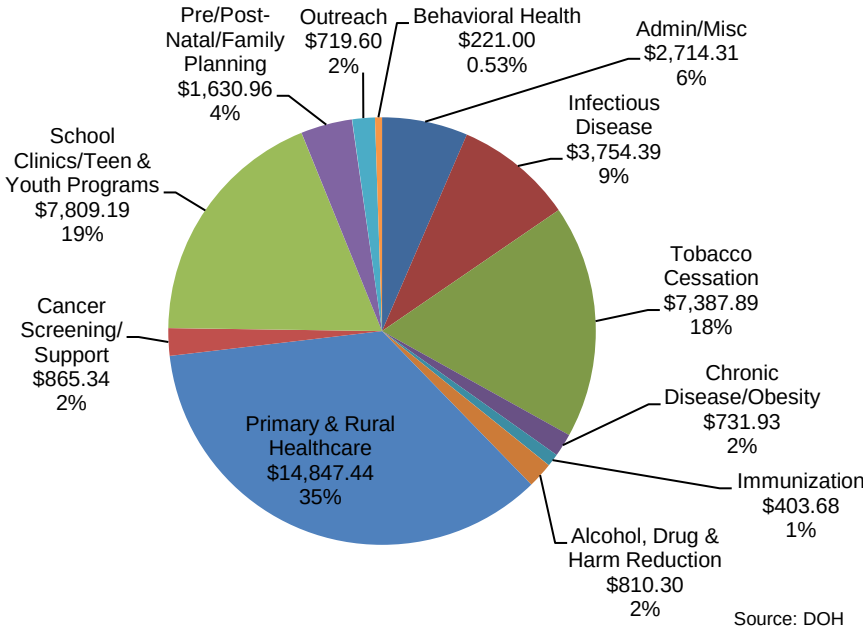
1. *Primary Care*
2. *School Clinics/Teen & Youth Programs*
3. *Tobacco Cessation*

PHD contracts emphasize task reporting and invoicing as key deliverables.

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. The Governor's Office released guidelines to all agencies regarding contract management with the intent to save taxpayer money while improving service. The PHD evaluated contractual agreements following these parameters and was able to reduce the total number of contracts by 154 between FY11 and FY12.

Graph 1. FY12 Contract Dollars by Function

(In thousands)



Source: DOH

PHD contracts focus on compliance reporting and not on outcomes and measuring achievement towards health goals. PHD contracts follow the DFA template, which while providing consistent contract language, emphasizes task reporting and invoicing as key deliverables.

Contracts do not incentivize vendors to identify potential cost savings. Outside of contracts that pay for services by the hour, all other contracts will pay the full contract amount. Even in cases where the contact stipulates a certain number of services to be rendered, the contractor bills to ensure the full contract amount is paid by the end of the term.

PHD oversight of contract deliverables focuses on validating task reporting and not analyzing impact to overall program and department initiatives. Program contract managers complete quarterly two-page reports reviewing contract performance. This process is performed using a standardized form that is focused on whether deliverables were completed. In many contracts, a measure of performance is receipt of monthly billing invoices.

UNM is the largest individual contractor for PHD with a total of 18 agreements in place for $2.3 million

PHD-contracted services may duplicate services subsidized by other programs such as Medicaid and county indigent care programs. UNM is the largest individual contractor for PHD with a total of 18 agreements in place for $2.3 million, and it is contracted to provide a variety of services including programs for uninsured clients meeting certain eligibility requirements, such as breast and cervical cancer screening, and pre-natal care. However, Bernalillo County also funds indigent primary care which includes wellness exams and routine screening through the UNM Care program. Moreover, stipulations of UNMH's lease agreement with Bernalillo County require the hospital to serve indigent patients as part of its obligation for receiving mill levy funds from the county.

Contract management does not include a process to identify high performing contracts or protect contracts from funding cuts. Due to the lack of measureable performance data in contracts, the PHD is unable to identify contracts that are having meaningful impact on department initiatives. Having this information could assist the PHD in making strategic decisions and address spending cuts with minimal negative impact to programs.

There is a network of 96 medical and dental primary care clinics in 31 counties across New Mexico.

Primary care is the largest contractual function of PHD, without a strategic plan to address service needs. State general fund dollars support the Rural Primary Healthcare Act (RPHCA), which provides funding to 27 entities including individual clinics, clinic systems, and government entities for the provision of primary care in underserved areas of the state. There is a network of 96 medical and dental primary care clinics in 31 counties across New Mexico. The PHD's Primary and Rural Health program (PRH) manages the award and fund distribution process. PRH does not have a formalized process for deciding where additional clinics are needed.

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. Clinics are required to provide level of service reporting showing staffing levels, number of clinical visits, and number of patients served. However, contracts do not include any performance measures related to a clinic's efforts towards reducing acute or chronic conditions. Federally-qualified health centers (FQHC) routinely report on health statistics as part of their requirements for federal funding. Eighty-four of the 96 primary care clinics operating in New Mexico are FQHCs, and have this same data readily available.

Primary care contracts do not include any performance measures related to a clinic's efforts towards reducing acute or chronic conditions.

Elimination of federal funding for health councils has impacted council ability to participate in system health issues.

The state pays the associated costs for 47 facilities.

The per square foot rent costs for the state ranges from five dollars in Roswell to $15.49 in Moriarty.

Improved partnerships locally are needed to cut costs and improve service delivery at public health offices. The DOH is seeking partnerships with community groups to expand the capacity for services and education to New Mexicans. Improving community partnerships is evidenced by movement of prenatal services to the community provider system, a team approach with the New Mexico State University Cooperative Extension Offices to provide nutritional education to diabetics and the general public, a new integrated information system for the exchange of child immunization data between primary care clinics and DOH, and collaboration with local health councils and community organizations in federal grant applications.

Continued efforts are still needed to increase communities' response to local health issues. To attain a role as the entity that fills gaps in service and functions as the health policymaker, the PHD must pursue more partnerships which build community involvement in solving local health issues.

Local governments are not providing their share of resources to support public health offices. New Mexico's organization of the public health system is described as a centralized model, with the DOH responsible for the administration of the system. State statute mandates counties to be financially responsible for leases and associated costs for the regional and local county health office. The statute goes on to obligate the counties' financial participation for personnel expenses. The existing partnerships between counties and the PHD vary from region to region, with little relationship to the statute.

In some cases, the state is paying lease rates or associated costs that exceed market values. The existing lease and associated cost information was shared with the Property Control Division of the General Services Department. The Division identified 10 situations where lease or associated costs were high or extremely high compared to those properties managed by the Division.

The PHD electronic information systems are not integrated or do not allow easy retrieval of information relevant to the care of clients. Each office operates with a minimum of three separate information systems. A single client at one site could be receiving services from three service programs and care information would be entered into all three systems. The systems do not integrate the data and do not allow easy retrieval of information. With the existing configuration of systems, clinicians and administrators cannot discern patterns in data and have access to useful information to manage individual patients and populations of patients.

No centralized state system exists to monitor the practice of publicly-funded health care providers. Previous program evaluations identified the state's lack of an integrated information system which would aggregate all clinical and financial data relating to clients served in publicly-funded insurance programs. Such a system would allow the state to better monitor the quality of services delivered, prevent duplication of services, scrutinize billing practices, and develop a database to better determine appropriate funding to primary care, public health offices, and managed care organizations.

Key Recommendations

The Legislature should modify the Public Health Act to accurately reflect state and county financial responsibilities for facility and personnel costs associated with public health facilities or the PHD should clarify state and county governments' financial responsibilities for public health offices through changes in regulations.

The PHD should:
Develop AGA performance measures for clinical services which relate to the state's health status and PHD service activity performance;

Refine the budget reporting systems so useful information is generated with which to manage regional and local offices budgets and conduct routine audits of regional and local offices to evaluate business practices;

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

Require measureable health data as a contract performance measure to assess how contract services advance DOH strategic priorities;

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; and

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 completion of the agreement.

BACKGROUND INFORMATION

Purpose.

The purpose of the Public Health Division (PHD) of the Department of Health is to provide a coordinated system of community-based public health services focused on disease prevention and health promotion to improve health status, reduce disparities, and ensure timely access to quality, culturally competent health care. The general public is likely not aware of the vast scope of responsibilities and functions of the public health office system or the personnel expertise required to fulfill the mission.

Organizational Structure.

Determination of a state's public health system structure is made by the state and has minimal mandates from the federal government. Three organizational models for local public health systems exist in the United States. Nearly 30 percent of states have a centralized or largely centralized governance structure where local health offices are primarily led by employees of the state and the state retains authority over most decisions relating to budget, public health orders, and the selection of local health officers. Another 50 percent of the states have a decentralized or largely decentralized model with local health units primarily led by employees of local governments with those governmental entities retaining authority over certain decisions. Five states, including New Mexico, have a shared or largely shared governance system where governance might be led by a local or state entity. However, in New Mexico, the DOH is the governing body for public health. The PHD, in the *2011 State Profile Report to the Association of State and Territorial Health Offices*, describes the New Mexico model as an umbrella organization with centralized relationships with local health departments.

Colorado and Arizona expressed concern with their decentralized models. With governance at the local level, significant differences in funding, services, and program fidelity create concerning disparities in health outcomes across the states.

In New Mexico, the health districts, appointment of health officers and powers and duties of health officers are established by the Public Health Act, 24-1-4 NMSA 1978.

The New Mexico public health system is organized into five regions. (**Appendix B**). Fifty-four local public health offices are assigned and administratively responsible to one of the regional offices. Two of the offices are located in correctional facilities.

The public health office system is one of seven components in the Public Health Division. (**Appendix C**). Many programs administratively responsible to other bureaus provide services in or to the local public health offices. The local offices and these programs work in concert to perform the essential public health functions identified by the federal and state health departments. (**Appendix D**).

Public Health Office Functions.

Public health offices congregate an array of state and federally-funded services:

- Vital records (birth and death certificates);
- Disease prevention and communicable disease case finding, counseling and education, treatment, follow-up, and contact tracing to include: sexually transmitted diseases, human immunodeficiency virus (HIV)/AIDS, childhood diseases such as whooping cough and measles, tuberculosis, hepatitis C and harm reduction interventions;
- Women, Infant, and Child (WIC) programs (Supplemental Nutritional Program for women, infants and children);
- Prenatal care;
- Chronic disease detection and prevention services;
- Family planning;
- Children's Medical Services;
- Families First perinatal case management;
- Child and adult immunizations;
- Pharmacy services; and
- Breast and cervical cancer screening.

Although not every service is offered in every local public health office, most all are available somewhere in the region based on availability of trained staff.

In addition to services provided for public health offices by other divisional program staff, vendor contracts are in place to assist the PHD in accomplishing its functions.

Strategic Plans and Goals.

The FY13 departmental strategic plan identifies the following as the most pressing health issues in New Mexico:

- Adequacy of the healthcare workforce;
- Obesity in children;
- Teen pregnancy rate;
- Oral health;
- Mental health and substance abuse in teens and young adults;
- Increased deaths due to diabetes;
- Incidence of drug overdose deaths (intentional and unintentional); and
- Injuries sustained as the result of falls by the elderly.

Objectives specific to the Public Health Division stated in the plan include:

- Prepare public health regions for national accreditation;
- Apply a common approach for process and programmatic improvement required for accreditation;
- Increase immunizations for all New Mexicans;

- Reduce teen pregnancy;
- Increase the proportion of new mothers who had recommended levels of health care before, during, and after pregnancy to assure optimal physical, mental, and oral health; and
- Decrease the transmission of infectious diseases and expand services for those with infectious diseases.

Funding.

The public health division is funded through state and federal funds. Federal funds are targeted to specific programs or initiatives.

Contracts between the Human Services Department and the Medicaid managed care organizations allow public health offices to bill and receive reimbursement for eligible services.

Expense Budget.

Budget allocations are made to regional offices, which in turn provide resources to local public health offices. Cost allocation for staff from other PHD bureaus remains with that bureau and is not considered as expenses for the regional offices. Local public health office expenses could not be provided by the PHD.

Personnel salaries and benefits account for over 80 percent of costs.

For the past four years, each of the regional offices has contained costs within the budgeted amounts.

Infrastructure.

Public health offices are housed in public and privately-owned buildings. County governments are statutorily obligated to financially support regional and local public health offices. Recently built clinics favorably compare with private facilities, while others are in need of significant upgrades or replacement.

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

Numerous and sometimes competing health challenges and federal and state requirements complicate the efficient and effective public health service delivery function. Federal core functions and essential services for public health, local health needs, the DOH strategic plan, PHD performance measures, and accreditation goals are driving forces for the delivery of healthcare services in public health offices. With direction coming from so many sources, the task of reconciling the PHD's capacity to fulfill its mission with identified needs and available resources is muddled. Further, significant health, education, and socio-economic challenges, along with a vast geographic service area and funding constraints compel the Public Health Division to better define its purpose and prioritize objectives to improve the quality of life and health of New Mexicans.

Table 1. NM Health Determinant Rankings Compared to Other States 2010

Teen Births	49
Lack of Health Insurance	48
Early Prenatal Care	48
Poor Mental Health Days	46
Violent Crimes	45
High School Graduation	45
Immunization Rates	44
Occupational Fatalities	42
Pre-Term Births	39
Dental Visits	36
Low Birth Weight	33
Smoking	30
Primary Care Physicians	27
Infectious Disease	23
Stroke	23
Infant Mortality	12
High Blood Pressure	10
Binge Drinking	9

Source: United Health Foundation 2011

The state ranks poorly in many aspects of health status compared with the rest of the United States. Although some health issues are prevalent across the state, each region has specific issues to be addressed. Data compiled by the DOH Division of Epidemiology demonstrates even how the academic success of students affects the health of younger New Mexicans. Students who receive mostly C's, D's, or F's grades were much more likely to not exercise or practice healthy eating habits, be sexually active, get into physical fights, and use marijuana, tobacco or alcohol. New Mexico ranks second in the country for births to girls age 15 to 17 years. Suicide ideations and deaths are high among both boys and girls. New Mexico continues to be among the top states for drug-induced deaths, with prescription drug overdose deaths on a considerable rise. Cirrhosis and diabetes death occur more frequently in New Mexico than other states.

Funding constraints, from all funding sources, will require that interventions to resolve health issues be targeted by the community, produce improvements in outcomes through use of evidence-based practices, and are cost effective.

The PHD should continue to provide the basic public health services and not be expected to be the direct provider of all services and programs to resolve health issues. Its focus should be to fill gaps and provide policy leadership.

Overall funding decreased by 5 percent from FY11 to FY12. In previous years, decreases in state general fund could be accommodated by stable or increased funding from other sources.

Neither the regional administrative span of control nor the allocation of resources appears to relate to geographic size or population. Populations range from 662,564 in Region 3 to 251,000 in Region 4. Square miles range from 1169 square miles in Region 3 to 46,711 square miles in Region 5. It also does not appear as if the Epidemiology Division's compilation of regional data relating to health risks and disease prevalence is used to determine resource allocation.

The DOH is beginning the process to gain national public health accreditation. Per the Centers for Disease Control and Prevention, the accreditation process complements the National Public Health Improvement Initiative funded through the Affordable Care Act for national health reform. The voluntary accreditation process will provide a means for health departments to identify performance improvement opportunities, improve management, develop leadership, and advance relationships with communities. The process will require participation of other divisions in the DOH.

Accreditation is geared to measure the department's ability to perform the three core functions of public health (assessment, policy development, and assurance) and the 10 essential public health services (**Appendix D**). The intent of the process is to challenge health departments to "think about the business it does and how it does that business" and create greater accountability and transparency to policymakers and clients of the system. Accreditation will be viewed favorably in the allocation of federal dollars to states.

Development of policies and plans that support individual and community health efforts is an essential service of public health. However, care must be exercised in the accreditation standard referencing standardization across the system to not minimize the health concerns of local communities. As identified by the DOH Division of Epidemiology, health issues not only vary by region, but even down to the community level. Eight states and several local health departments participated in testing the accreditation process. Lessons can be learned from the results from Oklahoma during the testing phase. The state health commissioner credits the program with indentifying opportunities for the engagement of communities and collaborative planning processes, which has yielded dramatic increases in the number of community partners involved in local health planning meetings.

Statutes exist that dictate specific public health services. Although most statutory mandates do address the health of the public, certain mandates create unpredictable workloads, impacting the ability of the office to adjust staffing and other resources to meet other needs.

Table 2. Public Health Functions Mandated by State Statute

Vital records
Communicable disease identification, treatment, tracking
Sexually transmitted disease evaluation, treatment and tracking
HIV/AIDS screening, treatment and referral
Child immunizations
Adult immunizations
Harm reduction, to include needle exchange
WIC Food Assistance, nutritional education, and referrals
Family Planning
Breast and cervical cancer screening

Source: PHD

Three examples of mandated services that add uncertainty to workload predictions are: distribution of vital records, monitoring of communicable diseases, and management of tuberculosis medication regimes. Within each region, the public can obtain vital records (birth and death certificates) from a public health office. In addition to the positions paid for this service by the Epidemiology Division of the DOH, the PHD funds an additional $280 thousand in salaries and benefits per year to meet the demand. The division raised $1.8 million in FY11 through fees of $10 for each birth certificate, $10 for each amended birth certificate and $5 for each death certificate; however none of the revenue goes to the division. Three-fifths of all birth certificate revenue, one-half of amended birth certificate revenue, and one-fifth of the death certificate revenue is distributed to the Children, Youth, and Families Child Care Fund. The remainder is deposited in the state general fund. The hours dedicated to this function decreases the ability of the PHD staff to meet the health service needs of clients.

Identifying, tracking, and treating communicable diseases are *foundation* services for the establishment of state public health systems. A search of the literature and contact with the Centers for Disease Control and Prevention could not produce an algorithm for calculating time involved in monitoring and treating an infectious disease case for use in projecting budget needs. Both the time and volume of effort dedicated to a single case is not predictable, limiting the public health office in projecting the impact on the budget. (**Appendix E**).

Tuberculosis is also a DOH reportable disease. Once an individual has been identified as having active TB, the state starts treating the patient and tracking down contacts. Protocol requires direct observation therapy which requires the public health office nurse to administer medication on a daily basis, frequently in the patient's home or workplace. The nurse must have visual observation the medications were ingested.

Patients who are not compliant with the medication regime must be isolated to prevent infection spread. At this time, with no facilities meeting the need in New Mexico, patients are housed at the Texas Center for Infectious Disease for up to nine months at a cost of approximately $250 thousand. Because the Division does not presently have contracts with commercial insurers, insured patients presenting with active TB receive services free of charge. One patient has been

placed in the facility in 2011 and one in 2012. The cost of a single admission creates a budget concern for the PHD.

Performance monitoring for public health does not adequately investigate program outcomes. Performance in the public health system simply cannot be measured the same way as that in the private health sector. Public health is tasked with protecting, promoting, and improving the health of an entire population and public health agencies must develop a myriad of health services for diverse people with varying health concerns. The Turning Point National Program Office of University of Washington suggests the three core functions of public health as the starting place for development of performance measures: assessment, policy development, and assurance.

Table 3. Performance Measure Based on Public Health Essential Function

Essential Service	Performance Measure
Diagnose and investigate health problems and health hazards in the community	Capacity measure: trained staff and evidence-based protocols guide the immediate investigation of communicable disease outbreaks Process measure: timely investigations of communicable disease outbreaks are conducted on an on-going basis. Outcome measure: No preventable deaths occur in the communicable disease outbreak.

Source: Turning Points National Program

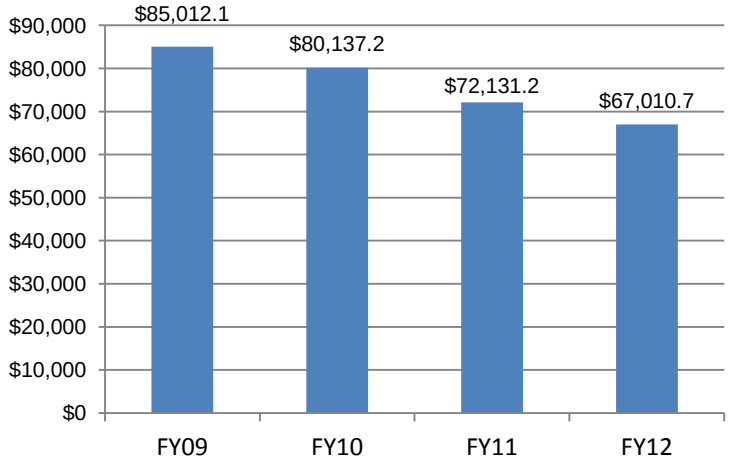
Eleven of the 12 performance measures listed in the FY13 DOH Strategic Plan for public health (**Appendix H**) are dedicated to process and not outcome; monitoring numbers of agency activities or interventions rather than the health outcomes of actions. As an example, the plan monitors the percentage of preschoolers fully immunized, but does not monitor the increases or decreases of contagious diseases as a result of the immunization rates. Unfortunately, the PHD performance monitoring does not provide complete information to policymakers regarding the value or quality of the services to the state.

In spite of the broad mission and number of strategic objectives, the PHD only reports on three performance measures in the GAA: number of teen receiving family planning services, number of human immunodeficiency virus prevention interventions, and percentage of children fully immunized.

A wealth of information, generated by the DOH Division of Epidemiology, regarding generic health status and disease specific information about residents by counties is available to the PHD. From this data, interventions could be employed and health status changes could be better measured so policymakers could make evidence-based decisions regarding the value and funding of programs to policymakers.

Given the state's diverse health challenges and resource constraints, the Public Health Division needs to improve resource allocation and budget management. The PHD receives funding from multiple sources: state general fund, other state funds, interagency transfers for Medicaid reimbursement, and federal grants. State general fund appropriations over the past four years have decreased more than 20 percent. In addition to regional and local public health offices, the PHD budget supports four bureaus, the pharmacy program, and the PHD administration. In addition to delivering program services in the regions, bureau staff serve as contract administrators for contractual services and grants programs.

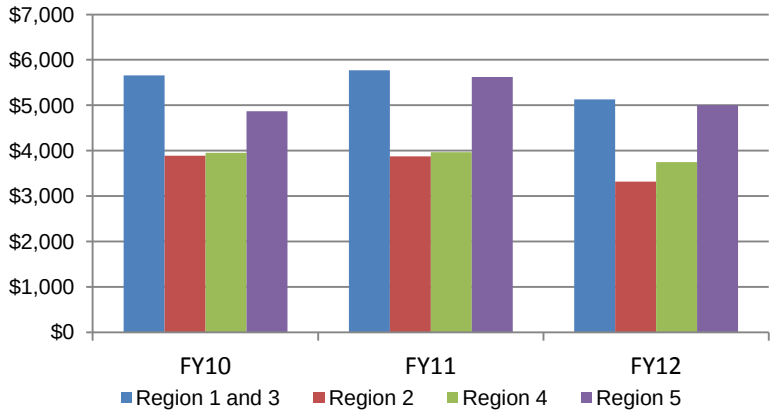
Graph 2. State General Fund Appropriations FY09-FY12
(in thousands)



Source: GAA

Budget dollars are allocated to regional offices, not directly to local public health offices. Resources are assigned or deployed from the regional offices to the local offices. Bureau staff provide program specific services, such as Children's Medical Services (CMS), Women, Infants, and Children (WIC) nutritional services, and chronic disease management in regional and local offices. It is also not possible to identify the number of encounters for special programs which occurred in local public health offices. For example, WIC encounters for their independent and co-located with public health offices are reported as a sum.

Graph 3. FY10-FY12 Regional Office Budgets
(In thousands)



Source: PHD

Division-generated financial data is not useful for regional and local office budget management. The cost allocation for bureau employees assigned to regions remains with the bureau. This is reasonable considering the reporting needed for special program contract and grants. However, when cost per unit of service is computed, only regional office costs are calculated for special program encounters, not the share on the local office level. This calculation misrepresents the costs per units, establishing lower than actual costs. An example of the value of accurate cost per unit of service data can be seen in review of Region 5 data.

Table 4. Cost per Unit of Service by Region
FY09-FY12

	FY09	FY10	FY11
Region 1 and 3	$15.14	$14.82	$14.18
Region 2	$19.18	$13.36	$11.81
Region 4	$13.18	$12.27	$13.18
Region 5	$16.79	$15.77	$22.17

Source: PHD

The much higher cost per unit of service in Region 5 raises questions: Is the data accurate? Are more expensive services being provided? Is staffing appropriate? What would be the cost if bureau personnel were included?

The PHD was unable to provide budget information for local offices. Local budget information is important for the PHD administration's evaluation of appropriate resource allocation.

The PHD must be judicious in the pursuit of federal dollars. Although federal dollars provide the opportunity to address state health issues, when those dollars are decreased or eliminated, the burden to maintain the program is placed on the state's budget. Sustainability must be a future focus when programs are created with federal funding.

As an example, with the decreases in Title X funding for the Family Planning Program, additional state general funds have been needed to supplement family planning services. Nearly $3 million in state general fund and other state funds are budgeted for this $7 million program.
In addition to future funding considerations, applications for federal funding should reflect local health needs. Otherwise, the strategic objectives of public health would be driven by federal initiatives and funding rather than local need.

Staffing cuts over the past three years have made it difficult for the PHD to sustain programs in public health offices. To comply with budget restrictions, thirty-four positions were eliminated. The DOH also instituted a mandatory 12 percent general fund vacancy rate, which was subsequently changed to a 10 percent general fund vacancy rate, for the entire department. With more vacancies and higher turnover, the freeze on positions may have caused a disproportionate impact on the regional and local public health offices. Clinical positions, including clerical support and disease prevention specialists, were excluded from the freeze initially however; clinical social workers were excluded from hiring. In November 2010, a mandatory freeze was implemented for all positions, including those that were 100 percent federally funded. Positions, including federal positions, were opened for hire in approximately March 2011 with the requirement to hold the 10 percent general fund vacancy rate. Although positions have recently been opened for recruitment, it is difficult to rebuild the system when there is a perception of instability, concern of salary disparities between the PHD and local competitors for workforce applicants, and a recruitment process which delays hiring. As of February 16 2012, per the State Personnel Office, the PHD has 957 approved full-time equivalent positions, of which 168.5 were vacant.

The local public health offices are not persistent or consistent in determining a client's Medicaid eligibility, or collecting third-party payments. The PHD has provider agreements with all four Medicaid managed care companies (MCOs). The contracts extend to all local public health offices, allowing reimbursement to the PHD for services provided to clients of the MCOs. Public health is reimbursed per the Medicaid fee schedule or MCO negotiated rates.
Presumptive Medicaid eligibility is only performed in a few of the public health offices. The PHD identified time and money as the constraints on its ability to perform eligibility screenings. In the past, PHD employed eligibility workers, but the positions were eliminated because the Human Services Department (HSD) could not reimburse the division for the service. The Medicaid program cannot reimburse the Public Health Division for presumptive Medicaid eligibility processing. According to federal Medicaid regulations, a public provider, such as another state agency, cannot be treated different than other public, non-state providers. The Medicaid program does not use federal matching funds for non-DOH eligibility determination providers so therefore, cannot reimburse public health offices for this function.

However, the HSD contracts with the New Mexico Primary Care Association (NMPCA) and that contract obligates the NMPAC to subcontract with agencies employing eligibility workers to increase Medicaid eligibility outreach screenings. For the past few months, workers have been placed on a part-time basis in four public health offices in central New Mexico. The workers average six successful eligibility screenings per half-day session.

Although federally-qualified health centers are the primary recipients of services from the NMPCA's program, the agreement also orders the contractor to identify and add other community organizations to the program.

Adherence to procedures for verification of Medicaid eligibility is inconsistent across the system. Clerical staff is expected to confirm eligibility through a search of the Medicaid database or client presentation of a Medicaid card. If the client is not enrolled in Medicaid, they are to be referred to an Income Support office for eligibility screening. The procedure is not consistently followed across the system. However, services will continue in spite of the client's failure to follow through.

Billings to the Medicaid program do not identify sites, but are billed only as "PHD". In FY11, the Medicaid program reimbursed the DOH more than $26 million for administrative and client services. Of that amount, only $54 thousand is attributed to the PHD. Special programs, such as Children's Medical Services, Families First, and Family Planning are identified in the billings so specific site locators can be used. Without knowing a billing site, PHD loses the ability to target opportunities to improve billing practices.

Although sliding fee scales and procedures exist, public health offices place nearly all clients at a zero-pay level. The ability of a client to participate in payment for services can be determined by a self-declaration affidavit from the client. No further documentation is required. However, some public health offices accept verbal verification of financial status from the client. The benefit of appropriately classifying financial status is demonstrated in the federal Family Planning Program regulations. The program requires public health to have a sliding fee scale and to collect fees, if appropriate. Fees collected for this program are to be used to "meet the increasing costs of providing family planning services and to expand services to adequately meet needs." Increasing the scrutiny applied to income verification could prove financially beneficial to that program.

Not all clients receiving services through the PHD are subject to a financial screening. Neither harm reduction nor hepatitis prevention clients are reviewed, even though they might be eligible for participating in a sliding fee payment program.

Other than Children's Medical Services, the PHD does not bill commercial insurance plans for services rendered to plan members. For convenience or confidentiality, insured clients receive services in the public health system. The PHD cannot be expected to seek contracts with all commercial health plans, but services could be reimbursed through single-case agreements. The PHD indicated future plans include investigating how to access funding from commercial plans.

Recommendations

The PHD should:

Develop Accountability in Government Act performance measures that relate to the state's health status and PHD service activity performance;

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;

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

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

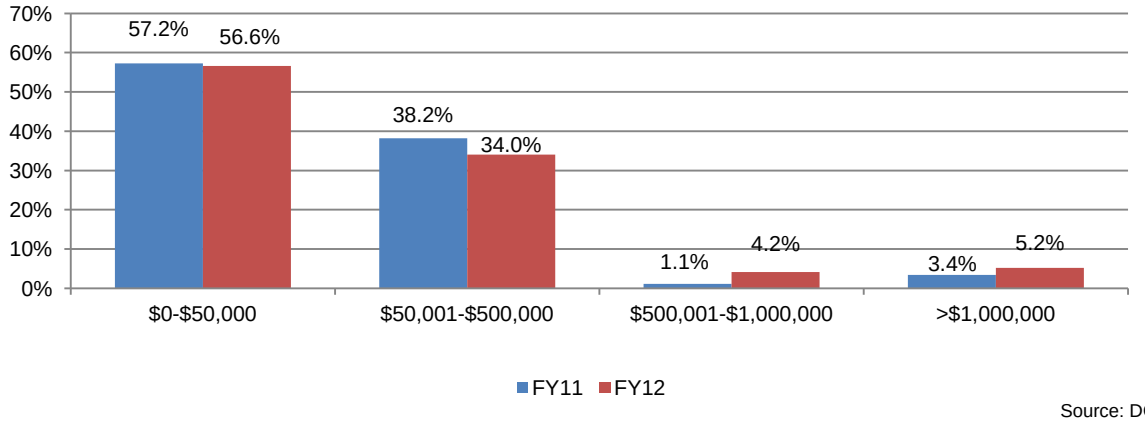
Work with the State Personnel Office to ensure that job descriptions and qualifications are current to the needs of the PHD and salaries are competitive with market competitors; and

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

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.

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. The Governor's office released guidelines to all agencies regarding contract management with the intent to save taxpayer money while improving service. The PHD evaluated contractual agreements following these parameters and was able to reduce the total number of contracts by 154 between FY11 and FY12.

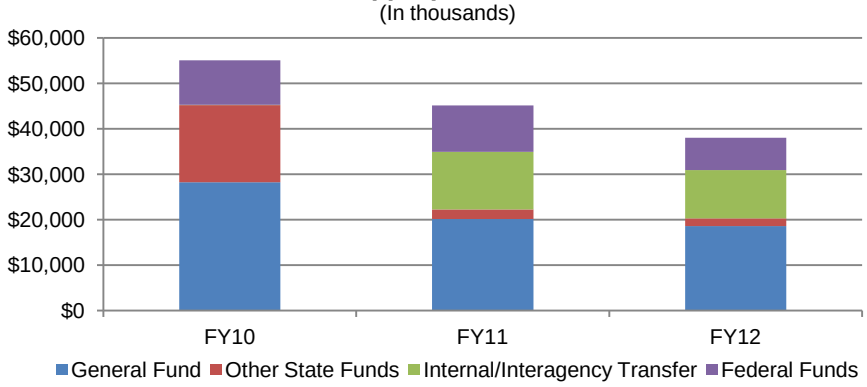
Graph 4. FY11-FY12 PHD Contracts
(Number of Contracts)



Source: DOH

PHD contract funding has decreased over the last three years, as ARRA funds run out and the state faced budget constraints. For FY12, contractual services accounted for 20 percent of the PHD's overall budget, therefore it is a target for cuts when budget dollars decrease. For example, when the PHD had to reduce spending by 40 percent, the division reduced contract spending, eliminating all health education contracts.

Graph 5. FY10-FY12 PHD Contractual Service Appropriations
(In thousands)



Source: GAA

The PHD's contracts span various health initiatives and range from $3 thousand to almost $6 million for FY12. PHD contracts cover various program initiatives including tobacco cessation, infectious disease education and intervention, cancer support services, and chronic disease management. Below is a sample list of contracts for FY12:

Table 5. Sample of FY12 PHD Contracts

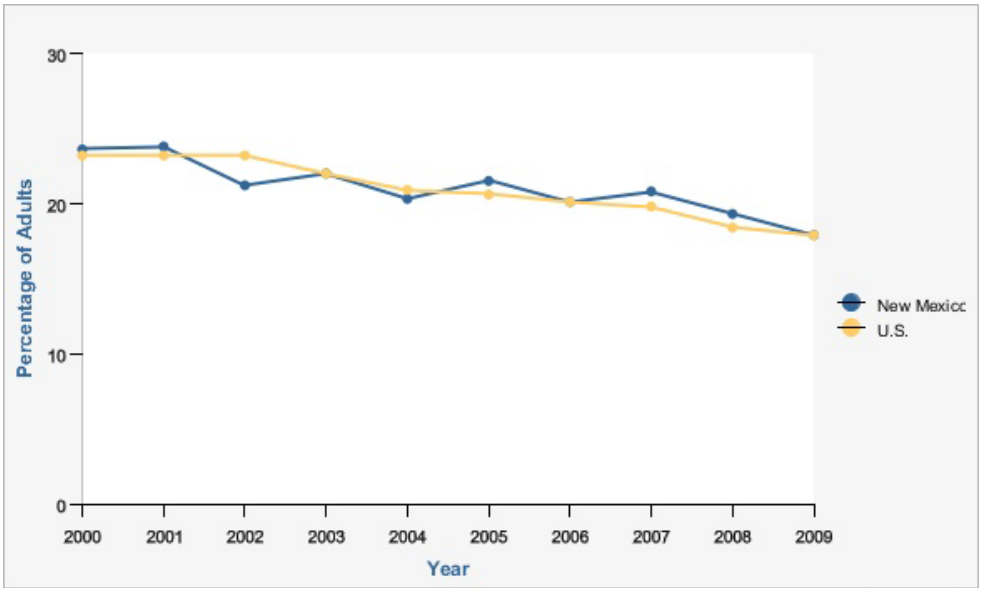
Vendor	Purpose	Amount
McKee Wallwork Cleveland, LLC	Tobacco Cessation	$5.7 million
La Clinica del Pueblo de Rio Arriba	Primary Care	$2.7 million
Oregon State Public Health Lab	Newborn Genetic Testing	$1.7 million
Santa Fe County	Child Wellness Oversight	$733 thousand
University of New Mexico	Cancer Screening	$129 thousand
NurseAdvice New Mexico	Telephone Advice Hotline	$364 thousand
New Mexico State University	Child Wellness and Nutrition	$302 thousand
National Dance Institute	Teen Activity and Nutrition	$185 thousand
Cooney Watson & Associates	Cancer Outreach and Education	$27 thousand
West Las Vegas School District	Teen Pregnancy Prevention	$50 thousand

Source: PHD

The PHD's contracts focus on compliance reporting and not on outcomes and measuring achievement towards health goals. The PHD contracts follow the DFA template, which provides consistent contract language, emphasizes task reporting and invoicing as key deliverables. All reviewed contracts included language stating that contractors are subject to site reviews, data report review, and scheduled consultations and observation of services being rendered. These actions focus on compliance that services are performed. However, the contracts have zero stipulations to measure impact of services on the target population.

The largest PHD contract is for $5.7 million for tobacco cessation and awareness activities related to the 1-800-QUIT-NOW program. The strategic goal of the contract is to promote tobacco cessation, prevent youth tobacco use, raise secondhand smoke awareness, and market to specific groups. The contractor creates monthly reports and meets monthly with the contract monitor. However, the contract has no performance requirements to demonstrate how this program is directly influencing tobacco cessation efforts. Performance is tied strictly to delivery of reports and invoices. As noted in the graph below, adult smoking rates have been erratic, and the PHD does not have sufficient data to conclude if the 1-800-QUIT-NOW marketing program is having any positive effect on reducing prevalence of tobacco use.

Graph 6. Adult Smoking Prevalence by Year, New Mexico vs. U.S. 2000-2008



Source: DOH

In the case of an HIV prevention contractor, the scope of the contract was to provide evidence-based HIV prevention interventions to high-risk populations. Reporting requirements focused on units of service, demographics, and staffing changes. The contractor was not required to gather baseline data on the target service population to measure effectiveness in preventing HIV, which makes it virtually impossible to determine the impact of services provided.

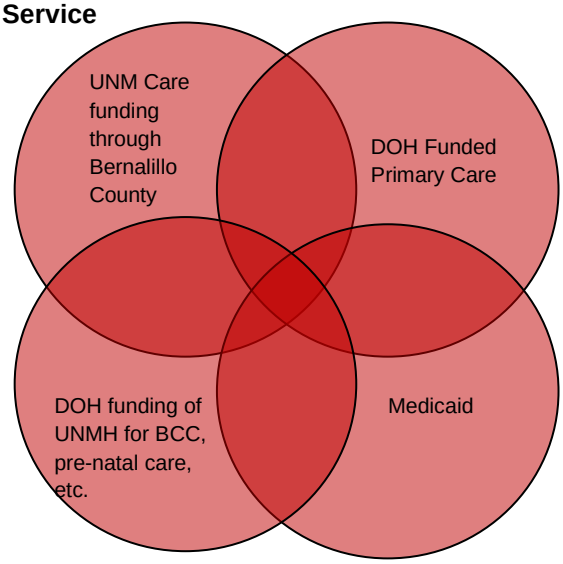
Contracts do not incentivize vendors to identify potential cost savings. Outside of contracts that pay for services by the hour, all other contracts will pay the full contract amount. Even in cases where the contract stipulates a certain level of service, the contractor bills to ensure the full contract amount is paid by the end of the term. This occurred in the case of University of New Mexico Hospital, contracted to provide high-risk pre-natal services to 300 women. When the hospital submits its monthly invoices, it is not required to include a summary of patients served during that month, and the total amount due is 1/12th of the total contract amount. So while the contractor must measure how many patients are served, UNM Hospital is not required to substantiate this in billings, making the performance measure worthless.

The PHD oversight of contract deliverables focuses on validating task reporting and not analyzing impact to overall program and department initiatives. Program contract managers complete quarterly two-page reports reviewing contract performance. This process is performed using a standardized form focused on whether deliverables were completed. In many contracts, a measure of performance is receipt of monthly billing invoices. In the case of UNM Hospital's Breast and Cervical Cancer Early Detection Program, the contract manager determined the monthly data submission requirement was met by all monthly invoices being submitted.

Similarly in the case of the Teen Outreach Program, providing stipends to students was confirmed by the contractor submitting stipend receipts to the contract manager. While deliverable monitoring is an important component of contract management, analyzing impact of contracted services on overall program initiatives would contribute additional value to understanding how contracts factor into achieving overall department goals.

The PHD's contracted services might duplicate services subsidized by other programs, such as Medicaid and county indigent care programs. UNM is the largest individual contractor for the PHD with a total of 18 agreements in place for $2.3 million. The university provides a variety of services, including breast and cervical cancer screening and prenatal care for uninsured clients meeting certain eligibility requirements. However, Bernalillo County also funds indigent primary care which includes wellness exams and routine screening through the UNM Care program. Moreover, stipulations of UNMH's lease agreement with Bernalillo County require the hospital to serve indigent patients as part of its obligation for receiving mill levy funds from the county. Additionally, Medicaid and the PHD's primary care contractors offer the same services UNMH is contracted to deliver. There is currently no appearance of coordination among the various publicly-funded programs among the HSD, DOH, counties, and other agencies to ensure the most effective and efficient care delivery occurs. In the case of UNMH alone, almost $1 million in potential savings could be gained from eliminating duplicate services and relocating these patients to other available programs to meet their needs.

Diagram 1. Potential Overlaps in Service

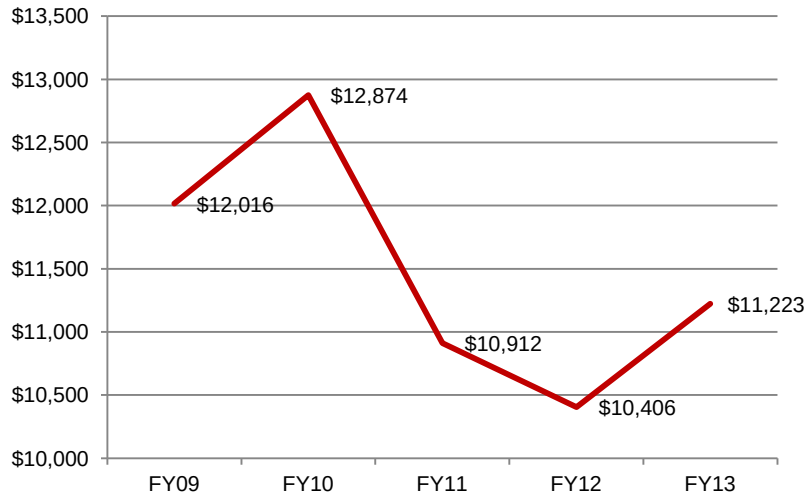


Contract management does not include a process to identify high performing contracts or protect contracts from funding cuts. Due to the lack of measureable performance data in contracts, the PHD is unable to identify contracts that are having meaningful impact on department initiatives. Having this information could assist the PHD in making strategic decisions and address spending cuts with minimal negative impact to programs. When the PHD had to reduce spending by 40 percent, all contracts for health education were eliminated

indiscriminately. Also, the LFC has observed that contracts have been paused before signature, and contract amounts have been reduced through amendments as a result of funding cuts, especially in the case of federal funds.

Primary care is the largest contractual function of the PHD, but the division does not have a strategic plan to address service needs. State general fund dollars support the Rural Primary Healthcare Act (RPHCA), which provides funding to 27 entities including individual clinics, clinic systems, and local governments for the provision of primary care in underserved areas of the state. A network of 96 medical and dental primary care clinics in 31 counties exist across New Mexico. Of these clinics, 38 are in northern counties, 18 in central counties, and 40 in southern counties. Eighty-four of these primary care clinics are designated as federally-qualified health centers (FQHCs) and receive federal dollars as their primary source of funding. The federal Health Resources and Services Administration (HRSA) manages awarding of FQHC status and distribution of federal grant dollars to approved clinics.

RPHCA General Fund Appropriations FY09-FY13
(In thousands)



Source: LFC

Primary care contracts span four years, and clinics must respond to an RFP to be considered for the next grant cycle. The PHD's Primary and Rural Health Program (PRH) manages the award and fund distribution process. PRH does not have a formalized process for deciding where additional clinics are needed, but the HRSA does have two requirements for the opening of a rural health clinic:

1) The clinic will be in an area designated by the U.S. Census Bureau as not having more than 50 thousand residents and;
2) The location has been designated by the state or the U.S. Department of Health and Human Services secretary as being medically underserved.

While these parameters applied to 88 percent of primary care clinics in New Mexico, there is not a strategic vision for the future of primary care in the state and how to deploy resources going forward.

Additionally, the HRSA publishes a ratings scale to determine whether counties are medically underserved on a scale of zero-100, where zero is severely underserved and 100 is sufficiently served. Scores are determined using a ratio of primary care physicians per thousand population, infant mortality rate, percentage of residents with income below poverty level, and percentage of population over 65 years of age. Scores for New Mexico counties range from zero to 61.8, with an overall average for the state of 46.5. Doña Ana County received a score of zero, indicating it is severely medically underserved. Doña Ana County has 14 medical or dental primary care clinics, all of which receive FQHC funding and state RPHCA dollars. On the other side of the scale, Valencia County received a score of 61.8, and maintains two clinics, both receiving federal and state funding. This disparity demonstrates that strategically targeting services to populations of most need should be a key consideration.

Table 6. Primary Care Snapshot by County

County	Number of Primary Care Clinics	County Population	% of Population Below Federal Poverty Level	HRSA Medically Underserved Rating (0-100)
De Baca	1	2,022	21.6%	0.00
Doña Ana	14	209,233	24.5%	0.00
Sierra	2	11,988	22.5%	18.10
Harding	1	695	19.1%	24.30
Colfax	3	13,750	17.2%	27.15
Sandoval	6	131,561	11.4%	34.10
McKinley	2	71,492	33.4%	37.80
Santa Fe	7	144,170	14.4%	38.87
Union	0	4,549	9.8%	42.10
Torrance	2	16,383	19.4%	46.00
Mora	2	4,881	11.9%	47.30
San Juan	1	130,044	20.8%	48.20
Otero	2	63,797	20.0%	49.45
Luna	3	25,095	32.8%	49.70
Socorro	1	17,866	26.8%	50.20
Cibola	1	27,213	24.0%	51.00
Hidalgo	2	4,894	22.6%	52.40
Catron	2	3,725	15.3%	53.00
Grant	3	29,514	14.8%	53.10
Eddy	3	53,829	13.6%	54.20
Quay	2	9,041	21.1%	55.00
Lincoln	2	20,497	12.9%	57.00
Lea	4	64,727	17.7%	57.40
Taos	3	32,937	17.0%	58.27
Guadalupe	2	4,687	28.2%	59.20
Roosevelt	1	19,046	22.8%	59.30
Bernalillo	7	662,564	15.6%	59.53
San Miguel	4	29,393	20.8%	59.90
Chaves	1	65,645	21.0%	60.90
Curry	1	48,376	20.1%	61.20
Rio Arriba	9	40,246	19.7%	61.60
Valencia	2	76,569	19.4%	61.80
Los Alamos	0	17,950	2.4%	N/A

Primary care clinics accounted for $11.9 million in contractual spending, or 28 percent of total contract dollars, without a single performance measure related to health outcomes. Contractually, primary care clinics have the duty to provide services to underserved areas and have the obligation to provide treatment regardless of a patient's ability to pay. Clinics are required to provide level of service reporting showing staffing levels, number of clinical visits, and number of patients served. HRSA data requirements for FQHCs are in **Appendix G**. However, contracts do not include any performance measures related to a clinic's efforts towards reducing acute or chronic conditions.

According to the DOH's 2009 *Selected Health Statistics Annual Report*, the top 10 causes of death in New Mexico included heart disease, stroke, diabetes, and influenza. FQHCs routinely report on health statistics as part of their requirements for federal funding, such as number of

patients with controlled diabetes measured through blood glucose levels and hypertension patients above or below an ideal blood pressure rate for their condition. This data is readily available for 84 of the 96 primary care clinics operating in New Mexico, and would be valuable resource for the PHD to assess health concerns and generate appropriate strategies to target health conditions. This will align with the DOH-identified essential public health function of monitoring health status to identify community health problems.

Recommendations.

The PHD should:

Strategically manage their contract budget to match public health priorities as described in the DOH Strategic Plan;

Reassess contract performance measures to also require measureable health data to better judge service effectiveness against DOH strategic goals;

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;

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; and

Mirror reporting requirements and performance measures to what the HRSA requires of federally-qualified health centers and use health data to measure effectiveness of this core public health function.

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

Local governments are not providing their share of resources to support public health offices. New Mexico's organization of the public health system is described as a centralized model, where the administration of the system is the responsibility of the Department of Health (DOH). The department states the secretary of DOH is the only person who can issue public health orders in the state, an authority not afforded to other state or local government officials.

Section 24-4-1 NMSA 1978 appears to require each county to be financially obligated for lease and associated costs for each county health office and the district office, although the DOH requires counties to provide facilities for only the regional offices. All counties have one or more public health offices, while regional (district) offices are located in Farmington, Santa Fe, Roswell, Albuquerque, and Las Cruces. San Juan County supports all costs for the Region I facility. Santa Fe and Bernalillo Counties pay associated fees, not rent, for Region 2 and 3 offices. The state pays rental costs for the Region 4 office, and over $170 thousand in associated costs for the Region 5 office.

Per statute, compensation for individuals hired, in addition to the district health officer, will be paid from the county general fund. No compensation expense for any of the 957 authorized state public health employees is paid by a county in New Mexico.

Which governmental entity assumes responsibility for lease or other associated costs is inconsistent. Public health offices occupy 329,848 square feet of space in offices throughout the state. The state's pays over $500 thousand per year for costs associated with the facilities including utilities, janitorial and maintenance services. More than $270 thousand per year in rental costs is for four public health facilities. Two of the leases are with individuals, one with a foundation, and the other with a county.

Table 7. Leases and Associated Costs for Public Health Facilities

Total costs assumed by county	14 counties for 16 local public health offices
Total costs assumed by city or village municipalities	2 municipalities for 3 local public health offices
Rental costs assumed by counties	19 counties for 26 facilities including regional offices in Bernalillo and Doña Ana
Rental cost assumed by municipalities	2 municipalities for local public health offices
Rental costs assumed by state	3 for local public health offices
Rental and associated costs assumed by state	2 for local public health offices

Source: PHD

The associated costs (utilities, janitorial services, maintenance) for 34 facilities are paid by the state. No written agreements are in place to specify actual services to be rendered, frequency of those services, or how disputes will be resolved. Counties assume responsibility for lease costs for the same number of facilities. No agreements exist that outlines the financial liability risks to which the state might be exposed, such as building damages or personal injuries.

If the intent of the statute places responsibility for each county to contribute to the costs of its regional office, no documents were produced that substantiates each county's participation in the costs for its regional office.

In some cases, the state is paying lease or associated costs that exceed market values. The existing lease and associated cost information was shared with the Property Control Division of the General Services Department. The division identified 10 situations where lease or associated costs were high or extremely high compared with those similar properties managed by the Division.

Rent costs to the state range from $5 dollars per square foot in Roswell to $15.49 per square foot in Moriarty. The associated expenses for 47 facilities are paid by the state.

It would be difficult to impose the long-standing legislation on local government entities. However, clarification of the statutes and regulations is needed to protect the state from unanticipated expense.

The DOH is seeking partnerships with community groups to expand the capacity for services and education to New Mexicans. To improve patient care and provide appropriate clinical placements for pregnant women, the DOH has partnered with local primary care and obstetrical programs deliver to prenatal services. Other than in the southern public health regions and with the University of New Mexico Hospital, the transfer of clients has been completed.

The DOH is developing a relationship between the state Department of Agriculture cooperative extension offices and the department. The extension offices offer dietetic training to diabetics and nutritional education to the public. The goal is to collaborate on the development and distribution of educational materials, share training space, and eliminate duplicate programs.

In December 2011, the DOH announced the success of a trial program to exchange immunization data among primary care clinics and the state's immunization data collection system. The system enhancement allows a direct transfer of immunization records from the electronic medical record in the clinic to the state system. This eliminates duplicate entry and is a significant timesaver for clinic staff. The system will now be expanded to other sites, including public health offices.

The loss of funding for local health councils has limited their ability to participate in local health planning. Federal Medicaid funding provided through a joint powers agreement is no longer available to fund health councils. Some councils receive financial support from local government entities and grant funding, allowing them to continue to function as in the past, but others rely on volunteer efforts. The PHD maintains staff to interact with the health councils, and provide as much support as possible.

Some progress is being made. In 2011, the DOH received a $1.5 million Community Transformation Grant from the Centers for Disease Control and Prevention. The priority issues to be addressed are tobacco-free living; active living and healthy eating; and evidenced-based preventative services, specifically focused on prevention and control of hypertension and high cholesterol. The DOH is collaborating with select community partners, including health councils, in this process.

Although a few public health offices enjoy a productive relationship with local behavioral health collaboratives, others were not aware of these groups or their established purpose. Local and regional offices expressed concern over the lack of behavioral health resources and the burden to public health offices in attempting to make referrals for these services.

Quantifying the value of health councils and local behavioral health collaborative would determine the amount of support which should be directed to these entities from state agencies. The groups do provide a portal into the community as federal funding increasingly requires community inclusion in their funding opportunities.

Patient records in the public health system are not integrated. Each public health office operates with a minimum of three electronic systems in which to document patient care services.

A comprehensive medical record does not exist for clients served within the public health system. Multiple programs provide services within public health offices: Children's Medical Services, WIC, Family Planning, and infectious and chronic disease management. Documentation of client services provided in each of the public health offices is entered into program-specific information systems. The basic public health system, known as BEHR for billing and electronic health record, is presently not capable of integration with the other program systems. As a safety net provider, public health offices deliver health screenings, direct health services, counseling and service referrals. In the instance of a newborn, the baby will require well-baby checks, immunizations, and might be receiving services and nutritional support from WIC or special care management from CMS. Each of these services will be documented in a different system, ignoring industry best practices and principles and obligations of federal health reform for integrated records, medical homes, and comprehensive care coordination.

The data entry process in the BEHR system does not allow for easy recovery of data. Much of the information entered into the record is a narrative form versus drop-down boxes which would allow the isolation and collection of specific data. Until system improvements occur, collection of data to monitor the quality and continuity of care delivery is onerous, if possible. The present system also hampers the PHD's ability to monitor workload and respond appropriately to staffing and operational needs.

No centralized state system exists to monitor the practice of public-funded health care providers. More of the PHD's contractual dollars are spent on primary care clinics than any other contracts. In most situations, the primary care clinics and public health offices share patient populations: financially unsponsored and Medicaid patients. Previous program evaluations identified the state's lack of an integrated information system that would aggregate all clinical and financial data relating to clients served in publically funded insurance programs. Such a system would allow the state to better monitor the quality of services delivered, prevent duplication of services, scrutinize billing practices, and develop a database to better determine appropriate funding to primary care, public health offices, and managed care organizations.

Recommendations

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

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

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

SUSANA MARTINEZ, GOVERNOR

CATHERINE D. TORRES, M.D., CABINET SECRETARY

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

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.

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

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

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.

A 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 kaizan, MAPP, King County Washington, Turning Point, Baldridge, 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

Title V - Maternal Child Health National Performance Measures	State 2010 Results	State 2015 Goal
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.	100.0%	100%
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. (CSHCN survey)	53.2%	55%
The percent of children with special health care needs age 0 to 18 who receive coordinated, ongoing, comprehensive care within a medical home. (CSHCN Survey)	41.6%	43%
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. (CSHCN Survey)	56.6%	59%
Percent of children with special health care needs age 0 to 18 whose families report the community-based service systems are organized so they can use them easily. (CSHCN Survey)	85.7%	90%
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.	33.7%	36%
Percent of 19 to 35 month olds who have received full schedule of age appropriate immunizations against Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, and Hepatitis B.	70.9%	75%
The rate of birth (per 1,000) for teenagers aged 15 through 17 years.	25.8	24
Percent of third grade children who have received protective sealants on at least one permanent molar tooth.	48%	50%
The rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children.	4.6	2
The percent of mothers who breastfeed their infants at 6 months of age.	49%	53%
Percentage of newborns who have been screened for hearing before hospital discharge.	*	97%
Percent of children without health insurance.	11.9%	10%
Percentage of children, ages 2 to 5 years, receiving WIC services with a Body Mass Index (BMI) at or above the 85th percentile.	25.4%	20%
Percentage of women who smoke in the last three months of pregnancy.	9.3%	6%
The rate (per 100,000) of suicide deaths among youths aged 15 through 19.	15.8	12
Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.	*	70%
Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.	64.0%	72%
Title V - Maternal Child Health National Outcome Measures	**State 2010 Results**	**State 2015 Goal**
The infant mortality rate per 1,000 live births.	5.8	5.5
The ratio of the black infant mortality rate to the white infant mortality rate.	1.9	1.7
The neonatal mortality rate per 1,000 live births.	3.4	3.1
The postneonatal mortality rate per 1,000 live births.	2.2	1.9
The perinatal mortality rate per 1,000 live births plus fetal deaths.	*	*
The child death rate per 100,000 children aged 1 through 14.	20.1	17
Title V - Maternal Child Health State Performance Measures	**State 2010 Results**	**State 2015 Goal**
Decrease the percent of women with a live birth who had no health care coverage for prenatal care.	6.4%	5%
Increase the percent of pregnant women and new mothers receiving support services through community home visiting programs.	16.4%	18%
Reduce unintended pregnancy in New Mexico to less than 30% of births	46.9%	45%
Decrease the percent of women initiating prenatal care after 10 weeks that did not get care as early as they wanted	48.5%	45%
Decrease the percent of middle school students that report using alcohol within the past 30 days.	16.2%	15%
Reduce the proportion of women who report being physically abused by husband or partner during pregnancy.	3.9%	3%
Increase the proportion of women who exclusively breastfeed their babies through six months.	18.7%	24%

State Population: 2,065,932
Live Births: 28,317

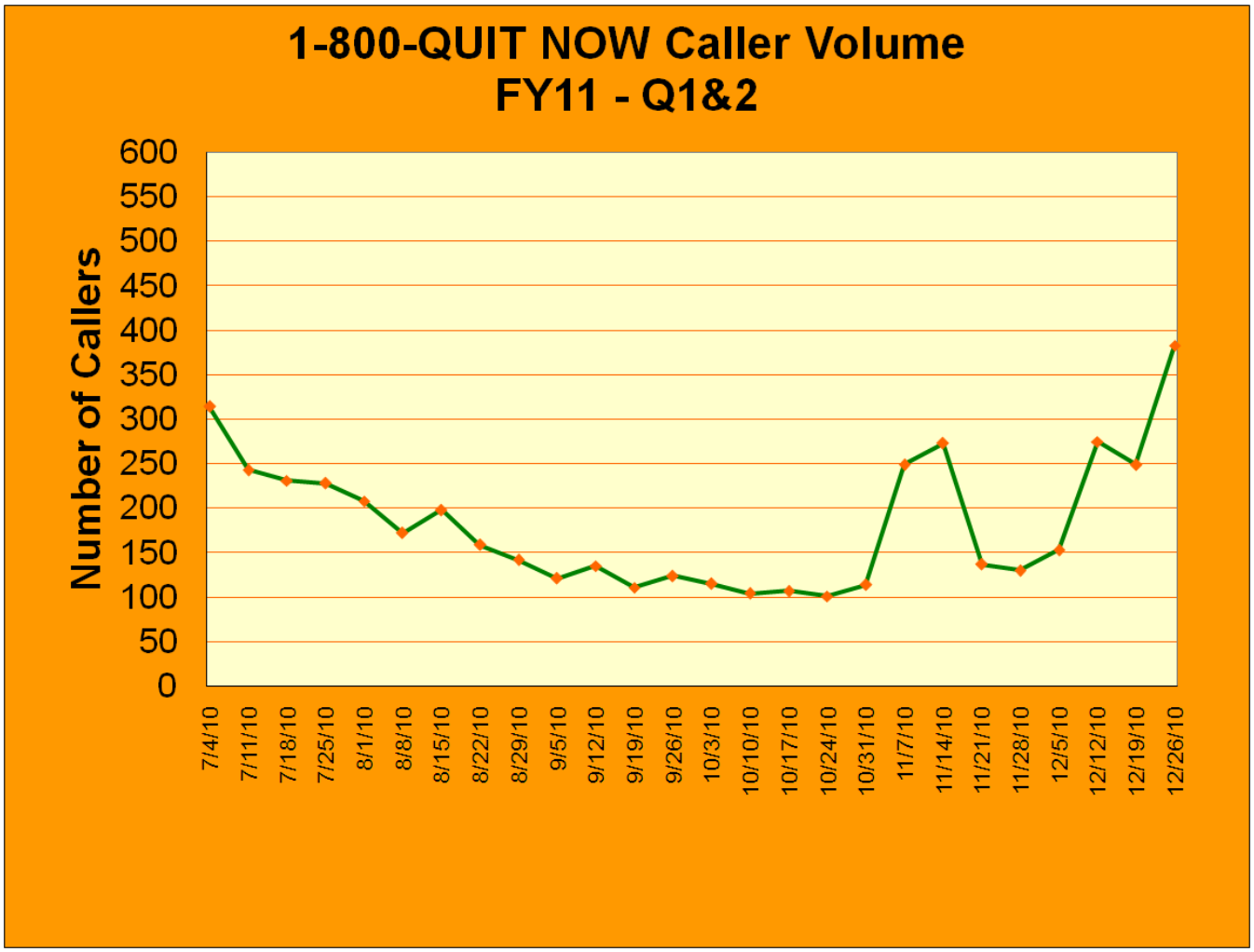
Indicators for the annual reporting year may be unavailable or provisional at the time of reporting and may be updated or finalized throughout the year. Please contact the State for details about the indicator data.

https://perf-data.hrsa.gov/MCHB/TVISReports/Snapshot/snapshot.aspx?statecode=NM

Attachment C—Performance Measures Tracked by the Public Health Division

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

Attachment D—Caller Volume to DOH Tobacco Quitline



Attachment E--*New Mexico*

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

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

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.

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

NAME	***Brief Description of the Purpose of the Group***
PHD Director's Office	
Governor's Early Learning Advisory Council	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.
Nurse Advice NM Advisory Committee	Provides information and advice to further the mission of NurseAdvice New Mexico. The NANM Advisory Committee reviews NANM'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 NANM Board of Directors for consideration.
New Mexico Public Health Association	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.
Family Health Bureau	
Certified Nurse Midwifery Advisory Board	The CNM advisory board makes recommendations to the department regarding the regulation of CNMs.
Child Fatality Review	Review child deaths
CMS Advisory Board	Advise the CMS Children and Youth with Special Health Care Needs program
CMS Newborn Genetic Screening Advisory Board	Advise the CMS Newborn Genetic Screening program
CMS Newborn Hearing Screening Advisory Board	Advise the CMS Newborn Hearing Screening program
Community Data Collaborative	Make data more widely available, data-to-action
Early Childhood Action Network (ECAN)/Early Childhood Comprehensive Systems (ECCS) State Team	A State Team is required to steer/advise 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.
Family Planning Advisory Committee (FPAC)	The purpose of FPAC is to review and approve information and educational materials used by clinics and projects supported by the Family

	Planning Program. This process ensures that these materials are appropriate for the populations and communities for which they are intended.
Folic Acid Committee/Media Campaign	Strategic planning for preconception health-related media and education; partners include HSD Medicaid and March of Dimes
Geospatial Advisor y Committee	Integrate data and geospatial technologies for state government.
Licensed Midwifery Advisory Board	The LM advisory board makes recommendations to the department regarding current standards and conduct of LM practice of LMs.
Maternal Mortality Review	Review maternal deaths
Multi-Agency Team: Council on Young Child Wellness (MAT)	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.
New Mexico Pregnancy Risk Assessment Monitoring System Steering Committee	Provide guidance for PRAMS survey revision, data dissemination and translating data to policy and program improvements
Health Systems Bureau	
New Mexico Area Health Education Centers (AHEC) Advisory Workgroup	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.
J-1 Visa Waiver Program Advisory Workgroup	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.
New Mexico TeleHealth Alliance Advisory Committee	The Alliance meets to provide technical, program support to members, and enable them to effectively share resources.
New Mexico Health Service Corps (NMHSC) Advisory Committee	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.
New Mexico Higher Education Department (HED) State Loan Payment Advisory Committee	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.
New Mexico Oral Health Advisory Council	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.
New Mexico Primary Care Association Board	OPCRH is an Ex-officio Board Member.
New Mexico Health Resources, Inc Board	OPCRH is an Ex-officio Board Member.
New Mexico Dental Support Center Dental Provider Meeting	The purpose is to provide information to rural and

	community health clinic dental providers' on the area of clinical performance improvement, and to share best practices. 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.
Clinical Performance Improvement Committee	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 clinical topics from statewide and national meetings. Data are also presented from UDS results, Patient Satisfaction Surveys and any other clinical surveys that are done.
New Mexico Provider Retreat Planning Committee	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
Health Homes and Primary and Behavioral Health Care Integration Committee	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.
State Office of Rural Health Region D Committee	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.
Quarterly Office of Primary Care Region VI Conference Calls	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.
Monthly Office of Primary Care Conference Calls	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
New Mexico State Team Conference Call	The purpose of these calls is to identify and discuss priorities, needs, opportunities, and share information on how HRSA programs and

	resources can compliment regional, state, and local resources. Additional goals of the call include fostering and strengthening collaboration on the state level, while supporting the states' ability to increase access to health care, build the health workforce, eliminate disparities, and support stakeholders in realizing the vision of healthy communities and healthy people.
Healthy Aging Collaborative	Promote senior wellness. Staff volunteers to participate on the Executive Committee.
Hispanic Advisory Committee - Optum Health	Promotes Hispanic needs for behavioral health.
NM Immunization Coalition	Increase awareness and advocacy for school immunizations
NM Coalition on Asthma	Increase awareness and advocacy for asthma
APS School Health Advisory Council	Helps guide health practices of the schools within APS
School Based Health Center Partners	Technical assistance and training guidance for school based health centers statewide
School Nurse Advisory Council	Training and technical assistance in clinical best practices for school nurses statewide
Child Fatality Review Board	Review of all suicide related adolescent fatalities, provide recommendations for improving outcomes
Prevention Policy Consortium	Planning and coordinating substance abuse prevention efforts statewide
NM Youth Risk and Resiliency Survey Steering Committee	Plan, conduct and oversee the implementation of the bi-annual NM Youth Risk and Resiliency Survey.
Managed Care Organizations Planning Council	Review and improve MCO and SBHC relationship and work.
NM Health Equity Workgroup	Promote health equity in NM, inform our communities, connect individuals, communities and organizations and act to improve health equity in NM.
Head to Toe Conference Steering Committee	Planning and implementation of the annual conference for school health personnel
School Health Educators Institute Planning Committee	Planning and implementation of the annual conference for school health education teachers
National Assembly of School Based Health Centers Annual Conference Planning Committee	Planning and implementation of the annual conference for school based health center personnel
Native American Youth Suicide Prevention Task Force	Training and technical assistance on Native American youth suicide prevention.
Healthy Weight Council	Training, technical assistance and promotion of obesity prevention
Youth Intervention, Prevention and Education in School/Communities Workgroup	Increasing positive youth development opportunities in schools and communities statewide
National Network of Adolescent Health Coordinators	Planning and coordination of adolescent health activities nationwide
New Mexico/Colorado CHIPRA grant leadership team	Leadership and guidance for the collaborative school based health center, quality improvement grant

New Mexico CHIPRA grant team	Leadership and guidance for the NM portion of the school based health center, quality improvement grant
New Mexico Community Health Worker Advisory Council	Established in 2006 as a result of senate Joint Memorial 076. Community group that advises OCHW on design & implementation of a statewide, voluntary, competency-based training & certification process for CHWs. 25 members represent all regions of the state and diverse experience in practice, training, & support of CHWs.
University of New Mexico Masters of Public Health Acceptance Committee	Review and recommend MPH candidates for acceptance into the UNM MPH Program
New Mexico/Southern Colorado Community Health Representative (CHR) Association	Promote collaboration, skill development and networking among CHR programs and stakeholders
Indian Health Services (IHS) Health Promotion Disease Prevention Health Council	Share within IHS programs and strategize around collaborative opportunities towards tribal health
Northern Promotora Committee	Promote collaboration, skill development and networking among Northern New Mexico Promotora programs and stakeholders.
Diabetes Advisory Council Native American Partnership	Promote skill development and knowledge for CHRs and other health care workers in tribal communities concentrating on diabetes prevention and control.
Southern NM Promotora Committee	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.
New Mexico Community Health Worker Association	Promote and support recognition and the professional development of community health workers across the state.
Infectious Disease Bureau	
Community Planning and Action Group	Statewide advisory and workgroup to develop strategic plan for HIV and hepatitis prevention. Required by federal funders to advise the program.
Clinical Preventive Initiative—Immunization Workgroup	Work with NMMS and community providers to address clinical issues related to promoting immunizations.
HIV Advisory Council New Mexico HIV/AIDS Treatment & Services Program	Statewide advisory and workgroup to develop strategic planning for HIV/AIDS Treatment and Services. Required by federal funders to advise the program.
Medical Advisory Board New Mexico Medical Cannabis Program	Make recommendations to Secretary of Health about conditions to be covered by the Medical Cannabis Program.
Chronic Disease Prevention and Control Bureau	
Breast and Cervical Cancer Early Detection Quality Assurance Committee	Assure quality delivery of program services consistent with clinical guidelines and CDC

	requirements. Facilitation provided by the Breast and Cervical Cancer Early Detection Program (federally-funded) Federal grant requirement.
New Mexico Chronic Disease Prevention Council	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.
New Mexico Arthritis Advisory Council	Coordinate arthritis activities statewide in order to effectively address arthritis approaches and strategies with community partners. Provide support and participation. Federal grant required.
New Mexico Cancer Council	Coordinate cancer activities statewide in order to effectively address cancer approaches and strategies with community partners. Provide support and participation. Federal grant required.
New Mexico Diabetes Advisory Council	Coordinate diabetes activities statewide in order to effectively address diabetes approaches and strategies with community partners. Provide support and participation. Federal grant required.
Colorectal Cancer Medical Advisory Committee	Assure quality delivery of program services consistent with clinical guidelines and CDC requirements. Facilitation provided by the Colorectal Program (federally-funded) Federal grant requirement.
Region 1/3	
Belen School District	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.
Resiliency Corps	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.
Midwest NM CAP	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,

	transportation, and Family and community services.
PMS Advisory Committee	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.
McKinley County Breastfeeding Taskforce	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 & raising Breastfeeding rates in McKinley County.
Valencia County Breastfeeding Task Force	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.
San Juan Breastfeeding Task Force	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.

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.

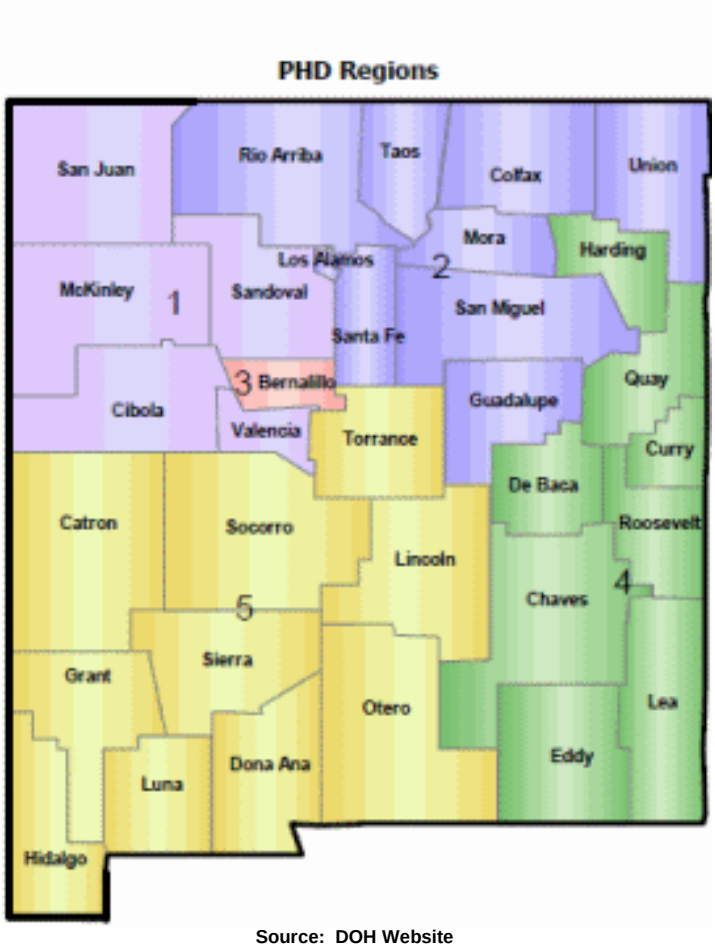
Evaluation Team.
Charles Sallee, Deputy Director
Pamela Galbraith, Lead Evaluator
Maria D. Griego, Evaluator

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

APPENDIX B: PUBLIC HEALTH DIVISION REGIONAL MAP



Source: DOH Website

Region 1: San Juan, McKinley, Sandoval, Cibola and Valencia

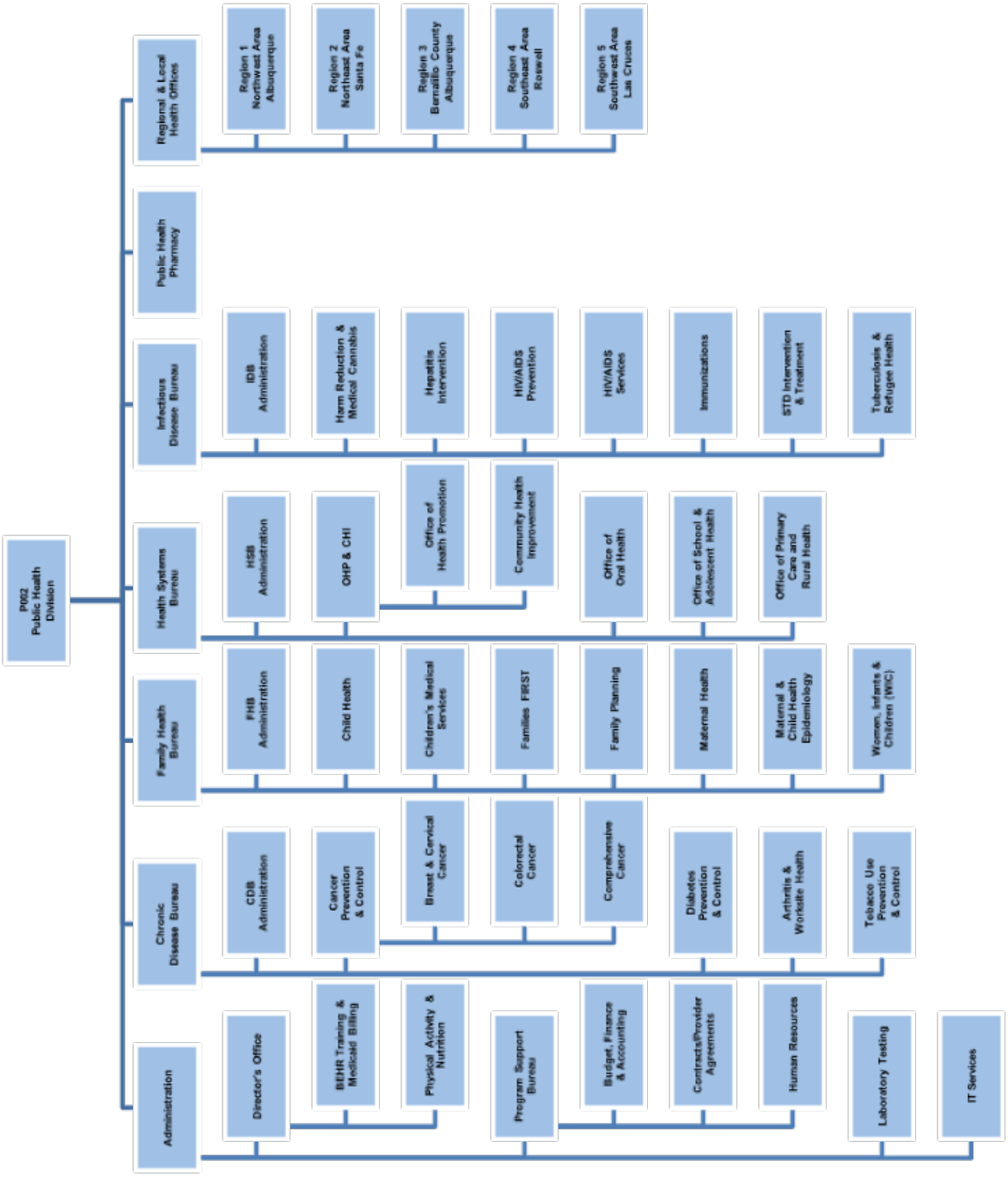
Region 2: Rio Arriba, Taos, Colfax, Union, Los Alamos, Santa Fe, Mora, San Miguel and Guadalupe

Region 3: Bernalillo County

Region 4: Harding, Quay, De Baca, Curry, Roosevelt, Chaves, Eddy and Lear

Region 5: Torrance, Catron, Socorro, Lincoln, Grant, Sierra, Hidalgo, Luna, Dona Ana and Otero

APPENDIX C: PHD ORGANIZATIONAL CHART



APPENDIX D: THREE CORE FUNCTIONS AND TEN ESSENTIAL PUBLIC HEALTH SERVICES

Essential Services

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

Core Functions

Assessment Policy Development Assurance

APPENDIX E: PERTUSSIS CASE STUDY

On October 4 DOH received a report of pertussis in a hospitalized infant. A public health nurse (PHN) at the local office contacted the parents to initiate a case investigation. The purpose of a case investigation is to confirm the diagnosis; identify others at risk (a contact), notify them of their risk and recommend steps they can take to reduce that risk; and to identify, if possible, a source for the disease, all in an effort to limit spread of the disease. For pertussis, a "close contact" is someone with any of the following exposures to a confirmed case while the case was contagious: household members; direct face-to-face contact; direct contact with respiratory, oral, or nasal secretions; or shared confined space in close proximity for $\geq$ 1 hour.)

During the conversation with the parent, the PHN established that the infant had 8 close contacts that needed antibiotics to protect them. We gathered enough information so we could notify the contacts; some were referred to their primary care providers, but for those with no primary care providers, the PHN and health officer provided medication to 15 contacts.

Of the infant's 8 close contacts, 6 had symptoms of pertussis and were also cases. All of those contacts were interviewed by the PHN. Some of the contacts were not fluent in English, so interviews were done using an interpreter, which takes more time than a direct interview.

For each of the six newly identified cases, the same process was followed.

In this example, the newly identified cases were in group settings such as schools, which added more complexity to the follow up. When cases in a group setting, such as schools or child care centers are identified, the time spent on the investigation increases dramatically. The PHN must work with the school nurse and guide her on next steps; draft notification letters to parents; identify close contacts and notify them by phone (with a letter backup); field many calls from parents and schools about other symptomatic kids; refer symptomatic contacts for evaluation and testing.

How we deal with potential exposures in childcare, school and other group settings is decided on a case-by-case basis (taking into consideration the age of the child, whether the contacts are high risk, whether there are other symptomatic people in that setting, etc.). If all children in a group setting are determined to be close contacts, then we call each parent and send them a letter in case we can't reach them by phone. These calls are made ASAP, meaning that we often work late notifying 30-40 families in a day. In the case example here, we had two classes of students to be notified: one of 15 students, and one of 20 students.

Contacts that have symptoms that might be early signs of pertussis will get a follow-up call from the PHN in 1-2 weeks to see if they meet the clinical picture of a case. If any of these contacts actually become a case of pertussis, the whole process begins again for each new case.

APPENDIX F: PRIMARY CARE CLINIC COST AND ENCOUNTER DATA

	FY10			FY11		
Clinic Name	**Encounters**	**Contract Dollars**	**Cost per Encounter**	**Encounters**	**Contract Dollars**	**Cost per Encounter**
ABQ Healthcare for the Homeless	18,166	$620,000	$34.13	15,102	$620,000	$41.05
Ben Archer	128,009	$723,000	$5.65	136,232	$723,000	$5.31
De Baca	10,478	$181,000	$17.27	10,618	$181,000	$17.05
El Centro	85,434	$1,418,300	$16.60	85,434	$1,418,300	$16.60
El Pueblo	15,060	$200,000	$13.28	13,380	$200,000	$14.95
First Choice	160,297	$1,067,900	$6.66	166,619	$1,067,900	$6.41
Guadalupe County	9,466	$130,000	$13.73	9,305	$130,000	$13.97
Hidalgo Medical Services	43,345	$320,100	$7.38	48,305	$320,100	$6.63
Jal Clinic	6,792	$98,000	$14.43	6,906	$98,000	$14.19
La Casa de Buena Salud	67,388	$750,000	$11.13	68,471	$750,000	$10.95
La Clinica de Familia	90,829	$1,179,000	$12.98	89,966	$1,179,000	$13.10
La Clinica del Pueblo de Rio Arriba	9,096	$290,000	$31.88	9,962	$290,000	$29.11
La Familia Medical Center	64,201	$941,000	$14.66	60,104	$941,000	$15.66
Las Clinicas del Norte	31,283	$680,000	$21.74	32,421	$680,000	$20.97
Luna County	4,925	$67,000	$13.60	5,487	$67,000	$12.21
Mora Clinic	5,800	$257,000	$44.31	6,123	$257,000	$41.97
Nor Lea	45,376	$225,000	$4.96	48,996	$225,000	$4.59
Pecos	13,769	$221,200	$16.07	13,961	$221,200	$15.84
PHS- Carrizozo	7,493	$99,000	$13.21	8,133	$99,000	$12.17
Presbyterian Medical Services	126,919	$1,380,000	$10.87	121,761	$1,380,000	$11.33
Quay County	4,370	$125,000	$28.60	4,685	$125,000	$26.68
SC Colfax	4,482	$69,000	$15.39	4,964	$69,000	$13.90
Torrance County	3,446	$110,000	$31.92	3,568	$110,000	$30.83
Village of Logan	4,535	$97,000	$21.39	5,074	$97,000	$19.12
Women's Health Services	12,077	$258,500	$21.40	12,644	$258,500	$20.44

APPENDIX G: PRIMARY CARE CLINIC PRODUCTIVITY DATA

Clinic Name	FY10			FY11			Year Over Year Change Encounters	Year Over Year Change Unduplicated Clients
	Encounters	Unduplicated Clients	Encounters per Client	Encounters	Unduplicated Clients	Encounters per Client		
Albuquerque Healthcare for the Homeless	18,166	4,233	4.3	15,102	4,065	3.7	-3064	-168
Ben Archer	128,009	34,524	3.7	136,232	34,885	3.9	8223	361
DeBaca	10,478	2,776	3.8	10,618	3,116	3.4	140	340
El Centro	85,434	20,299	4.2	85,434	20,299	4.2	0	0
El Pueblo	15,060	4,724	3.2	13,380	4,585	2.9	-1680	-139
First Choice	160,297	54,903	2.9	166,619	61,711	2.7	6322	6,808
Guadalupe County	9,466	685	13.8	9,305	759	12.3	-161	74
Hidalgo Medical Services	43,345	3,199	13.5	48,035	13,572	3.5	4690	10,373
Jal Clinic	6,792	1,328	5.1	6,906	1,481	4.7	114	153
La Casa de Buena Salud	67,388	18,953	3.6	68,471	21,594	3.2	1083	2,641
La Clinica de Familia	90,829	27,527	3.3	89,966	27,898	3.2	-863	371
Rio Arriba	9,096	2,679	3.4	9,962	2,898	3.4	866	219
La Familia Medical Center	64,201	14,796	4.3	60,104	12,606	4.8	-4097	-2,190
Las Clinicas del Norte	31,283	10,243	3.1	32,421	9,207	3.5	1138	-1,036
Luna County	4,925	2,341	2.1	5,487	2,358	2.3	562	17
Mora Valley Community Health Center	5,800	1,716	3.4	6,123	1,273	4.8	323	-443
Nor Lea	45,376	14,590	3.1	48,996	15,565	3.1	3620	975
Pecos	13,769	3,436	4.0	13,961	3,443	4.1	192	7
PHS- Carrizozo	7,493	3,836	2.0	8,[133]	2,165	3.8	640	-1,671
Presbyterian Medical Services	126,919	46,063	2.8	121,761	40,350	3.0	-5158	-5,713
Quay County	4,370	1,484	2.9	4,685	1,458	3.2	315	-26
SC Colfax	4,482	1,678	2.7	4,964	1,546	3.2	482	-132
Torrance County	3,446	1,246	2.8	3,568	1,156	3.1	122	-90
Village of Logan	4,535	1,087	4.2	5,074	1,426	3.6	539	339
Women's Health Services	12,077	4,199	2.9	12,644	4,495	2.8	567	296

APPENDIX H: HRSA REPORTING REQUIREMENTS FOR FQHCs

Each year HRSA health center grantees are required to report core set of information that is appropriate for monitoring and evaluating performance and for reporting on annual trends. The UDS is the vehicle used by BPHC to obtain this information.

- Patient counts by age and gender, race, and ethnicity.
- Patient counts by income level and third party insurance source.
- Patient counts for special population groups (individuals experiencing homelessness, migrant and seasonal farm workers and their family members).
- Staff full-time equivalents by position, and encounters and patients by provider type and service type.
- Data on selected primary diagnoses for medical visits and selected services provided.
- Data on prenatal care program pregnant and postpartum women patients and their newborn infants.
- Direct and indirect expenses by cost center.
- Revenue from service to patients, including charges, collections and allowances by payor as well as sliding discounts and patient bad debt.
- Other revenue.

APPENDIX I: FY13 PHD PERFORMANCE MEASURES

FY13 PHD

Performance Measures

- Percentage of preschoolers full immunized
- Number of teens 15-17 receiving family planning services
- Number of eligible women, infant and children receiving services
- Number of HIV/AIDS prevention interventions
- Percentage of individuals re-enrolling in syringe exchange who are not sharing syringes
- Number of syringes returned
- Percentage of individuals diagnosed with primary or secondary syphilis
- Number of participants in youth suicide prevention and outreach activities
- Percentage of children enrolled in Medicaid receiving dental services
- Number of calls to 1-800-QUIT Now helpline
- Number of visits to school health centers